# A qualitative evaluation of the GMC's trainer recognition framework

Final Report

July 2019

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# Acknowledgements

# Executive Summary

## Background

The GMC's Trainer Recognition Framework was introduced in 2012, and since 2016 it has been mandatory for all education organisers (postgraduate deaneries, medical schools) and local education providers (NHS Trusts and Health Boards) to provide the GMC with details of trainers working in four defined roles (the named educational and clinical supervisors in postgraduate education, and those with responsibility for oversight of medical student progression, and for coordination of placements in undergraduate education).

Examination of recognition data for postgraduate deaneries and medical schools across the UK shows some variability in the proportion of recognised trainers to postgraduate trainees, but a very large range in the ratio of medical students to undergraduate trainers. There is therefore a difference in the processes in different localities.

This study set out to qualitatively evaluate the recognition framework in its third year of implementation by addressing four research questions:

1.  How aware are stakeholders in different settings of the trainer recognition framework?
2.  What, if any, impact do stakeholders identify as arising from the trainer recognition framework?
3.  What factors are key influences of awareness and impact?
4.  How may trainer recognition be developed to deliver sustained positive impact?

## Methods

In total, 261 individuals took part in the study, in 43 separate data collection activities across the UK. Focus groups, interviews, workshops and item-of-discussion in national meetings were used to collect qualitative data from doctors in recognised and non-recognised roles, including some in senior educational roles (eg, training programme directors, directors of medical education, postgraduate deans), and trainees. Some education managers also took part.

## Findings

### Awareness

There was little awareness of recognition among many trainers. Where they were aware, it was often incidental, through interaction with local processes, such as access to training events and appraisal, and the ownership of the GMC and the regulator's role in process were relatively invisible. Gauging the extent of awareness can be complicated by uncertainty over terminology, with 'recognition' sometimes being used to denote other processes, including job planning. There was even less awareness of the recognition framework among trainees.

### Impact

Some participants felt that recognition has had no discernible impact, but this may be confounded by variability in their awareness. For others, positive and negative effects were identifiable. Some of these are practical, and reflect direct changes for trainers or for educational processes, while others are more abstract and symbolic.

The reflection of recognised roles in job planning constitutes an important, concrete material impact, but was variable, both in nominal recognition in job plans, and the realism of those job plans. This varied between LEPs, and in some places the inclusion of educational roles in job plans was felt to be more transparent, and fair, than in others. In relation to job planning in particular, a difference in scope and impact of undergraduate roles from postgraduate was evident.

Most practical impact was however incidental, through training and appraisal processes which are not specific to, nor defined in terms of, trainer recognition. Perceptions of the value of these processes varied. Many trainers felt that they can be superficial and serve a 'box-ticking' function rather than actually developing trainers' expertise. However, some felt that they have benefited directly from training, and welcomed the opportunity to have their educational roles reviewed in appraisal. The extent and quality of educational appraisal varied widely, even within LEPs.

Recognition, and its associated processes, has had a direct effect on the supervisor population, with a process of 'self-selection' being evident, where doctors may withdraw from supervision if they cannot, or choose not to, undertake the required training and Continuing Professional Development. This may be associated with a *de facto* improvement in quality, if less engaged or committed trainers leave, but some participants felt that good trainers may be deterred by these requirements.

The symbolic value of recognition *per se* was also felt to be limited, with trainers in non-recognised roles often feeling it did not matter. There were also some who felt that it may be more important for newer consultants or Specialty and Associate Specialist (SAS) doctors, as a role to support their career development. However, there was a feeling that recognition has indeed contributed to a '*professionalisation'* of education and training. This was also indicated in a perceived clarity of what trainees can expect from supervisors.

Those in senior roles felt that recognition provides benefit in postgraduate education, albeit one which has not been fully capitalised upon as yet. Evidencing this is hard, but they felt that existing quality processes – including GMC surveys, but also patient-centred outcomes such as Care Quality Commission (CQC) reports – were sensitive to changes arising from improvements in supervision. Cultural change, and the development of mutually supportive communities of practice among trainers were also identified through anecdotal and 'soft intelligence'.

## Factors shaping awareness and impact

Awareness and impact were both shaped by local processes including training and appraisal. Even at a local level interpretation and communication varied between LEPs, with directors of medical education and managers within LEPs influencing how interpretation is received. Leadership at all levels is therefore important for consistent and effective implementation.

An important element of variability was in the process of identifying and notifying recognised trainers. Even in postgraduate education, where roles are fairly clearly defined, it is not always easy to identify the necessary trainers and involves substantial administration in making contact with individual clinicians and checking of details. This is an ongoing process to check records and activity of those who may not be continuing in educational roles. These processes have not been resource-neutral, and the time and resources required for the collation and maintenance of records are, for the most part, additional to those required for delivering training and appraisal.

The scope of recognition, and in particular the boundary between routine clinical supervision and the responsibilities of being a named supervisor, is an important element of implementation which may shape

awareness and impact. While supervisors may have specific formal responsibilities for trainees, that others do not, this may not be clear cut. The distinction between educational and clinical supervision was also not clear for all participants, with varying interpretation between specialties.

### Undergraduate recognition as a distinct area

It was evident that recognition is less clear, and less relevant, in undergraduate education. There was less clarity about its potential benefit, and overall relevance to undergraduate education was felt to be low – the term 'trainer' being essentially a postgraduate one. This is because the undergraduate roles were felt to be ill-defined, and not reflective of the range of other important undergraduate supervision roles. Some undergraduate trainers felt this suggests undergraduate education is not valued to the same extent as postgraduate, as equivalent roles are not recognised. Undergraduate roles were rarely recognised in job plans, adding to this perception of differential value.

There was also variability in how recognition is interpreted between medical schools, which may have a knock-on effect for individuals moving between similar jobs at different institutions. Some schools take a pragmatic approach to recognising a number which is seen as manageable, while others apply a more literal reading of the role definitions.

The extent to which alignment between postgraduate and undergraduate roles can, or should, be achieved appears to be uncertain. Some feel that recognition could provide greater parity of impact if similar roles are defined for recognition in the two sections. However others suggest the ways in which education and training are delivered and managed in the sectors as being too great.

### Future development

Participants' views of how recognition should or could be developed focused on improving the clarity of its intended function as communicated to trainers, and in the use of the GMC's regulatory 'teeth' to ensure that job planning requirements in particular are enforced. Desire for changes to the scope of the framework was not clear-cut, with some feeling there are currently non-recognised roles which should be, and others feeling that an increase in the number of roles will just increase bureaucratic burden. Some felt that the framework may benefit from redesign as a progressive set of standards, indicating achievement of excellence and so providing aspiration to a career in medical education.

## Conclusions and implications

The headline finding is that the potential of recognition has yet to be fulfilled, but there are pockets where those benefits are being shown.

A crucial starting point would be to consider ways of awareness-raising among the whole trainer constituency. The devolution of process and definition to local areas has potentially helped implementation, and too much prescription by the GMC is unlikely to provide additional benefits. However, a degree of increased clarity around some areas, job planning in particular, would likely be of benefit to trainers. Addressing this is likely to be a political and practical challenge, but was identified as a barrier to engagement, and as something that would enhance practical quality of supervision.

The appropriateness of the recognition framework for undergraduate medical education appears questionable, both in language and intent. Its potential value for undergraduate trainers, and medical schools, does not seem to be demonstrated. While education is discussed as a continuum, there remains a dichotomy. Recognition is unlikely to resolve that duality, but needs to acknowledge it.

# Contents

# List of abbreviations

**DME**    Director of Medical Education

**EO**    Educational Organiser (a Postgraduate Deanery or Medical School)

**LEP**    Local Education Provider (a provider of clinical placements – usually an NHS Trust or Health Board).

**LRMP**    List of Registered Medical Practitioners (the medical register held by the GMC)

**SPA**    Supporting Professional Activity (time defined in a clinician's job plan for work other than clinical service delivery).

**TPD**    Training Programme Director

# 1   Background

The trainer recognition framework was introduced by the GMC in the *Implementation Plan* of 2012. [1] Its introduction reflected concerns about the variability of training and supervision in secondary care, due to factors that included a lack of training and support for supervisors, and their not having time to provide support to trainees (factors which continue to have relevance). Planned as a parallel system to the statutory approval of trainers in primary care, trainer recognition aimed to 'promote and enhance the value of training both in individual job plans and within the organisations that employ doctors involved in training' (para 29). While the *Implementation Plan* indicated a statutory approval for secondary care trainers would be pursued, this was ultimately not felt to be necessary as implementation proceeded. Rather the status of an individual doctor is associated with, and viewable with, their record on the List of Registered Medical Practitioners (LRMP) – the medical register.

In most other respects, implementation has proceeded as planned, and since June 2016 educational organisers (EOs; deaneries and medical schools) in the UK have been required to provide the GMC with a record of trainers who perform any of four defined roles.

## 1.1   Scope of the framework

The framework was based around a generic definition of a medical trainer as 'an appropriately trained and experienced doctor who is responsible for the education and training of medical students and/or postgraduate medical trainees which takes place in an environment of medical practice' (p15). It limited the *requirement* for recognition of trainers to four defined roles in order to minimise regulatory burden. However, it did allow local discretion for recognition to be extended to other doctors, including Specialty and Associate Specialist (SAS) doctors, in educational roles, and indicated that the contribution of other trainers outside medicine could, and should, be acknowledged and supported locally by EOs and local education providers (LEPs).

The four defined roles are summarised in table 1. The postgraduate supervisory roles contrast with the leadership functions, and numerically fewer roles, set out for undergraduate settings. The specification of 'named' postgraduate supervisors was intended to emphasise the responsibility of trainers for specific trainees, and in the case of named clinical supervisors to emphasise the distinction between this responsibility and general workplace clinical supervision.

## 1.2   Processes of recognition

The *Implementation Plan* set out a range of functions required of educational organisers and local education providers (LEPs, the organisations within which students and trainees undertake clinical placements). The main functions, summarised in Table 2, are the selection and identification of trainers, the provision of training and support, the management of resources, and providing data to the GMC. The *Implementation Plan* identified these functions as those that should already have been in place, so making recognition cost neutral, but with greater formalisation spreading good practice and improving quality.

There is an implicit hierarchical structure in these responsibilities, with operational details resting with LEPs and higher order functions with EOs, but the framework allows for local flexibility, and recognises that existing effective relationships do not need to be changed. However, the responsibility for recognition rests with EOs, which are accountable to the GMC under the framework.

Trainers must comply with requirements for training and appraisal set out by local organisations, but these are not specified directly by the GMC. Similarly, while the *Implementation Plan* states that LEPs should ensure trainers are supported through appraisal and revalidation, how recognition should be represented in those processes is not prescribed.

Processes relating to job planning, appraisal and dealing with concerns are not specified in detail. The *Implementation Plan* indicates that educational roles should be appropriately reflected in job plans, and the NHS consultant contract is clear that medical education activities should be included within Supporting Professional Activities (see Box 1), but there is no specification of what the time allocation should be:

> *The time commitments will vary from individual to individual but must be clearly spelled out in job plans for all trainers active in any of the roles requiring recognition and also where relevant for other trainers (eg sessional supervisors). (Implementation Plan, para 110)*

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**Box 1.   Job planning and the NHS Consultant Contract**

The unit of working time in secondary care is the Programmed Activity (PA), usually four-hour periods. Under the standard consultant contract, these sessions are divided between direct clinical care (DCC) and supporting professional activities (SPAs), with time allocated and accounted for in a formal job plan. The 2003 consultant contract indicated a distribution of 7.5 DCC and 2.5 SPA sessions, but often this is 8:2, or for new consultants may be 9:1. Details of PAs are negotiated at a local level. Other roles provided for in the contract (Additional NHS Activities and External Roles) can be allocated PAs on an individual basis.

The contract provides examples of activities in each category. [2] While not exhaustive, most educational activity is included in SPAs (participation in training, medical education, continuing professional development, formal teaching). Some specific roles are included as 'Additional NHS Activities' (including undergraduate dean, postgraduate dean, clinical tutor or regional education adviser).

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## 1.3   The content of the framework

The Framework was based on a framework for professional practice published by the Academy of Medical Educators (AoME) in 2010. [3] This described activities which professional educators must undertake, within seven 'framework areas': ensuring safe and effective patient care through training, establishing and maintaining an environment for learning, teaching and facilitating learning, enhancing learning through assessment, supporting and monitoring educational progress, guiding personal and professional development and continuing professional development (CPD) as an educator. In each of the areas, expected performance for 'the effective supervisor' and 'the excellent supervisor' are defined, along with examples of evidence and suggested content for training courses.

The framework areas, as used in the *Implementation Plan,* provide a structure for the areas of educational practice which should be evidenced, and specify process requirements. The standards for training are contained in the GMC's *Promoting Excellence* document [4], which was designed to reflect the recognition framework.

While the GMC recognition framework refers to the 2010 AoME publication, the AoME revised their framework in 2014. [5] Much of the content is the same, but this later version refers to five 'domains' instead of the seven 'areas'. Descriptors are more explicitly referred to as standards, with three rather than two levels of performance, linked to Membership or Fellowship of the Academy.

**Table 1.** Recognised roles as defined in the *Implementation Plan*

|  | Label | Description |
|---|---|---|
| Undergraduate | Those responsible for overseeing students' progress at each medical school | 'Medical schools will identify and recognise one or more doctors at the school who are responsible for overseeing students' trajectories of learning and educational progress. They might be NHS consultants or clinical academics acting as block or course coordinators.' |
|  | Lead coordinators at each local education provider (LEP) | 'Medical schools will also identify and recognise one or more doctors at each local education provider responsible for coordinating the training of students, supervising their activities and ensuring these activities are of educational value.' |
| Postgraduate | Named educational supervisors (ES) | 'A named educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement or series of placements. Every trainee must have a named educational supervisor. The educational supervisor helps the trainee to plan their training and achieve agreed learning outcomes. He or she is responsible for the educational agreement and for bringing together all relevant evidence to form a summative judgement at the end of the placement or series of placements.' |
|  | Named clinical supervisors (CS) | 'A named clinical supervisor is a trainer who is responsible for overseeing a specified trainee's clinical work throughout a placement in a clinical or medical environment and is appropriately trained to do so. He or she will provide constructive feedback during that placement. He or she will lead on providing a review of the trainee's clinical or medical practice throughout the placement that will contribute to the educational supervisor's report on whether the trainee should progress to the next stage of their training.' |

**Table 2.** Main responsibilities of Educational Organisers and Local Education Providers as set out in the Implementation Plan

| Educational organisers | Local Education Providers |
|---|---|
| a  Taking the lead role in recognising trainers, including establishing criteria and processes consistent with the GMC's standards and requirements. | a  Identifying trainers currently in the roles requiring recognition and choosing recognised trainers to perform the four roles. |
| b  Reaching agreements with local education providers on respective roles and responsibilities. | b  Ensuring that sufficient trainers are in post and available to train. |
| c  Quality managing training arrangements at local education providers and their job planning for training in light of the GMC's standards and the seven AoME areas. | c  Supporting trainers through: |
| d  Reviewing available information before deciding to recognise individual trainers. |    i  job plans<br>   ii  appraisal and revalidation<br>   iii  support for the training and professional development of trainers<br>   iv  dealing effectively with concerns and difficulties. |
| e  Passing on information to the GMC about the GP trainers identified; and, once the GMC has the necessary statutory powers, also passing on information about other trainers requiring GMC approval. | d  Taking effective action where training is poor, and remediation is not sufficient. |
| f  Reporting regularly to the GMC on the adequacy of the job planning at each LEP in their area and generally cooperating with quality assurance by the GMC. | e  Mapping their arrangements against the seven areas of AoME's *A Framework for the Professional Development of Postgraduate Medical Supervisors*[3] and ensuring that the GMC's standards are met. |
|  | f  Liaising with EOs in accordance with agreed arrangements eg on establishing databases of recognised trainers which can be accessed by both LEPs and EOs. |
|  | g  Being accountable for the use of the resources received to support medical education and training. |

## 1.4   Associated literature

A search of academic databases found very limited literature directly relevant to the framework. The formal accreditation of individual educators or supervisors does not appear to be common, although examples of formal frameworks which describe the parameters of good supervision were found.

Empirical work which informed the development of the AoME framework was published in 2010. [6] This involved qualitative analysis of data collected across London, with the explicit aim of defining a framework and assessment portfolio for supervisors. This identified a lack of clarity of supervisor roles, responsibilities and training, and how accreditation of trainers would align with revalidation, which was being introduced at the same time. There were concerns about duplication and workload. Engagement and motivation of supervisors was also mentioned as problematic due to increasing service pressures, clinical accountability and requirements from regulators.

An Educational Supervision Agreement was introduced in Wales as a means of standardising and clarifying the relationships between supervisors, LEPs and the Wales Deanery (now part of Health Education and Improvement Wales). It was planned from the outset with trainer recognition in mind. A mixed-methods evaluation of the agreement was carried out using questionnaires and interviews one year after implementation. [7] Overall, participants indicated that the agreement had a positive impact on all stakeholders. Findings showed that the agreement professionalised the Educational Supervisor's role, that it increased the accountability of both Educational Supervisors and Health Boards, and provided leverage to negotiate SPA time and CPD activities. Interview data showed that supervisors thought that it enhanced accountability for all stakeholders and that they hoped the agreement would improve Health Board compliance ensuring that supervisors are looking after junior doctors. However, they also reported that high clinical workload affected use of SPA time, that trainers did not always get SPA time in practice and that they did not feel recognised or supported. Since the evaluation, the agreement has been extended first to named clinical supervisors, and subsequently to the recognised undergraduate roles. [8]

Outside of medicine the Accreditation of Clinical Educators (ACE) scheme was launched by the Charted Society of Physiotherapy in 2004. This voluntary scheme was intended to give educators the opportunity to consolidate and develop their skills and knowledge, thus raising the profile of the role of clinical educators. It aimed to enhance the quality of clinical education in the UK by improving consistency and reliability, and providing a baseline of standards. A qualitative evaluation of the framework, based on 13 clinical educators' experiences, [9] found that motivation for taking part in the ACE scheme was that it provided a formal opportunity to develop knowledge and understanding, and to gain recognition for their role that was not 'too academic' (that is, felt practically relevant). Some felt it was an obligation to better their skills and knowledge. It also provided clarification of their educator's role, and left them feeling more confident. All educators thought that it had also benefited students' learning experience.

Overall, this evidence suggests that formal processes for the recognition of educators are desirable and beneficial, and can help professionalise medical education and increase the value of the supervision for all stakeholders. It can clarify educational roles and provide a structure for development. However, there are some areas of challenge, in particular, ensuring that time for educational activity is available.

## 1.5   National profile of recognised trainers

In order to establish the context of recognition, data held by the GMC on the numbers of recognised trainers in different areas of the UK were reviewed. This provided an indication of the prevalence of these roles standardised to the size of learner populations.

These figures indicated a difference in the scale of recognition of postgraduate and undergraduate trainers. The populations of students and trainees are similar in size, with student numbers being 89% of trainees. However, the numbers of undergraduate trainers are a fraction of postgraduate figures (4%). This reflects that they are pitched at different levels in relation to their learner populations – postgraduate roles are closer to the learner, and so a ratio closer to 1:1 is to be expected, while undergraduate roles have responsibility for large numbers of students.

The number of trainers in postgraduate recognised roles varied substantially between regions, from 554 to 6714, though the ratio of trainees to trainers was in a fairly small range from 0.6 to 2.8 (median 1.2). By contrast, not only did the number of undergraduate roles vary widely between medical schools (from 7 to 145), but the ratio of students to recognised trainers ranged from 4.1 to 119.2. Actual staff-student ratios will not vary to this extent, and so this range is highly suggestive of different approaches to the interpretation of undergraduate definitions.

Overall, 896 trainers are recognised in both undergraduate and postgraduate roles (meaning 67% of those in undergraduate roles are also recognised in a postgraduate capacity).

## 1.6 Research objectives

The research aimed to evaluate the impact of trainer recognition as identified by stakeholder groups, and identify what these groups considered as directions of future development. Research questions reflecting these aims were:

1. How aware are stakeholders in different settings of the trainer recognition framework?
2. What, if any, impact do stakeholders identify as arising from the trainer recognition framework?
3. What factors influence awareness and impact?
4. How may trainer recognition be developed to deliver sustained positive impact?

## 2   Methods

The project took a qualitative approach, with focus groups as the primary mode of data collection. These were supplemented with workshops, one-to-one interviews and group discussions as part of agenda items in meetings.

### 2.1   Selection of data collection sites

Sites were identified across the UK, with representation from the four nations, including three regions of England (North East England, Kent, Surrey and Sussex (KSS) and the East Midlands). In anticipation of variability in the processes of recognition in English regions, we selected sites that had different ratios of trainees and students to recognised trainers, as indicated in data held by the GMC (see section 1.5).

### 2.2   Recruitment

Following initial contact with postgraduate deans, individuals within EOs and LEPs were contacted in order to arrange data collection activities – focus groups, interviews and workshops. Invitation to focus groups was facilitated by contacts in each location, while a direct invitation for interview was made by the research team.

Workshop participants were attendees at national and regional events, but their participation in the research activity was voluntary. An information sheet and letter from the GMC was distributed by email beforehand.

### 2.3   Methods

*Focus groups*: Focus groups followed a discussion guide containing questions of awareness of recognition, perceived impact, local processes, and potential changes to the framework or processes (see Appendix A). These main topics were covered in each focus group, although the emphasis of each varied as discussion evolved. Focus group discussions lasted between 45 and 60 minutes, were recorded with consent, and transcribed.

*Workshops*: Workshops took place during timetabled sessions at national and regional meetings. They differed from focus groups in that there were generally more participants, and sessions were designed to provide learning outcomes for participants. Sessions began with a brief introduction to the trainer recognition framework, and the evaluation project. Small group discussions followed, with group feedback and discussion as time allowed. Primary data were captured through written notes generated during discussions, although some group discussions were recorded as *aide memoires*. Shared online documents (Google docs and Google forms) were used to capture views on particular questions. Workshops lasted 30-45 minutes.

*Interviews*: Interviews were conducted with senior clinicians and education managers. Questions followed a schedule drawn from the focus group guide, but with more focused questions on local processes – how information is captured and transmitted, and how recognition relates to processes of appraisal and quality management. Depending on context, some of these interviews were audio-recorded and transcribed, while others were captured in contemporaneous notes. Interviews took around 30-40 minutes.

*Meetings*: Additional viewpoints were gathered from attendance at formal meetings where discussion was more limited than in focus groups or workshops. Discussion was captured through notes and shared online documents. These discussions lasted 10-30 minutes.

## 2.4   Participants

In total, 261 participants contributed to the research in 25 focus groups, 3 workshops, 2 meetings and 13 interviews across the UK. All groups contained male and female participants, from a range of clinical specialties and with a range of experience in training (as trainees and trainers).

Participants included undergraduate and postgraduate recognised roles, non-recognised roles (including those undertaking workplace supervision), and senior educational roles we refer to as 'leaders' (these included Foundation School Directors, Training Programme Directors (TPD), Heads of Speciality Schools, Directors of Medical Education (DME), Postgraduate Deans and Associate Deans). Non-clinical educational managers involved in the implementation of recognition also took part, and learners were represented by postgraduate trainees at different stages of training. No participants identified themselves as Specialty and Associate Specialist (SAS) doctors, though an SAS tutor represented this group of doctors. Table 3 summarises the participant numbers, although these figures are indicative only, as individual clinicians will occupy several different roles.

Table 3.    Data collection activities and numbers of stakeholders represented in each

|  | Total number of activities | Senior roles/ managers | Trainees | Trainers * | Total |
|---|---|---|---|---|---|
| Focus Groups | 25 | 47 | 19 | 74 | 140 |
| Interviews | 13 | 14 |  |  | 14 |
| Meetings | 2 | 33 |  |  | 33 |
| Workshops | 3 | 27 |  | 47 | 74 |
| Total | 43 | 121 | 19 | 121 | 261 |

*includes trainers in both recognised and non-recognised (workplace) supervisor roles.

Invitations to participate did not distinguish between recognised and non-recognised trainers, and while some groups focused on the undergraduate context, most participants have experience of both undergraduate and postgraduate education. However, to establish representation of different groups, focus group and workshop participants were asked to indicate their educational roles on a sign-in sheet. Not all participants provided this information, but Table 4 summarises responses received, illustrating the range of experience represented. Data were provided on sign-in sheets by 147 participants, many of whom indicated multiple roles.

Table 4.    Frequency of recognised and non-recognised roles indicated by participants

| Educational role | Number of participants |
|---|---|
| Named Educational Supervisor | 83 |
| Named Clinical Supervisor | 79 |
| Undergraduate Oversight | 31 |
| Undergraduate Coordinator | 12 |
| Training Programme Director | 14 |
| Director of Medical Education | 5 |
| Other non-recognised PG | 125 |
| Other non-recognised UG | 116 |
| Trainees | 11 |
| Non-clinical managers | 10 |

## 2.5    Analysis

Qualitative data analysis used the framework approach, [10] which takes an initially deductive approach to analysis in order to consider how data address *a priori* questions. Following initial familiarisation with transcripts, these were coded with descriptive labels derived from the research questions (that is, reflecting elements of awareness, impact, process and future development). These were sorted into overarching themes and interpretive narratives developed to answer the research questions. Emergent themes and concepts within these broad areas were developed inductively from the data. Initial codes are presented in Appendix B.

## 2.6    Ethical considerations

The project was reviewed by the Newcastle University Faculty of Medical Sciences Research Ethics Committee (ref 1639/8816). Information sheets were sent to participants in advance where possible, and in person to focus group and workshop participants. Informed consent was obtained in writing where possible, and otherwise verbally.

# 3 Findings

The framework analysis considered the key elements of the research questions: awareness of the GMC's trainer recognition framework, perceptions of its impact, the factors which shape those outcomes, and potential for future development. The findings are therefore structured along these lines, although additional elements are noted. Illustrative quotes are provided for key points, and are from trainers' focus groups (FG) except where otherwise indicated. 'Leaders' refers to participants with a senior (management) role in education or training.

The perspectives of postgraduate trainers and trainees are presented initially. Data relating to the undergraduate context identified particular differences and challenges, and so is presented as a distinct section.

## 3.1 Awareness

Explicit awareness of trainer recognition was limited among trainers and trainees.

Trainers were largely unaware of the role of the GMC in recognition, and were surprised that their status is recorded and available with the medical register.

There was frequent incidental awareness of the processes associated with recognition – such as training and appraisal.

Lack of awareness may be compounded by a lack of a clear message around the terminology – 'recognition' was associated with different experiences.

### 3.1.1 Awareness is limited

> *'It was the first time I'd heard the phrase when I got the email from you.' (FG9)*

Awareness of trainer recognition varied considerably, but was generally limited. Some said that they knew *'literally nothing'* (FG17) and had only become directly aware of the framework through participation in the research project. Others however knew a great deal, but these were often those in senior positions with direct responsibility for recognition.

Some trainers had been in their role from before the recognition framework was introduced, and so may understandably have been unaware. However, others who were presently in senior educational roles (such as a TPD), or who had more recently become trainers, were also found to be unfamiliar with the framework. Some had heard of recognition and were aware of what it meant in general terms, but still lacked knowledge about its details and the implementation process.

Notably, participants were often unaware of the role of the GMC in recognition, with some expressing surprise when told their supervisor training was related to GMC policy, and that their status was recorded on the LRMP (several participants checked their record online during focus groups when told). Despite its invisibility in this process, the profile of the GMC was noted – *'stamp of authority isn't it, the GMC still has some standing'* (FG2) – although some questioned the need for the GMC to have a role, seeing trainer governance as a local issue.

*'I'm not that sure what the role of the GMC is in all of this as I have been appointed by HEE to be TPD and I've got recognised time in my job plan as an educational supervisor. I fulfil the requirements that are needed so I'm not quite sure.' (FG20)*

Conversely, however, some individuals referred to the statutory process of GP trainer approval in comparison to processes in secondary care, and perceived higher quality of training in GP as a strength of regulation.

Most trainers expected that trainees would not be aware of recognition, and this was borne out by trainees themselves. While some trainers felt that this did not matter, some thought it would give trainees a fuller understanding of the educational context and be more in control of their own learning. If trainees are aware of what they should expect from trainers, it allows them to identify when they may raise concerns about supervision, and gives them a legitimacy to do so.

### 3.1.2 Awareness is incidental

While explicit awareness of recognition was low, there *was* awareness of processes associated with recognition, specifically supervisors' job planning, training and appraisal. These were educational arrangements recognised in their own right, rather than necessarily being linked to something known as the 'recognition framework'. Some trainees were also aware of supervisors having specific time for supervision.

Some appraisals were explicit about recognition, albeit '*buried*' (FG22) in the appraisal platform, meaning trainers may find out *'by accident'* (FG16). However, this was not the case for all, and in many instances, appraisal considered individuals' CPD and educational experience without directly relating this to recognition.

### 3.1.3 Terminology compounds lack of awareness

Explicit knowledge of recognition may be affected in part by semantic confusion over what is referred to by 'recognition'. For some, questions about recognition were hard to answer, as in this example from the beginning of one focus group.

*'And maybe the terminology, or the title of it, which I think throws me slightly. So I sit here going 'what is [the researcher] referring to?' I think I've got it now. So, I think most people have got it, but they just don't use the same terminology.' (FG4, leaders)*

In particular, recognition was understood in a vernacular sense of work being recognised in a job plan, which is true for some, but not all recognised roles (discussed in the next section). This confusion runs through much of the data, and we do not attempt to tease it out fully, in large part because the confusion reflects the reality of participants' perceptions, but also because job planning is a key element of how educational roles are incorporated into doctors' work, and so the framework's actual impact.

Further, the record of recognised status on the LRMP, where participants were aware of it, led some to associate recognition with revalidation, and specialty accreditation. These aspects of professional practice are more clearly specified and understood than recognition, and hence a perceived lack of similar specification for recognition was confusing.

## 3.2   Impact

Impact on individuals and at an organisational level was identifiable, although some felt that recognition had not had any effect.

Some impact was material and associated with the processes of recognition. Job planning was the most concrete of these, but skill development through training and appraisal is also identified.

Other impact was more symbolic, such as cultural changes around the professionalisation of education, the development of educational communities of practice, and increasing the status of educational roles for individual doctors.

Evidence of impact was limited, although participants inferred effects through existing quality metrics, from trainee surveys to CQC inspections.

The extent to which participants could identify impact explicitly arising from trainer recognition was obviously constrained by their awareness. However, positive, negative and neutral effects were apparent as arising from recognition processes.

Positive effects – some from participants' actual experience, others anticipated – were identified for individual trainers, and organisations. Some effects were clearly practical or material, involving changes in practice, processes, behaviours or attitudes, while others were more abstract or symbolic, reflecting changes in identity or culture. However, at the heart of these lies a complex relationship between the organisational context and individual trainers, and so we will avoid being too reductive.

> *'I don't understand it, it is interesting because I think after the initial grumbling, I think the recognition thing has been quite positive.' (FG4, leaders)*

> *'It's about status and recognition and motivation and having the time. It's a complicated thing isn't it?' (Interview 1, DME)*

Some felt that recognition had had negative effects. These included direct and indirect costs associated with the process – through administrative support time, and the time spent by clinicians in logging CPD etc. A further risk was disenfranchisement of 'good' trainers who could be alienated by the process.

> *'They believe in medical education as their core root of what they do, it's about investing in the future of medicine and when we started challenging people to provide evidence, it went to the core of that and they felt is as critical. That was my sense. (FG6, leaders)*

Many others indicated they could see no real need for recognition, or any direct effect. At its most extreme, this view was that recognition was purely superficial, and an *'expensive waste of time'* [FG18].

> *'It probably has some value, but at the moment it just feels more like a, it feels a bit tokenistic really. It just doesn't really feel particularly meaningful.' (Interview 5, LEP undergraduate lead)*

However, these views were not always entirely negative, with some noting that they did not see any impact 'yet', suggesting they acknowledged potential effects. For some, the lack of impact could be addressed by enhancing recognition, and increasing available sanctions, or 'teeth', available through the framework.

### 3.2.1 Material impact

#### 3.2.1.1 Job planning

Recognition had a positive impact through requiring some educational roles to be explicitly accounted for in job plans – typically 0.25 SPAs per trainee for being an ES, and 0.25 SPAs for being a CS, although this tariff was capped, and could vary considerably between LEPs. However, even when time was ostensibly provided, this did not mean it was genuinely available for supervision. These views were expressed by trainers and trainees, but perhaps confounded by an underlying mistrust of the transparency of the job planning process: '*the smoke and mirrors of job planning*' (Interview 12, undergraduate lead).

While there were criticisms of the cultural impact of job planning, with some suggesting that the requirement to account for time in such a detailed way was effectively de-professionalising medicine, there was also widespread desire for educational roles to be recognised in job plans.

There was a clear consensus that education and supervision is time-consuming, lengthening individual consultations and reducing the numbers of patients who can be seen in a clinic. While clinical time is accounted for in direct clinical care sessions (DCC, see Box 1 on p2), the educational component is not explicitly addressed.

For many there was a sense of unfairness in job planning, which could itself be demotivating. In most places educational roles, even with a tariff, were treated generically as supporting professional activities (SPAs). This meant that those with no educational roles could use time for research or other CPD activities, whereas supervisors could not. In at least one location new consultants were on contracts with fewer SPAs than their more established colleagues, limiting the time they had available to take on educational roles.

Perceived fairness was also raised in the balance of clinical and non-clinical work, and how educational work may be perceived by those with a greater clinical load. This may go beyond job planning into questions of how work and 'non-work' are perceived in medicine.

#### 3.2.1.2 Training and CPD

The recognition process provided prompts for trainers to engage with training for their educational roles. While recognition *per se* might not be trainers' motivation for engagement with training events, the increased availability of training and the encouragement to take part was linked to the requirements of the recognition framework.

There were many examples of good practice in CPD delivery, with accessible, diverse training activities in a range of formats giving opportunities for networking (see Box 2). However, for some, local CPD provision was too broad, unengaging, or simply did not address elements of practice they felt were relevant (paralleling comments on recognition being superficial). Single CPD sessions providing evidence for all domains were felt to have this superficial, 'box ticking', quality. This may be a trade-off with the efficiency and logistics of delivery for organisations. There was a feeling that increasing the salience of training for individual trainers may increase its practical value, and also engagement in the process.

> '*Going on one or two single day courses isn't going to turn you into a motivated person that looks after your trainees in a pastoral way, which is really what they're looking for.*' (FG9)

Some noted direct benefits of training in the form of discrete development of knowledge and skills, with some feeling that the training had enabled them to provide effective supervision. Here, access to more customisable

training (such as online courses) identified on the basis of individual need, or new consultants for whom generic training had fresh value, may have been particularly relevant. Some also noted the importance of meeting other trainers through attending face-to-face training, regardless of content, in order to develop individual relationships.

There were additional material benefits for some trainers. In one location, recognition provided material impact through access to university resources, while others mentioned study leave to attend training. One TPD noted that centralisation of training reduced their workload because they did not have to design it.

A different type of effect on the quality of supervision from requirements for training was identified through a 'self-selection', or filtering of trainers who felt that training requirements were too onerous. Some suggested that those who were not prepared to undertake training or CPD may not have the right attitude or commitment to education.

> *'We had some delightful conversations with people who went, 'I don't have another day a year to spend on CPD' and we went, 'maybe this isn't for you'. So then we had a lot of that self-selection at the beginning. Every time we have a new phase we have more people going, 'this isn't for me, I can't do this, I can't sign up to your ethos', which is ongoing professionalisation.'* (Interview 2, Associate Dean)

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**Box 2.    High quality training opportunities**

There were many examples given of convenient, affordable and practical training events in the sites visited.

In Northern Ireland, a menu of training opportunities has been established for achieving and maintaining recognition. Mapping to their 'STATUS' programme, events relate to 'S'upervisory skills; 'T'eaching the Teacher; 'A'nti-discrimination (Equality and Diversity Training); 'T'rainee Support and training 'U'nique to 'S'pecialty (for example, curriculum changes).

Events have been oversubscribed, with opportunities for networking also supporting a sense of community.

'I think there's a huge choice of CPD training offered by that in terms of achieving recognition and maintaining recognition courses. I think it's hugely beneficial' (FG4, leaders).

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### 3.2.1.3    Management

Direct impact was also noted through effects on programme management. Recognition required an audit of all doctors in training roles, all of whom some EOs and LEPs may not have been aware. They were therefore obliged to generate a fuller picture of their trainer capacity than they had had previously.

Recognition may also change management going forward. One TPD, who had been previously unaware of recognition, indicated that they would now consider recognition when identifying new supervisors – checking whether they were already recognised, or had undertaken training – rather than approaching them purely on the basis of their having potential capacity.

Recognition provided clarity about the roles and expectations of supervisors amongst trainers themselves, trainees, and those in senior positions. There was an implication that the system, and not just supervision itself, had been professionalised, having been *ad hoc, [and] rather amateurish'* (FG2).

*'It's made a very positive impact. We certainly don't have junior doctors running around saying 'I don't know who my supervisor is?' which could be a problem in the past. Despite the fact there was supervision going on and there were educational supervisors, but it was very much on a 'will you be my supervisor?'' (FG8)*

Clarity was enabled by written standards and formal processes for training and appraisal. The presence of 'standards' meant that there are clear indicators of whether the minimum supervisor specification is being met. This was voiced by trainees as identifying two main functions of recognition. Firstly, as a mark of quality that trainers have been trained and are competent to supervise, and secondly, as an indicator that they are entitled to have expectations of supervisors, and that those expectations be fulfilled. It was noted that clarity of roles and expectations may benefit the wellbeing of both trainees and trainers by reducing uncertainty, and provide trainees with 'protection' from poor quality supervision.

However, impact on local management may be limited if funds associated with educational roles are not directly reflected in job plan time to support training. While not universal, several participants, including those in senior roles, felt that monies associated with education and training were often dispersed across an LEP rather than directly supporting training. We have no direct evidence that this is actually the case, but it was a common perception. While not specific to recognition, this may be the root of unrealistic job plans, and the lack of flexibility to allow trainers to shed clinical workload. It may also be indicative of a more general failure to recognise the economic value of education and training to an organisation.

*'I think part of the problem is the trust do not recognise or don't care about that because that's not really generating any money for them, it's not seeing any patients for them. That's the reason so why do it and then you think 'why am I doing it?' it's because I want to do it for the trainees.' (FG22)*

*'And so over the last few months and certainly the year ahead, we are going to be much more vigorous in making sure that we can see a direct line between the money we are putting into the system to help produce time and checking to make sure that time is made available because I'm sure that this will have a huge positive benefit in the world now.' (Interview 4)*

The requirement that all named supervisors be recognised was transmitted to some trainers. Some had been told directly by their LEPs or EOs that as recognition was mandatory to have trainees, they would lose their trainees if they did not keep up to date. This was not always associated with explicit awareness of recognition, but the mandatory nature of training. Some educational leaders indicated such action had indeed been taken. However, this was balanced by the realities of clinical workload, and the need to have trainees available to deliver a clinical service. Losing trainees is therefore often not in a department or LEP's interests. This means that unrecognised or untrained supervisors may remain in place in some locations.

On the other hand, the risk of liability on the part of EOs and LEPs was raised, if non-recognised trainers had a role in progression. We heard an example of an ARCP outcome being challenged for this reason, and other participants had identified the risk. Conversely, increased personal liability, and a potential rise in indemnity insurance premiums, was mentioned as a consequence of being in a recognised role.

### 3.2.2 Symbolic impact

Some impact on organisations and individuals was not described in direct material terms. Rather it appeared to be more distal and ill-defined, though nevertheless still real. We refer to this as symbolic impact, arising from the identity and cultural value of recognition.

Key amongst these effects was the perceived increased professionalisation of education – namely, a particular professional status being conferred on educational roles, and valuing education as a distinct professional skill, which must be developed and maintained in the same way as clinical practice. An associated idea was the visibility of education within the workplace, and awareness that it constitutes an important part of medicine. This visibility was not necessarily indicative of culture change, which implies some internalisation and sustainability, but it may be a precursor to an embedded cultural change. Acceptance of the language of education, and of processes associated with training, CPD and recognition has increased.

> *'My perception is that it raises the profile of education enormously and what we do through the appraisal process and it made certain that we're giving high quality supportive training [with] the right ethos. I actually think recognition of trainers has pushed that agenda enormously.' (FG23)*

There were also references to recognition enabling 'communities of practice' – essentially, a sense of trainers belonging to a greater whole, with new networks developing across and between organisations. Participants described the value of recognising and building relationships with colleagues in similar roles, leading to opportunities to share learning and experience. This feeling was also expressed by trainees and educational leaders, who felt that they knew their trainers better through their being more visible.

> *'Very much a community of practice. And particularly for people who are in a smaller clinical grouping who may feel they are the only person carrying the torch for education in their group, being able to discuss student as well as trainee issues.' (FG8)*

Formal trainer networks are an important part of this, but the more important point is that these networks move beyond the superficial, or purely functional consequences, and have intrinsic value in themselves.

At an individual level, recognition may confer additional status on doctors in educational roles – being an *'educator plus'* (FG2) in the words of one participant. From this perspective, recognition provides an indicator of quality that trainers are *'fit for purpose'* (FG17), and indeed are '*worthy of*' (FG23) the role of a trainer. This symbolic value is ostensibly outward looking, but is also reflexive, helping trainers to feel '*they are professionals in their role*' (Interview 2, Associate Dean).

However, some felt that a symbolic benefit had been lost in implementation and the focus on other procedural elements. Some described symbolic value in somewhat superficial terms – *'getting your tick'* (FG25), or a *'stamp of approval'* (FG24), and both trainers and trainees questioned whether the status of being recognised actually signifies educational competence.

> *'It was a process that was going to professionalise and encourage the educational development, and somewhere along the line we have ended up getting into a process which looks much more like a contract performance review, expected behaviours sort of arrangement.' (FG8)*

Ultimately, for a sector of the trainer population this symbolic value was not recognised, and triangulated by a general indifference to recognition expressed by many participants who were not in recognised roles. While some felt there was an implied difference in status between those in recognised and non-recognised roles, others felt that recognition did not add anything to their practice.

> *'Does it [not being recognised] matter to me as an individual? No, not really.' (FG2)*

This resonated with the feeling that education is part of a doctor's role, and so should not always involve additional recognition or reward. Some felt that recognition may be a symptom of an adverse underlying

cultural change – over-formalisation of roles undermining previous conventions. Formal recognition may risk indicating that education is no longer part of everyone's job, but a separate activity. The benefit of recognising education as a distinct skill set is in tension with it being seen as a core part of clinical practice. There is therefore a perceived risk that privileging some educational roles may have adverse consequences for perceptions of non-recognised roles.

### 3.2.2.1 Prospective value

Some felt that symbolic value may be more relevant for newer trainers, providing benefits for career development as a marker of specific experience and skills. This value for older, more established trainers in this respect is therefore minimal, but it was mentioned in the context of providing evidence for clinical excellence awards.

Some trainees also referred to recognised status as being an aspiration and a position that would be sought (see Box 3). The framework offered reassurance that there would be standards and support for them to act as a supervisor in the future.

> *'I think I would definitely like to [be a recognised trainer after CCT] and mentoring is something that appeals to certain people and I think it's nice to have it recognised and have time set aside, so yeah definitely.' (FG14, trainees)*

Recognition therefore has the potential to be motivating and add value to an educational role, as a distinct element of a medical career. This change may be indicated by more established doctors now taking on the identity of an educator, rather than seeing it as an integral, but unarticulated, part of their role.

> *'More people are now identifying themselves as being educators and are not just simply saying 'I've been a consultant in this department for N years, and what I need to be told about training trainees can be written on the back of a stamp', sort of thing.' (FG8)*

These subtle changes in the outlook of individual doctors, from trainees to established consultants, may feed into a change in culture.

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**Box 3.    Supporting supervisors of the future**

We spoke to many trainees who were enthusiastic about taking on educational roles as a consultant.

In Scotland, the ambitions of senior trainees (those within 1 year of CCT) have been captured in a 'trainer-ready' programme. This addresses the fundamental elements of both Clinical and Educational Supervision and has led to the Deanery having a 'queue' of new consultants ready to take on the supervisor role.

The initiative has proved successful, and with positive workshop experiences may indicate *'that's where the future lies' (FG6, leaders)*.

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### 3.2.2.2 Evidencing impact

It was generally felt that 'hard' evidence of impact does not necessarily exist in current quality metrics. However, at an organisational level, some felt that quality had improved since the introduction of recognition, as indicated by formal and anecdotal trainee feedback (including from the GMC National Trainer Survey, local surveys and visits), and trainee performance on exams. The oversight and quality control functions exercised by

more senior roles (TPDs or DMEs) were also felt to be aided. Notably some educational leaders made the connection between quality of education and quality of patient care, drawing on evidence such as CQC inspections, while recognising that the causal relationship may be hard to demonstrate.

> *'It's very unusual to have very poor supervision and yet fantastic clinical care.' (Int4, Postgraduate Dean)*

Cultural change was equally thought hard to evidence, but there were some proxy markers of this in evidence of greater engagement with education. Examples included high uptake of training events, including waiting lists for some courses, high numbers of applications from trainees and new consultants to become an Educational Supervisor and supportive communication from senior managers.

However, the trainee perspective was of note here, with several describing experience of supervision which was variable, and at times, inadequate.

> *'I've had, you know, official educational supervisors and official trainers and they don't know what they're meant to be doing, which means that I think, well, the system can't be working'. (FG15, trainees)*

No quality processes are felt to be explicitly designed to be sensitive to effects of recognition. For example while the GMC's national training surveys contain specific items about educational and clinical supervision, they do not mention recognition. While these measures could be compared with numbers and types of recognised trainers, effects are potentially confounded by a number of personal and organisational factors. Where participants referred to quality processes, they were clear that effects are hard to identify.

> *'I think some of the things are very difficult to measure. Morale can be difficult thing to measure, the level of engagement. My overall impression would be quite positive, but it's very difficult because there are those intangible things, they can't be measured. You know how they always want to keep performance indicators and they are actually really hard to get in this arena, I think.' (FG4, leaders)*

## 3.3   Factors shaping awareness and impact

Awareness was largely shaped by processes associated with the identification and notification of recognised trainers. A fundamental element of this was the interpretation of the scope of included trainers, and particularly the threshold between 'clinical supervision' and being a named clinical supervisor.

Impact was shaped by local leadership at all levels, and by explicit local processes of training and appraisal.

Identification was labour intensive for EOs and LEPs, and so could be limited by resource.

Notification was similarly limited, but compounded by a lack of clear ownership of the recognition process.

The availability of sanctions related to recognition – whether the removal of recognition from trainers who do not meet the standards as set out in 'Promoting Excellence, or sanctions against organisations which do not support trainers – may be key elements of potential impact, but were currently lacking.

In this section we consider in more detail the factors which shape awareness and impact of trainer recognition.

### 3.3.1 Interpretation of the framework

As noted earlier, the trainer recognition framework was designed to not be overly prescriptive, and deliberately lets local organisations apply their own interpretation of definition and processes within broad parameters.

The framework is predicated on two elements – the scope of recognised trainers as set out in the four defined roles, and the seven areas of supervisor practice, derived from the Academy of Medical Educators. These areas are in themselves rather general, and so any mapping of CPD or other activity to those domains is not assured. While often referred to as standards by participants, the descriptors associated with these areas do not aspire to be standards to be met, but rather to describe the role of a supervisor, as they set out what a supervisor should do, not necessarily how well they should do it.

### 3.3.2 Scope

The scope of the framework is a key element of its effectiveness, and its limitations. Limiting the mandatory requirement for recognition to four roles was perceived as excluding some trainer roles, or functions, from recognition. This may influence perceptions of the value of those roles, and place them outside the quality processes associated with the framework. One participant felt frustrated that as a senior educator they were not eligible to complete the GMC trainer survey because they are not a recognised trainer, despite having extensive experience and knowledge.

A major challenge which shapes implementation is the interpretation of the defined roles. This is particularly acute in the undergraduate setting, and specifics of the undergraduate roles are discussed later on, but it is also true of postgraduate roles, despite those definitions being more discrete.

#### 3.3.2.1 Clinical supervision versus 'clinical supervisor'

The crux of this challenge of interpretation was the difference between 'clinical supervision', which is broadly understood to be any instance of a doctor overseeing the work of a junior, and being a 'named clinical supervisor' in the terms of the framework.

> 'The issues we came up against initially were disaggregating the role of named clinical supervisor, as defined by the GMC, from clinical supervisors which applies to a much, much bigger group again – pretty much anyone who comes into contact with a trainee in a clinical environment.' (FG8)

'Clinical supervision' was seen as being an inherent part of the medical role, meaning that such recognition would be unnecessary, and potentially counterproductive.

> 'It's one of the duties of the doctor, so it's not anything special.' (FG18)

By contrast, the 'named clinical supervisor' has a distinct but related role, which participants saw as being defined by responsibility for the trainee, signing off assessments, providing feedback, advising on career plans and helping them to develop. For educational supervisors an additional element of planning the 'journey' of the trainee was identified, and by trainees the importance of pastoral support and mentoring skills, which are not a universal strength. Named supervision also encompassed a responsibility to deal with trainees in difficulty, which workplace supervision does not have to deal with beyond immediate issues of safety.

Therefore, while there are boundaries between the non-named workplace supervisor, named clinical supervisor and named educational supervisor roles, these boundaries can often be blurred, and the definitions provided by the GMC do not describe all roles. Even within nominally recognised roles, trainers reported that there was variability between geographical areas, specialties and departments in the way the educational and clinical supervisor roles were being applied. Some specialties have a named educational supervisor, but not a named clinical supervisor, and rather any consultant who is working with the trainee on the ward at any given time is responsible for the trainee, thereby completely eliding the distinction between named and non-named supervisors. Examples were also given of there being no distinction between educational and clinical supervisors – not just the same individual occupying both roles, as may be the case in small specialties, but that there was no meaningful distinction between them.

The interpretation of this threshold between levels of supervision is an important element shaping the scale of the task of recognition in a given context, and the resources required to implement it.

A risk identified with the elision of these types of supervision is that those carrying out non-recognised workplace supervision may become less engaged with that activity if they feel they are not getting the same reward as those in named roles.

### 3.3.3 Local leadership

While not explicitly raised often by participants, all the processes which shaped the impact of recognition are themselves shaped by the leadership within organisations – from high level positions within EOs to the specifics of clinical departments within LEPs. We heard examples where the attitude of senior leaders within EOs and LEPs could affect how well, and in what detail, recognition is implemented.

> *So for a while we were able to keep it up and then we got a new dean who was like 'remind me again why we are being so difficult?' and suddenly you were trying to make the case and if someone is predisposed to saying 'it's actually not that important really, is it?' then it's quite hard to push it forward. (FG26)*

> *'The director of medical education feeds into the annual appraisal cycle of supervisors with formal feedback obtained from trainees about individual supervisors to make sure that they are doing what they should do. I think that's really helpful.' (Interview 4, Postgraduate Dean)*

However, leadership intent can still be challenged by the complexity of inter-organisational delivery. The specific context of other organisational challenges – for example a Trust being in Special Measures – may mean that senior management has other priorities, and while education should be part of that, it may not be the most significant.

### 3.3.4 Local processes: Identification and notification of trainers

Recognition is implemented through local processes, as specified in the *Implementation Plan*. These processes are the key drivers of awareness and impact, and there appears to be substantial variability in processes across the UK. However, there are some commonalities between sites, and we have identified some elements of good practice.

The first important process is the identification of trainers. This was a labour-intensive process, often done manually and involving liaison between organisational leads (clinical and non-clinical), trainers and others, such as specialty schools and college tutors. It required ongoing maintenance, through keeping records up to date, for example when trainers retired, so that accurate records are returned to the GMC periodically. The key

challenge to this process was the staff time required to capture and collate this information, and return it to the GMC.

Some locations managed this by recognising *all* doctors who work with trainees, on the basis that all practising clinicians are to some extent 'clinical supervisors' (discussed in the 'Scope' section). Some recognised all educational supervisors as clinical supervisors, on the basis that the skills to be a named clinical supervisor are a subset of those for educational supervision.

The second main process which affected participants' awareness of recognition was the way in which they were notified of their recognition status. This highlighted a lack of clarity in ownership of the process. Some had received notification from their employing LEP or the local EO, and as such thought it was purely a local process. While the EO is responsible for recognition, this indicates why awareness of the GMC role is so low – there is no direct communication from the GMC regarding recognised status at all. In many places there was no direct notification at all that participants were aware of, presumably because the EO has not implemented such a process. This may be because of a lack of resources, or because notification is not a stipulated element of the framework.

Overall, processes were seen as essentially bureaucratic, and the challenge for organisational stakeholders was ensuring that bureaucracy is appropriately functional in terms of information flows, and delivering intended benefits. The intention of the *Implementation Plan* had been that recognition would be cost neutral and based on existing processes, and it seemed that this aspiration had not been achieved, in the view of many participants.

Overall, the need for local organisations to develop their own bespoke processes to suit local contexts, with often little direct resource, appears to have a direct effect on awareness of recognition *per se*, and of individuals' recognised status.

### 3.3.5    Local processes: Training and CPD

Impact was also shaped by the implementation of different processes, specifically around training/CPD and appraisal. Integrated processes appeared to be beneficial, and were more apparent in some nations than other (see Box 3).

While all trainers should receive training and CPD in order to be recognised, this did not seem to be the case. There were indications that old practices of informal selection persist, perhaps justified because it minimises use of resources.

> *[A TPD chair] feels that that's far too much bureaucracy and far too cumbersome. So educational supervision of medical SHOs is much more done on a seniority basis, you've been doing it X number of years. And there are two people in particular who just don't get it, barely use the e-portfolio let alone understand how to deal with a failing trainee. And there's nothing I can do. (FG7)*

Where training was mandatory it was still of variable perceived relevance and quality. Some participants felt that flexible and targeted training was more effective than generic sessions, and there were some references to in-house training, within specific departments, being more relevant than Deanery or even Trust-wide courses. Some systems may allow specific gaps to be identified and individual trainers' needs to be targeted. Supervisors for trainees at different levels may need different training. While some skills will be generic,

knowledge of different curricula and assessments at foundation, core and higher specialty training will be different.

Appraisal was another key process in both awareness and impact. The educational content of appraisal varied widely, with some having no explicit educational appraisal, and some having quite detailed mapping to the framework. However, even where appraisal systems directly referred to the framework areas, the quality and depth of appraisal was felt to depend on the individual appraiser, and their experience, knowledge and interest in educational issues.

Given starkly differing approaches to implementation, the question was raised about how inclusive the framework should be, and how that may influence impact. The issue was raised that if the recognition process is universal, does it still have any value? An inclusive approach may simplify the process, but may undermine the symbolic value of recognised status, and so undermine the cultural benefits of raising the profile and esteem of educational roles. There is also the risk that any effect on quality is diluted, as there would be no incentive to achieve more than minimum standards. There was no strong evidence to suggest this had happened, although the variability of supervision was raised by trainees.

> *'Just based on my massively varied experience of having lots of supervisors over the years, the quality of mentorship varies considerably, so if it was just a blanket for the whole thing, I probably wouldn't think about it seriously.' (FG27, trainee)*

Related to this, there was felt to be a lack of feedback to trainers, limiting their ability and incentive to improve. Both trainers and trainees felt that quality of supervision would be better regulated if trainers received feedback from trainees as part of the recognition process. However, there was acknowledgement that trainees providing feedback on their supervisors could be a sensitive area especially in smaller specialties or geographical locations.

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**Box 4.   Integrated process**

A common call amongst participants was to minimise bureaucracy and ensure integration and coherence of processes.

The whole-nation approaches of Scotland, Northern Ireland and Wales appear to have some more success in raising awareness than the more fragmented approaches across English regions. However, even then awareness of the GMC role is low.

In Scotland, the existence of an explicit 'Recognition of Trainer' section in the appraisal system meant that there was a clear highlighting of the vocabulary at least. In Northern Ireland, trainers get a certificate from NIMDTA, but this meant that our participants tended to see this as NIMDTA originated, rather than a GMC-led process.

In Wales, a tripartite Educational Supervision Agreement, introduced to support implementation of Recognition, has afforded valuable functionality in Deanery processes and has been extended to all recognised roles. The agreement is signed by educational supervisors working in hospital-based foundation, core and specialty training in Wales, in partnership with the local education provider and Wales Deanery. It was rolled out across Wales from 2013, following initial piloting.

The single system is well received by clinicians. It affords simplicity in a complex system and promotes commitment of supervisors to Recognition requirements, and of LEPs to protected trainer time (job planning), resources and support.

Finally, impact was also limited by the perceived burden of duplication across processes and systems. Just as awareness of the recognition framework was confounded by different interpretations associated with the term 'recognition', its value was potentially diluted by other conflicting systems, such as Royal College requirements and revalidation, and need for different forms of evidence. Some locations had integrated IT systems which removed some of the burden, and so mitigated one potential barrier to engagement from trainers.

There were concerns about data quality, attributed in part to a disconnect between GMC and local processes – some who thought they were recognised (because of local notification) found they did not have recognised status on the LRMP. This could be because of an error in or misunderstanding of local data (meaning they may not actually be recognised), or a lag between their local record being updated and returned to the GMC and the online LRMP being updated.

### 3.3.6    Local processes: Sanction and renewal

A key area of potential, but not necessarily realised, impact was in the ways in which recognition of individual trainers may be renewed, or terminated. This process shapes impact partly because it shapes expectations of a role, partly because of its effect on resources, and partly because it has a direct effect on the quality of trainers.

Some locations adopted an approach of annual renewal, some over a 3-year or 5-year period, while others did not have any limit. Even with renewal, there were different discourses, with some talking of 'term limits', others a default 'lapsing' and others a more punitive-sounding 'delisting'. While trainers' recognised status may lapse due to not being up to date, this could be presented as a sanction rather than a lapse. There are therefore presentational as well as process aspects to the removal of recognised status.

The potential was also raised for recognition to be used as a sanction against *organisations* which do not meet the requirements of the framework, and this was often felt to be an area in which current processes are lacking. Many felt that the system needs 'teeth' in order to have impact in maintaining and improving quality, and that these teeth are not available.

## 3.4    Specifics of undergraduate recognition

The undergraduate context presented particular differences and challenges for recognition.

Some participants felt that the recognition framework is focused on postgraduate roles, and implicitly devalues undergraduate education.

The role definitions were not readily interpretable, leading to variability in approaches – some attempting to follow the letter of the definitions, others applying them more pragmatically.

The undergraduate recognised roles do not reflect the same level of educational involvement as the postgraduate ones, with perceived anomalous differences and a lack of equity in job planning.

Lack of consistency may mean recognition is not portable between medical schools.

While some of the issues discussed so far are relevant to recognition in both postgraduate and undergraduate sectors, there were a number of challenges for the framework specifically relating to undergraduate roles which were identified.

A key point made was that the framework was focused on postgraduate medical education, and lacked relevance for undergraduate trainers. By inference, undergraduate education felt undervalued in comparison. Symbolically the very use of the term 'trainer' aligned the framework with postgraduate training – '*the word trainer is not recognised in undergrad*' (FG8).

Further, given that undergraduate programmes already have robust selection criteria and training in place for clinical faculty in the recognised roles, the issue then for medical schools is who/what is recognition for?

> *'I find that as a director of undergraduate education I'm the only person officially in the Trust that has to have any trainer recognition for undergraduate education because I'm involved in the governance of it all. That's ridiculous, because actually it's either important or it isn't and if what the GMC have said is that 'actually we don't think that undergraduates are that important', well why is any of it important?'* (FG18)

### 3.4.1    Definition of roles

GMC data showed that there are fewer recognised trainers in undergraduate roles across the UK (see section 1.5). There are also marked differences in numbers recognised between medical schools. There appeared to be three main factors contributing to this. Firstly, differences in interpretation of the roles as defined in the *Implementation Plan*, secondly, local differences in the roles actually present in these settings, and finally, differences in engagement with the process, which related to perceived value of recognition for undergraduate trainers.

A widely cited problem was how the undergraduate recognised roles are defined in the framework. These were felt to be poorly specified, and the language fundamentally inappropriate for the educational roles in medical schools, leading them to taking '*a bit of a guess*' (FG8) as to who should be included. This was compounded by variability in the actual clinical workforce in medical schools. While there are common activities across schools, the functions or responsibilities of local staff differed, with a range of organisational structures and staff job titles.

All were shaped though by the framework definitions, with the recognised roles being those who 'led or organised' educational programmes, as compared to those who had face-face student contact. The direct contrast here with postgraduate recognised roles, which are focused on trainee contact, was noted in several groups. This meant that doctors delivering considerable amounts of medical student teaching/training, who may have most to gain from recognition, are excluded from the process.

The distribution of undergraduate faculty between medical school and LEP was a further problem. Some schools focused on trainers based in LEPs rather than actually located in medical schools, because fewer are based in medical schools, and it was felt that educational recognition would have more added value for those based in the clinical environment.

Given such wide variation in approaches, a key practical repercussion here was the particular lack of 'portability' of undergraduate recognition – that is, a trainer could move between medical schools, and while performing the same essential role in both they may only be recognised in one, but not the other.

### 3.4.2    Semantics and pragmatics in determining eligibility

There appeared to be different strategies for selecting those to be recognised in different medical schools, with scope for defining large or small numbers. Some medical schools interpreted roles literally from the

implementation plan, while others considered the pragmatic approach of what was manageable within existing local administrative and/or training resources. Two comments at one event attended by more than one medical school illustrate this difference:

> *'We've taken it literally from what the GMC have said, that the people involved in making progression decisions [should be recognised].' (FG8, leaders)*

> *'We looked at the numbers that we felt were manageable and we aimed at recognising a manageable number.' (FG8, leaders)*

Both these schools faced a similar question of how broad and how deep to go into role hierarchies, but took different approaches based on the information in the *Implementation Plan*. Even if it was not a deciding factor in how to approach identifying trainers, the workload of this process was substantial, and it was felt that the GMC did not provide any incentive for further considerations of undergraduate roles.

> *'Currently from a simple organisational point of view it's far easier to manage 7 in our return than to manage 200. There's no incentive for us to share more than the 7 with the GMC because it doesn't help us. If there was a reason to do it- that [it] was seen to be a good thing – we'd do it.' (FG25)*

### 3.4.3   Comparison with postgraduate roles

The undergraduate roles contrasted directly with the trainee-facing roles recognised in postgraduate training, but many undergraduate teachers felt they delivered non-recognised functions that were very similar to postgraduate clinical supervisors. The lack of congruence was also illustrated in the undergraduate, but not the postgraduate dean, being required to be recognised (albeit acknowledging that the roles have different functions).

> *'The way we have interpreted it anyway, in the under-graduate world the program lead, so the dean, has to be recognised and approved and that's not the case in the post-graduate world.' (FG6)*

However, a common situation was that clinicians involved in undergraduate teaching were often also involved in postgraduate supervision, and many participants shared a view that the postgraduate process was sufficient to recognise those individuals. While many individuals expressed concern that clinical teachers were under-represented in recognition, this concern may not extend to supporting additional processes *per se* for the undergraduate roles. This was illustrated by one undergraduate leader:

> *'I have people who come to me and say 'I need to be recognised as a trainer. Don't worry I'm already recognised by the trust, so can you just rubberstamp this for me please?'' (FG26, leaders)*

Further, an anomaly of undergraduate recognition noted by participants was that the two undergraduate roles had differing functions – oversight of progression being a directly educational function and placement coordination a more administrative one. Yet, the practice criteria articulated in the framework expected of both these undergraduate groups are the same. Notably, the AoME highlighted that the framework areas had been drafted before recognition was introduced, and questioned the success of their application to the undergraduate setting.

### 3.4.4    Impact of undergraduate recognition

There was frequent expression among participants in undergraduate education that the framework was of limited relevance in the undergraduate context. This was partly because it was felt to be superfluous, as robust quality assurance processes are well established in undergraduate medical programmes. However, it was also thought to be paradoxically targeted at those who are least involved in the delivery of education. This meant that recognition has no bearing on quality measures of undergraduate programmes, in contrast to postgraduate training where metrics such the National Training Surveys contain targeted items addressing supervision.

Impact – symbolic and material – was also tempered in the undergraduate setting. Symbolically, recognition may have less value than other processes relating to medical school teaching. The standards and expectations of a lecturer were thought to be arguably higher, and harder to achieve, than of a postgraduate supervisor, meaning that the intrinsic value of the university role was regarded as higher than any symbolic value conferred by recognition. Further, the well-established process of 'recognising' clinical teachers through honorary university status incurred material value through access to online resources, library and other university facilities.

### 3.4.5    Job planning

There were few examples of undergraduate roles being directly addressed in SPA time in job plans, compared to the common use of tariffs for postgraduate supervision roles. This reflected a common perception of undergraduate education in LEPs being under-resourced and under-recognised, with little transparency in how undergraduate tariff is used.

While some LEPs did provide explicit PAs for undergraduate roles, this was most often for specific course leadership functions (although not just the recognised roles) and formal teaching sessions, rather than day – day clinical teaching or supervision functions. Some indicated that the range of student-facing activities were just part of the 'norm' of doctors' practice – '*We just do it*' (FG24) – and perhaps 'easier' than postgraduate training. However, the expectations and workload of medical student teaching was notable and for many, the lack of explicit time through job planning suggested a lack of awareness on the part of LEPs of this important work.

> '*I think it should be recognised because it's a role you should take at least as seriously as you take your supervision of a trainee. It's a much shorter relationship but it's still just as important.*' *(FG2)*

This parallels postgraduate 'clinical supervision' not being recognised, and was similarly problematic.

Job planning for undergraduate roles, by contrast to postgraduate education, was *'very messy'* (Interview 11, undergraduate lead). For postgraduate supervision there are clear requirements for meetings and assessments, but the often short-lived, intermittent and opportunistic nature of medical student placements complicates calculations of teaching time and accurate job planning.

Therefore, while there was some indication that undergraduate trainers may be rewarded in terms of university titles, they receive far less practical reward in relation to time in NHS sessions. There was concern that trainers may be deterred from undergraduate roles because of this lack of remuneration. This poses a dilemma for those at the coal face of managing undergraduate delivery, where job planning is complex, and appears potentially underfinanced.

*'As long as undergraduate teaching can disappear into SPAs there is no way out of it. It is a vicious cycle and I think the PA system probably has to be broken down before you can really move on… Unless undergraduate teaching is going to have a huge boost of capital because I don't think it could ever compete with postgraduate remuneration.' (Interview 11, undergraduate lead)*

If recognition is explicitly linked to job planning (which, as noted earlier, has offered currency to postgraduate trainers), the financial implications of recognition means that there may be little appetite among LEPs to extend the scope – and awareness – to 'supervisor-equivalent' roles in undergraduate programmes.

### 3.4.6    Burden

There was also concern that the recognition process might pose a risk for the delivery of undergraduate education.

As noted above, there were many reports that the expectations and demands of teaching of medical students, in a stretched clinical arena, creates a greater burden to clinicians than workplace supervision of trainees. For example, the time taken with each patient in a clinic setting is increased, meaning longer or more clinics are needed to see the same number of patients. Hence there was some concern that any additional perceived burden caused by 'paperwork' of recognition processes might be seen as a challenge to competence, and disengage clinical teachers from undergraduate delivery.

*'Some of these people have been teaching 20-25 years and doing it well. Why are they now telling me if I want to continue in this role I have to do a course? As one clinician said to me, 'it's almost like saying what I've been doing for the past 12 years wasn't right, it was of no value'. So it's just putting an extra barrier in place.' (FG4, leaders)*

## 3.5    Future development

Some participants felt the system was adequate, and that any changes may be cumbersome for embedded systems.

However, participants did identify potential changes to improve the function and impact of the trainer recognition framework as:

- The clarity of the framework, in terms of purpose and process, could be improved.

- The scope of recognised roles could be revised, particularly in undergraduate settings.

- Processes of appraisal may be more defined and made fit for purpose, with direction on specific educational appraisals, with trained appraisers.

- Sanctions available through the process may be necessary to deliver the potential benefits.

- Recognition has the potential to enable culture change, and may provide a mechanism for the development of medical education as a fully recognised subspecialty, with equivalent career and status implications.

Some participants felt the system, while not perfect, was adequate as it stands, and understood that a lot of effort had been put into the development of appropriate local systems. Requiring changes or standardisation could therefore be cumbersome, adding to the complexity and resource needed, and thereby be potentially counterproductive. Benefits that had been achieved could continue and be built upon by consolidation and refinement of those systems.

There are, however, some areas where potential change is implicit, and many participants identified explicit areas in which future development of the framework could be considered – particularly around the scope and process of recognition – but all with the aim of furthering the achievement of its objectives.

Some participants, both trainers and trainees, felt the current process provided a baseline of sufficiency, but that further development would, and should, lead to greater improvement and move from that baseline towards excellence.

> *'I always got the impression that there was, you know, deliberately they're introducing it with quite a low bar and then year by year they put the bar higher to sort of push up standards. That was my understanding of it. Whether that was right or wrong, I don't know.' (Interview 5, LEP undergraduate lead)*

This section summarises some of the suggestions that were made regarding scope and process of the framework.

### 3.5.1    Clarity

A fundamental change suggested was to improve clarity of the purpose and function of the framework. The benefits of the framework are in part not realised, participants felt, because the intent is not clear. They thought any future development of the system should therefore be simple, and its function clear. An increasingly complex system may alienate engagement, and any change in scope must be clearly functional.

### 3.5.2    Scope

Much discussion of change focused on the scope of the framework, and the definitions of roles. The level of prescription in the current definitions was felt to be unhelpful. However, while some suggested that the scope of recognition should be broader, others felt that broadening scope would dilute any value conferred by the exclusivity or scarcity of recognition. One indicated that the optimal level of prescriptiveness may be to provide either more freedom, or to set out roles explicitly. As was implicit in much of the data, this demonstrates a lack of awareness that the framework allows recognition of any doctor.

> *'I think the terminology either needed to be much more prescriptive or much less prescriptive, so in other words it could have been a case of 'right can you recognise people involved in medical education? Devise a system and off you go'. Or 'your medical educators need to be doing this and this and this, and those are the people we are thinking about'.' (FG8)*

Where interpretation of roles within the framework is a challenge, it may ultimately limit the awareness of eligible individuals and its impact on them.

There are also questions around roles which currently fall outside the framework. Many participants felt there were numerous additional educational leadership roles being undertaken by senior clinicians that should be recognised – including TPD and DME roles. They felt that recognising these leadership roles would help increase the perceived value and professionalisation of medical education.

*'The third level is about a programme director type level / undergraduate equivalent, and I think then you are into the realm of a smaller number of people doing these roles and they should be trained and highly committed to the roles and should be recognised. A programme director should be something really to aspire to.' (Interview 1)*

Conversely, some saw it as a paradox that clinical teachers are not represented in recognition figures, and that consequently they fall outside of quality metrics, which is in contrast to postgraduate training where there is a closer link between recognition and educational delivery.

Many participants felt they should be recognised for their supervision of non-medical trainees and staff (including Physician Assistants (PAs), midwives, paramedics, nurses and advanced nurse practitioners (ANPs)). They felt that the workload and responsibility was similar to, or even greater than that for medical trainees. With increasing numbers of PAs (who are to be regulated by the GMC [11]) and ANPs, this may become more pressing, although some felt there may be resistance from LEPs because non-medical trainees bring less income. Again the conflation with job planning is part of this – as this time is not job planned and recognition is a lever for that explicit acknowledgement of time – but there were also wider points that such interprofessional supervision may be an effective way of standardising the quality of supervision and training of these developing professions.

A second group who currently falls outside the recognition framework are medical trainees themselves. Some thought that if they had a supervisory role, for example, for a more junior trainee or medical students, then there should be some form of recognition for this - to give them the time and dedicated space to be able to deliver training, to be able to show career progression and that they are interested in an education role. Others indicated that support for educational roles may come with recognition (for example, relevant courses and some standardisation of what and how to teach).

*'So, speaking as a clinical fellow I feel it's a bit of an outcry that you might have people with this GMC recognition status on the register who could perhaps get away with meeting a trainee a few times a year compared to, I spend nearly half my week actively teaching.' (FG27, trainee)*

However, a few trainees expressed concern that it would add additional work and unanticipated responsibility to their job.

Non-consultant specialty and associate specialist (SAS) doctors are not precluded from recognition, and we heard of some being considered as educational supervisors, although none of our participants identified themselves as such. We heard that SAS doctors found it hard to integrate educational roles with their clinical work. Providing support and training in the same way as consultants, with recognition as a lever, may help share the supervisory burden and improve the work experience of this group.

*'In terms of the non-career grade doctors, or the specialty doctors and the associate specialist. There is, there was particularly, at least there was a sense of that, they're not trainers as such, but this recognition would definitely go much forward in terms of delivering all the education supervision'. (FG24)*

*'Recognising non-consultants like SAS grade doctors, so there is a role for them in training, being recognised trainers and having the time and also that adds value to their role and makes them stay in the profession etc.' (Interview 1)*

The potential for non-medical staff to be recognised within the framework was also discussed. While outside the GMC's regulatory purview, some participants (particularly those in undergraduate settings) felt that non-

medical staff with roles in educating medical students and trainees should be recognised in the same ways as that of doctors. One medical school did maintain an internal register of those who had met the standards for recognition but were not GMC registered. This is in line with the framework, but lacks the perceived value of GMC branding.

However, others felt that this was not necessary, or appropriate, with one participant noting that they did not think the GMC (and by extension doctors) should bear the costs of extending recognition to non-medical groups. Where other healthcare professions are involved which are not regulated by the GMC, some inter-regulator recognition may be possible.

### 3.5.3    Process

#### 3.5.3.1    Undergraduate and postgraduate

Some felt that the system could be simplified by a clearer articulation of the relationship between undergraduate and postgraduate recognition, with some suggesting that a single system of recognition would be more straightforward, and potentially remove the imbalance between undergraduate coordinating, and postgraduate supervision roles, which implies a differential value of roles in the two areas.

One participant went further, suggesting that all trainer recognition processes – for GP and secondary care – should be standardised, while acknowledging that such an overhaul would be complex, and require amendment to the Medical Act.

#### 3.5.3.2    Appraisal

Participants also indicated that processes around appraisal could be improved, with greater specification of appraisal requirement, and appraisers specifically trained for educational appraisal and the meaning of recognition. While this was present in some locations, it was not consistent and often required a two-step appraisal process. Part of this could include greater feedback to trainers from trainees, and greater oversight from a level between supervisors and DME or TPD – a 'super-supervisor'.

Systems and infrastructure supporting appraisal and CPD could be more straightforward and reduce the perceived burden of administering recognition.

#### 3.5.3.3    Increase sanction

In terms of process, a common suggestion was that recognition has no 'teeth', and so could be improved if the GMC, in particular, articulated greater sanctions if the requirements of the recognition framework were not followed. This was particularly true with regard to a more specific mandate for job planning, and the specification of time for educational roles, but could encompass training and appraisal.

More explicitly, several felt that the monies associated with education and training do not reach education and training, and that processes could be improved to ensure this. This goes beyond job planning, to making sure job plans are realistic and fulfilled, and that money follows training to departmental level. Whether this falls into the GMC's regulatory power through quality assurance was not clear, but some felt it was an area in which it may be able to exert influence.

### 3.5.4   Culture change

It was suggested that impact may be greater if medical education were placed more centrally in clinical practice, and so, for example, rather than DMEs being champions of recognition as they often are, that it should be clinical directors who are responsible for ensuring trainers are supported to meet requirements of recognition in a department.

#### 3.5.4.1   Medical education as a specialty

It was suggested more than once that medical education could be recognised in a similar way to clinical specialties, so that trainer recognition would become a formal mark of competence. This would then provide the direct association with quality, and provide the 'exclusivity' value, that some felt was missing.

Having some form of recognition for students and trainees as part of such an approach may help develop educational roles at an early stage. This could translate to a formal training and development pathway for trainers. A full set of developmental standards, or an explicit curriculum, could enhance this and increase symbolic and material impact. These would allow trainers to indicate progression, and some participants felt that more challenging educational scenarios (for example a trainee in difficulty) implicitly involve a higher level of responsibility and capability which is not formally recognised.

### 3.5.5   Recognition as a marketing tool

Some indicated that recognition could be used more actively as a mark of quality, with numbers of recognised trainers being a proxy. Recognition figures may provide a means of improving an LEP or a department's profile and be used in advertising to attract trainees. Some noted that units and departments have reputations which are shared informally by trainees, and while some implied that recognition is therefore redundant, recognition could implicitly codify this reputational value. Conversely, having trainees confers educational status on departments.

# 4 Discussion

The project set out to answer four main evaluation questions. Qualitative data collected across the UK has allowed us to identify answers to these questions, and consider some wider contextual issues.

The first question was, *'How aware are stakeholders in different settings of the trainer recognition framework?'*. To which the brief answer is that they are not very aware. There is implicit awareness through mandatory processes, but little explicit knowledge.

Secondly, *'What, if any, impact do stakeholders identify as arising from the trainer recognition framework?'*. Again, much impact arises from incidental engagement with processes, rather than being clearly attributed to the recognition framework. This does not mean that there is no direct effect, but rather that it is opaque. There is a perception of direct effects on organisational culture, but the evidence for this is not strong. The strongest material effect for most individual trainers is in job planning, and specific time for training roles being associated with the recognition of those roles.

Thirdly, *'What influences awareness and impact?'*. At the highest level, the scope of recognition – who is identified as being eligible – determines its impact. More practically, local processes mediate the impact of recognition, and there are indications that more integrated processes such as found in Scotland and Wales, in particular, enhance awareness. However, the ultimate enabler or barrier appears to be dependent on the specific local leadership in LEPs, or even departments. This ultimately drives the selection of trainers, appraisal systems, the implementation of job planning, and the workload that allows or undermines that job planning.

Finally, *'How may trainer recognition be developed to deliver sustained positive impact?'*. Trainers suggested a number of ideas which may improve processes, and so the impact of recognition. Others can be identified through considering the findings in relation to these questions as a whole.

This section will therefore focus on how the factors which determine impact and awareness may be considered to improve the function of the framework. The intention is not to prescribe specific change, but rather suggest avenues in which change could be considered. Many of these changes are in implementation, and so rest with EOs and LEPs rather than the GMC, and so the final section considers what these potential changes may mean for the GMC in particular.

## 4.1 Impact and awareness are not independent

The primary issue we have identified is that explicit awareness of trainer recognition was low across trainer and trainee populations, and even where it was known about, it was not associated with the GMC. This was demonstrated by, but also compounded by, a semantic confusion over the term 'recognition', which people did not associate with the GMC framework. Recognition was often conflated with educational work being recognised in job plans.

It could be argued whether this actually matters, because there *is* awareness of, and engagement with the training and appraisal processes which support recognition, but it seems that the potential benefits of recognition may be enhanced by greater awareness of its content and purpose. We suggest two reasons for this, one symbolic, and one functional and related to the material impact of the framework.

Firstly, increasing visibility of recognition may increase its subjective value to trainers as a mark of competence and achievement. While some trainers do recognise the benefits of engagement with CPD and appraisal, there

is little intrinsic reward from recognition status. That value may be linked to process elements, such as how exclusive and directly related to quality the status is perceived to be, but a simple increase in awareness will also be instrumental.

On the second point of material impact, awareness is low not just of the existence of recognition, but also its purpose. Greater clarity and visibility of its aims, transmitted to the entire trainer constituency may help to ensure that those aims are fulfilled, and avoid the risk of training and appraisal being, or being seen as, superficial 'box ticking'.

## 4.2    Revisiting scope

The clarity of purpose of recognition was also clouded by its scope, and uncertainty over which roles are included, and why. While the *Implementation Plan* does describe the rationale behind the given definitions, this is not always clearly understood. For postgraduate roles, the threshold between 'clinical supervision' and the responsibilities of 'named clinical supervisor' was not intuitive, and may be confounded by particular working practices in specialties or units. This is an aspect where the framework as it currently stands may need revision, or at least clarification. How this distinction is communicated to trainers may need revisiting.

On the other hand, many highlighted the anomaly that some senior roles are not directly recognised. Again, this may not be problematic, but does conflict with perceived, or inferred, functions of recognition – as a mark of expertise or status, or as an element of quality assurance processes.

Medicine is increasingly shaped by workforce issues, and is more interdependent with non-medical professions, including newer clinical professions such as Physicians' Assistants and Advanced Nurse Practitioners. We heard of a substantial workload involved in training these professions, which is not currently recognised in any way. Conversely, other professions may be taking on greater roles in training medical trainees and students. While the former case may be more straightforward, there are questions of regulatory demarcation in relation to both. While LEPs may need to do more to recognise this work, it may be beyond the scope of the regulator to address the issues. However, some inter-regulator initiative may be possible, perhaps engaging multi-professional EOs.

In undergraduate settings the questions of scope are more profound, with a common feeling that the rationale for the two roles was not clear, and that they did not clearly or consistently map to actual roles in undergraduate settings. This was an aspect of a more general disconnect between undergraduate and postgraduate aspects of recognition.

One possible inference from criticisms of scope is that defining roles which encompass the entirety of an individual's practice is too limiting, and that articulating definitions in terms of discrete skills or activities (such as formal supervision, responsibility for progression, oversight of assessments, etc.) may be more flexible and readily translatable to different implementations of supervisory roles.

## 4.3    Articulating undergraduate and postgraduate education

Many in undergraduate education felt that recognition was not suitable for the undergraduate domain, and served no clear purpose. They felt that the overall framework was built around postgraduate training, with undergraduate education as an afterthought. This extended from the language of 'training' rather than 'education', through to the details of the defined roles.

In particular, they questioned why there was no parallel between the undergraduate and postgraduate roles – the former being structurally higher leadership roles than the latter. Postgraduate roles identified as similar to the undergraduate definitions, such as TPDs and DMEs, are not recognised, while, conversely, the responsibility for supervision of medical students, analogous to clinical supervision, is also not recognised. This asymmetry undermines perceptions of the whole framework. In practical terms, it was frustrating to many that undergraduate roles are not recognised in job plans, while postgraduate roles are. The picture is further confounded by many people having both undergraduate and postgraduate roles, one, both and neither of which may be recognised.

There is a more fundamental challenge for medical education here that goes beyond the recognition framework, but may inform approaches to reconciling these contradictions. On the one hand, undergraduate and postgraduate are seen as very different domains, with different terminology, functions and relationships with clinical practice, albeit often delivered by the same people. On the other, medical education is talked about as a continuum, implying that the change from medical school to practice is subjectively important for the student/trainee, but does not necessarily require a radical shift in educational perspective. At the moment, the recognition framework reinforces the former view, whereas it may benefit its impact and acceptance to consider how it may reflect the latter.

## 4.4   Impact and quality

Some participants were sceptical about the association between recognition and actual impact on the quality of supervision and training. While others felt there had been demonstrable impact, they conceded that the association is not direct. A clearer mapping between the aims of recognition, and clear KPIs – whether in GMC surveys, or specified but devolved to local quality processes – may help present the case of its value to those who are sceptical.

A related issue may be reconsidering the content and function of the domains of practice which underpin the framework. While individual trainers knew little of them, it was noted that they do not provide a set of developmental standards that allow individual trainers to demonstrate quality in their educational practice, or improvement. Returning to the detail of the revised AoME standards [5] may provide the necessary scaffolding, but these may not be appropriate for the breadth of educational roles to which recognition applies.

An incidental driver for quality is the 'self-selection' of trainers, with the CPD and administrative elements of recognition deterring those who may not be committed to education, and so implicitly may not be the most effective trainers. However, this cannot be guaranteed to be a sustainable assumption, and the risk is that the body of trainers may atrophy, not through a lack of commitment, but rather a simple lack of time – for engagement educational activity but also with the administration of recognition – as other clinical pressures increase. A balance of the trainers' time for development and appraisal against the need for robust quality assurance should be sought.

## 4.5   Providing 'teeth'

A frequent criticism of the recognition framework as it stands is that it does not have 'teeth', or provide sufficient scope for sanction. This has two elements. Firstly, there is no clear process on how a poorly performing trainer should be identified in the terms of the recognition framework, nor how recognition of a supervisor should be removed.

Secondly, and of more substantive importance to most respondents, there is no sanction against organisations (LEPs) which are felt not to be fulfilling their roles. Most discussion in this area focused on the job planning element, but training/CPD and appraisal were all variable, and all potentially open to improvement through a 'carrot and stick' approach ,which the framework had potential to action.

However, sanctions need to be proportionate, and pragmatic. While EOs can and do remove trainees from individual trainers as part of quality processes, an organisational level sanction may be deemed disproportionate if service delivery would suffer.

## 4.6    Changing culture

Finally, and despite questions and uncertainty about the form and function of the framework, there does seem to be a sense that recognition is having benefit at a cultural level to 'professionalise' education. While this may be hard to evidence in concrete terms, the feelings of those in training and leadership roles should not be dismissed. Even the most negative voices among our participants suggested the visibility of education is greater than previously.

In support of culture change, one strategy, where recognition may be a tool, may be to increase the association between education and training, and clinical practice. While discrete board-level representation of educational issues through DME and Dean/Associate Dean roles can be essential to maintain organisational focus, there is also scope to embed educational responsibilities more clearly in clinical leadership roles. As one senior respondent indicated, placing ownership of recognition with the Clinical Director of a department may further embed educational practice within clinical, and workforce, concerns. It may also help change the perennial issue of educational funding not reaching, or at least not transparently reaching, educational processes.

A further positive outcome of culture change will be to develop the profile of medical education as a recognised specialty within medical careers. Recognition may have a role to play if reconfigured as a developmental system signposting progression and expertise.

## 4.7    Implications for the GMC

Our discussion has focused on high level issues which affect the overall function of the GMC's trainer recognition framework. Not all of these are directly related to the framework itself, and we recognise that not all may be directly within the GMC's responsibility or control.

Therefore, we do not suggest how the GMC may best develop recognition in the future, but rather summarise the implications in a series of questions which it may want to consider:

- How can awareness of recognition as a GMC process be best improved?
- How can understanding of the intended function of recognition be best improved?
- Is widening the scope of recognised roles desirable to deliver the aims of recognition?
- Can undergraduate and postgraduate concerns be reconciled in a single framework, or may a disarticulated approach be more functional for both?
- How prescriptive can the GMC be in terms of processes of training, appraisal and job planning?
- What degree of sanction can the GMC proportionately bring where recognition processes are not followed?
- Can, and should, strong evidence markers of quality improvement be linked to trainer recognition, or is the current triangulation of general training quality indicators and soft intelligence sensitive and specific enough?

- What is the need, or potential, for inter-agency working, between regulators and education organisers, to provide a joined-up system for multi-professional recognition of those involved in training of doctors?

Our data suggests that there is at least some desire for the GMC to take a lead in all of these areas, but also that trainer opinions on these questions are likely to be varied, and so any decisions will need to be informed by high level policy drivers rather than any consensus of demand. Any changes to the current approach will need themselves to be carefully framed and communicated to stakeholders at all levels.

# 5 Conclusion

As an overall evaluation of the trainer recognition process so far, we conclude that it has been partially successful. There is a feeling among trainers and leaders that the processes associated with recognition have enabled quality and visibility of education, though incurring a cost in implementation. However, there is room for improvement and change, fundamentally based around improved clarity of both its existence and function.

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# Appendix A: Example focus group guide

Focus group discussion guide as adapted for trainer focus groups. Slight variations in questions were used for trainees, senior roles and managers. The sequence of questions is illustrative only, as individual group discussions may cover topics in any order.

Focus group questions - TRAINER
[Info sheet, consent form, sign-in sheet]

The project is evaluating the trainer recognition framework introduced by the GMC in 2012.
For those who may not know, this means that doctors who perform one of four defined roles have an indication on their record in the medical register that they are a 'recognised trainer'.
The roles are, in PG education, named educational and clinical supervisors, and in UG education those who oversee student progression, and those who coordinate clinical placements [ref to definitions document]. There is leeway for interpretation at a local level.

In the focus group we would like to discuss:
AWARENESS: your knowledge of the framework
PROCESS: how it works in practice
IMPACT: whether it makes a difference
CHANGE: any ideas you may have for future development.

[Start recording]

| Topic area | Trainer questions |
|---|---|
|  | Firstly, what you know about trainer recognition and how it relates to your job. |
| Awareness<br>How aware are trainers and learners of trainer recognition?<br>Do they know if they are recognised/if their trainers are recognised? | What do you know about the recognition of trainers?<br>The sign-in sheet asks about recognised roles, but is anyone not sure if they're in a recognised role?<br>    [Refer to definitions]<br>    What do you think about the UG and PG roles?<br>How have you been informed of your recognised status?<br>Do you know that recognition is recorded on the medical register?<br>What roles are recognised in your organisation?<br>Are you aware if colleagues are recognised or not?<br>Would you expect a trainee to know (or to care)? |
| Impact<br>Does it affect individual?<br>Do learners think it makes any difference?<br>If advertised, would it make a difference?<br><br>Does recognition provide time in job plan?<br>What does it mean for those not recognised? | What value does recognition have for you as a trainer?<br>    What do you get out of it? (eg esteem, career progression).<br>Does being 'non-recognised' matter?<br>Can anyone give an example of how it has affected their work?<br>Does recognition change how you do your job?<br>    … how you approach training/CPD?<br>Are trainers visible and valued in your organisation?<br>    Is that linked to recognition?<br><br>How is recognition represented in job planning?<br>    Can you use that time? [Check how related to specific role]<br>What does that mean for non-recognised trainers?<br>    Is there a risk of 'two tier' educators?<br><br>Can recognition improve the quality of education and training? |
|  | Next, how recognition works... |

| Topic area | Trainer questions |
|---|---|
| Process<br>Individual perspective | What do you personally have to do to be recognised?<br>      Do you know what happens to your information?<br>Does it vary between programmes (Foundation, Specialty)?<br><br>Has it changed?<br>Does recognition integrate with CPD/appraisal/revalidation?<br>Is recognition a fair process (eg LTFT, SAS)? |
| Changes<br>What would you change?<br>Role definitions/detail?<br>Process? | What would you change about trainer recognition?<br>      Roles<br>      Awareness<br>      Process<br>Are the right roles recognised?<br>What roles, jobs or activities should be recognised that aren't?<br>Does this include non-medical roles? |
| Opinion<br>General opinions | How do you feel about recognition of trainers?<br>Is the recognition process positive/negative/neutral? |

# Appendix B: Initial qualitative coding framework

Coding framework being used for initial stage of qualitative analysis.

| Code | Definition |
|---|---|
| Awareness | Individual trainers' awareness of recognition. Including: their own recognition status and recognition framework in general. Include terminology/semantics of recognition. |
| Impact | References to any changes in behaviour or attitudes. References to how change is identified. References to negative impact/burden. |
| Sanctions | Consequences for individual doctors of not being recognised – including de-recognition as an individual sanction, and use in relation to organisational sanction. |
| Standards | Any references to the AoME standards |
| Process | References to information flow, requirements for recognition, responsibility of individuals and organisations. Includes revalidation/appraisal. Include development of process since introduction. Also include attitudes towards process – ie is effective; weaknesses of process 'tick box' etc. |
| Job planning | References to job planning, PAs, remuneration within LEPs |
| Job planning - fairness | Explicit references to fairness/unfairness of job planning |
| Trainer knowledge | Whether trainees have appropriate supervisors, and any processes for matching them. Includes knowledge of curricula. May include other facilitators |
| Trainer attitudes | References to trainers' attitudes towards education. |
| Range of educational roles | What constitutes educational activity and educational roles, and what should be recognised. Include variation between specialties, other roles that may not be recognised. Includes appropriateness of recognised roles across UG and PG, and potential change. Includes 'education is part of being a doctor' comments. |