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HOW TO IMPROVE SURVEY RESPONSE AMONGST FOUNDATION PROGRAMME TRAINEES, RESULTING IN A SHIFT IN CULTURE

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Introduction: North Tees and Hartlepool NHS Foundation Trust has 88 Foundation Programme (FP) trainees. They can be overwhelmed with numerous requests to complete surveys over the year. Our aim was to help the trainees understand the importance of the two main surveys we wished them to complete. These were the Foundation School Your School Your Say (YSYS) survey and the General Medical Council (GMC) survey. Any other requests for survey completion were filtered by the Medical Education Foundation Team throughout the year. YSYS compares the Trust with the other eight Trusts in the region on many different points from Educational Supervisor support, to Information Technology access. The GMC survey ranks the Trust nationally. Five years ago we did not have 100% response for these surveys. We decided to put together a strategy to improve the return rate.

Method: The FP team drew up a list of do's and don'ts as a code of practice.

Do

Ensure they understand the importance and how it impacts on their teaching and training

Be persistent, with gentle reminders. Reminders given via emails and at generic teaching

Show them how this is linked to the relevant domain in their e-portfolio

Motivate them by telling them the percentage of trainees who have responded as well as the Trusts regional position

Highlight who to contact if they have not received the link or are having any issues

Send the survey link to their personal emails, they sometime struggle to access emails at work

Book out a computer suite before teaching sessions

Congratulate and thank them for completing the survey

Don't

Don't expect all trainees will complete the survey independently

Don't overload them with numerous other surveys during the year

Don't mass email, only email those who have not completed the survey

Don't make a distinction between F1 and F2 trainees

Don't let a few negative and disengaged trainees impact on other trainees

DON'T BULLY THEM

Results: Since 2015 the Trust has year on year had a 100% response rate for YSYS. In 2016 and 2017 we also achieved a 100% response for the GMC survey.

Conclusion: We acknowledge that trainees find completing surveys a boring task and believe it fails to impact on their teaching and training. They may have move to another job or Trust by the time any actions on survey results have been taken. Perseverance from the FP team together with the strategy of encouragement and acknowledgement, can produce a significant shift in culture through the years. F2 trainees encourage the F1 trainees to complete the surveys. They have seen and experienced changes influenced by the survey results. This has also had a positive impact on the GMC survey this year amongst all grades of trainees. The Trust has 240 trainees and we received a 100% response rate this year.

Hopefully this impacts on trainees attitude and helps them to engage in other national surveys. It also helps to raise the team spirit and again hopefully the positive trend will continue in future.

References

<https://madeinheene.hee.nhs.uk/>

http://www.gmc-uk.org/education/national_summary_reports.asp

11-2

RETROSPECTIVE DATA COLLECTION RESEARCH AND AUDIT OF SERVICES AT A FEMALE GENITAL MUTILATION (FGM) CLINIC IN EAST LONDON

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Introduction

Violence against women is a pandemic of diversity and FGM is a leading example of a human rights violation on a global scale. With no clinical indication, at least 200 million girls worldwide have been subjected ⁽¹⁾.

The clinic staff need to know what they are dealing with to better their training/education to be able to better serve clients. Given the lack of audits/clinical research, there is a continuous need to evaluate the services that women with FGM access. This was the first project carried out at this clinic.

Aims

Improve services and staff training/education on FGM in our FGM clinic by understanding:

- Clients' profile
- Referral source
- FGM
- Management/follow up
- Safeguarding
- Notable inconsistencies

Standards: RCOG FGM guidelines

Methods

Analysis of client paper and electronic notes from 01/01/2015 to 31/12/2016 (2 years)

Results

Clients booked—37

Attended—31

Age range—16 to 63 years of age

Ethnicity—74% Somalian

Country of birth—61% Somalia

Self-referral—27%

GP—24%

Psychological issues—45%

Urinary problems—23%

Dysmenorrhoea—39%

Dyspareunia—39%

Difficulty with penetration—16%

Sex not pleasurable—6%

Asymptomatic—23%

Type of FGM—48% Type 3

Age at FGM—61% 5 to 9 years of age

Deinfibulation offered

Yes—36%

82% of which were deinfibulated

DEMEC 2017 – abstract poster submission : Category 11: Other

Anaesthesia – 78% Local

STD screening–16%

Contraception discussion–13%

No planned follow up–19%

FGM follow up–54% DNA

FGM law explained–61%

HSIC enhanced dataset and purpose explained–55%

Any daughters under the age of 18–16%

Would the client allow their children to have FGM–61% Not Documented (ND)

Clients aware of their own genitalia being abnormal

Yes–49%

ND–36%

Advocate present–97% ND

Interpreter present–97% ND

Cases not electronically coded–84%

Conclusion & Recommendations

1. The extensive results give insight into clients' profile, needs and what care is offered. Collectively this has filled knowledge gaps and points to improvements needed particularly with safeguarding.
2. Need for holistic service to address the complex cases, including psychosexual, social and medical management.
3. Further FGM training, education and guidance for healthcare professionals and continued advocacy campaigns.
4. Improve documentation by redesigning documentation template, move to electronic records.
5. Repeat: 2018.

References

- (1) United Nations Children's Fund. *Female Genital Mutilation/Cutting: A global concern*. UNICEF. New York. 2016. Available from: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf [Accessed 2nd March 2017].

11-3

IDENTIFYING THE ACTUAL SALARY COSTS OF FUNDED MEDICAL AND DENTAL TRAINEE POSTS IN WALES

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Introduction:

A fundamental role of the Wales Deanery (WD) is to ensure the use of resources allocated to training is used appropriately.

The placements for over 2800 training posts are managed within a constrained £46m budget allocated from Welsh Government (WG). Training posts are funded at the mid-point of grade plus associated on-costs. Due to budget constraints posts are funded either 100% Deanery, 50% Deanery/50% Local Education Provider (LEP) or 100% LEP.

Prior to 2015/16, despite receiving returns from LEP's, there was a lack of consistency in how data was being reported. This created uncertainty to make informed decisions around funding allocations which led to the criticism of funding levels being provided.

Methods:

Utilising limited available data on INTREPID (Trainee Database System) to produce a dataset of individual trainees against each training post throughout Wales for 2015/16

Working with NHS Wales Shared Services, the dataset was enhanced to include trainee National Insurance numbers as a key field, to allow cross referencing with LEP pay feeds. This dataset was used to create a template for LEP's to complete with actual salary costs for each trainee.

Upon completion of templates by LEP's, this data was amalgamated to create a detailed dataset of funding and actual spend for all Training Grade posts throughout Wales. This complete dataset was analysed to produce a wide range of reports showing actual costs against budget by LEP, by training level, by speciality, on an individual post as well as all of these combined.

Results:

Analysis has been provided using training post data and agreed funding allocations to over 2800 posts across Wales incorporating all specialities and grades. 90% of posts have returned actual salary costs when trainees were in post. For future years, systems have already been proactively put in place to reduce this differential to an immaterial level.

The changes made have led to a significant reduction in the input time required from LEP's into the process as the majority of data is provided in a consistent manner.

Using this as a base, further analysis has been possible including indicative total budgets for trainee salary and bandings, comparison of indicative budgets to actual costs incurred through data received from health boards. Data has been further analysed across percentages of post funding, health boards, specialities and grades.

Conclusion:

The data available and future analysis over a period of time will make a significant difference to the mechanisms with which training monies are allocated within NHS Wales. The process offers the potential to weight funding allocations based on specialties and/or locations.

Our understanding is that the data available is the first of its kind available in the UK.

11-4

STUDENT WELLBEING: HOW MEDICAL SCHOOL IMPACTS HEALTH SEEKING BELIEFS

Withdrawn

11-5

DR JARGON PAEDIATRICS: A TEACHING RESOURCE TO HELP HEALTHCARE PROFESSIONALS IMPROVE PAEDIATRIC COMMUNICATION SKILLS

Withdrawn

11-6

REDUCED ABILITY TO PERFORM EMERGENCY VASCULAR ACCESS AMONG MEDICINE AND SURGERY RESIDENTS

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Introduction: With increasing recognition of intra-osseous (IO) access as an effective alternative to intravenous access in critical situations, competence of skill by residents has increasing clinical value. Although previously demonstrated that skill acquisition can be rapidly attained with a single training session, little is mentioned about the ability to retain the skill with time or within a simulated clinical scenario.

Methods: First year residents were trained in proper placement of IO catheters via the EZ-IO device. A 2-hour training session by a certified instructor included review of indications, contraindications, alternatives, and site selection prior to hands-on training of the critical steps in the procedure. Each learner was required to independently demonstrate competence in IO placement on a synthetic model at the end of the session. Six weeks after the initial training, learners were tested in IO placement within a trauma simulation. Data was collected to evaluate learner retention of the critical steps.

Results: Among the learners, none had experience in IO placement prior to the initial session. All learners demonstrated competence in the skill after training. Within the six-week interim between skill acquisition and testing, none had additional exposure to IO in the clinical or training environment. With testing, 100% of learners retained knowledge of clinical indication, alternatives, and site selection, 73% recalled contraindications, 67% located the correct insertion site, 82% prepped the site, 27% selected the appropriate cannula, 73% drilled correctly; 55% confirmed proper depth; 27% confirmed marrow aspiration; 36% confirmed patency by flushing.

Conclusion: Although skill acquisition of IO placement is rapid after a single training session, there is demonstrable loss of skill retention with time. Factors which may contribute to this deterioration include lack of clinical exposure and testing within a simulated clinical scenario. A resident skills curriculum may benefit from repeated procedural training sessions in a simulated clinical setting.

11-7

HOW TO USE SMART PHONES SMARTLY

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Introduction:

As educators we have all delivered sessions in competition with learners' smart phones. The smart phone is a fixed feature in our society and as such can be an unwelcome presence in our teaching sessions. As medical educators we need to think of ways to incorporate smart phones into our educational sessions in order to promote interactivity, engagement and active learning. This topical issue is deserving of careful consideration and further discussion.

Audience response systems (ARS) have been in use over the last decade and have been shown to enhance student learning. We suggest based on our experiences that the smart phone and instant polling are an important extension of this, with a long list of positive features:

1. **Active Learning** – Connecting with learners through familiar mediums promotes engagement within the session
2. **Instant feedback for facilitators** – In line with constructivism facilitators can modify sessions in order to suit learners' needs and prior knowledge
3. **Instant feedback for learners** – One feature of effective feedback is its timeliness. Virtual polls allow for near-instantaneous feedback allowing learners to check and modify knowledge throughout the session
4. **Anonymous** – Learners can see where they sit within the cohort in terms of opinions and knowledge. Virtual polls are a safe environment where comments can be made and questions asked without fear of embarrassment
5. **Fun** – Virtual polls can introduce a game-like element and promote a collaborative learning environment
6. **Accessible** – The smart phone industry represents a £133bn industry within the UK, therefore the assumption is the vast majority of students will have access to one

Methods:

We utilised an ARS in the form of "polleverywhere" at the start of a teaching session to check prior knowledge, opinions and audience demographics.

Results:

This enjoyable interactive method allowed us to engage with our learners and we were able make small modifications so our teaching session was relevant to our learners. This supports many of the advantages we identified when using smart phones.

Conclusion:

As medical educators we need to embrace the technology boom and develop robust methods to involve smart technology into our teaching practice. We believe that interactive polls via smart phones can be used as a valuable adjunct to group teaching. By including the smart phone into our sessions we negate its use as a distraction and can engage our learners fully.

11-8

GIVING SOMETHING BACK: INTRODUCING GP TRAINEES TO TEACHING IN LOCAL SCHOOLS

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Background

Widening access to medicine and positively promoting general practice as a career presented an opportunity for GP trainees to become involved with schools in the locality. This project aimed to facilitate final year GP trainees to set up, plan and lead a school-based educational session for children

Summary of work

We identified primary and secondary schools in the local area, which were interested in inviting GP trainees talk to their pupils. The trainees arranged a session which reflected the needs/interests of the pupils, broadly: promoting medicine/GP as a career, healthy living and introducing pupils to the role of a GP.

Summary of results

Feedback shows the sessions were quite varied in content according to the schools' needs and that they were positively received by the all: trainees found the session uplifting, and innovative, whilst schools found the idea exciting and interesting. Participants (trainees and schools) found the sessions novel and useful. The scheme had, however, an unintended consequence in revealing need from the schools' perspective of more support for pupils' mental and social health.

Conclusions

The project helped trainees to gain wider experience of the locality and developing their educational skills. The schools welcomed the sessions and it allowed them to share some of the challenges they face.

Take home messages

The project demonstrated the need for closer interaction between schools and primary care to build links as well as to support schools.