EMTA State of Training Report: 2023

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Executive summary

"The objective of the EMTA survey is to promote parity and quality within EM training. The data highlights areas of good practice that may be worth sharing, areas of weakness that may be worth attention and can start to inform further exploration on how to improve training… faster. Many of the questions link explicitly to RCEM TSC's own quality standards"

Background:

The annual EMTA survey has been running for 6 years. It is led by a select group of data specialist trainees within the EMTA committee using the GDPR–compliant REDcap system. It has been co-designed with trainees within the committee and stakeholders within RCEM committees. The data contained within this report aggregates or compares 2021/22 and 2022/2023 data formed from a total of 1722 responses. Delays in analysis and reporting relate to the extensive nature of the data and the granularity within.

This survey provides the best opportunity for EMTA and subsequently, RCEM, to understand the key issues facing emergency medicine trainees across the UK. Particularly where the GMC survey lacks specificity. Each year we have our core questions, supplemented with additional questions on recent topical themes and developments. Questions are informed by the EMTA committee and many other key RCEM committees relating to their area of specialist interest. Alongside the GMC data we are able to identify key areas of concern. This in turn informs our advocacy priorities moving forward.

Most notably, the survey provides clear but extensive data to help both RCEM, and even local training sites facilitate positive change.

Dissemination:

The survey data is formatted into a report presented to RCEM council and cascaded to all other relevant RCEM committees. The report is accessible to trainees and trainers through the EMTA website and promoted via regional whatsapps, newsletters, school emails and social media. We later publicise the findings and recommended improvements, through infographics on EMTA branded social media.

The data is also presented at National conferences including the EMTA annual conference, with a significant update due on 27-28th Feb 2024 as well as RCEM ASC 2023.

EMTA is in the mid-stage development of a data dashboard and regionalised league tables to help regions benchmark themselves against each other and the national average. With the next round of data it will be possible to provide data at a Trust level.

The data will be formatted to report on trends with the third round of data collection to take place from February 28th 2024 for 2 months.

Key issues:

- Significant number of trainees are LTFT with 80% WTE being the most popular option. Worryingly the GMC data highlights that EM trainees are consistently at the highest risk of burnout. 14% of LTFT rotas are still not adjusted pro-rata leading to many lost teaching opportunities for trainees unfairly affected.
- Whilst 7 in 10 trainees report their post-meets their training needs, 3 in 10 do not. 17% disagreed with the statement "my post meets my training needs" in 2022; up from 14% in 2021.
- Significant numbers of trainees reported they had no senior leads for US, QI, simulation and research within their departments. Even in cases where there were such leads, many selected that they did not add value to training in post. For USS specifically, it is concerning that more than 2/3rds of trainees do not feel the entrustment scales used by trainers accurately reflect skill levels.
- Lack of exposure to minor injuries and paediatrics remains a perpetual problem, with more than a 1/3rd of trainees reporting they see adults and children with minor injuries rarely or never.
- People's interpretations of the definitions of bullying, harassment, incivility and undermining may be different, but they are universally negative experiences. There is a clear indication that these negative experiences are disproportionately experienced down a hierarchy gradient. 35% of trainees have reported this affecting their patient care.
- The vast majority of trainees felt their TPDs and HoS were approachable and supportive however their appears to be significant variation between regions and a significant gap between the bottom and top 5 regions for this variable.
- Despite challenging environments many trainees felt there was a "proactive teaching culture" within their department. We have seen an increase in access to simulation. The majority of trainees reported their FEGS to be useful, accurate and fair.
    - There is a clear correlation between reports of proactive teaching culture and the availability of teaching sessions per fortnight. This could provide an objective marker of local quality and TPDs, HoSs and TSTLs could promote a minimal level of teaching opportunities.
- There is significant variability between regional reporting on EDT provision.

Action points for discussion and Council:

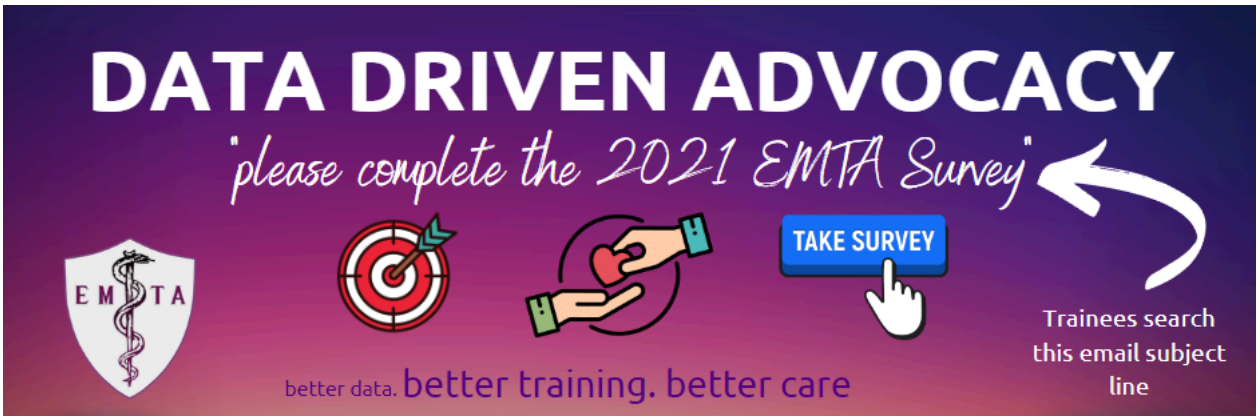
- **EDT** - The provision of Education Development Time has been well received by trainees. Unfortunately, there are significant issues with the parity of provision. We need to ensure that this time is honoured especially on the backdrop of burnout, increased portfolio evidence and curriculum requirements.
- **Exams** - EMTA recognises the huge multiphase work done by the exams team in the last 2 years and how this has markedly improved the exam process for trainees. We note the change from Pearson Vue as the main supplier is imminent in 2025 also. Continued transparency is imperative and we expect to see trust levels increase in future surveys.
- **Paediatrics** - Overall EM trainees are much less confident dealing with sick children than with sick adults. Paediatric arrests, sick neonates and emergency deliveries are high acuity but very low occurrence events; so a simulation programme would be beneficial and could improve general trainee confidence with managing these.
- **Curriculum support** - QI, simulation, research and US training provision remains highly variable.
- **Incivility**. Reporting rates remain high. Ongoing work with RespectED and other activity need to be reinforced. The worst of incivility, such as bullying, is typically perpetrated along a hierarchy gradient thus requiring better self-policing within the senior and consultant bodies.
- **Parity in Training** - All departments are under significant pressure and whilst this is not uniform, nor is the number of Consultants and trainees within a department, the variation in training cannot be excused by demands. This is demonstrated by many still delivering thriving training environments and experiences.
- **Promoting engagement -** This survey takes approximately 15-20 minutes to complete. If slots were given during regional teaching, especially amongst core trainees who engage less, we could see better participation which would improve the data's validity. Page 15 highlights regions with the lowest response rates which will reduce the reliability for these regions.

Introduction

This report summarises data from the EMTA 2021-22 Surveys. Over the 2 years, we have had 1,722 responses from at least 158 Hospitals with a similar distribution in characteristics such as age, gender, grade, LTFT and geography. Between 2021 and 2022 overall statistics have been broadly similar (as we would expect year to year) and where a shift has occurred it will be stated. This report will build upon the EMTA 2021 infographic-based report to reinforce positive and negative deviance. To build upon 2021 summary statistics this report will specifically add more detailed commentary on regional variations to provide Heads of School and Training Programme Directors (TPDs) with potential focus areas for improvement and opportunities to share where they excel to promote good training practices across the UK.

Since 2021 we have started to develop an EMTA Training Survey Data Dashboard and regional league tables. This is mid-stage work informed by the data, our committee and conversations with stakeholders across RCEM. This will need further refining through qualitative research to weight the most important markers of good training and focus limited resources on that which will produce the most value.

The next round of data collection will begin to explore trends in training and is to coincide with our 2024 Conference (February).



Objectives and Drivers

The primary drivers of this work are to

1. improve training standards, faster, for Emergency Medicine Trainees through ***data-driven advocacy*** to change policy around training delivery at RCEM, NHS Workforce, AMRoC and GMC levels.
2. improve equitability of training so that delivery is fairer throughout all regions - 'no trainee left behind '.

This report and our survey will work towards this by gathering and summarising evidence from trainees to identify and share good practices to develop policy and interventions to support the;

- Maximisation of learning opportunities, the quality and **equitable** delivery of training
- Improving **retention** of existing trainees through better working experiences
- **Sustainability** of working lives in Emergency Medicine
- Promoting **flexibility** for trainees to develop specialist interests
- **Communication and transparency** between RCEM, EMTA and the training body to promote better policy and trust amongst our members.

We have updated the EMTA Survey with the intention of demonstrating trends and changes over the next 5 years as trainees and the College adapt to the RCEM Curriculum 2021. We hope to refine and improve the survey but keep questions consistent to aid comparisons in the future.

The report and survey builds upon the data collected in the EMTA Surveys of 2015, 16, 18 and 19. Due to the pandemic, a survey was not conducted in 2020. The new EMTA Survey is designed to not duplicate other data sets such as the GMC's National Training Survey (NTS) where possible. The NTS is extensive and the data captured requires distillation to communicate issues highlighted to a broader audience - particularly those with the power to alter policy affecting trainees.

Commentary on training data and this survey more broadly

EVIDENCE-BASED TRAINING POLICY

The volume of data collected on trainees is staggering, but the utilisation of it is still insufficient or at best, poorly communicated. Going forward RCEM and the NHS need to explore how to resource their trainee advocates, with the NHS National Education and Training Survey, the GMC survey and our own speciality-specific survey not yet being utilised in a way that optimises the decision-making and resource allocation at local, regional and national levels.

Collectively this data could provide a comprehensive overview of the 'State of Training' in EM in collaboration with the RCEM Dean, Training Standards committee and NHS workforce. After all, it is the trainee advocates who have lived experience, domain knowledge and the most to gain from this being done well. The involvement of trainees in decisions in this space is akin to involving patients in healthcare system design and research.

The digitalisation of society and increasing use of data is occurring at pace and RCEM needs to consider how it prepares to become a data-fluent organisation. EM workforce wellbeing and retention is a James Lind priority and whilst trainees are at the sharp end, understanding pressures here can have wider workforce implications. Growth of this work may include qualitative methods to build upon our understanding of what are the best metrics of EM training and continue to understand how to improve things and potentially more importantly, the barriers to them. Data is being increasingly used to inform College advocacy for the Emergency Medicine profession and our departments to great effect. RCEM already leads in many aspects of the training sphere too with a wealth of expertise in human-factors, developments in critical appraisal, Quality, Ultrasound, Simulation and the expansion of EDT as a most recent example, but there's always more to be done. How it is done, is an important question to, with evolving governance to improve decision-making, as best demonstrated by the incorporation of EMTA into RCEM in a way that shows we are valued and important contributors and leaders.

With the high rates of burnout (fig. 1), a staggering 'need-for-recovery'[1] and attrition especially at ST3 transition, it is now more crucial than ever that we develop our data-driven decision-making to improve trainee wellbeing, organisational transparency and membership engagement.

Collaboration and a clear vision are required in equal measure if we are to lead in becoming data-fluent in matters related to training, retention and well-being.

Supporting insight through data visualisation

We are keen to support trainers at local, regional and national levels to be able to better engage with the data to bring their own scrutiny, analysis and ideas to the space. We hope to increase the value of the survey and in turn, receive reciprocal support by encouraging completion of it locally.

Naturally, being at the bottom can be quite triggering, especially for medics who pride themselves generally, in quiet the opposite. The reaction from a leader(s) found in this position is usually defensive. We would encourage reflection and a focus on how to improve things, rather than a defence of the current track record which we and most trainees, are not particularly interested in or even questioning. WE are simply presenting the data as it has come through.

Whilst there will no doubt be biases in the data, and imperfections, as with any survey, the difference between regions that have otherwise very similar characteristics by way of respondents' grades, demographics and data collection period cannot be credibly explained away by imperfection in our methods alone. Where big differences exist and persist, this is likely to represent ground truth.

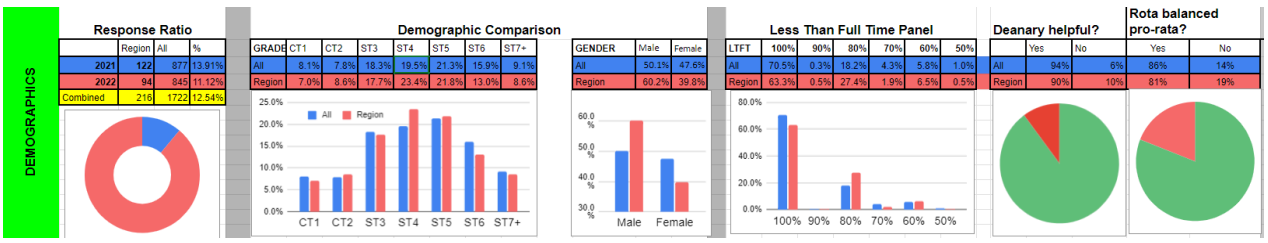
This data however may have been handled imperfectly too and where there are large differences we invite additional review before any actions are taken as part of natural due diligence. We will provide specific data as requested to support this process and support and perform an additional data check ourselves.

Dashboards

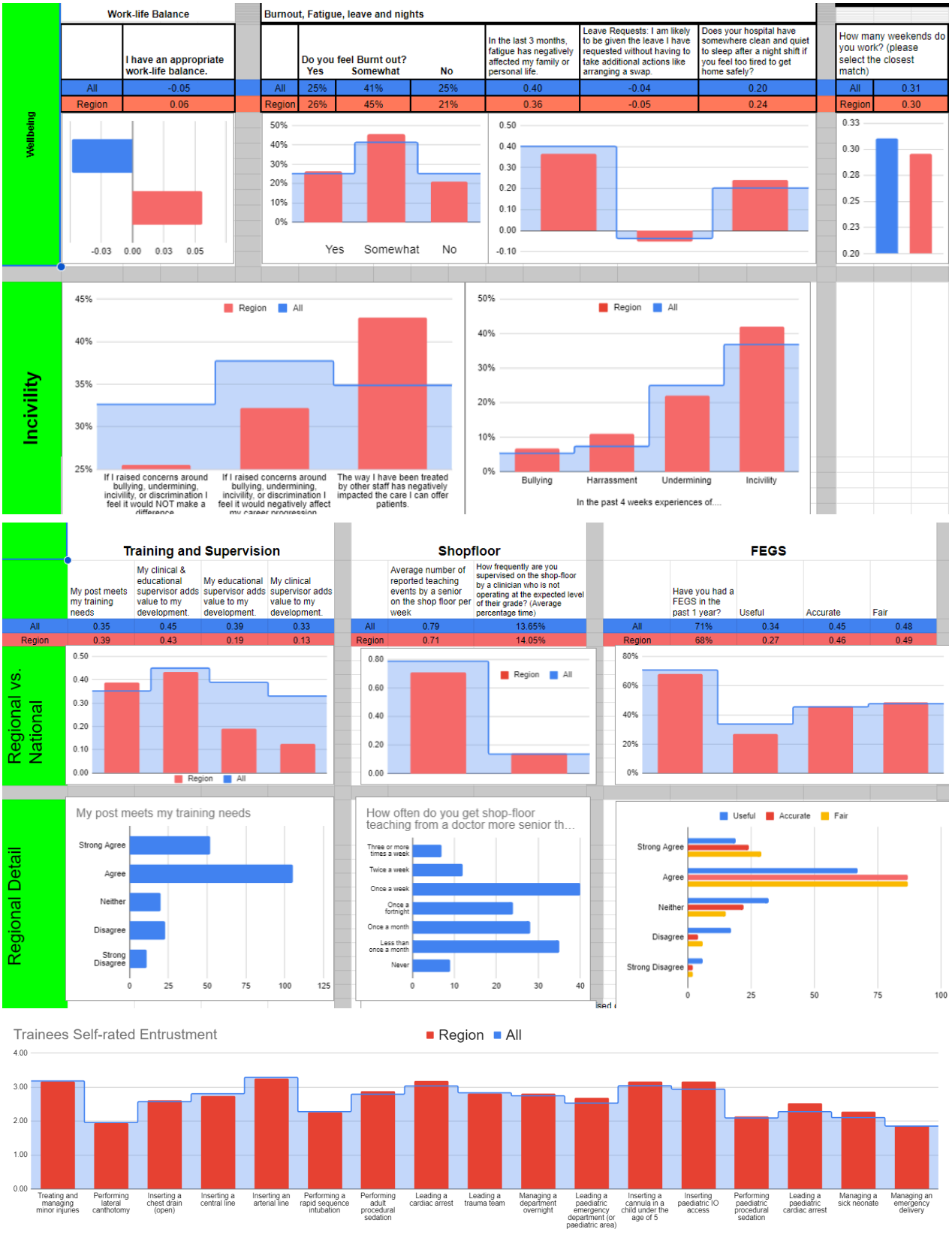
Dashboards are being used increasingly to present data as a form of intelligence. However, doing a dashboard well requires presenting the relevant information in an easy-to-understand format. At present these mock-up dashboards are an early prototype and require refinement through engagement with stakeholders and trainees. As well as supporting qualitative work or research. These currently cover multiple items with **RCEM TSC's own Quality Standards.**

A full exemplar dashboard can be seen here - Please note the tabs at the bottom breaking the data down by demographics, incivility, supervision, leadership, teaching, training exposure and self-rated EM skills. You may comment on the dashboard to support development.

The current dashboard is formatted so the top row of graphs helps compare a region to the average of all other regions and the second row provides their region's granular data. The plan is to add a new top row that demonstrates their three-year trend against the comparator group.



Dashboard Screen shot Demo



League Tables

The current league tables is a crude representation of the data to support comparison. However, the "ranking" are in no way weighted based on importance but demonstrates how the data could be further arranged to support insight generation. Combining qualitative research could support developing weighting based on importance and impacts to better understand performance where it matters.

The below figure is a redacted league table of 7 of the 15 regions including the 4 nations. This combined 2 years of data and could provide a moving average going forward. The two central columns of numbers represent the total data set average and an average of the regions if they were equally weighted.

Responses	8	**870**	57	44	98	34	132	114	27	78
LTFT Average	8	**88.5%**	89.9%	90.2%	90.6%	87.9%	85.8%	85.8%	97.8%	84.4%
Rank				**15**	**9**	**12**	**10**	**6**	**2**	**1**
Supervision and Training				15	11	14	10	7	2	1
Teaching				12	9	10	7	8	6	5
Valued Leadership				13	5	15	12	9	4	1
Wellbeing				15	14	12	9	8	3	2
Incivility				15	4	12	10	11	2	1
EDT provision				14.84	14.37	14.58	12.34	17.76	21.00	15.91
Supervision and Training										
My post meets training needs	3	**36%**	39%	31%	34%	33%	34%	34%	50%	55%
My deanary contributes positively to my learning n	4	**47%**	50%	33%	40%	37%	39%	61%	69%	74%
My clinical supervisor adds value to my training	4	**45%**	47%	42%	42%	40%	45%	39%	54%	49%
My educational supervisor adds value to my trainir	4	**44%**	46%	33%	43%	38%	46%	39%	54%	49%
Quality of FEGS	4	**41%**	42%	31%	44%	38%	39%	39%	51%	40%
Inappropriate supervision	2	**24%**	23%	27%	27%	20%	19%	27%	16%	14%
Quaity Improvement	3	**31%**	31%	16%	32%	22%	32%	33%	33%	55%
US - Supervision	4	**40%**	38%	36%	39%	42%	44%	42%	45%	38%
US - Diagnostic Scans per week	2	**2.72**	2.57	2.88	3.17	3.11	3.44	2.69	2.05	1.12
Research - Opportunities	5	**59%**	58%	66%	58%	39%	63%	51%	52%	74%
EDT time (hours)	1	**17.4**	18.4	16.4	15.9	16.6	14.4	20.7	21.5	18.9
EDT - On vs Off the shop floor flexibility	8	**89%**	87%	80%	87%	91%	91%	96%	92%	95%
Teaching										
Teaching culture	3	**32%**	36%	27%	37%	32%	39%	29%	39%	60%
Teaching session availability (per fortnight)	1	**1.39**	1.38	0.77	1.45	1.29	1.84	1.57	1.26	1.85
Shop floor teaching (per week)	1	**1.04**	1.07	0.79	1.21	0.76	0.96	0.98	1.18	1.16
US - Local Teaching (Y/N last 3 months)	5	**51%**	58%	43%	35%	71%	57%	35%	82%	77%
Simulation - Local Teaching (past 6 months)	1	**1.27**	1.38	1.07	1.13	1.03	1.61	0.97	1.30	1.51
Simulation - Regional Teaching (Past 6 months)	0	**0.62**	0.80	1.03	0.53	0.59	0.41	0.58	0.81	0.33
Journal club availability (per month)	0	**0.72**	0.70	0.53	0.63	0.84	0.52	1.16	0.63	0.48
Valued Leadership										
Local Ultrasound	5	**51%**	54%	50%	45%	53%	58%	48%	60%	65%
Local QI	4	**44%**	45%	40%	55%	25%	39%	43%	32%	50%
Local simulation	3	**36%**	37%	20%	49%	22%	29%	45%	42%	66%
Local Research	2	**27%**	28%	26%	35%	23%	19%	10%	22%	36%
TPD (Approachability and Supportiveness)	5	**57%**	63%	61%	54%	43%	54%	67%	88%	93%
Wellbeing										
Work-life balance	-	**-3%**	-5%	-18%	-1%	-4%	-7%	7%	12%	-3%
Fatigue negatively affecting personal life	4	**43%**	45%	43%	28%	34%	45%	41%	46%	41%
Annual Leave	2	**25%**	27%	-4%	9%	28%	26%	24%	34%	59%
Weekend intensity	0	**0.31**	0.31	0.31	0.32	0.30	0.29	0.29	0.32	0.30
Incivility										
Bullying	6	**6%**	5%	10%	9%	6%	8%	8%	4%	3%
Harrassment	9	**9%**	8%	15%	7%	9%	7%	13%	12%	3%

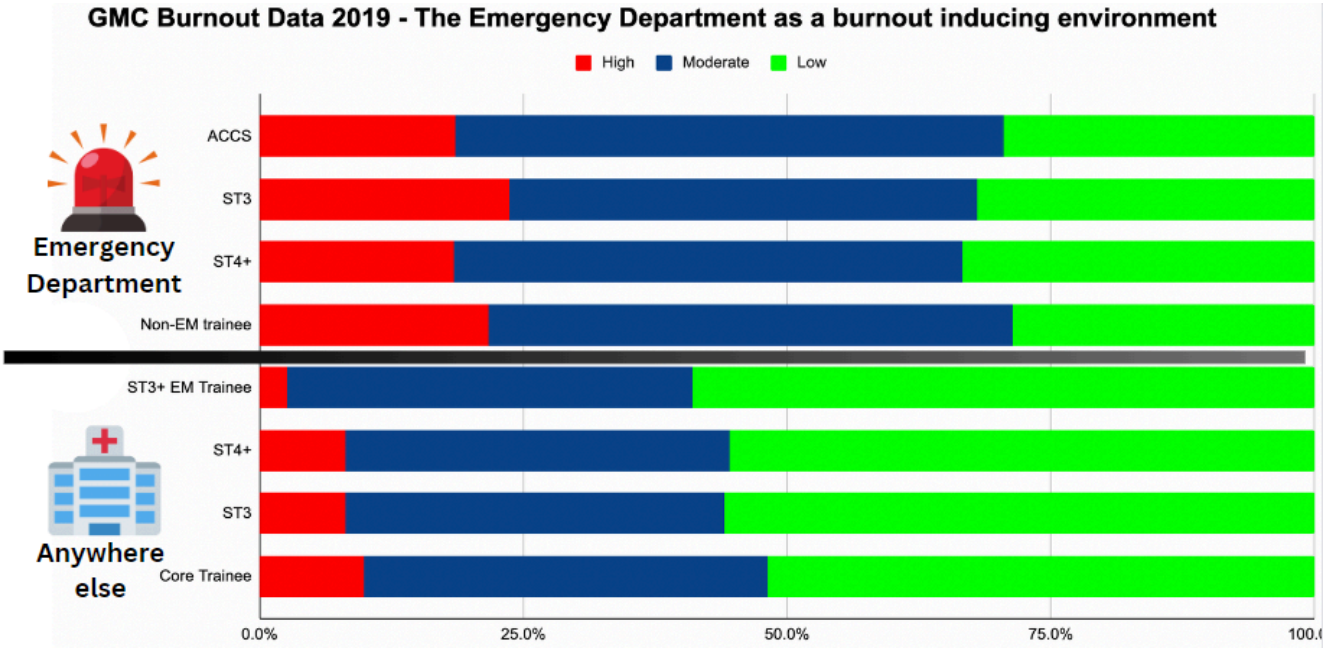
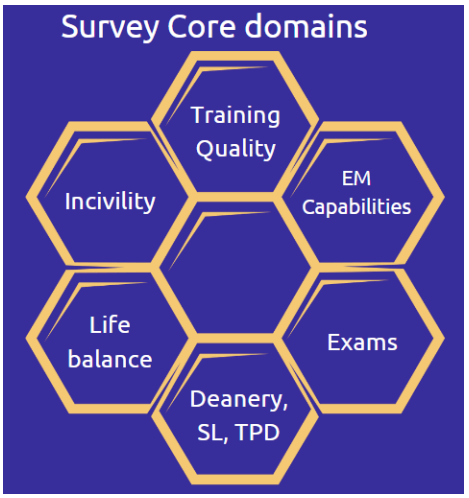


Figure 1 - GMC Data 2019 - Burnout comparison by working environment and grade.

Burnout, workload and negative experiences have only been reported in higher volumes in subsequent surveys.[2] A revised 2023 version of this chart is currently in production by the GMC

Methodology



Domain and Question Selection: Questions were selected and categorised based upon the structures used in the previous EMTA Survey, the GMC National Training Survey and the RCEM committee organisation. The value gained by including each question was weighed up against the burden placed on participants by including more questions. The GMC NTS Team and Statisticians kindly analysed the GMC 2019 pre-pandemic data to provide additional information on the questions within their 200 set which had the strongest association with the Copenhagen Burnout Inventory. This helped us determine high-level domains to group questions under. **We also reviewed and linked these to TSC Quality Standards (Appendix iten 1)**

Inclusion Criteria: Open to all UK trainees specialising in Emergency Medicine on the nationally recognised training programme. This includes trainees undertaking time out of programme (OOP), less than full-time training (LTFT) and maternity leave.

Distribution: Primarily via email addresses stored by the RCEM with 5 reminder emails spaced 2 weeks apart. The survey was promoted and participation was encouraged via Twitter, Facebook, WhatsApp, RCEM Learning Podcast, our Conference and App.

Data Collection Period: Winter each year.

- 2020/21 - November 24th - 5th January
  - launched at the EMTA 2021 National Conference (Online)
- 2021/22 December 6th - February 10th
  - launched on the December episode of the RCEM Learning Podcast
- 2024 - Launching at the EMTA conference on February 28th 2024

Platform: We used REDCap, a GDPR-compliant and secure data capture tool to conduct the survey and store the data. Data was analysed in Microsoft Excel, to calculate descriptive statistics. All analysis was decoupled from personally identifiable information (email addresses).

Question types: The questions continue to use free text, binomial, rank order and 4 and 5-point Likert scale responses, and were designed with reference to published guidelines.

Piloting and Quality Control: The survey development team designed the revised survey over the course of 2020 and consisted of a core committee including the Data Lead, Chair, immediate past Chair, TERN Fellow and Research and Publication EMTA representatives. This team met monthly.
Questions were peer-reviewed by trainees on the EMTA committee with specific consideration from the Wales, Scotland and EDI representatives to maximise inclusion and applicability across the region.

Specific areas of the question set were co-developed with

- Research and Publication Committee (Research set)
- PoCUS SIG (Ultrasound set)
- Sustainable Working Practices Committee (Wellness and incivilityset)
- QI subcommittee (Quality Set).

It was also sent to other members of the RCEM Executive for comment including the President and Dean as well as Training Standards and the Head of Quality for TSC at the time.

The Survey was piloted by members of the committee to test the time to complete and the final feedback was incorporated to improve flow and question order for a better user experience. Not all questions were compulsory.

Question changes going into 2023

Additions	Rational
Overall Job Satisfaction	Following discussion with Simon Carley, overall satisfaction, may provide a good comparator to see if specific variables correlate to help determine which factors are of greater importance. We currently have "my post meets my training needs" which is training-specific.
Actual contracted hours	To evidence regional variation in the hours required for "Full-time" training and LTFT training, resulting in discrepancies between regions in how much time a trainee has to do before they can CCT.
If LTFT, what is the FTE contracted hours if known	
Emergency Capabilities - Resuscitative Hysterotomy and Thoracotomy	Explore confidence in delivering some of the rarest procedures within our curriculum
Scale 1-10 how challenging is getting WPBA assessments signed off in your placement?	Interesting to trainers and training leads. Many trainees find themselves often chasing basic sign-offs creating stress and making their training and portfolio requirements feel deprioritised
Updating the Disability question to include long-term conditions and mental health	Many do not consider themselves disabled but have illness or neurodivergency / mental health challenges. <5% considered themselves disabled but illness and other aspects will be higher and more reflective of the

	ground truth
Dual Trainees only - Potentially free text - Have you noticed how specialities and others speak differently to you depending on whether you are wearing you ED hat or ICU hat	Dual trainees note anecdotally a remarkable difference in how they are spoken to depending on how they introduce themselves. The rate of reporting around difficult referrals remains high and understanding how much of that is related to how ED is seen as a professional group is in itself, interesting.
Consider / Minor Amendments	Rational
Granularity regarding caring responsibilities e.g. single parent, disabilities, children or adults +/- Pregnancy Status	Pregnancy is a protected characteristic. Trainee story regarding difficulty following a need to adopt due to family issues and becoming a single parent
Adding Divorced, Widowed, Living With Partner to Relationship Status	11 selected prefer not to say as the current categories might not fit their circumstances
Overall trust in RCEM	Trust is a critical marker of a membership organisations communications and decisions. We currently ask about trust in RCEM examinations, and this will no doubt be linked. We have seen the huge drop caused by the significant error as expected. However decisions re: membership and FRCEM, exams and public statements will all affect this overall rating. This would be of greater use to RCEM than EMTA and may be better in a general members survey.
Questions on the PA issue	Extremely topical and important to the membership. Could actually increase general participation in the wider survey if it is demonstrated to include areas of focus that they deem important.
Optional section related to an external piece of work around rotas - Add at the end.	The EMTa survey has good participation >800 per year. Related work and research could use this to deliver on their own focus areas that are relevant to EMTA's mission statement. The GEM section on the 2021 survey had 600 continue and complete it despite being entirely optional and having already complete approx 15-20 minutes.
For the incivility section do we ask which staff group are the perpetrators?	Women report much more undermining and uncivil behaviour being experienced. This may be partly down to anecdotally known issues with female-feamle interactions across power gradients that are often reported by younger female doctors.
Remove	Rational
All things related to strikes	Done as a one-time thing
GEM Question set	One time only.

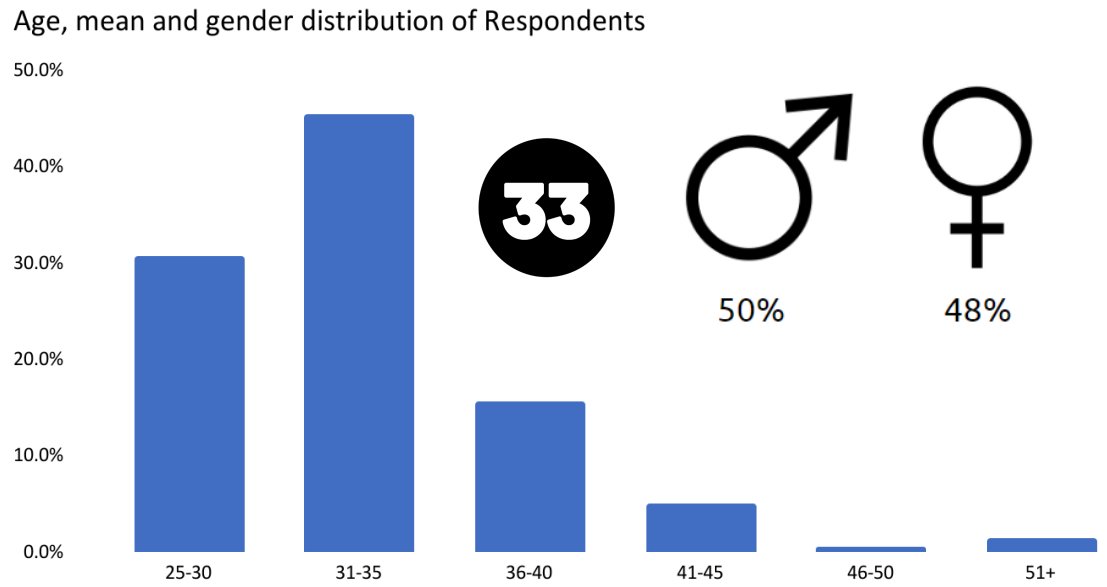
Data Analysis and Synthesis

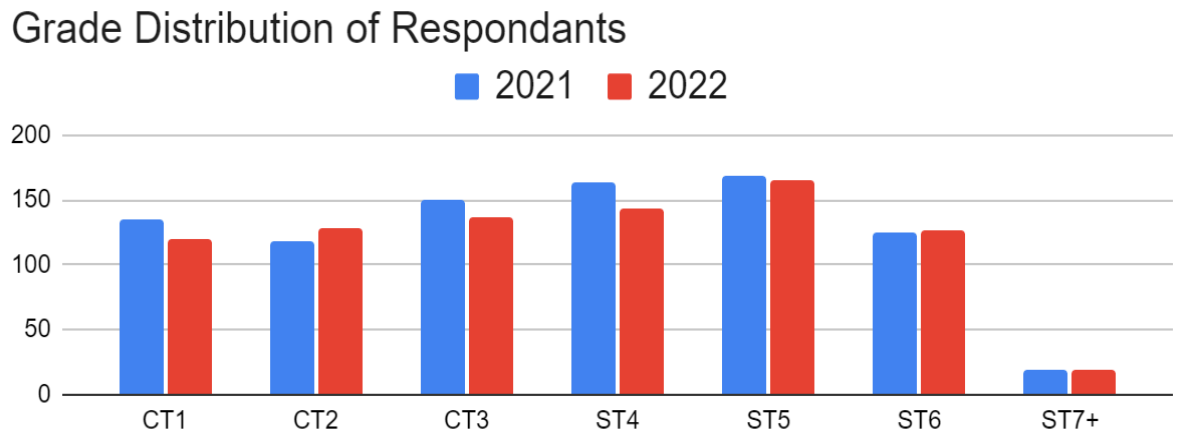
Participation: A total of 1,722 responses were collected over the 2 cycles.

- 877 in 2021 - **Approximately 46%**
- 845 in 2022

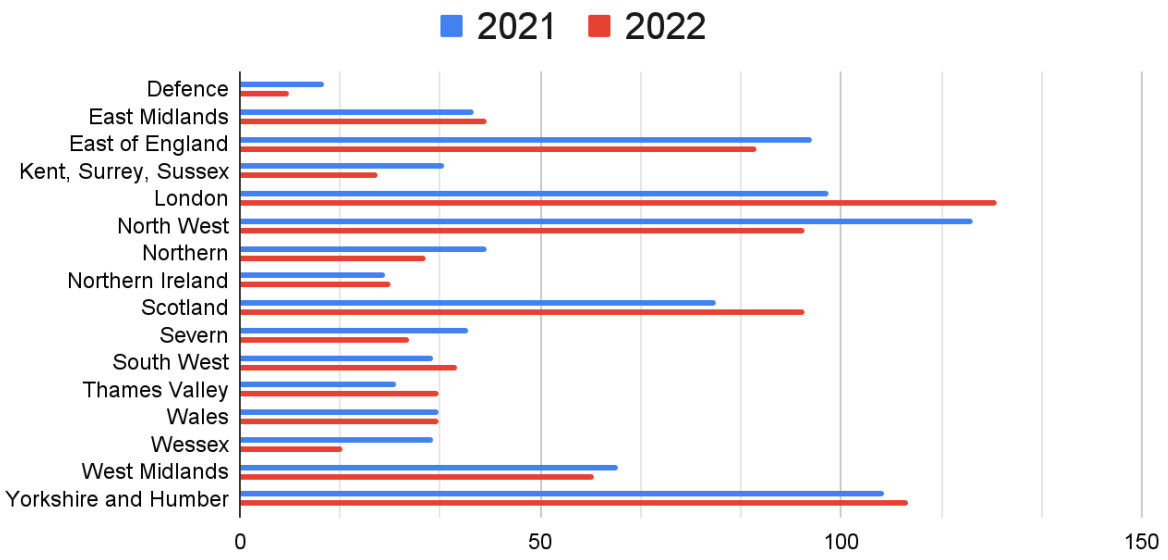
A difference of greater than 5% between years with samples this size may be of statistical significance. This will be highlighted.

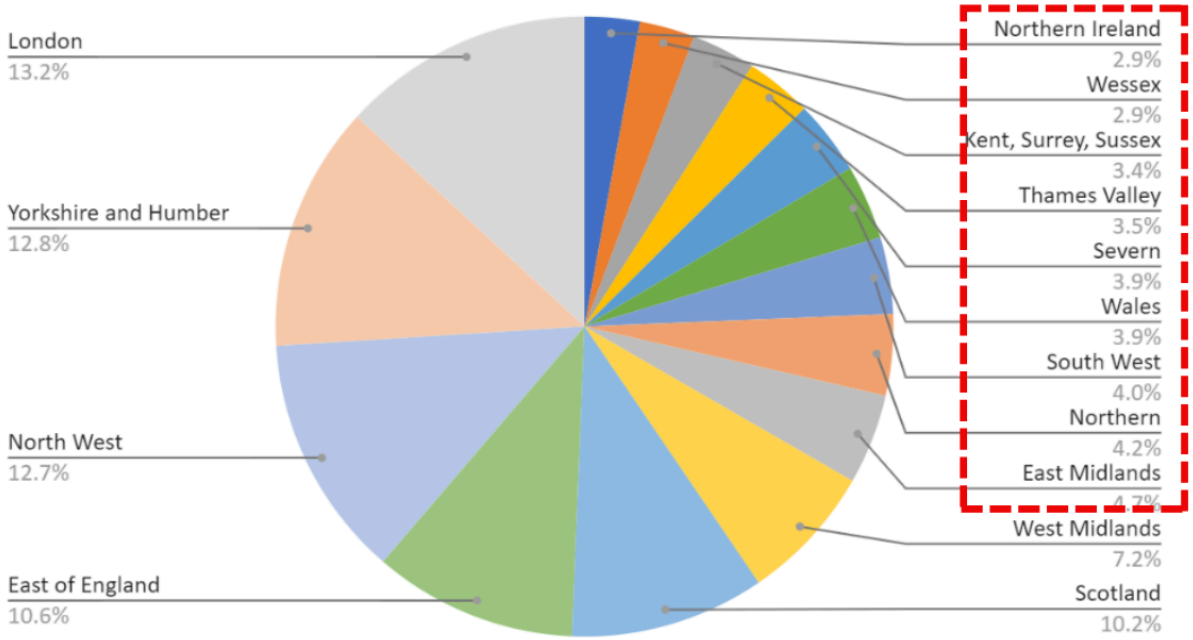
Demographics





Distribution of response by region absolute numbers and as proportions of the data

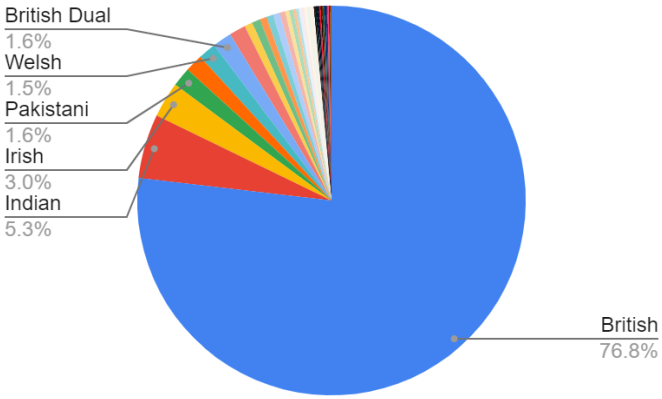




Whilst the distribution does mirror the size of deaneries there was a range of approximately 1 in 3 and 2 in 3 participating. This in part reflects the presence of EMTA representatives in each region and local levels of engagement with us too. We will work to specifically improve EMTA representation in deaneries in the bottom third (red box on graphic).

Distribution of protected characteristics among the respondents

The Equality, Diversity and Inclusion section was optional and conducted at the end of the survey. 1328 agreed to complete this, 77% of the total respondents. There was a fall of 8% between 2021 and 22. This may represent the lack of specific reporting on this data thus far. A deeper dive into the data and potential relationships with other core outcomes is to be had after the 3rd iteration of collection.



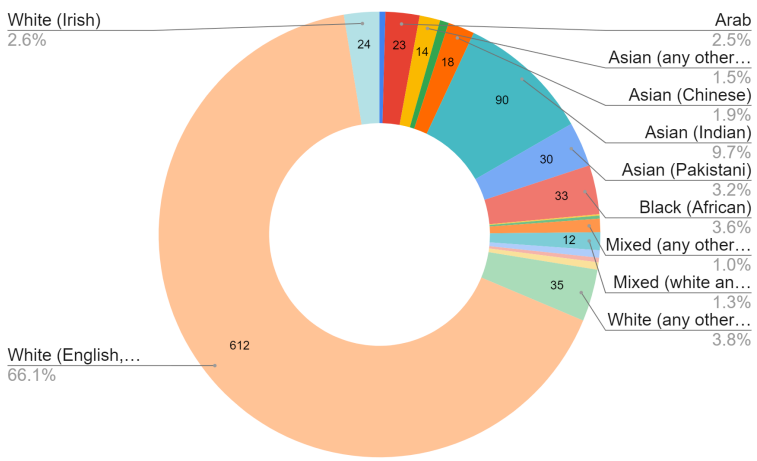
Gender identity

99.1% identified as being the same gender as their assigned sex at birth. 0.6% (n=6) identified otherwise. 0.3% Preferred not to say.

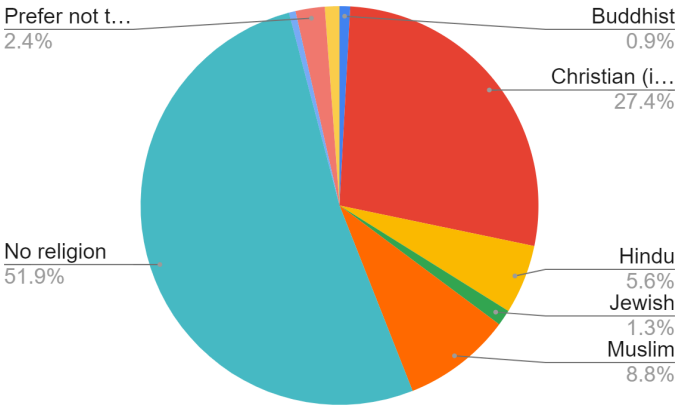
Other Nationalities included

African, American, Asia, Bangladeshi, Belgian, Bruneian, Canadian, Croatian, Dutch, English, European, French, German, Greek, Jordanian, Kenyan, Kuwaiti, Malaysian, Myanmar, Nigerian, Northern Irish, Polish, Portuguese, Romanian, Russian, Singaporean, Slovenian, South African, Sudanese, Venezuelan.

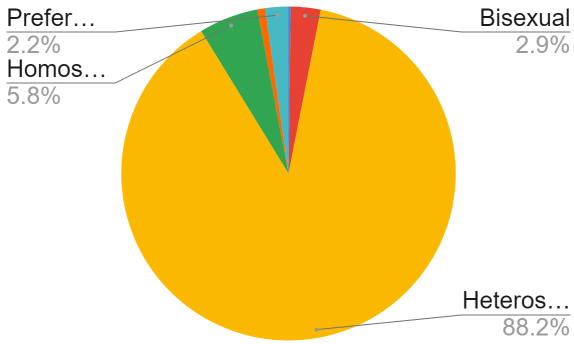
Ethnicity



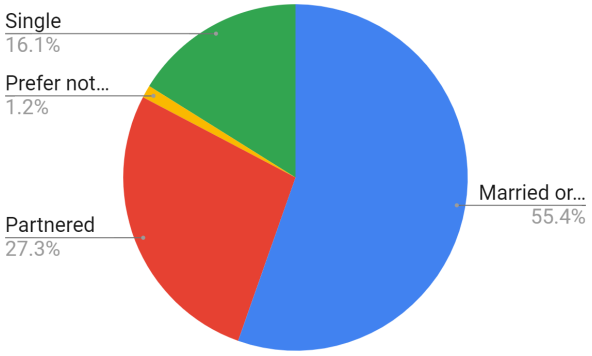
Religion



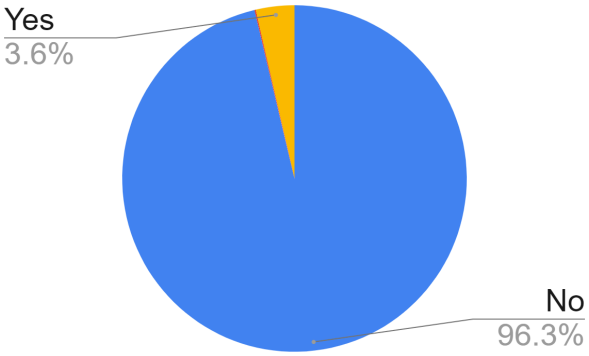
Sexual Orientation



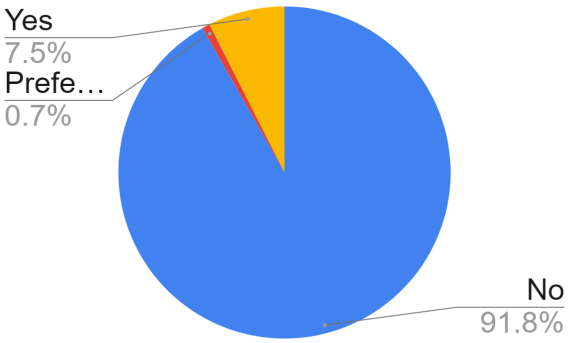
Relationship Status



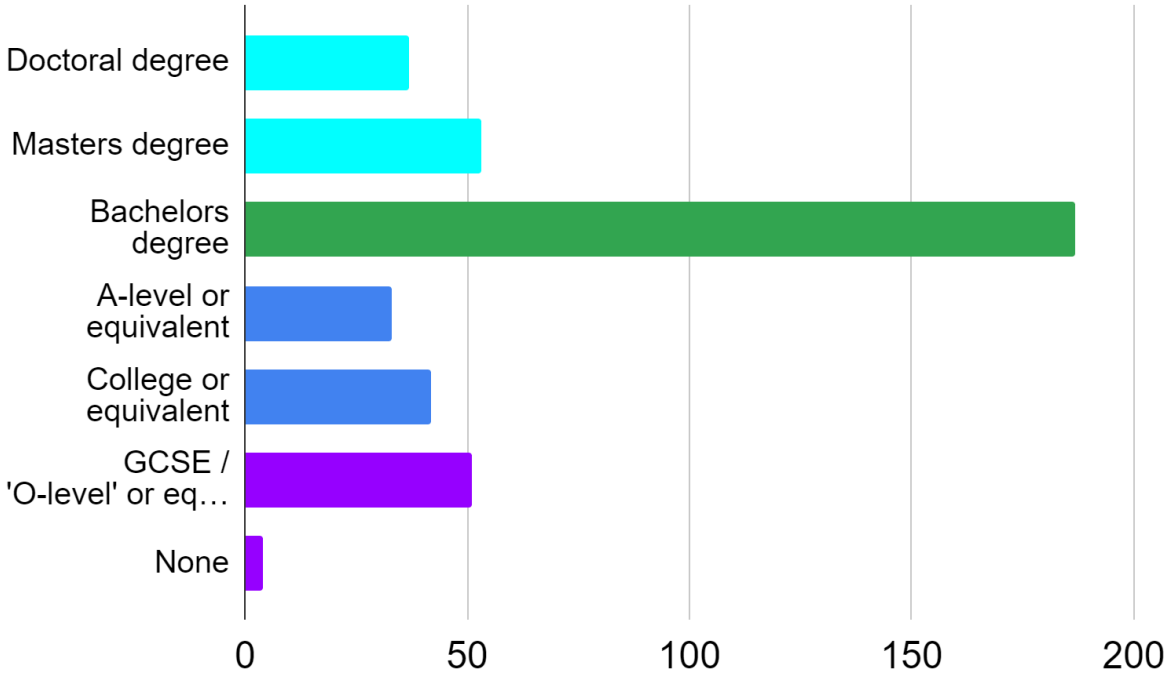
Do you consider yourself disabled?



Do you have primary caring responsibilities? Not including children

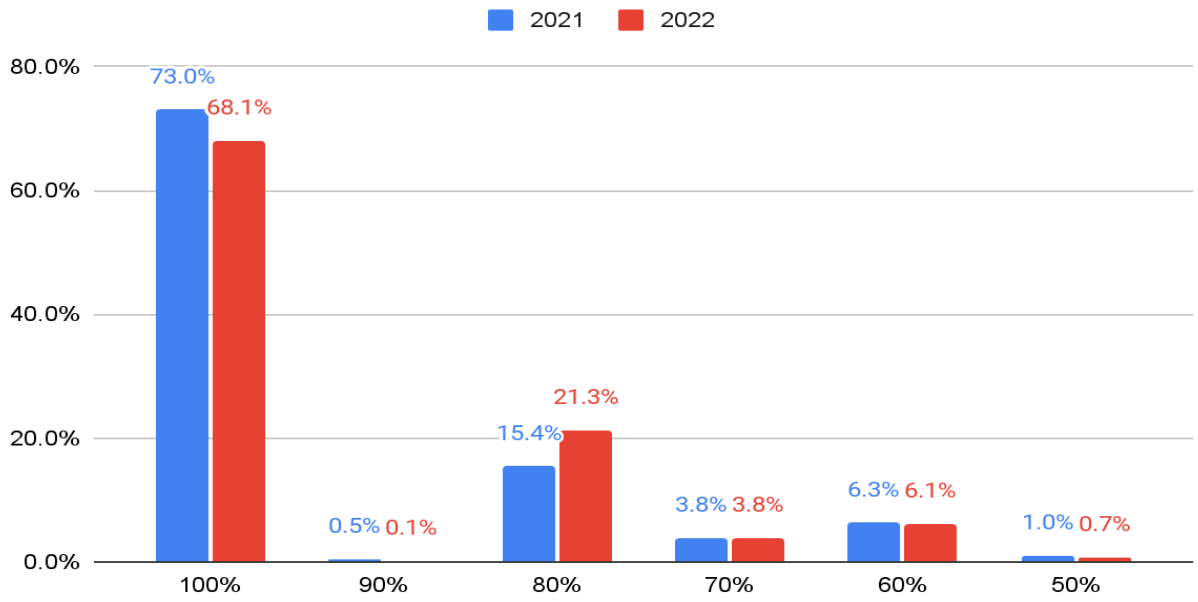


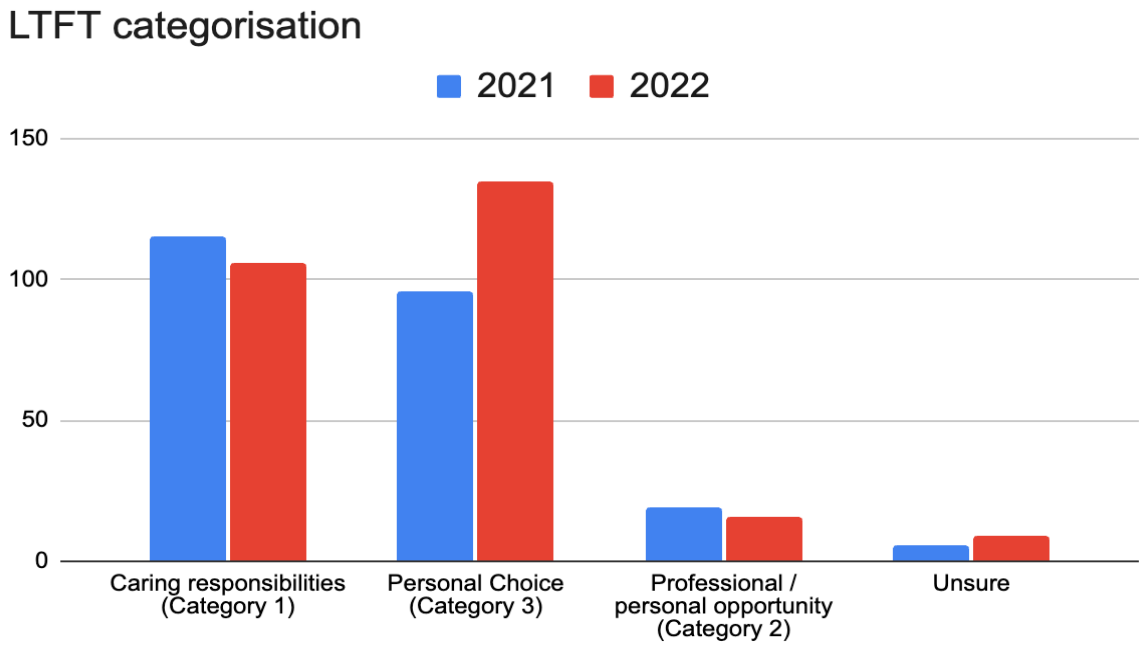
Trainees parents' level of education (growing up) - n = 409 (only asked in 2022)
68% of respondents had a parent with a higher degree, much higher than the baseline population.



It is important that the medical community has a better representation of people from less well-resourced backgrounds. Especially as the burden of health inequalities is born by people from there. A more diverse workforce spanning class and opportunities.

Less-than-full-time





Less than full-time working (n=505) is becoming increasingly popular within Emergency Medicine trainees with 80% WTE being the most common choice . This possibly reflects the normalisation of Category 3 - "Personal Choice" as a mechanism to slow down training for improved work-life balance. Portfolio careers are increasingly the norm and being promoted in Emergency Medicine - this may come under Category 2 or 3. Pursuit of a clinical:non-clinical:work-life balance for a longer-term sustainable career is a mechanism to balance the demands and stresses of the Emergency Department itself (fig. 1).

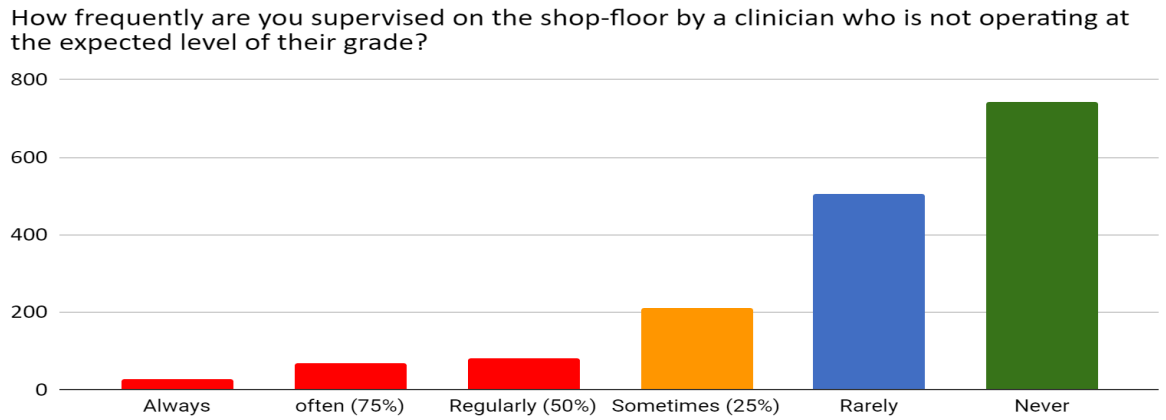
14% of rotas are still not adjusted in a pro-rata manner. For some this may be a personal choice; however, the default should be a balanced rota as daytime learning opportunities (sim, teaching, consultant presence) are disproportionately impacted when they are unbalanced.

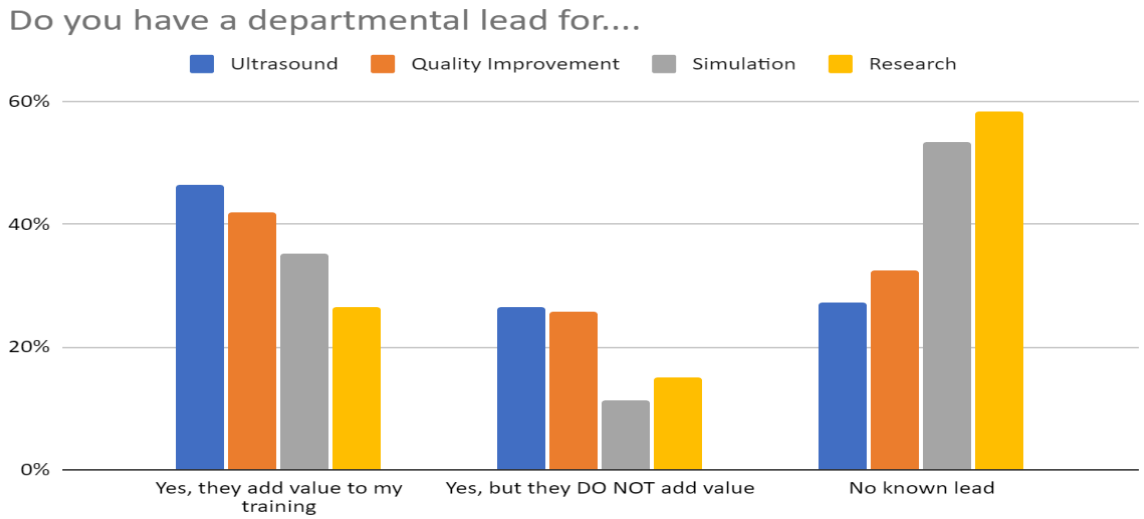
6% reported their deanery as unhelpful during the process of going LTFT.

Training Quality

Supervision

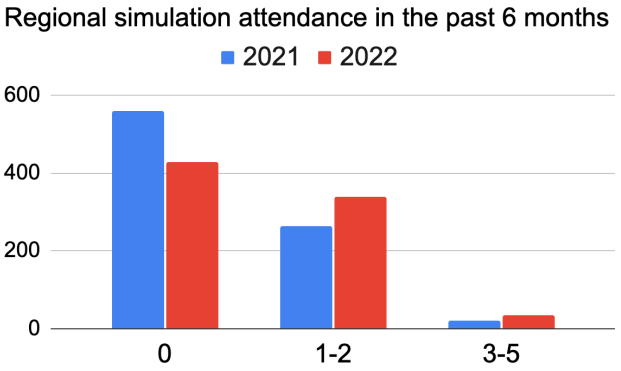
23% (~1 in 4) trainees report being supervised by someone who they do not believe is operating at the expected level of their grade at least 25% of the time. 10% report this occurring half the time or more.





There has been a **4% and 5% increase in departmental Ultrasound and Simulation Leads respectively.** The others remain static. QI and Ultrasound have significant ARCP requirements and CCT thresholds which requires a need for improvement in these spaces to support curriculum delivery.

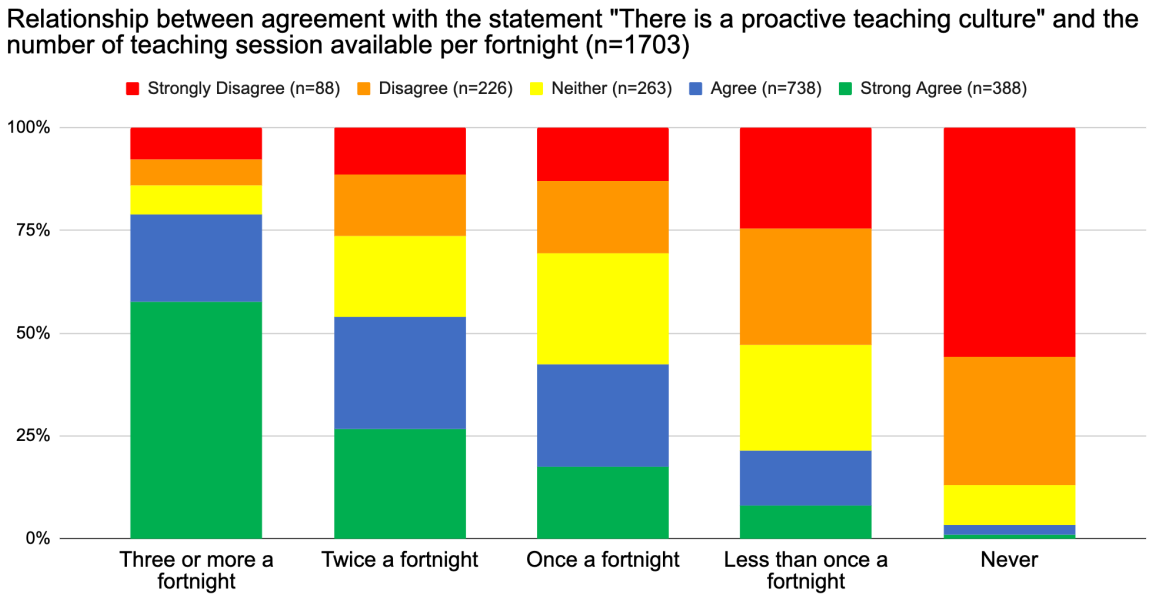
There appears to be a significant increase in trainees reporting having at least one regional simulation in the past six months, an increase of 13%. With the **average 6 monthly simulations increasing from 1.2 to 1.31** reported events



Teaching Culture and Provision

A clear relationship exists between trainees reporting a e "proactive teaching culture" and the objective availability of teaching sessions across a fortnight. Providing multiple quality opportunities requires the Consultant body to be willing and resourced to do so.It also requires trainees to make efforts to attend, creating a demonstration of value in both directions.

On average there are 1.5 teaching sessions a fortnight, or just under 1 per week. 66% (n=1,129) of trainees agreed or strongly agreed that there was a"proactive teaching culture". 18% (n=316) responded negatively.



N=1711	10.60%	44.80%	17.00%	21.60%	6.00%

On average 0.8 teaching sessions are attended per week (n=1,380). Fixed days off for LTFT trainees require there to be different opportunities throughout the weeks and months. The top 3 reasons for being unable to attend teaching are included below.

Reasons for being unable to attend teaching

Out of hours working	Service Demands	Falls on a day off	Other (free-text)
11%	**7%**	**10%**	**5%**

The free-text comments largely highlight a significant shortfall in regular, structured teaching in a clinical environment.

Frequency and Timing: Teaching is mostly monthly, not weekly, clashing with night shifts and rest days, leading to missed opportunities.

Consistency Issues: Sessions are often cancelled, attributed to workload or low attendance, creating a lack of reliable training. Rota coordinators can also be unsympathetic of the need to balance service against training opportunities.

Specific Groups Left Out: Certain groups, like registrars or those on specific rotations, have no dedicated teaching.

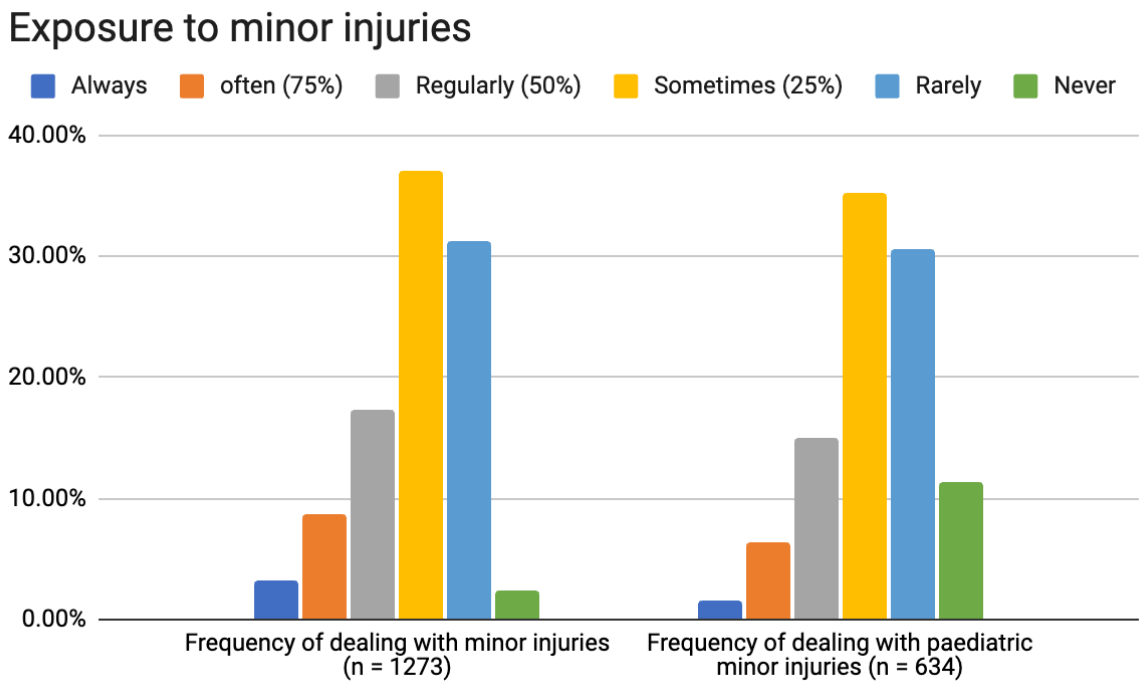
Limited Access: There's a notable absence of local sessions, with some unaware of any available teaching. Few

sessions have been held over extended periods.

Scheduling Conflicts: Rota coordination problems are evident, with limited flexibility to accommodate teaching schedules.

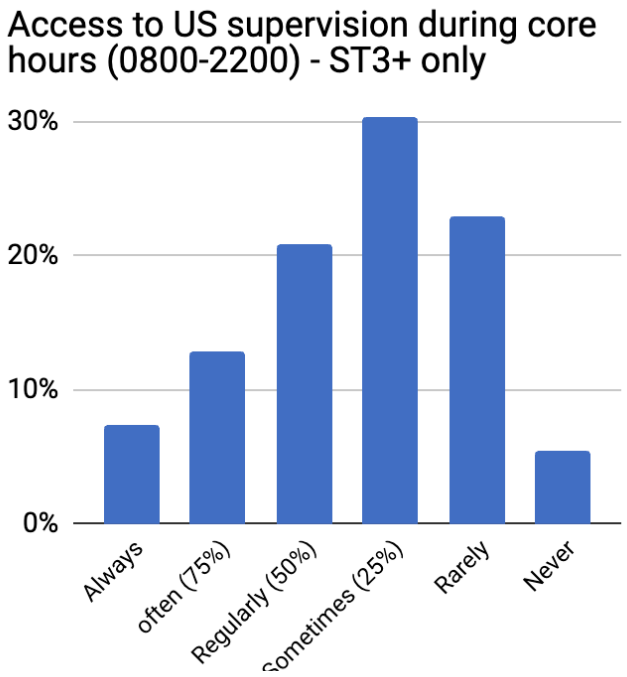
COVID-19 Impact: Many sessions were cancelled due to the pandemic, exacerbating the issue.

14% of ACCS respondents (n=759) reported being denied teaching opportunities during their ICM, Anaesthetics and Acute Medicine blocks due to their status as an EM trainee.



Many trainees report getting little or infrequent exposure to both minor injuries in both adults and paediatrics. With over 30% of trainees stating it is 'rare' or never happens.

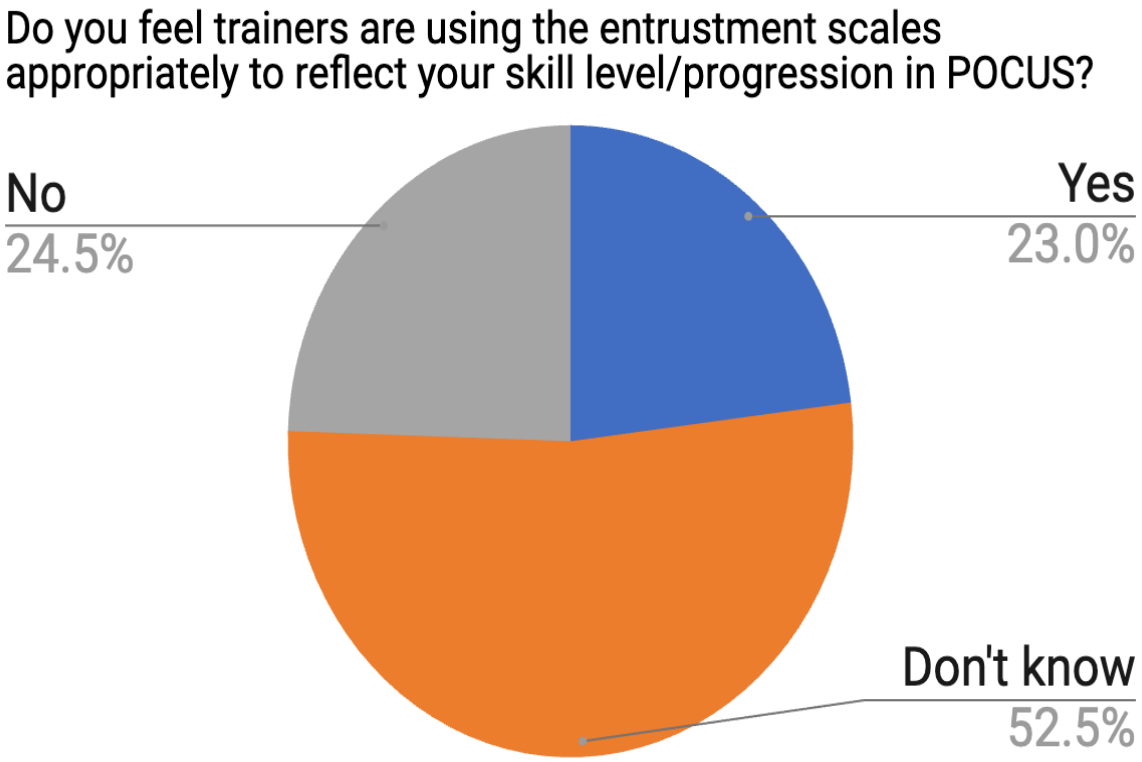
Ultrasound



There has been no change in reported access to US supervision between 2021 and 2022. **The average number of scans per week** (diagnostic or procedural) **is 2.07** (2022 - n = 759). This variation between those who scan often and scan little remains an issue. There are also gendered differences reported on last year - https://www.emta.co.uk/emtasurvey

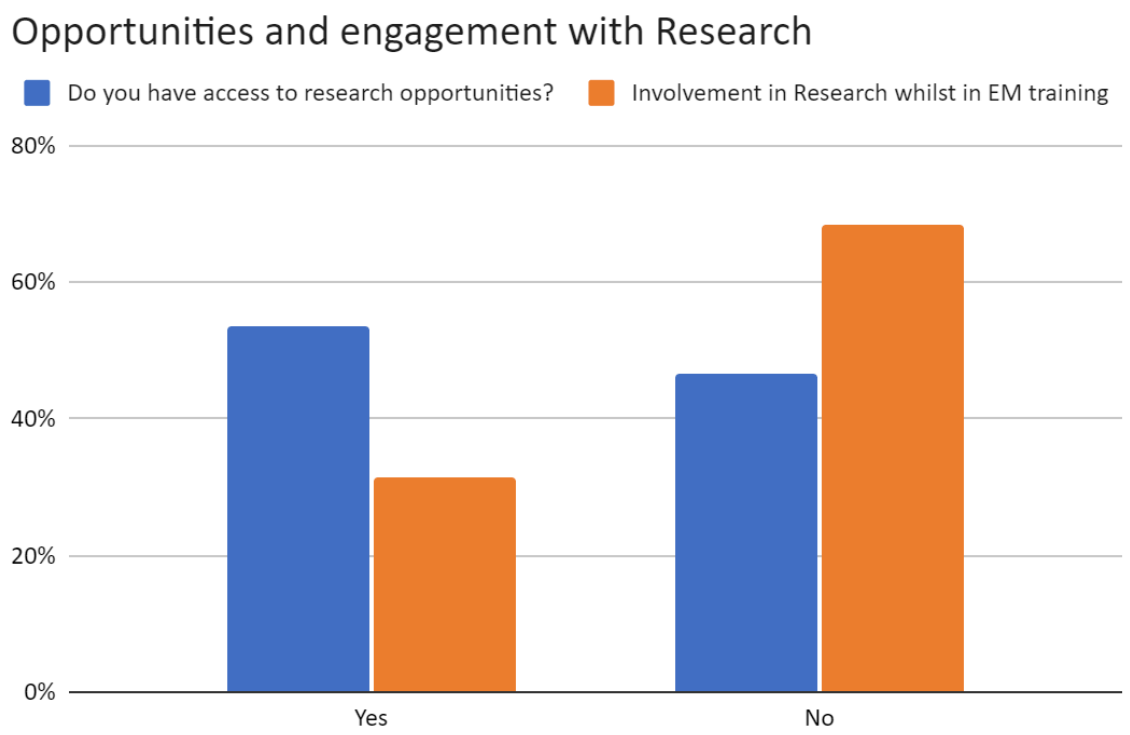
Only 44% of trainees have received any local US teaching in the 3 months prior to the survey

A more detailed dedicated report on US is to follow from the EMTA Ultrasound Representative.



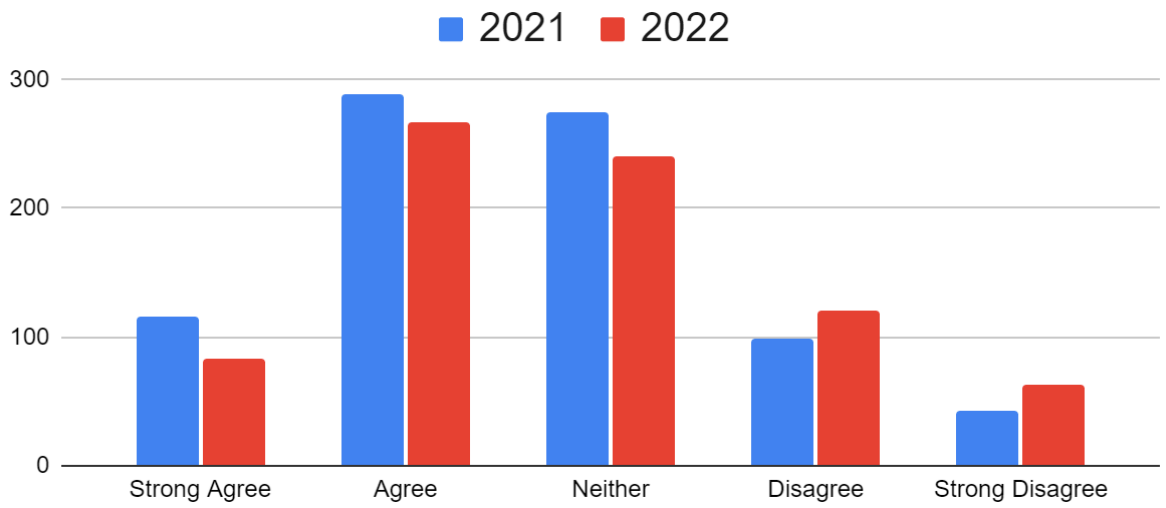
Research

There has been no change between 2021 and 2022 in research opportunities and participation

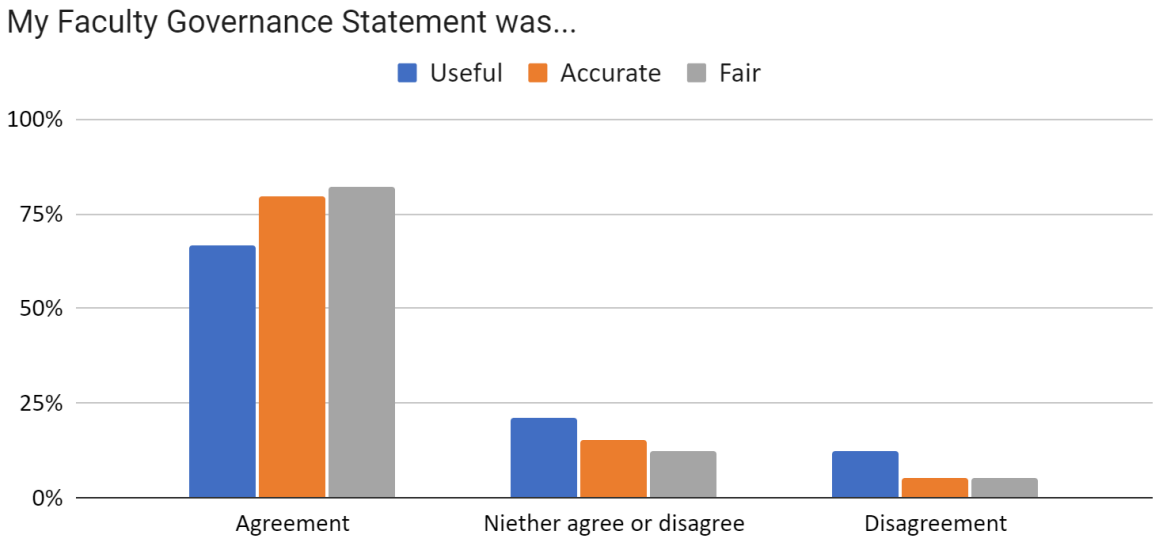


There has been a potentially significant decrease in agreement with the statement "Do you feel participating in research improves your clinical practice?" with a 6.5% increase in negative sentiment and 4.1% decrease in positive sentiment to 45%. There has been no significant change in the number of trainees reporting opportunities to research at roughly 50/50 and involvement in research at 31% and 32% for 2021 and 2022 respectively.

Do you feel participating in research improves your clinical practice?

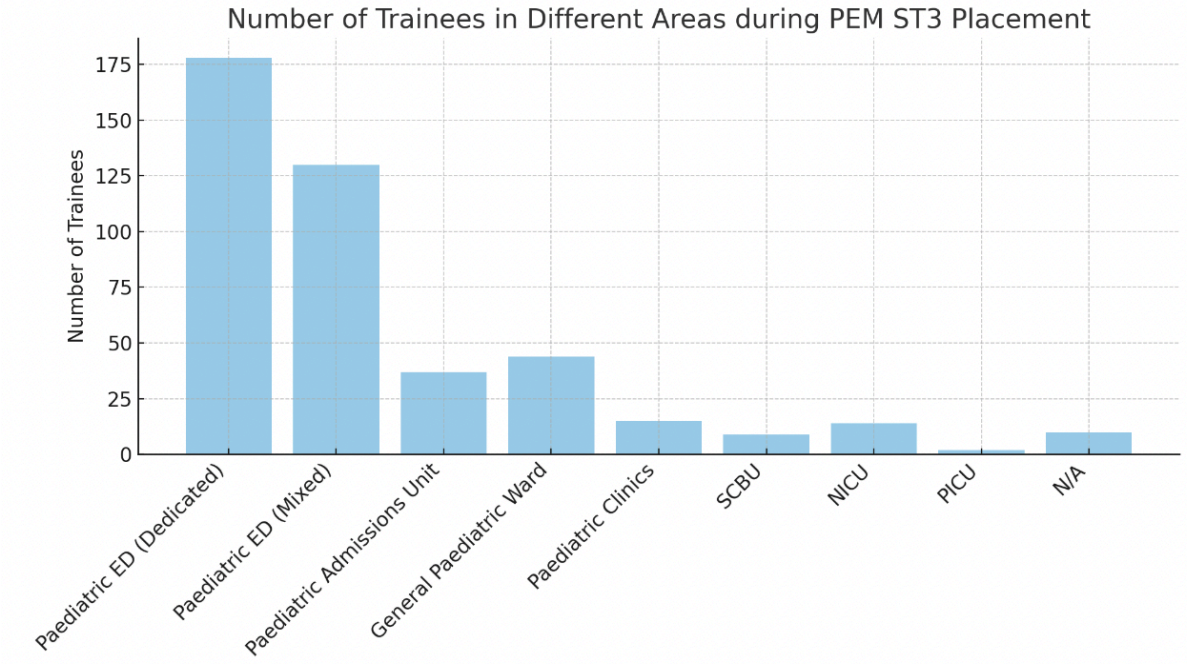


Feedback



The majority of trainees felt their FEGS was useful, accurate and fair. However in a small percentage...5% (n=66) of trainees reported concerns being raised in their FEGS. Of these, ~1 in 5 (n=12) reported that concerns were not passed onto them before their ARCP. A trainee should not receive negative FEGS feedback for the first time via the ARCP processes. Constructive learning development should be explored candidly by supervisors prior to ARCPs to support trainees in meeting their requirements.

Paediatrics



While during their ST3 year trainees report low access into other peadiatric inpatient areas such as Admissions units and clinics. f

Emergency Capabilities

Overall assessment of core capabilities has remained similar between 2021 and 2022. With the exception of:

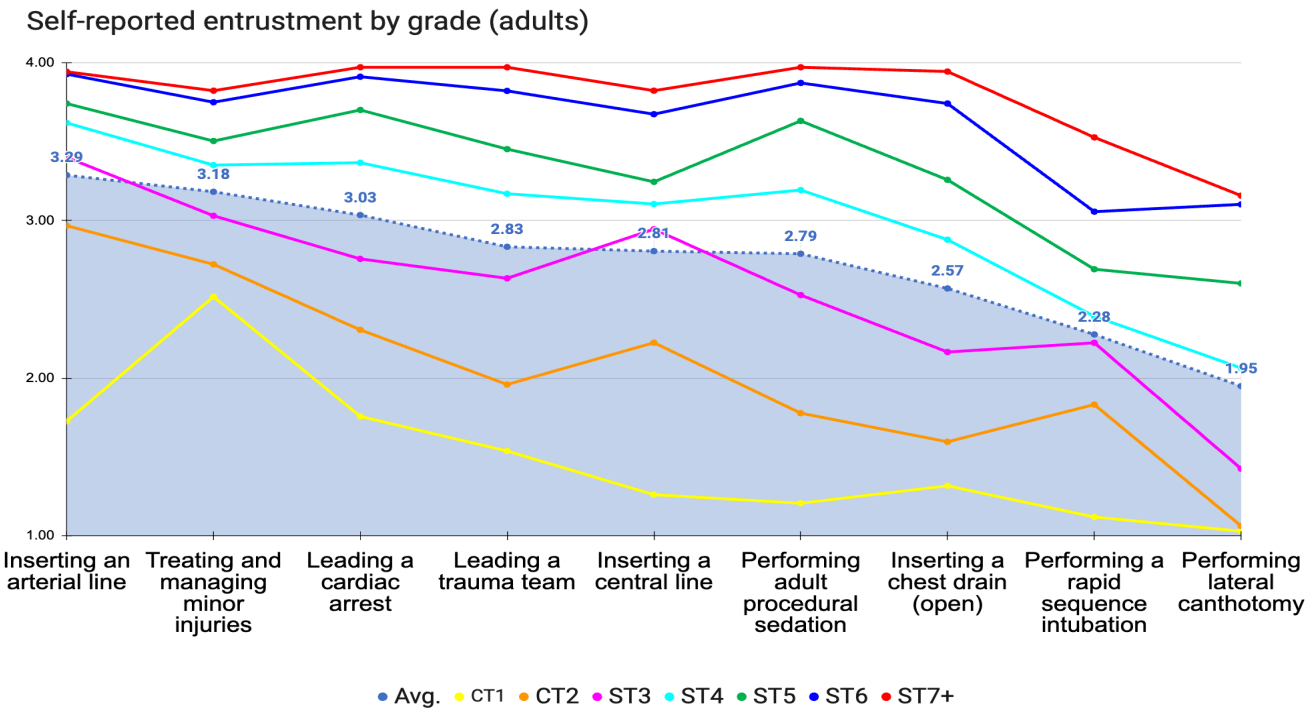
- performing an RSI (8.8%),
- paediatric sedation (7.6%),
- and managing an emergency delivery (6.2%)

These 3 have shown significant increases in people self-rating as an entrust of 3 as compared to 1, 2a or 2b previously. A significant increase in ratings of 4 has not yet been seen.

The RSI and Paediatric sedation shift is possibly a result of post-covid recovery training for those who had their anaesthetic placement impacted. It may also reflect the growing stock of Consultants and Dual-trainees who feel more confident in these skills.

Adult Capabilities

It is clear that training results in increasing confidence in core emergency skills as one moves through it. Lateral Canthotomy and RSI are areas of weakness. Improvements in RSI would likely improve confidence in procedural sedation also.



Current Policy Commentary

Entrustment scales for the procedural skills are shown broadly to increase with grade of training.

Considerations for policy

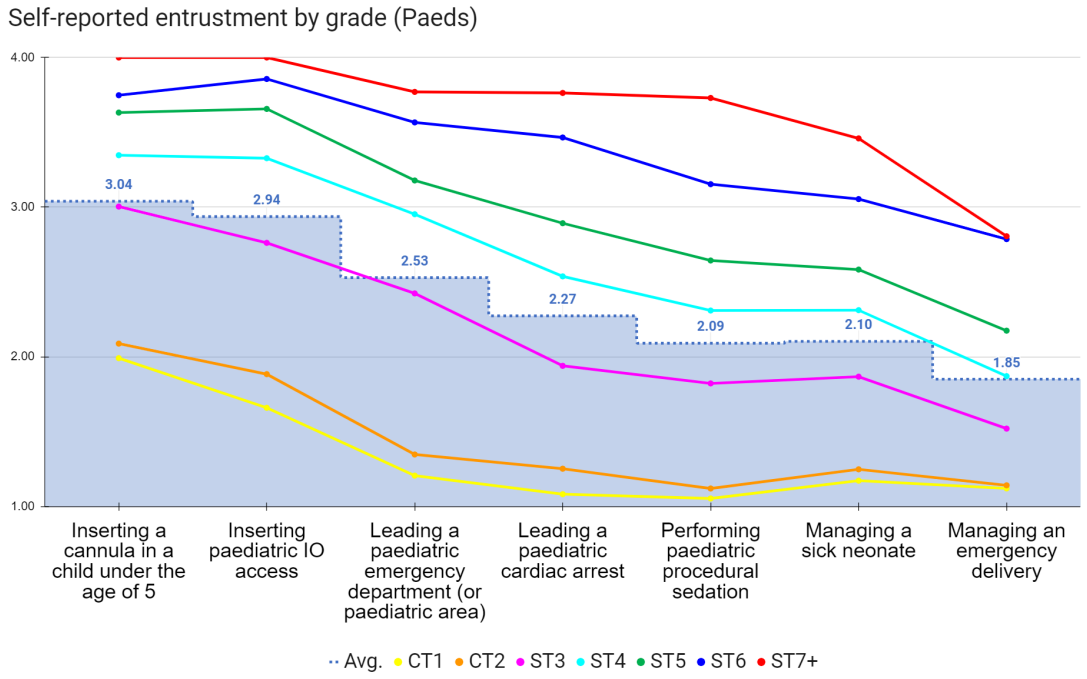
Ensure all trainees have access to a HALO simulation course

EDT time is protected and trainees encouraged to gain experience in these areas which can be challenging on the shop floor. Departments are encouraged to rota trainees to dedicated minors shifts where possible.

Paediatric Capabilities

Overall trainees are less confident dealing with sick children than with sick adults. Paediatric arrests, sick neonates and emergency deliveries are high acuity, low occurrence events, so a simulation programme would be beneficial for improving overall confidence in managing these complex situations.

Considering ST3s do a dedicated paediatrics rotation and some are based in departments as the most senior EM doctor (though supported by Paediatric specialists +/- intensivists of ST4+) you might expect more confidence in managing sick children. This data may demonstrate however the totality of one's experience and confidence as an Emergency Clinician is significant in self-ratings for specific areas. Even on paediatric rotations, the occurrence of high-acuity events is lower than in an Adult setting, so sheer numbers of exposures may also play a part.



Current Policy Commentary

The College is now recommending HSTs are provided with paediatric exposure aiming to fulfill a requirement for a minimum of 20% of WPBA in this patient group.

Considerations for policy

Specific recommendations to Simulation leads and that community to focus simulation efforts involving sick neonates,emergency deliveries and paediatric cardiac arrest

Considerations for future research or exploration of the survey data

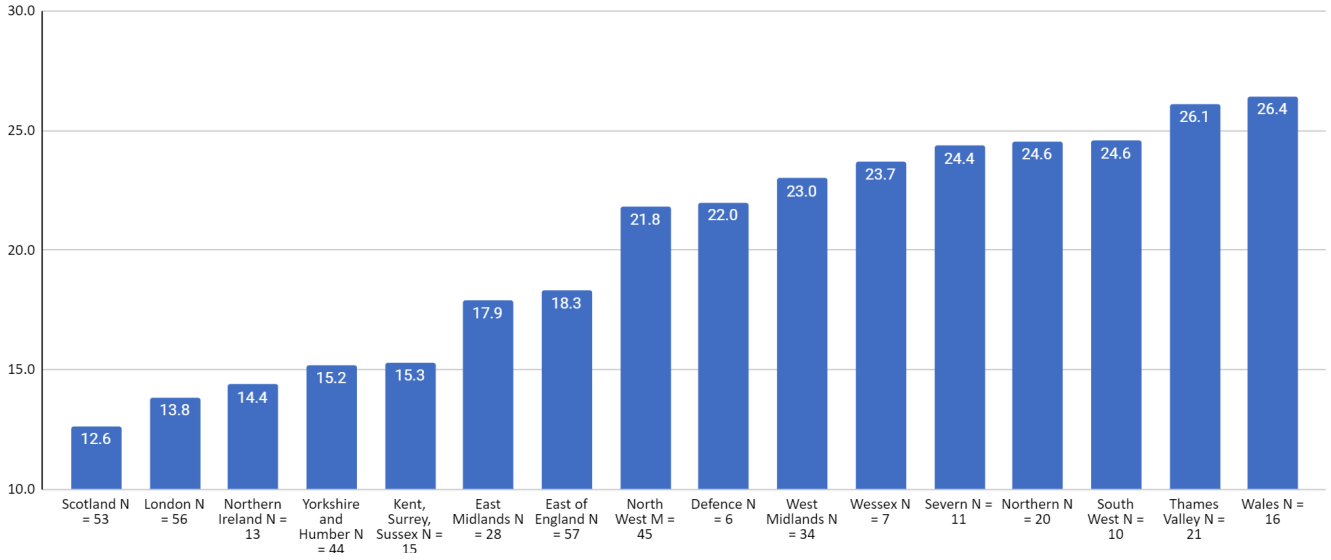
How does the training environment such as a mixed paeds ED, dedicated Paeds tertiary ED or PICU placements affect confidence levels or exposure to case-mix.

Deanery, TPD and EDT

EDT was brought in to recognise the significant requirements to deliver on 4 non-clinical domains and administer the portfolio to meet ARCP requirements with the RCEM 2021 Curriculum update. This equates to 15-20% of a Senior trainees time and 5-10% of more junior trainees.

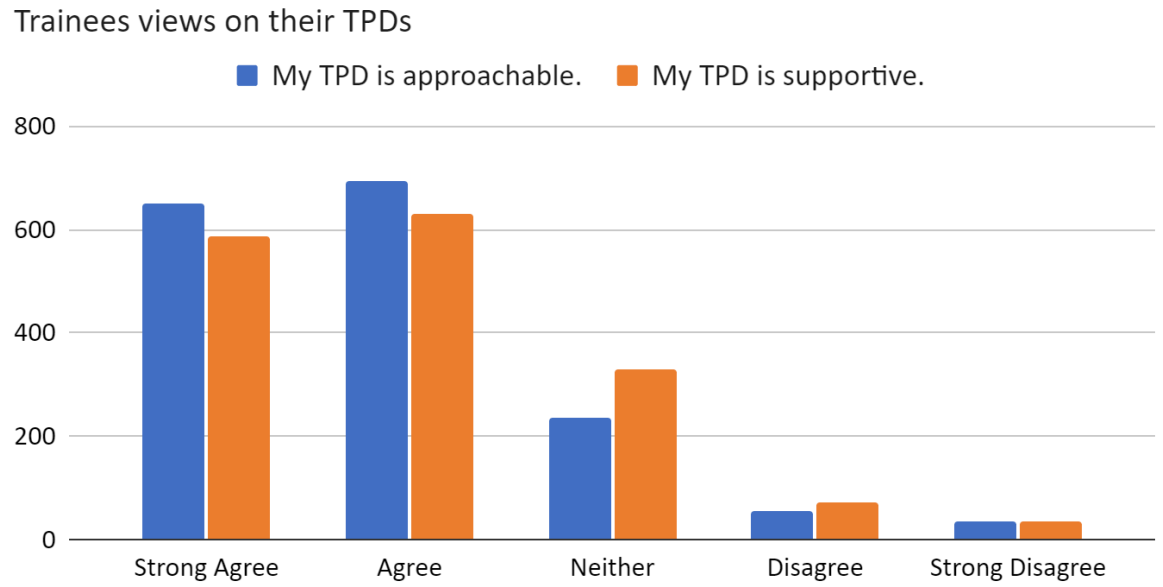
The high-levels of burnout, workload and limited opportunities to administer training during service hours is part of the reason this policy came into being. Trainees however are expected to deliver more consistently on the portfolio requirements and particularly the Generic SLOs in Research, Management, QI, and Education competencies which this time supports. Half the time at higher levels is expected to be used for clinical progression (attending teaching, study, skills days and time in areas of developmental need like anaesthetics or paediatrics).

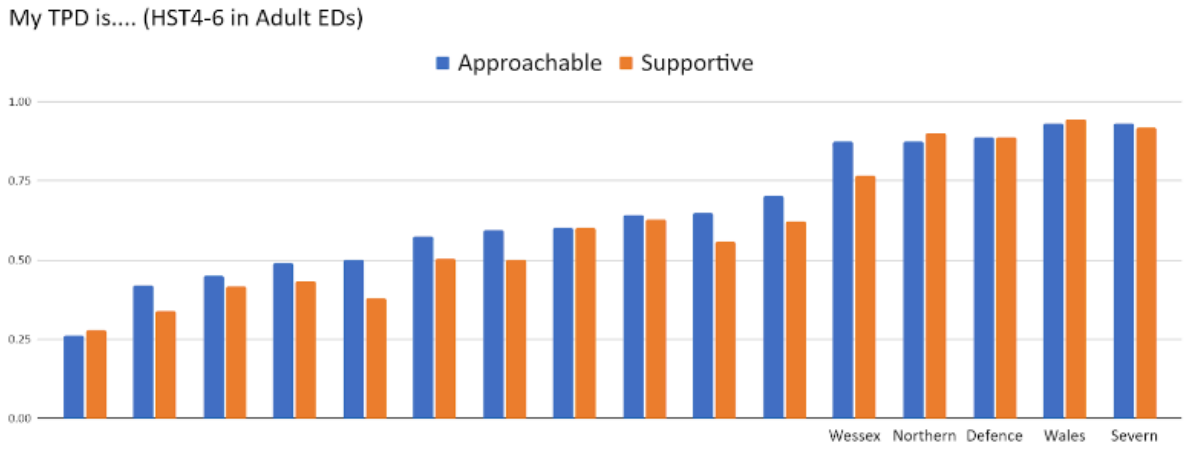
EDT League Tables (Comparing ST4-6 full-time trainees in Adult EDs only) - 2021 and 2022 Aggregated (N = 463)



Provision is also not consistent however with huge regional and inter-departmental variation. This is due to a mixture of factors such as culture, Consultant and non-training grade numbers and departmental pressures.

** We note that since this survey some regions have made changes which have improved access to EDT. We hope to see this reflected in the third round of data and reports on trends.





We have started to ask about TPD approachability and supportiveness (regions redacted) as a mechanism to shine light on how those in positions of authority can over a persons career progression need to also reflect on how they manage their own leadership and pastoral styles to and how they can promote a psychologically safe environment across their regions which may promote raising concerns if and when had.

Current Policy Commentary

The incorporation of EDT time across the speciality is recognised and valued by trainees but has also been recognised by the Enhancing Junior Doctors Lives Working Group as a great shining example of a way to ensure protected time to enable the development of a rounded trainee.

Considerations for policy

Despite current system pressures this EDT is protected and the value to trainees is highlighted throughout the college. Perhaps a consistent exploration of ways to record EDT activities could further be explored by RCEM.

Considerations for future research or exploration of the survey data

Continue to ensure that access to EDT time is a key source of questioning in the survey, and where challenges have been overcome we share this good practice.

Exams

There was a significant drop in the number of trainees reporting that they 'trust' the exam process from 77% in 2021) to 55% in 2022. Similarly, there was a 15% drop to 63% in those reporting that there was 'clear communication' about exams. This was to be expected with the FRCEM results error that occurred between these samples. 2023's data will be telling of the impact the reforms and efforts to improve communication have made but it is likely that the restoration of trust will take time.

There were improvements in agreement with the statements "the exam ran smoothly" by 9.6% and with "The exam was a fair assessment" by 5.3%.

Current Policy Commentary
Trust in the exam process has seen a significant decline given the challenges faced in recent years.

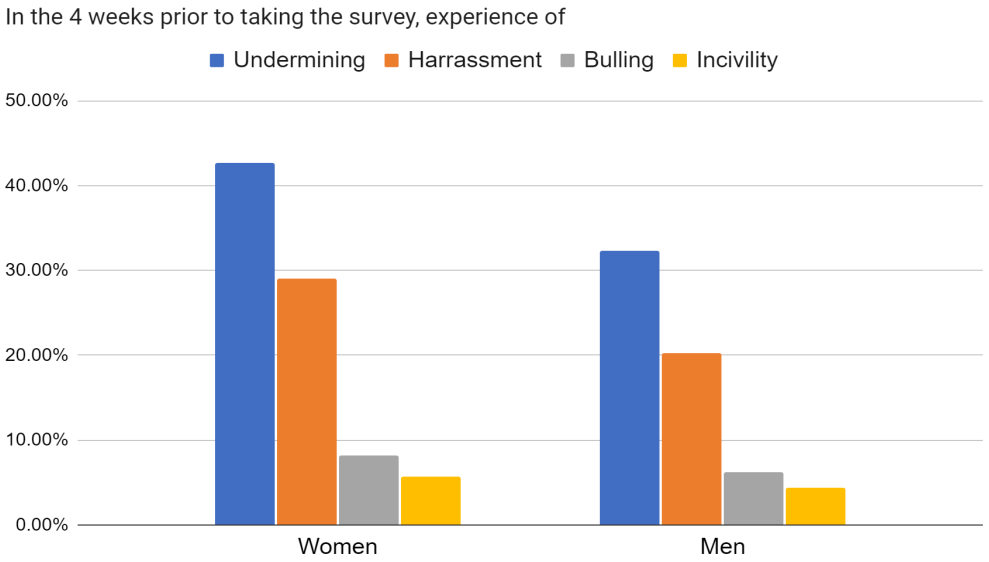
Considerations for policy
EMTA recognises the significant work of the Exams team and has witnessed many of the improvements and has worked closely with them.

Considerations for future research or exploration of the survey data
The 2024 Survey will no doubt reflect the impact of the changes on trainees

Incivility

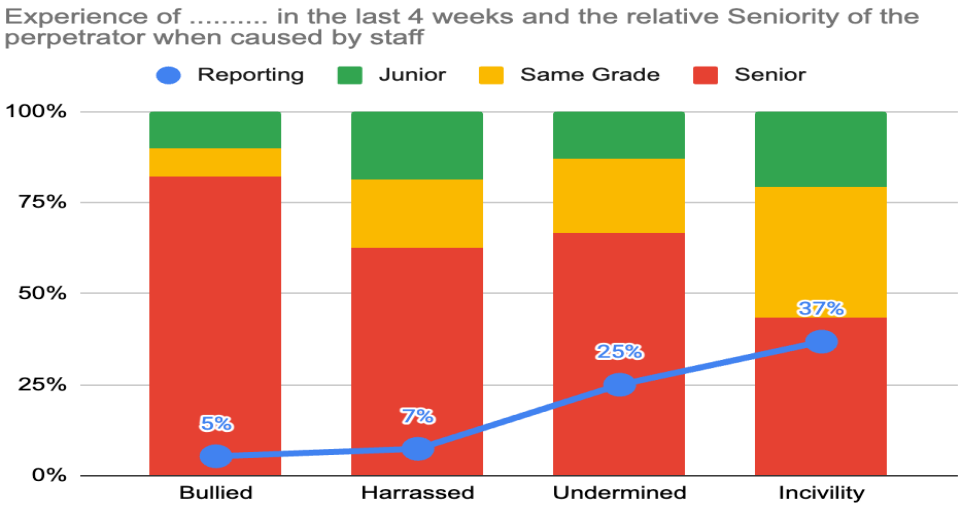
Significant amounts of negative behaviour are experienced by staff in the emergency department. This is partly due to the high acuity and high volume of interactions that occur in such an environment. Part of the data will be down to individuals lacking awareness of how their behaviour may impact others and there may also be a small group of problem individuals who disproportionately generate the negativity. This data does not explore who the perpetrator is by staff group such as medics, nurses and others. We know anecdotally that young female doctors feel they have a harder time than their male contemporaries and this may explain the below discrepancy seen.

N = 1650



People's interpretations of the definitions of bullying, harassment, incivility and undermining may be different but they are universally negative experiences. There is a clear indication that these negative experiences are disproportionately experienced down a hierarchy gradient.

35% of trainees have reported negative experiences with staff affecting their patient care.



Current Policy Commentary
Despite reflecting previous information this is still shocking to see. The worst of incivility, such as bullying, is typically perpetrated along a hierarchy gradient thus requiring better self-policing within the senior and consultant bodies.

Considerations for policy
Work alongside RCEM on projects and workstreams to tackle incivility. To encourage and support trainees to speak up where possible.

Recommendations

- **EDT** - The provision of Education Development Time has been well received by trainees. Unfortunately, there are significant issues with the parity of provision. We need to ensure that this time is honoured especially on the backdrop of burnout, increased portfolio evidence and curriculum requirements.
- **Exams** - EMTA recognises the huge multiphase work done by the exams team in the last 2 years and how this has markedly improved the exam process for trainees. We note the change from Pearson Vue as the main supplier is imminent in 2025 also ans welcome the invitation for EMTA to be involved in this process. Continued transparency is imperative and we expect to see trust levels increase in future surveys.
- **Paediatrics** - Overall EM trainees are much less confident dealing with sick children than with sick adults. Paediatric arrests, sick neonates and emergency deliveries are high acuity but very low occurrence events; so a simulation programme would be beneficial and could improve general trainee confidence with managing these.
- **Curriculum support** - QI, simulation, research and US training provision remains highly variable. RCEM needs to support departments to recruit leads in these areas to champion training. Where this is not possible to promote cross department support.
- **Incivility**. Reporting rates remain high. Ongoing work with RespectED and other activity need to be reinforced. The worst of incivility, such as bullying, is typically perpetrated along a hierarchy gradient thus requiring better self-policing within the senior and consultant bodies.
- **Parity in Training** - All departments are under significant pressure and whilst this is not uniform, nor is the number of Consultants and trainees within a department, the variation in training cannot be excused by demands. This is demonstrated by many still delivering thriving training environments and experiences.

Limitations

The survey is responded to by approximately 40-50% of trainees. This may expose it to responder bias. It does however have a very diverse spread of regions, demographics, ages, and protected characteristics. Breakdown of the data by region shows some significant variance in positive and negative reporting which makes it less likely that only those with a certain disposition towards their training experience are likely to respond. We may be in fact approaching a representative sample by virtue of engagement rather than by design.. We are exploring with RCEM comparisons with their data and aim to demonstrate this in the next cycle. We also aim to push engagement in groups that are less represented such as ACCS and some regions.

The similarities in the responses between the 2 years across almost all questions support the notion of survey and question reliability. The responses between each year were over 800, which would reduce statistical variation, and good question and survey design would typically result in similar responses if all other conditions were kept equal. We know that year to year there is rarely a

substantial change in the provision and culture of training though pressures year on year in the health service are increasing, in some areas, exponentially. We could explore testing question reliability further and formally down the line if we are resourced to do so.

Taking the Survey Forwards

Trend Reporting

We will have 3 sets of data points spanning just over a 2 year collection period after April 2024. We will then be able to present the data through the lens of change over time.

Local level reporting

In 2021 we decided not to ask which hospital peopel trained at as we felt we lacked the resource to meaningfully anlayse it. This lacked foresight for the growth in our vision and capabilities around this work. We realised increasingly that whilst national policy influence is important, supporting on the ground training delivery is more so. Anecdotally we have been informed how the data on ultrasound helped support a business case for additional scanners. The ability of this work when granularised to department level to support other aspects of resourcing for specific curriculum delivery is not currently realised. Therefore we have added a question to capture department-level data and after 2024 data collection we will aggregate responses, to protect anonymity, and report more detail. We will attempt to highlight areas of excellence (positive deviance) which TPDs could do local investigation to explore best practice, and areas of need (negative deviance) so that these best practices may be deployed. The dashboard prototype for regional and national comparisons could be repurposed for local vs. regional. The same could be done for the league tables.

Research

Attempts to quantify subjective experiences through surveys are not without risks and should be continuously supported and updated by qualitative work. This survey has been significantly influenced by the expertise of trainees who have decades of advocacy experience paired with their own lived experience. This gives them the domain knowledge necessary to create a meaningful data capture tool that adds value to the policy space it attempts to influence. This paired with stakeholder engagement at RCEM committee level has resulted in a robust piece of work. However, further refinement and work to improve its credibility are required. This could take the form of

Qualitative research

1-2-1 interviews, focus groups and free-text response gathering could be used to better understand which metrics (aspects of training) within both the GMC survey and EMTA survey are of the most importance or value. This could support a more weighted scoring system as each data point is not made equal in terms of impact. This work would require ethics approval.

This could combine the trainee and trainer perspectives.

This would be useful is reducing the current length of the survey too. Helping decide which should be removed and what new elements should be added. The core question set should remain to monitor trends over time, but new questions will arise as the EM training landscape changes too.

Deeper Analysis

Current data analysis is mostly descriptive with commentary and inferences drawn from the experience of the EMTA committee within reports and further inferences by stakeholders upon data presentation.

Exploration of relationships between data points such as that demonstrated on page 21 (teach culture vs teaching session availability) in combination with qualitative work could help determine what objective aspects of training drive the subjective experience and skill acquisition desired by the curriculum. This would help us find a 'signal in the noise' and move us away from the current 'data rich, insight poor' paradigm.

Publication

Previous EMTA surveys have been summarised and published in the European Journal of Emergency Medicine by Dan Derbyshire. The current updated and more robustly designed survey has significant potential for successful publication improving EMTA and RCEMs reputation and the credibility of the Survey.

Additional analysis of the data to explore differences in training experience between groups has the potential to highlight inequalities in training provision along protected and other characteristics. , particularly after the third round of data collection when numbers of subgroups e.g. ethnicity categorise, LBGTQ+ and others are more substantial and reliable

Appendix of Terms

RCEM - Royal College of Emergency Medicine
HEE - Health Education England
NHS - National Health Service
GMC - General Medical Council
NTS - National Training Survey
OOP(E,R,T) - Out-of-Programme (Experience, Research, Training)
CCT - Certificate of Completion of Training

Appendix items

1. RCEM Training Standards Committee Quality Standards

v. Local QI lead
- In Survey + do they add value

vi. Local US lead
- In Survey + do they add value

viii. SIM training opportunity
- In Survey + do they add value
- Reported sim opportunities.

xii. 50% shifts have direct consultant supervision
- Ratings of inappropriate supersions

xv. Local training programme
- Teaching culture and teaching opportunity set
- US, QI, Sim provisions

x. Local feedback mechanism
- FEGS question set

xi. Comply with SPA recommendations for trainees

EMTA metric - Annual leave and Study Leave (TIRED Study links a correlation for an increased Need-for-Recovery where participants had issues with being granted leave)

2. Distribution

Distribution: EMTA Committee, EMTA Membership, RCEM President, Dean, Executives and Council, All RCEM Staff and committee chairs, Training Standards, Exams, Curriculum, Sustainable Working Practices, Equality and Diversity, Quality in Emergency Care committees members and the Statutory Educational Bodies - HEE, NHSE, GMC and Devolved nations

GMC Data 2019 Analysis

Table 1 - Questions that correlate most with Burnout Scores

Questions categorised into themes to support the survey question design.

Table 3 - GMC NTS 2019 Survey Coding, Categorisation and abridged description

Code	How values are derived	Category	Description (abridged)
167	Positive - Very Good + Good	Overall Satisfaction	Clinical supervision - Overall
160	Positive - Very Good + Good	Overall Satisfaction	Teaching - Overall
158	Positive - Very Good + Good	Overall Satisfaction	Induction - Overall
170	Positive - Strong Agree + Agree	Overall Satisfaction	The post will be useful for my future career
169	Positive - Very good + Good	Overall Satisfaction	How would you describe this post to a friend
199	Negative -V.high + high degree	Overall Satisfaction	Do you feel burnt out because of work
157	Positive - Strong Agree + Agree	Working Environment	Induction - Information about the workplace
192	Positive - Strong Agree + Agree	Working Environment	Supportive Environment - A fully sppurtive environment
195	Positive - Strong Agree + Agree	Working Environment	Supportive Environment - Supports confidence building
82	Positive - Strong Agree + Agree	Working Environment	Supportive Environment - Senior Colleagues are receptive to disagreement
114	Positive - Strong Agree + Agree	Working Environment	Team Work - between the MDT is encouraged
115	Positive - Strong Agree + Agree	Working Environment	Team Work - between clinical departments is encouraged
116	Positive - Strong Agree + Agree	Working Environment	Team Work - between specialities/Asking for assitance
183	Negative - Daily + Weekly	Working Environment	Workload - Work over rostered hours (daily or weekly)
198	Negative -V.high + high degree	Working Environment	Workload - "Is your work emoitionally exhausting"
188	Positive - Never + Less than monthly	Clinical Supervision and Curriculum Coverage	Appropraitely informed to obstain consent
168	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Adequate Experience - To achieve competencies
166	Positive - Very good + Good	Clinical Supervision and Curriculum Coverage	Clinical Supervision - Out of hours
111	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Confidence in opportunities relevant to Profession experience
112	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Confidence in opportunities for Practical Expereince
113	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Confidence in opportunities for Clinical Expereince
156	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Educational Supervision - Contact from supervisor
178	Positive - Daily or Weekly	Clinical Supervision and Curriculum Coverage	Feedback - Informal Feedback (Daily or weekly)
110	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Handover - As a learning opportunity
97	Positive - Strong Agree + Agree	Clinical Supervision and Curriculum Coverage	Handover - Involvement of the MDT
131	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Rota given in advance of starting
173	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Local Teaching - Protected time
174	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Regional Teaching - Protected time
136	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Mandatory local training - Protected time
137	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Rota Design - Educational opportunities are rarely lost due to rota gaps
138	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Rota Design - Gaps in rota addressed to protect training
139	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Rota Design - There are enough senior staff to deliver the appropriate level of care
140	Positive - Strong Agree + Agree	Rotas, Protected teaching and Study Leave	Rota Design - Rota design helps promote educational opportuities
161	Positive - Very good + Good	Rotas, Protected teaching and Study Leave	Study Leave - Encouragement to take leave
185	Negative - Daily + Weekly	Rotas, Protected teaching and Study Leave	Workload - Does your work pattern leave you feeling short of sleep (daily/weekly)
117	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Educational Governance - Know how to Raising Concerns about Training
118	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Educational Governance - Confidence concerns would be addressed
119	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Educational Governance - Confidence to esculate when concern not addressed
159	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Educational Supervision - Talking to someone in confidence
100	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Reporting Systems - I've been made aware of how to report patient safety incidents
101	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Reporting Sytems - Culture of proactively reporting concers
102	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Reporting Systems - Culture of learning lessons from concerns raised
103	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Reporting Systems - Confidence that concerns are dealt with
104	Positive - Strong Agree + Agree	Raising Concerns - Educational and Clinical	Reporting Concerns - Feedback on concerns raised

Table 2 - GMC Data 2019 - Percentage scores across all questions and speciality training grades reviewed

Table 1 - Percetage scores across all questions and specialty training grades		ACCS	ST3	ST4+	ST	ST3	ST4+
Category	Info	EM			Others		
Clinical Supervision and Curriculum Coverage	Appropraitely informed to obstain consent	99	99	100	89	94	95
Raising Concerns - Educational and Clinical	Educational Supervision - Talking to someone in confidence	93.2	87.7	94	92.4	94.6	94.7
Clinical Supervision and Curriculum Coverage	Confidence in opportunities for Clinical Expereince	91.5	91.6	95.3	92.6	95.6	94.6
Working Environment	Team Work - between the MDT is encouraged	90.7	92.1	86.7	88.1	90.4	89
Raising Concerns - Educational and Clinical	Reporting Systems - I've been made aware of how to report patient safety incidents	90.5	90.6	94.1	88.7	91.4	93.3
Overall Satisfaction	Clinical supervision - Overall	87.5	84.2	84.6	86.2	91.8	92.4
Raising Concerns - Educational and Clinical	Educational Governance - Know how to Raising Concerns about Training	87.2	85.7	92.4	88.3	91.7	91.8
Overall Satisfaction	The post will be useful for my future career	86.6	90.6	90.3	87.4	93.3	91
Clinical Supervision and Curriculum Coverage	Educational Supervision - Contact from supervisor	82.3	81.3	86.9	85.6	91	90.5
Raising Concerns - Educational and Clinical	Reporting Systems - Culture of learning lessons from concerns raised	81.2	87.7	80.1	78.6	86.2	81.1
Working Environment	Supportive Environment - A fully sppurtive environment	80.7	77.3	79.8	80.2	86	83.2
Raising Concerns - Educational and Clinical	Reporting Sytems - Culture of proactively reporting concers	79.8	83.3	82.2	78.8	85.1	82.3
Clinical Supervision and Curriculum Coverage	Adequate Experience - To achieve competencies	79	79	86	82	90	87
Working Environment	Induction - Information about the workplace	74.1	72.9	78.8	73.6	82.2	80.5
Clinical Supervision and Curriculum Coverage	Clinical Supervision - Out of hours	73.7	64.6	63.5	74.3	81.2	79.4
Working Environment	Team Work - between clinical departments is encouraged	72.7	83.7	73.6	75	81.7	77
Overall Satisfaction	Induction - Overall	72.1	72.3	71.1	70.4	78.6	73.3
Clinical Supervision and Curriculum Coverage	Confidence in opportunities for Practical Expereince	72.1	74.1	82.5	73.1	82.4	84.6
Overall Satisfaction	I would recommend this post to a freind	71.4	72.9	77.7	75.5	83.7	82.9
Rotas, Protected teaching and Study Leave	Local Teaching - Protected time	71.4	73.6	70.6	69.7	80.2	69.5
Working Environment	Team Work - between specialities/Asking for assitance	71.3	75.1	64.1	69	75	72.9
Working Environment	Supportive Environment - Supports confidence building	70.8	70.4	69.8	69.7	79.8	73
Raising Concerns - Educational and Clinical	Reporting Systems - Confidence that concerns are dealt with	70.3	75	74.8	69.9	81	72.5
Raising Concerns - Educational and Clinical	Educational Governance - Confidence to esculate when concern not addressed	69.9	72.8	80.8	71.7	78.5	79.6
Raising Concerns - Educational and Clinical	Reporting Concerns - Feedback on concerns raised	69.1	76.9	71.2	67.3	80	67.3
Clinical Supervision and Curriculum Coverage	Confidence in opportunities relevant to Profession experience	68.5	77.2	85.3	77.6	86.1	84.8
Working Environment	Supportive Environment - Senior Colleagues are receptive to disagreement	68.4	69.5	73.6	69.9	76.9	74.5
Overall Satisfaction	Teaching - Overall	67	61.6	65.6	73.3	81.3	78.6
Rotas, Protected teaching and Study Leave	Regional Teaching - Protected time	66.6	75.3	80.4	71.3	82.5	73.7
Rotas, Protected teaching and Study Leave	Rota Design - There are enough senior staff to deliver the appropriate level of care	64.9	58.6	53.1	70.7	81.7	76.4
Raising Concerns - Educational and Clinical	Educational Governance - Confidence concerns would be addressed	64	65.3	67.9	70	77.8	73.5
Rotas, Protected teaching and Study Leave	Rota given in advance of starting	61.5	63.5	72.8	35.9	38.6	38.3
Working Environment	Workload - "Is your work emoitionally exhausting"	55.6	58.1		44	48.8	47.3
Working Environment	Workload - Work over rostered hours (daily or weekly)	55	44.8	48.2	52.9	67.3	71.8
Rotas, Protected teaching and Study Leave	Study Leave	51	57.1	60.6	59.7	69.5	62.4
Rotas, Protected teaching and Study Leave	Mandatory local training - Protected time	50.1	49.3	58.3	48.7	60.8	
Rotas, Protected teaching and Study Leave	Rota Design - Gaps in rota addressed to protect training	50	44.8		50.4	62.9	52.9
Rotas, Protected teaching and Study Leave	Rota Design - Educational opportunities are rarely lost due to rota gaps	47.5	43.7	47.6	36.6	42.3	40.8
Clinical Supervision and Curriculum Coverage	Handover - As a learning opportunity	46.9	47.2	51.7	22.4	17.1	21.8
Rotas, Protected teaching and Study Leave	Workload - Does your work pattern leave you feeling short of sleep (daily/weekly)	46.6	42.4	37.3	57.8	67.1	54.5
Clinical Supervision and Curriculum Coverage	Feedback - Informal Feedback (Daily or weekly)	45.2	34	29.2	26.6	25	28.2
Overall Satisfaction	Do you feel burnt out because of work	37.3	45.5	37.2	49	64.8	53.3
Rotas, Protected teaching and Study Leave	Rota Design - Rota design helps promote educational opportuities	31.9	33		35.6	40.5	40.6
Clinical Supervision and Curriculum Coverage	Handover - Involvement of the MDT	23.1	26.2	21.3	62.5	71.9	70.2

Table 3 - GMC Data 2019 - Areas with -5% or less percentage difference between EM and non-EM training posts

Category	Description	ACCS	ST3	ST4+
Clinical Supervision and Curriculum Coverage	Adequate Experience - To achieve competencies	-3	-11	-1
Clinical Supervision and Curriculum Coverage	Educational Supervision - Contact from supervisor	-3.3	-9.7	-3.6
Clinical Supervision and Curriculum Coverage	Confidence in opportunities relevant to Profession experience	-9.1	-8.9	0.5
Overall Satisfaction	I would recommend this post to a freind	-4.1	-10.8	-5.2
Rotas, Protected teaching and Study Leave	Rota Design - Gaps in rota addressed to protect training	1.3	-16	
Rotas, Protected teaching and Study Leave	Study Leave is encouraged	-1.9	-10.2	-11.2
Rotas, Protected teaching and Study Leave	Rota given in advance of starting	-8.5	-14.3	-0.7
Rotas, Protected teaching and Study Leave	Rota Design - Educational opportunities are rarely lost due to rota gaps	-2.9	-19.2	-5.3
Clinical Supervision and Curriculum Coverage	Clinical Supervision - Out of hours	-0.6	-16.6	-15.9
Rotas, Protected teaching and Study Leave	Mandatory local training - Protected time	-9.6	-20.2	-4.1
Overall Satisfaction	Teaching - Overall	-6.3	-19.7	-13
Overall Satisfaction	Do you feel burnt out because of work	-10.7	-20.5	-9
Clinical Supervision and Curriculum Coverage	Handover - Involvement of the MDT	-12.5	-14.3	-19.3
Rotas, Protected teaching and Study Leave	Rota Design - There are enough senior staff to deliver the appropriate level of car	-5.8	-23.1	-23.3
Working Environment	Workload - "Is your work emoitionally exhausting"	-19.7	-19.5	
Rotas, Protected teaching and Study Leave	Workload - Does your work pattern leave you feeling short of sleep (daily/weekly)	-24.2	-25.3	-15.5
Clinical Supervision and Curriculum Coverage	Feedback - Informal Feedback (Daily or weekly)	-12.6	-33.1	-25.3
Rotas, Protected teaching and Study Leave	Rota Design - Rota design helps promote educational opportuities	-17.1	-31.8	

Table 4 - GMC Data 2019 - ST3's in EM provide worse ratings across the board

List of Hospitals by Respondents numbers (Year 2022 only)

2022 was the first year we collected hospital-level data.

We will only report on a hospital level every 2-3 years to protect the anonymity of those responding who may be in the current programme. If numbers are less than 3 there will be no hospital level data published.

Aberdeen Royal Infirmary (NHS Grampian)	10	Prince Charles Hospital, Merthyr Tydfil	2
Addenbrooke's Hospital (Cambridge University Hospital NHS Foundation Trust)	18	Princess Alexandra Hospital	1
Aintree University Hospital (Liverpool University Hospitals NHS Foundation Trust)	6	Princess Alexandra Hospital. Harlow	1
Airedale Hospital (Airedale NHS Foundation Trust)	5	Princess of Wales Hospital (Cwm Taf Morgannwg University Health Board)	4
Alder Hey Children's Hospital	3	Princess Royal University Hospital (King's College Hospital NHS Foundation Trust)	1
Altnagelvin Hospital (Western Health and Social Care Trust)	3	Queen Alexandra Hospital (Portsmouth Hospitals NHS Trust)	10
Antrim Area Hospital (Northern Health and Social Care Trust)	9	Queen Elizabeth Hospital (Gateshead Health NHS Foundation Trust)	3
Arrowe Park Hospital	1	Queen Elizabeth Hospital (Lewisham and Greenwich NHS Trust)	5
Barnet General Hospital (Royal Free London NHS Foundation Trust)	2	Queen Elizabeth Hospital (University Hospitals Birmingham)	3
Barnsley Hospital (Barnsley Hospital NHS Foundation Trust)	3	Queen Elizabeth Hospital, King's Lynn	1
BASILDON AND THURROCK UNIVERSITY HOSPITSL	2	Queen Elizabeth University Hospital (NHS Greater Glasgow and Clyde)	13
Bedford Hospital (Bedfordshire Hospitals NHS Foundation Trust)	4	Queen's Hospital (Barking Havering and Redbridge University Hospitals NHS Trust)	5
Birmingham City Hospital (Sandwell and West Birmingham NHS Foundation Trust)	1	Queens Medical Centre (Nottingham University NHS Trust)	13
Blackpool Victoria Hospital	2	Rotheram Hospital (The Rotherham Hospitals NHS Foundation Trust)	6
Bolton Hospital (Bolton NHS Foundation Trust)	13	Royal Alexandria Hospital (NHS Greater Glasgow and Clyde)	8
Bradford Royal Infirmiary (Bradford Teaching Hospitals NHS Foundation Trust)	9	Royal Berkshire Hospital (Royal Berkshire Hospital NHS Foundation Trust)	5
Bristol Royal Infirmary (University Hospitals Bristol and Weston NHS Foundation Trust)	7	Royal Blackburn Hospital (East Lancashire NHS Hospital Trust)	2
Broomfield Hospital	2	Royal Cornwall Hospital (Royal Cornwall Hospital NHS Trust)	1
Calderdale Royal Hospital (Calderdale and Huddersfield NHS FT)	1	Royal Darwin Hospital	1
Charing Cross Hospital (Imperial College Healthcare NHS Trust)	5	Royal Derby Hospital (University Hospitals of Derby and Burton NHS Foundation Trust)	12
Chelsea & Westminster Hospital (Chelsea & Westminster Hospital)	5	Royal Devon & Exeter Hospital (Royal Devon & Exeter Hospital NHS Foundation Trust)	9
Colchester General Hospital (East Suffolk and North Essex NHS Foundation Trust)	2	Royal Free Hospital (Royal Free London NHS Foundation Trust)	2
Conquest Hospital (East Sussex Healthcare NHS Trust)	1	Royal Infirmary of Edinburgh (NHS Lothian)	10
Countess of chester	1	Royal Liverpool University Hospital (Liverpool University Hospitals NHS Foundation Trust)	6
Craigavon Hospital (Southern Health & Social Care Trust)	3	Royal London Hospital (Barts Health NHS Trust)	15
Croydon University Hospital (Croydon University Hospital Trust)	4	Royal Oldham Hospital (Pennine Acute Hospitals NHS Trust)	2
Cumberland Infirmary (North Cumbria University Hospitals NHS Trust)	4	Royal Preston Hospital (Lancashire Teaching Hospitals)	5
Derriford Hospital (University Hospitals Plymouth)	5	Royal Shrewsbury Hospital (Shrewsbury and Telford Hospital NHS Trust)	3
Doncaster Royal Infirmary (Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust)	2	Royal Stoke University Hospital (University Hospitals of North Midlands)	7
East Surrey Hospital (Surrey and Sussex Healthcare NHS Trust)	1	Royal Surrey County Hospital (Royal Surrey NHS Foundation Trust)	1
Forth Valley Hospital	1	Royal United Hospital (Royal United Hospitals Bath)	5
Frimley Park Hospital (Frimley Health NHS Foundation Trust)	3	Royal Victoria Hospital Belfast (Belfast Health and Social Care Trust)	6
Glasgow Royal Infirmary (NHS Greater Glasgow and Clyde)	9	Royal Victoria Infirmary (Newcastle-upon-Tyne Hospitals NHS Foundation Trust)	6

Gloucestershire Royal Hospital (Gloucestershire Hospitals NHS Foundation Trust)	7	Russells Hall Hospital Dudley	1
Grange University Hospital (Aneurin Bevan Health Board)	9	Salford Royal Hospital (Northern Care Alliance NHS Foundation Trust)	7
Great Western Hospital (Great Western Hospital NHS Foundation Trust)	4	Scarborough Hospital (York Teaching Hospital NHS Foundation Trust)	1
Harrogate District Hospital (Harrogate District NHS Foundation Trust)	4	Southend Hospital (Southend University Hospital NHS Foundation Trust)	2
Heartlands Hospital (University Hospitals Birmingham)	4	Southmead Hospital (North Bristol NHS Trust)	5
Hillingdon Hospital (Hillingdon Hospitals NHS Foundation Trust)	2	Southport and Formby District General Hospital (Southport and Ormskirk Hospitals NHS Trust)	1
Homerton University Hospital (Homerton University Hospital Foundation Trust)	2	st peter's hospital	1
Horton General Hospital (Oxford University Hospitals NHS Foundation Trust)	2	St Richard's Hospital	1
Huddersfield Royal Infirmary (Calderdale and Huddersfield NHS FT)	6	St. George's Hospital (St George's NHS Hospital Trust)	9
Hull Royal Infirmary (Hull University Teaching Hospitals)	15	St. Helier Hospital (Epsom and St Helier University Hospitals NHS Trust)	4
Ipswich Hospital (East Suffolk and North Essex NHS Foundation Trust)	7	St. James's Hospital (Leeds Teaching Hospital Trust)	9
James Cook Hospital (South Tees Hospitals NHS Trust)	2	St. John's Hospital (NHS Lothian)	2
James Paget University Hospital (James Paget Hospital and NHS Foundation Trust)	2	St. Mary's Hospital (Imperial College Healthcare NHS Trust)	7
John Radcliffe Hospital (Oxford University Hospitals NHS Foundation Trust)	6	St. Thomas' Hospital (Guy's & St Thomas NHS Foundation Trust)	12
Kettering General Hospital (Kettering General Hospital NHS Trust)	4	Stepping Hill Hospital (Stockport NHS Foundation Trust)	2
King George Hospital (Barking Havering and Redbridge University Hospitals NHS Trust)	1	Stoke Mandeville Hospital (Buckinghamshire Healthcare NHS Trust)	1
King's College Hospital (King's College Hospital NHS Foundation Trust)	6	Sunderland Royal (South Tyneside and Sunderland NHS Foundation Trust)	5
King's Mill Hospital (Sherwood Forest Hospitals NHS Foundation Trust)	2	Torbay Hospital (Torbay and South Devon NHS Trust)	8
Kingston Hospital (Kingston University Hospital and NHS Foundation Trust)	4	Tunbridge Wells Hospital (Maidstone and Tunbridge Wells NHS Trust)	3
Leeds General Infirmary (Leeds Teaching Hospital Trust)	7	Ulster Hospital (South Eastern Health and Social Care Trust)	2
Leicester Royal Infirmary (University Hospitals of Leicester NHS Trust)	6	University College Hospital (University College London Hospitals NHS Foundation Trust)	4
Leighton Hospital (Mid Cheshire Hospitals NHS Foundation Trust)	3	University Hospital Coventry (University Hospitals Coventry & Warwickshire NHS Trust)	10
Lincoln county hospital	2	University Hospital Crosshouse (NHS Ayrshire and Arran)	3
Lister Hospital (East and North Hertfordshire NHS Trust)	5	University Hospital Hairmyres (NHS Lanarkshire)	2
Luton and Dunstable University Hospital (Bedfordshire Hospitals NHS Foundation Trust)	7	University Hospital Lewisham (Lewisham and Greenwich NHS Trust)	4
Macclesfield District General Hospital (East Cheshire NHS Trust)	2	University Hospital Monklands (NHS Lanarkshire)	5
Maidstone Hospital (Maidstone and Tunbridge Wells NHS Trust)	1	University Hospital Of North Durham (County Durham and Darlington NHS Foundation Trust)	2
Manchester Royal Infirmary (Manchester University NHS Foundation Trust)	6	University Hospital of Wales (Cardiff and Vale University Health Board)	6
Medway Maritime Hospital (Medway NHS Foundation Trust)	2	University Hospital Southampton NHS Foundation Trust (University Hospital Southampton)	6
Milton Keynes University Hospital (Milton Keynes University Hospital NHS Foundation Trust)	3	Walsall Manor Hospital - Walsall Healthcare NHS Trust	1
Morriston Hospital (Swansea Bay University Health Board)	1	Warrington Hospital	3
Musgrove Park Hospital (Somerset NHS Foundation Trust)	3	Warwick Hospital (South Warwickshire NHS Foundation Trust)	3
New Cross Hospital (The Royal Wolverhampton NHS Trust)	6	Watford General Hospital	2
Newham University Hospital (Barts Health NHS Trust)	4	West Suffolk Hospital	1
Ninewells Hospital, NHS Tayside	7	Wexham Park Hospital (Frimley Health NHS Foundation Trust)	6
Norfolk and Norwich University Hospital	6	Whipps Cross Hospital (Barts Health NHS Trust)	4
North Devon district	1	Whiston Hospital (St Helens and Knowsley Teaching Hospitals NHS Trust)	3
North Manchester General Hospital (Pennine Acute Hospitals NHS Trust)	1	Whittington Hospital (Whittington Health NHS Trust)	5
North Tees Hospital (North Tees and Hartlepool Hospitals NHS Foundation Trust)	6	William Harvey Hospital (East Kent Hospitals University NHS Foundation Trust)	2
Northampton General Hospital (Northampton General Hospital NHS Trust)	2	Wishaw Hospital (NHS Lanarkshire)	4
Northern General Hospital (Sheffield Teaching Hospitals NHS Foundation Trust)	15	Worcestershire Royal Hospital	1

Northumbria Specialist Emergency Care Hospital (Northumbria Healthcare NHS Trust)	3	Worthing Hospital	1
Northwick Park Hospital (London Northwest University Healthcare NHS Trust)	3	Wrexham Maelor Hospital (Betsi Cadwaladr University Health Board)	2
Peterborough City Hospital (North West Anglia Foundation Trust)	8	Wythenshawe Hospital (Manchester University NHS Foundation Trust)	5
Pinderfields Hospital (Mid-Yorkshire NHS Trust)	11	York Hospital (York Teaching Hospital NHS Foundation Trust)	1
Prince Charles Hospital, Merthyr Tudful	1	Ysbyty Gwynedd (Betsi Cadwaladr University Health Board)	3