UNIVERSITY OF GREENWICH

Institute for Lifecourse Development

Evaluation of the implementation of Educator Burnout Initiatives in London

Professor John Foster, Dr Marianne Markowski

Institute of Lifecourse Development
Centre for Workforce Development
Faculty of Education, Health and Human Sciences.
University of Greenwich.
London SE10 9LS

j.h.foster@gre.ac.uk
a.m.markowski@gre.ac.uk

Index:

Evaluation of the implementation of Educator Burnout Initiatives in London

Page

1. Executive Summary 3- 9

Full- Report

2.1 Introduction 10
2.2 Our Approach 11
2.3 Structure of this Report 11
2.4 The context around educator burnout in Primary Care 12
2.5 Action Plans 12
2.6 Summary of the empirical data collected in the evaluation. 13
2.7 Summary of the survey results. 13
2.8 Summary of the observations (Online Training) 14
2.9 Summary of South-East London Primary Care Educator Conference. 16

Second Phase : Summary of the empirical data collection

3.1 Summary of the Focus Group 18
3.2 Summary of the interview with Senior Nurse. 21
3.3 Summary of the interview with the GP pharmacist. 23
3.4 Summary of the interview with Training Hub Manager 25
3.5 Summary of the interview with the Primary Care Dean 27
3.6 Summary of the interview with the Burnout Practice Lead 29

4. Conclusions and Recommendations 32

Evaluation of the implementation of Educator Burnout Initiatives in London

Report 10.1.24

Authors: Dr Marianne Markowski, Dr John Foster

Executive summary:

Background

Burnout has been defined as "a syndrome of emotional exhaustion, depersonalization, and a sense of low personal accomplishment that leads to decreased effectiveness at work" (Maslach, Jackson and Leiter 1996). A systematic review/meta analysis (Ghahramani et al. 2021) examining burnout in healthcare professionals during the Covid-19 pandemic was conducted. Amongst the most common symptoms were emotional exhaustion, depersonalisation, and lack of personal accomplishment. The same review which included frontline and non-frontline workers found that over half of their samples had experienced burnout during the Covid pandemic. Similar systematic reviews emphasised the high prevalence of burnout in primary care nurses (Monsalve-Reyes et al. 2018) and general practitioners (Karuna et al. 2022).

Health Education England (HEE) London, now NHSE Workforce Training and Education Directive, commissioned Greenwich University Enterprises Limited (GUE Ltd.) to evaluate the implementation of the Primary Care Educator Burnout initiatives in five Integrated Care Systems (ICS) in London. GUE's activities took place from July 2022 until October 2023.

In the first part of this project (i.e. observations of training offered and survey results from Oct-April 2022), a focus was placed on understanding what types of burnout initiatives and support services were offered. The overall guiding questions for this part of the evaluation were:

- What type of content is covered?
- Who is being reached?
- Are there any gaps?

The second part of the project (i.e. the focus group and interviews in May-Oct 2023), was concerned with the overall questions:

- What worked well?
- What could be improved?
- What are the key aspects of the educator burnout initiatives in primary care in London, that can be adopted in other Primary Care Networks (PCN) (or ICSs) in other parts of the country?

Methodology

A pragramatic mixed methods approach was adopted and the data collected was as follows:

Part One

a) Action Plans to address Primary Care Educator Burnout Iniatitives in each ICS- i.e pan-London
b) Feedback from survey in March 2022 organised by HEE concerning the support provided to Primary Care Educators to prevent burnout at the time.
c) Observation and participation of online training
d) Observation and participation of a face to face multi-professional primary care educator training day organised by South East London Training Hub.

Part Two

e) Focus Group discussions structured around questions for recognising burnout in yourself and others, the experience of burnout, and support options available for dealing with burnout or avoiding burnout.
f) A series of semi-structured interviews to explore the issues that had become apparent during the previous data collection schemas.
    - Senior Primary Care Nurse
    - GP based pharmacist
    - Training Hub Manager

   There were two other interviews which aimed at clarifying and consolidating some of our findings and considering lessons to be learnt for the future. These were as follows:
    - Primary Care Dean for NHSE Workforce Training and Education Directive (GP)
    - Burnout Practice Lead for South London (Adult Nurse)

Data were analysed using thematic analysis based on the principles of Braun & Clarke (2017).

Findings

Part One

Given the resources available it was not possible to get a comprehensive pan-London picture across all the stages of data collecton. There was a possibility that there were areas of good practice that the research team have not been able to locate. Thus it is important that these are shared and working in silos is avoided. When the study began the research team was expecting that data collection would be focused on the experiences of GPs and practice nurses. However, as the study has rolled-out the Additional Role Reimbursement Scheme (ARRS) has started to become embedded in primary care practice. This has meant that there could be up to fourteen primary care professional roles all with different training and well-being needs.

Each ICS was asked to draw up an action plan to address burnout in their locality. One of the suggestions was to collect data to ascertain the extent of burnout of clinical educators. There was a recognition that many modes of communication were GP-centric and there was a need to consider the needs of other professional groups. There were also plans in place for both online and face to face training and suggestions to improve health and well-being. As part of the action plan each ICS was asked to identify a burnout champion .

In March 2022 HEE conducted a survey across all five London PCS concerning the support provided to Primary Care Educators to prevent Burnout at the time. There were over three hundred respondent and over 90% were GP trainers. One to one support in the form of coaching, well-being and mentoring were popular. Peer support was also valued, over three quarters of the sample described themselves as being in a peer support group and a further fifteen percent would be interested in participating in

this. Developing resilience and having a greater understanding was seen as important in preventing burnout. More training was seen as important.

There were then two semi structured questions allowing free text responses. It was felt that the greater workload during the pandemic had resulted in burnout and exhaustion. This and remote communication had made supporting learners difficult. The final survey question asked for suggestions to support primary care educators to manage their own burnout, these included peer and buddy support, team building and taking exercise.

Part of the first stage of data collection was to observe three online training workshops provided by the South West London Training hub. The uptake of these sessions was low. The sessions lasted approx. 2 hours, which included a short break away from the screen, they were attended by 2-4 individuals. Most were GPs but there was one practice manager who also attended. The focus of the workshops explored what constituted a positive work culture, tips to promote health and well-being and digital hygiene. Following the online training both researchers were invited to attend a primary care educator training day run by South East London Training Hub. Over 140 participants attended and half of the attendees were GPs including trainers, partners and educator leads. The other participants were a mixture of nurses, health care assistants, paramedic education leads and there were a further ten who were "unspecified". Arguably the key finding was that throughout the day the terms *burnout* or *resilience* were not used, the preferential term was promotion of health and well-being or similar. As this study has continued there has been a move away from using the term *burnout* in communications.

Part Two

The experiences to date were then used to inform an online focus group, which was attended by three GPs and a care coordinator. There were three female participants and one male GP. Following analysis three themes emerged- a) Experiencing and recognising burnout; b) Variability of structures in primary care and c) Changes in work culture and workload.

a) Experiencing and recognising burnout:

Two of the four participants stated that they had experienced or are currently experiencing burnout. The other two had witnessed burnout in their colleagues and their trainees. All participants pointed to the stresses and strains of the Covid lockdown. The circumstances that led individuals becoming burnt out were the excessive workload, not enough time, isolation and a lack of opportunity to de-brief. None of which were recognised by their managers. However, there was an acknowledgement that recognising signs of burnout in colleagues was difficult and this was particularly the case for locums and agency staff. The care co-ordinator pointed out receptionists and administrative staff were often the contact point for patients and became the target for their dissatisfaction and often their was minimal support for them.

b) Variability of structures in primary care

There was an acknowledgement that great variability in practices was present, because these were individual businesses with differing management and governance structures and local challenges. This meant that the level of support available was not systematic. There was a brief discussion of the role of the well-being champions.

c) Changes in work culture and workload

In recent years there has been an increased burden placed on primary care and GPs now have to inititiate much of the secondary care and social care procedures and assessments. The Covid lockdown increased these pressures as prior to lockdown many GPs and practice nurses were approaching retirement and have now retired. There was then a discussion of some of the generational differences. Older GPs typically worked 70-80 hours and tended to carry on until they retired. In contrast younger GPs wanted a better work-life balance, often to accommodate childcare needs. In consequence there was a reluctance to take on a partnership or other senior roles.

The research team felt there were gaps in their knowledge across the five ICS and in consequence a number of semi-structured interviews were carried out. It was clear that practice nurses and pharmacists were expected to take on key roles in primary care and these should be explored further. Finally, there were two interviews, one with a Primary Care Dean and the other with a training hub manager who will be responsible for the promotion of health and well-being in primary care educators and learners. The aim of these two interviews were to clarifiy our findings and to talk about possible ways forward.

1. Primary Care Nurse

The interviewee who was a senior nurse reflected how she did not realise that she had experienced burnout until the lockdown had ceased and felt there was minimal support for herself or her colleagues despite the fact they had to continue to see patients face to face during the pandemic. She then went onto to discuss her perceptions of being a primary care educator as a nurse. She believed primary care approval procedures were GP centric and that nurses had difficulty in getting support such as training days and protected time. She felt that some GPs and practice managers did not see nurses as "medically trained" in comparison to some professional groups such as pharmacists. The culture was that those nurses who were able to attend nurse-run support forums or training were expected to feed their learning to the rest of the nursing team.

2. GP Based Pharmacist

Recent expansion of the primary care team now includes clinical pharmacists, thus the research team felt it was important to gain insight into the experience of a pharmacist. The interviewee stated that she had experienced burnout whilst working in a community pharmacy and had subsequently moved to primary care. Her perception was that GPs are still try to work out how pharmacists will operate in primary care. In addition, pharmacy foundation training had not been updated to reflect these developments.

She described her typical working day. The clinic started at 9 am and finished at 1pm. There was a half hour lunch break and then she worked through to 5pm. She was also expected to write prescriptions, help with blood forms in reception and fit in her administrative tasks, discharge summaries and audits. So in practice she rarely had a lunch break. Having worked in more than one GP practice she felt this was typical and that GPs or practice managers had minimal insight into challenges GP-based pharmacists faced. The previously described generational issues were also present for pharmacists and there was a culture where long hours were seen as the norm and a reluctance to admit you were struggling. There was minimal attention paid to promoting your own health and well-being in pharmacy training.

Pharmacists have a number of steps they have to take annually to retain their professional registration and they are supposed to be given five days off for training updates. Whether this is

allocated will be dependent on the practice policy and other demands. In her experience there were training opportunities were dependent in which ICS she worked in and the attitude of the practice towards allowing pharmacists training opportunities during working hours.

Peer support networks were still in their infancy, there is a "whats app" group which included community and hospital based pharmacists but this was entirely devoted to clinical queries and there was no discussion of burnout or excessive workload. She was unaware of the presence of the health and well-being champion in her ICS.

3. Training Hub Manager

The research team interviewed the training hub man to explore educator burnout activities. Her first insight, was that the term burnout was discouraged and replaced by "supporting our educators and trainees." The lockdown had meant that all training was delivered online and there was now a mixture of online and face to face training. Since the lockdown there was a recognition of the importance of face to face contact. There was also a recoginition that prior to the lockdown, training days had largely been targeted at GPs and it was now important to target nurses, pharmacist and other clinical staff. The discussion then focused upon channels of communications again there was a recognition these had been GP-centric and this was no longer appropriate. The correct terminology was also key. There were also logistical difficulties in organising training; for example GPs could access training mainly during the day whilst pharmacists typically could only access it in the evening.

Online contact had meant that it was now very difficult to recognise and support struggling colleagues hence the importance of face to face contact. Another issue she pointed to was the lack of human resources or occupational health resources as GP surgeries were small businesses. Thus any support was individually led and informal rather than structurally driven. She suggested that it should be mandatory for primary care surgeries to have a health and well-being policy, which would include details of where individuals can be signposted for additional support resources.

4. Primary Care Dean

The Primary Care Dean chaired the steering group for the project and was also a practising GP. There was a discussion about the support networks that were in place and she acknowledged these tended to be GP centric. She then discussed the Additional Role Reimbursement Schemes (ARRS). This is the policy driver to bring more professions into primary care- there are fourteen possible professional roles and include pharmacists, physician associates, paramedics and social prescribers. This means that having a largely GP-centric training culture was now no longer appropriate.

Thus the aim now was to develop multi-professional faculty groups across London drawing upon the examples of good practice in GP training and learning from the challenges they have faced. However, there is the issue of "protected time" which currently is only guaranteed for GPs, whether other professions receive this is down to local practice. She pointed to the multi-professional South East London Training Hub day that has been briefly described as an example of excellent practice that should become a model for other ICSs.

The ARRS scheme is presenting challenges for primary care as some professional groups are not fully integrated, leading to a sense of isolation and stunted professional development. As a result there is an issue with retention with 15% leaving primary care within one-two years. This led on to a discussion of the importance of the practice manager, who are key to the development of a healthy working culture as they appoint staff and can drive work force changes. These have a number of networking forums but are not recognised as educators. However, she was open to inviting practice

managers to training and education events. If administrative staff or receptionists are struggling the avenue of support would be the practice manager. The interview concluded with a recognition of the importance of the exit interview to help promote a healthy working environment. These should be held at ICS levels so that changes could be initiated at an appropriate level quickly.

5. Training Hub Manager

The final interview was with the training hub manager for South East London who is responsible for driving the promotion of health and well-being. As the previously described interview pointed out South East London training hub is regarded as a driver of good practice. The interviewee's professional background is an adult nurse and she will take a key role in the promotion of health and well-being in primary care educators. The interview commenced with a brief discussion of the primary care working culture and a recognition that each GP practice is an individual business and the only learning that has a direct financial benefit for the practice, is currently the GP. Thus the GP learner structure is well regulated and financed and supported. In contrast, nurse educators can struggle to get protected learning time to update their professional skills. This led to an acknowledgement that the definition of the primary care educator is unclear, and has become even more apparent under the ARRS inititiative. Again the structure for GPs is very clear, unlike all the other professional groups, they join a register of educators and this formally acknowledged by their practice. They can only do this within a practice that is an approved learning environment. Thus one of the main challenges centre around approval issues which require GP leadership .

She felt there were burnout support initiatives in primary care but again these were GP focused and only open to people who could be identified as an educator. Thus there were no formal processes in place for nurses or others in ARRS roles who are experiencing burnout unless they were designated as an educator. There are processes in place to address this. Southeast London ICS now has peer-support groups for different professional groups.

The previous interview with the primary care dean touched upon the fact a number of ARRS were leaving primary care after a short period. This interview focused upon the difficulty of nurse retention many of whom are approaching retirement. Other issues contributing to this were the lack of protected learning time for nurses. This is guaranteed for GPs but not for nurses even those with a trainee and terms and conditions especially in terms of maternity and sick leave are less favourable for primary care nurses than if they were employed by the NHS.

Conclusions and Recommendations

This evaluation provided a snap shot of some of the issues facing primary care educators both at a local and regional level. The research team started off with the assumption that most of the data collection would be GP and practice nurse focused. As the study continued it became clear that with the implementation of the Additional Role Reimbursement Schemes (ARRS) this was no longer the case. There were now up to 14 different professional groups working in primary care and much of the work now should be focused on supporting these new groups of primary care educators. We have become aware of many areas of excellent practice that have evolved during the study but it is particularly important these are shared at an ICS level and silo working is avoided. We conclude this executive summary with some recommendations for ICS and training hubs in particular to consider with the aim of rolling out good practice on a pan-london basis and thereafter possibly nationally.

These should be seen within the context of "Our NHS People Promise" which is a promise "to work together to improve the experience of working in the NHS for everyone" (NHS England 2023).

- The term burnout is largely to be discouraged and replaced with terms such as "promotion of health and well-being" or "supporting our staff". This change has largely been operationalised.
- It should be mandatory for each primary care practice to have a health and well-being policy.
- Regular face to face meetings of the ICS trainers so that good practice can be shared more efficiently and to give room for shared learning.
- The Additional Role Reimbursement Schemes (ARRS) provides significant challenges for primary care and there are now up to fourteen different professional groups in primary care. There has to be greater awareness of how to support these groups- training/network opportunities and protected time etc.
- Greater thought should be given to primary care educator approval schemes and re-evaluation of the term primary care educator especially following the introduction of ARRS.
- Especially following ARRS greater promotion of peer support groups at an ICS level.
- Greater steps to promote awareness of the well-being champions in each ICS.
- Notwithstanding the need to respond to local needs there should be a core agreement across all ICS as to the role of the health and well-being champions
- To continue with a mixture of multiprofessional online and face to face training but place. greater emphasis on face to face ICS multiprofessional organised training events.
- Some consideration of appropriate channels of communications and terminology to reach different professional groups. To date they have tended to be GP-centric.
- Greater thought as to the role of the practice manager in promoting health and well-being of primary care staff. This could include ensuring staff from different professional groups are given network/training opportunities and protected time.
- Practice Managers given training so they can provide support for administrators and reception staff.
- Exit interviews to be held at an ICS level so that there can be immediate learning and changes implemented to promote health and well-being as soon as possible.
- Greater training and awareness of time-management as a mechanism to promote health and well-being and stress management.
- Promotion of peer-networks and Multiprofessional faculty groups across all professions.
- Consideration of the use of social media technology such as Whats App groups to promote health and well-being as well as being focused on clinical issues.
- Greater research into the needs of different professional groups in primary care such as pharmacists.
- Greater research concerning how to promote a healthy work-life balance in primary care educators and other staff.

Evaluation of the implementation of Educator Burnout Initiatives in London

Full Report 10th Jan 2024

Authors: Dr Marianne Markowski, Professor John Foster

2.1 Introduction

Burnout has been defined as "a syndrome of emotional exhaustion, depersonalization, and a sense of low personal accomplishment that leads to decreased effectiveness at work." (Maslach, Jackson and Leiter 1996). A systematic review/meta analysis (Ghahramani et al 2021) examining burnout in healthcare professionals during the Covid-19 pandemic was conducted. Amongst the most common symptoms were emotional exhaustion, depersonalisation, and lack of personal accomplishment. The same review which included frontline and non-frontline workers found that over half of their samples had experienced burnout during the Covid pandemic. Similar systematic reviews emphasised the high prevalence of burnout in Primary Care nurses (Monsalve-Reyes et al. 2018) and general practitioners (Karuna et al. 2022).

University College London conducting an evaluation into a London based GP trainer programme. One of the issues identified in the report was stress and burnout on the part of GP trainees (and trainers) (Griffin et al. 2018) and Moffett et al. (2019) point out that a reduction in stress in Primary Care staff improves patient outcomes.

Health Education England (HEE) London, now NHSE Workforce Training and Education Directive, commissioned Greenwich University Enterprises Limited (GUE Ltd.) to evaluate the implementation of the Primary Care Educator Burnout initiatives in five Integrated Care Systems (ICS) in London. GUE's activities took place from July 2022 until October 2023 and comprised the following activities:

- Negotiating ethical and research governance procedures
- Attending steering group meetings as set up by NHSE Workforce Training and Education Directive to bring stakeholders from all five London ICS together
- Gathering and collating data collected by the ICSs regarding the burnout support services offered
- Observing burnout support initiatives and training activities to support Primary Care educators
- Runnning a focus group with individuals working in Primary Care who had either experienced or were interested in attending burnout support services. The participants came from different ICSs.
- Conducting interviews with key stakeholders. These included the Primary Care Dean for NHSE Workforce Training and Education Directive, the South London burnout project lead, a nurse in Primary Care, a community pharmacist and a Training Hub manager for North East and South West London. The aim was to gather their views on the current implementation of burnout support services for all educators in Primary Care and capture their recommendations as well as best practices.

2.2 Our approach

The researchers leading this evaluation are rooted in pragmatism, which is a research paradigm that aims to bridge the gap between the structuralist orientation of older approaches, e.g. quantitative-based surveys and newer interpretative approaches, e.g. unstructured interviews (Creswell & Creswell, 2018; Creswell & Plano Clark, 2011). Based on this pragmatic stance Dr Markowski and Professor Foster utilised a mixed methods approach to elicit data from a number of participants and situations. The interviews with the Primary Care Dean for NHSE Workforce Training and Education Directive and the South London burnout project lead were placed towards the end of the project, which allowed to collect data while co-constructing observations on findings from previous points of data collection (Kvale & Brinkmann 2009).

In the first part of this project (i.e. observations on training offered and survey results from the HEE co-ordinated survey in March 2022), the focus was on understanding what types of burnout initiatives and support services were offered. The overall guiding questions for this part of the evaluation were:

- What type of content is covered?
- Who is being reached?
- Are there any gaps?

The second part of the project (i.e. the focus group and interviews in May-Oct 2023), was concerned with the overall questions:

- What worked well?
- What could be improved?
- What are the key aspects of the educator burnout initiatives in Primary Care in London, so they can be adopted in other Primary Care networks (or ICSs) in other parts of the country?

2.3 Structure of this report

- Context around project
- Empirical activities & outcomes' summaries
- Recommendations for further educator burnout initiatives in Primary Care and maintaining good practice

2.4 The context around educator burnout in Primary Care

NHSE Workforce Training and Education Directive recognised after the COVID 19 pandemic many staff in Primary Care were close to or had experienced burnout. The group of educators were affected, and this included GPs, nurses and other non-prescribing clinical staff. A loss of educators meant less capacity to train future health care staff. A report by the Health Foundation in 2023 stated that 71% of UK GPs said their job was 'extremely' or 'very stressful', which the highest precentage of the 10 countries surveyed alongside Germany in this report. It further reports that *"UK GPs were also among the least satisfied with practising medicine, work-life balance, workload, time spent with patients and other parts of their jobs"* (Beech et al . 2023).

The NHSE Workforce Training and Education Directive realised the need for initiatives to ensure that Primary Care Educators were well supported and not burnt out so that they were able to train the prospective workforce. For this study NHSE set up a steering group with stakeholders from each of the five ICS based in London and which met every 6-8 weeks. Each ICS has a Training Hub and these Training Hubs have set-up multi-professional faculty groups to engage all educators, not just GP educators, but also nurses, pharmacists and other non-prescribing roles. Furthermore, each ICS had a 'well-being champion' appointed to strategically promote well-being and initiatives to prevent burnout in their ICS and who attended the steering group meetings. Each ICS has a different profile with differing number of GP surgeries, which were either training practices approved learning environments.

2.5 Action Plans

Each ICS was allocated £17,000 by HEE and asked by the steering group to provide an action plan to address burnout in educators for their locality. They were asked to identify the needs in their area, these included focusing upon Primary Care educators, identifying burnout rates, using existing structures, and the correct terminology to target the relevant professional groups. They were then asked to specify interventions to address these issues. One of the ways to address these local needs was to conduct surveys to understand the priorities of the area and utilise existing resources: in particular educator away days. This would be accompanied by health and well-being initiatives such as taking breaks away from the computer and work place, going for walks and using mindfulness and other reflective techniques. Some of the action plans identified a number systems in place to support GPs but there were other groups of educators where the support structures were less established – these included Primary Care nurses, pharmacists, physiotherapists and other allied health professionals. The action plans also recognised the legacy of Covid 19.

As part of the action plan the ICS were asked consider the risks/barriers to addressing burnout. These included lack of capacity or opportunities to engage with health and well-being activities, unnecessary duplication, the danger of operating in silos and the general pressures of Primary Care working.

As part of the plan the ICS's were asked to consider what would be their key deliverables. These were understanding the effect of burnout on educators, learners, and patients via well-being surveys, raising awareness of burnout in all educators and ensuring that all educators were offered the opportunity for support, including away days. They were then asked to consider what would be the indicators of success/progress. These were the uptake of away days or other forms of health and well-being support, percentage of survey responses, general morale, and engagement in additional professional networking opportunites, and other non-work related social activities.

Finally, each ICS was asked to identify a burnout champion (though by the end of the project there was a move towards promoting a positive work culture with initiatives to support health and well-

being rather than focusing upon burnout. This was seen as having negative connotations.) They were then expected to consider how to integrate the burnout champions within their every day practice.

Each ICS set out activities to avoid and manage burnout. The well-being champion fedback about these activities in the steering group.
The appointed champions at the time were

- **(Southeast London) SEL** – Liz Nicholls, liz.nicholls@nhs.net
- **(Southwest London) SWL** – Khateja Malik, khateja.malik@nhs.net
- **(North central London) NCL** – Beth McKinnon, bethany.mckinnon@nhs.net
- **(Northeast London) NEL** – Asad Khan, asad.khan35@nhs.net
- **(Northwest London) NWL** – Caroline Durack, carolinedurack@nhs.net

2.6 Summary of the empirical data collected in the evaluation

Following analysis of the action plan we had the following empirical data collection points:

First phase:

- Review of the survey results
- Observation training course 1
- Observation training course 2
- Observation training conference

Second phase:

- 10th May 2023: Focus group with 4 participants (a mixture of participants from different ICSs)
- 25th May 2023: semi-structured interview with a Senior Nurse employed in the ICS Southeast
- 23rd June 2023: semi-structured interview with Training Hub manager North East London
- 12th July 2023: semi-structured interview with a Pharmacist, West London
- 19th July 2023: semi-structured interview with the Primary Care Dean for NHSE Workforce Training and Education Directive
- 4th Oct 2023: semi-structured interview with the Burnout Practice Lead for Southeast London

All participants consented to being recorded. The recordings were transcribed, and data was analysed inductively and deductively using thematic analysis (Braun & Clarke 2017).

2.7 Summary of the survey results

Pan-London structured and unstructured data were collected by HEE in March 2022 concerning the support provided to Primary Care Educators to prevent burnout at the time. Data was collected from all five London based ICS areas and three hundred and one individuals responded to the question concerning what was their professional background. Over 90% of the respondents were GPs. There were 484 responses to the question “Would you be interested in different categories of 1 :1 support.” The Most endorsed responses to this question were (n=118, 24.3% on each occasion) were firstly, coaching and secondly greater well-being support. Other responses were mentoring (n=99, 20.4%), nothing (n=86, 17.7%) and finally career support (n=63, 13.0%). Three hundred and four individuals responded to a question concerning peer group membership. There were (n=227, 74.6%) were already in a peer support group, (n=43, 14.1%) would like to be in one and (n=34,

11.1%) did not wish to access peer support. The final structured question was " What further ideas do you have for supporting Primary Care Educators and educational teams across London?" There were three hundred and eighty eight responses to this question. The most endorsed was "resilience"(n=139, 35.8%), followed by "understanding burnout" (n=130, 33.5%) and (n=104, 26.8%) replied none. There were fifteen suggestion of "other forms of support", these included greater resources and support services, a reduction in bureaucracy and sources of support, such as policies and greater training on the promotion of health and well-being issues.

There were then two semi structured questions allowing free text responses. The first one concerned how education had been impacted by the pandemic. Amongst the responses were burnout and exhaustion, greater workload, the difficulty of conducting remote interactions between educators and learners and some felt the trainees were challenging. The final question asked for suggestions to support primary care educators to manage their own burnout, these included peer and buddy support, team building and taking exercise.

2.8 Summary of the observations (Online Training).

Dr Markowski and Dr Foster observed three events independently.

The first session Dr Markowski observed took place on 13th March 2023 (10-12 noon online) and was entitled "Supporting educators: Resilience and burnout". It was delivered by "the WorkWell Doctors", which is an initiative set up by two Doctors. The 2-hour workshop was delivered online. There was a low attendance rate (only two participants), but this contributed to a very welcoming and warm space for participants to share their feelings and views.
The course was excellently delivered in terms of pace, content and interaction. The course covered "the wheel of control" – which can help to distinguish what an individual can change and what is out of their control. It further covered exercises such as appreciation activities, breathing exercises and tips on how to form (positive) habits. Nutrition and exercise were also covered by giving information and practical tips to encourage these. Lastly, they offered signposting to useful contacts and sources of support as well as suggestions on well-being apps they could access.

Professor Foster observed two online training sessions. The first was entitled "Supporting educators: culture, digital well-being and time management" and took place on 16th March 2023. There were also two participants (the meeting took place early evening 5-7pm)- one who was an operations manager and the other a GP returning from maternity leave. It was agreed that a positive workplace culture is a result of a strong vision, collaboration and communication and goals and rewards. It was also stressed that a positive workplace culture resulted in greater staff health and well-being and improved patient outcomes. The rest of the session focused upon time and workload management. The key should be to handle a task once if possible- spend 15-30 seconds now rather spending 30 mins later as other distractions will be present. The example provided was dealing with an abnormal blood test now rather than waiting. The general rule is the 2 minute limit- if it can be done in 2 minutes, do it now. The key being a clear prioritisation of tasks- urgent, medium, not urgent and also consider delegation of tasks. Is this a good use of my time? Am I the right person to carry out this task? The final focus was on digital well-being. When using computers templates should be encouraged if possible and drafts of common summaries. The relationship with sleep and impaired digital health was stressed and also agree a protocol re answering emails away from work. The importance to taking a regular break from the screen was also stressed ideally accompanied by going on brief collective walks (i.e everyone takes a break).
The final session examined rest and sleep. There are different types of rest- physical, mental, sensory, creative, social, emotional and spiritual. The individuals were asked to consider what is the right type of rest is best for them-ideally by timetabling in creative rest activities. Both facilitators

stressed the importance of some collaborative activities (such as lunchtime walks) as promoting health and well-being in Primary Care staff. The second online session was a consolidation of the two previously described sessions, it took place on the 20th March 2023. It was attended by 3 GPs and a practice manager. The meeting took place at 2-5pm during office hours.

Both sessions were well paced and as interactive as possible within such low numbers. There was a comfort break integrated into the session in which everyone undertook not to look any screens (including mobile phones) for 10 minutes.

Professor Foster and Dr Markowski both observed the Educator conference, which took on 26th April 2023 at Glazier's Hall in Central London.

2.9. Summary of South-East London Primary Care Educator Conference. April 26th 2023

The research team were invited to observe this conference which was attended by 142 participants. Half of the attendees were general practitioners including trainers, partners and educator leads (n=72, 50.7%). The other 70 people were a mixture of nurses, health care assistants, paramedic education leads and there were a further ten who were "unspecified". Both researchers attended different breakout workshops as follows

Dr Marianne Markowski

Workshop 1: Finding meaning in medical education

This workshop was participatory and offered space for communication between attendees. Participants were seated in a large circle. The educator explored with attendees the "human dimensions of supervision" and posed the question of what brings meaning to our work. Many responses from the small group discussions were centred around the relationships people have at work (with patients, students, colleagues), but also around barriers such as heavy workload and a lack of mixing with a variety of colleagues. The second question explored in group discussions was around the hidden curriculum at their workplaces and how culture and structures influence the learning experience as well as the sense of belonging.

Workshop 2: Teaching Ethics in Clinical practice

This educator explained about the variability of 'ethics' teaching in the education of clinical staff. He further demonstrated how ethical decisions are constantly made in daily practice working with patients (e.g. mental capacity act, access to records covid vaccines). The educator provided participants with some discursive tools and ask them to discuss them in small groups with the aim of making more informed ethical decisions based on 'moral reasoning'.

Workshop 3: Supporting neurodivergent learners

This educator provided attendees with an overview on the language employed, as well as the tensions and paradoxes in our understanding of neurodivergent learners (e.g. diversity and inclusivity vs categorisation and labels). He invited attendees to share their knowledge and experience of working with neurodivergent learners. The key challenges and characteristics for the key neurodivergent conditions were presented: dyslexia, dyscalculia, dyspraxia, ADHD, autism. He encouraged attendees to challenge the deficit-based approach to neurodivergence and to include reasonably adjustments in a timely manner. He pointed to sources of support (e.g. Professional Support and Well-being provided by HEE or equivalent, access to work), whilst emphasising that the relationship between educator and student is most important in offering a supportive environment fitting to their needs and abilities, even if the neurodivergence is undiagnosed.

Workshop 4: Supporting Learners following a career break

The educator explained about the "Supported return to training" (SRTT) scheme and how it was still an underused resource. Only a few attendees were aware of this scheme, which offers £3000 support to facilitate the re-starting of work. One GP had used it for a person returning into practice

from burnout. The educator explained the current challenges with the scheme, which were mainly centred around low awareness, great variability between different GP practices, other professions such as nursing have no awareness of SRTT, and a lack of overview on whom was or was not returning to practice. Using the 'Johari window' approach participants discussed in small groups whether this framework could be used to support the return of a trainee into practice. The framework appeared useful considering that workplaces also change while the trainee or colleague had been absent.

Overall Conclusion:

All four workshops that Dr Marianne Markowski attended provided space for discussions and sharing experiences, which is likely to help anyone to reflect on their current practice. In the first two workshops most attendees appeared to have been GPs, in the 3rd and 4th workshop a greater number of nurses and other health professionals were noted.

In the first workshop workload stresses were articulated, but no direct strategies to address it were discussed, yet emphasis was placed on the feeling of 'belonging' at work and this included relationships and good communication. Workshop 2 and 3 also only touched tangentially on the topic of burnout, yet in both workshop frameworks and / or tools were offered to support reasoning and decision making. Workshop 3 and 4 both pointed to sources of support and workshop 4 clearly addressed returning to work after a career break. However, burnout was not directly discussed.

Professor John Foster

Professor John Foster attended the following sessions as an observer and participated in some of the individual and group discussions. This was particularly the case for workshop 3 and 4.

Workshop 1: The importance of stories

This interactive workshop focused upon the contrast between taking histories and allowing stories/narratives to emerge. Stories and narratives enable the educator or practitioner to see the patient, trainee or colleague as an individual with a life story rather than someone who has contacted Primary Care because they are unwell who has to be assessed within a 10-minute window.

Workshop 2: The Psychology of Communication/Difficult Conversations

This workshop largely took the form of providing guidance when holding "difficult conversations" either with patients or as part of the learning/supervision process. Part of this was understanding the communication norms of different cultures. In particular, the practice of direct questioning (the example given was Germany) and indirect questioning (the example being the English- dependent on the context/nuance and often having double meanings.)

A structure from psychotherapy was introduced called the "Drama Triangle". This is the tendency to get stuck in a cycle that involves repeating the roles of persecutor, rescuer, and victim. By integrating a sense of clear boundaries, compassion and an understanding of vulnerability of all actors, it becomes possible to achieve a "Healthy Balance" by balancing assertiveness, attunement and self-awareness.

Workshop 3/4: Stepping into your Authority.

This was a two-part interactive session based upon coaching/mentoring principles using a model espoused by Nancy Kline and the creation of a "Thinking Environment" that facilitates a non-judgemental environment enabling an individual to resolve their own problems by giving them space to do so. These are the principles that underpin action learning sets.

The first session set up the model by asking the participants to reflect on things they remember. Thereafter working in pairs we were asked to use Kline's principles to describe a frustrating practice situation whilst the second person remained silent in order to encourage the first person to examine their own position and possibly generate their own solutions. In the second session (following lunch) we were divided into groups of three. Using similar principles there was one person describing a frustrating practice-based situation and the others were consultants who asked open ended questions and thereafter all three participants reflected on the situation.

Overall Conclusion:

All four workshops that Professor Foster attended provided very useful techniques to encourage healthy communication and, in this way, promote health and well-being. None of these explicitly referred to burnout and how to avoid/cope with it. In one of the workshops' interactive session, one participant described feeling burnout because of work-based frustrations.

2nd Phase Summary of the empirical data collection

3.1 Summary of the Focus group

On 10th May 2023 four participants took part in the focus group. One participant was a care coordinator, three were GP trainers, one participant was a GP trainer who experienced burnout and was currently still off work. The care coordinator's main task was to work with individuals who did not have a clinical role, but working in GP practices alongside the receptionist to call patients' for their health checks (e.g smear tests, bowel screening, blood tests etc) with a view to reducing the GPs' work load. Three participants were women and one was male.
The focus group discussions were structured around questions recognising burnout in yourself and others, the experience of burnout, and support options available for dealing with burnout or to avoid burnout.

Utilising thematic analysis (Braun & Clark 2017) we developed the following three themes:

1. Experiencing and recognising burnout
2. The variability of structures in Primary Care
3. Changes in work culture and workload

1. Experiencing and recognising burnout

Two of the four participants stated that they had experienced or are currently experiencing burnout. The other two had witnessed burnout with their colleagues and / or with their trainees. The latter two had been active in the past in setting up support for GP trainers and other clinical colleagues to counteract the pressures that Primary Care had during the COVID 19 pandemic. This entailed identifying a well-being champion, who could sign post anyone who is/was experiencing signs of struggling to the appropriate services, and it included "*24/7 access to counselling services or in-*

person services". GP trainers were also able to refer their trainees to occupational health for support.

One participant was a GP who was currently off work since she had experienced burnout. She described the factors that led to her becoming burnt out. These were her workload, not having enough time, isolation and lack of opportunity to debrief. She felt that carrying out her role as a patient supporter and advocate over an extended period contributed to her becoming burnt out. This was exacerbated by having no avenue to off load her frustrations. Thus she described going home as: "*When you go home the last thing you want to do is talk to your family, your loved ones because you've been emotionally sucked dry."*

She did not experience joy in her work anymore as she was fatigued mentally and could not make decisions and yet kept going. Unsurprisingly, her line manager did not notice these changes in her as she explained:

"My boss didn't recognise that there was a problem and I emailed her to let her know and she said "I haven't noticed any problems with your work" and I was like "well that's because my work was the last thing to have slid, my emotional, my mental, my family well-being had deteriorated to nothing but my work" and I only chose to give up, not give up, stop because I finally started to question my ability to care about what the patient was saying, to care about the work that was coming in."

One participant explained how it was particularly difficult to recognise burnout in locums and bank staff:

"You can pick up early warning signs but if you're running a place on locum or bank staff it becomes difficult to actually get to know them and understand when they're starting to wobble a little bit and they may not know you well enough to come to you if they are struggling and in that situation we might rely on them going to their GP if they recognise that there is a problem and very often they don't recognise it until it's too late."

She continued to describe the GP working culture:

"We don't recognise it (stress/burnout) as doctors until it's too late often and we kind of feel that well we're going to go on and on literally until the house of cards just collapses one fine day and by that time of course it's a little bit too late."

One of the participants was a care coordinator, her job role has been described at the beginning of this section (see p18). She explained that she felt burnt out in Febuary and March as this is the time where everyone is trying to hit the target deadline of 31st March. She observed many receptionists and other administration staff taking the brunt of patients' dissatisfaction and stress as they were the first contact point.

"I've seen patients literally screaming their guts out at the reception staff and, you know, abusive language and the reception like just now someone said is they go through so much before they reach the GP so, you know, they've calmed down and then they meet the GP but then the reception has to face everything."

She further explained that it depended on the practice on how administration staff are supported, usually this was via the practice manager.

2. The variability of structures in Primary Care

In this focus group only two ICSs were directly represented NWL and SWL, although one participant had been working in a number of GP practices which may have been outside these two ICSs. Through the contributions by all of the participants it was apparent there was great variability between GP practices across the different ICS.

As one participant stated: "*GP practices aretheir own little business and each one would have their own structure depending upon, how many patients they look after, how many partners they have, what sort of management structure, it's very variable, incredibly variable."*

The variability depended on the size of the practice, the set-up of governance of the practice (such as partnership model, number of salaried GPs, locums, trainee practice, F2 trainee practice) the number of staff (clinical and admin), the practice manager. The environment of the ICS was also important and influenced the support received by Training Hubs and additional extended services offered in the PCN. This variability meant that there were different offerings to support well-being, in the different ICSs or PCNs. In consequence it was difficult to follow how the information about those offerings reaches the individual practices and thus staff.

This participant explained: "*I know in our area we have well-being champions in each PCN. I know that they have meetings quarterly in some areas but I'm not part of those meetings so I don't know what sort of things are discussed. It might just be an awareness sharing thing but how that gets cascaded down I couldn't say."*

3. Changes in work culture and workload

During the focus group conversations several changes in workload and also work culture became apparent. Firstly, participants articulated the increased workload due to the COVID 19 pandemic, with less staff being available as many had to isolate or shield themselves. In addition, secondary care had delegated (as part of wider policy decisions) more tasks to Primary Care, yet no substantial support was given to underpin this additional burden and experienced staff (both clinical or administration) were leaving.

"Primary Care in general is absolutely knackered because of a lot of, you know, the workload has come out to Primary Care but hasn't necessarily gone back into secondary care. And just the expectation that, you know "oh yeah, your GP will do this, yes go back to your GP, they will do that" and whether it's sort of secondary care or even social care where "well go to your GP for that letter" without realising that we're also working with literally the people that have gone, left us during Covid because they were at that time shielding, were either very nearing retirement and they didn't come back because they retired or they are just so absolutely exhausted that they cannot come back."

This participant described how a GP partner left as they found the changes difficult, but they remained in the workforce with less responsibility.

"One of my partners there left the practice and rejoined as a GP retainer because they couldn't, I mean that was mainly burnout, they couldn't cope with the amount of work which was increasing."

He also mentioned how other GPs left for New Zealand as *"it had a better work life balance."*

The group further pointed towards the generational issue, where the previous generation of doctors *"carried on and despite everything, the lack of sleep and stress and everything".* This participant expressed: *"That [older] generation now instead of asking for help probably what they do is they retire when it reaches to that point where they can no longer work or they just reduce their hours."*

He continued with his observation that trainee doctors are different now since they are more likely to expect a better work life balance and are not attracted to working long hours. Therefore, the partnership model for GP practices will be in danger as younger GP do not want to take on this level responsibility.

"This new generation is very different. For good or bad, I think it's going to change the nature of work in NHS because very few of them will want to be partners because of the scale of job and responsibility levels. There are few new partners going into practices, they would like to do a locum job where they go to different practices, they just see patients and come out and there is no admin or managerial responsibility and this is the new generation, so that is another trend which is going to go and they want the work/life balance. So while say 20 years ago everybody wanted to be a partner because it was offering much better financial prospects but also work/life balance etc, now very few doctors want to become partners and that is because the new generation is aware of these things such as healthy work life balance."

He continued by describing his own experience: *"I think it's the older generation of doctors, me and older GPs. I remember working 70/80/85 hours a week and we just did it because we felt this is how worked as doctors. And we were all stressed but we carried on and mistakes used to happen and people carried on and despite everything, the lack of sleep and stress and everything, and I think that generation now instead of asking for help probably what they do is they retire when it reaches to that point."*

One participant in the focus group described a positive change in work culture. She explained that her practice had now implemented a well-being activity where they met every Monday for a well-being exercise.

"Every Monday we have a well-being session, so we have an exercise for our team, we are forty members, so we do this exercise and if we face any issues then we know whom to contact, our line manager and then she'll take it forward and send us for some therapy."

Following the observations and focus groups it became apparent that there were other groups of primary care educators than GPs who had their own specific needs. So we decided to interview a primary care nurse educator and pharmacist. To gain some insights into training needs a Training Hub manager was also interviewed. Finally, there were two wrap-up interviews one with the Primary Care Dean and the other with a nurse who is now taking a leading role in promoting health and well-being in primary care educators. The aims of these interviews were to clarify some of the findings and consider a way forward.

3.2 Summary of the interview with Senior Nurse

The content of the 1-hour long interview with the senior nurse supporting the multi-professional training routes in PCNs, fitted into the Focus Group themes. The summary of this interview concentrates on the uniqueness of situations and experiences in regard to nurses and trainee nurses in comparison to other professions as primary care educators. The interviewee emphasised that many of her observations and answers were routed in the specificities of her PCN and work environment.

1. **Experiencing and recognising burnout**

The interviewee explained that during the COVID-19 pandemic and lockdowns nurses were 'overlooked' as nurses still saw patients face-to-face as baby immunisations or smear tests etc. could not be conducted over the phone. The appointments were 15 minutes long and yet this was still not sufficient time to clean and aerate the room.

"Certainly in my area, nurses were definitely, completely overlooked. They felt like they were being hung out to dry. All the GPs and everybody else were not seeing a patient but the nurses had to see patients, obviously for baby imms and smears."

It was only after the COVID-19 pandemic had ended that she had the time and space to realise that she had experienced burnout. Furthermore, she only labelled her experiences 'burnout' after she had heard the term being used at the educator day. Before realising this, she had noticed she got exhausted, irritated and turned into someone who did not empathise with her patients anymore. She still feels easily exhausted with her current workload.

She held a clinical lead role in her CCG and tried to champion the nurses' work and to ensure they were better protected during Covid times. However, COVID-19 meant that her clinical lead role was put on the 'backburner' for six months therefore she felt angry and frustrated. *"I wasn't able to make people understand that nurses needed to be protected and I became Mrs Angry."*

Nursing colleagues were the main form of support for nurses working in Primary Care and there was a degree of professional isolation. They did not necessarily speak to their practice manager about their experiences, or possible struggles, as it is not that *"kind of relationship"*.

There were (bulletin) emails towards the end of the COVID-19 pandemic, which contained helpline numbers for places to ring when an individual was stressed, but she described how this felt *"tokenistic"* for her and her colleagues. She continued explaining that there was and is very little targeted support for nurses regarding burnout, nor that it was even recognised by non-nursing colleagues.

There has been some steps to address some of these concerns and these will be described later (page 31).

2. **The variability of structures in Primary Care**

The interviewee described the variability of support structures in Primary Care. At times, there could be an HR person, but usually, they had no experience of pastoral support or occupational health issues. She described how surgeries struggle to keep good admin staff and only a few loyal ones stayed. Many newer ones left due to heavy workloads and how they were treated by frustrated patients.

She further commented how working as a nurse in a small practice could be a very isolating place. *"In the bigger practices, you'll probably get a couple of nurses who will be on at the same time but in the smaller practices, you won't. So it's a very isolating role and if you haven't got the support of your partners or a practice manager, as I said, it's a lonely place, I think."*

She further explained how other clinical professionals such as pharmacists and physician associates are thought of to reduce the doctors' workload, and are considered to be *"medically trained"*. In her

view, it was and still is not appreciated how nurses also reduce the doctors' workload by carrying out tasks such as wound dressings, immunisations and health checks .

In her ICS there was relatively little communication with other nurses and opportunities for networking. Communication was via a generic bulletin on a Friday afternoon and a quarterly newsletter from the PCN nurse facilitator. The nurse practice forum (which is now being delivered by the Training Hub) has been operationalised since the lockdown takes place every two months for 1.5 hours before the 'academic half day'. She considered the nurse practice forum as a *"one-way information stream"* rather than a two-way information-sharing opportunity but she tended to arrive early to catch nursing colleagues for personal exchanges.

Whether a nurse could go to the bi-monthly academic half day depended on how open GP practice or surgery was for nurses to take time off. Practices tended to expect their nurses to cascade information between them, yet nurses working for the practice did not always meet each other as their clinics or working times overlapped. She explained: *"If you've got three or four nurses in a surgery maybe, if you're lucky, they'll go, "oh, well, one can go and then she or he can feed back." They're not actually getting the bigger picture which is about being with colleagues to be able to share things and just hear what's going on for yourself."*

3. **Changes in work culture and workload**

The interviewee recounted how practice mangers and GPs seem to have a lack of understanding for what nurses actually do as they have given only 10 minutes for a travel vaccination appointment *"because all you do is give an injection",* yet the nurse also has to carry out a risk assessment and understand where the person is travelling to, all of which takes longer than 10 minutes. She also touched upon the generational difference where older nurses (e.g. nurses older than 60 years) were likely not to argue about shorter appointment times, but to follow what they were told.

In her view the ideal workplace would strive to be "a good employer" and it should make nurses feel like respected and valued members of the Primary Care team and that there would someone if nurses needed someone to talk to. The well-being person should be trained for this role and possess the skill of asking the right questions like a therapist would do. She considered mentoring and coaching for e.g. Advanced Clinical Practice (ACP), but it needed to be from with someone from the outside of the practice to be beneficial.

3.3 Summary of the interview with the GP pharmacist.

The pharmacist provided perspectives of two different areas of pharmacy, the first was the community pharmacy (and there she also worked for a large chain of pharmacies) and secondly, a GP-based pharmacy. Furthermore, she was a part-time lecturer at an HEI, teaching trainee pharmacists. Our summary focuses on key points concerning pharmacists' training and experiences of working in Primary Care in comparison to other areas in pharmacy.

The role of the GP pharmacist

The interviewee described how the role of the GP pharmacist is still relatively new and there is a little awareness of what the GP pharmacist does. At the moment, most pharmacy graduates choose hospital or community pharmacies rather than GP based ones. The low awareness was also due to GP surgeries still trying to understand how to employ GP pharmacists in the most suitable way and this extended to employing foundation trainees. She described: *"At the moment foundation training*

is still behind in terms of getting applicants in to do their foundation training year at the GP surgeries. That is because of the apprehension of GP surgeries of having a foundation trainee because they're still finding their feet in terms of having a pharmacist let alone a foundation trainee, so they don't know where to place them."

She explained the benefits of working in GP surgeries over community pharmacy are able to maintain the clinical skills and prescribe. In comparison, in the community pharmacy business skills and advice over the counter (counselling) skills were required. She felt that business skills were currently not sufficiently addressed in pharmacist training as pharmacies are businesses. Community pharmacies are based on a business model, and need to follow the correct path in terms of dispensing prescriptions. e.g. special cremes otherwise the money could not be claimed back from NHS Business Service Authority (BSA).

Reflecting on her own experience of working as a GP pharmacist she described the lack of understanding by GP practices and GP managers on the activities involved and the time given for running a clinic by a pharmacist. She recounted: "*I have a clinic that starts at 9 o'clock, and stops at 1 o'clock, I have a half an hour lunch break, then my clinics would start up again every ten minutes until 5 o'clock when I left, but in between those times I'd be expected to do prescriptions, to help reception with the blood forms that I was doing, doing my admin tasks, so doing discharge summaries, and on top of that doing my audits and everything so it was essentially impossible to actually run to that time, so I would never get a lunch break. And I remember speaking to our medical director and said that this, 'I'm struggling here in terms of my workload, in terms of the timings', and I know one of the comments that I got back was, 'maybe this surgery is just too fast-paced for you'. But it wasn't…"*

Given the difficulty of fitting all the tasks into the time allocated by the GP practice, she then left to work for another practice and found that the situation was very similar. The interviewee introduced the concept of "recycling", which in this context meant: *"They'll move from federations or to a different GP surgery in hope that the clinics will be better or in hope that their practice manager will be more understanding, their workload will be less, but it isn't, it stays the same. So essentially the pharmacists are recycled through the system until they get to a point and think, 'I've had enough. I no longer want to practice'. Then they'll start looking for other jobs."*

The interviewee indicated that the attitude towards working long hours held by older generations in GPs had filtered through and that there was an issue with younger generations of pharmacists having *"the confidence of being able to say no – I'm struggling."* She recalled that in her training there was one slide called 'house keeping', that consisdered time management and 'avoiding burnout'.

She further explained that every year a pharmacist needed to submit four CPD activities, a peer observation and reflective statement to keep their qualification and registration. Employers were supposed to give 5 days off to do the training, however this was dependent on practice policies. In her experience with Primary Care, it was only when she was employed with the federation that she had the time off to do the training. The ICSs also varied in that respect. In West London they had regular meetings for pharmacists, half a day every month, but in North London it was one day every 3 months.

Recognising burnout and support options

She then described how she noticed burnout in health care sectors and that this has been more noticeable since COVID-19. She explained about how GP pharmacists' typically burnout. At first, there is a settling in process, but soon and due to their prescribing skills, their role changed into becoming the first point of contact rather than the GP for all kinds of queries that were prescription and medication related, whilst their day-to-day work and admin continued.

In comparison she explained that community pharmacists were burnt out even before Covid-19 as staffing levels were already an issue then. "*Community pharmacy has been I think burnt out for a number of years even before Covid, but after Covid it was more. It was the staffing levels were sometimes what they should not be."*

During Covid she felt she had become burnt out and she described her own experiences of working as community pharmacist. Initially she was working with a second pharmacist sharing two stores, but due to illness in other stores her second pharmacist was relocated, and typically the interviewee worked 8am-7pm without breaks continously until the business decision was taken to remove her second pharmacist completely. She recounted that she mainly slept when she had days off and was always ill in her holidays. She had little social life and was too exhausted to engage in conversation. In the end, she realised that she had to leave community pharmacy in order to recover and have a life again.

In contrast hospital pharmacists were less isolated as they were better embedded into a larger system. She explained *"the advantage of hospital pharmacy, they have a bigger team as opposed to a community or a GP practice pharmacist. They have that network".* In consequence, she believed they were less stressed. She also recalled how the large pharmacy retailer she used to work for had a *"health and well-being support"* line, but at the time she did not use it, nor was she aware of anyone else using it.

Currently in her GP work, there is a'whats app' group with other pharmacists in her federation for clinical questions. Yet, no one talks about burnout in this group or excessive workloads. She was unaware whether there was a well-being champion in her federation.

When asked how she would create greater awareness around well-being and avoiding burnout she answered that she would use training days i.e. the quarterly meeting to promote well-being by including an half an hour of information sharing between them. She also recommended having a weekly half an hour slot at the workplace to allow people to talk about what is stressing them out and/or to do some mindfulness as she had seen benefits of these in other workplaces.

3.4 Summary of the interview with Training Hub Manager.

A one hour long interview was held on 23rd June 2023 and although a similar interview guide was employed, the focus of his interview became to understand the implementations of the initiatives in more detail and any lessons that could be learnt.
This interviewee gave a perspective on the 'educator burnout activities' offered in her ICS which were partly built on the experiences gathered from other ICSs. In particular, they learned from the SW ICS to pay attention to wording and not to use "burnout" as a term. Instead, her ICS now used the expression "*supporting our educators"* for the educator burnout activities.

Her ICS provided a mixture of activities, some of which were online and those attracted an attendance of around 40%. They also added their offerings to the existing training days, i.e. the GP

trainer day, yet in this way only GPs were reached. In order to reach other groups such as nurses, pharmacists and other clinical staff in Primary Care, they added their content to 100 existing event days, which included Multi-Disciplinary Team (MDT) events. Her ICS had also encouraged face-to-face encounters/meetings where possible as there was a realisation that actual exchange between people was important.

Communication channels and use of language

The Training Hub was good at reaching the GPs, but they wanted to reach all staff who had a role in mentoring, coaching or in the education of their peers. She learned from other ICS that there should be *"different sets of comms for different sets of people and you need to be quite specific in our language. Different people, groups of people will recognise different languages. "*

Her ICS had learned to speak to GPs through the Training Hub communications, to engage with pharmacists through the local pharmaceutical committee and nurses through the nurse leadership groups. She emphasised the importance of relationships in reaching the different professions and that this was best achieved by going out locally to the various groups *as "it's a hard sell on e-mail".*

A further differentiation to be made was with the language used for the role of the educators, which meant generic language in comms did not work. She explained: "*It's the language we're using for educators, pharmacists are known as tutors. Nurses are known as assessors. GPS are known as trainers. Practise managers are known as mentors. They're all kind of doing the same job. But all of them have very different titles. So actually when you're doing it from a communication point of view, for us, it's really difficult to have generic comms."*

Time and place for the classes

She further found that the logistics of arranging classes for the different professions was challenging, for example, GPs would access training mainly during daytime, whilst pharmacists had only time in the evening, but then she had a difficulties in finding a facilitator that was available.
During COVID-19 in her ICS one-to-one confidential support was available. They also offered sustainable and local options such as peer group support, 1-to-1 coaching, mentoring and support by local charities.
She considered adding these signposts for courses and offerings during the (GP) educator approval process, however she realised *"we don't have the same approval process for a pharmacist educator or a nurse educator. These processes just don't exist for us to plug into."*

Introducing 'positive' standards and policies

In her view, the constant re-structuring and changes in funding in ICSs added to the causes of burnout and the virtual world has not helped with recognising burnout. She explained that was *"because you're not in an office together the way you used to be to be able to checking how someone actually looks, actually if someone feels sad or is burnt out."*
In her view when someone was struggling, they would be getting support one to one and check ins, but there was not generic process, it was all "*very individually led and informal"*. There was and is no occupational health as the small business model did not offer *"a good enough occupational health structure in place."*
In her opinion, to achieve change where well-being is placed higher on the Primary Care agenda was make it mandatory for GP surgeries to have a well-being policy. She suggested each surgery should have something like a *"directory of services",* where people can be signposted to or access support resources should they require them. Her aim would be to included non-clinical staff (such as

receptionist / admin) in any further initiatives as they *"have a such a huge role to play as they are the backbone in a lot of these organisations."*

3.5 Summary of the interview with the Primary Care Dean for NHSE Workforce Training and Education Directive

This 1-hour long interview with the Primary Care Dean NHSE Workforce Training and Education Directive, which was formerly Health Education England covering South London, provided a general overview of the promotion of well-being in Primary Care. In the second half, the interviewers (Dr Markowski and Dr Foster) presented their observations on this project for feedback.

The interviewee described how the promotion of 'well-being' for Primary Care staff is a "*balancing act against a huge workload that everyone is managing the whole time."* From her experience as a practising GP, she described the lack of overall guidelines to promote well-being but pointed out the benefits of coffee breaks and other opportunities to feedback concerns and exchange experiences in person (i.e. face-to-face meetings). She further mentioned the importance of outside services that offered coaching and well-being mentoring. Yet, she was very aware that many of these opportunities were GP-centric and that GP educators in many ways had the most developed support systems in place.
"A lot of that [support] is very GP-orientated, so we're talking very much about educators, the support available to them from the educational structures therein, but that's much more, better developed for GP educators than other educators. "

The interviewers offered their observations on the evaluation of the project's activities to that point (July 2023). There was some excellent coordination of well-being activities and courses offered in some practices, but this was piecemeal. There seemed to be a lack of awareness among staff of well-being champions and the message of "well-being or support" for staff was not systematically communicated to all groups of educators. There was an "old culture of working long hours" and there was no consistent and systemic structure for a person to be able to admit they were struggling and or notify when a colleague was struggling. A further issue was that burnout was frequently only recognised at a later point when staff took time off and they were ill. The interviewee stated that the point she felt she might intervene was when there was a perception that the colleague had become unsafe. Thereafter burnout was usually diagnosed through another GP in a different practice.

Multi-professional faculty to support integration

When being asked about the possibilities for integrating the wider network of Primary Care staff she pointed to the role of the multi-professional faculty groups. *"In London we very much wanted to do that through the multi-professional faculty groups. There's a long tradition of GP trainers meeting and having protected time to talk about their training, talk about their trainees, talk about challenges they're having or, sharing good practice and developing a community of practice, and that's quite robust, but that doesn't happen for our other Primary Care colleague educators"* Ideally, the GP educator model, which included protected time and networking could be applied in the training for the other professions.

She explained the benefits of the multi-professional training days. The research team attended the one held in South East London where educators, GPs, nurses and other professionals came together. The aim was to learn, discuss, exchange strategies to manage workload or challenges and potentially speak about their burnout experiences, even informally over a coffee. According to our interviewee, the Southeast London Training Hub had been leading in creating networking opportunities at ICS, Borough and at PCN level.

Integrating well-being into the learning environment approval process

A way to promote well-being in Primary Care would be to include this as a criterion in the learning environment approval process for a GP practice or surgery. The learning environment approval recognises all educators in the PCN but educators for individual professions have their own processes. The approval process at the PCN level requires educational co-ordination and ideally a lead person. However this individual requires a degree of funding and protected time, which is challenging and will be dependent on local practices and priorities.

Another notable development concerning further professions in Primary Care and whose well-being also needed to be considered was the Additional Role Reimbursement Scheme (ARRS) roles. This has meant that there are now more different professional groups such as pharmacists, physician associates, paramedics, and social prescribers working in Primary Care. These are not currently fully integrated, and can lead to feelings of isolation and lack of development. Hence there are now difficulties with recruitment and retention, she explained: *"There's about fourteen ARRS roles (fully reimbursed by NHSE). This has led to a huge expansion with these members of staff in practices, and Training Hubs have a role in supporting them working in Primary Care. There's been a King's Fund report about how there's a lot of churn, they feel isolated, they don't see opportunities for development, they feel they're working too hard. So a lot of them are leaving, and we heard this morning in the retention meeting that 14.3% are moving on within one to two years of being in a placement."*

According to our interviewee, the Training Hubs now play a key role in Primary Care and provide education training and a forum to network for specific professions as well as multi-professional events. However, there may *"still be some practitioners who wouldn't know what a Training Hub is, or who they should contact."*

The Role of The Practice Manager

Whilst there are support structures in place for GPs and the professional groups will have professional structures in place such as the NMC , there is minimal support for administration or reception staff. This would be provided by the practice manager. The interviewee explained: *"Practice managers are absolutely key to the well-being of the business because they're appointing staff. They can look and see how it's run, bring about changes, think about that sort of work the workforce needs against what, the workforce availability. They also have sophisticated ways of assessing the number of appointments that are needed and who's available to meet them, and dealing with all those staffing issues."*

Practice managers have (networking) forums and various journals, as well as academic journals. They often come from other NHS management roles. The interviewee was open to the suggestion to include practice managers to the multi-professional events and responded with *"because they're not recognised as educators, which is a bit short-sighted of us because, I mean, I have done things where the practice managers have been involved in the education because they're often setting up the timetable for the new learners, they're looking to see if the trainers have got enough time, so they are key."*

In this interview, it became apparent that the learning environment approval has an important role. It was important to look at the approval stage again and to ensure that all staff (clinical and non-clinical staff – including admin and reception) had access to networking, support and exchanges as this made for a better and high-quality learning environment.

She described: *“Besides the practice manager, there are other staff who are supporting the learners. They may not be the actual educators, but in a Primary Care, if a trainee doctor doesn't know what to do, they will just ask anyone. They can knock on anyone's door, so everyone is part of having a learning environment.”*

Sharing Good practice

The interviewee further mentioned how ICS Training Hub leads now meet regularly to share good practice. Furthermore, the Primary Care School Board, meets virtually every two months to celebrate good practice and consider introducing changes if appropriate.

Lastly, exit interviews were discussed as further strategy to gather information on positive working culture(s) and where more guidance may be needed to support a good working culture. These exit interviews should be held at ICS level so timely change could be initiated.

3.6 Summary of the interview with the Burnout Practice Lead for Southeast London

The burnout Practice lead for Southeast London is a general nurse, and she was the Training Hub manager for Southeast ICS until recently. She has moved into role of ICS burnout project lead. The 1 hour long interview started with her providing an overview of her experiences of the project before the interviewers offered their observations of the project.

Our interviewee portrayed the general practice landscape. Each general practice is an individual business and the only learning of any financial value to the practice is the GP registrar learner. Furthermore, any research that’s been undertaken nationally and locally has been targeted at GP educators. She described: *“So that created an issue for me being a nurse at the very beginning of the project in that we were working off research that was very tailored towards the GP educator and how that system works. And that system is very regulated, well financed and well supported. Both from the educators’ perspective and the learner's perspective. Nurse educators have always struggled to a get permission from their employer, the GP, to be allowed to have learners for which they are not funded and the protected time around that and the standards around that are not well supported.”*

The definition of the Primary Care educator is unclear

She pointed to the challenge of understanding who is an educator in general practice. *“Particularly now that we've got all these additional ARRS roles. So we've got physios, physician associates, non-clinical roles, like non-clinical care coordinators and social prescribers, they still need support and educating and supervising, and yet the system mostly expects supervision to come from a GP as the employer.”*

She explained that there is a new programme, which allows non-doctors to train non-medical prescribers. *“Non-GPs or non doctors can train and undertake a training programme to be a non-medical prescriber supervisor and to sign off another non-medical prescriber.”*

According to her, the greatest challenge is the lack of a clear definition on who counts as an educator in Primary Care. She explained: “*there is still no clear definition of who is an educator in Primary Care is. For a GP it's very clear they have to have undertaken the Educators programme and then they join a register of educators with HEE, and they are formally recognised and acknowledged.*

It's a status that they have within their practice. They become a training practice because there is a trained GP. And the practice has to be an approved learning environment."

Learning environment approvals are still GP (only) led

She confirmed the comments of the previous interviewee re approval issues. There was a new initiative to approve a whole PCN geography rather than an individual practice as a learning environment – a concept akin to secondary care where every department in a building would be approved. However, she described despite a large number of nurse, pharmacy, non-clincial educators in the practice, a learning environment cannot be approved without GP leadership. The system is/was GP centric and therefore lacked clarity around inclusivity for other educator roles in Primary Care. *"When we're running projects around protecting educators from burnout, if you don't identify yourself as an educator, you're not tapping into those support resources. "*

No formal processes for Nurse and ARRS roles experiencing burnout

The interviewee stated that there were no clear systems in place for an individual to seek support if they felt they were experiencing burnout in a primary care setting: "*There wouldn't be any formal process. It would partly depend on the structure of the practice, whether s/he was there on her own or whether they were part of a team. It would be down to the local Training Hub who has those relationships with the practice to then go in and try and support."*

She emphasized the importance of the involvement of a neutral person, not actively involved in that borough, which can lead to a more strategic approach. This outside person – most likely from a Training Hub – could have a chat with the individual, look at the workload and ascertain whether there is any support available. "*If they've got more than one learner or if other people in the practise aren't supporting that learner, we now have processes where learners can be shared. This might be about bringing in another educator to support them, or move them out so that they're not there for the whole time of the placement. And we do have our pop in sessions for all non-GP educators now, which are held at Southeast London level so they can drop in and and meet with their peers. If that didn't solve the situation, then there might be a need to go in and talk to the employer, around having that protected time. Its about being able to support the educator in order to be able to support the learner in order to be able to support patient care. So it's having those discussions with the employer that are helpful.*

The interviewee explained that it was more likely to get feedback from someone experiencing burnout through the learner rather than the educator as they had strong learner feedback mechanisms in place. However, whether these support mechanisms could be utilised was dependent upon the individual recognising that they needed help and being prepared to seek it.

The value of peer networking for support

In the Southeast ICS there are now peer support groups for all the different professions which are managed at the Southeast London level as well as on local levels. She described: "*Nurses who are on academic programmes are supported through SE and all of our nurses, new to general practice, have a mentor at Southeast level."*
One of the positives from the Covid Pandemic is delivering training or networking sessions virtually, which allowed for continuity and flexibility. She also emphasised the benefits of returning to face to face meetings.

Nurse Retention in Primary Care

The interviewee discussed changes in the work culture as the 10-minute production line for appointments was not the way to retain staff. Although the reasons for the 10 minute appointment slots were unclear, she further pointed out that GP educators had at least protected learning time, which nurses and other educators did not have even with a trainee. There are further issues that impact on retention of primary care nurses. In particular, practices nurses do not get paid maternity leave or sick leave in addition to the statutory minimum limits which meant many nurses leave to work in secondary care. When nurses applied for positions in Primary Care, they needed to have negotiated their salary. Agenda for change salary bands can be used but whether this is the case is a local decision.

Summary of support Systems now available in South East London

We concluded the interview by asking her to summarise the support networks that were locally available. These changes have occurred since the lockdown.

She described that in the Southeast London ICS there are currently two systems for support, firstly the well-structured GP educator system and secondly the peer learning network. "*We have quite a big team of educators here and we [the Training Hub] actively recruit on behalf of general practice nurses and then support them through the GP and academic programme, so we have a peer support network for them and any nurses new to general practice. We engaged with them and support them to undertake the fundamentals programme.*

In the southeast London ICS there are now peer networks for all professions, including clinical pharmacy, physician associate, paramedic, nursing and social prescribers and care coordinators. One group that still seemed to receive little support was the group of administrators and receptionists. *"I don't know of any formal support groups for receptionists or administrators practice managers. Once you get to assistant practise manager or manager level there are really good strong Forums, but for the people on the ground front desk, I think their support is not good."*

4. Conclusion and Recommendations

The original intention of this evaluation was to consider the challenges faced by educators in Primary Care most of whom were general practitioners. One of the main findings was the support systems in place tended to be more established for GP trainers and there were other professional groups that needed greater support in a primary care setting.

London is divided into five Integrated Primary Care Systems (ICS). This was a pan-London study and there was representation on the project steering group from each ICS. Each ICS was asked to present an action plan to address burnout in their locality focusing on Primary Care educators. Each one considered identifying burnout rates in different groups of primary care educators and considering alternative modes of communication to reach each one. They were then asked to consider some interventions to address burnout in Primary Care. One of these was the provision of educator away days which would be accompanied by encouraging a number of health and well-being initiatives such as taking breaks away from the computer and work place, going for walks and mindfulness and other reflective techniques. All the action plans recognised the legacy of Covid 19. The action plans were then asked to consider some of the barriers to addressing burnout. These included the lack of opportunity for some people to engage in health and well-being activities unnecessary duplication, the danger of operating in silos and the pressures of Primary Care working. As part of the action plan each ICS was asked to identify a burnout champion who would help to integrate the initiatives into daily practice. However as the study continued there was a move away from using the term burnout and resilience (as both of these were seen as having negative connotations). The preferential terms were promotion of a positive work culture and health and well-being.

In March 2022 HEE conducted a survey across all five London PCS concerning the support provided to Primary Care educators to prevent burnout at the time. There were over three hundred respondents and over 90% were GP trainers. One to one support in the form of coaching, well-being and mentoring were popular. Peer support was also valued, over three quarters of the sample described themselves as being in a peer support group and a further fifteen percent would be interested in participating in this. Developing resilience and having a greater understanding was seen as important in preventing burnout. More training was also seen as important.

There were then two semi-structured questions allowing free text responses. It was felt that the greater workload during the pandemic had resulted in burnout and exhaustion. This and remote communication had made supporting learners difficult. The final survey question asked for suggestions to support Primary Care educators to manage their own burnout, these included peer and buddy support, team building and taking exercise.

Observation of Training

Both researchers observed online and face to face training independently. The online training was delivered by “WorkWell Doctors” during the morning work hours (10-12). The first session lasted approximately 2 hours including a short break away from the screen. It was attended by two participants (both GPs). Amongst the issues that were considered in the session observed by Dr Markowski were understanding the amount of control an individual has over their situations and putting over the message about not getting stressed about issues you cannot control. The session then went on to consider a number of coping strategies such as breathing exercises and taking breaks away from the screen and measures to promote physical and mental health and a healthy diet. It concluded by signposting useful contacts and sources of support as well as suggestions of well-being apps.

Professor John Foster observed two online training sessions delivered by the same facilitators. The first one was entitled "Supporting educators: culture, digital well-being and time management." The meeting took place at 5-7pm and was attended by two people, one who was an operations manager and the other was a GP returning from maternity leave. The initial focus was upon the importance of a positive work culture and how this resulted in better staff health and well-being and improved patient outcomes. The rest of the session focused upon time and workload management. One of the key tips was if you can do something in 15-30 seconds do it now, rather than spending 30 mins later as other distractions will be present. The example was dealing with an abnormal blood test now rather than waiting until later. The general rule is the 2 minute limit- if it can be done in 2 minutes, do it now. The participants took a short break away of the screen and the second part of the session considered the promotion of digital well-being. The key take home message was to agree a protocol re answering emails away from work. The final session examined the importance of rest and sleep. In conclusion the participants were asked to consider what work-based activities could be used to promote a positive work culture. Among the suggestions were taking regular breaks from the screen and going for group lunchtime walks. The second session was consolidation of the previously described online training. It took place 2-4.30 pm and was attended by three gps and a practice manager.

Following attending the online training both Dr Markowski and Prof Foster attended the South East London Educator Conference which was run by the South East London training hub. It was attended by over 140 Primary Care professionals, half were general practioners including trainers, partners and educator leads (n=72, 50.7%) The other were a mixture of nurses, health care assistants, paramedic education leads and there were a further ten who were "unspecified." Arguably the most important finding was that the term burnout was not used throughout the training day, the emphasis was upon the promotion of health and well-being. Dr Markowski observed and participated in workshops examining what is a healthy work based culture, the teaching of ethics in clinical practice and how to support neurodivergent learners or those returning to work following a career break. Professor Foster also observed and participated in four workshops. There were two held in the morning and a further two in the afternoon (these were devoted to the same theme.) The first morning workshop examined the importance of seeing the patient as a person with a life story rather than in terms a diagnostic label. The second workshop considered how to have difficult conversations. Following the lunch break he attended a two session workshop entitled "Stepping into your authority". This involved introducing some coaching/mentoring principles that underpin action learning sets. This can provide an individual with the techniques and space to help an individual to resolve their own issues/problems.

<u>Focus Group Findings:</u>

After the researchers had observed both the online training and the workshop run by South East London Training hub, an online focus group was held of four participants. One participant was a care coordinator, three were GP trainers and one GP had experienced burnout and was currently still off work. Three participants were females and there was a male GP. Following analysis three themes emerged:

a) Experiencing and recognising burnout
b) The variability of structures in Primary Care
c) Changes in work culture and workload

<u>Experiencing and recognising burnout:</u>

Two of the four participants stated that they had experienced or are currently experiencing burnout. The other two had witnessed burnout in their colleagues. The latter two had been active in the past

in setting up in their ICS support for GP trainers and other clinical colleagues to counteract the pressures that Primary Care was experiencing.

The participant who was still currently off work described the circumstances that led to her experiencing burnout as excessive workload, not having enough time, isolation and lack of an opportunity to debrief or off-load her frustrations. These factors and the pressure she felt having to advocate for her patients led to her becoming increasingly fatigued and left her with an inability to make clinical decisions. None of these developments were recognised by her line manager. This discussion led to consideration of the work place culture. The pressure to keep going (both external and internal) meant it was difficult to recognise colleagues who were struggling who kept going until they collapsed. This was particularly acute in the case of locums and agency staff. The care coordinator pointed out that receptionists and administrative staff were often the contact point for patients and became the target for their dissatisfaction. If they needed support, they would have to disclose this and it would be provided by the practice manager.

The variability of structures in Primary Care

This focus group only had representation from two ICS but it was clear that there was great differences across all practices. This was mainly because these were all individual businesses with differing management and governance structures and local challenges. There was also a discussion about the role of the well-being champions. One of the participants in a senior role was aware of their function and the fact they held monthly meetings. Other members of the group were not aware of their existence.

Changes in work culture and workload

The discussion then focused upon the policy changes that have led to Primary Care taking a greater role in healthcare delivery. GPs now have to inititiate many secondary care and social care procedures and assessments. The Covid lockdown had exacerbated the problem as many GPs and practice nurses were nearing retirement and had either retired in the interim or become so exhausted they had retired early.

There was also a perception of generational differences. Older GPs tended to think nothing of typically working 70-80 hours per week and just carrying on as working like this was seen as normal. Instead of asking for help they retired or reduced their hours. Younger trainees tended to want a better work-life balance and often requested to work part-time to fit in with their child care or other caring needs. In consequence their were in some practices a reluctance become a partner and take on other senior roles. One of the participants felt there was now a greater emphasis on the promotion of work place well-being and that they had now introduced break away sessions to allow all practice staff to discuss any issues they are facing. They were chaired by the practice managers. She felt that issues had been resolved and if they were not the practice manager had signposted the individuals to avenues so they could get additional support.

Semi-Structured Interviews:

Following the observations and focus groups it became apparent there were other groups of primary care educators than GPs who had specific needs. So we decided to interview a primary care nurse educator and pharmacist. To gain some insights into training needs a Training Hub manager was also interviewed. Finally there were two wrap-up interviews one with the Primary Care Dean and the other with a the individual who is now taking a leading role in promoting health and well-being in primary care educators. The aims of these interviews were to clarify some of the findings and consider a way forward.

Primary Care Nurse

This recorded interview lasted nearly an hour. The interviewee who was a female nurse felt that during the Covid-19 pandemic the stresses on nurses were great as they still had to see patients face to face to conduct procedures such as baby immunisations or smear tests. It was only after the lockdown stopped that she realised she had suffered from burnout. She experienced this as exhaustion, irritation and lacking in empathy for her patients. She still feels easily exhausted with her current workload. She has a senior nursing leadership position and perceived that her exhaustion meant that she was not able to support or advocate for her nursing colleagues.

Her perception was nurses were professionally isolated in Primary Care. Nurses supported each other as they did not tend to confide to the practice manager. Towards the end of the Covid-19 pandemic there were bulletin emails, which contained helplines if people were feeling stressed. She felt this was "tokenistic" and generally there was little recognition of nursing support needs in Primary Care for nurses in comparison to doctors. There have been steps to address this and these were summarised in the final interview.

She went on to describe the variability of support structures in primary care. Larger practices may have someone with human resources responsibilities but often they had minimal experience of providing pastoral support or occupational health issues. Many surgeries struggled to retain administration staff or receptionists - there was a high turnover and newer staff tended to leave because of the workload and the fact they were often the first point of contact for frustrated patients.

She went on to expand on her theme of the isolation of the primary care nurse because of what she perceived as the lack of support from the partners or practice manager. She felt that unlike other primary care clinical professionals such as pharmacists or physician associates. Nurses were not seen as "medically trained" but as someone who predominantly was employed to reduce the workload of doctors. There was a lack of understanding of what the role of nurses was in Primary Care. An example she provided was the travel vaccination. It takes longer than 10 minutes to give the injection because this has also has to be accompanied by a risk assessment.

In her ICS at the time there appeared to be little opportunity to network or communicate with other nurses. There was a generic bulletin of a Friday afternoon and a quarterly newsletter compiled by the PCN nurse facilitator. There was now a nurse practice forum, which took place every two months for 1.5 hours before the "academic half day." She regarded this as largely a "one-way information stream" rather than a two-way information-sharing opportunity. She tended to arrive early if possible to chat to people informally. However, whether a nurse was able to take advantage of the these training opportunities was dependent on the local practice. The expectation would be that the information was cascaded down to the nursing team.

Primary Care Pharmacist

Pharmacists are now taking a larger role in the delivery of primary health care so the research team felt it was important to gain some insight into the experience of a pharmacist.

The interviewee had worked in a community pharmacy and was now a GP-based pharmacist, so she could make useful comparisons. The role of a GP pharmacist is comparatively new and both pharmacists and GPs are still trying to ascertain what the role entails. In consequence most new pharmacy graduates are choosing hospital or community based practice areas. This extends to pharmacy foundation training and there is a reluctance to place trainees pharmacists in Primary Care. She felt that the main benefits of being Primary Care based was that clinical skills were

maintained and there was a greater opportunity to prescribe treatments compared community pharmacists where business skills are paramount.

She then described her typical working day. The clinic started at 9 am and she finished at 1pm. There would then be a half hour lunch break and following lunch she worked through to 5pm. She was also expected to do write prescriptions, help with blood forms in reception and fit in her administrative tasks, discharge summaries and audits. So in practice she rarely had a lunch break. Having worked in more than one GP practice she felt this was typical and that GPs or practice managers had very little insight into challenges GP-based pharmacists faced. There was also the previously described generational issue where long hours were accepted as the norm. She also felt there were problems with admitting you were struggling and required help. Issues such as time management or "avoiding burnout" were also barely touched upon- as she recalled in her training, there was one perhaps two slides devoted to "housekeeping."

In order to maintain their registration, annually a pharmacist has to submit four CPDs accounts, a peer observation and a reflective statement. They are supposed to be given five days off for training updates. Whether this is allocated will be dependent on the practice policy and other demands. In her experience there were different training opportunities dependent in which ICS she worked in and the attitude of the practice towards allowing pharmacists training opportunities during working hours.

She felt that burnout had become more noticeable since the lockdown period and explained the likely process for GP pharmacists. Initially, there was a settling in process but as they had prescribing responsibilities they were quickly underpressure to increase their prescribing function and during this time their administration responsibilities were also increasing. During the lockdown period she was working as a community pharmacist and experienced burnout. She was working in two different stores and was typically working 8am-7pm. As a result she was barely sleeping and had minimal social contacts.

There was a "whats app" group for other pharmacists in her federation (including community and hospital based) but this was entirely devoted to clinical queries and there was no discussion of burnout or excessive workload. She was unaware whether there was a well-being champion in her federation or not. There are training days and she felt these could be an appropriate vehicle to discuss health and well-being. She had also observed work places where there had been regular half-hour slots to allow people to discuss their frustrations or use some mindfulness techniques. She felt these could be beneficial.

Training Hub Manager

The interviewee provided some insights into "educator burnout activities". The first insight drawing upon the experiences of South West London was not to use the term "burnout" this was replaced by "supporting our educators (and trainees)". There was now a mixture of online and face to face training but there was a recognition of the importance of face to face contact. Finally, that many of the training days were virtually all targeted at GPs and it was now important to target nurses, pharmacist and other clinical staff.

Building on this theme she talked about the importance of appropriate channels of communication- again these have tended to GP-centric. Once again drawing on the experiences of other ICS there was a recognition of the need to use different avenues and terminologies to reach professional groups, rather than an all-group generic emails. GPs were known as "trainers", nurses "assessors" and pharmacist educators were called "tutors". Practice managers were known as "mentors."

There were also logistical difficulties in organising training, for example, GPs could access training mainly during the day, whilst pharmacists typically could only access it in the evening.

She concluded by pointing out the impact of constant restructuring and changes in funding arrangements in ICS and felt that this made it difficult to recognise and support struggling colleagues. This was especially the case as much contact was now conducted online. Another issue she pointed to was the lack of human resources or occupational health resources as GP surgeries were small businesses. Thus any support was individually led and informal rather than structurally driven.

She suggested that a way forward was for it to be mandatory for Primary Care surgeries to have a health and well-being policy which would include a details of where individuals can be signposted for additional support resources. She stressed that this should include non-clinical staff such as receptionists and administrators.

There were finally two interviews which were largely focusing on a way-forward by discussing some of our findings to date.

Primary Care Dean

The Primary Care Dean chaired the steering group for the project and took a key role in accessing the funding for this work. She stressed the importance of promoting health and well-being in Primary Care but this has to be put into the context of delivering a huge workload. There was a discussion of some of the support services including coaching and mentoring for educators, though she was aware, currently these were GP-centric. The aim now was to develop multi-professional faculty groups across London drawing upon the examples of good practice in GP training and learning from the challenges they have faced. Key initiatives she pointed to were: providing protective time, multi-professional training days and greater networking opportunities for non-GP professional (and non-professional) groups. She pointed to the multi-professional South East London Training Hub day that has been briefly described as an example of excellent practice that should become a model for other ICS.

Expanding on the issue of the inter-professional learning she went on to discuss the Additional Role Reimbursement Schemes (ARRS). This is the policy driver to bring more professions into primary care- there are fourteen roles and include pharmacists, physician associates, paramedics and social prescribers that are included. Currently they are not fully integrated and this can lead to a sense of isolation and stunted professional development. This is leading to difficulties in retention and she quoted a figure she had just been given in a recent meeting that 14.3% ARRS professionals are moving on within one to two years of being in a Primary Care placement.

The interview next considered the role of the practice manager. These are key to the development of a healthy working culture as they appoint staff and can drive work force changes. They have a networking forums and are targeted by a number of practice-based and academic journals but they are not recognised as educators. However she was open to inviting practice managers to training and education events. If administrative staff or receptionists are struggling, the avenue of support would be the practice manager.

Training and supporting health and well-being are clearly priorities. There are regular ICS training hub and Primary Care School Board meetings, which share and celebrate good practice. The interview concluded with a recognition of the importance of the exit interview to help promote a

healthy working environment. These should be held at ICS levels so that changes could be initiated at an appropriate level sooner.

Former Training Hub Manager South East London

As the previously described interview pointed out South East London training hub is regarded as a driver of good practice. The interviewee's professional background is an adult nurse and she will take a key role in driving the promotion of health and well-being forward following this evaluation. The interview commenced with a brief discussion of the Primary Care working culture and a recognition that each GP practice is an individual business and the only learning that has a direct financial benefit for the practice is that of the GP learner. Thus the GP learner structure is well regulated and financed and supported. In contrast nurse educators can struggle to get protected learning time to update their professional skills. This then led to an acknowledgement that the definition of the Primary Care educator is unclear, and this has become even more apparent under the ARRS inititiative. Again the structure for GPs is very clear, unlike all the other professional groups, they join a register of educators and this is formally acknowledged by their practice. They can only do this within a practice that is an approved learning environment. Thus the main challenges centres around approval issues which require GP leadership to be implemented.

The interviewee then considered burnout support initiatives in Primary Care, which she felt was still GP focused. There were a number of initiatives that were available but they were only open to people who could be identified as a GP educator. Thus there were no formal processes in place for nurses or others in ARRS roles who are experiencing burnout. This support would be provided by the local training hub but not all practices are/were part of the training hub network. There are/were a number of steps now in place to address this, the most important being the involvement of a neutral person from another ICS training hub who could talk to a struggling individual to look at their workload and ascertain whether there was additional support available. They could also possibly talk to the employer and perhaps negotiate some protected time. There is now a recognition of the role of peer support, Southeast ICS has peer-support groups for different professional groups at both an ICS and local levels.

There is a difficulty in nurse retention in Primary Care in a group, many of whom are approaching retirement. One of the issues that concerned her was the lack of protected learning time for nurses. This is guaranteed for GPs but not for nurses even those with a trainee. It should also be noted that their terms and conditions, especially with regard to maternity and sick leave are less favourable than if they were employed by the NHS.

To conclude in the interview we asked the interviewee to summarise the support systems available at the Southeast London ICS. There were number of changes that had occurred since the pandemic lockdown. There is now a well-structured GP educator programme and the greater peer learning support. There are now peer networks available for GPs, nurses, clinical pharmacists, physician associates, paramedics, and social prescribers. There were also good forums for practice managers but minimal support for administrators and receptionists.

Recommendations

Much of this evaluation has involved understanding the culture and needs of Primary Care, especially since the Covid pandemic lockdown. It is also important to note that the situation is evolving and during the study there were significant changes in the inter-professional profile, in particular the ARRS scheme. However, it should be noted that the resources available meant there

was a limited pan-London picture and it is possible there are examples of excellent local practice we have not been able access.

This evaluation has provided a snap shot of some of the issues facing Primary Care Educators both at a local and regional level and the initiatives to support a positive working culture in the different ICSs. The research team started off with the assumption that most of the data collection would be GP and practice-nurse-focused. As the study continued it became clear that with the implementation of the Additional Role Reimbursement Schemes (ARRS) this was no longer the case. There are now up to 14 different professional groups working in Primary Care and much of the work now should be focused on supporting these new groups of primary care educators. We have become aware of many areas of excellent practice that have evolved during the study but it is important that these are shared at an ICS level and silo working is avoided. We conclude with some recommendations for ICS and training hubs in particular to consider with the aim of rolling out good practice on a pan-london basis and thereafter possibly nationally.

These should be seen within the context of "Our NHS People Promise" which is a promise "to work together to improve the experience of working in the NHS for everyone" (NHS England 2023).

- The term burnout is largely to be discouraged and replaced with terms such as "promotion of health and well-being" or "supporting our staff". This change has largely been operationalised.
- It should be mandatory for each primary care practice to have a health and well-being policy.
- Regular face to face meetings of the ICS trainers so that good practice can be shared more efficiently and to give room for shared learning.
- The Additional Role Reimbursement Schemes (ARRS) provides significant challenges for primary care and there are now up to fourteen different professional groups in primary care. There has to be greater awareness of how to support these groups- training/network opportunities and protected time etc.
- Greater thought should be given to primary care educator approval schemes and re-evaluation of the term primary care educator especially following the introduction of ARRS.
- Especially following ARRS greater promotion of peer support groups at an ICS level.
- Greater steps to promote awareness of the well-being champions in each ICS.
- Notwithstanding the need to respond to local needs there should be a core agreement across all ICS as to the role of the health and well-being champions
- To continue with a mixture of multiprofessional online and face to face training but place. greater emphasis on face to face ICS multiprofessional organised training events.
- Some consideration of appropriate channels of communications and terminology to reach different professional groups. To date they have tended to be GP-centric.
- Greater thought as to the role of the practice manager in promoting health and well-being of primary care staff. This could include ensuring staff from different professional groups are given network/training opportunities and protected time.
- Practice Managers given training so they can provide support for administrators and reception staff.
- Exit interviews to be held at an ICS level so that there can be immediate learning and changes implemented to promote health and well-being as soon as possible.
- Greater training and awareness of time-management as a mechanism to promote health and well-being and stress management
- Promotion of peer-networks and Multiprofessional faculty groups across all professions.
- Consideration of the use of social media technology such as Whats App groups to promote health and well-being as well as being focused on clinical issues.

- Greater research into the needs of different professional groups in primary care such as pharmacists.
- Greater research concerning how to promote a healthy work-life balance in primary care educators and other staff.

Acknowledgements:

The authors acknowledge the literature review “Addressing burnout in clinical educators” (Burgoyne 2022) which has informed the research questions and methodology of the current study. Details of the search can be accessed through Brighton, UK, Sussex Health Knowledge and Libraries. Please contact kevin.burgoyne@nhs.net for details of the articles accessed in the search in the first instance.

References

Beech J, Fraser C, Gardner G, Buzelli L, Williamson S, Alderwick H. Stressed and overworked. The Health Foundation; 2023 (https://doi.org/10.37829/HF-2023-P12).

Clarke, V., & Braun, V. (2017). Thematic analysis. The Journal of Positive Psychology, 12(3), 297-298.

Creswell, J.W. and Creswell, J.D. (2018) Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. Sage, Los Angeles.

Creswell, J.W. and Plano Clark, V.L. (2011) Designing and Conducting Mixed Methods Research. 2nd Edition, Sage Publications, Los Angeles.

Ghahramani S, Lankarani KB, Yousefi M, Heydari K, Shahabi S, Azmand S. A Systematic Review and Meta-Analysis of Burnout Among Healthcare Workers During COVID-19. Front Psychiatry. 2021 Nov 10;12:758849. doi: 10.3389/fpsyt.2021.758849. PMID: 34858231; PMCID: PMC8631719.

Griffin A, Knight L, Page M, Crampton P, Viney R and Rich A. (2018) A Critical Evaluation of the London GP Trainer Programme. https://www.ucl.ac.uk/medical-school/research/our-research/critical-evaluation-london-gp-trainer-programme

Karuna C, Palmer V, Scott A and Gunn J. (2022). Prevalence of burnout among GPs: a systematic review and meta-analysis. British Journal of General Practice, 72 (718): e316-e324. **DOI:** https://doi.org/10.3399/BJGP.2021.0441

Kvale, S., & Brinkmann, S. (2009). InterViews: Learning the craft of qualitative research interviewing (2nd ed.). Sage Publications, Inc.

Maslach C, Jackson SE, Leiter MP. (1996) *Maslach Burnout Inventory Manual*. 3rd ed. Palo Alto, CA: Consulting Psychologists Press.

Moffett J , Crawford R and Pawlikowska T. (2019) Enhancing clinical educator well-being. THE CLINICAL TEACHER 2019; 16: 306–311

Monsalve-Reyes C, San Luis-Costas C , Gómez-Urquiza J , Albendín-García L , Aguayo R and Cañadas-De la Fuente G. (2018). Burnout syndrome and its prevalence in Primary Care nursing: a systematic review and meta-analysis. BMC Family Practice 19:59 https://doi.org/10.1186/s12875-018-0748-z

NHS England (2023). Our NHS People Promise. https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/.