Building our understanding of professional support services offered to doctors in training

Executive summary

As part of our wider programme of research into variation in performance in medical education and training, we interviewed representatives from deaneries and local education and training boards (LETBs) that provide professional support services across the UK.

Professional support services exist to provide help, guidance and access to additional training and support for doctors in training, to help with career development and to remedy problems they may have. Our recent review of the standards for medical education and training focused on the importance of supporting learners and trainers, as one of the key themes.

We found there is wide variation in the support services provided for doctors in training across the UK. This variation covers how services are structured and the types of support available.

Lots of factors are important when supporting doctors in training, but there is generally a lack of robust data and evaluation, which makes it difficult to implement evidence-based programmes, particularly when considering preventative measures and early interventions.

Interviewees gave a range of suggestions about how we could get involved with professional support, both at a national level and through work with individual organisations via our Employer Liaison Service.

Some of these suggestions include working with deaneries and LETBs to share best practice, to help evaluate services and to develop a clearer evidence base. Alongside this is the potential for us to help support services to develop better data collation, to assist with evaluation of services, particularly in the longer term. Some interviewees felt it is important that we should remain separate from the provision of support services, rather than being closely involved.

Why did we interview support service providers?

We have been working with others involved in medical education and training for a number of years, collecting and analysing data to help us understand how doctors in training progress through their careers. Our initial data analysis showed variations in performance and attainment, and at the end of 2014 we developed a dedicated work programme to help us understand the reasons for this. Throughout 2015, we're carrying out research into differential attainment in medical education and training.

As part of this work, we want to understand the support services that are available to doctors in training around the UK, and find out more about barriers to progression and how effective support can help to overcome these. We know from our quality assurance visits that all deaneries and LETBs invest in support programmes for doctors in training, so we wanted to systematically review the types of support available and how they are delivered. Appendix 1 includes more details about how we did this review.

Our wider analysis has initially shown that international medical graduates, graduates from ethnic minority backgrounds, men and older doctors in training tend to progress through their training less smoothly than other doctors in training. As such, we were particularly interested in hearing about experiences of supporting these groups of doctors. However, this paper also considers the broader landscape of professional support, including how support services are developed, prioritised and evaluated.

How is support organised, accessed and delivered?

Most professional support services can be broadly grouped into one of three structures.

- **A tiered service** where there are formally identified hierarchies of support, starting locally in the first instance, eg overseen by educational supervisor, and then possibly referred to the director of medical education within a trust or to the Training Programme Director or Head of School for their specialty. Unresolved or complex cases are then referred upwards to a centralised service, typically similar in structure to the designated units described below. This is the most common approach described.

- **A designated professional support unit (PSU)** which manages all individuals who need support across a deanery or LETB. Most often, these utilise a case-management approach, with each individual assigned a case manager to carry out an assessment and arrange appropriate support and advice. Units that do not form part of a tiered process sometimes operate on a self-referral basis alone.

- **Local support only** where issues are managed by supervisors and educators without a formal central service. Additional support is also available through Lead Employer services. This arrangement is much less common.

An exception to the structures above is the Defence Postgraduate Medical Deanery, where support is delivered during residential programmes, and through collaboration with the local deaneries and LETBs where doctors in training are placed.

Within these structures there is much variability in how services run. There are clear differences in what support is available in different areas. Additionally, in some areas professional support is linked with careers advice, less than full time training services, and coaching and mentoring services. There is also variability as to whether professional support services are seen as being linked with or separate to performance review processes and disciplinary issues.

What did deaneries and LETBs tell us about their professional support services?

The survey findings were broad, and have been grouped according to some of the key areas of discussion during the interviews.

Types of services provided

All organisations outsource at least some of their services, often to other organisations, for instance wellbeing and counselling services. Many have contracts with individuals for specific services, such as communication skills training. Some organisations have links with local universities to provide support in certain areas, and in other cases this also contributes to ongoing research, eg around dyslexia support.

Access to occupational health is available through all organisations, although in those areas where support is locally managed, these services are provided by employing trusts.

Counselling or psychological support and assessment was also mentioned by all organisations, but the level and duration of support varies. For example, many areas offer a confidential counselling or wellbeing service, often with a limited number of sessions. In other areas access to these services is provided through lead employers, while elsewhere mental health assessments are available but there is no ongoing management.

There are many other services that are available in some areas, but not all. There are also differences in who provides services, such as where exam support is offered – in some areas it is delivered through professional support services, but in other areas it is the responsibility of individual specialty schools. The following services are examples of support offered in some deaneries or LETBs.

- Communication skills training

- Mentoring or coaching

- Exam preparation courses

- Dyslexia assessments and support

- Cultural awareness training

- Resilience training

- Assertiveness training

- Careers' guidance

- Language and linguistic support

- Autism spectrum disorder assessments and support

- Time management skills training

- Portfolio skills training

Availability of services varies

Generally, there is a lot of variability in what services are available, and also who can access the different services. There are clear differences in the levels and type of support available to doctors in training, purely dependent on the geography in which they train.

While there could be benefits to a standardised approach across the UK, it is important to make sure that services are suitable for local need, and that they are also accessible to people in all areas. Many interviewees noted that services have developed differently across the UK, and that in some cases this was due to different local structures and need.

Benefits of pooling resources

Some areas recognise the potential benefits to pooling resources with other organisations, and are exploring this as an option, particularly with organisations that are geographically close to their own. In London, one professional support service is shared by three different LETBs. The Defence Postgraduate Medical Deanery also works with other deaneries and LETBs to arrange for their doctors in training to access services in the area where they are geographically based during training.

Who can access support services?

In some cases the services are only for doctors in training. Other areas include dentists, while others make it available to non-trainee doctors too (in some cases this is available through self-funding). Some interviewees felt that services should be available to other health professionals, and in some areas they already are. A number of organisations identified a desire to make the services more widely available than they currently are. Some services have also been developed specifically for certain groups of doctors (see case study 1).

Case study 1: Health Education Thames Valley

A range of services have been developed in Thames Valley to support doctors who qualified outside of the UK, or whose nationality does not allow automatic residence in the UK. These include specific career guidance, visa guidance, tailored inductions, support for refugee and asylum seeking doctors, and advice about training and employment.

In some areas the support is also directed at those who deliver training. For example, support services also target training around cultural awareness, or managing doctors in training who need support, at educational and clinical supervisors and trainers.

Additionally, a small number of organisations have developed programmes of support aimed at preventing problems, or early intervention. These programmes use factors such as selection centre performance, International English Language Testing System scores, and international medical graduate status, to identify individuals who may benefit from tailored support and offer this pre-emptively, sometimes optionally (see case studies 2 and 3). It was highlighted that these programmes need to be based on proper identification of each individual's issues and subsequent access to relevant support in order to be effective. These programmes are predominantly linked to general practice training in the examples that were given.

> **Case study 2: NHS Education for Scotland, South-East Region**
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> In general practice, people who score lower in recruitment to GP training are identified and given an extra induction, which is then used to deliver further support for this group.

What are the referral processes for the professional support services?

> **Case study 3: Health Education East Midlands**
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> An early intervention programme has been developed for doctors training in general practice. People who score poorly in terms of being patient centred and communication skills at recruitment are identified and invited to attend for early intervention before they begin training. This covers areas that are commonly problematic such as e-portfolio, reflective writing and communication skills. They have tried to take the support that is often given following exam failure and introduced it from the outset of training.

Most processes need the educator or referrer to complete a referral form. When individuals are referred to a service, they have to be informed, and in some cases have to agree to the referral.

Self-referral for support is a recognised option in some areas, whereas in others it is not available.

In some organisations, support services can only be accessed through self-referral. So although educators and supervisors might suggest services to a doctor in training, they cannot refer them to the services.

How organisations promote the services also varies and, as might be expected, where self-referral is not available there tends to be less promotion of the service to doctors in training.

How does support link to the Annual Review of Competence Progression (ARCP) processes?

In many organisations, referral for support is often associated with ARCP outcomes, and an outcome 3 (where a doctor in training is deemed to need additional training time because of inadequate progress) is a common reason for accessing support services, along with exam failure. Other organisations highlighted that requiring support should not form part of the ARCP assessment process, and that this was important for removing stigma and encouraging engagement.

These differences raise some wider questions about the nature of professional support, and whether it is seen as being aligned with management of underperforming doctors in training, and linked with fitness to practise concerns, or whether it is about professional and personal development, or indeed a combination of all of these factors. The different approaches, for example, to whether professional support is integrated with appraisal and ARCP processes, and who has the responsibility for referral (the doctor in training or the supervisor), suggests that there are fundamental differences in the perceived function of professional support across the UK.
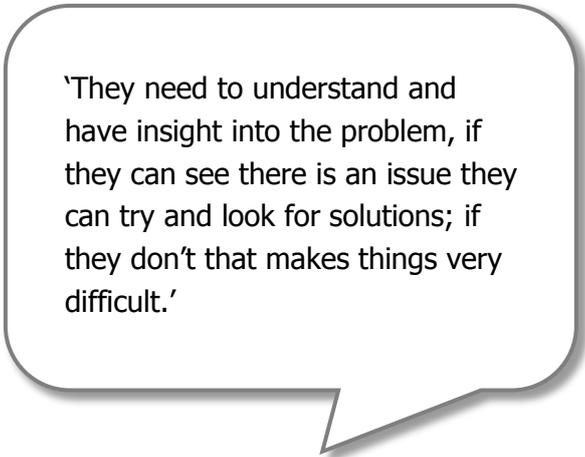
How are professional support services delivered?

The vast majority of services are delivered through face-to-face interactions, but telephone, email and video-conferencing are used at times. Often face-to-face approaches are used for initial introductions and assessment, with follow-up through other means, such as telephone or email. Video-conferencing, eg using Skype, is occasionally used by individuals who are contracted to provide a specific service, such as linguistics assessments, to overcome issues of geographical access.

Experiences of supporting doctors in training to overcome barriers to progression

A really clear determinant of success is individual insight into an issue, and willingness to change. This was repeatedly identified as the key factor that affects the success of an outcome, with many organisations highlighting that if an individual lacks insight it is very difficult to achieve a successful outcome.

'They need to understand and have insight into the problem, if they can see there is an issue they can try and look for solutions; if they don't that makes things very difficult.'

The issue of insight becomes particularly relevant when we consider the differences in referral routes in different areas. While only allowing self-referral

may make it more likely that individuals accessing services have insight into any problems, it may also make it less likely that those with lack of insight, or fears about stigma, actually seek and access support.

An interesting point was raised in reference to documentation, and the importance of recording concerns. It was explained that often when a case is reviewed, previous assessments by supervisors do not indicate any concerns, yet when discussed verbally, those supervisors may well agree with the reasons for referral.

Raising concerns about bullying and undermining is sometimes difficult for individuals because of concerns about naming people involved. A number of interviewees discussed the need to consider the wider team and context when assessing the individual, to try to identify issues that may go beyond the person who has been referred.

Similarly, referral routes need to be flexible enough to allow for the fact that doctors in training may have concerns or problems that are directly related to their supervisor. If a referral process relies on the supervisor in order for the doctor in training to access support, there is obviously a need to have an alternative means by which a doctor in training can raise concerns and seek help.

The need to normalise, and destigmatise support was mentioned frequently by interviewees. For some, it is important to make the experience a positive opportunity for development rather than a pejorative process. Again, this is obviously closely linked to the wider organisational culture around the role of support, and whether it is seen as being a performance management system, or a professional development process.
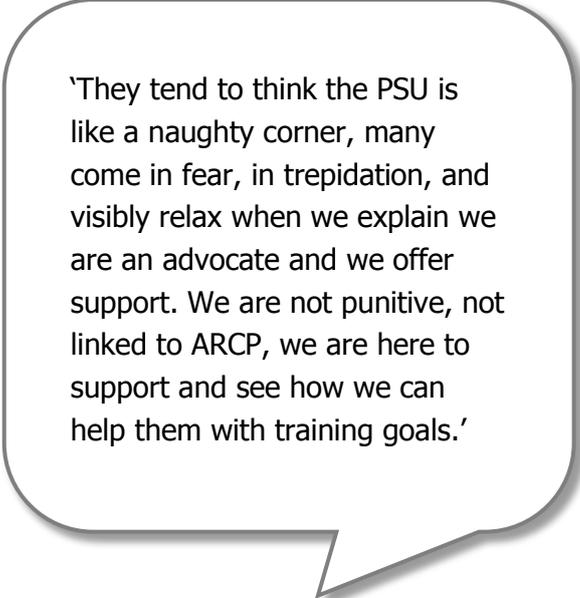
'They tend to think the PSU is like a naughty corner, many come in fear, in trepidation, and visibly relax when we explain we are an advocate and we offer support. We are not punitive, not linked to ARCP, we are here to support and see how we can help them with training goals.'

Linking in with the work being done in some areas looking at early interventions, having open discussions about groups that may face problems was suggested – as was understanding and acknowledging cultural differences and the impact of these. Some felt it is often difficult to do this because of potentially being seen to single out certain groups, particularly if the evidence base was lacking.

Some interviewees also felt that while it is important to look into cultural issues and that they are often an explanation for differences, it is also important to recognise that expected standards must still be achieved. It was also suggested that if individuals are accepted onto training programmes there is a need to work with them and help them to develop to make sure they are meeting the required standard.
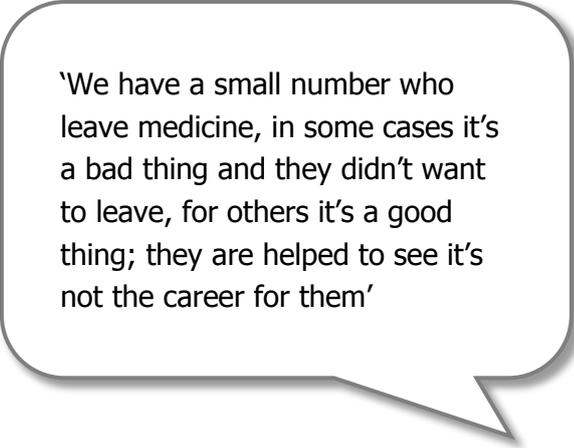
> 'We have a small number who leave medicine, in some cases it's a bad thing and they didn't want to leave, for others it's a good thing; they are helped to see it's not the career for them'

It was frequently mentioned that a good outcome is not always about a return to training. For some people, that specialty, or even medicine overall, is not the correct career choice, and some organisations reported individuals who were relieved to be able to voice that and make plans as to what to do next.

Some highlighted that geographical factors often play a role. Particularly as poorer performing doctors in training are less likely to get their location of choice, familial and social support systems are often compromised, and this is not always an easy issue to fix.

This also means that certain geographical areas, which might be less popular with doctors in training, are more likely to get doctors in training who have performed less well at selection processes. Particularly if this is a recurrent issue, it means that those doctors in training with more need for support might well be placed in areas with many other peers and supervisors who also need additional support.

Certain aspects of training in the Defence Postgraduate Medical Deanery were identified as being specific to those doctors in training in the military. The first is the limited geographical spread of placements for certain specialties, due to the small number of military hospitals and the fact that they are mainly in the south of England, and the impact of this on social support and family contact. Secondly, it was highlighted that it is not possible to undertake less than full time training within the military, which becomes unsuitable for some doctors in training and as such, this is the most common reason for not finishing training.

How do the organisations use information and data?

There are a variety of approaches to data collection and evaluation across the UK. Some organisations collect very little information about the individuals, while others have detailed data collection processes and associated analysis of trends.

Longitudinal follow-up is seen as an important area for development, and our recent release of ARCP and exam data was noted by some to be a positive move towards greater clarity and unity of data.

Protected characteristics are not routinely recorded across the UK, and although many interviewees recognised the value of such

> 'It's very positive that the GMC is looking at this – some of the data being collected about foundation trainees, where they go, patterns of behaviour, is all really important. Looking at any early predictions is really helpful.'

data collection it is not something they have yet been able to develop. Commonly collected information included:

- stage of training

- ARCP outcomes (especially as this was often the reason for referral in many places)

- specialty.

A small number of organisations have developed, or are in the stages of developing, databases for the collection of data or case management. In one pilot, the individuals accessing the service are being given access to their file on the case management system, so that they can see the information being shared.

There is no consistent minimum data set, and much variability between organisations. For those that do routinely collect data, information is collected on a range of factors including medical school, age, gender, less than full time training status, international medical graduate status and previous exam performance. Similarly, using the data for research is done at different levels in different organisations. As might be expected, those who do not routinely collect data in a coordinated way tend not to undertake research or audit as often or as consistently.

For those who do analyse the data, this varies widely. Many carry out internal reporting of caseload and casemix, in some cases to identify areas of focus, eg particular specialities. It is common to present information about the service at annual conferences and events held by the organisations, occasionally with case studies and discussions. In some instances data is used to develop the service, or resources (see case study 4).

For many, lack of data, or the small numbers of individuals for whom information was available is often a limit to doing research, or to feeling like any findings are evidence based. One organisation has looked at data and identified that transitional periods may be closely associated with requiring referral to support services, but don't feel that the findings are robust enough to action. Some areas do share work nationally, and occasionally internationally. Often information is presented at conferences and a small number have had articles published about their work.

> **Case study 4: Health Education East Midlands**
>
> Qualitative research was conducted which reviewed previous cases that had been successfully managed, and used the findings to develop an evidence-based tool for supporting doctors in training. This tool was shared locally, and the findings have been published.

Formal evaluation of services is uncommon and only a small number of organisations routinely seek feedback from those using the services. Those that do, have different approaches, and different levels of uptake. Some offer anonymous feedback mechanisms, while others ask for it by email. In one case research is being done with a university to evaluate services in a formal, systematic way.

Are support service providers mindful of confidentiality?

All organisations are aware of the need to consider confidentiality closely, although there are a variety of approaches. Some organisations do not hold any paper notes, some have a separate electronic case management database, and in some areas, certain discussions between staff involved in support services are not minuted.

Most organisations felt that it is imperative to inform the individual and get their consent before they are referred to the support service. But a small number recognised situations – particularly around severe mental illness – where this might not be possible.

Similarly, some organisations insist that the doctor in training must agree to being referred to the support service, or that they must be the one to contact the service and become engaged. Others highlighted situations where a referral has to be made even if the individual doesn't agree, eg because of patient safety concerns. This again highlights different approaches to professional support – in some areas it is aligned with performance management processes, and in others it is entirely separate from any appraisal or formal remediation.

In terms of information sharing, there are a variety of approaches. Many felt it crucial that any information shared between staff about a case is discussed, and in some cases approved by, the individual concerned. There are recognised issues about trying to share information when the doctor in training doesn't feel comfortable, and concerns about how best to navigate this, eg around ill health or personal issues.

For many of the outsourced services, particularly around psychological support, the support staff do not get access to the details of the sessions, or the outcome. They often get data about whether an individual has made contact, and in some places the number of sessions attended. Some felt it very important that these services are seen as separate. However, others highlighted the difficulty if an individual is felt to be a risk to patients or themselves, around how and when confidentiality should be breached.
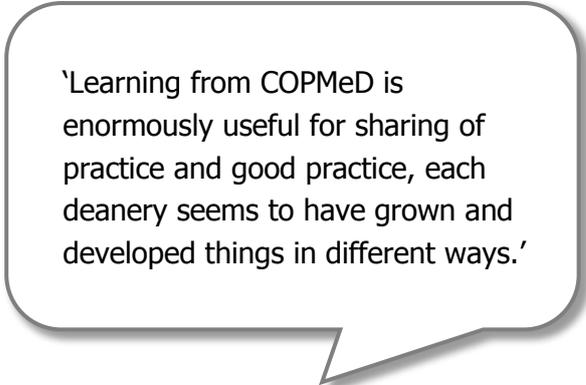
Developing services and sharing practice

Interviewees repeatedly raised the need for more-coordinated data collection and more-detailed analysis. For some, the benefit of longitudinal data collection is an important part of this, to track outcomes over time.

Some ideas about ways services could function in future included team-based approaches to development, to work with a broader range of health professionals. Other ideas

included the development of beacon sites for each specialty that could be developed as placements for those who need additional support, and making closer links between professional support and revalidation processes.

All organisations felt that links with the Conference Of Postgraduate Medical Deans of the UK (COPMeD) are valuable, and this was the most consistently mentioned network. Others included the colleges, the National Association of Clinical Tutors, the Association for Medical Education in Europe, and English Deans. Many organisations felt that they share practice informally with other support services too. Many reported that a UK-wide network gives opportunities to share practice and learn from other areas, as well as being able to discuss complex or difficult cases and consider possible approaches.

'Learning from COPMeD is enormously useful for sharing of practice and good practice, each deanery seems to have grown and developed things in different ways.'

What did interviewees say about our role in professional support services?

As part of the interview process, we asked participants for their views on our role in relation to professional support services, and what involvement they thought we could have in the future. There were a variety of responses, and there is not a clearly unified view on this from the people we spoke with.

Our employer liaison advisors were cited by many organisations as being closely involved with professional support processes. Often, organisations discuss open GMC cases with their advisors to make sure they identify all individuals who might need support, and to make sure that anyone involved in one of our investigations is offered support where available. There were also some people who reported discussing individuals who are receiving support with the advisor to get advice about thresholds for referral to us. Where discussed, they were viewed very positively.

The majority of those interviewed felt that we have a role in developing standards for professional support services. Although some interviewees highlighted that there will continue to be differences in structures and approaches, which will require flexibility, many felt that guidance about provision of support would be helpful. UK-wide standards from the GMC were seen to be important, both in terms of professional support being seen as valuable, and in being a lever to help secure funding and investment.

Some felt that we should work with organisations such as Health Education England to share practice and, in England, to support further collaboration across LETB boundaries.

There were some discussions around our role and standards for entry to medical school and postgraduate training. Some felt that academic excellence may not be the best criteria for selection into medical school, and that more needs to be done around resilience and

preparedness for medical students in view of the environments in which they now work as doctors.

Our role in quality assuring the value added by training programmes was also raised. Some interviewees noted that if colleges are recruiting doctors in training, it could be viewed that they have a responsibility to support the development of these individuals so they have a good chance of progressing to the next stage. Similarly, some interviewees highlighted that our data on outcomes at deanery and LETB level should be more clearly linked to longitudinal data.

Particularly in some geographic areas that get a greater proportion of lower scoring candidates, some representatives felt that their doctors in training are more likely to have poorer outcomes in exams and ARCPs. They said it was important to recognise that this isn't just a measure of the quality of the organisation.

Importantly, some people interviewed also felt it is important that we are separate from professional support. They suggested that the regulator should not be closely aligned with development and support for individuals, and should remain removed from such processes.

Others welcomed the potential collaboration, and work such as the Welcome to UK Practice programme is seen as the start of us being involved in offering support. Our role in helping to coordinate the data across the UK is also seen as a positive idea by some participants.

Next steps

Although all deaneries and LETBs across the UK provide professional support to doctors in training, there is wide variation in all facets of professional support services. Structures, access arrangements, types of services available, and the way support services are integrated into appraisal and performance management processes differ greatly across the UK.

We have a responsibility to oversee standards of education and training and have set standards about support given to doctors in training as part of this.

One of the challenges is the lack of accessible evaluative information on how effective the support mechanisms that deaneries and LETBs offer are.

We need to consider how the data we produce could help deaneries and LETBs to understand what support doctors in their training programmes may need and to evaluate their services, particularly in the areas of prevention and early identification of problems.

There are a wide range of UK-wide and local organisations involved in funding, coordinating and delivering professional support across the UK. We need to consider how we work with these organisations and where the responsibility lies for any actions resulting from this work.

Appendix 1: How we carried out the interviews

A semi structured, telephone-based interview was developed as the most appropriate methodology for the survey.[*] A pilot telephone survey was carried out with a deanery, and the survey redrafted based on feedback from the participant and the researcher.

Of 21 identified deaneries and LETBs (see the table below), 19 took part in the interviews. In one organisation, two interviews were conducted in view of a recent merging of two deaneries, resulting in a total of 20 interviews being conducted (including the pilot).

Both of the organisations that did not participate were regions in Scotland (which formed one deanery on 1 April 2014). In one case, this was because they directed us to a contact in NHS Education for Scotland who had already been interviewed. The interviewees included postgraduate deans, responsible officers, and associate deans (often with a specific remit for professional support).

Working independently, three researchers carried out the telephone surveys, taking notes during the calls. The researchers had a conversation after the initial interviews to identify any additional discussion points that were arising, or problems with the survey in practice.

Each interview lasted approximately one hour, with an additional hour for write up and reflection by the researcher immediately following the interview

The notes from all of the interviews were reviewed by one reviewer (also a researcher) for the purposes of drafting this report.

[*] Many thanks to Dr Julia Whiteman, postgraduate dean of Health Education North West London and COPMeD Lead Dean for performance, for assistance with early drafts of the survey and ongoing support and guidance throughout the work undertaken. This work builds on an earlier survey carried out by Dr Whiteman between 2013 and 2014.

Deaneries and LETBs invited to take part in survey	
Defence Postgraduate Medical Deanery	Health Education Wessex
Health Education East Midlands	Health Education West Midlands
Health Education East of England	Health Education Yorkshire and the Humber
Health Education Kent, Surrey and Sussex	NHS Education for Scotland
Health Education North Central and East London	NHS Education for Scotland (East Region)
Health Education North East	NHS Education for Scotland (North Region)
Health Education North West	NHS Education for Scotland (South-East Region)
Health Education North West London	NHS Education for Scotland (West Region)
Health Education South London	Northern Ireland Medical and Dental Training Agency
Health Education South West	Wales Deanery
Health Education Thames Valley	