Kent Academic Repository

King, Annette and Jenkins, Linda M. (2009) *GP training capacity in East Kent - a research study.* **Project report. Centre for Health Services Studies, University of Kent, Canterbury**

Downloaded from

The version of record is available from

This document version
UNSPECIFIED

DOI for this version

Licence for this version
UNSPECIFIED

Additional information

Versions of research works

Versions of Record
If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts
If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in *Title of Journal* , Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

CHSS
University of **Kent**

Centre for Health Services Studies

GP training capacity in East Kent – a research study
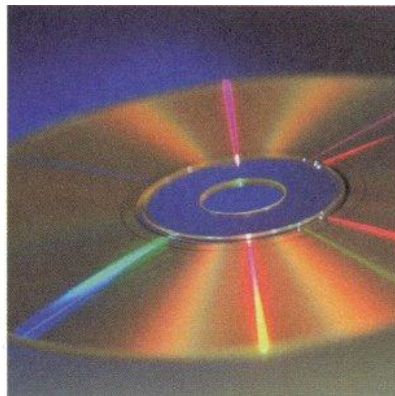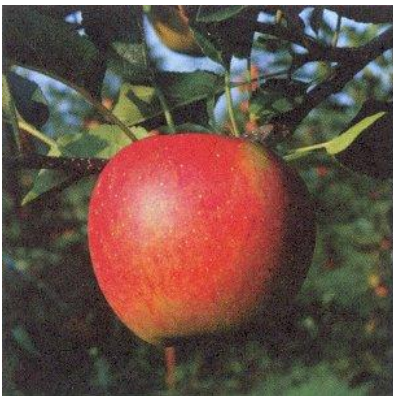
Annette King
Linda Jenkins

Centre for Health Services Studies
University of Kent

July 2009

Centre for Health Services Studies

CHSS is one of three research units of the University of Kent's School of Social Policy, Sociology and Social Research and contributed to the school's recent Research Assessment Exercise 6* rating. This puts the school in the top three in the UK. CHSS is an applied research unit where research is informed by and ultimately influences practice.

The Centre is directed by Professor Andy Alaszewski and draws together a wide range of research and disciplinary expertise, including health and social policy, medical sociology, public health and epidemiology, geriatric medicine, primary care, physiotherapy, statistical and information analysis. CHSS supports research in the NHS in Kent and Surrey and has a programme of national and international health services research. While CHSS undertakes research in a wide range of health and health care topics, its main research programmes comprise-.

- o Risk and health care
- o Health and social care of vulnerable adults
- o Public health and public policy
- o Injury prevention and surveillance
- o Ethnicity and health care

Researchers in the Centre attract funding of nearly £l million per year from a diverse range of funders including the ESRC, MRC, Department of Health, NHS Health Trusts and the European Commission.

For further details about the work of the Centre or for more copies of the report please contact:

Peta Hampshire
Administrator
Centre for Health Services Studies
George Allen Wing
University of Kent
Canterbury
Kent CT2 7NF

Tel: 01227 824057
E-mail: p.r.hampshire@kent.ac.uk
Fax: 01227 827868
www.kent.ac.uk/chss

Acknowledgements

Contents

List of Tables

1. Executive Summary

1. This research project was commissioned by NHS Eastern & Coastal Kent PCT (ECK PCT) as part of its clinical workforce development to look at reasons why there are comparatively fewer GP trainers and training practices in East Kent compared to other areas. ECK PCT wished to commission research to understand the current low level of provision among GP training and to use the research results to improve the provision of GP training placements in the NHS Eastern and Coastal Kent area.

2. The report summarises the findings of the various stages of the report, including the literature review, interview study, and survey and makes a number of recommendations.

Literature review

3. There is little research into GP training as a profession. This is surprising given the increase of the duration of training for GPs and the increasing pressure of developing training places to accommodate the new training formats. The research evidence highlights issues of time protection and concerns about support from partners in the practice as potential barriers in developing GP training. There is emerging evidence from a study in one Deanery that training practices may outperform non-training practices in achieving QOF targets.

4. A number of policy publications addressed issues in GP training over the last two years, chiefly in the wake of the findings of the Tooke inquiry 'Modernizing Medical Careers, Aspiring to Excellence' (MMC). The RCGP review group highlights a number of issues in relation to the capacity of expanding GP training: it will require additional resources, additional infrastructure and a cultural shift in training.

5. The current research evidence available on GP trainers and on issues of capacity is sparse. There is a need to expand the evidence base and gain a better understanding of what the pertinent issues are about GP capacity. This seems to be particularly important given a policy context which is moving quite rapidly into fundamental changes in GP training.

Interview study

6. Becoming a trainer - GPs entered training through a variety of routes. Three factors stood out and were highlighted by the research participants as important in deciding to become a trainer. The first was the positive training experiences GPs had themselves as trainees and the enthusiasm of their trainers while going through training. A second factor involved

choosing training among a number of other possible professional activities. A third factor was the 'readiness of the practice' in supporting the trainer preparation and in accommodating a trainer. The experienced trainers in particular had quite strong views about an appropriate balance of being interested in being a trainer, and also the needs of the practice.

7. Becoming a training practice - Practices tended to start with FY1 and FY2 level training and then went into registrar training. While some GPs thought this route a useful pathway for developing training, one GP in the focus group perceived it to be a rather inflexible process.

8. The first year of practice throws up additional training needs, as new trainers settle into their new roles. The buddy system, whereby an experienced trainer acts as support to newly qualified trainer, was regarded as a good support system by one trainer, as were the local trainer group meetings and the support offered by the programme directors and the Deanery.

9. Setting up as a training practice can be administratively burdensome. Once established, some of the initial pressures to comply and set appropriate processes in motion diminish.
The preparation for receiving a GP trainee for the first time can entail a lot of additional work and pressures.

10. Room restrictions are a further factor in determining whether or not the practices are considering developing more trainers. Space cannot be developed quickly, and some practices look at a substantial rebuild.

11. Collegial support- An important element for successful and sustainable training over time is the collegial support available to trainers. Respondents differentiated between support from within the practice and from the network of GP trainers in the locality and through the professional support in the Deanery.

12. Financial remuneration and administration - There was agreement among GPs in the individual interviews and the focus group that the time devoted to training was unlikely to be covered by the training grant. Trainers acknowledge that with time there are benefits to the practice, once the GP registrar becomes more experienced - there was no agreement whether the service commitment covered the training investment. There was greater clarity about the

administrative costs involved in various aspects of training, the burden placed on support staff, and on trainers. GPs thought that this could be better supported and acknowledged.

13. Trainees' needs – Some practices and trainers found it difficult when trainees had problems with the programme of training. The way registrars take to the training and develop their skills impacts on how much time trainers will have to spend on direct supervision, additional tutorials, feedback and general support. Interviews and focus group raised problems such as cultural and language barriers and the range of experiences registrars bring to the training and their suitability for the GP work.

14. Changes in the profession - As the demographics of qualified GPs change, they may influence how training is seen in the practice context. Some part-time GPs and GPs with other commitments may find it difficult to become trainers.

15. GP practices as enterprises - GPs were uneasy about the costs of fulfilling the requirements of practice accreditation, contract administration and internal management of training. As GP practices are becoming more commercially aware and adopt a business culture in their operations, all activities will come under greater financial and cost scrutiny. A similar argument was put forward in relation to the growing demands on practices and the difficulties in keeping on top of additional work. While some of the growing work portfolio may mitigate against taking on or expanding training, the service commitment of the trainee also offers opportunities to address new work areas.

16. Issues specific to Kent- East Kent was regarded as remote and was not 'attractive to registrars'. Some GPs had experience of challenging training contexts, for example they worked with trainees who struggled, whilst others were very satisfied with the ability of their trainees.

17. Travel- Most of the GPs interviewed thought that the location of the training facility in Gatwick was difficult to reach and required additional time out of the practice. There was a concern that the current payments for taking part in (post-training) courses was insufficient because trainers had to stay overnight. As a consequence, some trainers did not attend meetings on a regular basis.

18. Covering out-of-hours training - The way out-of-hours training is organised in East Kent posed a problem for some trainers in that they found it difficult to schedule in trainees for their out-of-hours experiences. Not all of the GPs commented on this as a problem.

19. Trainers were in favour of the MRCGP qualification, because it enhances the standard of the GP qualification. There was less agreement on whether the MRCGP membership was of particular value to well-established and long-serving GPs who might consider becoming trainers late in their careers, although GPs understood that MRCGP is a pre-requisite for becoming a trainer.

20. The training relationship - Respondents agreed that the experience of working with a young doctor can be rewarding, and for some trainers contributing to the new generation of GPs is a core motivation.

21. Keeping up-to-date- Training helps to keep trainers informed about the developments in medicine and clinical practice. Registrars are of benefit to the practice environment.

22. Professional recognition – Further professional qualification is not a priority for trainers.

Non-trainer survey

23. A short postal survey was sent to all 247 non-trainer GPs in non-training practices. 81 replies were received representing an encouraging 33% response rate and indicating that the subject was of some interest to those not involved in training. Three quarters of the respondents were male GPs, nearly two-thirds were under 55 and less than half had membership of the Royal College of General Practitioners (MRCGP).

24. The general view was that the number of trainers in East Kent was on the low side. 28 respondents said they were interested in being a trainer. There were some differences between the 28 who were interested in becoming a trainer and those who were not (see points 32 and 33 below).

25. Despite it being a survey of GPs not involved in training, the response was very positive about the benefits of training, for example in providing personal development, keeping up to date, and being a (rare) opportunity to work closely with a colleague. Many were interested in sharing their knowledge.

26. Respondents felt that it was difficult to free their own time to train, to safeguard protected time for training activities, and within the practice extra time would be needed for discussion of cases.

27. Three quarters in the survey felt that it was a professional part of being a GP to train the next generation, but similar numbers felt they had insufficient space. Significant numbers also felt that it conferred status to be a training practice.

28. Relatively fewer survey respondents saw the advantages of extra remuneration, additional capacity, and being easier to recruit, compared to the disadvantages of consultations taking longer, the reduction of space and trainers carrying out fewer surgeries.

29. There was some ambivalence about practices' ability to take on a training role, as around half said it was too time-consuming to go through the process of practice accreditation (this was the most cited barrier).

30. A small number of the respondents had been trainers but had given up. Comparing their answers to the results as a whole, fewer ex-trainers regarded the barriers as a problem.

31. As many as one third said they were interested in becoming a trainer. These were no different in terms of gender, practice size or their perceptions about the shortage of training places, but they were more likely to be younger and have MRCGP. Compared to other respondents, those thinking about becoming a trainer were much more interested in teaching colleagues and felt that training was a professional part of being a GP. Fewer felt that the status conferred on a teaching practice was an advantage, and they were less concerned about the disadvantages of working in a training practice, apart from the extra time required for discussing cases.

32. Those who were not interested in becoming trainers felt they had too little time, that it would be detrimental to their work-life balance, that the burden was too great on their practice, and that there were other professional activities or practice targets on which they would rather concentrate.

Discussion

33. Personal - The interviews and the focus group discussion indicated that trainers and non-trainers shared an awareness of the personal benefits of training. However, this does not seem to be sufficient motivation for wanting to become a trainer. In the survey a third of respondents expressed in interest in becoming a trainer. Recruitment of trainers should concentrate on this group of 'potential trainers', rather than attempt to 'convert' GPs who are not interested.

34. Within the wider East Kent health community, there may be opportunities for strengthening the positive perceptions of training further.

35. Professional - Training GP registrars involves the whole practice and trainers depend on the commitment and continued support of colleagues. Because it is perceived to be resource intensive for the practice, it is unlikely that all practices will be willing to become training practices within the current system.

36. Strong perceptions about training as being difficult may be a barrier for some practices to consider training at all.

37. There is a need to support training in established practices. One way of shoring up support in practices would be to enable GPs in existing training practices to become trainers. The group training practice which participated in the focus group may be one model for development. In that practice, there is a strong commitment and support for training internally; training is part of the ethos and philosophy of the practice.

38. Another group that may be a further source of new trainers may be salaried GPs. Because of the contractual constraints of salaried GPs work under, it appears that it is difficult for them to engage with training.

39. Practical – Time constraints on the time that the trainer can take out of the practice restricts participation in training related events. This may be an area where the PCT could step in and provide extra financial and administrative resources to enable trainers to participate fully in training commitments.

40. It is difficult to quantify the actual time commitment to training. A lot will depend on the experience of the trainers, the trainer-trainee relationship and the individual needs of the trainee. Some interviewees thought that there is a need for additional support for newly accredited practices and newly qualified trainers to support them through the first year of training.

41. Space - Adaptations and rebuilds require time. It clearly is a major investment requirement for East Kent practices and the PCT, and there may be the opportunity to draw on the DH investment grant for this.

42. Resources – Some respondents highlighted that some GP trainees had additional, non-GP training related training needs (for example in language training) which they thought was not covered within the current provision and could be addressed locally.

Recommendations

From an external perspective, we would recommend that he ECK PCT consider the following:

1. The findings of the study indicate that there may be a limited number of new practices suitable for training in East Kent. The survey indicates that interest in training in East Kent is limited - realistically, trainers need a degree of personal enthusiasm plus a suitable and supportive practice environment to train. It may be useful to focus recruitment on GPs who express an interest in training and who work in suitable practice environments, which can support a trainer.

2. Expanding training in existing practices may be a further strategy for developing additional training places. The multiple trainer model offers a number of advantages, not the least that the practice is familiar with training. Drawing the group of salaried GPs into training may be another route into expanding the current training base. However, this is likely to have considerable additional resource implications for practices which may have to be absorbed by the PCT.

3. One strategy for developing greater interest in training in the patch and for increasing the confidence of potential trainers would be to combine offering a programme of practical support for training with a work-stream which is aimed at strengthening

perceptions about advantages of training and being a training practice. This may involve further work in drawing out practice benefits of training and promote these among GPs in East Kent.

4. There is a need for additional resources to support training. Non-training practices perceive training as a potential liability in terms of resources and training practices have highlighted gaps in covering certain aspects of training activities. These include back-filling GP time when travelling to training related events, and additional travelling expenses.

5. ECK PCT should consider additional support to help practices through the process of accreditation, by supporting practices administratively and/or financially through the application process.

6. The first year of training can be quite challenging for a training practice and the new trainer. It would be useful to explore with newly accredited practices and trainers what additional resources would be helpful to them.

7. There may also be the opportunity to strengthen the support structure for trainers and trainees further through providing additional courses locally or by rotating existing provision to make access easier in East Kent.

8. ECK PCT should proactively promote its interest in and support of GP training in East Kent. Interview participants were surprised and encouraged by the interest the Trust is showing in training; most were not aware of it. There may be an opportunity for open and direct dialogue with trainers in the type of support that could be developed. From the response we received when interviewing, GP trainers would welcome this. This could build on the good relationship between the Deanery and workforce development team.

2. Introduction

This research project was commissioned by NHS Eastern & Coastal Kent PCT as part of its clinical workforce development to look at reasons why there are comparatively fewer GP trainers and training practices in East Kent compared to other areas. Only 25% of GP practices were training practices and 8.9% of GPs in East Kent were GP Trainers, compared to other areas where it is thought that the majority of practices train. Kent, Surrey and Sussex GP Deanery is responsible for co-ordinating GP training in the area and needs to increase the numbers of GPs actively training. NHS ECK PCT needs to support this and secure the future supply of GPs.

There is an added urgency in that there will be substantial changes in GP training from next year onwards, with GP trainees having to spend 2 years in general practice in the future (currently the training period is one year). Although the increase will be incremental, there is urgency in developing new GP training places in the locality to accommodate this shift.

ECK PCT wished to commission research to understand the current low level of provision among GP training and to use the research results to improve the provision of GP training placements in the Coastal and East Kent area. The specific research questions posed were:

- Why is the take-up of GP training low in the area?
- What are the barriers for GPs in the locality to take on GP trainees?
- What can the ECK PCT do to make providing GP training places more attractive to GPs?
- Are there examples of good practice (policies/initiatives/approaches) which ECK PCT can use/build on to improve on the GP training provision in East Kent?

The following report summarises the findings of the various stages of the report, including the literature review, interview study, and survey. This is followed by a discussion of the findings and a number of recommendations, which the PCT may wish to discuss further. The Appendix describes the methods used.

3. The literature review

The aim of the literature review was to identify relevant research and evidence on General Practitioner (GP) training in the UK. We were particularly interested in finding research relating to the perceptions and experiences of GP trainers in England following the recent

changes in GP training regulations and approaches. The approach taken for the literature review is described further in the Appendix.

While the review was meant to be focussed, we found little direct research evidence on the perspective of GP trainers and GP capacity. It is not clear why this is the case, but a number of factors may be involved:

- GP training is an evolving area of clinical education and it is difficult to develop a research agenda in a fluctuating environment. The current developments in GP training towards extended periods of training are comparatively new and their impact has not yet filtered through the policy or academic research agendas.

- The Royal College of GPs is conducting its own investigation into various aspects of training. Results of consultations and research flow into this in summary form to inform policy development. Original research seems to be rarely published and evidence is directly obtained from stakeholders.

Whatever the reasons for the limits of research in this area, for this literature review we had to draw on a limited body of articles. References that were considered for inclusion initially were mostly not research based, but opinion pieces and other types of articles. In the following, the literature is ordered into two categories: research and evidence on GP training in England, and a commentary on the policy context of the evolving context of GP training.

3.1 Current research into training issues for GPs

While educational issues are discussed in the wider clinical education literature, there is little research carried out into issues relating to GP training as a profession or into developmental issues and problems in GP education. This is surprising given the increase of training times for GPs and the increasing pressure on developing training places to accommodate the new training formats (The Future of Medical Careers (MMC) 2008).

Views on medical education in primary care

A national postal survey by Fraser et al. (2007) asked registrars, trainers and other educators about the proposed changes to the content and structure of GP training. It achieved responses from 817 GP registrars (GPRs), 521General Practitioners within two years of qualification registered on the higher professional education scheme (HPEs) and 559 primary care medical

educators (PCEs) from across the UK, and a response rate of 61.7%. Although not specifically targeted at GP trainers, trainers agreed with the views of other groups which endorsed a three-year training programme following the two-year foundation programme. They wanted this time to be equally distributed between General Practice and hospital placements and supported more time spent in General Practice. The findings indicate that there is convergence in the view among trainees and trainers that GP training requires substantial time for specialisation.

Professional education

Waters and Wall (2007) surveyed the views of GP trainers on their educational development needs in the West Midlands Deanery. The survey identified a number of issues as barriers for GP trainers to develop their qualifications. While some, although not all, trainers had an interest in developing their professional qualification as teachers, over 56% identified time constraint and difficulties in gaining protected time to pursue further education. The perceived attitude of partners in the practice was identified as the most important determinant of whether or not trainers felt they could engage with educational courses.

In a further, qualitative study, Waters and Wall (2008) explored the perceptions and motivations of GP trainers in relation to professionalisation further. GP trainers were 'ambivalent' towards further qualifications; on the one hand they valued better additional qualifications as equipping them better in their training, on the other hand they perceived barriers in the attitudes of partners in the practice and in the lack of protected time to study for further qualifications. The authors stated that trainers expressed disappointment at the lack of leadership and direction from the Deanery for their educational CPD.

Quality indicators and training practices

Houghton et al. (2006) studied whether training practices performed better than non-training practices using the Quality of Outcomes Framework (QOF). They found that training practices outperformed non-training practices on QOF targets. Although the results are encouraging, they are limited because of the regional nature of the study. However, it is a first indication that training may enhance practice performance, adding quantifiable value to the practice.

From this rather unsystematic research evidence, issues of time protection, perceptions and concerns about support from partners in the practice, are identified as potential barriers in

developing training further. In the Houghton report there is an emergent theme of developing a better understanding of the advantage of training; however, this would need to be explored further.

3.2 The policy context of GP training

There are a number of policy publications on GP training over the last two years, chiefly in the wake of the findings of the Tooke inquiry 'Modernizing Medical Careers, Aspiring to Excellence' (MMC) (2008), which recommended that GP specialty training should be expanded to five years.

As the result of the Tooke inquiry, the Royal College of GPs and the Medical Education England (MEE) are currently undertaking a review of extending GP training and the implication of this. The review includes a consultation of stakeholders which were invited to contribute. NHS Employers highlighted the need

- To improve the attractiveness of the GP training as a career pathway in the MMC
- For further research into the curriculum needs for GPs
- For enhancing training capacity, support and supervision
- For robust transitional arrangements to sustain the changes as the result of MMC.

In its interim report to the Department of Health (RCGP 2008), the RCGP raises a number of issues in relation to the capacity of expanding or extending GP training, highlighting the fact that an expansion would

- "Place unprecedented demands on the training infrastructure, with an estimate of increasing the numbers by GP trainees, 300% if GP training was extended to 3 years (point 21)

- Need to be underpinned by a substantial investment programme to deliver the expansion. (point 22)

- Require a reconsideration of the reward structure/ payment to trainers. (point 23)

- Lead to a shift in balance between trainers and trainees, changing the ratios from 15:1 to possibly 4:1 and may result in placement requirements of an average of one trainee per practice (points 24, 25, 26)

The interim report also stresses that the cultural and demographic changes would need to be taken into account. The review, due to report in May 2009, has now been extended further on request to HM Treasury – the reasons for this have not been published as yet (RCGP 2009b).

One recent policy development has been the announcement by the Department of Health in May 2009 of an allocation of an £100 Million for 2009/2010 to invest in upgrading GP surgeries to training practices. This investment is targeted specifically at under-doctored areas. It is not clear whether this announcement is in response to the current stage of inquiry and an attempt to preempt some of the likely delays in implementing the changes to GP training. Building new premises to accommodate the expansion of GP trainees will take time.

The current research evidence available on GP trainers and on issues of capacity is sparse. The few studies that were identified however show an interesting range of issues emerging – the most interesting of these is the study of the potential impact of training on the performance of practices. There is clearly a need to expand the evidence base and gain a better understanding of GP training and its local, regional and national contexts. This seems to be particularly important given a policy context which is moving quite rapidly into fundamental changes in GP training. Systematic research into the benefits of GP training for practices, the local health economy and the NHS in general may be one pathway of increasing the credibility and willingness among the GP profession in participating in an expansion of GP training.

4. Interview study

This section summarises the findings of the interview study, comprising of the semi-structured interviews with GP trainers and one GP training director, and the focus group.
Three sections will be discussed: 1) the issues relating to becoming and being a GP trainer and a training practice, 2) training related experiences for individual trainers and for the training practice and 3) the personal motivations and drawbacks of training as reported by respondents. In order to keep the report manageable and within the brief of the study, the emphasis of the report will be on issues that relate to the context of training and those aspects

of the wider (East Kent) environment of GP training experience. However, as respondents provided a wide ranging commentary on GP training and did not necessarily differentiate between, for example the curriculum requirements of GP training and the context it is embedded in, where appropriate reference will be made to all aspects of training. Clearly, not all of the issues raised can be influenced by the PCT; however, they are part of the experience of training.

4.1 Theme 1: Becoming a trainer and being a training practice

From the perspective of GPs, training comes as a package. It involves not only the registrar stage, but also the FY placements, plus other training activities (for example participation in pilots). Even wider, the commitment to training may also include training of other staff. GPs commented on the fact that there seemed to be an expectation that the practice would be fully fledged practices over a shorter period of time and that those who were training medical students would develop into registrar trainers rather more quickly.

Deciding to train

The interview schedule asked about why and how GPs had come into training.

For some, it had been a longer standing interest, which had been realised when an opportunity arose in the practice. The new trainer described it as follows:

> When I came to work here in Kent there were several areas that I wanted to develop and becoming a trainer again became an issue because there isn't a trainer in this practice. So I just felt that I would be very interested in doing it. (GP01)

Two of the longer established trainers also reported that circumstances of personal interest and the practice environment had led them into becoming a trainer:

> I had been in the practice from … - so it was quite a long time before I undertook that because there were things that needed to be changed within this practice before I felt ready to do that (GP03).

> Partly interest and partly having my arms twisted I think because the trainer in the practice was appointed director of the training scheme and there was a trainee without a trainer so I took up training. (GP04)

[I] continued to train after I became a partner so I was involved in [training] … I think the other thing is they're probably fairly desperate for trainers so I was appointed, so I think it was probably his enthusiasm really as much as anything than encouraged me (GP02)

While the initial route into training appears varied, three factors stood out and were highlighted by the research participants as important in deciding to become a trainer. The first is GP trainers had positive training experience themselves as trainees and experienced the enthusiasm of their trainers whilst going through training as inspirational:

Well I think that the example had been shown to me by my training practice and I had enjoyed the experience as a very positive thing. … and then I went to E. and I admired my trainer very much and the way in which they work and I thought that one day when the time's right I'd like to take on that role as well (GP03).

The decision to become a trainer, well it was a training practice already and in fact my trainer was the senior partner in the practice so I had a really good experience as a GP trainee … (GP02)

GPs in the interviews shared an intrinsic interest in training, teaching and mentoring as an activity which informed their decision to become a trainer. Being enthused by others and shown that training can be worthwhile and enjoyable seems to be a good advert for becoming a trainer. This is perhaps not surprising, given that the training relationship between trainer and trainee is close and apprentice like.

A second factor influencing the decision to become a trainer is that it is often a result of a decision making process, which involves a choice between different activities. At the individual level the time commitment makes choices necessary:

I suppose having said training doesn't stop us doing – personally, it probably does because there are things that – if I can give an example, I mean I might want to do a bit more in cardiology for instance, but I actually just don't have the time and I had to stop being programme director because I really couldn't do both. Just couldn't do both justice, so I suppose there are things I would have done had I not been a trainer.

As a practice, I don't think we've not taken on any projects that we would have otherwise done. (GP02)

In this sense, training is a specialisation within a GP practice, alongside other specialities. At the practice level, however, GPs stressed that training did not necessarily stop the practice from developing new services and specialised areas of activities or targets, not the least due to the fact that GP trainees were an asset:

I think you've got to organise that in, it's not a conflict, its an advantage for the GP registrar to be able to learn how these things work and can actually devolve some of the learning to people who've got skills – they can spend time with your QOF clerk to learn about practice management. My partner XXXX who's been heavily involved with the QOF has handed over [to the trainee] some of the things he's had to do – perhaps run a small audit, and he's said well, he's discussed it with the GP registrar, they've thought about it and then gone off and done the audit and presented back to him, so it's actually win-win because the audit got done, the GP registrar learnt and it was to everybody's benefit. (GP01)

No I can't think of anything we have chosen not to do because of the pressures of training. If anything it would be the other way round – we would be able to use appointment time freed up by the trainee to do things. (GP03)

I suppose there are two sides to that, one is that we get the help of the trainees – they are involved in the targets – QOF targets or any other project that's going on – so they get involved in helping and in fact we sometimes use these smaller areas for the trainee to focus on as a learning and practical experience, so we get the benefit there. But against that is the time and energy I am spending on the trainees that I can't put towards helping with QOF. (GP02)

Our interviews were conducted with GP trainers in practices with a number of partners and we did not have the opportunity to interview in smaller practices – which may struggle to

accommodate training among other required specialties[1]. However, even within the training practices, the decision to expand training tended to be carefully considered.

A third factor participants in the interviews highlighted is a perceived 'readiness of the practice' in supporting the trainer preparation and accommodating a trainer. The experienced trainers in particular had quite strong views about an appropriate balance of being interested in being a trainer, and also the needs of the practice. When asked whether there were plans to expand training in the practice, trainer GP02 thought that they had no interest as the younger colleague was fairly inexperienced and the practice was currently too busy:

> We haven't got any plans at the moment. One of our newest appointed doctors would be interested in training but she's only just started so she's got to find her feet. … (GP02)

> There's quite a large elderly population and high incidence of deprivation, so there is little time for people to sit down and think about becoming a trainer and going off to go on courses (GP03).

This was echoed by two GPs in the focus group, who also stressed the need for a balance between the trainer requirements and the practice needs:

> We are under great pressure to expand. At the moment with xxx training doctors we are ok, but they want us to expand. There are two issues here, one is the number of patients and continuity of care. ….

> We believe that you shouldn't have too many doctors seeing the same patient and that really to sustain one registrar you need at least three to four thousand patients, four to five thousand per registrar ….

This cautiousness about engaging in training was echoed in the experience of the new trainer, who needed to reassure the partners in his practice a number of times in the build-up of the practice accreditation about the feasibility of managing training commitment within their practice context.

---

[1] For a breakdown of the interview selection criteria, please see the Methods section under 9.2.

I think there was a lot of anxiety right from the beginning, before we even took a registrar. About what it would mean for the practice. And what it would mean for me personally working with the other partners. …. you can present how you feel it is going to work. …. I think we must have had three or four meetings where I explained what would happen. (GP 01).

It is not so much that practices are against training, but that engaging with training, particularly the extended training of a registrar, has implications for the practice. These need to be carefully considered and assessed on whether or not it is the appropriate time for taking this additional work on. Practices will also want to be assured that individual GPs are at the right point in their careers to take on the extensive training commitment.

Training to be a trainer

We asked in individual interviews specifically about any commentary on the current training programme. The newly qualified trainer had enjoyed the training programme. Clearly the experienced trainers had only arms-length knowledge about the current training programme; therefore their commentary was about the wider context of training, including FY1 and FY2 training, and the practice implications of the overall training activities.

All of the GPs interviewed individually and as part of the focus group were partners in practices which participated in FY1 and FY2 level training – and in some instances these colleagues were considering developing the training further to trainer level. While some GPs thought this route a useful pathway for developing training and a process of 'natural' progression, one GP in the focus group perceived it to be a rather inflexible process, with expectations that training should move from FY1 and FY2 to registrar trainer:

I thought it is unhelpful because you may feel you want to specialise in FY2 or FY1- it's another hoop it seems to me (GP- Focus group)

This view was not shared by all GPs. However, the conversation around the combination of FY1, FY2 and other training schemes highlighted the fact the GP registrar training is not the only type of training GP practices have, but that it is embedded in other training activities of doctors, and also of other clinical professionals in the practice. This in turn can contribute to

the need to prioritise some training activities over others – it may on occasion lead to conflicting pressures and external expectations.

The programme director interviewed also highlighted the competing pressures and demands of GP practices, which may hinder the further expansion of GP training in practices, or could be a barrier to developing further training:

> When you look at what you are expected to do as a general practitioner – you've got to be a manager, a researcher, be part of a practice based commissioning cluster … (Programme Director)

Support for new trainers

Like any other educator training programme, the first year of practice throws up additional training needs, as new trainers settle into their new roles. GP01 thought that the buddy system, whereby an experienced trainer links with a newly qualified trainer, offered a good system, as were the local trainer group meetings and the support offered by the programme directors and the Deanery. Knowing that support is available and accessible is important in supporting newly qualified trainers early in their training career.

Where there may be continuing gaps in supporting newly qualified trainers, these may lie in accessing practical support. The newly qualified trainer for example identified further training needs in developing useful training formats through electronic software – finding the time to access appropriate IT training in his case seemed difficult. Development needs only tend to surface through the experience of training and of course are quite individualistic. In the interviews, we did not get a sense of whether and how these practical skills needs of trainers were addressed – but it may be something which could be supported at local level.

Practice accreditation

Alongside the requirements of the training, the new trainer also reported that he also had to lead on the accreditation process for the practice. While acknowledging in particular the input of the administrative staff in this process, the ultimate responsibility and the pressure to fulfil the requirements still lay with him.

> I would say it is quite an arduous process becoming a training practice. … There were a lot of issues around approval dates and whether we would have enough time for

preparation. … So we were under a lot of pressure and there was a lot of work for a couple of months. (GP01)

Once established, some of the initial pressures to comply and set appropriate processes in motion diminish. For some practices, the compliance with regulations to retain training status becomes routine – and while it is still an administrative burden, it tends to be absorbed into the practice routine (see also next section). One of the long-established training GPs we interviewed argued that the preparation for accreditation and subsequent re-accreditation was about demonstrating that a practice met the appropriate standards expected of modern GP practices rather than asking for additional things to be put in place.

Any up to speed practice which has the organisational set-up which is in fact required for us to achieve our QOF targets – any practice of high QOF achievers should easily be able to accommodate a GP registrar as the systems are already in place. They have to be organised and it's just a case of scheduling in the doctor. and scheduling the time for the training. (GP02)

However, other participants highlighted that training incurs considerable administrative burden.

It seems that from the perspective of a practice which embarks on training for the first time, and that of newly qualified trainers, the preparation for receiving a GP trainee for the first time can entail quite a lot of additional work and pressures. There is a need for additional support, particularly in relation to understanding and fulfilling the external bureaucratic processes involved and also in setting up the internal administrative systems and processes. It may be an area where additional support would be helpful to trainers and practices which embark on training.

Accommodation

Room restrictions are a further factor in determining whether or not the practices are considering developing more trainers in their practice. Space cannot be developed quickly, and practices therefore look at a substantial rebuild.

In East Kent … in some areas there have been rebuilds, but in other areas, the actual physical practices are small (Programme Director)

We do have a room problem. The practice was rebuilt in 2003 and we have outgrown it. There is a conflict between developing other services and developing the training. … it is a balance and we haven't quite worked out how we are going to do it. What happened is that we stopped having FY2 because we now have a registrar… we have made an application to convert [into a further consulting room] because that would allow us to have another registrar or a FY2. (GP01, new trainer).

Although again this surgery has been here for xxx years … and although it has been adopted and adapted, we haven't a lot more to go. (GP02)

Overall, becoming a GP trainer and establishing a training practice is manageable; however it is also a lot of work and involves uncertainties. Additional sources of support, for example in the form of additional administrative or developmental input/advice/resources, the process could be further streamlined and made easier. One of the GPs interviewed also suggested that setting up a 'one-stop shop' with the Deanery and PCT to work out applications, contracts and payment issues would make the setting up of training much easier.

4.2 Theme 2: Experiences in training

In this section we report on what respondents raised about trainer and training issues beyond the set-up phase of training. We were particularly interested in drawing out issues which may affect the sustainability of training in a practice or which could be barriers for practices to taking up training.

Collegial support

An important element for successful and sustainable training over time is the collegial support available to trainers. Support is not only needed in times of crisis, for example when there are problems with individual trainees, but on a continuous basis throughout the training activities. Again respondents differentiated between support from within the practice and from the network of GP trainers in the locality and through the professional support in the Deanery. Surprisingly, three of our respondents stated that they were not aware that the PCT was interested in supporting training in the locality and that they welcomed this support.

While trainers reported that they received generally good support from colleagues in the practice, it can cause tensions on occasion, particularly when the practice is under pressure.

Sometimes it can be difficult to make other partners realise the time commitment required for training activities. In particular, it can be difficult for non-training GPs to understand the need to keep lists down on training days in order to conduct their training session. As GP 03 pointed out, this may be a particular challenge in practices where there is only one GP trainer and there is no experience of training otherwise.

> In this practice I think I now get support. Wasn't always the case. Because we've been a training practice for so many years, and at some point we had more than one trainer, that the other partners have some understanding, but I think if you've not been one, I think it's quite difficult to know what the trainer is up to and your colleagues might think 'Oh, he's having an easy time, not doing very much of your list today, when in fact you're probably busy and you've got to catch up in the evening. … (GP03)

Trainers also appreciated the trainers' workshop and the support available through the Deanery.

> Certainly the GP trainer group I've been involved in, there's one trainee who has difficulty at the moment and it's been really good the way the trainers have come together and supported that trainer (Programme Director).

> The trainers' workshop is probably the most supportive organisation, if you like and because I've known the trainers for years, and that's a personal thing rather than professional support and the trainer's workshop is a really useful backup if we have problems. (GP04).

Financial remuneration and administration

The issue of remuneration for training is complex. There was agreement among GPs in the individual interviews and the focus group that the time devoted to training was unlikely to be covered by the training grant:

> Well the immediate direct financial remuneration isn't it – although it is part of it. It's a huge commitment. There is a close relationship between GP trainer and registrar. It has to be and you have to be there for them all the time. (GP03)

The trainer's grant does not really adequately support the trainer. … In terms of the time that we spend with trainees, that [the training grant] is well outspent. If we were to employ a locum for all the time that I'm out of practice on the expected trainer days and workshops and interviews and all the other things I do, so the money covers barely my absence … (GP04)

In addition, trainers reported that they were dealing with training issues out-of-hours and weekends. At the same time, however, trainers acknowledge that with time there are benefits to the practice, once the GP registrar becomes more experienced - however, there was not necessarily agreement that the service commitment covered the training investment:

In the early stages, as the trainer, I get the bulk of the requests by the trainee to come and look at this or that or the after-surgery debriefing,…. so it takes a lot of my time, but the practice as a whole gains by having quite experienced doctors now … you can't really discount that, maybe 60 appointments (GP 04).

Is the amount of service commitment you get from a GP registrar worth the additional responsibilities and down time that one gets by doing it? I think if it were purely from a financial package, the answer is a very definite no. (GP- focus group).

In the way we run it, it's probably cost neutral. I would take sort of a two hour gap out of a surgery once a week but the trainee is also seeing patients during the week so that probably compensates for the lack of appointments. (GP04)

It is probably quite difficult to set-up an accurate balance sheet of time invested in training and session commitment by the registrar, given the way GP partners work collaboratively in the practice. GP04 reported also that when fully costed out, the training grant did not cover the cost of buying out the time of a salaried GP, who was interested in becoming a trainer. This was because the cost of this GP could not be as easily 'soaked up' as GP04's absences – his cover was more easily arranged because he was a partner and because he was more flexible with his hours. This may be a problem for the future – as the business model of GP practices takes increasing hold and also more GPs work in a salaried capacity, the flexibility around accommodating training might diminish.

There was greater clarity about the administrative costs involved in various aspects of training, the burden placed on support staff, or in some cases, the trainers themselves. GPs thought that this could be better supported and acknowledged.

> With every training grant, in a way, recognising that the trainer's time is taken up with that, there ought to be additional funds. There is of necessity quite a large chunk of admin that goes with that. Not that I necessarily do – my practice manager does. The timetabling person has to do that and it deflects them from other tasks etc. (GP03).

> At the moment, [the administrative] all costs come out of the trainer's grant so we could easily estimate the time spent secretarially and by the practice administrator, which is very much involved in all the admin of the trainees and that would help a lot, it really would. (GP04)

This need for additional administrative support is an area that was also identified as important by the group practice. Although in their case, the practice business manager and the designated training coordinator took on the role, the time still had to come out of practice time and needed to be absorbed as part of the overall administration of the practice.

For practices with a number of qualified trainers, a specific issue arises when not all training partners have a trainee at all times because of the practicalities of room allocation. While trainers are not training, the requirements to keep training skills going are not compensated, making it a net loss maintaining trainers in the practice. This issue was raised in the focus group as a particular issue to multi-trainer practices.

> We have only two registrars in the practice at a time because we can't fit them in, but we [trainers not currently having a trainee] have to maintain our training skills, our training commitment to go to other meetings in that year when we are not training…. (GP- focus group)

Trainees' needs
One of the difficult issues for practices and individual GPs to deal with is if trainees have difficulties with the programme of training. Not surprisingly, the way registrars take to the

training and develop their skills impacts on how much time will have to be spent on direct supervision, additional tutorials, feedback and general support.

> It depends on how good your registrar is, but if you've got a very poor one you might have to do a lot of preparation for tutorials, if you've got a good registrar they'll teach you and learn themselves in the process. (GP02)

Specific issues that were raised in the interviews as being problematic were cultural and language barriers [at least in the past], which had not been picked up on in the selection process. It was not clear from the interviews whether this was still a problem.

A further issue highlighted in the interviews was the range of experiences registrars can bring to the training and their suitability for the GP work they are training for:

> At the assessment, the criteria is whether the person is trainable or not trainable. The vast majority of people end up trainable. … Although they may have been trainable, I am not sure whether they are entirely suitable (GP 02).

> I think we should be blunt … you had two GP registrars who we know within a month or so of being in practice were barely trainable. (GP- focus group)

In some instances it had caused problems for practices and led to practices giving up training altogether.

> Although we had some quite difficult trainees over the years in Kent… they caused a lot of complaints and things so one practice gave up completely because they had a series of difficulties. (GP02)

Collectively, dealing with trainee registrars who struggle with aspects of the training can have an impact on how training is perceived in the locality

> I was amazed he had gone through, not him as a person, but the experience and relevance of what he had done, ,… it puts a big pressure on you or somebody else to carry on the training, because they are struggling. And when other practices hear

about the struggles we have you can't blame them for not being that enthusiastic …
(GP – focus group)

GPs also acknowledged that the support through the programme directors and the trainers' workshop was helpful in airing and addressing problems encountered in training. It was also seen as a support mechanism to deal with the stress of difficult training situations and coping with internal conflict over training in practices.

The discussion around trainees highlighted the fact that some GP trainers would like to have greater ownership of the selection of trainees.

There is the relationship between the apprentice and the tutor and actually there are issues when you don't always get on with your apprentice and actually you are enforcing a one-to-one role on a very close working basis for a whole year and I don't think that can be imposed from above. …. (GP – focus group)

A number of GPs in the focus group, for example, argued that in order to develop sustainable relationships with trainees which then can survive difficulties and problems that may arise in the training year, they needed to be part of the selection process rather than being expected to take on GPs. Clearly this is not something that can be addressed locally or falls necessarily into the remit of the PCT. However, it may be possible to develop further support structures, for example by making resources available which would further underpin the training through which specific issues could be addressed early.

Changes in the profession

In the interview discussions, GPs highlighted a number of changes that may affect the ability and willingness of GPs to do training.

Changing demographics of the GP profession

As the demographics of the qualified GPs change, they may influence how training is seen as a viable specialisation in the practice context. A couple of the experienced GPs made reference to the changing aspirations and expectations of younger GPs coming into the profession:

I can understand why some of my younger partners are saying 'I want this time to spend with my family', because in the early days, it just didn't happen. The surgeries used to start at five and go on to seven. That was 1982 and it was often 8pm and 9pm that you'd get in. I am glad those bad old days have gone (GP02).

It may be that younger doctors may not be attracted into doing training because of the additional commitment that would be imposed on them. People like to say 'Well I want to work from such and such a time to such and such a time and then go away because I've got other commitments'; it is seriously difficult for female doctors who have children to find appropriate child care, so that they can do this. (GP03).

Some part-time GPs and GPs with other commitments may find it difficult to become trainers. Being a trainer requires flexibility in hours, it may infringe on personal time and requires time away from home; conditions which may not be acceptable to some groups of GPs.

GP practices as enterprises

As mentioned above, there is a perception that financially training, and in particular the administration that goes with it, are not sufficiently compensated. In particular, GPs were uneasy about the costs of fulfilling the requirements of practice accreditation, contract administration and internal management of training.

While the financial dimension does not seem to be decisive in the decision to begin or continue to train, balancing training with other opportunities for expanding the practice can be difficult. As the outlook of practices becomes more entrepreneurial, the choice of what to do and whether to start and/or continue with training becomes more pressing.

Quite often nowadays, partners will look at the financial side of it and they'll say 'we'd earn a lot more money if you were running a clinic for something or other' – getting involved in practice based commissioning and things. (GP03)

There are several new local enhanced services, a number could easily earn £8000 with a few mornings a year, and if my time was devoted to that you could earn five times as much (GP04)

As GP practices are becoming more commercially aware and adopt a business culture in their operations, all activities will come under greater financial and cost scrutiny. Training will have to be able to hold its own in that environment in the longer term.

Demands

A similar argument was put forward in relation to the growing demands on practices generally and the difficulties in keeping on top of the expansion of the GP work, and squaring the different areas of work.

> Three of us have got a sort of sub interest in what we do, [list of additional work interests]...there are significant time commitments which further puts pressure on training and I don't think any of us could possibly do more, whether we liked to, want to or not. … We haven't got the time to develop additional clinical interest and I think that's probably true for most trainers. (GP – focus group)

One of the GPs suggested that the presence of trainees could be helpful in responding to new targets and developments; he saw having a trainee as an advantage for the practice:

> It is an advantage for the GP registrar to learn how these things work and we can actually devolve some of this learning – they can spend time with your QOF clerk to learn about practice management. They can run a small audit, …, and the registrar has gone off and done the small audit and presented it. … It's actually win-win because the audit got done, the GP registrar learnt and it was to everybody's benefit (GP02)

While some of the growing work portfolio may mitigate against taking on or expanding training, the service commitment of the trainee also offers opportunity to incorporate new work areas.

Issues specific to Kent

The interview schedule asked GPs whether they could identify any issues specific to Kent which may be a barrier to training. Participants mentioned that in the past East Kent had gone through a period where the qualifications of registrars had not been particularly high compared with the national average, and that this perception may still be in circulation. One explanation for this was that East Kent was regarded as remote and was not 'attractive to registrars' (GP04). In addition, the above mentioned problems with struggling trainees may

have contributed to a perception of training locally as 'difficult'. From the commentary in the small number of interviews, some GPs had challenging training contexts, while others were very satisfied with the ability of their trainees. Of course, perceptions can have long-lasting effects.

Travel commitments

Most of the GPs interviewed thought that the location of the training facility in Gatwick was difficult to manage. Gatwick was too far to travel for meetings and therefore required additional time out of the practice.

> The major problem for East Kent is where Gatwick is – its' far too far away and actually prejudices East Kent significantly. When I went to the course, it was terribly convenient for trainers in Surrey to get in the car and we can't. So none of my colleague in the trainer group is going to go, they won't. (GP 02)

> One feature that's remained constant is not facilitating people from East Kent to attend, because quite a lot of the meetings are held at a significant travelling distance away from here (GP-focus group)

The problem is amplified for trainers attending the trainers' course, and can be a considerable burden for the practice to back fill the extra time for trainers to attend the course.

The cost associated with attending courses also has an impact on whether trainers felt that they could attend. There was a concern that the current payments for taking part in (post-training) courses was insufficient because trainers had to stay overnight. As a consequence, some trainers do not attend meetings on a regular basis, which they regretted.

> Realistically to be sure of being in a meeting in Gatwick, you have to allow two and a half hours each way. That is the day gone. Or if you have a whole day meeting in Gatwick, you need to stay overnight …. (GP- focus group).

> You get a concessionary rate at Gatwick Hilton if you have to stay overnight. There is nothing to stay for overnight, so you spend a couple of days there and you are out of pocket. So I'm not doing that. Anybody who's in Margate or the other side of

Canterbury is not going to drive all that way and pay for it. When you're on a course, it demands 100% of your attention all day long, it is very demanding. (GP02).

Covering out-of-hours training

The way out-of-hours training is organised in East Kent posed a problem for some trainers in that they found it difficult to schedule in trainees for their out-of-hours sessions. Not all of the GPs commented on this as a problem, but for some, the restrictions on how many trainees can be accommodated by the out-of-hour service meant that this part of the training was difficult to organise. GPs found it difficult to understand the reason for the restrictions.

Just the same way as apparently the GP registrars are an advantage to the practice here because they are doing a service commitment, there should be an augmentation of the out-of –hour service. I think they should think again. (GP 02)

MRCGP and trainer qualifications

Although not exclusively an East Kent issue, the qualification requirement in relation to the membership and the training accreditation were discussed as part of the local and regional issues.

Overall, trainers were in favour of the MRCGP qualification, because it enhances the standard of the GP qualification. There was less agreement on whether the MRCGP membership was of particular value to well-established and long-serving GPs.   Most GPs thought that the majority of practicing GPs in the area by now had this qualification – however, one of the participants pointed out that for historical reasons there may still be a cohort of GPs without this entry requirement

In East Kent there was a strong negative feeling against the college maybe 20 years ago, and so now it's an entry qualification, established GPs often find themselves without their MRCGP (GP03)

In the interview, we addressed the issue of the non-transferable nature of the training qualification. Not all GPs were aware of this. However, it had been an issue in the practice of GP01 where there was an experienced GP trainer from another area, who could not train because by moving area, the qualification was now void. One of the focus group members

explained that as the training was linked to the locality and the practice, the qualification could not be transferable. We did not pursue this topic in any depth, but there may be an opportunity to tap into an existing pool of experience and interest.

4.3 Theme 3: Keeping motivated

Under this theme we discussed the motivations and reasons trainers had for training and to continue to train, even when circumstances were difficult.

The training relationship

Respondents agreed that the experience of working with a young doctor can be rewarding and a core motivation of being a trainer. Working closely with a colleague on clinical issues during the training process was cited by the newly trained GP as one of the motivations for doing training:

> I have enjoyed it so far … I enjoy the contact with one other person to discuss cases and look at issues, and look at evidence and such things (GP01).

Others agreed when asked about what they liked about working closely with a registrar:

> It's all those things how you're challenged, how you see somebody develop and I think that is the real thing what made you do it. (Programme Director)

> It keeps you on your toes and it's quite nice to have someone else you see regularly because although GPs work in groups, you can become quite isolated because by the time you've done your surgery and you've got to rush out to your visits, you might not see your colleagues very often. (GP03)

> I've really enjoyed having young doctors around and the stimulation of trying to keep up to date with them, and yes, personal enjoyment as much as anything. I'm with a lot of very good trainees who've been successful and stayed in the area and carried on and I keep in touch with a few of them. (GP02)

The close working relationship that develops between trainer and trainee and the mentoring aspect it entails may not suit everybody and therefore may be a limiting feature of developing

GPs interest in training in the locality. In turn, this may limit the pool of those GPs who would come forward to train at any point in time. In addition, the skills and predisposition required and the level of personal commitment expected, may also limit the number of GPs who would be suitable trainers.

Training the next generation of GPs

For the more experienced trainers, an added source of continued motivation in training was also developing a new generation of GP and developing their younger peers into GPs. GP03, who has been a trainer for a long time, expressed it as follows:

> I am very proud of my registrars and what I've got back is actually seeing these doctors and quite a number of them have gone into practice within the locality and I am pleased about that. (GP02)

> If you believe in traditional – take that as you will – General Practice and the value of it, and if you believe and wish to propagate it, you wish to propagate your concept of the best way to provide the best care for patients. (GP – focus group).

Keeping up-to-date

Another reason why trainers enjoy training is that is helps to keep them informed about the developments in medicine and clinical practice.

> It drives me, I think it makes me look at my own practice more intensely. And it is great to learn more, because I learn from the registrar. They are much more up-to-date than I am. (GP01)

> Personally, I am grateful to have my GP registrars because it's through them that I keep up-to-date. I could imagine myself getting very entrenched, but you've got to be on your toes, you've got to discuss things with them, you've got to know …. It's probably the best thing that's happened to me in my medical practice …. (GP02)

> …It's a good challenge to your own practice or to have someone else challenge it and keeps you on your toes (GP03)

It is not only the individual trainer that benefits from the registrar, but GPs also acknowledge that registrars are of benefit to the practice environment. For one of the GPs being a training practice also enhances the reputation of the practice.

> I am proud of my practice being a training practice and I feel that it helps. I want my practice to be well regarded and being a training practice is part of that and so if I can maintain that standard I am happy with that. (GP02).

> The training experience for the practice has been very positive and the GP registrars have all of them brought a quality to the practice which was otherwise missing. (GP02).

The programme director interviewed highlighted in her interview that it is sometimes a challenge for GPs to hold on to these very positive experiences in the light of the everyday pressures of training and in times of difficulties. Some of the reflective work that has been initiated as part of the work with trainer groups is an attempt to harness the undoubted enthusiasm and overcome the difficulties.

Professional recognition of trainers

As part of the interview discussion we asked about views on awarding recognised training qualification, for example in the form of a certificate in clinical education. The question arose as the result of the literature review and the options of a professional qualification and career pathway for clinicians engaged in teaching (clinical educators). It did not seem something that trainers had seriously considered. This was somewhat surprising given the considerable work involved in becoming a trainer and the efforts involved in training.

> GP: I don't know, I've never really thought much about that because it doesn't bother me. (GP02)

> Ha, I think it would be nice to have a little label rather than 'GP trainer', but that's because I just have become one and it has been quite a lot of work to get there (GP01)

Over time, as the field of clinical education develops [generally and specifically in primary care], professional recognition of trainers may be a pathway to embed training formally as a specialty in the range of GP activities and within the quality criteria for practices.

5. Non-trainer survey results

5.1 Response profile

81 replies were received within two weeks of sending the survey out (response rate of 33%). While we only have the views of those who replied, the response rate compared well with other surveys of GPs, indicating there was a fairly high level of interest in the subject, especially as the survey was sent to GPs in practices that were not currently involved in training. A small number (N=5) of replies were from ex-trainers. See Table 1.

Table 1 Response profile

	Non-trainer	Ex-trainers	Not stated	Total respondents	Non-trainers under 55 + MRCGP	Interested in becoming a trainer
Number of respondents	68	5	8	81	28	28
% men	72%	100%		74%	71%	71%
% under 55 yrs old	66%	20%		63%	100%	83%
% with MRCGP	41%	60%		42%	100%	61%
% in practices with 4 or more GPs	71%	80%		71%	71%	61%

The results are given below. As well as giving the overall views, it is noted where the views of ex-trainers diverge. The analysis focused on the response from GPs under 55 years old who have MRCGP (N=28), as these might be a target group to get involved in GP training in the future. Those who said they were currently interested in becoming a trainer are also shown separately in order to see where their views differed.

While the majority were not interested, over a third (35%) replying to the survey said at the time of the survey they were interested in becoming a GP trainer, and slightly more (42%) thought that colleagues in their practice were considering becoming a trainer. (Q2, Q3 on survey in Appendix.). GPs interested in being a trainer were younger and more likely to have MRCGP. Among younger GPs with MRCGP, over half (54%) were interested in being a trainer.

The general view was that the number of trainers in East Kent was a bit low. 5% said it was too high, 26% it was about right, 43% it was a bit low, 14% much too low, and 12% gave no reply (Q4).

5.2 Advantages and disadvantages of working in a training practice (Q5)

Disadvantages were more highly endorsed than advantages, with the main problems being seen as the time required for discussion of cases (for 78% of respondents). Non-trainers saw the reduction of space as a major problem (70% said this), that consultations would take longer (65%), and that the trainer would do fewer surgeries (51%). Younger GPs with MRCGP ('potential trainers') held similar views on the disadvantages. Ex-trainers and those interested in training agreed that extra time was required in discussion, but fewer endorsed the other disadvantages. See Table 2.

The main advantage was seen as the status conferred on a training practice (63%), with between 35%-38% seeing the extra remuneration, additional capacity and easier recruitment as advantages. Few (12%) thought that it made getting locum cover easier. Potential trainers held similar views on the advantages. From their position of experience, rather fewer ex-trainers endorsed the list of advantages, although two out of five said there was status attached to being a training practice. Those interested in becoming trainers were also less likely to say that training conferred status on the practice.

Table 2 Advantages and disadvantages of working in a training practice

		All respondents	Ex-trainers	Non-trainers under 55 + MRCGP	Interested in becoming a trainer
Practice advantages (Q5)	Confers status on the practice	63%	40%	64%	32%
	Extra remuneration	38%	20%	32%	39%
	Additional capacity	38%	20%	36%	36%
	Easier to recruit	35%	0%	43%	32%
	Easier to find locum cover	12%	0%	18%	7%
Practice disadvantages (Q5)	Extra time is required for discussion of cases with trainers	78%	80%	82%	82%
	Space in the practice is reduced	70%	40%	71%	61%
	Consultations take longer	65%	40%	57%	57%
	Trainer does fewer surgeries	51%	20%	57%	39%

5.3 Participating in training (Q6)

A number of positive statements were heavily endorsed by GPs. Nearly all saw training as a way for personal development, an opportunity to keep up to date in their practice, they were interested in sharing their knowledge, and saw training as an opportunity to work closely with a colleague (90%-95%). The main negative statements were seen as it being difficult to free time to attend training sessions and to safeguard protected time for training (80%-86%). See Table 3.

Large proportions also felt that it was a professional part of being a GP to train the next generation, and nearly two-thirds were interested in teaching colleagues. However, many did not have space to accommodate trainees, or felt they had insufficient time. 58% thought the remuneration was inadequate to cover costs and 43% said the burden of training was too great for their practice to carry.

Ex-trainers rated the positive statements more highly compared to non-trainers. Potential trainers were also very positive, with as many as 82% saying they were interested in teaching colleagues. Space was also a problem for 79% of potential trainers, and 71% felt that remuneration was inadequate to cover costs.

Those thinking about being a trainer were more interested in teaching and felt it was a professional part of their job to train the next generation. They were less likely to say they had too little time or that the burden of training was too great for their practice.

The survey did not ask about the impact of training on quality of care for the individual trainer or the practice as a whole, and impact on quality of care was not identified as a factor in respondents' free text comments.

Table 3 Participating in training

		All respondents	Ex-trainers	Non-trainers under 55 + MRCGP	Interested in becoming a trainer
Agree with positive statements (Q6)	One way for personal development for an experienced GP	95%	100%	100%	100%
	An opportunity to engage with up to date developments in medical practice	95%	100%	96%	93%
	Interesting to share my knowledge and experience with junior colleagues	94%	100%	100%	96%
	An opportunity to work closely with a colleague in everyday practice	90%	100%	96%	93%
	A professional part of being a GP is to train the next generation of GPs	74%	80%	86%	86%
	I am interested in teaching colleagues	65%	60%	82%	93%
Agree with negative statements (Q6)	Difficult to free the time to attend training sessions and other events	86%	80%	89%	89%
	Difficult to safeguard protected time for training	80%	80%	93%	79%
	We do not have enough space to accommodate trainees	73%	40%	79%	79%
	I have too little time available to being a trainer	69%	60%	68%	43%
	Remuneration for training is inadequate to cover the costs	58%	60%	71%	54%
	The burden of training is too great for our practice to carry	43%	40%	39%	29%

5.4 Main barriers to becoming a trainer (Q7)

This question was not answered by everyone, and asked those who had thought about becoming a trainer what they saw as the main barriers.

Over half thought that getting the practice accreditation was too time-consuming. There were also many who said there were other more important professional activities to deal with or targets to achieve, that becoming a trainer would take too long, it would be detrimental to work-life balance, and it would be difficult if not a partner in the practice. See Table 4.

It is interesting to see which barriers were rated differently by ex-trainers. On practical issues, considerably fewer ex-trainers thought that it was too time-consuming for practice accreditation, that it was difficult if you were not a partner, or if you were working part-time.

Also fewer ex-trainers said there were more important professional activities to deal with, or that it was detrimental to work-life balance.

Again replies from non-trainers who were under 55 years old and had MRCGP were quite similar to all replies, apart from there being fewer saying that they would rather concentrate on achieving targets within the practice.

Those thinking about being a trainer were more likely to feel that practice accreditation was too time-consuming, but on the other hand they saw work-life balance as less of a barrier and were less likely to have other professional activities or targets to pursue.

Table 4 Main barriers to becoming a trainer

		All respondents	Ex-trainers	Non-trainers under 55 + MRCGP	Interested in becoming a trainer
Barriers to becoming a trainer (Q7)	It is too time-consuming to go through the process of practice accreditation	52%	20%	54%	61%
	There are other professional activities that are more important at this moment in time	46%	20%	50%	32%
	It takes too long to become a trainer	44%	40%	46%	46%
	It is detrimental to my work-life balance	43%	20%	43%	25%
	It is difficult being a trainer unless you are a partner in the practice	42%	20%	46%	46%
	I would rather concentrate on achieving other targets in the practice	40%	40%	29%	29%
	It is difficult being a trainer if you are working part-time	38%	20%	32%	32%
	The training sessions are too far away	27%	20%	25%	29%

6. Discussion

The findings of the interview study of trainers and the short survey of non-trainers indicate that GP training is complex and multi-dimensional, and that training is enmeshed in personal, professional and practical considerations. The following discusses some implications of the findings and highlights how the ECK PCT could engage with and support training.

6.1 The personal dimension of being a trainer

At a personal level, positive experiences of being a trainee, the role model of a dedicated and skilful trainer and also the experience of being in a thriving training practice were highlighted by respondents as shaping their interest in becoming a trainer. The interviews and the focus group discussion also indicated that trainers shared an interest in and enjoyment of the training process itself – working in a mentoring relationship with junior colleagues, seeing colleagues grow into competent professionals and facilitating this process were valued aspects of being a trainer. Further satisfaction was derived from seeing the results of successful training in the retention of talented doctors and in contributing to the next generation of GPs. The interviews also indicated that personal motivations and positive aspects of training may contribute to sustaining trainers through difficult periods.

However, awareness of personal benefits of training does not seem to be sufficient motivation for wanting to become a trainer. In the survey, non-trainers under 55 agreed with the statements relating to the personal benefits of being a trainer; however, only a third of respondents expressed in interest in becoming a trainer. From this we would conclude that the overall cohort of "potential" trainers is likely to be comparatively restricted – and only a proportion of those will eventually train to be trainers. It may be that recruitment of trainers should concentrate on this group of 'potential trainers', rather than attempt to 'convert' GPs who are not interested in any case. As we understood from key informants from the Deanery, work is already ongoing in identifying potential new trainers and enabling them to take training forward.

Within the wider health economy, there may be opportunities for strengthening the positive perceptions of training further, for example by promoting and showcasing GP training and the qualities of GP trainers, not only to the medical and health community, but to the wider public and other stakeholders. This could be further helped by the fact that a majority of respondents agreed that training confers status on the practice (63%). It is interesting to note

that among those GPs interested in training, only 32% agreed with this statement. In the individual interviews, this perception was also not explicitly expressed, suggesting that there may be a need to enhance the appreciation of current and potential trainers of the external perceptions of training and the potentially high regard training can convey to the practice.

6.2 Professional aspects of training

Training GP registrars involves the whole practice and participants in the interview study stressed that support of other partners in the practice is important in GP training. Trainers depend on the commitment and continued support of colleagues, because the training requirements will involve adaptation of practice routine: trainers will have shorter patient lists than their non-training colleagues on training days, and they will be away from the practice because of training related commitments. Practices will need to consider carefully whether they can support training. For this reason, it is unlikely that all practices will be willing to become training practices within the current system. If the RCGP inquiry concludes that training has to be expanded by 300% and this is accepted by the DH, then it is likely that the way training is organised and supported will have to be changed. The interim report already suggests that that would have major resource and financial implications.

However, it seems that there are quite strong perceptions about training which may be a barrier for some practices even to consider training. In the survey, the majority of respondents agreed more strongly with statements which highlighted difficulties of incorporating training commitment into their current personal workloads and practice activities than with statements which highlighted potential advantages. This was also the case for respondents interested in training. Furthermore, survey respondents perceived the process of practice accreditations as time-consuming and complex. This suggests an undercurrent of a perception of training as being "difficult", i.e. requiring high commitment, being resource intensive and potentially distracting from other goals and therefore not manageable. Perceptions can be entrenched and difficult to shift. The Deanery is already undertaking work with individuals and non-training practices to enable training.

There seems to be a need to support training in established practices. As interview participants reported, non-training partners in a training practice can lack understanding of the time requirements for training and appreciation of training. This is understandable in the context of pressures for increased productivity in practices; however, it can be difficult and de-motivating for trainers. The problem can be exacerbated if there are problems, for

example with the progress and performance of trainees. Again, the Deanery is already undertaking work in this area in a number of ways. For example, trainers we interviewed valued the system of peer support through trainer meetings and also like to participate in other training events (although they were difficult to access). But there may be a role for the PCT to support this work strategically and to help develop already established training practices to expand training. One way of shoring up support internally would be to enable GPs in existing training practices to become trainers, so that the internal support structure is strengthened. The group training practice which participated in the focus group may be one model for development. In that practice, there is a strong commitment and support for training internally; training is part of the ethos and philosophy of the practice. In this model, not all trainers actively train in each given registrar training cycle, but rotate their training year-on-year. This has the added advantage of breaks in the training commitment, which allows individuals to pursue other interests and potentially prevents 'burn out'.

There are of course a number of challenges associated with training in this way: for example, there is the need to balance consistency of patient care with having a number of trainees in the practice; keeping trainers accredited when they are not training is an additional cost to the practice. Drawing on accredited practices may not yield a large new number of GPs to accommodate more registrars.

Another group that may be a further source of new trainers may be salaried GPs. Because of the contractual constraints, salaried GPs find it difficult to engage with training. However, given that the number of this category of GPs is likely to increase in the future as new models of GP practices develop, it may be useful to investigate the capacity for integration of this group of GPs in training.

6.3 Practical support for training

The study identified a number of issues which are pragmatic barriers to expanding the capacity of training. Some issues were outside the scope of what the PCT can engage with directly, including issues relating to the curriculum of training, and around recruitment and trainee quality. These are not addressed here.

Time

Constraints on the time that a trainer can take out of the practice restricts participation in training related events. Attending courses in Gatwick or London, for example, was identified

as problematic because of the extra time it takes to travel to and back from the venue. A major issue related to back-filling the extra GP time; the training grant did not stretch to cover this extra expense. This may be an area where the PCT could step in and provide extra resources to enable trainers to participate fully in training commitments.

Potential GP trainers also perceived the accreditation process in the practice as time consuming. They expressed concern that it would interfere with other important practice activities. Again this may be an area where the PCT could help develop streamline the process or provide input to support accreditation.

It is difficult to quantify the actual time commitment to training, in terms of preparation for training, time spent with trainees, and the administration of training. A lot will depend on the experience of the trainers, the trainer-trainee relationship and the individual needs of the trainee. However, it seems that there is a case for offering additional support for newly accredited practices and newly qualified trainers to support them through the first year of training. Again the Deanery has its own support system, but there may be further targeted support that the PCT can offer, in the form of extra resources trainers and practices can draw on. For example, one of the trainers interviewed suggested that a one-stop advice service to help with the complexities of the accreditation could be very helpful to practices undergoing accreditation.

There was also a suggestion that there may be further work the PCT could do to lighten particularly the administrative load for training practice generally. For example administering the GP registrar contract puts additional pressures on practice administration; there may be other areas where the PCT could take an active role in supporting training activities.

Space

In order to train, the practices need to be able to provide adequate space. For participants in the interview study, expanding training would have required further adaptations to the premises and some practices did not have the space to expand further. Respondents in the survey also cited space as a barrier to training. Adaptations and rebuilds require time. It clearly is a major investment requirement for East Kent practices and the PCT, and there may be the opportunity to draw on the DH investment grant for this.

Resources

The most important resource required by practices was further financial support for training in the form of additional grants for costs currently not directly covered by the training grant and the registrar grant.

However, there may be options for providing additional resources in the form of adding a local educational programme for registrar training which could be developed in partnership with the Deanery and the trainers and which could complement the Deanery programme. There may be issues in the continuous development of trainers and particularly newly qualified trainers, which may be additional to what is already on offer. The newly qualified trainer, for example expressed an interest in developing further skills in IT to use in tutorials. Providing access to and promoting this type of one-off training may be available within the local context. Some of this will already be available, but there may be areas that could be supplemented.

A number of trainers raised the problem of fitting their trainees into the out-of-hours service. There may be the opportunity for the PCT to facilitate a solution on the current restrictions on the number of trainees that can be accommodated by the service.

Any resources that would be made available, whether in the form of additional grants for trainers and practices to draw on or in the provision of complementary services or programmes, would send a tangible signal that the PCT is supportive of training in East Kent.

6.4 Limitations of the study

This a small scale study and exploratory in nature. Consequently, while the approach used a combination of qualitative and quantitative methods to triangulate findings, findings should be treated as indicative rather than exhaustive.

Particular limitations included limitations of relevant literature to form a basis for interview and focus group questions. A wider range of views on training from a number of additional focus groups would have been preferable. However, adaptations to the interviews and survey sample were made to compensate for these limitations. The response rate from the survey is in line with other academic studies with GP respondents.

The study is local and therefore findings cannot be generalised. Whilst it is likely that some of the experiences and views reported reflect those of other areas, further research is needed to determine to what extent the context of training in East Kent is typical or different from other areas.

7. Recommendations

From an external perspective, we would recommend that the ECK PCT consider the following:

1. The findings of the study indicate that there may be a limited number of new practices suitable for training in East Kent. The survey indicates that interest in training in East Kent is limited - realistically, trainers need a degree of personal enthusiasm plus a suitable and supportive practice environment to train. It may be useful to focus recruitment on GPs who express an interest in training and who work in suitable practice environments, which can support a trainer.

2. Expanding training in existing practices may be a further strategy for developing additional training places. The multiple trainer model offers a number of advantages, not the least that the practice is familiar with training. Drawing the group of salaried GPs into training may be another route into expanding the current training base. However, this is likely to have considerable additional resource implications for practices which may have to be absorbed by the PCT.

3. One strategy for developing greater interest in training in the patch and for increasing the confidence of potential trainers would be to combine offering a programme of practical support for training with a work-stream which is aimed at strengthening perceptions about advantages of training and being a training practice. This may involve further work in drawing out practice benefits of training and promote these among GPs.

4. There is the need for additional resources to support training. Non-training practices perceive training as a potential liability in terms of resources and training practices have highlighted gaps in covering certain aspects of training activities. These include

back-filling GP time when travelling to training related events, and additional travelling expenses.

5. ECK PCT should consider additional support to help practices through the process of accreditation, by supporting practices administratively and/or financially through the application process.

6. The first year of training can be quite challenging for a training practice and the new trainer. It would be useful to explore with newly accredited practices and trainers what additional resources would be helpful to them.

7. There may also be the opportunity to strengthen the support structure for trainers and trainees further through providing additional courses locally or by rotating existing provision to make access easier in East Kent.

8. ECK PCT should proactively promote its interest in and support of GP training in East Kent. Interview participants were surprised and encouraged by the interest the Trust is showing in training; most were not aware of it. There may be an opportunity for open and direct dialogue with trainers in the type of support that could be developed. From the response we received when interviewing, GP trainers would welcome this. This could build on the good relationship between the Deanery and workforce development team.

8. References

Department of Health (2009) GP Practices £100m capital programme guidance, Dear Colleague Letter 6 May 2009, DH, accessed @ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_098860, 26 May 2009.

Finch, Rob (2005)'GP training is threatened by lack of space' *Pulse*, 11 June 2005, vol./is. 65/23(18-).

Fraser, A. et al. (2007) 'Directions for change: a national survey of general practice training in the United Kingdom', *Education for Primary Care*, 2007, vol./is. 18/1(22-34), pp. 1473-9879

Houghton, G., et al. (2006) 'Do GP training practices achieve higher QOF points? A study of the quality and outcomes framework in Birmingham and the Black Country'
Education for Primary Care, vol./is. 17/6(P 557-571), pp. 1473-9879.

MMC Inquiry (2008) *Aspiring to Excellence. Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. Led by Professor Sir John Tooke, Aldridge Press, Chiswick, London

NHS employers (2009) Medical Education, accessed via http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Latest-news/Pages/Latest-news.aspx June 2009.

Ritchie, J. and Lewis. J ed. (2003) *Qualitative Research Practice*, London: Sage.

Royal College of General Practice (2009a) *A Review of GP Specialty Training in the UK*
A Project to conduct an Option Appraisal on the issues surrounding the recommendation by the Tooke Report for 5 Years Specific Specialty Training for General Practitioners, Interim report for the Department of Health, RCGP 2009. accessed @ http://www.rcgp.org.uk/pdf/gp_training_Review_of_GP_Specialty_Training_in_the_UK_-_Interim_Report.pdf , March 2009.

Royal College of General Practice (2009b) *Extending GP Training Project – an update, RCGP*, RCGP, accessed @ http://www.rcgp.org.uk/gp_training/extended_gp_specialty_training.aspx, June 2009.

Waters M. and Wall, D. (2007) 'Educational CPD: how UK GP trainers develop themselves as teachers', *Medical Teacher*, September 2007, vol./is. 29/6(e160-9), pp. 1466-187X

9. Appendices

9.1 Methodology

The research approach was to adopt a mixed methods research approach, combining some focussed literature reviewing, a small number of focus groups, individual interviews and a short survey, to build up a comprehensive understanding of the issue locally with a view to provide agreed and actionable recommendations. The aim of combining quantitative and qualitative approaches is to develop some in-depth and contextual understanding, which would be tested through the survey. The research commissioners had approached the Local NHS Ethics committee in advance of the study to determine whether the study required ethics approval. The study was not deemed to fall within the NHS Ethics regulations. The research team submitted the study design to the departmental ethics committee of the School of Social Policy, Sociology and Social Research at the University of Kent and ethics approval was granted.

The study kept to the overall plan of using mixed methods to elicit a range of views on GP training. However, a number of adaptations were made to the design as a result of some unforeseen barriers encountered in the conduct of the study.

The following adaptations were made to the study methods:

- o Care was taken to recognise different local perspectives on GP training, and this led to one or two additional preliminary interviews being required to establish contact and get insights from the Deanery and GP training leads in East Kent.

- o It was difficult to organise focus groups, and although agreement was established for several to take place, only one was possible in the time available, which included all the trainers in one practice. It would have been preferable to have more than one focus group perspective to draw on.

- o As the interviews and focus groups had good coverage of trainers and training practices, it was decided that the survey should be re-focused to cover non-trainers in non-training practices.

- o It was difficult to identify a comparable area to East Kent that had high levels of GP trainers and which could be used to highlight good practice, so no interviews were held in other geographical areas. For a comparison to be useful methodologically, there needs to be acceptable criteria for comparison. The

research team investigated a number of strategies for identifying potential case studies for comparison. Desk-top and internet research were conducted into other Deanery areas and contact was made or attempted with the RCGPs and NHS Employers as organisations with an interest in and knowledge of GP training outside the Deaneries. However contacts made were either unsuccessful in gaining a response or have as yet not yielded a result. Not being able to set the East Kent in a somewhat broader context is a limitation of the study design.

Setting up interviews and finding interview dates with GPs proved more difficult than expected. GPs are a 'hard to reach' group to engage with research. This is well known. However, the research team had made the assumption that the local nature of the study would make access easier on this occasion. This proved not to be the case. As a consequence recruitment to individual interviews required more time than anticipated. A similar problem was encountered with setting up focus groups. Organising focus groups using existing training days or meetings did not work as anticipated – the timeframe required to do this went beyond the project time frame.

Analysis and interpretation of material from the literature review, the interviews, focus group and survey responses went according to plan. Overall, the problems encountered in setting up the study meant that the project went over the original time frame.

Literature review

A focussed literature review was conducted to identify research and evidence in GP training. Five iterative searches were conducted, using the search engines of MEDLINE, HEALTH BUSINESS ELITE, HMIC. Search terms used were 'General Practitioners', 'GP trainers', 'GP train*' and combined with 'deanery'. Searches were limited to UK, ENGLAND and increasingly narrower time limits were set – to 2006. 156 references with abstracts were retrieved. Abstracts were reviewed by one researcher and full articles were downloaded for 8 articles.

In addition, the researchers scanned the relevant website of the DoH, Deanery and Royal College of GPs to identify further documents and relevant articles. Three further references were identified this way.

Interview study

The interview study was designed to provide some in-depth understanding of the issues in registrar training in East Kent. By using individual interviews, the aim was to use the opportunity to collect detailed data from participants and probe the issues around training in some depth. This was combined with focus group research. Focus groups allow participants to reflect on their on views and actions within a group setting; the dynamics of the group setting encourages the further exploration of insights and viewpoints. For the context of this study, the focus groups were also to explore in more detail the practice issues involved in training.

Recruitment to the interview study

We conducted five individual interviews with trainers in April and May 2009, using the trainer list which had been kindly provided by the Deanery, plus two other GP trainers through other channels. As we were interested in obtaining a range of views, we discussed the list of trainers with the Associate Dean and asked to highlight trainers which matched the following criteria:

- new trainers
- experienced trainers
- ex-trainers

In addition we decided to approach trainers in each training group across East Kent to geographically cover the locality.

We approached a total of nine trainers to participate in the study and arranged a total of five individual interviews. The reasons stated for not participating in individual interviews were mainly to do with a lack of time or other priorities.

The profile of the interviewees is a follows: (Please note that the details of the trainers interviewed have been kept deliberately vague to maintain the identity of the individuals confidential).

Table 5 Profiles of interviewees

GP number	Training status	Trainers in practice	Other information
GP01	new trainer,	one	new training practice; FY1+2 training
GP02	experienced trainer	one	established training practice; one partner considering training
GP03	experienced trainer	one	experienced training practice, considering further trainers
GP04	experienced trainer, approaching retirement age	one	established training practice; investigating training succession in practice
Programme Director	experienced		
Focus group	Experienced trainers, new trainer	5	in one practice

The trainers come from different areas in East Kent. The experienced trainers also had varying roles in the area, including being training programme director.

Through the GP list we also identified group practices and trainer groups and approached three for a focus group. We decided approaching existing groups of trainers rather than trying to organise a new focus group, because of the timescale of the study and because it became apparent that it would be difficult for individual GPs to free time to attend a group during the day and that there was little enthusiasm to organise it in the evenings.

We received agreement for one GP practice. Reasons for not participating in the focus group included the time-scale of the study – no meeting dates were available in that time. In the case one of the group practices approached, the practice decided against participation after considering the request.

Interviews and focus group

Research participants for the individual interviews were approached through either an initial telephone call or via email. Following a positive response, a date for the interview was arranged. In advance of the interview date, we either emailed or faxed the project information sheet and consent form, plus an abbreviated interview schedule. We also stated that we wished to tape record the interview if possible.

Interviews were to be conducted using two semi-structured interview guides (attached below), which explored three themes: 1) the experience of being a new trainer and setting up as a training practice, 2) experiences of training and 3) the personal motivations of training.

Interviews were scheduled to last no more than one hour. In the interview, the interviewer introduced the project once more and clarified any additional questions the interviewee might have. She then asked for the consent form to be signed and to switch on the recorder. Interviews lasted between 40 and 55 minutes. The interview schedule was used as a guide and the interview was conducted in an open manner, allowing interviewees to expand on topics and address additional issues. The interviewer took notes. At the end of the interview, participants were offered a gift voucher as a thank you for participating.

The arrangements for the focus group were similar to those of the individual interviews. The focus group questionnaire (see below) covered similar topics to the individual guide, but was focused more on the practice experience. An exchange of emails and phone calls clarified some issues in advance of agreeing to participate. The focus group discussion was conducted by the two researchers. At the focus group meeting, further questions about the study were answered and the consent form signed by participants before the focus group commenced. The focus group was also recorded. At the end of the focus group, each participant was offered a gift voucher as a thank you.

Analysis of interviews and focus group

The interviews and focus group were fully transcribed. The transcriptions were analysed using a modified version of the frame method, an analytic technique which maps information on different topics thematically, allowing a broad, but focused analysis of the themes addressed in the interview (Ritchie and Lewis, 2003). It involves an iterative process of coding verbatim data from the interviews thematically, using the topics covered in the interviews as a guide but modifying them according to new and emergent themes. These are then mapped onto thematic charts for further analysis and interpretation. In this way the views, experiences and examples of the research participants were integrated into a common analytical framework and compared and summarised.

Survey of non-trainers

The proposal was to carry out a short survey on East Kent GPs to test out the extent to which findings from reviewing the literature review and from face-to-face contacts were more

widely held, in particular to understand more about the perceived barriers to becoming a trainer.

At the start of the research there were fewer than 40 GP trainers in East Kent, out of a total of 470 GPs working in 114 practices. Attempts were made to contact those involved in training to take part in interviews and focus groups. When it came to the survey, it was decided that coverage of the trainers had been quite good, but little was known about the majority of GPs, namely the non-trainers in non-training practices. A survey of the latter individuals seemed more appropriate in terms of sharing the respondent burden and gathering new perspectives.

A list of GP names and addresses was provided by the PCT and was used as the basis for a postal survey. It was not possible to get a complete and reliable list of email addresses for the survey. Names of GPs and practices known to be involved in training were excluded from the list, as were GPs working in the prison service. This left 247 non-trainer GPs working in non-training practices who were surveyed.

The survey was designed to be quick and easy for GPs to complete, and to be of interest to them in order to get a good response. The survey was anonymous, no reminders were sent, and a pre-paid return envelope was supplied.

As planned, the content of the questionnaire was fed by earlier parts of the study, and in reality this was mainly what we learnt from East Kent informants. As well as demographic information, the survey asked if individuals were interested in becoming a trainer, and about their views on the benefits and costs of being involved. The main questions were about the advantages and disadvantages to the practice, whether individuals agreed with positive and negative aspects of being a trainer, and what the main barriers were.

The questionnaire is attached with the research instruments in Appendix 9.2.

9.2 Research Instruments

Project information sheet – GP Training Capacity in East Kent
April 2009 (Vs. 3)

This information sheet provides information about a project on GP training in East Kent. It accompanies the consent form.

Aims of the project

The project aims to understand better the experience of GP trainers/training practices; the reasons for becoming trainers, existing barriers to taking up and continuing GP training activities and how GP training can be enhanced and supported for trainers and training practices in East Kent. The project will feed into the ECK PCT development programme in GP capacity building for training. The project aims to collate a range of views on the issues, particularly from current and past GP trainers and other stakeholders. The project will run until April/May 2009. The project builds on previous and other current work.

Participation

You are invited to participate in the project as somebody who can contribute their views about and experiences of GP training. Your participation is voluntary and you can with withdraw from the project at any time without giving a reason. What is said in interviews and focus groups will be confidential and we will not share your identity with anybody outside the research team. We will anonymise the identity of participants in any reports coming out of this study.

The team

The project is carried out by The Centre for Health Services Studies, a research unit specialising in applied health related research, at the University of Kent in Canterbury. We conduct research in a wide range of areas related to Health and Social Care. Linda Jenkins and Annette King will carry out the work for the project, and will conduct the interviewing and focus group facilitation.

The approach

The study involves a mixed method approach, including a brief review of published work, a small number of interviews and focus groups with those involved in GP training locally and an email survey to local GP practices at the end of the project.

The commissioners of the project

The project has been commissioned by the workforce development team at Eastern and Coastal Kent PCT.

Ethics

We sought the opinion the of the chair of the Local Research Ethics committee as to whether the project required NHS research ethics opinion. We were informed that it does not fall under the NHS Research Governance Framework and therefore did not require Ethics approval. The project falls under the research governance of the University of Kent and has been processed in accordance with these.

Expenses

The project can reimburse out-of-pocket expenses and we will bring along claim forms for this to the interviews/meetings. We are unable to offer payment for participation in the project. However, we do appreciate the time committed to the project and would like to acknowledge your contribution by offering you a modest gift voucher, which we will bring along to the focus group/interview meeting.

Contact details

Please contact for further information:

Annette King
CHSS, University of Kent
Canterbury CT2 7NF
Tel.: 01227 823672
Email: a.m.king-9@kent.ac.uk

Linda Jenkins
CHSS, University of Kent
Canterbury CT2 7NF
Tel: 01227 824327
Email: l.m.jenkins@kent.ac.uk

Background information:
1. How long have you been a trainer?
2. What made you decide to become a GP trainer?

We are looking to explore a number of themes and your views and experiences

3. Theme 1:   Key features of becoming and being a GP trainer and being a training practice: requirements for training and the standards that are
3.1 MRCGP qualification – is it necessary, does it have advantages?
3.2 Preparation and training on becoming a trainer - does the system work for you? Were you aware of this?
3.3 Do you feel that you get enough support in being a trainer? What could be improved?
 Requirements of becoming a training practice? What is the impact on how a GP will view training?
3.4 What are the costs and benefits of being training GP ?
 Monetary side: allowances and fees; comparison with other speciality work?
Time: enough time made available?
How is that negotiated and supported externally?
 3.5 Do you think that there is sufficient professional recognition of GP training? How is it viewed professionally?   (as compared to other options of clinical specialisation?)
3.6 Locally in East Kent, are there any specific issues that have an impact on GP training?
 - allowances,   management and support, planning, trainees (how they are selected and personal rapport you build up?)

Theme 2: Practical and organisational issues on GP trainers in your practice
4. 1 Are there issues about the current facilities you need for training? Buildings/room, timetables?
4.2 Do you feel supported by your non-training colleagues? By the practice? By others?

In terms of managing the practice, what is the impact of your work as a trainer?
- Arrangement for locum over
- Cover by colleagues
- Alignment with other targets?
- Protected time?
- Potential for expansion of practice work with trainee GPs?
4.3Are there issues locally which have an impact on GP training in your practice (large patient lists, unfilled posts, high local demand (students or issues of deprivation)?
Is there additional support that could be made available to you to break down the barriers?

5. Theme 3: Personal motivations/issues of being a trainer
5.1 What do you enjoy about being a trainer?   What are the rewards/ satisfaction?
5.2 What impact does training have on your personal development as a clinician?
(eg. Keeping up to date?)
5.3 How does training impact on your time?
- on other activities?
- on personal time?
Are there other relevant issues?
Future plans: How long are you intending to stay a trainer?

Are there natural life cycle of being a trainer?

6. Final question:
Reflecting on what we have said, what can the PCT do increase the GP training in the East Kent area?
Do you have any recommendations?

Is there anything that could be added?   Have we covered all the issue?

Thank you very much.

Background information:
1. How long have you been a trainer?
2. What made you decide to become a GP trainer?

We are looking to explore a number of themes and your views and experiences
3. Theme 1:   Key features of becoming being a training practice: requirements for training and the standards that are required
3.1 MRCGP qualification – is it necessary, does it have advantages?
preparation and training on becoming a trainer   -   what are the implications for the practice?
3.2 Requirements of becoming a training practice? What is the impact on how a GP will view training?
3.3 What are the costs and benefits of being training GP practice?
3.4 Monetary side: allowances and fees; comparison with other speciality work?
3.5 Time: enough time made available?
How is that negotiated and supported by externally?
3.6 Locally in East Kent, are there any specific issues that have an impact on GP training?
 - allowances,   management and support, planning, trainees (how they are selected and personal rapport you build up?)

Theme 2: Practical and organisational issues on GP trainers in your practice
4. 1 Are there issues about the current facilities you need for training? Buildings/room, timetables?
4.2 As trainers, do you feel supported by your non-training colleagues? By others?
4. 3 In terms of managing the practice, what is the impact of your work as trainers?
 - Arrangement for locum over
- Cover by colleagues
- Alignment with other targets?
- Protected time?
- Potential for expansion of practice work with trainee GPs?

5. Theme 3: Personal motivations/issues of being a trainer
5.1 What do you enjoy about being a trainer?   What are the rewards/ satisfaction?
5.2 What impact does training have on your personal development as a clinician?
(eg. Keeping up to date?)
5.3 How does training impact on your time?
- on other clinical activities you may want to develop
- on personal time?
5.4 Future plans: How long are you intending to stay a trainer? How long do you think one should be staying as a trainer (burn out)?
6. Final question:
Reflecting on what we have said, what can the PCT do increase the GP training in the East Kent area?
Do you have any recommendations? (3)
Is there anything that could be added?   Have we covered all the issue?
Thank you very much.

GP Training in East Kent

*Dear GP colleague - I would be very grateful if you can spare a minute to give your views on this topic. This survey is for GPs in East Kent who are **not** currently involved in training. Your response will be treated anonymously and will be used by Eastern & Coastal Kent PCT and the Kent, Surrey and Sussex Deanery, for developing the capacity for training GPs locally. It is part of a study being undertaken by the Centre for Health Services Studies at the University of Kent to collate a range of views on the issues, and build on previous work. On the advice of the Local Research Ethics committee, the project falls under the research governance of the University of Kent. I much appreciate your time – thank you.*

Please tick the boxes that apply to you

1. Are you a   non-trainer ☐   ex trainer ☐

2. At the present time are you interested in becoming a GP specialist trainer?   Yes ☐   No ☐

3. Are any of your colleagues in the practice considering becoming trainers?   Yes ☐   No ☐

4. Do you think the number of GP trainers in East Kent is   too high ☐
   about right ☐
   a bit low ☐
   much too low ☐

5. What do you think are the advantages and disadvantages of working in a training practice?

     extra remuneration ☐
     additional capacity ☐
     easier to find locum cover ☐
     easier to recruit ☐
     confers status on the practice ☐
     other advantages *(please specify)*

>

     consultations take longer ☐
     extra time is required for discussion of cases with trainers ☐
     trainer does fewer surgeries ☐
     space in the practice is reduced ☐
     other disadvantages *(please specify)*

>

6. Considering what you know about GP training, please rate the following statements

Participating in training is:

Agree

Disagree

One way for personal development for an experienced GP ☐

☐

An opportunity to engage with up to date developments in medical practice ☐

☐

An opportunity to work closely with a colleague in everyday practice ☐

☐

A professional part of being a GP is to train the next generation of GPs ☐

☐

Interesting to share my knowledge and experience with junior colleagues ☐

☐

I am interested in teaching colleagues ☐

☐

Difficult to safeguard protected time for training ☐

☐

Difficult to free the time to attend training sessions and other events ☐

☐

I have too little time available to being a trainer ☐

☐

Remuneration for training is inadequate to cover the costs ☐

☐

We do not have enough space to accommodate trainees ☐

☐

The burden of training is too great for our practice to carry ☐

☐

Please write in any other comments

7. If you have thought about becoming a trainer in the past, what do you see as the main barriers?

Yes *No*

It is difficult being a trainer if you are working part-time ☐ ☐
It is difficult being a trainer unless you are a partner in the practice ☐ ☐
It is detrimental to my work-life balance ☐ ☐
There are other professional activities that are more important at this moment in time
☐ ☐
It takes too long to become a trainer ☐ ☐
It is too time-consuming to go through the process of practice accreditation

☐ ☐
The training sessions are too far away ☐ ☐
I would rather concentrate on achieving other targets in the practice ☐ ☐

Please write in any other barriers

[   ]

8. Please give your   age   [   ]

                      gender   Male ☐   Female ☐

                      years of experience in general practice   [   ]

9. Do you have MRCGP?   Yes ☐   No ☐

10. How many GPs are there in your practice?   [   ]

_____

—

THANK YOU – please return in the freepost envelope

Annette King, Centre for Health Services Studies, George Allen Wing, University of Kent, Canterbury, CT2 7NF