

SPESC Facilitator Training: A Model of Faculty Support

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Background:

Small group work is a common aspect of many courses, aligning with the principles of adult learning⁴ and constructivism¹, and leading to an increase in deep rather than superficial learning. Additionally this form of learning supports the formation of Communities of Practice⁶. The Problem Based Learning pedagogy is now ubiquitous in many medical schools around the world and Practice Based Small Group Learning has become increasingly popular as a means of continuing professional development for GPs.

These forms of adult learning require support of skilled facilitators who focus on guiding group discussion to drive learning in a student-centred approach, rather than taking the traditional teacher-centred role of giver of information⁷.

In 2001 NHS Education for Scotland centralised training for all GPs who wished to become Trainers, with the new course becoming a mandatory requirement for any GP in Scotland wishing to take on this role. (Scottish Prospective Educational Supervisor Course – SPESC). The course is delivered in small group format, with each group supported by an experienced facilitator.

In 2017 the GMC published their new document “Promoting Excellence”, giving standards for all medical education across the whole of the UK. Theme 4 stipulates that educators should be inducted, trained and supported in the role.³

What do we do already?

SPESC Facilitator Training and Support Model:

Selection for the role by application and interview

Initial co-facilitation for complete course with experienced facilitator

Peer facilitator support at the end of *each* day to discuss problems and share learning

Annual Facilitator Workshop:
Skills development & Feedback
Sharing of information
Calibration
Appraisal

What do we think?

Feedback from SPESC facilitators:

Co-facilitation allows observation and role-modelling.

Feedback during co-facilitation enhances performance.

Workshop gives opportunity to try new things and learn from others.

Meetings with peers ensures practical and emotional support.

Moving from observation to solo facilitation is like an apprenticeship.

What does the literature relating to facilitator training and support say?

A search was performed of the following: Scottish Enhancement Themes Literature (1 paper); Ovid MEDLINE & ERIC search (7 papers), Google (2 papers). Key words used were: facilitator or facilitation, and training or support.

The papers reviewed were from a range of countries but mainly comprised those from a range of health settings including medicine, dental education, nursing and multi-agency groups (nurses, dieticians, physiotherapists and exercise physiologists), with an additional one considering provision of inter professional education within undergraduate healthcare programmes. One paper studied the training of university teachers generally, with no focus on any one particular subject area.

Analysis of the literature in this area revealed only one paper that looked at the effect of training teachers on student learning⁵. One further study assessed facilitation skills following training with 75% of facilitators assessed as achieving at least basic levels of competence². A small number of papers, of variable quality, examined self-efficacy in facilitation skills following formal training courses, with mixed results, but a suggestion that training improves confidence. There was no consensus on the format of facilitator training, although most papers supported an ongoing programme that included initial workshop and some further support. A number noted the value of feedback in improving facilitation skills.



What have we done with this?

The model used to train SPESC facilitators broadly aligns with the key themes emerging from the literature review, and is popular with current members of the SPESC Faculty who value the support and opportunities for skills-enhancement. On this basis, and in order to try to address the issue of facilitator development and support in our Regional Groupwork programme, the North of Scotland GPST Education team have adopted the principles of this model.

For a number of years feedback had suggested the need for increase in facilitator training within this setting. For the year 2016-17 we have supported the Groupwork facilitators by building in a formal meeting at the end of each session where individuals can share challenges and learning from the day. A facilitator workshop is also planned for more formal skill development.

Early feedback from the facilitators would suggest that this model has been positive, as they feel much more supported. Ideas and good practice are now routinely shared with the peer support having been particularly useful when dealing with difficulties within a group.

What next?

To further build on this work, it is hoped to expand this model of facilitator training and support to include Secondary Care colleagues who facilitate other courses offered by the Faculty Development Alliance (FDA) as currently there is no provision for formal peer support and skill development for this group.

References:

- ¹Bruner, J. (1977) The Process of Education, Cambridge, MA: Harvard University Press.
- ²Bylund CL, Brown RF, Lubrano di Ciccone B, Diamond C, Eddington J, Kissane DW. (2009) Assessing facilitator competence in a comprehensive communication skills training programme. Medical Education; 43:342-349
- ³General Medical Council. (2016) Promoting excellence: standards for medical education and training. Manchester: GMC
- ⁴Gibbs, G. "Learning by Doing: A Guide to Teaching and Learning Methods. Further Education Unit Oxford Polytechnic." (1988).
- ⁵Gibbs G, Coffey M. (2004) The impact of training university teachers on their teaching skills, their approach to teaching and the approach to learning of their students. Active Learning in Higher Education; 18(1):87-100
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- ⁷Wetzel M. (1996) Developing the role of the tutor/facilitator. Postgrad Med J.; 72:474-477



Undergraduate medical Placements: a Student Centred Approach

Dr K Ferguson, Dr C O'Dowd

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Introduction

Medical school curricula and assessments have to meet certain standards set by the General Medical Council (GMC). Each deanery has to ensure that the training programs delivered by teaching hospitals will enable the student to demonstrate what is expected of doctors as outlined in the GMC's Good Medical Practice, and to achieve the appropriate learning outcomes. (1)

The opening of the Queen Elizabeth University Hospital (QEUH) in 2016, with a state of the art teaching and learning centre, was an excellent opportunity to modernise, modify and improve on medical student placements and teaching delivery.

Aim

Third year Glasgow medical students completed a 5 week medical placement at the QEUH. The clinical teaching fellows designed a new teaching program based on previous student feedback. The program is varied, incorporating a range of teaching styles, such as case discussions, small group tutorials and bed side teaching. This study was designed to evaluate the effectiveness of this new teaching program.

Method

Anonymous questionnaires were completed by a total of 51 students at the end of their placements. Students were asked to rate different elements of the new program including case presentations, radiology teaching, Clinical teaching fellow teaching, consultant teaching, and the placement overall.

How would you rate the following (please tick appropriate box)

	Excellent	Above average	Average	Below Average	Poor
Placement Overall					
Radiology teaching					
Wednesday tutorials					
Thursday Case presentations					
Acute receiving ward					
Teaching fellow teaching					
Consultant teaching					

Would you be happy to return to QEUH for a future medical block?

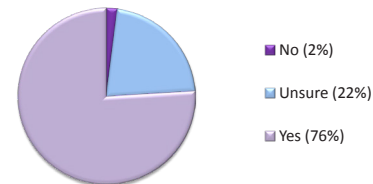
Is there anything you particularly enjoyed?

Do you have any suggestions to improve the block?

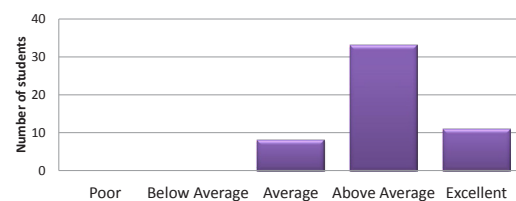
Figure 1. Questionnaire

Results

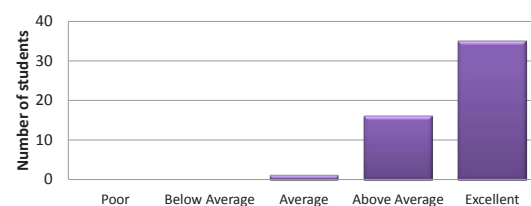
Would you return to the QEUH for future placement?



How would you rate the placement overall?



How would you rate Clinical Teaching Fellow Teaching?



Students comments:



Conclusions

Clinical teaching fellow presence on a placement is extremely valued by students – through both delivering teaching and being familiar face to help throughout the block. They have dedicated with time to teach, can address issues raised by feedback and can act as a point of contact between students and deans of education.

To engage students a variety of teaching styles and approaches should be used when designing programmes. Involving students in planning of the teaching programme and responding to their feedback is essential for student engagement and successful outcomes.

Reference.

1. GMC (2013) Good Medical Practice. Retrieved 15/2/17. Available from: <http://www.gmc-uk.org/guidance/goodmedicalpractice.asp>



Grand Rounds Unites in a Remote Hospital in Papua New Guinea



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Introduction

Tari Provincial Hospital (Fig 1) is a remote hospital in the highlands of Papua New Guinea. This is an area which sees a wide variety of medical and surgical cases from tropical diseases to major trauma resulting from tribal fighting and domestic violence.

As with most hospitals in developing countries it is under resourced with a wide variety of staff skill and experience. Until one year ago Medicine Sans Frontiers (MSF) were running both the surgical and trauma teams and the medical and paediatric services were run by the PNG Department of Health. This inevitably lead to a divide within the hospital between medical and surgical services.

However, after the departure of MSF the hospital is now entirely under the Department of Health. One challenge of this transition has been bringing the hospital together as one.



Figure 1- Tari Provincial Hospital

Methods

It was decided after discussion by the medical team to introduce grand rounds once a week. The aim was to discuss interesting cases and specific learning points from them. It was held every Friday morning with posters placed to advertise and regular reminders given to staff to attend. (Fig 2)

Initially the cases were presented by ex-pat doctors but then local doctors, health extension officers, lab technicians and x-ray department were all invited to present and take part. Feedback was sought in the form of questionnaires sent to attendees.

Results/Discussion

On average there were 30-40 attendees every week. Feedback from the questionnaires was largely positive with 100% agreeing or strongly agreeing that the teaching was relevant, useful and allowed participation. Other comments such as “really useful discussion points”, and “allowed me to share my knowledge” really backed this up.

Date (Friday)	Department Responsible
24/2/17	Morbidity and Mortality
3/3/17	Surgery
10/3/17	Obstetrics and Gynaecology
17/3/17	Paediatrics
24/3/17	Internal Medicine
31/3/17	TB/HIV
7/4/17	Laboratory
14/4/17	Surgery
21/4/17	Obstetrics and Gynaecology
28/4/17	Paediatrics
5/5/17	Internal Medicine
12/5/17	TB/HIV
19/5/17	Physiotherapy
26/5/17	Morbidity and Mortality

Figure 2- Grand Rounds poster

Conclusions

The introduction of grand rounds has ensured that all hospital staff now have the opportunity to meet on a weekly basis to discuss interesting cases and receive teaching on a variety of topics. Not only has this allowed regular learning for all staff members but it has also improved communication and team-working and allowed everyone to have an appreciation of what all the different departments are now doing.

Acknowledgements

Thank you to Jacie Chick (clinical mentor), Dr Vincent and Dr Graham who helped organise and support the development of grand rounds.

Thank you also to all the Doctors and HEOs who presented cases and ensured that Grand Rounds continued after our departure.

What do you think was good about the sessions?

- Really useful discussion points!!
- Allowed to me to share my knowledge.
- Great to get new and up to date training.
- Good to have medical nurses involved.



What do you think could be improved about the sessions?

- More reliable power supply for projector.
- More time for questions.

BE MY BUDDY : NEW WAYS OF GP ORIENTATIONS FOR FOUNDATION AND GP TRAINEES

Muhammad Syahmi Roslan

AIM

To identify trainees learning difficulties in working in GP Practice and creating an effective and reliable induction program to address the learning needs

METHODOLOGY

1. A cohort of junior doctors, Educational Supervisor and Practice manager were recruited to answer a survey based on August 2016 induction program in Muirhouse Medical Group (MMG), Edinburgh.
2. Once completed, the data were collected and analyzed
3. A new induction programs was created and applied on the new cohort of trainees for December 2016 intake
4. Feedback were taken and analyzed for further improvement

REFERRAL

IT TRAINING

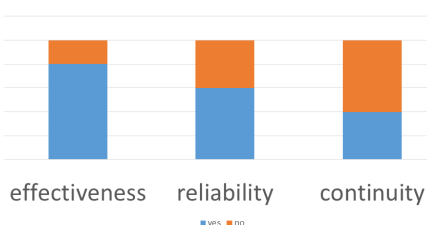
Seniority GAP

BOOKLET

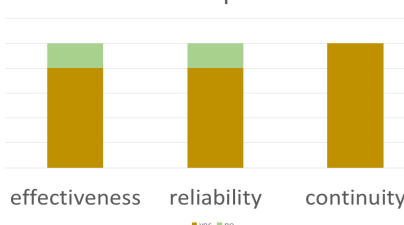
CATCH UP SLOTS

JOINT SURGERY

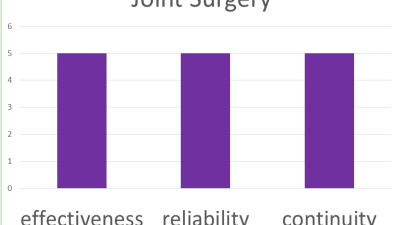
Booklet



Catch Up Slot



Joint Surgery



CONCLUSION

- The introduction of GP booklet, catch up slots and joint surgery are effective in addressing trainees learning needs and difficulties
- Trainees felt induction of booklet is not useful to be continued as it is only been given on the first day of induction
- Moving forward, sending the online booklet prior starting the placement might be useful in informing trainees about the GP Surgery

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2. <https://www.thegpsurgery.co.uk>. Accessed on 23 February 2017. Copyright
3. Richard M. Ingersoll, Michael Strong, The Impact of Induction and Mentoring Programs for Beginning Teachers, A Critical Review of the Research, First Published June 1, 2011

Acknowledgement

A very huge tahnk you to Dr Paul Hepple, GP at MMG. Dr Jane Hill, GP at MMG, Miss Donna Munro, Asst Practise Manager at MMG that help to ensure that this project is a success.

Development of a trainee quality improvement network

Introduction

Quality improvement (QI) has become a compulsory component of the latest curriculum in anaesthesia. In 2014, a group of trainees in the South East Scotland Deanery recognised the opportunities to train in QI methodology were scarce.

SQUARES was therefore created. It is a trainee network which aims to improve knowledge of QI methodology and provide opportunities for involvement in QI projects within the deanery and the U.K. in general.



SQUARES Constitutional Aims:

1. To establish a regional network of anaesthetic trainees who conduct multi-centre research and quality improvement with high potential for making an impact
2. To ensure that involvement in research and quality improvement is accessible to all anaesthetic trainees
3. To allow trainees to continue their involvement in research and quality improvement projects as they migrate around the deanery
4. To provide training in research and quality improvement for the educational benefit of South East Scotland School of Anaesthesia Research and Quality Improvement Network members

Methods

SQUARES offers multiple avenues to get involved:

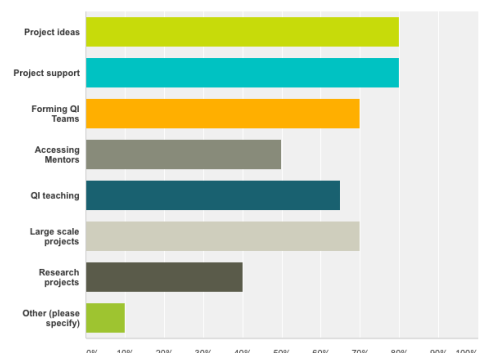
- The network runs an annual pan-deanery QI project involving a large number of trainees.
- Trainee involvement varies from simple data collection to local or overall project leadership.
- It hosts free QI methodology teaching sessions delivered to trainees in the deanery.
- A mentorship programme provides trainees with QI experts who provide project support on a one-to-one basis.
- Multi-site QI projects are undertaken – allowing trainees to remain involved in the same project while rotating through different hospitals.
- SQUARES forms part of a wider group of trainee associations across the country. This gives us the opportunity to participate in U.K. wide QI and research.

Results

Our projects have been presented nationally and internationally and been published in peer reviewed literature. These pan-deanery projects have led to measured improvements in 7 hospital sites within NHS Lothian, NHS Borders and NHS Fife. In a recent trainee survey, (n=20) 60% of respondents had been involved in a SQUARES net project and 35% had attended a QI methodology teaching session hosted by SQUARES net.

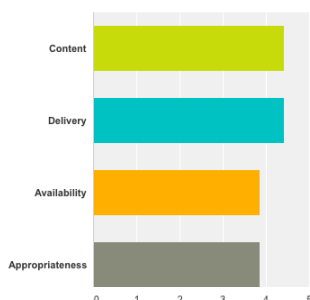
Thinking about what SQUARES could/should achieve for trainees, which of the following would you find most useful?

Answered: 20 Skipped: 0



How would you rate the quality of QI teaching from SQUARES Net?

Answered: 7 Skipped: 13



Conclusion

As health professionals, we aspire towards continual improvement in the delivery of quality care. QI methodology is recognised as a means by which this can be achieved. By identifying a gap in anaesthetic trainees' education, SQUARES successfully educate our peers, promote QI methodology and improve patient safety in South East Scotland.

Regular airway training improves confidence and competence in Foundation Year 1 doctors



K. Reid, C Ferguson, E Gaughan & S Kilpatrick

St John's Hospital, Livingston

Aims

Despite receiving Basic Life Support training during medical school, FY1 doctors reported low confidence in airway management skills. Simple airway techniques, if performed correctly, can be life saving. We planned to provide training in basic airway management to FY1s to improve their competence and confidence. This would be done during Foundation Programme weekly teaching sessions to minimise disruption to service provision, using existing resuscitation equipment.

Methods

- FY1s were invited to attend a simulation-based teaching session
- Participants managed a simulated emergency scenario, assessed by a structured marking scheme
- A teaching session on airway techniques was delivered
- Further opportunity to manage the scenario was offered following teaching
- Questionnaire to assess confidence in airway management

Results

Competence in management of a collapsed patient improves following skills teaching

FY1	Pre-demo	Post-demo
1	12	16
2	11	15
3	15	17
4	11	17
5	13	17
6	11	17
7	10	17
Average	10.4	16.5

Table 1: Seven FY1s attended a pilot session. None had received Basic Life Support training in the preceding 6 months. The average score (maximum 17) for the scenario was 10.4 prior to skills teaching, and 16.5 after.

Subjective confidence in all aspects of basic airway management is enhanced

	Pre-demo	Post-demo
Initial approach	4	4.1
Simple airway manouvres	3.8	4.2
When to use adjuncts	3.4	3.6
Choice and insertion of adjunct	3.2	3.9
Insertion of igel	2.4	3.8

Table 2: Mean Likert scores of confidence in airway management. Likert scale was 1= Never performed skill, 2= Not competent even with supervision, 3= Competent with supervision, 4= Competent without supervision, 5=Expert

Conclusions

- ✓ A simulation-based teaching session in basic airway management improves competence of FY1 doctors (Table 1)
- ✓ Subjective confidence of participants to perform various aspects of airway management was enhanced (Table 2)
- ✓ **Based on the results of this study, a new teaching session on airway management has been incorporated into protected foundation doctor teaching once in each 4 month clinical rotation to ensure regular skills update**

“Hands on practice in an informal environment”

“Excellent practical advice”

“Approachable tutors”

“Relevant”

“No pressure, good environment for learning”



An Innovative Approach to Undergraduate Peer Educational Clinical Skills Teaching

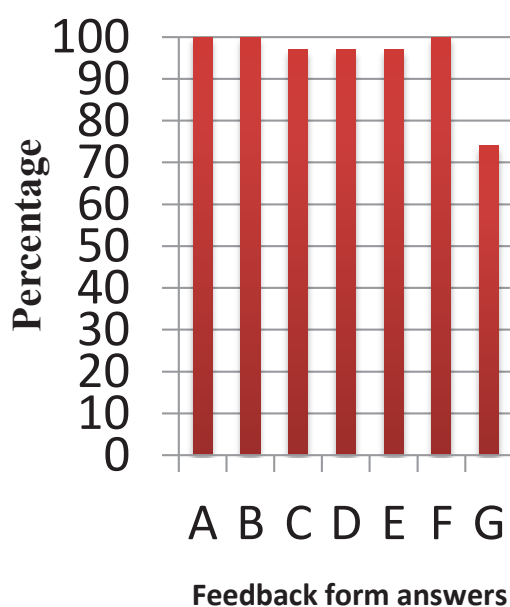
C. Robertson, Z. Al-Moasseb

Acknowledgements; University of Glasgow

Introduction

- Many medical schools use OSCEs to assess student practical performance
- In addition to school run formative events, peer groups (which are becoming increasingly popular) help students to pass these practical exams
- There are few, if any standardised, models to base peer education programmes
- The quality of these events and validity as teaching events vary
- We aimed to create a model for future peer education programmes with high tutor and student satisfaction

Results



A; Students rating event good or better (n=120)

B; Tutors rating event good or better (n=58)

C; Students and tutor felt this course was better than previous attended courses (n=178)

D; Students feeling incorporated teaching was needed (n=120)

E; Student now feels ready to sit OSCE (n=120)

F; Tutor supported integrated teaching time (n=58)

G; Tutor's agreed 2 minutes was optimum teaching time (n=58)

Methods

- We identified course weaknesses via social media surveys
- We created and ran a Mock OSCE, directed by year syllabus, with integrated teaching time (2 minutes)
- We created and provided tutors with comprehensive marking sheets, utilising curriculum and senior doctor approval
- 125 second year medical students signed up for the event, 58 junior doctors volunteered to tutor (tutors received teaching prior to event)
- Feedback was collected via hot debrief as well as tutor & student feedback forms

Discussion

- Our model appears to be highly successful and favoured by tutors and students
- The use of junior doctors to teach, second years in particular, was felt not to be necessary and could have been achieved with 4th/5th years from free text and hot debrief feedback
- From free text answers, students enjoyed the medical school's OSCE but felt it lacked as a teaching event. This finding is supported via the literature¹
- A key limitation was our inability to see how our OSCE affected pass rates – future years will help assess our model's effectiveness
- 2 minutes was calculated to be an optimum teaching time, although there is a trend to agree with this, future studies could allow optimisation of allocated teaching time
- Furthermore although teaching was guided it was not formally structured. Future projects could implement a structured feedback form in addition to marking sheets to help negate tutor variability²

References;

1. B. Chisnall et al, Evaluation of outcomes of a formative objective structured clinical examination for second-year medical students, international journal of medical education, 2015; 6: 76–83
2. N. Perron, The quality of feedback during formative OSCEs depends on the tutor's profile, BMC medical education, 2016;16:293
DOI: 10.1186/s12909-016-0815-x

Can a 'flipped classroom' approach improve learning of history taking and clinical examination in third year undergraduate medical students?

E MacDonald¹⁺², E L Cosgrove¹⁺², J G Boyle¹⁺².

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Background and Aim

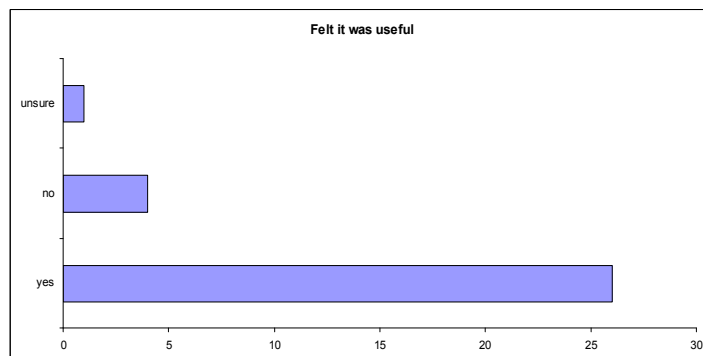
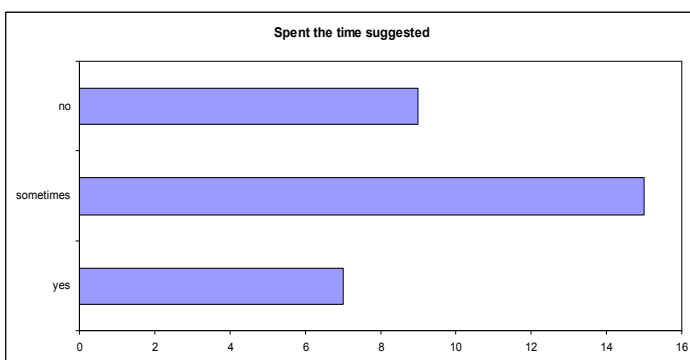
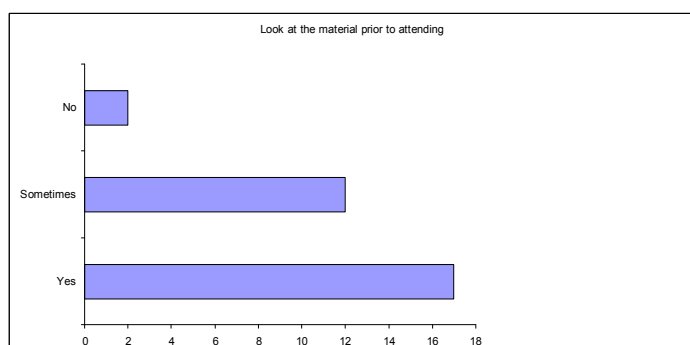
The flipped classroom allows students to engage in learning at a time, place and order suitable to them¹. It encourages students to take responsibility for their learning² and allows for greater exploration of clinical concepts. It should provide an opportunity for students to begin to develop clinical reasoning skills as basic concepts are covered prior to teaching sessions³.

Methods

Our flipped classroom took the form of prior preparation by students with online videos and a Microsoft™ PowerPoint™ slideshow of history and examination which should take an hour. This was accessed online by the students. This was followed by a teaching session to explore concepts further e.g. bedside teaching and case based discussions. Students were asked to fill in a questionnaire following the session to confirm if they had looked at the materials, if they spent the intended amount of time looking at the material, if they found it useful and if they felt more confident seeing patients as a result of the preparation.

Results

We received 31 feedback forms. All students had received the teaching materials in advance of the session. Of the students, 54% always looked at the material prior to the session, 38% sometimes looked at it and 8% never looked at it. Of those students who looked at the material they all said they felt better prepared for the session and only 6% felt it hadn't made them more confident going to see patients. When asked if they felt the prior preparation was useful 83% felt it was, 12% felt it wasn't and 3% were unsure.



Discussion

Many of the students seemed to enjoy this method of teaching as it allowed more time seeing patients rather than learning concepts. The main reason for not preparing in advance was that they felt we would go over the information on the day which we did end up doing for the students who were unprepared. Other concerns about the flipped classroom approach was finding the time to do the preparation in an already busy week. We therefore feel it is important to ensure that this time is available in the students timetable. A number of students commented on the fact that it allowed them to know the level expected of them. Students also felt better prepared and they felt that as a result they learnt more from the sessions.

Conclusion

Using a flipped classroom approach to teaching can be useful. Students get to spend more time practicing their skills instead of learning theory. The practical session becomes for consolidation rather than learning about a subject for the first time. The results of this study have demonstrated to us that this is also something that students enjoy. Our teaching program will continue to use this method however we plan to encourage more students to do the prior preparation by spending less time on the day going over the information which should have been learnt beforehand and more time seeing patients and practicing their skills.

References

1. Guest, D.D. and Staff, J. (2013) *What's missing from the flipped classroom model? AM rounds*. Available at: <http://academicmedicineblog.org/whats-missing-from-the-flipped-classroom-model/> (Accessed: 13 September 2016)
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Changing the Shape of Training.

Teaching Delivery for Doctors at Forth Valley Royal Hospital.

Dr Amy Tyler & Dr Claire Copeland
FVRH, Larbert, Scotland.

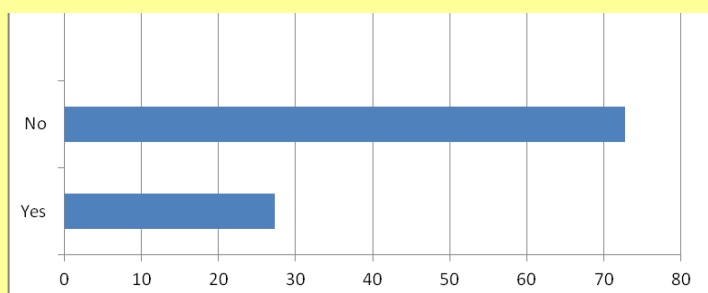
Situation

1. Trainees not meeting recommended teaching attendance.
2. Teaching provision felt to be lacking.
3. Currently, deaneries provide a monthly teaching session lasting 2-4 hours.

Background

- ♦ An average of 1 hour per week of *curriculum-relevant* teaching should be provided.¹
- ♦ Only 33% of trainees were aware of this.
- ♦ Trainees were surveyed on current teaching provision & **barriers to attendance**.
- ♦ A weekly teaching rota was created.
- ♦ Whatsapp group created

Assessment—is training adequate?



- ↓
- ♦ Ward commitments
 - ♦ Intensity of on-call work
 - ♦ Lack of awareness of sessions.

Recommendations

Shorter but more frequent sessions

Practical sessions

Encourage ownership of learning through trainee participation²

Sessions designed around curriculum requirements³

Use of social media

References

1. JRCPTB. Quality Criteria for Core Medical Training (CMT). 2015
2. The BMA. Employment and career advice. Teaching. 2012
3. The GMC. Promoting excellence: standards for medical education and training. 2016

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Foundation year one (FY1) doctors' attitudes and practices regarding the use of gloves and sharps boxes: influences and education



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Introduction

Wearing gloves for venepuncture/cannulation is recommended (1) as this has been shown to reduce virus transmission. A sharps box may also reduce needle stick injuries (2). Medical students initially learn venepuncture/cannulation in a clinical skills laboratory setting, followed by practising the procedures on clinical attachments. This study explores Foundation year one (FY1) doctors' attitudes and practices regarding the use of gloves and sharps boxes (PPE).

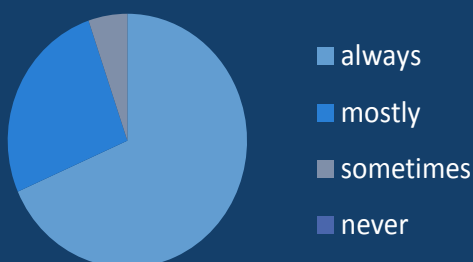
Methods

Foundation Year 1 Doctors (FY1s) in two Lanarkshire hospitals were asked to complete a questionnaire regarding their current practice and influences including educational experiences. There were 19 respondents. Ethical approval was gained.

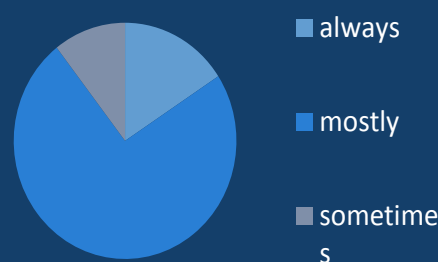
Results

- 68% reported always using PPE as students. Only 16% always use PPE in FY1
- 89% of FY1s reported they were always taught to use PPE in clinical skills laboratory teaching compared with 63% on clinical attachments.
- 16% reported having been actively taught not to use PPE at some point.
- Eight doctors' practice was influenced by a particular clinician, and only one of these doctors now always uses PPE.
- The reasons cited for not using PPE were difficulty palpating veins through gloves and a lack of availability of sharps boxes.

Did you use PPE as a student?



Do you use PPE as an FY1?



Discussion and Conclusion

- Multiple factors may explain why PPE is taught more commonly in the clinical skills lab than on clinical attachments.
- The reported factors affecting PPE use during FY1 were clinical, however education appears to be influential as some FY1s described role modelling, and many are being exposed to procedures being taught without using PPE on clinical placement.
- In my study, there was a high proportion of FY1s not always using PPE.
- Training for those who teach students on placement is essential to ensure that new doctors use PPE.
- Students should be taught strategies for vein location aside from glove removal. The availability of sharps boxes also needs to be addressed.

Dedicated time for workplace based assessments



Dr M Currer; Dr J Thomson

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Introduction

- WPBA are an intrinsic part of postgraduate medical training and certain topics and numbers are required to allow trainees to progress.
- The biggest challenge for completion is time, and assessments can become a “box-ticking” exercise rather than the valuable educational tool they can be if both trainer and trainee are engaged in the process.

Results/Discussion

- The system has been running for 6 months, and we have had good feedback from both trainees and consultants.
- Trainees find it easier to complete assessments and consultants feel less pressured during their clinical time.
- Not all trainees have provided “tickets” for immediate completion.

Method

- In Emergency Medicine (EM), it is difficult to give an appropriate amount of time and focus to discussions while on the shop floor.
- Our department decided to offer timetabled slots for completion of assessments.
- Each consultant nominates slots during SPA time that trainees can book.
- It is the trainees’ choice what type of assessment they undertake.
 - For CBDs we ask for a copy of the notes prior so they can consider areas for discussion.
 - For miniCEX, the trainee selects a patient in the ED and the consultant supervises their assessment and management, with clear time for feedback which is often not possible for the shop floor consultant to deliver.
- Allows ST4-6 trainees in EM to undertake Extended Scope Learning Events which look at shop floor management and non-technical skills in addition to clinical management.
- Forms should be completed contemporaneously.

Conclusion

- The system works well, ensuring adequate time for meaningful discussion and feedback.
- Trainees appreciate being able to plan their assessments, with a significant improvement in distribution of assessments over the whole placement.
- We plan to continue the system, making completion of electronic forms mandatory as delays devalue the educational benefit of feedback.

WPBA

=

Working together

Planned sessions

Benefits

All

“I find it helps to book in times with consultants to plan my WPBA ahead rather than in a rush near the end of the post. It also means I can choose a case that I want to discuss rather than the last one I have seen ” Junior doctor

“Trainees find it very helpful to have the dedicated & focused time with a consultant making the whole WPBA process more worthwhile and useful for all” – ED Consultant

Introduction

'Tomorrow's Doctors' reformed medical education, improving preparedness for transition to F1.[1, 2] Nonetheless students vary in how equipped they feel and there are established links between feeling unprepared and failure to cope in the workplace.[3] Mentoring improves satisfaction, social support, skills, professional behavior and reduces stress.[4] This concept of legitimate peripheral participation creates a safe ward learning environment.[5]

Aims

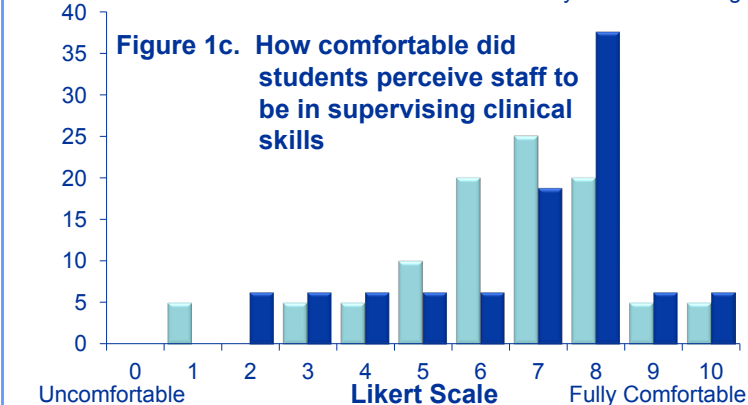
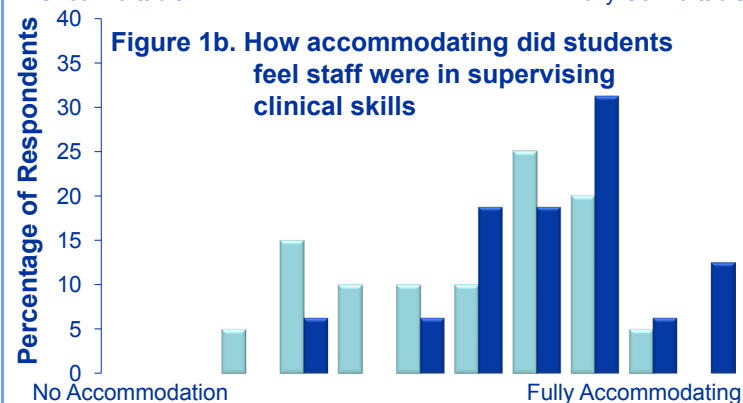
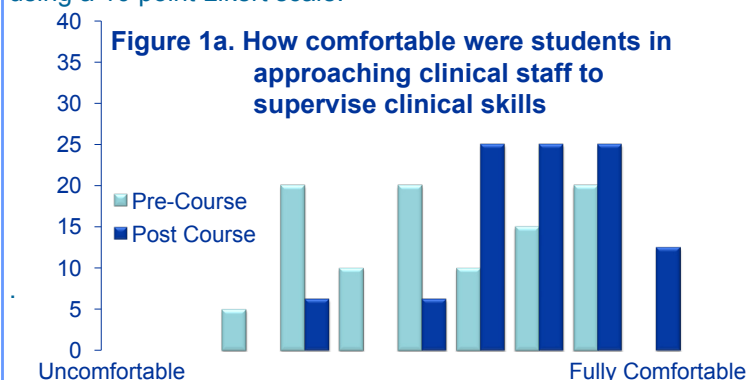
We aimed to increase student participation in ward activities, and create a welcoming and inclusive learning environment. We investigated whether routine F1 shadowing on clinical placements helped medical students in the transition to F1.

Methods

Fourth year medical student attitudes towards mentorship, preparedness for F1 and comfort in clinical settings were explored pre- and post-course. The F1s were questioned on their thoughts of acting as a mentor to the students.

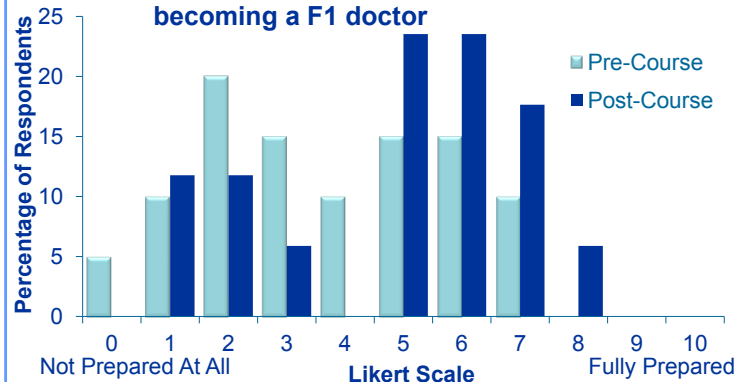
Results

20 pre- and 17 post-course questionnaires were completed using a 10 point Likert scale.



There was improved student comfort in approaching clinical staff (median 6 to 8), improved perceived staff accommodation for students (median 7.5 to 8.5) (**Fig 1**) and increased student readiness for becoming a F1 (median 4.5 to 6) (**Fig 2**)

Figure 2. Student self reported preparedness for becoming a F1 doctor



Pre-course data indicated students were keen to work with F1 mentors. Qualitative data (**Fig 3**) shows mentors were well received, made students feel part of the team and increased student involvement in ward work. Likewise 73% of F1's (n=11) surveyed felt mentorship was beneficial for the student, without detracting from their ability to complete clinical duties.

Figure 3. Word clouds generated from qualitative data of student opinions of F1 mentorship



Discussion

The compulsory F1 'shadowing' period introduced in 2014 has yet to be evaluated and the particular elements which equip a student for becoming a F1 have not been fully explored.[6] Likewise it is too early to understand what, if any, impact 'Promoting excellence: standards for medical education and training' with it's section on 'Outcomes for Graduates' will have.[7] Nonetheless mentorship/shadowing is often the most valued part of F1 induction and is associated with decreased F1 anxiety levels.[3]

Conclusion

Our study indicates that mentorship is beneficial to fourth year medical students enhancing their appreciation of independent medical practice. We propose that F1 mentorship for all undergraduate clinical placements may confer benefit.

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A smart app for smart trainees:

Developing a smartphone app to aid anaesthetic training in Scotland



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Introduction

The Royal College of Anaesthetists' (RCoA) training curriculum for anaesthesia¹ requires **over 800 competencies** are achieved over seven years of anaesthesia training in the UK. Many of these are evidenced by completion of workplace based assessments (WPBAs), which provide evidence the trainee has ultimately acquired the knowledge, skills and attitudes to be awarded the Certificate of Completion of Training in anaesthesia. In the 2015 vision document Realistic Medicine², the Chief Medical Officer for Scotland Catherine Calderwood stated:

"Doctors of the future must become innovators and engage in the use of technology to deliver medical education and improve patient care"

This study sought the views of anaesthetic trainees in Tayside as to the barriers to completion of WPBAs. A smart phone application (*Trello*TM) was then trialed. Trainees were surveyed following *Trello*TM implementation to assess changes to WPBA completion and access to training requirements.

Aims

This project aimed to evaluate whether the development and use of a training app improved accessibility to training requirements and WPBA completion in Tayside School of Anaesthesia.

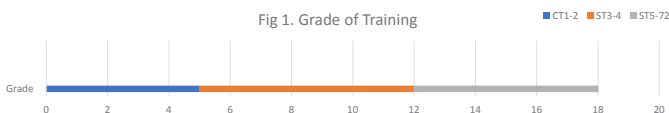
Methods

This was a prospective qualitative interventional study. Trainees at all stages of anaesthesia training were invited to participate. An initial questionnaire assessed trainee needs and formed the basis of app development. After implementing the app we re-surveyed the trainees to assess its efficacy and potential further developments.

Results

Following UREC approval, all anaesthetic trainees in NHS Tayside were invited to complete an 8-point online survey via email. 18 trainees (36%) responded to the initial survey.

Fig 1. Grade of Training



94% of trainees completed between 1 and 3 WPBAs a week. The majority accessed the curriculum via the RCoA website or local curriculum folders in the trainee's room. (Fig 2.)

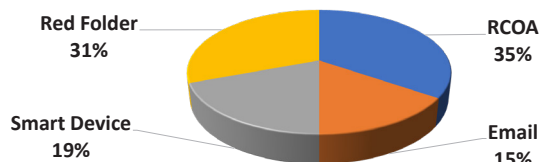


Fig 2. Source of information for WPBAs

Uncertainty over which WPBAs remained to be completed was the biggest barrier to completion of WPBAs (61%)(Fig 3.).

Fig 3. Barriers to WPBA completion

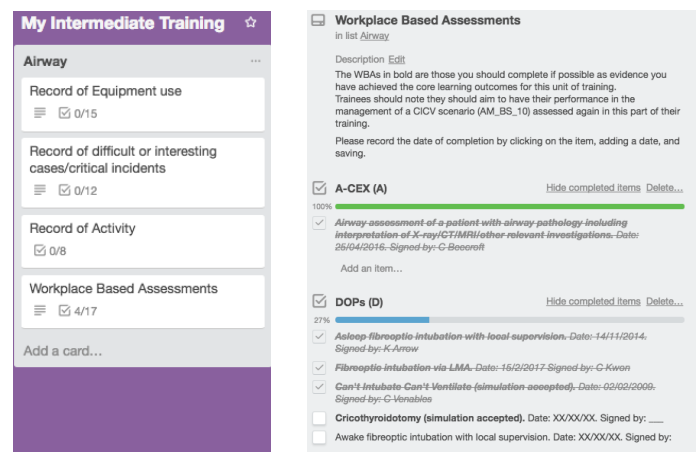
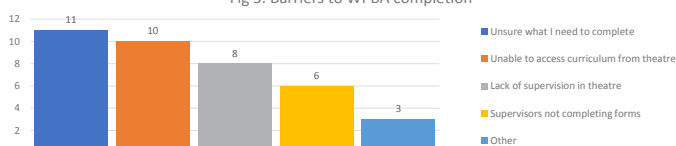
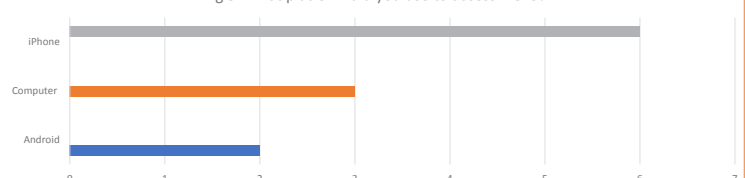


Fig 4. Trello App Screenshots

After the app was launched, feedback was obtained from 8 out of 13 participants (62%). Most trainees (75%) used an iPhone for access, compared to 25% using a phone supporting android software.

Fig 5. What platform did you use to access Trello?



75% found the app user friendly and most users utilised it frequently. (Fig 5.) A few problems were reported; they included difficulties setting up the personal account on the app, an absence of ICU/Pain training and difficulties ticking off boxes.

Being a trainee in an under-recruiting specialty: how does it feel?

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INTRODUCTION

Under-recruitment of trainees is a concern in a number of specialties and localities.¹ Anecdotal evidence and workforce data² suggests that knowing a department is short of trainees discourages trainees from applying. Hence, under-recruitment potentially is a self-perpetuating spiral immediately compromising care and, long-term, threatening availability of trained staff. This study focused on trainees in under-recruiting specialties. The aim was to explore their experiences, perceived effects and potential influences on future recruitment.

METHODS

This was a qualitative study. Semi-structured interviews were conducted with nine participants in two under-recruiting specialties, Anaesthetics and Emergency Medicine (EM), within one UK training region in early 2016. The approach of interpretive phenomenology³ with template analysis⁴ was adopted to frame data collection and analysis. Ethical approval was obtained.

RESULTS/DISCUSSION

Most participating trainees were satisfied with their training overall, with good departmental support being a key factor. The importance of formal teaching is shared by the trainees, however its prioritisation is varied between the specialties, contributing to perceptions of training. Trainees were determined to complete their programmes with some foreseeing breaks in training.



Positive Themes

Good departmental support

"We've got set lists of courses that are recommended, and the consultants have been really supportive in making sure that we get all the study leave." (P5)

"I had a problem when I was doing my final exam, just wasn't coping with working and studying... And the head of the department just said: Look take two, three weeks off... Just take unpaid leave and study at home until you get your exam. Just do your on-calls." (P4)

"There's a clear structure for on-calls... and they're always willing to come out" (P8)

Training protected by consultants taking on additional work

"The secretaries used to just bleep a trainee and say: Can you go to that theatre instead? But now they're not allowed to do that... the consultant body has sort of taken that... tried to cover that problem to help so that trainees can stay in their training lists." (P4)

"We've got a consultant on the shop floor from eight in the morning till midnight... from a training point of view that's fantastic, but then you're still getting a bit of autonomy overnight to run the department yourself, which is really good for training." (P5)

Formal teaching protected

"We have one full day per month dedicated to registrar teaching... we arrange them... we know from our curriculum, what we need to cover and what we struggle to cover in our day to day workload. So we try to target it at that." (P7)



Negative Themes

Work-life balance affected by clinical workload

"This Saturday we're short on a late shift and there's no one who is willing to do it. I know I'm free on Saturday, but... I feel like I've got this decision to make of, do I help my work or do I see my friend who I've not seen in a year who's in town?... You don't want to have to make those decisions. It shouldn't be a decision you have to make." (P9)

"I think what's difficult is trying to balance, like, home life, work life and having the extra burden of having to study as well." (P7)

Loss of senior trainees as second on-call (loss of training for critical decision-making)

"It is a shame, because there's definitely some educational benefit in being a senior trainee and being a second [on-call]. So having to kind of oversee a junior trainee doing things, them asking you for advice... So I'd only done that maybe two or three times before then you become the consultant who's getting asked." (P4)

Professional disrespect causing frustration and adversely influencing recruitment

"Emergency medicine... you hear people on the phone; we're notoriously associated as stupid doctors that can't make a diagnosis... it does get frustrating when you get the impression that the person you're trying to refer to is patronising you... and I think that puts a lot of people off." (P5)

CONCLUSION

The effects of under-recruitment are complex. The presence of factors producing effective clinical environments is important. Positive behaviours of seniors within departments to listen to and support trainees and training seem to offset detrimental effects of workforce shortage to some extent. Negative behaviours by others may outweigh these. The sustainability of the support given by consultants is uncertain however their engagement is central to the effectiveness of training.

Acknowledgements

Thank you to all the participants and the assistance provided by the Training Programme Directors in this study. This study was carried out by KY Chang as part of an intercalated degree focussing upon medical education.

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