FROM REALITY TO THE VIRTUAL UNKNOWN? HOW TO ENERGISE YOUR GROUP!

Ali, M*, Balachandran Nair, D, Bayoumi-Ali, M, Spolton-Dean, C, Vitello, S, Watkins, L. Cardiff University Medical Education, Cardiff University, Cardiff, Wales CF10 3AT

**Introduction**

In recent years, virtual learning has impacted on medical education. Virtual learning refers to education that does not restrict the learner in time and/or space.

One teaching activity that has evolved over time is the icebreaker. Icebreakers or energisers are used to engage learners by encouraging bonding and getting involved in specific tasks. Icebreakers are also important strategies to foster readiness to learn, allowing the educator to become acquainted with the learners and the group dynamics.

Traditionally, icebreaker activities have constituted face-to-face scenarios in group settings. However, as aspects of medical education are becoming virtual, so are ice breakers.

**Methods**

We used a construction activity as an icebreaker. We divided a group of 12 postgraduate students into two groups. Each group was given a specific item to construct by following a brief online teaching resource. Following this, one member from each group was asked to teach the opposing group how to make their item in person. The groups then discussed their experience of the virtual and face-to-face construction session.

**Results**

The learners enjoyed the online resource task, the benefits of which included allowing the learners to work at their own pace and review the online resource as often as necessary. It provided them with the opportunity to work as a group or as individuals.

A key issue that was identified was lack of feedback from the virtual resource, which prevented the learners from completing the task.

Some learners preferred the face-to-face construction task as the educators provided individualised feedback and tailored the instructions to them.

Overall, the learners responded well to the task, however, one group did not feel comfortable teaching the other group as they did not feel they had mastered the task well enough to teach it. This was an interesting finding as it resonates with clinical teaching situations where learners may not feel prepared after just learning a task themselves.

**Conclusion**

There are common features of icebreakers which are necessary whether it be in virtual form or face-to-face. It is important to ensure that icebreakers are related to future tasks in order to engage the learners early on. An icebreaker should be of the appropriate complexity and does not require any prerequisite skill. However, when face-to-face, educators can gain insight into the group dynamics.

As virtual learning becomes more prevalent, it is necessary to consider the use of virtual icebreakers not just as a way of engaging learners but also allowing educators to interact with them.
EVALUATION OF A PAN-LONDON TRAINING PROGRAMME FOR GERIATRIC MEDICINE
Kok K1, Meredith G1, Evans K1, Cottey M,2 Birns J1*
1 Department of Health & Ageing, Guy’s and St Thomas’ Hospital, Westminster Bridge Road, London
2 Care of the Elderly Department, St George’s Hospital, Blackshaw Rd, London

Introduction: Higher specialist geriatric training in London incorporates monthly, curriculum-mapped training days for specialist registrars. Historically, these training days were delivered locally in each of the four regions within London (North East; North West; South East; South West). Training programme directors from each region pooled their resources and developed a novel pan-London teaching programme to utilise the collective expertise.

Methods: Using validated assessment tools, a mixed-methods evaluation of the first four pan-London training days in geriatrics was used to analyse data from participants before and after training. This included both quantitative analysis from pre- and post-course questionnaires and thematic analysis of free-text responses about the course’s educational value and learning experience, with themes being developed by iteratively recoding and regrouping the data.

Results: Pre- and post-course confidence ratings in subject matter showed significant improvement following each pan-London training day (Table 1).

Table 1.

<table>
<thead>
<tr>
<th>Curriculum topic</th>
<th>n</th>
<th>Mean (SD) pre-course confidence score (range: 0-100)</th>
<th>Mean (SD) post-course confidence score (range: 0-100)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continence</td>
<td>35</td>
<td>49.1 (16.5)</td>
<td>68.8 (14.5)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Research, ethics and law</td>
<td>13</td>
<td>58.6 (17.4)</td>
<td>66.6 (12.3)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Service delivery</td>
<td>34</td>
<td>48.2 (17.8)</td>
<td>61.3 (16.1)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Medical negligence</td>
<td>23</td>
<td>58.7 (14.6)</td>
<td>81.9 (9.7)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Overall</td>
<td>105</td>
<td>53.7 (5.8)</td>
<td>69.7 (8.8)</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Qualitative analysis of free-text responses demonstrated 3 major themes for the pan-London training programme facilitating provision of ‘experts in the field’, maximizing subject matter delivery in a single training day, and the opportunity to network with trainees from other regions.

Conclusion: Training days are a core component of geriatric medicine training and a fresh approach and concept of providing them in a pan-London format was found to be educationally effective and efficient. Further analysis is required to evaluate the longer-term benefits.
A NEW AGE FOR THE OLD AGE TRAINEES’ CONFERENCE

Dr Charlotte Blewett, Dr Edward Dimelow, Dr Nick Long
Higher Trainees, Old Age Psychiatry, Sheffield Health and Social Care NHS Foundation Trust

Aim

To organize a national educational conference for old age psychiatry trainees.

Method

In November 2015, Sheffield-based trainees successfully bid to host the next Old Age Psychiatry trainee’s conference. To enhance attendance, the conference date was moved to January 2017, as fewer events were scheduled then that may clash. Invitations were extended to core trainees to showcase the specialty, which influenced the decision to theme the conference on clinical diversity in old age psychiatry. To achieve this, topics typically given less exposure were identified and speakers of high local and national reputation approached. A programme was devised with a mixture of lectures, interactive workshops and a debate. Trainees were afforded the opportunity to submit oral and poster presentations, with the best selected and judged by local consultants. The conference was held over two days to ensure broad content and allow networking opportunities.

Feedback forms were used to evaluate delegates’ views on the facilities and organisation, and the individual sessions using a 5 point Likert scale, and mean responses were calculated. Free-text feedback was also requested on positive aspects, and areas for improvement; this was evaluated with simple thematic analysis.

Results

69 attended the conference in total, with 68 as overnight delegates.

The mean global rating for the presentations was 4.32 (4.02–4.70). The mean global rating for the workshops was also 4.32 (ranging 3.86 – 4.77). The mean rating for question pertaining to the facilities and organisation was 4.60. These scores equated to a rating of ‘high’ to ‘very high’ quality.

The main positive themes were ‘well-organised’, ‘educationally valuable’, ‘good networking’ ‘relevant’ and ‘variety’. The main themes for improvement were ‘session-specific issues’, ‘facilities’ and ‘ideas for next time’.

Conclusions

The results demonstrate we delivered a high quality and diverse conference for old age psychiatry trainees achieving high scores for presentations, workshops, facilities and organisation. Suggestions from the feedback and the experience of the organiser’s will be used for future conferences.
EMERGENCY MEDICINE RUN THROUGH TRAINING IN THE UK: A PILOT

1 Health Education England; 2 Royal College of Emergency Medicine

Health Education England - Yorkshire and the Humber, Willow Terrace Road, University of Leeds, Leeds LS2 9JT

Introduction: The proposal to pilot run-through training in Emergency Medicine emerged from the Health Education England/Royal College of Emergency Medicine Workforce Implementation Group, in response to the workforce crisis within the specialty. It was hoped that the pilot would encourage specialty recruitment and reduce attrition. The 3-year pilot commenced in 2014 across all Deaneries and HEE offices.

Methods: Existing, eligible CT1, CT2 Acute Care Common Stem (ACCS) EM and CT3 EM trainees were offered the opportunity to convert to run-through status in January 2014.

1. Recruitment to 2014-2016 ACCS Emergency Medicine allowed successful applicants to choose either CT1 (uncoupled training) or ST1 (run-through training).
2. Recruitment to ST3/Defined Route of Entry-Emergency Medicine (DREEM) and ST4 Emergency Medicine would continue to allow additional entry points into EM training.
3. Annual surveys to Deaneries and HEE offices examined recruitment, run-through uptake, progression and attrition rates.

Results: In 2014, a total of 682 existing ACCS EM trainees were eligible to convert to run-through training; a total of 553 took up this option. Therefore, 81% of existing, eligible trainees in 2014 elected to move from uncoupled to run-through training.

In 2014, 88% of newly appointed trainees opted for run-through training via ACCS EM national selection. In 2015 and 2016, 87% of newly appointed trainees opted for run-through.

An increased number of applicants to ACCS EM has allowed an increased number of appointees since 2012. See Table 1. This has led to greater numbers progressing to higher training.

<table>
<thead>
<tr>
<th>Year</th>
<th>Posts Accepted in ACCS EM in UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>166</td>
</tr>
<tr>
<td>2013</td>
<td>236</td>
</tr>
<tr>
<td>2014</td>
<td>358</td>
</tr>
<tr>
<td>2015</td>
<td>373</td>
</tr>
<tr>
<td>2016</td>
<td>337</td>
</tr>
</tbody>
</table>

Table 1. New recruitment to Emergency Medicine training.

The proportion of trainees leaving the programme in 2016 has increased in comparison to 2015.

Conclusions

1. Run-through training is a popular option with trainees, as it removes the obstacle of an additional interview for those who complete curriculum requirements, and allows trainees to plan for 6 years (duration of emergency medicine training from ST1 to completion of training) as opposed to 3 years (duration of core level training).
2. The number of applicants to ACCS EM has increased sufficiently to allow an increased number of appointees since 2012.
3. A Retention Working Group is to be set up to examine the issues around attrition.
DOES A PERIOD OF IN-POST SHADOWING HELP TO PREPARE NEW FOUNDATION DOCTORS FOR PROFESSIONAL PRACTICE?

*Dr Campbell Z, L.  
*Intensive Care Unit, Brighton and Sussex University Hospitals, Eastern Road, Brighton, BN2 5BE

Introduction

The transition from medical student to doctor is a difficult time, with the change in responsibility comes increased anxiety and perceived stress. Various government initiatives, documents and policies have been primarily aimed at making this process more seamless, and in turn, decreasing the anxiety associated with this major transition. In 2011, Medical Education England, now Health Education England, proposed a strategy to tackle the transition process. This involved structured shadowing, immediately before commencing their post, for all new foundation doctors about to start work in the NHS. This was a national strategy aimed at making the process transparent, uniform for all junior doctors, more acceptable, and easing the burden of this transition. This research project aimed to explore whether this new approach to shadowing makes this transition process easier and whether it improves confidence about starting work as a foundation doctor.

Methods

This study is based on qualitative data gathered by interviewing seven new Foundation Year 1 doctors (FY1) at a district general hospital (DGH). The interviews were semi-structured and conducted between December and April of the FY1 year, which runs from August to August. The interviews were recorded, transcribed and analysed using a grounded theory approach. Major themes were sought and then explored in more detail.

Results

When shadowing is delivered in a structured manner immediately before starting work as an FY1 it improves confidence and decreases anxiety about starting work as a foundation doctor. The reasons for this are numerous and include: knowing the hospital, the job, the patients, and understanding their roles and responsibilities as a doctor.

Conclusions / Implications

The concept and practice of structured shadowing should be continued as it makes a real difference to confidence around starting work as a foundation doctor.

Feeling prepared to practice as a doctor is affected by numerous factors; these can be internal or external. Internal factors include personality, learning style and the development of professional identity. Identifying social and social-psychological barriers to transition may aid new doctors as they establish themselves within clinical teams. External factors include clinical placements, shadowing, induction and the support of others, especially clinical colleagues and supervisors. An increased awareness of organisational cultures as well as formally prescribed roles may make doctors more attuned to their new working environments.

The strategy to improve this difficult transition is multi-faceted and complex, but there are simple things that can be done. Following on from this project, deaneries should compare what works and what doesn’t work, and all foundation doctors should be given the same opportunities to have a positive and rewarding start to their professional career.
SIMULATION-BASED EDUCATION: UNDERSTANDING THE COMPLEXITY OF A SURGICAL TRAINING “BOOT CAMP”
*Jennifer Cleland1, Kenneth G Walker2, Michael Gale3, Laura G Nicol2
1 John Simpson Chair of Medical Education, Division of Medical and Dental Education (DMDE), School of Medicine and Dentistry, University of Aberdeen, Aberdeen, Foresterhill, AB25 2ZD
2 Highland Surgical Research Unit, NHS Highland and University of Stirling, Raigmore Hospital and the Centre for Health Science, Inverness, UK
3 Highland Medical Education Centre, NHS Highland and University of Aberdeen, The Centre for Health Science, Inverness, UK

Introduction
The focus of simulation-based education (SBE) research has been limited to outcome and effectiveness studies. The influence of social and cultural influences in SBE is unclear and empirical work is lacking. Our objective in this study was to explore and understand the complexity of context and social factors at a surgical Boot Camp (BC).

Methods
A rapid ethnographic study, employing the theoretical lenses of complexity and activity theory, and Bourdieu’s concept of “capital” to better understand the socio-cultural influences acting upon, and during, two surgical BCs, and their implications for SBE. Over two 4-day BCs held in Scotland, UK, an observer and two preceptors conducted 81 hours of observations, 14 field interviews and 11 formal interviews with Faculty (10, including Faculty lead, session leads and junior faculty) and participants (19 early stage surgical trainees/residents).

Results
Data collection and inductive analysis for emergent themes proceeded iteratively. This paper focuses on three analytic themes. First, the complexity of the surgical training system and wider healthcare education context, and how this influenced the development of BC. Second, participants’ views of BC as a vehicle not just for learning skills but for gaining “insider information” on how best to progress in surgical training. Finally, the explicit aim of Faculty to use SSBC to welcome trainees/residents into the world of surgery, and how this occurred.

Discussion
To the best of our knowledge, this is the first empirical study of a surgical BC which takes a socio-cultural approach to exploring and understanding context, complexities, uncertainties and learning associated with one example of SBE. We have shown that this kind of SBE is as much about social and cultural processes as it is individual, cognitive and acquisitive learning. Acknowledging this explicitly will help those planning similar enterprises and open up a new perspective on SBE research.

Acknowledgements
Our thanks to the Clinical Skills Managed Education Network (CSMEN) for funding this research.
MEDICAL EDUCATOR DEVELOPMENT IN WESSEX – FROM FOUNDATION YEARS TO CONSULTANTS AND BEYOND
Medical Education Fellows group, Health Education England (Wessex), Southern House, Otterbourne, Winchester, SO21 2RU.

Introduction
Health Education England Wessex (HEEW) has long believed in developing future medical educators. It recognises the educational landscape can be difficult to navigate, particularly when no clear developmental pathway exists. In response, over the last 10 years, what started out as a fellowship programme for higher trainees has developed into a ladder structure extending from Foundation Trainees through to Consultants, GPs and Staff and Associate Specialist (SAS) doctors.

Methods
The “Medical Education Fellows” (MEF) group was launched in 2005 to recognise the outstanding educational activities already undertaken by trainees. By breaking down silos between specialties, hospital and educational organisations it exposes trainees to a breadth of educational thinking, policy and leadership to develop their careers in education. It attracts no time or money, but rewards trainees with annual appraisal, development days, and the opportunity to organise a nationally accredited conference. It is led by one MEF and an HEEW Associate Dean.

Whilst the MEF group supports those already in the educational landscape, it became apparent that trainees with less experience struggled even to locate this landscape. Thus the MEFs developed a “Mentorship Programme” of one-to-one support as a precursor to the MEF role.

Likewise, whilst trainees who had recently completed specialist training continued to value the peer support provided by the MEF group, their needs were slightly different from the trainees so a linked “Medical Education Associate” (MEA) group was established, supporting MEF graduates through action learning sets.

Recent interest has been received from SAS doctors who, despite their wealth and diversity of experience, are often a neglected group.

Finally, annually one MEF undertakes a formal (i.e. time allocated and funded) “Secondment in Medical Education” with HEEW allowing a fully integrated experience of a higher education organisation.

Results
With over 50 past MEFs, currently we have 28 MEFs and 5 MEAs, providing mentorship to 14 mentees. MEFs have progressed to diverse educational roles including programme directing, research and lead university education roles.

Conclusion
We illustrate a ladder structure that has successfully supported the development of future lead educators in Wessex for over ten years. With current fiscal constraints such a structure (with minimal associated costs) could be very helpful for trainees and educators around the country.
USING FLIPPED CLASSROOM TECHNIQUES TO TEACH THE ACUTE INTERNAL MEDICINE CURRICULUM

Nicola Cooper
Consultant Physician & Honorary Clinical Associate Professor
Health Education England (East Midlands) and Derby Teaching Hospitals NHS Foundation Trust

Background:
The ‘flipped classroom’ describes an educational approach that reverses the traditional learning environment by mainly delivering instructional content outside the classroom (e.g. using online resources) and delivering activities, including those that may traditionally have been considered homework, inside the classroom. This approach has received a large amount of attention recently in the medical education literature.

Flipped classroom activities include activity learning or traditional homework problems. Examples include: small group activities, peer-to-peer teaching, skill development, practice exam questions, case based problem solving, debate, discussion, and project based learning. These activities allow more time to be spent in the classroom on developing higher order skills such as analysis, problem solving and clinical reasoning, as well as communication skills, teamwork and collaboration – while at the same time more effectively facilitating learning.

Methods:
In the East Midlands, there are 10 Acute Internal Medicine (AIM) training days held per year, organised by the Training Programme Director for Teaching & Learning. Around 20-25 Specialty Registrars attend. This allows flipped classroom techniques to be employed – to varying degrees – in the training day programme.

The poster will describe what was done - including setting up a dedicated website, mapping of the curriculum, and a description of the techniques used, with the opportunity for delegates to view two short videos on their smartphones by scanning QRG codes.

Evaluation and conclusions:
The poster will give examples of how this kind of teaching has been evaluated and conclude with the advantages and disadvantages of this approach to teaching and learning.
Introduction

Resilience can be described as the ability to bounce back or thrive in the face of stress and adversity. The literature has shown that physicians experience high levels of stress and burnout, and there has been increasing interest from the medical education profession as to whether doctors’ resilience can be enhanced through training. The GMC’s document ‘Doctors who commit suicide while under GMC fitness to practise investigation’ (2014) recommends that we ‘make emotional resilience training an integral part of the medical curriculum’. This work describes the creation and evaluation of a resilience workshop for junior doctors.

Methods

A discussion and activity based resilience workshop was designed specifically for trainees by a Leadership Fellow at Health Education England in the North East (HEENE). The content was based on a review of the literature, and trainees’ surveys. The workshop was advertised to all trainees in the region via email, and places allocated on a first come first served basis. A validated resilience scale called the Connor-Davidson Resilience Scale (CDRISC25) was used, whereby a higher score reflects higher resilience. This was completed anonymously by trainees pre-workshop, and 2 months post-workshop to evaluate whether resilience had increased and been maintained following training. Separate evaluation forms were completed during the workshop to assess course content, and trainees’ perception of the effectiveness of resilience training. Qualitative analysis of free text answers was performed.

Results

Workshop content included strategies to deal with stress, the use of positive psychology and a focus on well-being. The workshop was attended by 16 trainees in March and 14 trainees in April 2017. Of the March group, only one trainee felt the workshop did not increase their resilience, and all trainees felt that it met their aims in attending. The average CDRISC25 score pre-workshop for the March group was 67.7 (range 37-91, n = 15). The average CDRISC score 2 months post workshop had risen to 73.4 (range 60-82, n= 5). Further data from the March workshop, and full data from the April workshop are awaited. Qualitative data from the evaluation forms will also be presented.

Conclusions/Implications

This work suggests that trainees feel that resilience can be enhanced through training. This may help doctors to cope with a stressful work environment and could have other benefits such as reducing sickness absence, medical error, burnout and workforce attrition. Positive feedback from trainees suggests there is a demand for resilience training.
Background
A drop in recruitment numbers to general practice specialty training has left around a third of GPST (GP Specialty Training) posts unfilled nationally in 2015, raising concerns about the sustainability of the general practice workforce. The East Midlands deanery piloted a ‘Preparation for Specialty Training (GP) Scheme’ in 2014, which was successful and has been running each year since. This poster describes the establishment of a similar scheme in Wessex in order to support recruitment to specialty training.

Summary of work
A curriculum was designed and piloted for a new scheme - the Wessex Pre-Specialty Training Scheme (GP). It placed emphasis on the development of communication and professional judgment skills via reflective learning on practice, facilitated small group sessions, role play, observation and video consultations and shadowing a GP on a practice placement. Sessions were facilitated and evaluated by two GPST4 Fellows.

Summary of results
The scheme received positive feedback from participants, with three quarters achieving success in the application process for GPST during the scheme’s duration up until the end of the 2016 recruitment rounds. Feedback was gathered on the taught sessions to evaluate them.

Conclusions / Take home messages
The success of the scheme here and in other areas nationally, supports the use of structured educational input and GP placement time as a strategy to boost recruitment to specialty training. The scheme helped to equip early career doctors with important knowledge and skills required to be successful in gaining a place for GPST.
REFLECTION IN ASSESSMENT: IS IT JUST A GAME?

*Emily Edwards* (GP Education Unit), *Samantha Scallan* (GP Education Unit), *Johnny Lyon-Maris* (GP Education Unit)

GP Education Unit, Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

**Background**
The number of entries, curriculum links, and quality of reflective accounts are considered when writing the six monthly summative Educational Supervisor Report (ESR). There is wide variety in approaches to reflective writing taken by trainees and assessment relies on the judgment of one assessor. I wanted to explore the trainees’ views on the emphasis placed on reflection, their perceptions of ‘fairness’ and ‘validity’ of the process, and the subjective nature of the assessment of writing.

**Summary of work**
This piece of work was undertaken in the course of a GPST4 Fellowship year. A focus group was held with three first year GP trainees to explore their views. In addition they assessed an example reflective entry to look at its structure and focus. Findings from the discussion were examined in the context of literature in the field.

**Summary of results**
Participants recognised the value of reflection for personal and professional development. However, they also identified threats to the authenticity and quality of reflection due to: the number required, framing in the context of the curriculum, different beliefs about and styles of reflection, writing ability, headings used, and the need for better teaching about how and why to reflect. There was consistency in global impressions of quality of reflection in the example entry to suggest a degree of reliability in this assessment process.

**Conclusions / Take home messages**
Reflection in GP training appears to serve as a valid mode of assessment, though there is a need to examine and reduce the threats to the depth of reflection.


Introduction: Tomorrow’s Doctors’(1) states the expert use of ePortfolio is vital in progressing through foundation training, yet studies show Foundation Year 1 doctors (FY1’s) are not confident in its use(2). The national induction programme was established by NHS England in 2012, but gives no specific guidance(3), which has led to variety in course content(4).

FY1 Survival Guide (FY1SG) based in University Hospital Coventry & Warwickshire (UHCW) and George Eliot Hospital (GEH) offered peer-led teaching by Foundation Doctors to hospital inductees. We led a series of interactive workshops over three days with a focus on personal experience, one of which covered ePortfolio.

Methods: FY1SG was held in July 2016. There were ten (n=10) students at GEH and fifteen (n=15) at UHCW attending the ePortfolio sessions. Confidence questionnaires were distributed to students pre and post presentation. Questions covered confidence using the website, confidence in writing a reflection and listing types of Supervised Learning Event (SLE). Self-reported confidence scores pre and post presentation were then compared.

Results: The results indicated an improvement in trainee confidence. When asked ‘how confident do you feel about using the ePortfolio website’, 80% (n=10) of students in GEH stated they were not confident and 20% were not confident at all, while 64.2% (n=14) at UHCW stated they were also not confident at all. Questionnaires post session showed an increase to 90% feeling confident at GEH, with 37.5% feeling confident and 25% feeling very confident at UHCW. Similar outcomes were demonstrated with regards to understanding of FY1 requirements and confidence in writing reflections.

There was also an improvement in knowledge of SLEs, with 90% of students at GEH initially unable to recall a single SLE compared to 70% able to write at least three post presentation. At UHCW, familiarity with terms used in ePortfolio also greatly increased.

Conclusion: Our findings mirror previous studies(2) showing new FY1s lack confidence due to poor knowledge of ePortfolio terminology and requirements. The establishment of peer-led teaching alongside hospital induction has positively affected trainee confidence. This highlights the need for a standardised induction programme across deaneries with a specific focus on ePortfolio, as also identified by North Western Foundation School(5), and supports the introduction of the national ePortfolio in undergraduate training(6).

Objective:
An annual postgraduate Objective Structured Clinical Examinations (OSCE) for specialty trainees (ST) in Ear Nose and Throat surgery (ENT) and Plastic Surgery has been running in Health Education England North West (HEENW) since 2012. The purpose of this OSCE is to guide trainees on their progression through ST3-7 years, as well as provide an objective assessment for the TPD as compared to WBA (Work Based Assessments) in order to make an informed decision on when the trainee can progress to professional specialty exit examinations and subsequent certification of completion of training.

The aim of this study is to record the marks scored by 2 examiners completing a mark scheme which is a combination of a checklist and global scoring within an OSCE station. The inter-rater reliability (IRR) between the 2 examiners is assessed to see if there is variability and whether this is specific to a certain type of station or specialty.

Method:
43 stations were examined from ENT and Plastic Surgery ST OSCEs between 2014 and 2016, where 2 examiners were present in the station.

Inter-rater reliability analysis was conducted using intra-class correlation coefficients by two-way random, single measure ICC (2,1).

Results:
42 stations showed Inter-rater reliability analysis of "moderate" to "excellent" examiner agreement, ranging from 0.566 to 0.961 [ICC (2,1)=0.566, 95% CI: 0.131-0.812 to ICC (2,1)=0.961, 95% CI: 0.892-0.986].

One station showed "poor" agreement with a score of 0.378 [ICC (2,1)=0.378, 95% CI: -0.076-0.757].

Stations titled as viva, pre-op management, and practical were consistently placed in the categories "good" or "excellent". Stations assessing primarily management had consistently "moderate" agreement. Other types of stations had varied levels of agreement ranging from "poor" to "excellent".

Conclusions:
Many factors contribute to IRR, such as examiner bias, station format, ambiguity in checklists, conferring of examiners or hawk/dove examiners. Thus, where there is "poor" or "moderate" agreement, modifications could be made to those factors to improve agreement. In this study one station was found to show "poor" examiner agreement.

This study highlighted an overall "moderate" to "excellent" agreement between examiners, which leads to consider that the presence of two examiners may not be always necessary and consideration should be given to having only one examiner.
IS BASIC ULTRASOUND TRAINING A NECESSITY IN MEDICAL SCHOOL AND FOUNDATION PROGRAMME TRAINING?

*Dr. Pritika Gaur*, Dr. Dipal Mehta
3 Seymour Way, Leicester LE3 3LY

**Objectives:** To establish the views of current foundation year trainee doctors regarding the importance of diagnostic and procedural based ultrasound teaching in UK medical schools and foundation programmes.

**Methods:** An electronic survey was conducted of 60 current foundation year doctors from across the UK, presenting a series of questions aiming to assess current levels of ultrasound training as well as understanding whether this meets requirements and expectations in various clinical settings ranging from A&E to ITU.

**Main findings:** 83% of doctors had not previously received any formal basic ultrasound teaching in medical school or in foundation training. 36% of doctors were expected to perform basic ultrasound-based procedures under guidance in their various clinical postings e.g. US guided fascia iliaca block in A&E. As a result 93% of doctors felt there was a need for their medical or foundation school to provide teaching in ultrasound. In particular, there was found to be a need for teaching in ultrasound guided peripheral venous cannulation (94%), pleural procedures (91%) and ascitic procedures (81%).

**Conclusions:** Foundation year doctors appear to have an increasing requirement to be able to effectively use basic ultrasound in clinical practice. Despite this requirement there seems to be an unmet need in the form of formal teaching in medical schools and foundation programmes. Equipped with knowledge regarding basic ultrasound, foundation doctors would feel more comfortable applying this knowledge in the clinical setting, therefore leading to an improvement in patient outcomes.
INTEGRATING A NEW ACUTE GERIATRIC ROTATION INTO MEDICINE SUBSPECIALTY SENIOR RESIDENT TRAINING IN SINGAPORE – IMPLEMENTATION AND RESIDENTS’ PERSPECTIVES

*GOH K S
Consultant Geriatrician and Associate Program Director (Senior Residency), Department of Geriatric Medicine, Changi General Hospital Singapore
Changi General Hospital, 2 Simei Street 3, Singapore, 529889

Introduction
Management of geriatric patients is distinctive in the need to address complex needs and focus on the unique circumstances of each patient, modifying disease specific treatment guidelines to achieve holistic care. As the number of geriatricians does not commensurate with the growing elderly population, postgraduate medical education programmes should ideally incorporate geriatric medicine rotations; moreover the job scope of subspecialty medical consultants would involve significant interaction with the elderly. Prior to 2015, there was no requirement for advanced medicine specialty training programmes to integrate geriatrics into their curriculum. A new geriatric medicine rotation for medicine subspecialty senior residents (SRs or specialty registrar) was implemented.

Methods
Thirty seven SRs from 9 medicine subspecialties underwent a 1-month rotation in the acute geriatric unit of a tertiary teaching hospital in Singapore from 2015-2016. Teaching was delivered via acute geriatric unit rounds, multi-disciplinary team rounds, ambulatory clinics and topical lectures, in accordance with national residency training board recommendations. A cross-sectional survey of the SRs with regards to training methods, beneficial components and suggestions for improvement was conducted after the posting. Comparison of scores summating perceived beneficial components of the posting (positive feedback score) across subspecialties was performed using one-way ANOVA.

Results
The overall impression of the posting on the 10-point Likert Scale was 8.11 (SD1.07), with no significant difference between subspecialties. 73.0% of SRs did not cite any negative aspects of the rotation. Advanced internal medicine, infectious disease and haematology SRs provided the highest positive feedback scores (5.75, 5.0, 4.0 respectively; p=0.04). The most common components that residents found beneficial included: geriatric syndromes (59.5% of SRs), holistic interdisciplinary care (59.5%), comprehensive geriatric assessment (27.0%) and medication management (21.6%). Teaching during ward rounds (56.8%), geriatric consultations (43.2%) and multi-disciplinary rounds (32.4%) were the most valued training methods. The most common suggested improvements included requests for more ambulatory clinic and community exposure.

Conclusion
We have established a new geriatric rotation for medicine subspecialty SRs that was highly rated despite its short duration. This reflects residents’ appreciation of the needs of older patients as well as the importance of knowledge and application of geriatric principles, regardless of their subspecialty. Improving the rotation based on feedback may be achieved by increasing the posting duration. Integration of geriatrics content into residency training should be strongly considered for inclusion in all medicine subspecialty SR programs.
THREE (EDUCATIONAL) BIRDS WITH ONE (TEACHING MASTERCLASS) STONE

*Gregg SJ, Lee R, Round J, Vaughan S, Stellman R.
King’s College University London, St George’s University London and St George’s Hospital London
c/o King’s College University London, Advanced Paediatrics MSc.

Introduction:
Most teaching sessions attempt to educate just one group of learners. However, we sought to meet the learning needs of three different groups within a single workshop. We describe a novel approach in medical education combining observed micro-teaching and multidimensional feedback leading to the an effective session simultaneously for three separate tiers of participants.

Methods:
A one day ‘Teaching Masterclass’ was designed and supervised by a Teaching Fellow comprising facilitated, observed practical teaching experience in three formats; Small Group, Bedside and Lecture. Paediatric medical students were invited to session and they suggested topics. These were then allocated to MSc trainees, on a medical education module by the teaching fellow. The trainees then prepared ten-minute teaching sessions for the Masterclass. The fellow collated written feedback and facilitated discussion at the end of each session for MSc trainees on teaching performance.

The fellow had developed the session as part of a certificate in Healthcare Education, and was himself being mentored by a senior educator.

The MSc trainees completed a Likert Scale questionnaire estimating attitudes in each teaching environment. Feedback questionnaires were also completed by the medical students and teaching fellow.

Results

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre-course Mean Likert Scale Score</th>
<th>Post-course Mean Likert Scale Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel confident delivering small group teaching</td>
<td>5.2</td>
<td>8.5</td>
</tr>
<tr>
<td>I know how to make my small group teaching better</td>
<td>5.5</td>
<td>9.2</td>
</tr>
<tr>
<td>I feel confident delivering bedside teaching</td>
<td>5.5</td>
<td>8.5</td>
</tr>
<tr>
<td>I know how to make my bedside teaching better</td>
<td>6.0</td>
<td>8.7</td>
</tr>
<tr>
<td>I feel confident delivering lecture-based teaching</td>
<td>5.2</td>
<td>7.7</td>
</tr>
<tr>
<td>I know how to make my lecture-based teaching better</td>
<td>6.0</td>
<td>9.5</td>
</tr>
</tbody>
</table>

Likert Scale 1=Disagree, 10=Agree
No. participants=5

Free text responses in feedback questionnaires provided by medical students and the teaching fellow were also extremely positive regarding the educational value of the workshop.

Conclusions/Implications: Post course participant responses demonstrated increased confidence in delivering teaching in all areas observed in addition to increased self-awareness and knowledge of measures to improve delivery of teaching in the future.

Qualitative analysis of the free text feedback responses provided by MSc trainees, medical students and the teaching fellow also demonstrated extremely positive findings.

The authors recommend the wider use of similar models in postgraduate teaching training such as ST3 level registrar preparation courses.
TEAM APPRAISAL FOR FACULTY TEAMS: FROM EFFECTIVE STRUCTURES TO EXCELLENCE

Groves C, Wilkes K L and Saayman A G
Quality Unit, Wales Deanery, Cardiff University, Heath Park, Cardiff, CF14 4YS

Introduction
The Wales Deanery appointed Faculty Leads (for support of Trainees, Trainers and Quality) to each Local Education Provider (Health Board) in Wales in 2012. Subsequently, ‘Faculty Teams’, comprising all relevant stakeholders in each locale, were established to collaboratively support postgraduate medical training management.

Methods
The Deanery introduced annual Faculty Team Appraisals in 2013 to support continuous improvement in Faculty structures and function.

The initial objective was to understand organisational structures and systems within which Teams operated. The 2014 Appraisals focused on development of Team structures and processes with performance appraised against five key elements of internal group processes. By 2016, utilising the Aston Team Performance Toolkit\(^1\) and PRIMO-F\(^2\) framework for organisational development, factors impacting team function were explored with the aim of measuring team effectiveness through goal setting and review. 2017 Appraisals focused on identification and dissemination of best practice in Teams’ operation and activity.

Results
Over five years Appraisals have facilitated seamless transition from considering organisational environments to demonstrating team effectiveness and generating excellence in training provision.

Teams demonstrate increased cohesiveness and exhibit strengths including planning supported by a team approach, actively seeking opportunities for members’ development, increased engagement with Deanery and local training structures and an environment in which a Team and constituent members are proactive and innovation is encouraged.

Outcomes include Faculty Lead participation in scholarship and professional development activity, stakeholder involvement in Faculty Team activity facilitating succession planning, use of training quality concerns as the basis for quality improvement projects (sometimes led by non-clinical Team members), and direct, measurable improvements in postgraduate medical training quality pursuant to achievement of Team objectives set via Appraisal.

Conclusions
Implementation of Team Appraisals has supported the evolution of Faculty Teams from a position of uncertainty over members’ roles and Team function to a mechanism for effective training support for within Local Education Providers and, increasingly, a source of excellence in postgraduate medical training management.


TACKLING BULLYING & UNDERMINING IN FOUNDATION PROGRAMME TRAINING

*Hanley J* Director of Medical Education, O’Connor N Postgraduate Training Manager, O’Riordan A Foundation Programme Clinical Lead, Girdlestone A Workforce Development Assistant, Taberham M Workforce Development Support Officer
Newcastle upon Tyne Hospitals Foundation Trust, Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne, NE1 4LP

**Introduction:**
The Northern Foundation School ‘Your School Your Say Survey’ of Foundation Programme trainees (FPT) in 2015 indicated that that an uncertain number of FP trainees at Newcastle upon Tyne Hospitals felt that they had been personally subjected to and/or witnessed behaviour by others which has eroded their professional confidence or self-esteem.

The Trust has a zero tolerance to Bullying & Undermining behaviours and the Director of Medical Education alongside the Foundation Programme team developed a regular anonymous survey to gather information from trainees on the behaviours they were witnessing and experiencing.

**Method:**
The DME met with the cohorts of FPTs to discuss the results and signpost how trainees can access support and tackle behaviours themselves.

An online survey of 10 questions was developed which asked trainees whether they had witnessed and/or experienced any bullying or undermining behaviour and whether they had raised this with their Supervisor. Trainees were able to leave their contact details to discuss any concerns with the Director of Medical Education / member of the Medical Education Team.

The email was sent to FPT’s fortnightly and the Director of Medical Education met with the trainees at a mid-point, and at the end of the survey period to explore the results.

**Results:**
There were 768 responses to the survey.

- Of the 768 responses there were 55 (7%) reports of experiencing and / or witnessed bullying an undermining behaviour.
- Of the 55 reports only 10 (18%) were discussed with the trainee’s Supervisor.
- Of the 55 reports only 8 (14%) were discussed with the Director of Medical Education / member of the Medical Education Team.

**Conclusions / Implications:**
The survey method has been a successful way to gather information from the FPT’s.

It was reassuring to see that the absolute numbers of FP trainees reporting issues was low. However, those who did report problems were reluctant to discuss this further with either Supervisors or the Medical Education team. We are now working alongside an independent HR Officer who is exploring the barriers to raising concerns in this cohort.
FACILITATING CAREER DECISION MAKING FOR FOUNDATION PROGRAMME DOCTORS WORKING IN NORTHERN IRELAND

Harron C*, Parks L and Carragher AM.
Northern Ireland Medical and Dental Training Agency

Introduction

The GMC state that as part of their educational provision, learners must have access to careers advice and support. The Medical Careers Strategy and Shape of Training documents have indicated that careers support is particularly important at transitions in training e.g. that from Foundation to other training programmes. Previous research has indicated that doctors qualifying in the United Kingdom would appreciate enhanced careers advice.

Methods

This study used an action research approach to explore the career learning needs of Foundation doctors attached to the Northern Ireland Medical and Dental Training Agency (NIMDTA). Data sources included the feedback from careers educational events for Foundation doctors within the last 12 months, a focus group of Foundation doctors and a semi-structured interview with the NIMDTA Lead Educator tasked with the organisation of the generic skills programme for Foundation doctors. This data was analysed qualitatively by thematic analysis.

Results

Three themes emerged from the data analysis: delivery of knowledge by experts, enhanced access to resources and the contract between the Deanery and the trainees. The study revealed that the Foundation doctors wished to have more specific advice about career opportunities within specialities particularly around preparing competitive CVs. They identified barriers to this which included lack of knowledge of key career contacts, difficulties with securing experience within specialities of interest and the perception of incomplete information provided by the Deanery on flexibility within training.

A number of innovative solutions were highlighted. These included restructuring the career events which already occur, better signposting of opportunities and the use of technology such as webinars to overcome the restrictions placed by time and clinical practice. The research highlighted the importance of the contracting relationship between the trainees and those providing careers education on behalf of the Deanery.

Conclusions

Provision of careers resources for Foundation doctors remains an important source of support within training. Timely and enhanced access to relevant resources is of particular value.
DEVELOPING A NEAR-PEER STRUCTURED TEACHING PROGRAMME FOR THE MRCP PACES EXAMINATION

Hicken B*
Hereford County Hospital, Stonebow Road, Hereford, Herefordshire, HR1 2ER

Introduction: The PACES examination is difficult with only 45% of candidates passing. PACES teaching is sporadic and variable between hospitals, with few centres offering structured teaching. At Hereford County Hospital junior doctors found it difficult to organise and attend PACES teaching.

Methods: A structured PACES teaching programme was designed by a specialist registrar, including two one hour classroom sessions and one ward based teaching session per week. The structured teaching involved role-playing PACES stations under exam conditions, including presenting clinical findings and receiving feedback. Candidates were included if they were planning to sit PACES.

The main aims were to:

- Improve candidate’s overall confidence in passing PACES.
- Improve candidate’s confidence in performing each examination routine and eliciting positive signs.

All core medical trainees (n=6) attended regular sessions. Each individual completed a questionnaire allowing for qualitative and quantitative analysis. Using a Likert scale (0-10) overall confidence in passing and confidence performing each examination routine and eliciting positive signs before attending the programme was assessed. After three months attendance candidates were asked the same questions and the paired T-test was used to assess for a significant change.

Results: The mean increase in candidates overall confidence in passing was 4.8 (p=0.003). Every candidate’s confidence in eliciting positive signs showed a significant improvement after attending the programme. Every candidate’s confidence in performing each examination routine improved (table 1):

<table>
<thead>
<tr>
<th>Examination</th>
<th>Mean increase</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>3.0</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Abdominal</td>
<td>2.1</td>
<td>0.063</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>2.7</td>
<td>0.002</td>
</tr>
<tr>
<td>Neurology upper limb</td>
<td>3.0</td>
<td>0.002</td>
</tr>
<tr>
<td>Neurology lower limb</td>
<td>3.0</td>
<td>0.002</td>
</tr>
<tr>
<td>Cranial nerves</td>
<td>2.5</td>
<td>0.007</td>
</tr>
<tr>
<td>Speech</td>
<td>3.8</td>
<td>0.002</td>
</tr>
<tr>
<td>Station S</td>
<td>5.2</td>
<td>0.001</td>
</tr>
<tr>
<td>History taking</td>
<td>1.6</td>
<td>0.051</td>
</tr>
<tr>
<td>Ethics</td>
<td>2.3</td>
<td>0.009</td>
</tr>
</tbody>
</table>

Candidates awareness of the structure of the PACES examination changed from 33% (n=2) before to 100% (n=6) after. Every candidate stated the programme has changed the way they are now preparing for PACES and they would recommend this structure to others. The questionnaire revealed 100% of candidates found the sessions a useful revision aid, improved their medical knowledge and found tutor feedback useful.

Conclusions: A structured teaching programme has a positive impact on a candidate’s confidence and preparation for PACES. A structured teaching programme is recommended for PACES candidates across all hospitals.
A REGIONAL MRCP PACES COURSE DEVELOPED AND DELIVERED BY NEAR-PEER TEACHERS
Hicken B*, Twigg M
Hereford County Hospital, Stonebow Road, Hereford, Herefordshire, HR1 2ER

Introduction: The PACES examination has a pass rate of approximately 45%. Courses for the PACES examination are expensive and focus mainly on pathology recognition rather than structured physical examination and presentation of clinical findings which form 40% of the total marks awarded.

Methods: A free PACES routines course was developed by a specialist registrar. Candidates were invited to attend from the West Midlands deanery. They received a routines pack prior to attendance demonstrating how each examination should be performed. The course covered all examination based stations including station 5.

During the course candidates role-played each examination routine with clinical scenarios and received structured feedback on their performance.

The aims were to:
- Improve candidate’s confidence in performing each examination routine.
- Standardise candidate’s examination routines, allowing more time to focus on the identification of positive signs and presentation of clinical findings.

The course was delivered on two separate occasions and in total 11 candidates attended. Each individual completed a questionnaire allowing for quantitative and qualitative analysis. A Likert scale (0-10) was used to rate overall confidence in performing each examination routine before and after course attendance and the mean increase in exam confidence was analyse using a paired T test.

Results: 100% found the routines pack useful and agreed that structured examinations help candidates focus on other aspects of the PACES exam. All candidates reported improved confidence in performing clinical examination for 9 of the 10 topics covered.

The average value of the course was rated as 9.5/10. Candidates demonstrated a significant mean increase in confidence for each examination routine (table 1):

<table>
<thead>
<tr>
<th>Examination</th>
<th>Mean increase</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>3.63</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Abdominal</td>
<td>2.82</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>3.55</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Neurology upper limb</td>
<td>3.82</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Neurology lower limb</td>
<td>3.64</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Cranial nerves</td>
<td>3.64</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Speech</td>
<td>4.27</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Station 5</td>
<td>4.55</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Conclusions: This routines course has a significant impact on candidate’s confidence in performing each examination. Further development and roll out of the course across the deanery should be considered to allow more candidates to benefit.
Introduction: Near-peer learning has been shown to be useful in postgraduate medical teaching. There is little
dknowledge available about its applicability in the clinical setting, and nil in PACES teaching.

Methods: Candidates who attended the PACES routines course (n=11) were asked to complete two identical
questionnaires exploring their learning experience from teaching delivered by consultants and registrars.
The main aims were to:

- Identify whether near-peer teachers are more effective in delivering PACES teaching than consultants.
- Identify the quantity of teaching sessions attended.

Fifteen questions explored topics such as session delivery and teachers investment in the candidate’s exam.
Candidates rated each question using a Likert scale (1-5) and the paired T-test was used for analysis.

Results: Candidates attended an average of six registrar and four consultant sessions, all ward based clinical
teaching. Candidates average rating for registrar teaching was 4.8 and consultants 3.8 (p=0.01). 100% of
candidates felt registrars delivered teaching to the standard expected for PACES in contrast to 66% for
consultants.

For every question asked candidates demonstrated a mean increase in score for registrar colleagues compared
to consultants (table 1):

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean increase</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching improved my level of understanding about the subject</td>
<td>0.89</td>
<td>0.012</td>
</tr>
<tr>
<td>My level of knowledge on the subject is now</td>
<td>0.55</td>
<td>0.465</td>
</tr>
<tr>
<td>Teachers delivery of the information was</td>
<td>0.61</td>
<td>0.175</td>
</tr>
<tr>
<td>How would you described this as a use of time</td>
<td>1.27</td>
<td>0.001</td>
</tr>
<tr>
<td>How much did you enjoy the session</td>
<td>1.39</td>
<td>0.001</td>
</tr>
<tr>
<td>How much did the teacher appear to be enjoying the session</td>
<td>1.23</td>
<td>0.045</td>
</tr>
<tr>
<td>How relevant was the content</td>
<td>0.94</td>
<td>0.012</td>
</tr>
<tr>
<td>How would you rate the approachability of the teacher</td>
<td>1.27</td>
<td>0.017</td>
</tr>
<tr>
<td>How confident has the teacher made you feel about the PACES exam</td>
<td>1.89</td>
<td>0.012</td>
</tr>
<tr>
<td>How invested did the teacher appear in your exam success</td>
<td>1.67</td>
<td>0.067</td>
</tr>
<tr>
<td>How effective was the teaching at resolving your weaknesses</td>
<td>1.67</td>
<td>0.006</td>
</tr>
<tr>
<td>How aware was the teacher of what is expected in PACES</td>
<td>1.27</td>
<td>0.011</td>
</tr>
<tr>
<td>The teachers awareness of the PACES set-up was</td>
<td>1.34</td>
<td>0.004</td>
</tr>
<tr>
<td>How receptive was the teacher towards your input into the session</td>
<td>1.16</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Conclusions: Near-peer teachers deliver more effective PACES teaching and have a greater impact on a
candidates learning experience. This may be secondary to registrars recently passing and having a greater
awareness of its structure. Larger numbers are required to support these claims.
LESSONS FROM A REGIONAL APPROACH TO QUALITY IMPROVEMENT

*Houston, J¹, Kaufmann SJ¹, Newnham, A², Jesurasa, A³

1. Health Education England working across Yorkshire and the Humber, Willow Terrace Road, University of Leeds, Leeds, LS2 9JT
2. Paediatric Nephrology Department, Leeds Children’s Hospital, Great George Street, Leeds, LS1 3EX
3. Paediatric Neurosurgical Department, Alder Hey Children’s Hospital, E Prescot Rd, Liverpool, L14 5AB

Introduction: In 2016 the Academy of Royal Colleges recommended that Quality Improvement (QI) was included in the curriculum for all doctors in training(1). As part of a drive for culture change and support for continuous improvement, Health Education England (HEE) across Yorkshire and the Humber commissioned leadership fellows since October 2014(2). Working closely with Bradford Improvement Academy (IA), standards and a graded approach to QI training were developed in the form of ‘bronze’ (e-learning), ‘silver’ (1-day) and ‘gold’ (2-day) training(3).

Leadership fellows concurrently held engagement workshops that identified speciality schools and hospital trusts to participate in piloting the training. QI training was conducted in various trusts, however a lack of consultant training and lack of trust ownership were significant problems. To address this, training for consultants was developed and delivered, and a sustainable, trust-owned approach was championed.

Methods: We used a network of ‘gold’ trainers across the Yorkshire and Humber region to engage with QI training and strategy within individual trusts. We commissioned an annual conference to share good practice and with a view to developing a ‘community of practice’. The conference theme is ‘moving forward together’ and key goals include engaging primary care and multi-disciplinary health professionals. To this end, one of the keynote speakers is a GP and one of the workshops is devoted to engaging the multi-disciplinary team. We shared information and resources such as a QI ‘toolkit’, teaching slides and regional resources with local QI departments. We also developed a 2-day ‘practical’ course with a focus on supporting participants to complete a QI project between the two sessions.

Results: We found evidence of excellent QI work in the region including multi-disciplinary QI teaching; forums to support QI projects and QI project repositories. However, the QI offer varied greatly between hospital trusts. A number of different QI methodologies were being used. There was variable uptake of ‘bronze’ and ‘silver’ training. Common problems include QI training that was small capacity, not freely available or not well attended by frontline clinical staff.

Conclusion: This project demonstrates much good practice in the development of QI capacity and capability in Yorkshire and the Humber. We have found that ‘one size does not fit all’. However, allowing and supporting local methods to develop with oversight from HEE Yorkshire and Humber seems to be working and gaining momentum. To continue sustainable ‘embed and spread’ this approach should continue to be supported.

Acknowledgements: We would like to thank Maureen McGeorge, Dr John Bibby and the Improvement Academy for their work on this project.

References
3. Improvement Academy [Internet]. Improvement Academy. [cited 2017 May 18]. Available from: http://www.improvementacademy.org
SPECIALIST TRAINEE PERCEPTIONS OF JOURNAL CLUBS AS AN EDUCATIONAL TOOL IN ONCOLOGY

Hughes DJ (1, 2)*

(1) The Royal Marsden NHS Foundation Trust, Fulham Road, London, SW3 6JJ.
(2) University College London Medical School, Gower Street, London, WC1E 6BT.

Background:

Postgraduate medical education is centred around evidence-based medicine with a growing emphasis on continuing professional development. Oncology is one of many medical specialties with fast-paced research and updates, including new drugs, therapies and combinations of, which require trainees to readily adapt to new information that may inform daily practice.

Journal clubs are a well-recognised format involving critique and group discussion of recent literature with the aim of professional development. They are a useful way of keeping up-to-date with research and considered an effective tool in medical education.

There is no standardised approach to critically analyse a journal but a structured format can facilitate and promote acquisition of critical analysis skills.

This study aims to evaluate oncology trainee’s perceptions of journal clubs as an educational tool.

Method:

Specialist trainees (n=9) working in oncology at a tertiary oncology centre were asked to participate in a facilitated focus group on the topic of journal clubs as an educational tool. This qualitative study used thematic analysis of student perceptions with descriptive open coding applied to the transcript by the investigator. Codes were categorised into overall themes forming the basis of discussion.

Results:

The focus group of 9 participants generated 16 discrete codes, which were categorised into three overall themes (in bold). Trainees acknowledged the importance of journal clubs as an educational tool but felt they should be (1) relevant to their clinical practice. There was a shared concern over lacking the essential critical analysis (2) skills to fully participate in a journal club and a consensus that they should be focused towards their (3) training.

Conclusions:

Journal clubs can facilitate evidence-based education in oncology if they are directly related to clinical practice. Whilst trainees felt they did not have the analytical skills to fully contribute, they recognised the journal club as an opportunity to teach these skills. Further research is needed to develop a structured approach to journal clubs that allows development of critical analysis skills and promotes evidence-based medicine.

Acknowledgments and conflicts of interest:

None declared.
MRCP COURSES: KNOWLEDGE, ACCESS AND AVAILABILITY

Jawad S*, Bhandal M*
St Georges Hospital, Tooting

Introduction
The completion of MRCP is a significant and compulsory part of training and is required for progression to ST3 in the majority of medical specialities. Many trainees experience difficulty in the preparation of these exams, especially because it is hard to be aware of all the nationally available revision courses. Budgets vary between trainees so a comprehensive list would be ideal to help doctors to successfully complete the MRCP.

Aim and Methods
The aim of our project was to identify the current knowledge amongst post-F1 trainees of existing MRCP revision courses, and ascertain the demand for a comprehensive tool for courses in the UK. As a secondary outcome, we sought to find geographical discrepancies in course provision with a recommendation towards rectifying this.

To achieve this, we initially contacted multiple postgraduate centres across the country to gain information on the types of revision courses they provided for MRCP. We then asked them to circulate a simple online questionnaire to their trainees, consisting of questions with numerical scales as well as the opportunity to enter free text.

Results
Our primary online questionnaire had 37 respondents. The population was post-F1 trainees. These were all CMT trainees, with over 50% at CT2 level. 54% of respondents had attended at least one revision course, most commonly for PACES. When asked about how the trainees had discovered these courses, almost 60% replied with through word of mouth or colleague recommendation, rather than advertising or official documentation. Written responses for this question indicated searching online independently for available courses as well.

The most common course attended was PASS Paces (35%). 87% of courses attended were based in London, with very few attending those outside of London. Finally, a striking 100% of respondents replied ‘yes’ or ‘maybe’ to the suggestion of a comprehensive list of courses available in the UK.

Conclusions/Implications
Our questionnaire highlighted an overwhelmingly need for a comprehensive list of MRCP revision courses in the UK, to help trainees pass their exams. Currently only one website has attempted to put together a list of courses, however it focuses on PACES revision. We have therefore produced a list of all revision courses for MRCP Part 1, 2 and PACES, which has been circulated nationally to trainees. We want to make this list interactive, and so have spoken to the creators of the MRCP Paces website about making this a possibility.

As a secondary result, we identified the lack of geographical cohesion with courses, with the majority being held in London. This may give unfair geographical advantage to trainees in the South, and lead to increased time and financial constraints on those attending from afar. Thus we recommend that courses be designed in the Midlands or Northern areas, allowing for students from the North of England to have equal access to revision courses for MRCP.
RESPONSES TO TENSIONS BETWEEN SERVICE AND EDUCATION IN GENERAL SURGERY DESCRIBED USING PARADOX THEORY
Cleland JA1, Roberts R1, Kitto S2, Strand P3, *Johnston PW1,4, 1Centre for Healthcare Education Research & Innovation, University of Aberdeen, 2Department of Innovation in Medical Education, University of Ottawa, Canada, 3The Faculty of Medicine Centre for Teaching and Learning, Lund University, Sweden, 4The Scotland Deanery (North), NHS Education for Scotland, Aberdeen.

Introduction
Tensions between service and training expectations in pressured healthcare environments can have a detrimental impact on overall experience, training quality and job satisfaction. Management literature proposes that competing demands are inherent in organisational settings and it is not the demands as such that lead to negative outcomes. Rather, the people are the game-changing factor and how they and their organisations react to opposing tensions is important. Thus, we sought to explore how key stakeholders responded to competing service-training demands in a real-life surgical setting which had recently sustained a highly-publicised organisational crisis.

Methods
We used an explanatory case study approach in a general surgery unit. Public documents informed the research questions and semi-structured interviews (n=14) with key stakeholders were the primary source of evidence. Data coding and analysis were initially inductive but after the themes emerged, we used a paradox lens to group themes into four contextual dimensions.

Results
Tensions were apparent in the data, with managers, surgeons and trainees in conflict with each other due to different goals/priorities and divergent perspectives on the same issue of balancing service and training. This adversely impacted on relationships across and within groups. These tensions were long-standing but became apparent because of a public crisis. Yet while relationships and communication improved, the approach, or response, to achieving a better balance maintained the “compartmentalisation” of training rather than acknowledging education and service delivery are simultaneous and cannot be separated.

Conclusions and implications
Stakeholder responses to the tensions provided some temporary relief but were unlikely to lead to real change if the tension between service and training is considered an interdependent and persistent paradox. Reframing the service-training paradox may encourage adjusting responses to create effective working partnerships with which to furnish clinical learning environments. Our findings add to the body of knowledge on this topic, and will resonate internationally with all those engaged in clinical postgraduate training.
3-27
TO ERR IS HUMAN: SETTING UP A TRAINEE-LED RADIOLOGY LEARNING & DISCREPANCY MEETING - THE MERSEY EXPERIENCE
*Joseph R*, *Hare J*, Razzaq F, Rowlands P, Curtis J, Chawla S

1. Mersey School of Radiology
2. Imaging Department, Warrington and Halton Hospitals NHS Foundation Trust
3. Imaging Department, Royal Liverpool and Broadgreen University Hospitals Trust
4. Imaging Department, Aintree University Hospital NHS Foundation Trust

Introduction: In 2014, the hospitals of the Mersey region formed a collaborative hub for the reporting of out-of-hours CT (computed tomography) scans. The collaborative hub is staffed by four radiology trainees at grades between ST2-5 such that a 'senior' trainee is always on the same shift as a 'junior' which provides mentoring support. This new arrangement not only decreased the frequency of trainee on-call shifts thus allowing more training time, but also decreased the isolation felt by junior trainees whilst on-call. Every scan is reviewed by the consultant on-call, but one unintended consequence of the collaborative hub was the loss of face-to-face feedback from consultants regarding difficult scan interpretation. We endeavoured to combat this by setting-up a trainee-led learning and discrepancy meeting where errors and discrepancies in on-call reports could be discussed in an open and no-name, no-blame forum with a focus on education and learning from each other.

Methods: Two radiology trainees volunteered to lead the meetings. Cases were submitted by trainees and consultants across the region. The submissions were reviewed by the lead trainees, and cases with educational value were selected for presentation. A presentation was made giving brief details of the patient demographics and clinical information for each scan. The images from 18 selected cases were anonymised and uploaded to the regional imaging database.

Results: During the first meeting, the lead trainees took care to emphasise that the focus of the meeting was to be on education and learning from each other, rather than blaming one another or showcasing significant errors. The lead trainees presented each anonymised case, stimulating discussion where appropriate. Recurring errors were highlighted and tips for on-call reporting were shared amongst the trainees. Reviewing the images live was particularly helpful in illustrating key points. After the cases were reviewed, this was followed by a short lecture from a consultant on a challenging emergency radiology topic.

Conclusions: We present a narrative of the setting-up of a trainee-led radiology learning and discrepancy meeting. From our initial experience we feel that providing an open and no-name, no-blame forum for discussion of errors in healthcare can drive up standards by enabling trainees to learn from each other. There is heavy reliance on imaging out-of-hours for patient safety and management and ultimately, sharing our knowledge and experience in this safe environment can help radiology trainees in the interpretation of difficult scans and enhance patient safety.
REDESIGNING THE PATIENT SATISFACTION QUESTIONNAIRE (PSQ) USED IN GENERAL PRACTICE (GP) TRAINING

Rial J*, Sales B, Bodgener S
WPBA Core Group, Royal College of General Practitioners, 30 Euston Square, London, NW1 2FB

Introduction:
Patient satisfaction questionnaires (PSQs) are used by all doctors throughout specialty trainees training (collated as evidence in ePortfolios), as well as by consultants and GP principals as part of the appraisal/revalidation requirements. There is an increasing importance of the patient view as part of a ‘360-degree assessment’, recognising that patients are the end-users of health care. The PSQ collates information about a doctor, which can then be triangulated with other assessments. Evolving evidence suggests that the current Royal College of General Practitioners (RCGP) PSQ used during GP training does not adequately identify trainees in difficulty or provide discriminatory output values. At present there is no opportunity for patients to make free-text comments nor is there the opportunity to compare scores against peers to help benchmark the trainee.

Methods:
The RCGP Workplace Based Assessment core group has undertaken a review of the current PSQ; an evaluation of currently available PSQs was undertaken including those produced by the General Medical Council (GMC) and revalidation toolkits. A consultation was also undertaken with the Picker Institute to gain further expertise in patient experience.

The length of the PSQ was considered to ensure optimal completion rate in addition to gaining the adequate data covering broader competencies than in the current PSQ, which only assesses communication skills, and ethics. The rating scales were also considered in great detail to ensure all patients are able to understand and appropriately complete in addition to the tool being discriminatory between trainees performance.

Results:
A revised PSQ has been constructed in collaboration with trainees and patient representatives. It has subsequently been piloted in the GP setting. No patients reported any problems completing the questions or understanding their meaning and all questions were answered. We are currently undertaking a larger GP trainee pilot before submitting the revised assessment tool to the GMC for approval.

Conclusions/implications:
PSQs help trainees/doctors to reflect on how they work, and allow them to identify, modify and improve their practice. The revised RCGP GP trainee PSQ is shorter, more discriminatory, covers more competency areas, has the option for written feedback and can easily be compared against colleagues.
ASSESSING THE EDUCATIONAL QUALITY OF CLINICAL SESSIONS FOR CORE SURGICAL TRAINEES AND TRUST GRADES AT A REGIONAL PLASTICS UNIT

Khaw R* and Khwaja N
Department of Burns, Plastic and Reconstructive Surgery, University of South Manchester NHS Foundation Trust.

Introduction:
Alterations to rota arrangements at a regional burns and plastics unit improved compliance against Joint Committee of Surgical Training (JCST) quality indicators for consultant supervised sessions for plastic surgery core trainees. However, we wanted to study whether attendance at a consultant session directly equates with quality learning opportunities?

Methods:
A 2 week long prospective study was conducted in January 2017 evaluating the on-call shifts, theatre and clinic sessions of 2 core surgical trainees (CT) and 5 trust grade doctors (TG) at a regional burns and plastics centre. The quality of training sessions was assessed by the number of work-based assessments (WBAs) logged as well as their perceived usefulness using a 10 point Likert scale.

Results:
During the two weeks, 33 scheduled on-call shifts, 35 theatre and 12 clinics sessions were attended by the 7 doctors who participated in the study. Theatre sessions had an average Likert score of 7.4 (range 2-10), followed by clinic sessions with an average score of 7 (range 5-9) whereas on-call shifts achieved an average score of 5.6 (range 0-10). In total, 34 WBAs were submitted, with 50% WBAs (n=17) attained from theatre. Despite the lower Likert score, participants submitted 47% of WBAs (n=16) from the on-call shifts. Although there were 36 elective, 19 trauma and 3 burns theatre sessions available throughout the study period, 55% (32/58) had a CT or TG timetabled in the rota. In addition, 3 theatre sessions were attended out-of-hours through the participant’s own initiative. Only 15% (n=6) of the theatre sessions had participants involvement reported as “supervised scrubbed” (ST-S) or above. Participants reported they were mainly assisting (71%) or observing (13%) whilst in theatre.

Conclusions:
Efforts should also be made to improve learning opportunities during on-call shifts as this study illustrates that CTs and TGs alike utilise these sessions as a resource to document their clinical learning. Although the rota arrangements were compliant with JCST quality indicators, CTs and TGs are not getting valuable exposure whilst in theatre. Consideration of the cases’ complexity and the doctor’s level of experience does not seem to sufficiently account for this.
ARE PLASTIC CT TRAINEES GETTING TO THEATRE AND CLINICS? ASSESSING COMPLIANCE AGAINST JSCT (JOINT COMMITTEE ON SURGICAL TRAINING) QUALITY INDICATORS FOR CORE SURGICAL TRAINING IN PLASTIC SURGERY

Khaw R*, Khwaja N
Department of Burns, Plastic and Reconstructive Surgery, University of South Manchester NHS Foundation Trust.

Introduction:
The JCST (Joint Committee on Surgical Training) Quality Indicators for Surgical Training advise that Plastic Surgery CTs (Core Trainees) should attend 5 consultant supervised sessions, which should include three theatre sessions (one an emergency session) and one outpatient clinic per week. A retrospective audit was performed to determine compliance for Plastic Surgery CTs at a regional plastic surgery unit.

Methods:
For each Junior Grade, the average numbers of different sessions/week were calculated using rotas for August 2013 to August 2014. Following the results, ward cover sessions for CTs were minimised. The average session/week from August 2014 to February 2015 were re-audited and then a further re-audit was performed from August 2015 to January 2016.

Results:
For CTs, the average outpatient clinic sessions improved (from 0.3 to 0.8 to 1.2). Elective theatre sessions maintained above 1 (from 1.1 to 1.6 to 1.2) per week. Emergency theatre sessions saw the greatest improvement from 0.5 to 1.1 to 3 sessions per week. Ward cover sessions continued to be reduced; from 1.2 to 0.6 to 0.11 session per week. Over four sessions were missed per week due to leave, EWTD and nights, which leaves CTs ≤3 days/week to attend theatre and clinics as well as attending teaching and being on call.

Conclusions:
By formally allocating CTs less daytime ward cover; clinic and theatre sessions increased. Changes in rota working patterns may be required to do this. Further studies will include the review of educational quality of the consultant supervised sessions.
SUPPORTING THE DEPARTMENT IN DIFFICULTY

Kirtley J* General Manager, University Hospitals of Leicester NHS Trust, Department of Clinical Education, Jarvis Building, Infirmary Square, Leicester, LE1 5WW

Professor Carr, S Associate Medical Director/ Director of Medical Education, University Hospitals of Leicester NHS Trust, Jarvis Building, Infirmary Square, Leicester, LE1 5WW

Background

Competing pressures on the clinical environment are increasingly impacting on the quality of the educational environment. We have experience of a number of clinical departments where the training of junior doctors has been adversely affected and remedial action has been required to improve the environment.

Summary of work

This abstract describes a standardised process that has been implemented within a large UK Teaching Hospital when training challenges or issues within a department have been identified. A consistent approach has been taken, identifying key stakeholders and their responsibilities as well as reporting and monitoring arrangements.

Summary of results

The process consists of the following seven stages:

1. Issues identified
2. Initial communication
3. Analysis of data
4. Working group established
5. Action plan developed and monitoring agreed
6. Change implemented
7. Outcomes evaluated and reported

Each stage has guidance and minimum standards to be adopted. Data shows an improvement in departments where the process has been implemented.

Discussion

The process should be ‘scaled’ appropriately depending on the challenges identified. There should be representation from clinical, managerial and educational teams on the working group and junior doctors should be included unless there is a conflict of interest. A pro-active approach to data collection and analysis should be adopted, with the development of robust, local systems to ensure early identification of emerging challenges.

Conclusions

Use of a standardised process supports the department in their development of an action plan, monitoring and long term sustainability. The process can increase efficiency in resolving issues and improve engagement at Board level by introducing a clear direction to problem solving.

Take-home Messages

Early identification of challenges, a standardised approach to resolution and clearly identified roles and responsibilities will maximise the efficiency and outcomes of the increasing occurrence of departments with training challenges.
DEVELOPING TECHNOLOGY ENHANCED LEARNING (TEL) TO SUPPORT THE NORTHERN DEANERY EXAM TECHNIQUE COURSE FOR THE FELLOWSHIP OF THE ROYAL COLLEGE OF ANAESTHETISTS (FRCA) FINAL WRITTEN EXAMINATION

*Knight J, Noyes J
James Cook University Hospital, Middlesbrough
Anaesthetic Department, James Cook University Hospital, Marten Road, Middlesbrough, TS4 3BW

Introduction: In recent years the pass rate for the FRCA Final Written examination has been low nationally in part due to candidates poor exam technique [1]. In general one of the strongest indicators of student success is ability to participate in small group study [2]. For anaesthetic trainees, rota demands make attending small group sessions difficult. To address this we developed a course focusing on exam technique using Technology Enhanced Learning (TEL) to provide flexible small group study. We used the Quality Improvement Cycle of: Plan, Do, Check, Act, to improve the course.

Method: Plan: We developed a one-day face-to-face teaching session focused on exam technique. TEL, through a WhatsApp group, provided a platform to share summaries of articles read and discuss exam questions. A full mock examination was delivered one month prior to the FRCA Final Written examination.

Do: The first course ran from 12/10/16 until the March 2017 FRCA written exam, with 7 candidates. A second course began on 23/2/17 with 9 candidates.

Check: Feedback was obtained through questionnaires for the teaching days and SurveyMonkey for the TEL group work. Course success was also assessed by scoring candidates level of engagement in the teaching and group work and comparing it to their actual exam results.

Act: We developed the course based on the feedback from candidates.

Results: In course 1 candidates found the WhatsApp group particularly useful for Single Best Answer (SBA) discussion. Following the mock exam we introduced EasyClass to a struggling candidate. This was used to set and mark Short Answer Questions (SAQ).

Based on this we developed our EasyClass group to include all our candidates. Interim feedback from group 2 shows candidates are finding it equally or more useful than group 1 found WhatsApp (Graph 1).

From course 1, candidates who were considered to engage well in the course and in particular the WhatsApp group had better success at the most recent sitting of the written exam.

Conclusion: Using EasyClass as a TEL platform for group work for trainees has received positive feedback from candidates. Furthermore those trainees that engage well in such TEL go on to do well in the FRCA Final written Examination.


ENT VS PLASTIC SURGERY – A COMPARISON OF CROSSOVER OSCE STATIONS

M Kowal*1,2 medical student; L Garwood1 medical student; S Khwaja1 Consultant ENT Surgeon; N Khwaja2 Consultant Burns & Plastic Surgeon

1 Department of ENT, University of South Manchester NHS Foundation Trust.
2 Department of Burns, Plastic and Reconstructive Surgery, University of South Manchester NHS Foundation Trust.

Introduction:

Formative OSCEs (Objective Structured Clinical Examination) have been implemented in the North West (Health Education England North West) region to support the career progression of Otorhinolaryngology (Ear, nose and throat; ENT) and Plastic Surgery specialist trainees (STs). Due to common topics in the respective training program curricula, a number of identical stations were utilised for both assessments. The aim of this study was to identify any differences in performance between the two specialties, see if they were significant and expected and explore possible reasons behind them.

Methods:

Anonymised results from five iterations of formative OSCEs were used to obtain data on stations that featured in both ENT and Plastic Surgery assessments. Statistical tests were then employed to scores from eight stations. The confidence interval was set at 95% and the two-tailed p-values were reported. This allowed a comparison of identical stations sat STs of the two surgical specialties.

Results:

Eight identical stations had been used in both ENT and Plastic Surgery ST OSCEs between 2014 and 2016 inclusive. The ENT specialist trainees scored significantly higher marks than Plastic Surgery STs in the ‘rhinoplasty consent’ and ‘head and neck examination’ stations (p values = 0 and 0 respectively). The Plastic Surgery STs scored significantly higher marks in the ‘facial flaps’ station (p value = 0). The borderline statistical test result for the ‘rhomboid flap’ station (p value = 0.05) implied that Plastic Surgery trainees performed better in this task. There was no significant difference in performance of the two sets of trainees in the ‘pinnaplasty consent’, ‘neck dissection operation note writing’, ‘paediatric basic life support’ and the ‘operation game’ station (p>0.05).

Conclusion:

This unique comparison study has provided objective and structured evidence for the differences in performance between ENT and Plastic Surgery trainees. The observations support the use of transferrable stations between postgraduate OSCEs. This is particularly the case for generic skills which are common across all surgical specialties or specialty specific in those with areas of the curricula in common.
Introduction
In 2012 the Medical Education Team created a Conference to recognise the continuous development of medical training in Hull and East Yorkshire Hospitals NHS Trust. This abstract describes how the Conference, now known as Hull Education and Training Event - HEAT has developed from 2012 and the methods used to establish it as an annual event.

Method
We established a successful HEAT project team with administrative and technical skills. Our method is simple:

- Action Planning
- Programme
- Promotion
- Evaluation

Generating New Ideas!
We plan 12 months in advance, hold planning meetings, identify key leads for action points to successfully develop a concept that has grown into a well-known brand throughout our Trust and across the region.

Results
Below are the conferences held over that past 6 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Theme</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Making HEY Hospitals the Best Place to Train</td>
<td>43</td>
</tr>
<tr>
<td>2013</td>
<td>Safer Doctors, Safer Care</td>
<td>45</td>
</tr>
<tr>
<td>2014</td>
<td>Improving Quality for Better Patient Care</td>
<td>70</td>
</tr>
<tr>
<td>2015</td>
<td>Improving Patient Care Through Cultural Transformation</td>
<td>113</td>
</tr>
<tr>
<td>2016</td>
<td>Training by Assessment and Patient Experience</td>
<td>62</td>
</tr>
<tr>
<td>2017</td>
<td>Leadership – Opportunities to Excellence</td>
<td>109</td>
</tr>
</tbody>
</table>

Attendance has grown over the years. Our first conference in 2012 was held in an evening and following feedback we decided to move this to daytime. In 2013 we held this event in our Clinical Skills Centre to celebrate its second anniversary and the maximum capacity we could hold was 65 attendees. In 2014 we decided to include Core Medical Trainee’s Quality Improvement presentations for the first time. Trainees across the region presented to a judging panel, the winner of which went through to the Royal College of Physicians Learning to make a Difference Event. In 2015 we saw our biggest audience and also launched our Junior Doctor of the Year Award. This also saw the launch of the brand name HEAT! In 2016 our attendance dipped. Feedback highlighted that the QIP presentations from CMT trainees ‘did not fit’ so we looked to refresh ideas for 2017.

Conclusions/Implications
To enable the success of a large-scale event, it is essential that there is clear communication within the team members with a comprehensive action plan that has clearly set deadlines and leads for designated action points.

Our biggest hurdle is deciding the theme. We have learnt from 2016 that we need to choose topics that are current and interesting to attract the required audience. In 2017, we included Junior Doctors in our planning and this has also proved very beneficial with junior doctor engagement.
THE DRAMA OF COMMUNICATION: AN INTERACTIVE WORKSHOP TO ENHANCE COMMUNICATION SKILLS

Jo Murphy (Communication skills Consultant), *Johnny Lyon-Maris* (GP Education Unit), Samantha Scallan (GP Education Unit), Al Muir (Associate Lecturer, Bishop Grosseteste University)

GP Education Unit, Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

Background
Traditionally in training programmes for general practice, communication skills are taught by clinicians, enhanced by the use of direct observation techniques and video recordings of the trainee and patients or simulated patients. There are many similarities between a doctor’s communication skills and an actor’s performance abilities.

Summary of work
The workshop described here has been designed to highlight this crossover and thus help trainees develop their interpersonal skills. A drama-led approach looked at specific elements of the doctor and patient interaction. It analysed the relationship at various interaction points to promote greater awareness of the trainee-patient dynamic.

Summary of results
In this poster we describe how the use of professional drama skills can enhance learning for trainees by focusing on voice, gesture, the face and overall physicality, and present trainee feedback on the session. Using tried and tested drama techniques, trainees found the coaching helped them to heighten their response to their patients and extend their communication skills repertoire, without compromising their own authenticity. It sensitised them to how their body influenced interaction.

Conclusions
Coaching on communication skills using drama training has been well received by trainees, and their trainers, this poster describes how it may be used more widely.

Take home messages
Drama can add a new dimension to learning communication skills for the consultation.
A TRIP TO THE MOVIES: USING FILM TO FACILITATE COMMUNICATION SKILLS ASSESSMENT AND LEARNING

Dr Alexandra Macdonald, Dr Bryony Sales, Dr Samantha Scallan

Centre for Primary Care Education, South East Hampshire & Isle of Wight, St. James Hospital, Locksway Road, Southsea, Hampshire PO4 8LD

Wessex School of General Practice, Wessex Deanery, UK

Introduction

Communication skills are a core competency in the UK postgraduate Foundation Programme, but trainees lack opportunities to assess their development. Using film and television to teach communication skills in medicine is well documented (*Cinemeducation*). However, our approach of integrating this with role-play is novel in this context.

Methods

Facilitated sessions begin with a dramatic film or soap-opera clip covering a challenging communication scenario: breaking bad news, negotiating management plans or disclosure of a medical error. Literature suggests these are difficult communication encounters for doctors. The clip is paused at a critical point in the drama. The facilitator then replaces the patient and a trainee replaces the doctor. The scenario then continues through role-play. The rest of the group observes the interaction. The remainder of the clip is played, followed by group discussion. We find that the lighting, music and camera angles used in TV and film clips can set the scene and emotional content more effectively, draw in the trainee and make interactions feel more realistic.

All Foundation doctors on a General Practice (GP) rotation in Portsmouth have taken part in the Drama/Role-play Alternation Workshop (DRAW) since January 2014. Trainees completed pre and post-course questionnaires assessing communication skills confidence in various challenging situations.

Results

Confidence levels have consistently increased in all trainees in dealing with difficult scenarios. Foundation doctors report the DRAW session design adds significant additional benefit to their learning over and above standard role-play. The trainees describe the DRAW workshop as being the most useful and enjoyable teaching session they experience during their Foundation GP training, breaking negative associations with role-play. The film clip creates a more realistic role play scenario, which leads to deeper reflective discussions. The trainees are encouraged to share their experiences of difficult patient interactions, allowing peer discussion, support and problem solving to be nurtured.

Conclusions/implications

Film is an engaging medium within which difficult communication skills can be taught. The resulting interactions and discussions can be far more realistic and productive than those of staged role-play. The skills from DRAW are transferable between the hospital and GP setting, it also improves the trainee’s awareness of their learning needs.
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BELBIN AND BURNOUT IN GP TRAINEES
Dr A Macdonald, Dr B Sales
Wessex School of General Practice, Wessex Deanery, UK
Centre for Primary Care Education, South East Hampshire & Isle of Wight, St. James Hospital, Locksway Road, Southsea, Hampshire PO4 8LD

Introduction:
Burnout is a recognised syndrome impacting adversely on an individual’s professional and personal life and on patient care. General Practitioners are increasingly experiencing high levels of burnout. Evidence suggests burnout appearing as early as the training years. Recent data from Wessex LMC suggests 5% of GP trainees are talking about burnout. Certain demographics are known to correlate with higher rates of burnout, but this research could better identify those at risk. This could enable preventative strategies to be better targeted by educators.

Methods:
The aim of this research was to establish whether GP trainees’ Belbin profiles can predict risk of burnout to target resource-limited preventative pastoral support to the most vulnerable individuals. 26 trainees in final-year GP training completed a Belbin assessment which, together with observer assessments, categorised each into one of the nine Belbin types. They were also assessed on two measures of burnout level in trainees. The results were compared.

Results:
Of the 26 final-year trainees, 42% (11) scored highly in one or both of the GHQ-12 or OLBI burnout tests – a worrying figure. Separately, 38% (10) of the 26 trainees were Belbin profiled as either Completer-Finisher or Teamworker. The overlap between these two groups was remarkable: 90% (9) of the Completer-Finisher/Teamworker cohort were members of the high-burnout group.

Conclusions/implications:
Results suggest individuals with Belbin profiles of Completer-Finisher or Teamworker are much more likely to experience higher subjective levels of burnout during their training years than those with any of the other seven Belbin profiles. Although a small sample these results are clearly significant.
IMPROVING LEVEL 1 TEACHING PROGRAMME FOR PAEDIATRIC TRAINEES IN THE MERSEY REGION

Macwilliam J*, Hoyle E
Alder Hey Hospital, East Prescot Road, Merseyside, Liverpool L14 5AB

Introduction:

STEP 1 teaching is a monthly teaching programme for Level 1 (ST1-3) Paediatric Trainees in the Mersey Deanery. The teaching is organised by Paediatric trainees and is usually undertaken by Consultants from the tertiary centre where the teaching days are held.

Over the past 3 years, it has become clear that often the teaching topics are substandard and do not fulfil the *RCPCH curriculum. There is also a lack of teachers willing to dedicate time to this programme.

We therefore, as part of our Medical Education Fellowship, undertook an audit to identify the topics that were regularly taught over the past 2 years and how well the teaching complied to the RCPCH curriculum.

Results:

Compliance to RCPCH level 1 curriculum within Step 1 teaching was poor. Out of the 14 topics within the curriculum, three specialty areas had 100% compliance, four were never taught and of the other seven specialty topics, compliance of the teaching provided ranged from 20-88%.

Conclusions:

Certain specialties provided teaching that was very curriculum based, whilst others provided none or if they did, it did not adhere to the curriculum guidance.

There are many reasons why this may be the case including difficulty identifying teachers to provide teaching within a specialty, teachers not being provided with a list of objectives to meet within the sessions, teachers having different interests to those of the curriculum.

Due to this, we identified a quality improvement project to try and improve Level 1 Paediatric teaching and make it more compliant to the RCPCH curriculum.

Our aim is to create an 18 month rolling teaching programme incorporating each specialty area and gaining lecturers, not only from the tertiary centre but also from local district general hospitals with a keen interest in education to facilitate and provide teaching sessions. We are currently half way through the programme, and so far the informal feedback we have received has been positive, indicating the quality of sessions has improved.
A NEW APPROACH TO SUPPORT TRAINEE PROGRESSION GOVERNANCE WITHIN THE WALES DEANERY

Matthews Philip Professor * Sub Dean and Deputy Director of General Practice, Hon Professor at Swansea University Medical School, Frowen Beverlea, MSc Trainee Progression Governance Manager Wales Deanery Wales Deanery - School of Postgraduate Medical and Dental Education, Department of General Practice, Cardiff University, Neuadd Meirionnydd, Heath Park, Cardiff CF14 4YS

The purpose of this abstract/poster is to share practice of a centralised approach to ARCP Reviews and Independent Hearings.

Previously the coordination of a Review/Appeal was an “add on” to other people’s roles in the Wales Deanery. A draft policy existed but had not been operationalised. Coordination stood outside or parallel to speciality training programmes missing opportunities for improvement. Limited follow up missed chances to “look upstream” In 2016 the Wales Deanery set about to:

- agree an all-encompassing policy
- create a centralised specialised function/ unit
- implement a training and succession programme for Appeal Chairs
- create a governance framework linking Reviews and Appeals and ARCP Panels
- produce standardised documentation and guidance sheets

Tangible outputs have been achieved with a positive impact despite. For example:

- creating a centralised hub and dedicated secure email box with a single point of expertise, consistent advice and a quick response
- specialist support/ briefing sessions and guidance
- a comprehensive handbook / for consistent operational procedures
- dedicated training for lay members
- A new decision framework for Chairs at Appeals
- Another independent source of informal advice for trainees
- A suite of diagrams and flowcharts for training.
- A legal seminar for training programme directors
- Commitment to a post review of every Appeal.

Conclusions:

It is hope that our work can inform others. We think a centralised hub and specialist team is the most effective low risk approach. The standardisation of documents and guidance sheets have helped to overcome misunderstandings, poor practice and minimise the risk to the Deanery of challenge and expensive legal costs.

The team will focus look at more “upstream” activity to improve reporting which haa key effect on request for, and ultimate decisions of Reviews an Appeals.

Acknowledgements:

Professor Peter Donnelly FRCPsych, BA (Open) PGCME and Justine Cooper.
DEVELOPING A MRCP(UK) PACES TEACHING PROGRAMME WITH NOVEL PEER ASSISTED LEARNING ELEMENTS
*May A J, Marchant R, Ovens K (Brighton and Sussex University Hospitals)
Brighton Sussex University Hospitals, Royal Sussex County Hospital, Eastern Road, Brighton

Introduction:
Obtaining Membership of the Royal College of Physicians of the United Kingdom (MRCP(UK)) is a requirement for the completion of Core Medical Training (CMT) and of entering higher specialist medical training. The MRCP(UK) Part 2 Clinical Examination also known as Practical Assessment of Clinical Examination Skills (PACES) is traditionally perceived to be the most significant barrier to completion of the MRCP(UK). In 2009 the format of the exam underwent a change to restructure station 5 to assess candidates’ ability to integrate history taking, communication and physical examination (Elder 2011).

A peer led PACES teaching programme was developed at a teaching hospital with multiple hospital sites. This programme introduced peer assisted learning focussed initially on communication skills and then expanded to include the integrated station 5. This was in addition to traditional consultant and senior registrar led bedside teaching of physical examination that was already in place.

Peer assisted learning (PAL) is “learning through active help of peer group members” (Wadoodi 2002). PAL has been demonstrated to be an effective method of teaching communication skills in other medical specialties such as with anaesthetic trainees (O’Shaughnessy 2017) and psychiatry trainees (Chaturvedi 2010).

Methods:
The teaching programme was run across two PACES diets in 2016/2017. PAL sessions were planned to be once weekly in a 12-week period starting 6 weeks prior to the start of the exam diet. Feedback was collected from PACES candidates at the end of each diet alongside candidate pass rates. Candidates were asked to rank on 5 point Likert scale (from strongly disagree to strongly agree) the degree to which they benefitted from the PAL sessions as well as the overall programme. This was compared to feedback available from the previous 2 PACES diets in 2016.

Results:
14 out of 15 (93%) of respondents agreed or strongly agreed that the PAL communications teaching sessions were beneficial. 6 out of 7 (86%) candidates from the first diet of 2017 agreed or strongly agreed that the PAL led Station 5 practice was beneficial.

The overall teaching sessions over the two diets increased to 95 compared to 71 over the previous 2 diets.

All 16 (100%) candidates agreed or strongly agreed that the teaching programme was useful preparation for PACES. In the first two diets of 2016 9 out of 11 (82%) agreed or strongly agreed with this.

Candidate pass rates increased from 80% to 87.5% following the introduction of the PAL sessions.

Conclusions:
Peer Assisted Learning is an effective way of preparing PACES candidates for the communication stations and integrated station 5 that candidates find beneficial and leads to improved candidate results. Utilisation of peers as teachers through PAL is a feasible way of providing more PACES teaching and ensuring that all stations of PACES are covered within PACES teaching programmes.

References:


A BUNDLE OF NERVES? SELF-REPORTED ANXIETY IN FOUNDATION 1 (FY1) DOCTORS: A 6-YEAR ANALYSIS

*McCullough JH - Taunton and Somerset NHS Foundation Trust (1), van Hamel C - Severn PGME Foundation School (2)
(1) - Musgrove Park Hospital, Parkfield Drive, Taunton TA1 5DA
(2) - Health Education England, Deanery House, Unit D - Vantage Business Park, Old Gloucester Road, Bristol. BS16 1GW

Introduction: A growing body of evidence suggests that stressed and anxious doctors are more likely to make clinical errors, take time off work and to leave medicine altogether. However, there is relatively little data about anxiety among newly qualified doctors at the start of their career. Here we present repeated cross-sectional survey data collected over 6 years as evidence of a significant and growing burden of anxiety among Foundation 1 doctors (FY1s) in the UK.

Methods: We investigated self-reported anxiety among 6 consecutive cohorts of FY1s in the UK (2010-2016). In each cohort, participants completed an online survey during the first weeks of FY1 (total n=10,140), with a follow-up survey later in the year (total n=2,883). Participants completed the Leeds Self-assessment of Anxiety General Scale as well as responding to other Likert scale questions about workplace factors that may impact upon anxiety (e.g. “I feel part of a team”). Data was analysed descriptively and with bivariate correlation using SPSS.

Results: A large proportion of respondents screened positive for pathological anxiety in the first few weeks of FY1 (26.9%, n=2,657) and this figure remained high on follow-up (20.3%, n=566). Comparison of data across year-groups revealed a significant year-on-year increase in self-reported anxiety at the start of FY1 from 2010-2016 (r=0.02, p<0.05), but this trend was not significant on follow-up (r=0.02, p=0.31). Overall, anxiety was most strongly correlated with working beyond perceived competence (r=0.25, p<0.01), not feeling part of a team (r=0.22, p<0.01) and not knowing who to call for senior support (r=0.21, p<0.01).

Conclusions: This study highlights a large and growing burden of anxiety among FY1s, which is significantly associated with perceived lack of support. These findings potentially have far-reaching implications for:

- The trainee – growing mental health burden and risk of burnout
- The patient – care provided by doctors increasingly prone to error and less empathic
- The health service – workforce planning gaps due to sick leave and doctors leaving medicine

This study will inform further research into the following questions: Why are FY1s so anxious? Why is the prevalence of anxiety increasing? How can foundation schools better support FY1s?
Background
Feedback from GP ST3s has suggested several issues that compromised their learning in the ‘out of hours’ (OOHs) setting. Many felt their induction was unhelpful, clinical supervision appeared variable and unstructured, and more preparation would have been beneficial. Few of their GP trainers did OOHs work and they struggled to achieve continuity in clinical supervision. We hoped a workshop might equip our trainees with the confidence and knowledge to drive their own OOHs learning more effectively and address the needs identified.

Summary of work
A workshop ran on a Saturday morning 2 months into OOHs training so that trainees would already have some experience. All our final year GP trainees were invited and 12 attended (~33%). We used a mixture of directed small group work (challenging scenarios), presentation to the wider group (effective use of clinical supervisors, available resources) and open discussion.

Summary of results
We asked the participants to evaluate the workshop by completing a short questionnaire. The participants rated the workshop highly. They felt it had helped them to plan and direct their OOHs training more effectively and found the small group discussion of challenging OOH scenarios particularly helpful (they would have liked more time devoted to this). They also appreciated learning about resources for advice and guidance outside normal working hours and felt better equipped to use the existing framework of clinical supervision.

Conclusions /Take home messages
The workshop seems to have motivated trainees to engage more pro-actively with their OOHs training rather than simply ‘complete the hours’. This year we will extend it to include other training patches and offer a greater focus on small group discussion of OOHs scenarios.
‘OUT OF HOURS’: EXPERIENCES OF GP TRAINEES AND THEIR TRAINERS

*Ollie Morris* (GP Education Unit), *Samantha Scallan* (GP Education Unit)

GP Unit, Education Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

**Background**
Developing competence ‘Out of Hours’ (OOHs) remains an essential component of nMRCGP with distinct challenges from the ‘in hours’ setting. Many GP trainers no longer do OOHs work and cannot personally supervise their trainees. Anecdotal evidence suggested that trainees were experiencing difficulties achieving effective OOHs learning, so we undertook some research to understand this further and identify how trainers felt about supporting them.

**Summary of work**
We invited all our newly qualified GPs to complete a survey about their OOHs learning and emailed their trainers for their perspective.

**Summary of results**
13 of our newly qualified GPs contributed to the online survey (30% response rate). They identified learning needs through discussions with their OOHs clinical supervisors and personal reflection. They found their OOHs experience valuable but limited by the variety of sessions available: most of their sessions were home visits and their confidence was greatest here. They had least experience and confidence doing telephone triage. 18 GP trainers responded via email; only two of these still did OOHs work. They felt confident supporting their registrars develop OOHs competences, citing previous experience or aspects of ‘in hours’ work that they felt posed similar challenges. Four trainers expressed concern that lack of current experience in OOHs limited the support they could offer.

**Conclusions /Take home messages**
Evidence is emerging that our trainees struggle to achieve experience and confidence across the full range of OOHs settings (car, triage, clinics). Lost continuity in clinical supervision requires them to take a more structured and proactive approach to their learning if it is to be comprehensive and remain effective.
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WORKING WITHIN A REGIONAL RADIOLOGY ON CALL HUB – A MERSEY TRAINEES PERSPECTIVE

J Mullany* (1), J Curtis (2), S Chawla (3)

1. ST3 Clinical Radiology, Mersey Radiology Training Programme, Health Education North West, Regatta Place, Brunswick Business Park, Liverpool, L3 4BL
2. Associate Head Of School, Mersey Radiology Training Programme, Health Education North West, Regatta Place, Brunswick Business Park, Liverpool, L3 4BL
3. Training Programme Director, Mersey Radiology Training Programme, Health Education North West, Regatta Place, Brunswick Business Park, Liverpool, L3 4BL

Introduction

Increasing demands placed upon radiology services particularly acute out of hours imaging resulted in a situation whereby the frequency of trainees out of hours of work was approaching unsustainable levels. This impacted on the wellbeing of trainees, reduced time spent ‘in hours’ training and occasionally rota’s being non-compliant contractually. An alternative, more sustainable system was therefore required.

Method

Each of the 7 hospital sites associated with the on call hub previously had their own rota staffed by trainees. The hub brought these sites and trainees together to provide an out of hours radiology service based across two sites (Broadgreen Hospital & Aintree University Hospital). Local hospital trauma protocol meant 1 trainee is based at Aintree University Hospital, whilst 3 trainees are based at Broadgreen Hospital. There is a senior (ST4 to ST6) trainee covering each shift.

Results

There has been a reduction in the out of hours shift frequency (1 in 6 rota frequency to 1 in 10 frequency). This has resulted in trainees spending more time ‘in hours’. Allowing for more dedicated training from consultants and less reliance on providing service. The varied case mix within the hub has enabled trainees to gain experience in reporting a variety of cases including invaluable trauma experience. Having a senior trainee on each shift allows junior trainees to run findings by them. This encourages collaboration amongst colleagues and has resulted in a more supportive and likely safer working environment. With 4 trainees on call at any one time it allows trainees to arrange appropriate rest arrangements amongst themselves.

The hub has been received positively from a trainee’s perspective. As with any new system areas for improvement have been highlighted. Working in a hub has resulted in trainees not performing urgent out of hours ultrasound examinations. This has been offset by increased training time ‘in hours’ and often more ultrasound experience. Anecdotally trainees enjoyed the personal feedback after each on call shift. The hub has resulted in less one to one feedback. An e-mail system providing on feedback has been developed, which aims to reproduce similar quality on call feedback.

Conclusion

The introduction of the regional radiology on call hub has resulted in a better work life balance and more in hours training. As such it is a model for providing regional out of hours radiology cover that other regions should consider adopting.
HOW CONFIDENT ARE YOUR NEW DOCTORS? BENEFITS OF A FOUNDATION DOCTOR-LED TEACHING PROGRAMME

Farmer J, Worcestershire Royal Hospital, Worcestershire Acute Hospitals NHS Trust
Keaney K, Heart of England NHS Trust
Vigneswaran N, South Warwickshire NHS Trust
Muthalagappan S, University Hospitals Coventry and Warwickshire NHS Trust, George Eliot NHS Trust
Kaur A, Leicester Royal Infirmary
Shirish D, Birmingham Heartlands Hospital, Heart of England NHS Foundation Trust

Introduction: The start of new foundation year doctors is commonly titled ‘Black Wednesday’ in the UK or the ‘July Phenomenon’ in US. This is an anxious time for patients and doctors alike with 4-12% rise in mortality rates (1,2). Studies (3) have shown induction programmes do improve confidence and competence. A specific example from University Hospital Bristol (4) showed a 45% reduction in critical incidents in the first 4 months due to induction training.

We identified a key opportunity to increase the confidence of newly qualified doctors through a peer-led induction region-wide teaching programme by current foundation doctors. The Foundation Year 1 Survival Guide (FY1SG) was delivered over two years, with a series of interactive workshops over three days.

Methods: FY1SG was held at both University Hospitals Coventry and Warwickshire NHS Trust and George Eliot Hospital NHS Trust. In 2016, the FY1SG ran over 3 evenings between 27-29th July 2016, alongside formal induction. Foundation doctors voluntarily attended the programme, with 15-35 inductees per session.

Teaching topics included interpretation of blood results, ePortfolio, daily review, task prioritisation, on-calls and prescribing. These were delivered in 20-minute sessions, with a focus on personal experiences. Registrars were invited to attend providing structured feedback to speakers. Feedback was collected both pre and post workshop, in anonymous survey format, with direct assessment of confidence levels using a numerical scale (1-7).

Results: Confidence levels improved in all teaching areas. Prior to the ‘Daily Review’ workshop, 50% (n=20) felt unsure about their confidence and 50% did not feel confident in performing a daily review of a patient, compared to 61.1% feeling confident and 33% unsure after the session. Prior to the ‘Task Prioritisation’ workshop, 21% (n=14) did not feel confident and 50% felt unsure, whilst post workshop, 71% felt confident and 21% were unsure. Additionally pre-workshop, 15.8% did not feel confident and 57.9% felt unsure about reviewing patient observations, charts and test results. Post workshop, 63.1% felt confident and 5.3% very confident in this area. Confidence levels were successfully measured for the other workshops and showed similar improvements.

Conclusion: These results demonstrate participation in FY1SG in addition to hospital induction established by NHS England in 2012 (5) improved confidence amongst new doctors, which hopefully will positively impact on safety and mortality ratios. These results also highlight the real need for a peer led induction programme throughout hospitals for the region, and a call for a standardised induction programme throughout the country, as concluded by North Western Foundation School with 88% of its participations agreeing for standardisation nationwide (6).


VODCASTS TO SUPPORT EDUCATIONAL SUPERVISORS IN USING THE EPORTFOLIO
*Nicola O’Shaughnessy* (GP Education Unit), Johnny Lyon-Maris (GP Education Unit), Samantha Scallan (GP Education Unit)

GP Education Unit, Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

**Background**
Educational Supervisors (ESs) are required to validate online evidence presented by trainees in their ePortfolio over the duration of the GPST training programme. There is no formal, hands-on teaching for supervisors on how to use the ePortfolio, save for a 45 page manual. We aimed to develop more user-friendly, interactive support that draws upon new wave educational technologies and approaches to learning.

**Summary of work**
As part of a GPST4 Fellowship year, a suite of short video tutorials (‘vodcasts’) was designed and created by the GP Fellow. The vodcasts covered a range of topics, for instance accessing the ePortfolio and performing the various supervisor management and validation tasks. They use a live supervisor’s account and are recorded in real time. Users can search for specific tutorials without having to watch long clips for the relevant segment.

**Summary of results**
Early feedback from users has been positive. The use of video tutorials gives supervisors a more interactive source of information on how to use the ePortfolio; users can work at their own pace, pause and rewind as needed and they can follow the steps in completing a task on screen in real time. A more formal evaluation is underway, including usage statistics, and this will be presented on the poster.

**Conclusions**
This vodcast pilot has broadened the educational support tools for supervisors, and as it has been positively received, with opportunities for future development.

**Take home messages**
Vodcasts can be a useful additional tool for educational supervisors in developing their supervisory practice.
INTRODUCTION

Ward rounds are complex interactions between clinicians and patients that have several functions depending of the stage of the patient’s admission. To improve the clarity and quality of documentation of the first consultant ward round following admission to our Integrated Stroke Unit we sought to introduce a Structured Ward Round (SWR) tool. The overall aim of the quality improvement project was to improve adherence to best practice whilst providing person centred care. This part of the project focussed on improving the accessibility of information for junior medical staff to help inform discussions with patients/carers.

METHODS

We performed a survey of junior medical staff regarding the content and design of the SWR tool with particular respect to communication issues. This took the form of a questionnaire seeking to identify trainees’ key communication challenges and what information to include in a SWR tool to assist them. Using an iterative model of PDSA (Plan Do Study Act) cycles we refined the tool during the initial phases of its introduction (Sept ’16-Jan ‘17).

RESULTS

We surveyed nine doctors in a variety of training grades (3xF1, 2xF2, 2xClinical Fellow, 1xGPST, 1xStR). All described being routinely involved in communicating with patients/carers in the acute post-stroke period. 17 communication challenges were highlighted, the most frequent being discussion of prognosis following stroke (9/17). This was also the most frequently asked question by patients/carers according to those surveyed. When preparing for discussions with patients/carers, trainees gather information from various sources, the majority (11/19 responses) seeking it from medical notes, especially consultant ward round entries. Despite this, only 2/9 trainees described the necessary information being easily accessible. All trainees felt that standardised information would aid their discussions with patients/carers.

CONCLUSIONS

Postgraduate trainees are routinely involved in communicating with patients/carers and rely on access to the relevant clinical information to inform discussions. This is particularly pertinent to conveying prognosis. Our postgraduate trainees have developed a SWR tool as one means of improving documentation of key information. Further work continues to assess the impact of this intervention and to determine other ways of improving communication with patients/carers, including using prognostic tools and improving patient/carer involvement.
ENQUIRY-BASED LEARNING: JUSTIFYING INNOVATION THROUGH CURRICULUM DEVELOPMENT

*Rachel Owers* (GP Education Unit), *Samantha Scallan* (GP Education Unit), *Johnny Lyon-Maris* (GP Education Unit)

GP Education Unit, Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

Background
In 2012 an innovative programme of facilitated case-based discussions educational sessions called Enquiry-Based Learning (EBL) was implemented for GP trainees (ST1/2) in Southampton and Jersey. Sessions run on a monthly basis focusing on a main clinical topic. A bank of topics has now been written which runs on a two-yearly cycle. Other curriculum themes run vertically through many sessions, such as consultation skills.

Summary of work
In presenting the innovation to other GP educators, questions were asked about the rationale and to justify the development and use of the new programme: how did we know it was ‘teaching’ what the trainees needed to know? How did their learning build up over the three years of training? To explore this one session, based on mental health, has been considered in depth as a ‘learning case study.’ The session has taken place in 2012, 2014 and 2016, and has been evaluated through feedback from learners and facilitators, and a review of the EBL case material.

Summary of results
The findings of the case study concern themes around:

*Resources*: better understanding by tutor of how the case material has developed in complexity;

*Curriculum depth*: a wider perspective on areas covered and how they link up across sessions /years

*Teaching methods*: sharper awareness of facilitator and trainee fatigue – identified scope to better pace session to optimize engagement and learning

Conclusions
The EBL approach to ST1/2 education has allowed programme director educators to move beyond understanding session feedback as isolated events and instead see how it integrates with the programme as a whole and over time. Ongoing development and review sees future steps to involve trainees and facilitators to a greater extent and further examination of the ‘flow of learning.’

Take home messages
Justifying the EBL approach has led to greater understanding of its evolution, and insight into the learner /facilitator experience. Evaluation has highlighted the ongoing development of case materials, curriculum areas and educational practice of the EBL approach.
INTRODUCTION

Within a large paediatric teaching hospital it can be a challenge to signpost the appropriate learning opportunities to the correct audience in a timely manner. After feedback from trainees and staff about lack of awareness of teaching events, and lack of integration across the trust, a need for clear communication of learning opportunities was highlighted as a priority. The Post Graduate Medical Education (PGME) team at Great Ormond Street Hospital (GOSH) had previously used traditional flyers and group emails to circulate events. We wanted to try a novel approach bringing together teaching opportunities from across the trust through a free app.

METHODS

Members of the PGME team were trained in use of a new platform (Guidebook) to create an app specifically for GOSH education. Within the app a teaching calendar of events was created with details of how to book (if relevant), venue, timings and main audience. The platform also allows sharing of relevant external and internal websites and trust projects. The app has been included in induction paperwork and talks to improve new starter engagement. At the same time the use of PageTiger for creating a weekly newsletter pulling together teaching opportunities for paediatric doctors was also trialled. We also continued to advertise events using the traditional methods.

RESULTS

There have been 199 downloads of the app and 1233 sessions since it was launched in September 2016, with peaks noted around induction of new junior doctors. There have been challenges, particularly getting awareness of the app to all staff groups. Existing staff groups remain a challenge to reach. Over the course of the introduction the content of the app has evolved to include one of the projects for appreciative inquiry in the Trust, PRAISE tool, to allow positive feedback for colleagues. We are still gathering data on app usage and user experience.

CONCLUSIONS

Apps may not meet the needs of all staff entering the trust, but having a centralised location for all teaching across the trust allows for more coordination. Over the coming months we will continue with a quality improvement approach to developing the app functionality and promote its use. In the first instance moving to paper-free feedback for trainers through the app, automated sign in to the sessions, and allowing users to identify the key audience by colour coding teaching events.

ACKNOWLEDGEMENTS:

PGME team who have contributed to the development of this app and engagement.
3-50
FOUNDATION DOCTORS’ EXPERIENCE OF PATIENT SAFETY INCIDENT REPORTING
*Parks L, Lawson S, Hutchinson A, Carragher AM
*Parks L, Deputy Director; Lawson S, ADEPT Clinical Fellow; Hutchinson A, Clinical Facilitator; Carragher AM, Associate Dean and Director
Northern Ireland Foundation School (NIFS) at Northern Ireland Medical and Dental Training Agency (NIMDTA)
Beechill House, 42 Beechill Road, Belfast BT8 7RL, Northern Ireland UK

BACKGROUND:
In 2005 Foundation Programme training was introduced in the UK for the first 2 years of postgraduate medical training. To coincide with this new competency based medical training, a programme of “generic skills” was introduced in Northern Ireland with the aim of delivering interactive training on key topics to all new Foundation doctors.

This programme incorporated a module on Patient Safety which included discussion of critical incidents. Foundation doctors attending the training in 2007 completed a survey on their experiences of incident reporting.

The Patient Safety module was re-designed in 2013 with a greater emphasis on the benefits and barriers to reporting patient safety incidents, as well as highlighting the processes for reporting.

In light of this training and the wider evolution of patient safety culture in the NHS we felt it timely to survey our current foundation doctors to ascertain whether experiences and attitudes had changed over the past 10 years.

METHODS:
A survey based on the original work was electronically distributed to all foundation year two doctors. Their attitudes to reporting patient safety incidents were explored and compared with the previous group of foundation doctors.

RESULTS:
The original (2007) survey revealed 64% of foundation doctors had experienced a critical incident but only 21% had personally reported one. Involvement in a near miss was extremely common (93%) but only 16% of these were reported, with 12% of doctors having witnessed negative reactions toward reporting.

The recent survey shows that 43% of foundation doctors had experienced an adverse incident and of those that had, 45% had personally reported it. However whilst 53% had been involved in a near miss, only 21% of these were reported, and 26% of doctors had witnessed negative reactions to reporting.

CONCLUSIONS:
Reporting of patient safety incidents is essential so the incident can be reviewed and learning shared. Reporting systems serve an important function in raising awareness and generating a safety culture.

The trend amongst our foundation doctors remains that adverse incidents (those associated with harm) are more likely to be reported than near misses.

Unfortunately some negativity is still associated with reporting; the main barriers perceived by our foundation doctors included being unfamiliar with the reporting system, lack of time and fear of blame and consequences.

Education and feedback is imperative to encourage all frontline staff including foundation doctors to participate in the reporting of incidents in order to promote learning.
Introduction

In the UK, 2-6% of all doctors experience difficulties sufficient to raise concern about their performance. The Doctors and Dentists Review Group (DDRG) at Health Education England North-West receives referrals for trainees who have caused significant concern due to performance, conduct or health issues. The group ensures consistency and fairness in dealing with trainees in difficulty.

Aims

- Analyse the DDRG cohort and look at patterns of referral, process of management and outcome of each case and see whether it does what it is intended to do.
- Assess individual cases to evaluate whether earlier intervention could alter outcomes.
- Evaluate support given to trainees referred to DDRG and the trainee’s perception of the support received.

Methods

- Anonymised records of all trainees referred and on the DDRG database over the last 2 years will be examined in detail including demographic, placement details, types of difficulty, process of management and outcomes.
- Trainee E-portfolios will be anonymised and examined to assess if earlier identification and interventions were possible.
- Questionnaire and qualitative interview based study of trainees to evaluate their perception of the support received.

Results

This study is currently in progress and we are currently analysing 187 cases which have been referred to the DDRG in the last 2 years. This study is being conducted in close collaboration with the General Medical Council (GMC) who is providing longitudinal outcome data for these cases. This will provide a unique insight on longer term outcomes for these trainees who have been supported through this process. This to our knowledge has not been previously been done. This study should be complete to present in Autumn 2017.

Conclusions/Implications

This study will provide invaluable information of how the DDRG cohort are being managed, whether earlier intervention could alter outcome, provide longer term outcome data and inform the group of the trainee’s perceptions of the process and support received.
ASSESSING QUALITY OF EDUCATIONAL SUPERVISOR REPORTS AND SUPERVISED LEARNING EVENTS

1 Patel M, 2 Baker, P.
1 Postgraduate Associate Dean, Health Education England North West, 3 Piccadilly Place, Manchester M1 3BN, UK
2 Deputy Dean, Health Education England North West, 3 Piccadilly Place, Manchester, M1 3BN, UK

Introduction

Our previous research has shown that Educational Supervisor Reports (ESR) and Team Assessment of Behavior are strongly predictive of doctors in difficulty. However, quality of ESRs and Supervised Learning Events (SLEs) are variable and this study evaluates whether this can be improved using a structured form and targeted feedback to trainers.

Methods

A one page framework was used to assess the quality of each ESR (n=15) by the Renal Medicine ARCP panel at Health Education England North West (HEE NW) in 2014. Formative feedback was sent to each educational supervisor (ES) and their comments were invited and individually discussed. The successive ESRs (n=15) were then assessed by the Renal ARCP panel in 2015 and 2016 to see if there had been any improvement in quality. A similar framework was used to assess the quality of SLEs (sample of 3-4 per ES) by the Renal ARCP panel (n=21) in 2016 and trainee feedback was also collated. The ES and trainee feedback was assessed qualitatively using a thematic analysis.

Results

Successive ESRs showed:

- Significant improvement in quality with increase in “Excellent” grading from 13.3% to 80% and decrease in “Improvement required” grading from 33% to 0% from 2014 to 2016 (P<0.0001) (Figure 1).
- Detailed free-text comments referenced to multiple sources of evidence
- More constructive feedback with specific learning objectives incorporated into the personal development plan.
- Good evidence of learning from incidents.

The SLE quality was:

- Variable with 2/3 being acceptable.
- Minimal free-text limited to clinical skills.
- Few comments on generic skills including communication skills and professionalism.
- Feedback was poor and non-specific.

The ES and trainee feedback was:

- Overwhelmingly positive; trainees felt valued for being asked

Conclusions/Implications

A simple structured form to assess ESR and SLE quality during ARCPs can provide useful formative feedback to ES and this significantly improves quality of successive ESRs. The ESR quality work has now been rolled out regionally at HEE NW and nationally through the Joint Royal Colleges of Physicians Training Board.

Figure 1. Assessment of Quality of Educational Supervisor Reports
Assessment of Quality of Successive Educational Supervisor Reports

<table>
<thead>
<tr>
<th>Grading of Educational Supervisor Reports</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Required</td>
<td>33.3</td>
<td>7.2</td>
<td>0</td>
</tr>
<tr>
<td>Acceptable</td>
<td>53.3</td>
<td>42.8</td>
<td>13.3</td>
</tr>
<tr>
<td>Excellent</td>
<td>13.3</td>
<td>50</td>
<td>80</td>
</tr>
</tbody>
</table>

References

ENGAGING WITH PAEDIATRIC JUNIOR DOCTORS: BUILDING RELATIONSHIPS AND ENHANCING THEIR LEARNING AND OURS

Poisson J*, Parish EJ, Tobin H, Sharma S
Post Graduate Medical Education, Great Ormond Street Hospital, London, WC1N 3JH

Introduction:
Large quaternary hospitals, like Great Ormond Street Hospital (GOSH), facilitate a wealth of unique learning opportunities, however work is often thought of as service provision rather than experiential learning. At GOSH it was noted junior doctors were withdrawing from interacting in wider hospital activity, non-essential education and social events, which has made engagement with this group a significant challenge.

Our project aimed to improve understanding of the main issues facing junior doctors through the use of focus groups.

Methods:
We held focussed group meetings with junior doctors in their sub-specialty departments. The meetings were organised and chaired by the Postgraduate Medical Education (PGME) Team. We aimed to conduct 1-2 meetings a month with as many junior doctors available to attend, without impacting on service needs. The meetings took place around lunchtime for an hour and lunch was provided by the PGME department. The format was flexible and did not require an agenda. Minutes were taken, with a note of how many junior doctors attended. Issues and concerns were prioritised and any immediate actions were escalated accordingly to the Deputy Director for Medical Education.

Results:
Over 12 months we held 12 focus group meetings with an average of 5-10 junior doctors at each session. Minutes and actions were documented and collated to establish themes that included concerns over staffing levels, low morale and its impact on education and training, suitability of training posts and general paediatric training for core level trainees and surgeons. The meetings were an opportunity to build relationships and raise awareness of educational and quality improvement opportunities. Junior doctors reported they found the meetings to be a useful opportunity to confidentially raise their concerns and reflect on training opportunities.

Conclusion/implications:
The use of focus groups as an engagement tool enhanced the education team’s understanding of the concerns of junior doctors and how to improve the quality of education and training in real-time. It has also helped to identify areas of good practice and share these across the organisation. The lack of senior consultant presence helped to facilitate a confidential environment, which enabled a freedom of speech, yielding much more information to shaped learning events. We intend to conduct more sessions and revisit the same teams to check sustainable change has occurred.
Introduction:
The current climate of UK medical training presents challenges for educators and trainees. Proposed changes to work patterns have led to reports of junior doctors feeling unvalued. Many juniors are leaving postgraduate training or moving abroad. Furthermore, the changing scope of practice of non-medical colleagues may lead to confusion about the particular value of the role of doctors. It is therefore highly pertinent to consider how doctors currently perceive the purpose of their role. This study aimed to explore these perceptions among both newly graduated and senior doctors; to compare and contrast these perceptions; to consider what lessons for medical education can be learned from the findings.

Methods:
Participants were recruited from across South East Scotland via e-mail invitation. Juniors were defined as those who had graduated in the previous two years; seniors were consultants working in acute specialties. Data was collected via one-on-one, semi-structured interviews. Interviews were recorded, transcribed verbatim and the data underwent thematic analysis. Participants have been anonymised through use of pseudonyms.

Results:
Fifteen junior doctors and fourteen senior doctors have participated in this study. Among juniors, perceptions of the purpose of the doctor’s role included: empowering patients; shepherding patients as they navigate clinical information; facilitating patients in developing realistic expectations. Generally, the aim of making patients better was prized, and cases in which patients were cured were seen as most satisfying.

Views of the doctor’s role which emerged from the senior doctor interviews included: providing patients with the best possible quality of life; supporting patients from diagnosis to end of life; improving public health at a societal level. In contrast to the juniors, the senior doctors felt job satisfaction in cases where patients could not be cured, if there had been a comfortable, anticipated death. Seniors described their views of the role of the doctor as having been changed over time, and influenced by increasing patient expectations, changing patient demographics, and growing clinical responsibilities of other the multi-disciplinary team members.

Conclusions and Implications:
The findings suggest a mismatch between junior and senior doctors’ view of the purpose of doctors. Juniors tended to value a role in curing patients, whereas seniors tended to describe roles in promoting quality of life. Observed differences may relate to naivety among new doctors; learned cultural beliefs among experienced consultants. These findings highlight the importance of medical schools nurturing realistic expectations, and of the postgraduate training environment adequately supporting junior doctors whose self-perceptions may be challenged by the surprising complexities of practice.
WORKPLACE BASED ASSESSMENT IN CLINICAL RADIOLOGY – ATTITUDES AND ENGAGEMENT

Ramsden W H*(1) , Booth J(2)
1. Leeds Children's Hospital Clarendon Wing The General Infirmary at Leeds Leeds, West Yorkshire LS1 3EX
2. The Royal College of Radiologists, 63, Lincoln's Inn Fields, London WC2A 3JW

Introduction

Workplace based assessment (WPBA) was introduced into clinical radiology in 2010 and included evaluations of image interpretation, procedural work, teaching and audit. The assessments were subject to annual targets of 6, 6, 2 and 1 respectively. The aim of this study was to analyse trainees’ engagement with WPBA, in both terms of numbers undertaken and they and their trainers’ attitudes to the process.

Methods

The average number of WPBAs completed by radiology trainees throughout the UK between August 2011 and July 2012 was calculated by interrogating the ePortfolio. Subsequently 20 radiologists (8 trainees, 12 trainers) in West Yorkshire underwent semi structured interviews regarding their engagement with, and attitudes towards WPBA. The interview data were subject to thematic analysis for both groups, with the aim of presenting both views held in common and areas where the groups' opinions diverged.

Results

The numeric data indicated that 866 trainees undertook at least 1 WPBA during the year and the mean number of assessments per trainee was 22.9 (range 1-78). The mean numbers for each assessment comfortably exceeded the annual targets with the exception of attaining 2 teaching assessments during the year, where 1.9 was the mean.

The numeric results for Yorkshire were the closest to the nationwide average, implying that the interview data were not sourced from a region with an exceptionally high or low take up of WPBA. Most interviewees understood the formative ethos of WPBA, and there were examples of enthusiasts in both groups.

However, there was also evidence of assessments being undertaken in a peremptory manner to build numbers and being treated as summative episodes by both trainees and trainers. The latter was exemplified by some trainees wishing to obtain positive rather than useful feedback, and both groups cited examples of how assessments might be manipulated to this end. Such behaviours included selecting unchallenging cases, approaching assessors perceived as generous and requesting assessments retrospectively when an episode had gone well. There was evidence that some trainers did not challenge these behaviours, and some would collude in trainees' attempts to build assessment numbers.

Conclusions/Implications

Although trainees generally meet or exceed target numbers of WPBAs, there is evidence that the process may be manipulated to build numbers and obtain positive feedback at the expense of the (intended) formative ethos. Removing annual numeric targets might address the former, although it would also remove a driver to engage with the process. Currently WPBA feedback includes elements which are scored, and removing them to only allow freehand comment might reduce the summative nature of the assessments, paving the way for the introduction of completely formative supervised learning events into radiology training.
VIDEO BASED EDUCATION FOR PATIENTS WITH BLADDER CANCER: UROSTOMY MANAGEMENT AND AFTERCARE

Department of Surgery, University Hospital Southampton, Tremona Road, Southampton, SO16 6YD, UK

Introduction:
Cystectomy for bladder cancer patients is a major undertaking with high morbidity and life-long urostomy care thereafter. Social media and eLearning videos are powerful learning tools and can help improve learning, demonstrate practical or complex procedures and simplify difficult topics.

Methods:
We wanted to set up a patient education resource via a real-life series of sequential videos (Figure 1). This was done using patients undergoing cystectomy and urostomy formation.

Results:
We created a sequential series of 4 high quality videos using a multidisciplinary model using a patient who underwent cystectomy and urostomy formation, a specialist nurse and a team of oncology pelvic surgeons. These videos were received in a positive manner by the index patient who offered excellent feedback.

Conclusion:
Videos are a powerful medium of improving patient understanding of living with a urostomy. They help in patient counseling and might be a useful adjunct to clinical consultations. We aim to film further patient led educational videos and integrate these into the pre-operative ‘Surgery School’ and post-operative follow up clinics.

References:

FOCUSED TRAINING FOR THE NEW MEDICAL REGISTRAR – TASK SPECIFIC TEACHING AND IMPROVEMENT IN FOCUSED LEARNING OUTCOMES

Dr Andy Redfern, Specialist Registrar in Respiratory and Intensive Care Medicine, Northampton General Hospital* (Lead Author)
Dr Anoop Babu, Specialist Registrar in Respiratory Medicine, Lister Hospital Stevenage

Introduction: For many core medical trainees (CMT) becoming a medical registrar can generate trepidation after just completing this training stage. Many feel that the programme does not prepare them adequately and recently the workload for medical registrars has become substantial, with most saying it is high or unmanageable. To tackle this we generated training sessions focussed on the specific transferable skills and tasks required to be medical registrar on-call, rather than focussing on the more curriculum driven and knowledge based requirement of the CMT programme. We focussed instead on escalation planning and system failures, time organisation with delegation and on-call management skills.

Methods and Results: This took place twice over a 1 year period with 2 separate groups. Prior to the session the CMT doctors rated their confidence at managing situations with Likert scales from strongly disagree to strongly agree with 7 variables (other variables =disagree, somewhat disagree, neither, somewhat agree and agree with the appropriate weighting given to these variables (i.e. 1=strongly disagree, 7=strongly agree)). Following an afternoon of plenaries delivered either by consultants or registrars in the relevant fields, the doctors refilled in the same questionnaire. 31 junior doctors responded to the pre and post survey (see summary table).

<table>
<thead>
<tr>
<th>Question Put to Trainee</th>
<th>Average Score Pre Teaching</th>
<th>Average Score Post Teaching</th>
<th>% of candidates or agreed (scale 6 or more) pre teaching</th>
<th>% of candidates or agreed (scale 6 or more) post teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident that by the time I'm the medical sp on call I will have the relevant knowledge and experience</td>
<td>4.48</td>
<td>5.29</td>
<td>29.0</td>
<td>38.1</td>
</tr>
<tr>
<td>I am confident that I know how, when and when not to escalate a patient in respiratory failure on maximal ward O2</td>
<td>5.16</td>
<td>5.94</td>
<td>45.2</td>
<td>74.2</td>
</tr>
<tr>
<td>I am confident about making DNR decisions</td>
<td>5.15</td>
<td>5.81</td>
<td>45.2</td>
<td>67.7</td>
</tr>
<tr>
<td>I am confident in leading CPR</td>
<td>4.45</td>
<td>4.84</td>
<td>25.0</td>
<td>32.2</td>
</tr>
<tr>
<td>I am confident that I would know what to do with a patient persistently hypotensive despite fluid resuscitation</td>
<td>4.94</td>
<td>5.58</td>
<td>35.8</td>
<td>61.3</td>
</tr>
<tr>
<td>I am confident in recognising and treating cardiogenic shock (all causes) and aware of the potential interventions</td>
<td>4.35</td>
<td>5.32</td>
<td>16.1</td>
<td>48.4</td>
</tr>
</tbody>
</table>

Conclusions: The jump in responsibility from CMT to registrar is a daunting one and many trainees feel unprepared. Our main results so a lack of initial confidence in agreement with national surveys for multiple areas, especially with leading CPR (only 25% of doctors agreeing that they would be confident stepping up to lead an arrest), managing cardiogenic shock (16.1% agreed they were comfortable) and only 29% feeling they had the appropriate knowledge, skills and experience to perform the medical registrar role.

We showed improvements in trainee understanding and confidence in all the topics covered in both the mean score given and the number who felt they agreed or strongly agreed that they were confident in the task identified. Other specialities offer a focussed vocational programme at the start of training, e.g. the Initial Assessment of Competence in Anaesthetic training; in view of the confidence issues shown in our and national surveys, a similar approach prior to medical registrar commencement may improve confidence about the role and our results provisionally support this.

2 Royal College of Physicians. Hospital Workforce, Fit for the Future? A Report by the RCP 2013
Introduction:
The Foundation Programme (F1/F2) provides equivalent training and experience to all trainees. All jobs are designed so that the foundation doctor may achieve a number of learning objectives set out by the foundation programme curriculum.

Within the North West, only 13% of all foundation jobs, less than 1 in 6 rotations, are within a surgical specialty. In 2015, 15.9% of NHS admissions were to General Medicine, whilst 10.1% of admissions were to General Surgery. This suggests that the exposure of foundation trainees to surgery is disproportionate to the surgical workload of the NHS.

Others have suggested that one surgical foundation rotation is not enough time for a foundation doctor to gain the experience and training required to confidently deal with surgical presentations that they may face when working within other specialties.

This project looked at foundation doctors’ experience of surgical training, with additional teaching, beyond that of the foundation program and daily learning, and whether it resulted in greater confidence in the management of surgical issues.

Method:
A questionnaire was developed based on learning outcomes from the foundation program curriculum related to surgery. This was given retrospectively to F2s, whilst the same questionnaire was given prospectively to F1s within surgery.

The F2s had no additional surgical teaching other than that on their firm and weekly foundation teaching. The F1s were given a rolling 16-week surgical teaching programme, developed and delivered by middle grades on a variety of common and important surgical presentations and issues.

Results:
94% F2s felt there was not enough surgical teaching on their rotation compared to 60% F1s, and the majority of both cohorts felt that they would benefit from more surgery-specific teaching. 61% of F2s described their surgical teaching as poor, whereas 80% of F1s described it as good. There was no significant difference when assessing results regarding either cohort’s confidence in dealing with surgical presentations, investigations and management.

Conclusion:
Time spent on surgery during the foundation programme is limited and doctors may struggle to achieve the surgery-specific learning outcomes set out by the curriculum. Training time spent with foundation trainees must be used efficiently. Additional training opportunities, such as peer-led teaching, should be considered necessary in an attempt to help achieve such outcomes.

The additional training was appreciated by the F1 group who felt it contributed to good overall teaching; whilst both cohorts felt further training opportunities would be beneficial to their careers. There was no difference in confidence in managing key surgical issues between the F1s and F2s; however, this may be related to overall experience as a doctor.

There is scope for improvement of the foundation programme to advance surgical training.
CREATION OF A DOCTOR’S MESS RELATED PEER GROUP LED TEACHING PROGRAMME TO PROMOTE SKILLS RELATED EDUCATIONAL NEEDS AT PRINCESS ALEXANDRA HOSPITAL NHS TRUST

*Dr Jacob Roelofs*: Foundation Year 2 Doctor; *Dr Juan Vilarino*: ACCS CT2 Trainee
Mr Andrew Foster, Clinical and Simulation Lead; Dr Pratik Solanki, Senior Clinical Teaching Fellow
Medical Education Department, Princess Alexandra Hospital NHS Trust, Hamstel Rd, Harlow CM20 1QX

Introduction: Peer group delivered teaching is regularly used in medical schools throughout the UK, usually in the context of clinical skills, but is rarely in post-graduate education. Studies have suggested that there are numerous advantages of this model to both the student and the tutor (1). Students value learning in a more comfortable and supportive environment whilst the tutor may benefit from increased motivation to learn the subject and potential conceptualisation of the topic. In fact, certain studies have demonstrated that peer teaching is as beneficial to students, in regards to quality and exam marks, as conventional faculty lead teaching in certain subjects (2). We thus created a doctor’s mess peer group teaching programme based on the needs of the doctors at Princess Alexandra Hospital NHS Trust.

Method: Feedback was initially obtained from members of the doctor’s mess and topics created around their learning needs. The emphasis was on practical skills which were not easily attainable on the ward. Teaching sessions were scheduled at 5pm on alternate Thursdays, and sessions were advertised via email and social media. Once sessions were formalised appropriate peer tutors were sought to deliver them. Sessions include a tutorial on ultrasound guided cannulation led by an acute care common stem trainee and a teaching session on injections taught by a foundation trainee. Other sessions in the programme include FAST scanning, ascitic drain insertion and lumbar puncture. Hand-outs were provided after each session and feedback obtained. The confidence in performing the skill was explored using a pre- and post-session questionnaire in which participants were asked to report on a scale of 1 to 10, with 10 being extremely confident.

Results: Average (mean) feedback scores for the sessions are given below:

<table>
<thead>
<tr>
<th></th>
<th>Relevance</th>
<th>Structure</th>
<th>Variety of Teaching</th>
<th>Clarity</th>
<th>Involvement of audience</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Group Lead Teaching Sessions</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>5</td>
</tr>
</tbody>
</table>

Feedback scale: 5=Excellent; 4=Good; 3=Satisfactory; 2=Mixed; 1=Poor

Performing a paired T-test on confidence using software from GraphPad demonstrated a statistically significant improvement in confidence by 4.2 points or 42% (95% confidence interval: 2.74; 5.73) (p<0.001).

Conclusion: Although the peer group teaching programme at Princess Alexandra Hospital NHS Trust is currently in its infancy, there is a great opportunity to provide tailored teaching sessions based on the current needs of the doctors. Not only does the format of using peer lead teaching have potential benefits to both the tutors and the participants, it also removes the need for a designated educational faculty and so is advantageous from both a faculty time-consumption and financial point of view. Further studies are required to explore the larger impact of these sessions on the education of doctors and the potential development of an educational community within the doctors mess itself.

References


Introduction:
Assessment is a widely accepted part of the educational and accreditation process across health professionals. Assessment of doctors provides evidence of competence, and can confirm the doctor’s progression. WPBAs are designed to evaluate the authentic performance and progress made by doctors throughout their training trajectory in areas of practice that are most effectively tested in the workplace. Anecdotal evidence suggests there are disparities between how a WPBA is conducted in General Practice (GP) compared to a hospital setting. Hospital Clinical Supervisors are required to complete multiple different assessments for different specialties each of which use different grades and/or endpoints (the content and process for completion of tools vary across specialties). Research to date has shown many GP trainees question the reliability and usefulness of WPBA especially during their hospital posts.

Methods:
A small-scale educational enquiry was undertaken in the form of a qualitative case study. Three semi-structured interviews with hospital clinical supervisors and one trainee were undertaken and transcribed (mean duration 27 minutes) exploring the factors that influence the understanding of hospital clinical supervisors’ calibration and consistency in completion of WPBAs when rating trainees from different specialties (including GP). Data analysis was undertaken through an analytical iterative thematic process categorising and coding data, engaging with literature throughout the process.

Results:
Findings suggest there is little consistency amongst different specialties in the completion of WPBAs. There was an apparent lack of awareness of the trainee curriculum and competencies for the different specialties. Supervisors would welcome more easy access user-friendly resources (being mindful of the busyness of supervisors).

Conclusions/implications:
There is an identified need for training trainees and supervisors on the use of WPBAs. Training should ensure a shared understanding and a consistency in the use of WPBAs and the application of standards. Training should be role specific, outlining the correct use including any specialty specific requirements and purpose of WPBAs. This will promote the value of deliberate organisation and arrangement of WPBAs to both supervisors and trainees, engaging both parties in the assessments, supporting a longitudinal picture of a trainee’s development.

Keywords: Clinical Supervisors, WPBAs, GP trainees, case study
THE AUDIO-COT (CONSULTATION OBSERVATION TOOL) A TELEPHONE CONSULTATION WORKPLACE BASED ASSESSMENT (WPBA) FOR GENERAL PRACTICE (GP)

Sales, B.*. Bodgener, S.
Dr Bryony Sales; GP and Trainer Portsmouth; GP Programme Director, Portsmouth and Isle of Wight; member WPBA Group of RCGP
Dr Susan Bodgener; GP and Trainer Guildford; Associate GP Dean for HEE Kent, Sussex and Surrey; member WPBA Group of RCGP

Introduction
The use of telephone triage and consultations in healthcare is increasing, requiring trainees to acquire telephone communication skills in addition to face-to-face. It can be challenging for trainers to find ways to teach and assess telephone skills in an authentic way. The integration of the Audio-COT telephone consultation assessment tool in the RCGP ePortfolio enables all trainees to be assessed on their telephone consultation skills. It aims to capture the nuances of trainee telephone use without adding to assessment burden.

Methods
The current Royal College of GP (RCGP) COT supports holistic judgements about a trainee’s ability to consult. The Audio-COT has been specifically designed to assess telephone consultations during training using the same assessment methodology. An accompanying list of performance criteria was constructed, along with guidance on gaining appropriate consent. The tool has been developed in conjunction with GP trainers and trainees, evaluated and further refined in a national pilot to ensure its validity and reliability.

Results
The Audio-COT has General Medical Council (GMC) approval and is due to be integrated into the RCGP ePortfolio in Autumn 2017. There will be no increase in trainer/trainee assessment burden as Audio-COT(s) will be directly substituted for COTs.

Conclusions/implications
The Audio-COT provides an additional effective, user-friendly supervised learning event to formally assess and develop the clinical competence of trainees’ telephone consultation skills, ensuring patient safety and enhancing satisfaction and preparing the trainee for their GP career. The tool may have other applications such as training by out of hours providers or established GPs wishing to refresh their telephone consulting skills.
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INTRODUCTION OF A FORMAL QUALITY IMPROVEMENT PROJECT (QIP) IN GENERAL PRACTICE (GP) TRAINING

Sales, B. Tomson, M, Bodgener S
Dr Mike Tomson; GP and Trainer Sheffield; APD for GP HEE Yorkshire and Humber; member WPBA Group of RCGP
Dr Susan Bodgener; GP and Trainer Guildford; Associate GP Dean for HEE Kent, Sussex and Surrey; member WPBA Group of RCGP
Dr Bryony Sales; GP and Trainer Portsmouth; GP Programme Director, Portsmouth and Isle of Wight; member WPBA Group of RCGP

Introduction

Engagement with Quality Improvement activities is a mandatory part of the curriculum for GP trainees and is a General Medical Council (GMC) requirement. A Quality Improvement Project (QIP) can help to develop skills in leadership and team working as well as Quality Improvement itself. During training it is currently expected all trainees are involved in audit or QIP but it is not currently compulsory to undertake a QIP.

Methods

A national workshop was held to look at the feasibility of integrating a QIP assessment in the first two years of GP training (ST1/2), ideally when the trainee has their GP post. Feedback from the workshop showed a clear consensus that integration of a formal QIP is achievable and appropriate. Established QI activities taking place across the country during training were reviewed to build on current QI assessments and training opportunities. A QIP template with accompanying word descriptors for needs further development, competent and excellent was created engaging all relevant stakeholders throughout the development including trainees/trainers and experts in quality improvement theory. Multiple supporting materials for trainees/supervisors and programme directors have been created to complement the tool.

Results

Trainees are currently piloting the new novel assessment tool to validate it. It is anticipated a formal QIP will be introduced into the GP trainee ePortfolio once GMC approval is given. There will be no increase in supervisor/trainee assessment burden as it is anticipated there will be a reduction of Case based Discussions in the first /second year of training to reflect the QIP work.

Conclusions/Implications

Quality Improvement is a core part of the work of any health professional. The integration of a formal mandatory QIP in the RCGP ePortfolio will provide an additional effective, user-friendly workplace based assessment which links to five different competences and mirrors GMC training requirements. The QIP ensures trainees develop their understanding of quality improvement methods and provide a formal assessment, aiming to improve patient safety and prepare the trainee for their GP career. The tool may have other applications such as within the GP appraisal requirements or to the wider medical education community.
UPDATING GENERAL PRACTITIONER (GP) TRAINING EPORTFOLIO REFLECTIVE LOG ENTRIES

Sales, B*. Tomson, M, Bodgener S
Dr Mike Tomson; GP and Trainer Sheffield; APD for GP HEE Yorkshire and Humber; member WPBA Group of RCGP
Dr Susan Bodgener; GP and Trainer Guildford; Associate GP Dean for HEE Kent, Sussex and Surrey; member WPBA Group of RCGP
Dr Bryony Sales; GP and Trainer Portsmouth; GP Programme Director, Portsmouth and Isle of Wight; member WPBA Group of RCGP

Introduction

GP trainees are required to write reflective entries as part of their Workplace Based Assessment (WPBA), one component of the tripos of the Membership of Royal College of GP (MRCGP). Currently there are 13 options for learning log entries (Clinical Encounter, Professional Conversation, Tutorial etc.); consequently many trainees are confused as to which to use and often never use several of the options. Evidence from Annual Review of Progression (ARCP) panels confirms log entries are variably used, sections are left blank and that the process does not enable reflective practice for some trainees.

Methods

The WPBA group undertook a review of the current learning log format. The alternative Membership by Assessment of Performance (MAP) qualification was reviewed, in addition to post qualification requirements for appraisal across all four nations. Different reflective models/approaches were reviewed. Subsequently the log entries were re-designed to reflect the new General Medical Council’s (GMC) Generic Professional Capabilities and updated RCGP curriculum, integrating trainee/supervisor and lay advisor feedback.

Results

The use of the reflective boxes is less frequent than would be educationally appropriate as WPBA looks at learning based on what trainees actually do. Trainees often do not focus on GP competences in their entries (because they do not currently suggest links to them); too many log entries relate to knowledge or curriculum acquisition. The revised format of log entries encourages trainees to reflect on keeping up to date, reviewing what the trainee does, and learning from cases, data and events – Quality Improvement Activities and Significant Event Analysis as well as seeking and reflecting on feedback about what the trainee does (from colleagues, patients, leadership feedback surveys and unsolicited feedback such as complaints and compliments). A new approach to linking to population groups and competences rather than curriculum (current system) is proposed. The revised formats are formally being piloted.

Conclusions/implications

A revised approach to reflective learning log entries enables a new balance of required tools assessing WPBA; it mirrors the updated GMC’s expectation to assess Prescribing, Leadership and Quality Improvement. It also enables trainees to have a better way to respond to feedback. It is anticipated the revised learning log entries will be introduced into the GP trainee ePortfolio once GMC approval is granted.
A NATIONAL REVIEW OF CASE BASED DISCUSSIONS (CBDS) COMPLETED DURING TRAINEES FIRST YEAR OF GENERAL PRACTICE (GP) TRAINING

Bodgener, S, Sales, B*

Dr Susan Bodgener; GP and Trainer Guildford; Associate GP Dean for HEE Kent, Sussex and Surrey; member WPBA Group of RCGP
Dr Bryony Sales; GP and Trainer Portsmouth; GP Programme Director, Portsmouth and Isle of Wight; member WPBA Group of RCGP

Introduction

Workplace Based Assessments (WPBAs) contribute collectively to demonstrate the competence progression of an individual by recording their skills, knowledge and behaviours against those identified in the Membership of Royal College of GP (MRCGP) curriculum. Trainees are required to complete a minimum number of a range of WPBA tools every six months e.g. Case based Discussions (CbDs), mini-CEX (Clinical Evaluation Exercise), Multi-Source Feedback (MSF) and Clinical Supervisors Reports (CSR); this enables trainees to collect evidence for the 13 areas of professional competences which a trainee works throughout training to become competent in before qualifying as a GP. The collated evidence is reviewed at the trainees Annual Review of Progression (ARCP) panel. It is imperative that WPBAs are completed appropriately to inform fair and defensible ARCP panel decisions about trainee progression. Judgements arising from CbDs (one of the WPBA tools) are made by a variety of assessors throughout GP training in both the hospital and GP setting. This research explores how CbD assessments inform ARCP decisions.

Methods

Trainees identified at ARCP as needing extra training time (Outcome 3) at the end of their first year of GP training, were included (n=37). CbDs were chosen as both hospital and GP supervisors complete them, enabling an appropriate comparison.

Results

Results showed 11% Staff and Specialist Grades (SASGs)/Consultants rated trainees as needing further development compared to 69% of GPs despite the trainee being given an Outcome 3 at ARCP. 30.4% of the assessments completed by SASG/Specialist Registrars rated trainees as excellent. These results suggest the CbD when used in hospital is giving results which are worrying divergent from the other information about progress in this key group of trainees

Conclusions/implications

The results raise concern with regard to the consistency of judgements made by different groups of assessors, with significant variance between assessors of different status and seniority. Further work is required to determine whether the CbD is fit for purpose as a mandatory WPBA for GP trainees during their hospital placements. There is a need to improve the inter-rater reliability of CbDs to ensure a consistent contribution to subsequent decisions about trainees’ overall progress.
EARLY COMMUNICATION SKILLS INTERVENTION FOR ST1s
* Selina Sawhney* (GP Education Unit), Richard Crane (GP Education Unit), Hannah Gaynor (GP Education Unit), Johnny Lyon-Maris (GP Education Unit)

GP Education Unit, Mailpoint 10, Southampton University Hospital Trust, Tremona Road, Southampton SO16 6YD UK

Background
It is well known that trainees with low recruitment scores can struggle with communication skills on moving into a patient-centred care context. Typical areas of difficulty are: over emphasis on disease at the expense of the psychosocial aspects of the consultation and a rigid approach to consulting. This innovative approach to supporting ST1 trainees aimed to identify those needing support with communication skills as early as possible and to support their transition into a primary care-centred approach to consulting. The group comprised trainees scoring in the bottom 12% for recruitment to Wessex. The aims of the sessions were to help them gain early, additional exposure to general practice and to explicitly explore communication skills in a facilitated small group.

Summary of work
Over the course of a year, 12 trainees met for 3 whole day sessions. The programme of education provided:

- Q&A time with expert patients to explore patient expectations about the consultation;
- extra time in practice with an ST3 buddy;
- a forum to explore aspects of the consultation;
- time for reflection on verbal and non-verbal communication; and
- role play with simulated patients.

The group was facilitated by three First5 GPs. Feedback was gathered at the end of each session formally, as well as informally, and the facilitators also gave their reflections at the end of the year.

Summary of results
The ST1s reported benefitting by:

- raised awareness of communication skills – especially opening the consultation;
- better knowledge of the differences between primary and secondary care patient interactions;
- realising the importance of a focus on the whole patient, not the disease
- being alert to ICE and shared decision-making; and
- realising the importance of the relationship with the patient as the framework underpinning the consultation.

A fuller description of the findings will be presented on the poster.

Conclusions
Early intervention can support, but the nature and timing of successful interventions are as yet unclear.

Take home messages
A positive response to the sessions has seen them planned to continue for next year, and support may be extended into the ST2 year for the present group.
A NEW SYSTEM FOR GP TRAINER RE-APPROVAL IN DORSET: A PILOT
Alex Jones (Dorset GP Centre), Clare Wedderburn (Dorset GP Centre), *Samantha Scallan* (GP Education Unit)
Dorset GP Centre (RS07), Bournemouth University, Royal London House, Christchurch Road, Bournemouth, Dorset BH1 3LT UK

Background
Trainers and training practices are the cornerstones of GP training. Managers of GP postgraduate education are responsible for ensuring the quality of the training environment in line with GMC requirements. This has historically involved a system of training practice visits (educational team members visit the practice and interview the trainer, trainee and others involved in training) and individual trainer accreditation. Increasing trainer numbers and a large geographical patch area pose distinct challenges to Dorset with the current system of (re)/approval.

Summary of work
The poster reports a pilot for a revised format of trainer re-approval. Instead of team members visiting training practices, trainers and other key people involved travelled to the GP education office for re-approval, educational reflection and development time. Three iterations of the pilot format were evaluated using pre and post feedback surveys.

Summary of results
Attendees were questioned about their views on the existing process, the new pilot format and what they valued about re-approval. Seeing the GP practice and learning environment was identified as a key value of the current system as visitors could get a ‘feel’ for the training experience. Sharing reflection on practice with other trainers and meeting more patch educational team members were highlighted as positive aspects of the new approval format, along with time efficiency. More negative aspects for attendees were travel to the educational office and the absence of several staff members, particularly GPs, from the practice at one time.

Conclusions / Take home messages
The pilot proved to be a successful model for trainer re-approval. Following modification (based on feedback) the new format will be used on an alternate basis with the existing system in Dorset. Alternating the visit approach to trainer re-approval between Bournemouth University and the practice has benefits for all.
THE MENTORING OF ST1 GP TRAINEES BY ST3 GP TRAINEES: AN AID TO SUCCESSFUL GP TRAINING?
Ian Wyer (Dorset GP Centre), Alex Jones (Dorset GP Centre), Clare Wedderburn (Dorset GP Centre), *Samantha Scallan* (GP Education Unit)
Dorset GP Centre (RS07), Bournemouth University, Royal London House, Christchurch Road, Bournemouth, Dorset BH1 3LT UK

**Background**
Mentoring is well-evidenced as a way to promote reflection and insight. Between years mentoring for trainees can provide space for them to share information and experiences in a mutually supportive way.

**Summary of work**
The GPST mentoring scheme was designed to provide ST1 trainees mentoring time with a ST3 trainee to reflect on their training expectations, experiences and perceived challenges. ST3s were prepared for the role of mentor by attending an interactive teaching session using the TGROW(S) mentoring model.

**Summary of results**
Evidence from the evaluation of the mentoring session indicates that it was well received. Trainees reported enjoying the session and they identified positive outcomes for themselves. The majority of ST1s attending the session intended to make changes in one or more areas during the remainder of their three years of training and the majority felt the session had been useful. The process was also successful in introducing trainees to mentoring with the majority of ST1 and ST3s recognising its value, reporting that they wished to be involved in mentoring in the future.

**Conclusions /Take home messages**
Mentoring is a valuable skill, the principles of which are transferrable to the GP consultation and more widely. The session was valued by both ST1s and ST3s as an opportunity to gain an additional perspective on training.
DOCTORS WITH DYSLEXIA: A SYSTEMATIC REVIEW OF EFFECTIVE WORKAROUNDS
Rachel Locke (University of Winchester), *Samantha Scallan* (University of Winchester), Richard Mann (Health Education England (Wessex)), Gail Alexander (Dyslexia Consultant)
Centre for Medical Education, The University of Winchester, Winchester, Hampshire, SO22 4NR

Background
An increasing number of medical students are declaring dyslexia as a specific learning difficulty on entry to medical school. The implication of an increasing number of doctors with dyslexia is that it may impact on their performance in the workplace, on patient safety and potentially their fitness to practice. For educators, an awareness of the impact of dyslexia on learners in the clinical workplace is vital to identify whether dyslexia may underlie certain traits and behaviours; and to provide appropriate advice and support when dyslexia is identified.

Summary of work
A systematic search of the literature was undertaken, followed by a narrative review of studies meeting the inclusion criteria. The review used a priori research questions and focused on studies based on primary research evidence to identify the effects of dyslexia on doctors (in or post training) in the workplace, and adaptive strategies (‘workarounds’) in use.

Summary of results
The review identified five studies on dyslexia and qualified clinicians. The impact of dyslexia can include: writing/calculating prescriptions, writing patient notes, prioritising and making referrals. Strategies to minimise the effects of dyslexia include: use of adaptive technologies, the need for more time for mentors and supervisors, and awareness of ‘enabling’ and ‘disabling’ environments.

Conclusions / Take home messages
The difficulties associated with dyslexia are varied and may be unexpected. Medical educators may not be aware or knowledgeable about dyslexia and its impact, thus there is a need to promote greater awareness amongst them, as well as understanding of the implications for patient safety. Dyslexia is under-researched and lacks an evidence-base for support.
DOCTORS WITH DYSLEXIA: EXPERIENCES AND STRATEGIES
Rachel Locke (University of Winchester), Sharon Kibble (Independent Researcher), *Samantha Scallan* (University of Winchester), Gail Alexander (Dyslexia Consultant), Richard Mann (Health Education England (Wessex))
Centre for Medical Education, The University of Winchester, Winchester, Hampshire, SO22 4NR

Background
A growing number of applicants to medical school are disclosing dyslexia as a specific learning difficulty on entry, and this will lead to an increase in the number of doctors disclosing dyslexia in the workplace. The degree to which dyslexia has an impact on their performance in the workplace depends on the individual doctor’s level of self-awareness and skill in developing supportive strategies or ‘workarounds’. There is, however, little research on such strategies so primary research was conducted to identify effective workarounds and how they help to minimise the effects of dyslexia.

Summary of work
Qualitative data was collected to add to current research that is based mainly upon self-reported accounts of what works for nurses. Fourteen doctors with dyslexia took part in the research through interviews and surveys, two of whom were interviewed ‘in situ’ to provide detail about the workarounds in the working environment. Five key informants with knowledge about the support available participated in semi-structured interviews. Eleven trusts provided information about the support they give as employers of doctors with dyslexia.

Summary of results
Although most participants had experienced difficulties they had found individualised ways of coping to overcome the challenge presented by dyslexia. The main strategies were to assist with revision and exams, writing and spelling, reading, memory, time management and organisation. The ability to develop such personal strategies can be seen as a really positive attribute of dyslexia.

Conclusions /Take home messages
‘The dyslexic learns to adapt and cope and create systems for themselves to get by’ (interviewee).
Background:
The Intercollegiate Membership of the Royal College of Surgeons (MRCS) examination is one of the largest postgraduate surgical exams in the world. However, unlike other high-stakes medical examinations, both MRCS and many other surgical exams worldwide are yet to be validated.

To assess the predictive validity of this mandatory exam, we conducted a quantitative study to assess the relationship between MRCS (Parts A and B) and national selection interview score for general and vascular surgery in the UK.

Method:
Pearson correlation coefficients were used to examine the linear relationship between each assessment and linear regression analyses to identify potential independent predictors of national selection score. We included all UK medical graduates who had attempted the interview from 2011-2015.

Results:
84% (1231/1458) of candidates were matched with MRCS data. There was a significant positive correlation between Part B MRCS and national selection score (r=0.38, p<0.001).

On multivariate analysis, 17% of variance in national selection first attempt score was explained by Part B MRCS score and number of attempts (R$^2$ change 0.10 and 0.07, p<0.001). Candidates who required more than 2 Part B attempts were predicted to score 8.1% less than equally matched candidates who passed at first attempt.

Conclusion:
This study, the first of its kind for MRCS, supports both MRCS validity and its predictive validity. This work should be beneficial to similar surgical training models around the world, providing future selection committees with additional quantifiable evidence which could be used as potential scoring criteria for entering specialty training.
A SURVEY OF ACADEMIC ACTIVITIES OF GENERAL SURGERY TRAINEES AS A RESOURCE FOR SELF-DIRECTED PORTFOLIO DEVELOPMENT

Scroggie DL*
Department of General Surgery, Gloucestershire Hospitals NHS Foundation Trust, UK

INTRODUCTION

The general surgical curriculum in the UK specifies numerical minimums for the contents of a trainee's portfolio regarding publications, research projects and conference presentations. However, no data exist against which a trainee can assess their competitiveness. The aim of this study was to determine portfolio numbers for a sample of trainees as a facility for trainees to compare and improve their own portfolios.

METHODS

A 10-question survey was distributed to core surgical and specialty trainees in general surgery in the Northern Ireland Medical and Dental Training Agency. Responses were entered into a customised spreadsheet. Descriptive statistics and graphs were produced using OpenOffice Calc to illustrate the responses.

RESULTS

There were 37 valid responses to the survey. 78.4% of the questions were answered. There was representation of all grades from CT1 to ST7. No responses were obtained from an ST8.

The median (range) number of peer-reviewed published journal articles tended to increase with the training level, from 0 (0 to 2) for a CT1 to 9 (4 to 23) for an ST5. An extreme range was observed at ST7, from 1 to 24, with a median of only 1.5.

When considering numbers of research projects, considerable variation was observed which did not show any relationship to training grade. Low medians with wide ranges indicate that small numbers of trainees had engaged in exceptionally high numbers of research projects in comparison to the majority of their peers. The most extreme variation was in the ST3 grade, with a median (range) of 2 (0 to 15).

The number of oral conference presentations also demonstrated wide variation without any association with the year in training. The highest performance was at ST5, with a median (range) of 4 (2 to 15). Similarly, the number of poster conference presentations was not experience-dependent, with ST5 again achieving the highest numbers with a median (range) of 5.5 (5 to 10).

CONCLUSIONS

The portfolios of surgical trainees show remarkable variation, with a few trainees having exceptionally high numbers of publications, research projects and conference presentations. Portfolio numbers were not greatest in the most experienced trainees as might be expected; the ST5 grade achieved the highest median values overall. The results will facilitate reflection of surgical trainees upon the content of their own portfolios.
CHANGES TO OPERATIVE EXPOSURE FOR SURGICAL TRAINEES IN TRAUMA AND ORTHOPAEDICS FOLLOWING THE INTRODUCTION OF FULL SHIFT WORKING PATTERNS

Sevenoaks H 1, Ajwani S 1, Hujazi I 1, Sergeant J 2, Barrie J* 1, Mehta JV 1
1 School of Surgery, North West Deanery, Manchester, UK
2 Centre for Biostatistics, University of Manchester, Manchester, UK

Introduction

The majority of Trauma & Orthopaedic (T&O) registrars in the North West Deanery work in hospitals with 24-hour non-resident on-call patterns.

Some trusts in the region have been required to change to full shift patterns (including weeks of night shifts). Involvement in operative procedures constitutes a major component of higher surgical training. Completion of certain numbers of trauma and elective “index procedures” is a requirement for completion of training.

Aim

Our study set out to examine the impact on operative experience of the introduction of full shift patterns in two trusts (one District General Hospital (DGH), one teaching hospital (TH)) in North West England.

Method

This was a longitudinal study conducted across two NHS trusts who both implemented full shift patterns in 2016 for the T&O registrar rota. At both trusts, we analysed the operative logbooks of higher surgical trainees for full 6 month rotations pre shift working patterns i.e 24 hours non-resident on calls (August 2015 – February 2016) and full-shift working patterns (August 2016 – February 2017). Total number of procedures, levels of involvement and types of procedures undertaken were examined.

Results

The logbooks of a total of 28 T&O trainees across the two trusts and study periods were analysed.

The effect that shift work had on operative experience was different in the two trusts.

At the DGH, little effect was seen on mean total operative procedures undertaken per 6 months (146 pre shift, 144 post shift). Elective operating was largely maintained and a 16% uplift in trauma index procedures was seen after shift work was introduced (22 pre shift, 26 post shift).

At the teaching hospital (TH) however, there was a 16% fall in total procedures over the 6 month placements (159 pre shift, 133 post shift). The drop in total trauma procedures was 8% (77 pre shift, 73 post shift) with a 20% reduction seen in trauma “index” procedures (34 pre shift, 27 post shift) at the TH. Elective operating was more significantly impacted with a 26% reduction in overall elective operating (82 pre shift, 60 post shift) and a 41% reduction in “index” elective procedures (42 pre shift, 25 post shift).

Conclusions

This study highlights the variable impact on operating experience of changes to working patterns for T&O trainees. Further work is underway, as exploration of the reasons behind these differences would help inform rota designs to optimize surgical training opportunities.
Introduction

Nephrology is viewed by many junior doctors as a complex and sometimes overwhelming specialty, with few doctors gaining exposure to patients with significant kidney disease unless they rotate through a job in a nephrology department. We designed a free one day course with the aim of educating junior doctors on practical aspects of managing patients with kidney disease.

Method

The course took place in the on-site Education Centre of a large tertiary referral hospital, making it accessible to both junior doctors and Nephrologists. We advertised via email to regional post-graduate medical departments and displayed posters in all hospitals in our region. Topics were chosen to reflect aspects of clinical practice in which, in our experience, problems frequently arose. Candidates booking onto the course were encouraged to suggest further subject areas in which they lacked confidence, enabling us to tailor the course to their needs. Nephrologists with particular interests in medical education were asked to volunteer their time. Rotating through small group sessions encouraged interaction between learners and teachers.

Results

Learners from a range of specialties and levels of experience (from F1 doctors to Emergency Medicine Middle Grades) attended; 24 in total. We asked the attendees for both qualitative and quantitative feedback on each session, and asked them to score their confidence in key areas of renal medicine before and after the course. Learner confidence increased in all areas, most markedly in “prescribing for patients with kidney disease” (from 5.5 to 7.6 on a 1-10 confidence scale) and “managing a patient with a kidney transplant”, from 3.9 to 6.5.

Implications and conclusions

Overall the day was a success. We demonstrated an increase in confidence in areas identified as important to junior doctors by both learners and Nephrologists. Impact of this course was measured on Kirkpatrick’s hierarchy as “satisfaction of learners”. On repetition of this course we plan to make sessions longer (40 minutes rather than 30) to allow further interaction with the small group facilitator, and introduce a hands-on session demonstrating practical aspects of nephrology, (haemodialysis and peritoneal dialysis machines) to offer visual and kinaesthetic learning experiences. These changes reflect the feedback given. Ensuring learner comfort, selecting speakers with expertise and teaching skills and using learner-defined objectives were our learning points.
Introduction: The recent junior doctors’ contract negotiations highlighted wider, non-contractual concerns around flexibility in medical training. Health Education England (HEE) subsequently looked to explore innovative solutions and the development of new approaches to postgraduate training to improve morale and provide greater flexibility for junior doctors and dentists. The focus of this pilot was to explore the provision of more opportunities and wider access to less than full time training (LTFT). It was thought that a more flexible approach may:

- reduce ‘burn out’ and attrition;
- improve morale; and
- assist future recruitment.

Methods:
Applicants for LTFT training within the Gold Guide criteria are currently prioritised into two categories:

- Category 1: Trainees who have a disability, health issue or caring responsibility;
- Category 2: Trainees who have a unique opportunity for personal or professional development, a religious commitment or non-medical professional development.

It has been suggested that trainees who do not meet categories 1 and 2 do not apply or are disadvantaged from applying for LTFT training. The pilot therefore offered a third “category”:

- Category 3: Trainees who choose to train LTFT as a personal choice that meets their individual professional or lifestyle needs. That choice is not subject to the judgement of anyone else and is only limited by service considerations.

The pilot was made available to all existing higher Emergency Medicine (EM) trainees and current ST3 run-through EM trainees who were expected to progress to ST4 in August 2017. These trainees had a five week period to apply to partake in the pilot.

Results:
The pilot is currently subject to evaluation with results available by end of June 2017.
Number of applications by region to be incorporated into poster.

Conclusion:
Full evaluation to be incorporated into poster, as per the above. From the initial responses however it would appear that the more flexible offer of LTFT training will result in a modest service impact.

References: www.hee.nhs.uk
PERCEIVED CREDIBILITY; DOES HAVING CHILDREN CHANGE A CLINICIAN'S PROFESSIONAL PRACTICE?

Stilwell PAC*, Schindler N, Savery A, Fertleman C
The Whittington Hospital Magdala Avenue London N19 5NF

Background:
Paediatricians are commonly asked if they have their own children. Some evidence suggests that paediatricians who have children are perceived by parents to be more credible. Trust and credibility have been identified as important factors in the doctor-patient relationship. There is little research looking into whether paediatricians believe that becoming a parent makes a difference to their clinical practice.

Aim:
To establish if paediatricians perceive a difference in practice between those who have and those who do not have children, and identify potential learning needs.

Method:
We held four focus groups with paediatricians based in two hospitals. Each group was facilitated by a member of our team and recorded with consent of the participants. Key themes were identified and explored.

Results:
We obtained the views of 29 doctors at every level of paediatric training including consultants; 14 were parents. Doctors with children expressed strong opinions that personal experience of parenting was advantageous. They felt they were more empathetic in certain situations, had greater understanding of parental anxiety and spent more time communicating with families. Confidence was increased in assessing development and giving breastfeeding advice. Parental status of the paediatrician was not thought to affect their clinical decision-making process.

Doctors without children suggested that experience and training were more important than parental status in the development of their communication skills. They suggested that having young relatives assisted in learning about developmental milestones. Most participants without children felt under confident in giving breastfeeding advice.

Independent of parental status, participants felt that additional training in communication, development, breastfeeding and child behaviour would be beneficial.

Conclusion:
Participants held similar views to those previously identified by parents that having children may improve understanding of parental anxiety and communication with families. This may increase credibility. All participants could identify areas where additional training could improve practice. Whether having children affects the clinical practice of a paediatrician is an emotive topic and we have illustrated a range of viewpoints on this issue.
THE ‘MOTHER” SCORE – AN EVIDENCE BASED ASSESSMENT OF PREDICTING TRAINEE CONFIDENCE ON RETURN TO WORK AFTER MATERNITY LEAVE

van Boxel E*, Watson S2, Dawkins S3, Fordham J4, Mawson I5, Duncan S6, van Boxel G2
1) Paediatric Department, Stoke Mandeville Hospital, Mandeville Road, Aylesbury, Buckinghamshire, HP21 8AL
2) Magdalen College, Oxford University, High Street, Oxford, OX1 4AU
3) Paediatric Department, Great Western Hospitals NHS Foundation Trust, Marlborough Road, Swindon, SN3 6BB
4) Paediatric Department, Royal Cornwall Hospital, 2 Penventinnie Lane, Truro, TR1 3LQ
5) Neonatal Unit, St George’s University Hospitals NHS Foundation Trust, Blackshaw Road, Tooting, London, SW17 0QT
6) Paediatric Intensive Care Department, John Radcliffe Hospital, Headley Way, Headington, Oxford, OX3 9DU

Introduction:
In 2014 the GMC published a review on the phenomenon of ‘skills fade’ during time out of practice. Although it recognized that skills fade is related to time out of training, it reported there was a lack of information available on specific risk factors. One common reason for time out of practice is maternity leave. Here we report the results of a national survey of paediatric trainees to investigate experiences of returning to clinical work after maternity leave with a view to establishing what specific factors affect confidence on return.

Methods:
We conducted an online survey of doctors within the paediatric training programme (ST1-8) between March and May 2017. An email was sent out centrally to all 13 deaneries. Trainees currently on maternity leave and those who had completed a period of maternity leave were invited to submit anonymous responses. Statistical analysis was performed to establish those factors that independently predicted confidence levels on return to work.

Results:
We received 144 responses across 12 deaneries. 119 of those respondents had returned to work.

95.8% reported an initial lack of confidence on returning to work lasting more than a week (36.7% more than 3 months).

Analysis of the data revealed that the following were statistically significant independent risk factors for experiencing a lack of confidence on return that continued beyond 3 months: Those whose confidence took > 3 months to return had longer maternity leave times (25% were off for < 9 months compared to 42% whose confidence had returned within 1 month.) They were less likely to be working full time (6.8% versus 31.5%), were less likely to have undertaken medical revision whilst on maternity leave (75% versus 84.2%) and had done so less frequently (27.3% did revision at least monthly versus 38.5%). Working at a registrar grade was also associated with confidence returning more slowly (61.3% versus 79%).

Conclusion:
This work is the first to quantify what factors determine confidence on return to work following maternity leave. We propose a risk stratification score, the “MOTHER” score, to predict those trainees that are likely to feel less confident on return to work. In the score M: months out, O: other children, T: training stage, H: hours worked on return, E: educational activities, R: Recognition by consultant. Trainees with a high MOTHER score could be targeted for extra support on return to work.
EVALUATION OF A PILOT NAMED CLINICAL SUPERVISION AGREEMENT FOR WALES

*Webb K, Bullock A, Groves C, Saayman AG.

1CUREMEDE, School of Social Sciences, Cardiff University, 12 Museum Place, Cardiff, CF10 3BG, 2Quality and Postgraduate Education Support, Wales Deanery, Heath Park, Cardiff, CF14 4YS

Introduction
The GMC requires formal recognition of postgraduate trainers in secondary care. To promote high standards of postgraduate education and training in Wales and support the GMC’s implementation plan, the Wales Deanery introduced the Educational Supervision Agreement, a signed agreement between: an Educational Supervisor (ES); a Local Education Provider (LEP; the Health Board/Trust, i.e. Medical Director); and the Wales Deanery (Postgraduate Dean). Attention has now turned to Named Clinical Supervisors (NCSs). The purpose of this work is to evaluate the pilot of a NCS Agreement.

Method
We used mixed-methods to evaluate need, effectiveness and impact of the draft NCS Agreement in two LEPs. Telephone interviews (n=6) and an online questionnaire were conducted with those who signed the Agreement (n=50). Qualitative data underwent Thematic Content Analysis. Quantitative data were statistically analysed in SPSS.

Results
Interviewees were highly supportive of an Agreement for NCSs and described specific demands associated with supervisors. Over half (57%) of questionnaire respondents ‘agreed/strongly agreed’ the Agreement professionalised the NCS role. Most (83%) want an Agreement specifically for NCSs. Over half had had a job planning meeting in the last 6 months. All indicated NCSs would benefit from CPD for the role. Content included: teaching, trainer skills, completing assessments, managing difficult situations and supporting trainees. All indicated the Agreement had a positive impact on their role as a NCS, quality of training and patient care. Over half ‘agreed/strongly agreed’ the Agreement enhanced accountability, 38% felt it supported their negotiation of time for training and 33% that it provided leverage to negotiate recognition of SPA time within job plans. Supervisors wanted more feedback on their supervisory role (52%). Barriers to implementation of an Agreement were time and service commitments, different practises in specialties and overlap between the ES and NCS role.

Conclusions/implications
Participants felt the Agreement professionalised the role of NCS and articulated the need for an Agreement suited to NCSs. The Agreement impacted positively on their role, quality of supervision and quality of patient care. Respondents wanted a minimum CPD requirement, thereby raising standards of postgraduate education. Findings will inform the next iteration of the Agreement.

References
2. Wales Deanery (2013) Educational Supervision Agreement. Available at:
THE IMPACT OF MEDICAL EDUCATION FELLOWSHIPS ON FUTURE CAREER PATHWAYS

Winterbottom K*, Agius S
Health Education England (North West Office)

Introduction: There are different types of fellowships within postgraduate medical education and training, delivered in several regions across Health Education England (HEE).

A fellowship programme centred around medical education, primarily in secondary care, is currently operational in Health Education England North West (HEE NW) and Wessex regions, although programme structures are different.

The Medical Education Fellowship (MEF) programmes have been running for 8+ years, and require significant input and resources. Although the programmes have been consistently highly rated in local evaluations, there is limited published evidence as to the longitudinal impact of such fellowships on educational and career development.

Aim: To determine the educational and career development value of Medical Education Fellowships to trainees.

Method: MEF alumni (47 in total) from both regions were invited to participate in semi-structured interviews. Consent was secured to conduct, record and transcribe the interviews. Anonymous data were subsequently analysed using the thematic framework method.

Results: 9 interviews were conducted across HEE (NW) and HEE Wessex. Qualitative analysis of the interview data highlighted a number of common themes outlined in Table 1.

<table>
<thead>
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<th>Table 1</th>
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<tr>
<td><strong>Identity as an Educator</strong></td>
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<tr>
<td>• Highlights interest in medical education thereby creating opportunities</td>
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<tr>
<td>• Peer-support group of ‘like-minded people’</td>
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<td>• Provides unique networking opportunities</td>
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<td><strong>Career Development</strong></td>
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<tr>
<td>• Better understanding of educational roles and career landscape</td>
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<tr>
<td>• Increased opportunities at local, regional and national level</td>
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<td>• Enhanced CV providing ‘competitive advantage’</td>
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<tr>
<td><strong>Educational Leadership</strong></td>
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<tr>
<td>• Current plethora of educational roles including senior positions</td>
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<td>• Educational roles prominent focus alongside clinical responsibilities</td>
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<td>• MEF has enabled ‘fast-track’ into key roles</td>
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<tr>
<td><strong>Scholarly &amp; Academic Development</strong></td>
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<tr>
<td>• Academic component highly valued</td>
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<td>• Unique opportunities in educational research</td>
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<td>• Support to present and publish project work</td>
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Programme Enhancement
**Conclusions:** The title of ‘MEF’ helps create unique opportunities not easily accessible within clinical training. The ability to include the MEF on CVs and applications for consultant posts provides trainees with a ‘competitive edge’, and has impacted on the ability to ‘fast-track’ into key educational roles.

The programme is valued by trainees and provides them with the appropriate learning, skills and opportunities to become senior educators of the future.

**Next steps:** The findings from the research, aims to help contribute to the knowledge gap around the impact of postgraduate educational fellowships on career pathways. It will be shared across HEE to be used in the decision making process regarding the future of education fellowships.

References