IFF Research

SoMEP Barometer 2022: Deep-dive into the experiences of trainers

Prepared for the General Medical Council by IFF Research

April 2023

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1 Executive summary

Motivations

- The majority of trainers who took part in this research enjoyed their role, despite the challenges and additional demands on capacity that being a trainer entails. In particular, trainers enjoyed seeing the development of their trainees as they gained experience whilst under their supervision.
- Trainers tended to be altruistically motivated, describing a sense of duty to ensure their knowledge is passed on the next generation of doctors in order to improve the quality of the workforce, and subsequently improve patient outcomes and population health.
- Trainers also experienced benefits from being a trainer, through enhancing their own learning and development and through the variety that it brings to their day-to-day role.

Supervision approaches and focus

- Trainers described three aspects of supervision: formal, informal and modelling positive behaviours. Trainers agreed that the focus of their role was often to develop confidence, rather than competence. This is because trainees require a safe and supportive environment to practice the clinical and theoretical knowledge they have acquired to date and to learn to apply this knowledge under ‘real life’ circumstances.

Meeting competing priorities

- Trainers generally agreed that managing competing priorities is an ongoing challenge. Participants described having to constantly balance meeting patient needs (their primary responsibility) with supporting trainees and completing administrative tasks.
- Trainers described taking three different approaches to help balance their competing priorities: protecting time; collaborating; and being flexible. Protecting time was the preferred approach as it was seen to be the most effective way of ensuring trainers could spend enough time supporting their trainees without disruptions. However, this approach relied on buy-in from management which was not always felt to be present.

Changes over time

- Three separate but interconnected factors are felt by trainers to have had a negative impact on the quality of current and prospective trainee doctors: trainers being pressured to prioritise seeing patients over providing supervision; doctors in

training perceived to be pursuing a healthier work-life balance resulting in them spending fewer hours gaining clinical experience; and the impact of the COVID-19 pandemic resulting in fewer opportunities for some trainees.

Support for trainers

- Trainers tended to feel supported by their peers as well as administrative staff, sharing workloads and seeking advice when their competing priorities became overwhelming.

- Trainers felt their role was valued by their workplace when their managers respected and protected their supervision time. Some trainers also reported a culture of valuing and sharing knowledge in their place of work or within their specialism, which lent itself to them feeling supported. Conversely, trainers felt less supported in instances when they felt pressured by management to prioritise seeing patients over training.

- Trainers who described being supported by educational bodies felt that clear learning outcomes had been set, which provided some structure to work within. Trainers who felt unsupported by their educational bodies explained how selection and assessment processes had become too relaxed, leading to poor quality trainees getting placed under their supervision.

- Trainers outlined a three-pronged approach to making them feel more supported: having time recognised and protected for their supervisory role; financial renumeration as a token of appreciation for the additional demands on their capacity; and practical, tailored guidance on how to manage their competing priorities within their specialism.

2 Introduction & approach

IFF Research have conducted the SoMEP Barometer survey annually since 2019. One of the findings from this year's survey was that doctors with training responsibilities are finding it particularly challenging to manage their workloads and do not always feel supported[1]. In light of this, the General Medical Council (GMC) commissioned IFF to conduct some additional follow-up qualitative work with trainers, to understand more about their role and how they balance it with their other responsibilities as a doctor.

Approach

Ten depth interviews were conducted remotely (via Microsoft Teams or telephone) during the first two weeks of March 2023. Interviews took 45 minutes on average. The sample was recruited from the 259 respondents who had taken part in the 2022 Barometer survey, and told us that they:

- Had acted as a named clinical or educational trainer for postgraduate trainees. (A note on terminology, some respondents used the term clinical or educational *supervisor*).
- Gave permission for us to recontact them and a telephone number to do so.

Profile of interviews completed

Of the ten who took part, four were working in primary care and six in secondary care, including one SAS/LE doctor.

Nine out of the ten respondents were providing clinical supervision. Four were also providing educational supervision. The respondents often had a high level of experience, with over 10 years' experience in their area of practice. However, there were some trainers with less experience e.g. one who qualified as a GP three years ago.

Respondents took part from across the UK: seven in England, one in Northern Ireland, one in Wales and one in Scotland. A mix of respondents were recruited by gender, ethnicity and PMQ location.

It was typical for trainers to have one or two trainees formally under their supervision, at any one time. There were also instances of supporting four or five trainees formally. In addition to their formal trainees, trainers were often supporting other trainees informally or on an ad hoc basis. For example, medical students, Physician Associates (PA) or Anaesthesia Associates (AA) or other roles including nurses, midwives, paramedics, Advanced Clinical Practitioners etc. Because of these additional trainees, one trainer felt responsible for nine

[1] 2 in 3 trainers in our quantitative sample were specialists so their experience largely reflects that of specialists more broadly e.g more likely for high workload to be 'normalised' and to feel less supported by senior medical staff. However, within specialists, trainers are more likely to be 'struggling' (35% vs. 26% non-trainers) and to feel less supported by both senior medical staff and non-clinical management.

trainees. Another trainer worked with up to 35 trainees, sharing their supervisory responsibility with other colleagues.

Informal supervision included playing a role at induction - introducing all trainees to the setting e.g. operating theatre. It was also about demonstrating how to undertake tasks and being on hand to answer questions when various trainees were present. Those who had allocated trainees, also talked about the informal parts of that role, e.g. providing coaching and careers advice.

Note on interpretation

As ten interviews is a relatively small sample, caution should be used when generalising from the findings presented in this report. Findings are indicative and give a sense of areas to explore in further depth.

It is also worth noting that the perspectives shared here are those of trainers only, and at points, trainers' views on their trainees. The perspectives of trainees are not included here.

Furthermore, the interviews took place around the same time as the junior doctor strikes. It is possible that the strikes being topical had an impact on respondents' views, though there was no direct evidence of this. The strikes were only referenced by a few as an example of the health service being under pressure.

3 Motivations for being a trainer

Trainers tended to enjoy their training role. They had either actively pursued the path to becoming a trainer or had been pleased this was an expectation of their job role / a natural progression within it. They found the training role enjoyable as they were interacting and building relationships with trainees, and observing their development was rewarding. This positive view was in spite of the challenges and additional effort they had taken on as part of the trainer role.

Motivations for being a trainer were primarily altruistic. There was a sense of trainers wanting to give back to the system that they had benefitted from. In some cases, trainers talked about their own positive experiences of training and wanting to pass this experience on to others. Many hoped that through receiving good quality supervision, the trainees would go on to provide the same for the next wave of trainees.

"Nothing annoys me more than my colleagues complaining about the quality of doctors…and getting to the end of training and them saying I'm not sure these people are ready…well that's on us!"
- Intensive Care Specialist, Male

Linked to this, the desire to improve the quality of the workforce came across strongly. There were some mentions of reaching trainees early in their careers to maximise the positive impact on their development. Some trainers referenced their sense of responsibility for ensuring quality in the

next generation. The improvement to patient care that would result from improving the quality of the workforce was also widely referenced.

There were also trainers who had a passion for medical education which made them suited to the role and those who wanted to ensure that knowledge of their particular specialism was shared.

"Once you join the role, training is a part of it, you don't want the knowledge to die with you." ***- A&E Consultant, Male***

Trainers valued several benefits that the role brought to them. Some mentioned valuing the variety that being a trainer brought to their working life. This meant they were able to do more than solely clinical work, with one mentioning that this was particularly important in the context of a long-term medical career.

Others referenced career development, either directly or indirectly, by ensuing their knowledge stayed up to date. Trainers talked about how the relationship with the trainee was two-way and exposed them to resources and new knowledge that was useful. There were also examples of how trainees brought about opportunities for trainers to reflect on their own practice.

"It's interesting having people in the practice. They're young and fresh, we keep each other up to date. Sometimes they say, 'Why do you do it like that?' and that makes me think."
- A&E Consultant, Male

"[Trainees] teach you new things as well. They bring techniques from other places - it keeps you on your toes. It means you need to keep your knowledge up and be up to date." ***- Consultant Anaesthetist, Male***

In summary, trainers tended to find their supervisory role an enjoyable and important aspect of their continuous professional development.

There was, however, one trainer in the sample who did not enjoy the role and was performing it out of obligation. This doctor felt she was able to perform the role reasonably well but it was not something she enjoyed, especially as her clinical work involved a lot of emotional support giving.

"I don't enjoy it [training]. I feel too pressured. I do the best I can and think I'm reasonably good at presenting and educating as I've done a lot of it…I find it cumbersome to have to constantly look after somebody. There's a lot of counselling and reassurance in the job already." ***- Specialist Registrar, Female***

4 Supervision approaches and focus

Trainers described a range of aspects to supervision including formal, informal and modelling positive behaviours. Often these aspects are used in conjunction. Each of these aspects are discussed in further detail below.

Formal aspects

Trainers take responsibility for ensuring that trainees develop clinical skills and complete required tasks such as portfolios. Trainers mentioned carrying out tasks such as portfolio reviews, and debriefing trainees at the end of the day, or at the end of surgery. Trainers also described teaching by example and then asking trainees to carry out tasks independently.

Where there were gaps in knowledge, the priority was to plug them as much as possible. In order to fulfil these needs, trainers described how they made themselves available for questions from trainees during formal time slots or as and when they cropped up.

Modelling positive behaviours

Leading by example and modelling positive behaviours were felt to be important for the development of both clinical skills and soft skills. In terms of soft skills, trainers talked about helping trainees to develop the ability to plan and manage time, as well as how to be resilient. Teaching trainees how to manage their personal wellbeing and work-life balance were described as being important for longevity and were behaviours that some trainers described consciously attempting to model to trainees.

Communicating to, and interacting with, patients were also skills which trainers agreed were important for trainees to develop. Some trainers described how they modelled these interpersonal skills for trainees and provided feedback on their observations of trainees' interactions with patients.

Trainers also highlighted how they felt it was important to share their own personal experiences with trainees, to help them gain a breadth of understanding about different clinical cases and how to deal with them. For example, one trainer talked about how they anchored their teachings in examples of their previous cases and explained how their own approach had changed over time.

Informal aspects

Trainers talked about the need to provide some 'informal' types of support, which ranged from providing career advice or coaching to trainees about their next steps, to being aware that trainees may have challenges outside of work that affect their job performance. Some trainers referenced making themselves

"I try to sit with the trainees every two weeks for half an hour [1-1 or small group]. I give them my contact details. They know they can contact me any time. They can talk about how they're coping."
*- **Palliative Care, Male***

available to trainees outside of their contracted hours and making an effort to get to know trainees in a more holistic way, so that trainees would feel comfortable coming to them with challenges outside of work. How feasible this approach was depended on the setting and number of trainees the trainer was supporting.

Focus of supervision – developing confidence navigating 'real world' scenarios

Across all of the aspects of training described above, trainers agreed that the focus of their role was often to develop confidence, rather than competence. Competence was about having the knowledge and skill to undertake the required tasks. Confidence was about being able to operate in real-life settings independently. Competence was very important, but this was felt to be already present in most cases as trainees had developed sufficient knowledge through their academic training, and the role of the trainer was to help trainees apply their knowledge in a real life setting, through exposure to multiple clinical cases, discussion and feedback, and practising interactions with patients.

> *"You realise that there are all these people skills that you don't get taught… you've learned all this science, but what do we do in real life? … in theory you want to refer this person to a rheumatologist, but there's a 12-month waiting list, so what are you going to do now?"* ***- GP, Female***

However, plugging gaps in competence becomes the priority where trainees are identified as being below required standards. Some trainers mentioned instances of over-confident trainees who are unaware that they are lacking in competence, which was felt to be a particularly difficult situation to deal with. This relates to a sense from trainers that the power balance has shifted in favour of trainees over trainers – this is discussed in further detail below.

Trainer suggestions for peers

Trainers made some recommendations for those taking on the trainer role for the first time, which are detailed below.

Firstly, it was felt to be important to take a structured approach to meeting trainees' learning outcomes through planning, delivering and then reviewing learning. Some also encouraged new trainers to take a long-term view to think about how learning outcomes could be met during the trainee's time on their placement.

Listening and engaging with trainees was felt to be important to build relationships, and part of the holistic approach that some trainers described taking. This was about being attentive to trainees' overall learning and development needs, rather than solely meeting their core competency requirements.

Some trainers talked about how it was important to try out different methods of training, to find what best suited the trainer and the trainee. Trainers also talked about the importance of maintaining a training and development mindset, so that they could be aware of potential teaching opportunities as they came up.

Finally, striking a balance between maintaining respect and being supportive was mentioned – being friendly but firm. This was felt to be important so that trainees keep up a high standard of work.

> *"You have to be friendly, but you are not their friends – if you get too loose then people get sloppy… You have to prioritise safety."*
> *- **A&E Consultant, Male***

5 Meeting competing priorities

All participants said that meeting patient needs was their priority, with their role as a trainer coming second.

"The patients have to take priority so the trainees don't get as much time as they should do." **- *Specialist registrar, Female***

Trainers tended to spend approximately 10-20% of their working week fulfilling their training duties. A few GPs said that on average they spent closer to 30% of their time on clinical supervision. Within any given week trainers might also be expected to take on additional ad hoc responsibilities such as trainee inductions, medical student visits and attending events. In these cases, trainers could end up spending more time on their supervisory responsibilities.

Trainee needs could also impact the amount of time spent on supervision. Although most trainers said that on the whole, they did not prioritise one trainee over another, prioritisation could occur if a trainee is more proactive in seeking support; a trainee requires additional training and supervision (to plug gaps in knowledge); or if the trainee is dealing with an especially complex case.

Opinions were mixed when it came to whether trainers felt like they had enough capacity for their training responsibilities, with those able to protect their training time being more likely to say that it was sufficient.

Tools and approaches to balancing priorities

Trainers described taking three different approaches to help balance their competing priorities: protecting time; collaborating; and being flexible.

Protecting time

Protecting time was the preferred and most effective approach to meeting competing priorities and entails trainers negotiating with their employer or manager to have their supervision time protected and recognised as a core deliverable alongside patient care and administrative tasks. This helps ensure that the time spent on supervision is valued by the employer and not seen as an afterthought or nice-to-have.

Trainers also described compartmentalising training time in order to minimise disruptions during clinical supervision. In the longer-term, some trainers suggested that planning how training requirements will be met over the course of a trainee's placement also helps to ensure they have enough time allocated to their supervisory responsibilities.

Collaborating

Effective collaboration also played a role in balancing competing priorities. Trainers described seeking support from other trainers if their own workload became overwhelming. Some trainers also took a collaborative approach to debriefing or teaching trainees by providing group sessions, effectively reducing the time spent on each trainee. Having

access to a supportive 'infrastructure', such as drawing on administrative staff for support, was also mentioned as a tool to manage workloads.

Being flexible

A certain degree of flexibility is also key to prioritising. A few trainers explained how they would front-load their supervisory responsibilities and patient care during the day and then complete administrative tasks later, outside of regular working hours if needed. This ensured that they would have enough contact time with their trainees during a shift.

"I used to leave the feedback giving to the end of the shift but then you have too much pressure." ***- A&E Consultant, Male***

Many trainers also acknowledged that their priorities sometimes need to change on a daily or weekly basis, for example if an emergency arises.

6 Changes over time

Training is becoming deprioritised

"There is always pressure to provide more and more and that will chip away at training time and the only way to continue to provide quality training is to recognise that we need to train professionals, or they will leave".
– GP, Female

Several trainers felt that training is becoming less valued in their workplace. Many trainers reported a drive to prioritise clinical time in order to meet patient needs in response to current pressures on the healthcare system. This manifested itself as managers and senior leadership teams placing pressure on doctors to spend their contracted hours seeing patients rather than supervising trainees or pursuing other training and development initiatives. For example, some trainers felt that their Supporting Professional Activity time is being increasingly scrutinised. In the past, doctors were incentivised to take on additional teaching activities because they would either be financially renumerated, or they could justify time spent delivering training against their contracted hours. However, over time this has changed, and some doctors felt pressured to either prioritise clinical time or continue providing training but at the cost of their own free time.

"They've actually really changed the goalposts I feel, over the years... One example would be teaching on a postgraduate clinical course… It requires preparation, delivery, it brings money into the hospital… but there's no time allowed specifically in the contract for that."
- Consultant Anaesthetist, Female

Whilst this approach may be beneficial for patients in the short-term, trainers argued that in the longer-term this would have a negative impact on the quality of future doctors and subsequently worsen patient outcomes.

Attitudes towards work are changing

Many trainers commented that the attitudes that trainees have towards work, and in particular work-life balance, is changing. Trainers felt that in recent times an increasing number of trainees are very vocal and proactive about setting boundaries and protecting their work-life balance, for example by not working beyond their contracted hours; protecting time off and time allocated to their studies; or refusing to take on additional responsibilities

"I think it's a different generation with different priorities around work-life balance and they're much better at having an appropriate work-life balance. Consultants do however join having done far less cases and that is a problem."
– Consultant Anaesthetist, Male

that fall outside the remit of their role description.[2] It was perceived that this is in sharp contrast to previous generations, in which doctors worked long hours often at the expense of their personal wellbeing. Whilst trainers noted that this shift can be beneficial to reduce the chance of burnout and ensure longevity in their careers, they also felt that some trainees need to take a more flexible approach so that they can see more patients and therefore maximise their training opportunities. The perception of several trainers was that the general quality of trainees they supervise is dropping because they lack experience. One also mentioned that a lack of willingness to go over and above to ensure all work is completed could have a detrimental effect on patient care.

Impact of COVID-19

There are a lot of trainees coming through who've had a very rough time in the pandemic – a lot have been off for stress, haven't had rotations…It's meant that the skill base coming through as FY2s has been very eroded."
*-**GP, Male***

Another factor which trainers reported having a negative impact on the quality of trainees is the COVID-19 pandemic. In the short-term, the NHS' response to the pandemic resulted in trainee doctors being placed on emergency wards rather than rotating through several different clinical environments. This resulted in trainees have fewer opportunities to gain clinical experience and trainers felt that the quality of trainees suffered as a result. The emergency response also meant that trainees had less time to spend on their own learning and development.

Additionally, as a result of the traumatic experiences that many junior doctors experienced in dealing with life-or-death situations too early in their development, many trainees took time off to manage their wellbeing. This has further exacerbated the lack of experience that some trainees present with and affected the confidence of others.

In the longer-term, trainers reported that the deprioritisation of routine procedures in response to the pandemic has created a backlog of patients, leading to increased demand on their capacity to treat patients and taking away from the time they have available for supporting their trainees. This backlog has also created more ongoing demand for trainee's time, leaving less capacity for them to focus on their learning and development.

[2] It should be noted that The state of medical education and practice in the UK 2021 (gmc-uk.org) found that many doctors, including doctors in training, are regularly working beyond their rostered hours.

7 Support for trainers

How supported trainers feel

Trainers generally felt supported by their peers and colleagues. They reported feeling well supported by peers as they were able to take a collaborative approach to supervision, sharing responsibility for trainees and tasks between them. Trainers also felt they could reach out to their peers for support should they need to, as there was a shared understanding of the challenges and requirements of being a trainer. One example was a trainer working with 19 other consultants, who he met regularly with. This was a helpful opportunity to be able to discuss junior doctors informally and flag any areas to be addressed, particularly in the context of having limited time available to spend individually with trainees.

"We're a good team, we have a laugh. Two of the other partners are trainers, so we all know what it's like."
- GP, Female

"The nature of the job is episodic… the number of times you spend with any individual is quite small, unless you're their main trainer."
- Intensive Care Specialist, Male

This positive feeling of being supported extended to colleagues who did not share the supervisory responsibility. Administrative staff and other colleagues were described as being helpful in terms of playing a role in the induction of trainees, as well as ensuring there were effective processes in place to make the trainer's role easier.

There were some instances of peers and other colleagues not being able to share the supervisory requirements or support efficient processes however. Whether this kind of support is available or not seems to depend on the workplace.

Trainer views on support they received from management were mixed. There were some positive behaviours. For example, some instances of trainers feeling well supported by their senior leadership team in terms of having their training time ring-fenced, which trainers agreed was helpful. Some trainers also reported a culture of valuing and sharing knowledge in their place of work, which made them feel valued in their role as a trainer.

However, there were instances of trainers feeling that their leadership team did not prioritise training, which had a negative impact on the trainees' experiences. For example, one trainer reported a conflict with GP practice managers who wanted to treat as many patients as possible to maximise revenue, which they felt resulted in over-working trainees and not allowing sufficient time for their development. Also, some trainers felt they were not encouraged to pursue their own learning and development.

When it came to educational bodies and membership organisations, again some positive behaviours were noted. For example, some trainers felt that clear learning outcomes had been set, which provided some structure to work within.

However, there were some reported issues when it came to the role educational bodies and membership organisations are playing:

- Some felt there was a lack of integrity in selection and assessment processes, leading to poorer quality trainees.
- Educational bodies and membership organisations were also felt to be partly responsible for a perceived power shift in favour of trainees, in that the trainees' needs and/or rights were prioritised to the extent that trainers did not feel comfortable challenging them on poor performance.
- While not common across the small sample in this research, one trainer did not feel they had had adequate training from their deanery on how to be a trainer.

"The balance has swung too much in favour of trainees…It's scary to see how standards have slipped over the last 10 years... The trust is in the system to let people progress irrespective of their knowledge or skills. Are we creating a larger medical workforce, but a more dysfunctional one?"
*- **Palliative Care Specialist, Male***

The point here about a perceived power shift in favour of trainees was referenced in different ways. One trainer described how he had had an underperforming trainee, who he had tried to support. However, this trainee had not agreed that he needed extra help and had gone on to make a complaint about the trainer for being overbearing. This trainer felt it was difficult to hold trainees to account for fear of repercussions against trainers and that there was no protection for trainers in these kinds of situations. The same trainer described how he has also seen this dynamic as an examiner for undergraduate and postgraduate exams, where examiners are afraid to fail students. He feels where there is this reluctance to challenge trainees, it is leading to a drop in standards.

What support would make a difference for trainers?

Having protected time was the key aspect that trainers agreed on, in terms of how to make training responsibilities manageable. This was evident from those who already had this, and those who were aware they lacked it. There were reports from trainers without protected time of having to regularly miss their lunch break or make up a couple of hours of administrative tasks at the end of their day, so that they could prioritise the needs of trainees.

If a hospital consultant teaches, they get extra, but a GP doesn't get any more… We get £4000 per trainee but that just goes to the general budget…pro rata I'll probably get around 200 quid out of it."
*- **GP, Male***

Financial renumeration for being a trainer was not a primary motivator, but there was a feeling expressed by some that pay could be useful as a token of appreciation and recognition for the extra work that goes in to being a trainer.

Finally, trainers felt that some guidance on how to fit training responsibilities around other tasks for their respective specialisms would be helpful. Trainers felt this guidance could

come from hospital trusts and GP practices, and it would likely be in the form of peer support.

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Whether employer or employee, client or collaborator, we are all humans first and foremost. Recognising this essential humanity is central to how we conduct our business, and how we lead our lives. We respect and accommodate each individual’s way of thinking, working and communicating, mindful of the fact that each has their own story and means of telling it.

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