JUNIOR DOCTOR HANDOVER IN SURGERY

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INTRODUCTION:
With the increasingly fast-paced nature of the NHS, and high turn-over between teams, it has been well recognised that structured handovers play a pivotal role in ensuring patient safety, team efficiency and effective continuity of care. The aims of this Quality Improvement Project (QIP) were to evaluate the quality of junior doctor handovers amongst the surgical team at Great Western Hospital; to conceptualise and implement a proforma to prompt handovers of essential details pertaining to patient-related jobs; and to re-evaluate the effectiveness of the intervention post-implementation. The objectives were to prioritise patient safety, streamline efficiency and teamwork within teams and to enhance continuity of care.

METHOD:
This QIP adhered with the Plan-Do-Study-Act (PDSA) Cycle of QI Methodology throughout the 8-month project. Preliminary subjective baseline questionnaires were sent to the doctors to evaluate the current handovers. Objective ratings of handovers involving 53 patients were carried out over a week as per outlined parameters. Based on findings, a handover proforma was conceptualised to streamline efficiency of handover and productivity on the job. Quantitative outcomes were analysed as part of the re-evaluation of the QIP. Qualitative questionnaires assessed the teams’ opinions about the new handover proforma.

RESULTS:
Efficiency in length of handover improved from 5 minutes to 2 minutes per patient. Urgency of tasks being highlighted improved by 127.5%. Background of patient was increasingly highlighted by 83%. Clear actions of the tasks improved by 17.5% and situation improved by 29.9%. Feedback from questionnaires collectively revealed a positive impact after the implementation of the proforma.

CONCLUSION:
The use of the proforma significantly improved efficiency within teams. The addition of a column for urgency of task, ranging from 1 to 3 in level of importance, enabled doctors to effectively and safely prioritise all jobs handed over; ensuring patient safety was enhanced throughout busy shifts. This proforma ensured salient information was effectively handed over to teams, with cues to then handover to incoming teams. It also importantly improved streamlining of handovers, boosting efficiency and communication. This QI met all the aims and objectives set out, with plans to implement the proforma onto other departments within GWH.
QUALITY CRITERIA FOR CORE MEDICAL TRAINING – IMPACT ON EDUCATIONAL EXPERIENCE

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BACKGROUND: In 2015 the Joint Royal Colleges of Physicians Training Board (JRCPTB), acting on behalf of the three United Kingdom (UK) Royal Colleges of Physicians, launched a set of quality criteria designed to improve the quality of training and educational experience of Core Medical Trainees (CMTs) in the UK. These were implemented by UK postgraduate schools of medicine in 2015. This study evaluates the impact of these criteria on the quality of training.

SUMMARY OF WORK: The criteria were developed with key stakeholders from Core Medical Training (CMT) and were grouped into 4 domains which included:

a. Structure of the programme
b. Delivery and flexibility of the programme
c. Supervision and other ongoing support available to trainees
d. Communication with trainees.

Questions related to each of the domains were developed and included in the annual GMC National Training Survey (NTS) as programme specific questions. The survey results were analysed over 2015-2018 to evaluate the effectiveness of the criteria.

SUMMARY OF RESULTS: There were trainee-reported improvements from baseline (2015-2018) in at least 8 out of the 13 core criteria measured (Figure 1). These included improvements in attending:

- Post-take ward rounds and handovers,
- Outpatient clinics to meet curriculum requirements,
- Simulation training,
- Curriculum-relevant and Practical Assessment of Clinical Examination Skills (PACES) teaching,
- Department Induction
- Pre-Annual Review of Competence Progression (ARCP) appraisals and agreeing training plans before attempting Membership Royal College of Physicians (MRCP)(UK) exams.

DISCUSSION AND CONCLUSIONS: The results demonstrate that a co-ordinated UK-wide approach to quality improvement, focused on a specific set of clearly-defined and measurable outcomes that galvanise trainer engagement, can lead to greater trainee satisfaction in a demanding area of medicine without significant additional resources.

TAKE-HOME MESSAGES:

- Implementation of the Core Medical Training Criteria have led to significant improvements in quality of training and educational experience over the last 3 years.
- Where implemented, they can help improve trainee workload-to-learning balance, provide enhanced educational support and, together with critical learning opportunities, help better prepare trainees for the General Internal Medicine Registrar role.

REFERENCES:

DO SURGICAL TRAINEES WANT MENTORING? THE RESULTS OF ASKING A SCHOOL OF SURGERY

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INTRODUCTION:
The role of mentoring is not new in medical practice; Osler’s mentoring of Cushing is well celebrated. Training roles, trainee commitments and training centres have over recent years have become more rigid, formal and (in theory at least) accountable. Portfolios, formally documented meetings and annual reviews have become more ordered.

The same has not happened for the role of a mentor, as it has for role of a trainer. With loss of the firm structure, short rotations with complex rotas and frequent trainee relocation, the time and space for mentoring of a trainee is easily sacrificed. This is a potential problem in all postgraduate medical training.

In this deanery, there was varying degrees of engagement with efforts to support mentoring within the School of Surgery. This work aimed to identify if there was a scope for developmental mentoring to be supported and delivered, and looked at the perspectives and understanding of developmental training from both Trainees and Trainers, within the School of Surgery.

METHOD:
A survey was sent out to trainees, Training Programme Directors and Educational Supervisors in the East of England School of surgery.

RESULTS:
51 trainee and 24 consultant colleagues responded.

25/51 trainees felt they had not had a mentor since graduating medical school, and 23/51 trainees felt they had not had developmental mentoring. 5/51 were unsure if the mentoring they had experienced was developmental. 42/51 trainees answered that they did see a role for developmental mentoring, independent of and outside of clinical supervision (4 respondents were ‘unsure’).

21/24 Consultants responded that in the current environment, they saw a role for developmental mentoring, independent of and outside of clinical supervision (3/24 were unsure). 22/24 Consultants answered that they would encourage trainees to engage with developmental mentoring (2/24 were unsure). Only 11/24 consultants felt they had received developmental mentoring during their own training.

CONCLUSIONS AND IMPLICATIONS:
The survey results were very reassuring regarding the appetite for developmental mentoring in this School of Surgery. However, the overall active engagement is lacking.

The free text comments highlighted areas for focus to increase the accessibility to developmental mentoring, and the barriers that exist to both understanding and utilisation. The buy-in from leaders within the school will be key to achieving the positive outcome of a sustainable mentoring scheme.

Annual specialty reporting is used to ensure that there are robust processes within training programmes to meet GMC standards as outlined in Promoting Excellence and to enhance the training experience for trainees and support for trainers. It allows a different perspective for the Quality Unit in the Medical Deanery of Health Education and Improvement Wales (HEIW) to that received from LEPs (Local Education Providers). In addition, evidence of areas of good practice could be shared between specialties. Previously, the forms were considered a bureaucratic burden by the chairs of the specialty training committees (STCs) and training programme directors (TPDs), for whom the relevance was not always clear. Whilst initial response rates were high these started to dwindle as did the quality of the information provided. We wanted to change the process to one that would encourage engagement, by making it more relevant and easier to complete and ultimately be a mechanism which has the capacity to drive improvement.

**PROCESS:**
Feedback regarding the process was sought and considered by a focus group. Questions were honed and manipulated to fit within a RAG system and whilst some qualitative information was required to contextualise responses, the aim was to create a questionnaire that was much less burdensome. This was then piloted and tweaked before sending out to the Specialty Schools for completion.

**RESULTS:**
There was a small percentage rise in the number of completed questionnaires returned to the Quality Unit. In addition, and more importantly, it was clear that the responses were more focused on the questions and therefore more relevant. The RAG system created an easy reference to where the specialties viewed areas they needed to improve and initial feedback about the forms was mainly positive. The results provided information which could be used to enhance consistency and improve processes across training programmes and the reporting format lends itself to easy ongoing review through the year.

**THE FUTURE:**
Further amendments will consider the feedback received and the process will remain iterative, although the RAG should allow trends to be viewed over time. The results will be used to enhance the robustness of processes across training programmes and offer the potential for trends to be identified in the future.
DEveloping an online tool to support community dentist appraisal

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Introduction:
The Revalidation Support Unit (RSU) was commissioned by Welsh Government to develop and pilot a bespoke, end-to-end appraisal system for the Community Dental Services (CDS) in Wales.

All CDS dentists must complete the annual renewal process each year to retain their General Dental Council registration and undertake an annual appraisal as part of their terms & conditions of service.

The RSU consulted with a number of key stakeholders to develop the system including Welsh Government, Health Boards and the British Dental Association to ensure it met all contractual and regulatory requirements of CDS dentists.

Methods:
All CDS dentists have the opportunity to undertake their annual appraisal on our Dental Appraisal System (DAS) during the 12-month pilot (commenced in September 2018). Previously, all appraisals were completed on customised paperwork within each Health Board. The RSU met with all Health Board CDS Clinical Directors to try to align their requirements into a unified online appraisal platform.

Each dentist is required to agree an evolving PDP on the system with their Appraiser following their appraisal meeting, thus fulfilling one of the key requirements of the Enhanced CPD Scheme (part of the Annual Renewal process).

Results:
The RSU has undertaken an interim review of the pilot to assess progress and feedback from all users. The review demonstrated a number of benefits and considerations including:

Benefits of DAS:
- Enables CDS dentists to meet key regulatory and contractual requirements
- Unified approach to CDS dentists appraisal

Future Considerations:
- Explore methods to increase engagement
- Provide stakeholders with evidence-based findings to determine next steps in regards to CDS dentists appraisal

Conclusion:
All dentists provide feedback via DAS following the completion of their appraisal. The RSU will collate and analyse the feedback into a final report, which will provide key data for stakeholders to consider in determining the future delivery of appraisal in the Dental Community.
A PICTURE SPEAKS A THOUSAND WORDS: USING RUN CHARTS TO IMPROVE THE QUALITY OF CLINICAL TEACHING

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INTRODUCTION: Student evaluation of teaching is an important component of quality assurance processes in higher education. Medical schools regularly disseminate student evaluation of teaching data to clinical placement providers. These data sets measure student satisfaction, identify areas of concern and highlight good practice. They are used to improve teaching and enhance the student experience. To enrich the quality of data disseminated to educators run charts were created to summarise student evaluation of teaching data. A run chart is a line graph of univariate data plotted over time. Run charts are integral to Quality Improvement and may be used to identify variations in data over time and highlight outliers.

METHOD: Run charts were generated for the following clinical specialties from September 2017 to June 2019: general surgery, general medicine, paediatrics and obstetrics and gynaecology. Placement providers received run charts summarising their performance and anonymised data for other units. Data was generated on 8 occasions for general surgery and general medicine and on 12 occasions for paediatrics and obstetrics and gynaecology. A benchmark of 80% of respondents rating quality of the placement as “very good” or “good” was used to determine a minimum threshold for student satisfaction. See Figure 1 for example run chart.

CONCLUSIONS: While most teaching units maintained a consistent level of performance the run charts did highlight some variations. Two units with consistently poor student satisfaction scores over several years commenced a major re-structuring of their teaching programme following receipt of run charts.

This tool provided educators with timely and informative comparative data aligned with the format of other data sets used routinely in the clinical workplace. It serves to integrate the information provided by each evaluation with time, and allows educators to identify the signal (consistent significant trends) from background noise (minor variations) of feedback. Importantly, it can motivate outliers to change practice.
MEDIROTA, THE FUTURE TO IMPROVING WORK-LIFE BALANCE
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INTRODUCTION:
To enable the National Health System to operate effectively 24 hours a day, seven days a week, a lot of advanced planning and scheduling of staff is required. Rota scheduling can be highly time-consuming, costly and confusing with last minute changes often required. Furthermore, rota scheduling has a significant impact on the work-life balance of staff and trainees. The Obstetrics and Gynaecology (O&G) department at East Lancashire Hospital Trust currently uses a rota system created and managed online using Google Docs.

AIMS:
The aim of the quality improvement is to improve the current rota system, focusing on providing an easy to use online system for admin staff and a secure mobile-friendly app for all trainees and staff. The end goal is to be able to secure educational teaching sessions, provide fair opportunities and allocate the required number of training slots for speciality interest sessions through the use of an admin portal reporting system.

METHODS:
The current rota system’s security, accessibility, efficiency and ease of use was evaluated using a survey questionnaire as part of the PDSA (Plan-Do-Study-Act) cycle 1. A rota app designed and tailored to the needs of the O&G department was implemented for the PDSA cycle 2. Interventions tested, included providing a safe to use a mobile-friendly app that displayed the trainees current schedule was trailed for two weeks. Feedback was collected through an online survey after the testing phase.

RESULTS AND DISCUSSION:
The implementation of a mobile app resulted in a significant increase in the security of the rota system. Security increased from seventy-three percent (73%) to one hundred percent (100%). This was achieved by implementing a username and password-controlled login. The user satisfaction rate increased to ninety-five percent (95%) from sixty-nine percent (69%). By using the mobile app and the unique admin portal system, the management and control of the rota system will be improved, and the educational slots provided for the trainees will be secured.

CONCLUSION AND RECOMMENDATIONS:
For the PDSA cycle 3 to occur, the completion of the mobile app and the admin portal are required. With the input of the current rota staff, the completion of the admin portal can proceed, and any unmet needs can be addressed before commencing the next PDSA cycle 3 in July 2019. Implementation of MediRota as the official rota system in the Obstetrics and Gynaecology department will commence in August 2019.
EVALUATING THE IMPACT OF ‘NEXT GENERATION GP’: A NATIONAL LEADERSHIP PROGRAMME FOR GP TRAINEES AND EARLY CAREER GPS

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BACKGROUND:
Leadership is a key competency in the UK GP training curriculum. However, it is known that GP trainees can complete training without a clear understanding of the complex NHS system they will work within, and lacking the skills to lead change effectively.

‘Next Generation GP’ is a national leadership programme for trainees and newly qualified GPs. It aims to: energise participants through contact with inspiring local and national leaders, facilitate their engagement in peer-networks, and empower participants with the skills and knowledge to lead change within their practice workplace and beyond.

SUMMARY OF WORK:
The ‘Next Generation GP’ programme comprises six evening sessions over 6 months; in each two leaders share their experience in an interactive workshop. Between February 2017 and December 2018, 428 participants took part in 7 courses running in 6 locations across the UK.

All participants (n.428) completed a ten question pre- and post-course evaluation looking at their knowledge of and learning about leadership, as well as space for free text reflections.

SUMMARY OF RESULTS:
Responses were analysed pre- and post-session, within and between locality cohorts. Overall, participants reported improvement in knowledge of: the structure of primary care in the NHS and its relationship with wider healthcare services, leadership skills; greater confidence and motivation to take up leadership opportunities - many participants reported the intention to take up leadership roles in organisations such as clinical commissioning groups or local medical committees.

Fee text responses were grouped by theme, revealing four headline areas: ‘inspiration,’ ‘conversations with leaders,’ ‘confidence,’ and ‘personal action /development.’

DISCUSSION AND CONCLUSIONS:
Findings from the evaluation suggest that the ‘Next Generation GP’ programme is meeting a need for leadership education for GP trainees and newly qualified GPs at the point of transition to a complex and rapidly changing NHS. The programme actively promotes engagement in local leadership networks and roles both during training and in the early years post qualification. The evaluation findings will inform future developments such as virtual networking and follow up engagement activities.
TRAINING PROGRAMME QUALITY REVIEWS: DO WE ALREADY HAVE THE ANSWERS?

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BACKGROUND:
The 2018 GMC National Training Survey revealed concerns about loss of training opportunities, intense workload and burnout. Local training programmes that are committed to delivering relevant improvements must understand the specific issues they face.

This pilot study aimed to get a broad sense of what issues Core Trainees (CT’s) thought were relevant to the quality of training and explore some of these perspectives through a focus group. This were then contextualised with other sources of data to develop a plan for simultaneous improvement and evaluation.

METHODS:
A cohort of 9 completing CT’s were invited to a focus group and 6 attended. It was facilitated by a specialist trainee (ST) familiar to the CT’s rather than an authority figure as frank discussion was a priority. The 90 minute transcript was then thematically analysed (saturation not reached). Complementary data sources included the ‘CT Exit Questionnaire’ from Aug 2016- Feb 2018 (53) and 2 interviews with members of the Junior Doctors Committee.

RESULTS:
Thematic analysis identified 6 themes:
• Training was hard work clinically and non-clinically but was overall positive experience with a trainee focused approach.
• There are issues of having two trusts in one training scheme with disconnect and perceived difference in quality of training.
• Numerous factors affected experience of rotations including community versus inpatient and their suitability for training at different stages.
• Support for trainees could be better, especially in particular areas such as post serious incident or transition from CT to ST.
• Issues with Psychotherapy experience, particularly teaching and training
• The structured teaching programme was great in principle and could be improved in practice

Questionnaire responses revealed CT’s having overall positive experience, valuing the breadth of clinical placements and the protected teaching time. It also identified a demand for specific training on ST transitioning.

Current trainee led improvement projects were identified in the following areas: improved support for trainees (serious incidents), psychotherapy training, improving choice of rotations, ST transition teaching and improving International Medical Graduates support.

CONCLUSION:
The pilot focus group had value identifying issues missed by questionnaires. Further groups are justified to explore different cohort perspectives. Interestingly, improvement projects already being undertaken by trainees were consistent and even expanded identified themes although did not capture all issues. This provides an efficiency opportunity for the postgraduate department as enhancing such projects through support and investment utilises the insight and efforts of trainees. Other resources can then be focused on ensuring enough perspectives are explored to reveal unknown themes and to address issues that are not already being worked on.
OCCUPATIONAL THERAPY: AN EMERGING ROLE IN PRIMARY CARE

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BACKGROUND:
GPs in the UK are under significant pressure in delivering primary care and this has highlighted the need for workforce development. Occupational therapists (OTs) are highly skilled practitioners working across health and social care sectors. Educated at pre-registration level to work with physical and mental health issues, OTs can potentially provide valuable support to GPs. To date OTs are not routinely utilised within primary care. For over 10 years the University of Southampton OT Department has developed placements in a range of settings for students, but never previously in primary care.

The focus of this study was to determine whether role emerging placements in primary care enhanced the learning of OT students and to consider what can be learned about the role of occupational therapy in primary care.

SUMMARY OF WORK:
A case study approach was used to evaluate the project. Methods of data collection for this study included: observation of small group teaching sessions and end of placement interviews with students, educators, and members of the primary care teams involved in the placements.

FINDINGS:
Analysis of the data indicates OT skills can be utilised in general practice in a number of ways, in certain areas, potentially saving face-to-face consultations with GPs.

CONCLUSION:
OTs are an under-utilised profession in frontline primary care. The role of OT has not been well researched as a ‘first point of contact’ healthcare professional in primary care. OTs’ broad training in mental health, physical frailty, and learning disabilities are potentially valuable to service delivery in general practice.
“BECOMING THE MED REG” - FROM PILOT TO A SOUTH LONDON PROGRAMME

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BACKGROUND:
The role of Medical Registrar has traditionally been perceived as challenging. In recent years, trainee satisfaction has declined, and specialty recruitment has been disappointing with trainees seeking alternative career paths. We surveyed Core Medical Trainees (CMTs) at King’s College Hospital NHS Trust in order to understand the key issues driving trainees away from this role. The following key themes were identified:

- Taking referrals and giving advice
- Leadership
- Prioritisation and decision making
- Confidence managing arrests and acutely unwell patients
- Burnout and stress

We felt that these apprehensions were not currently being addressed consistently either during CMT training or in various Medical Registrar preparation courses. This programme was initially delivered to CMTs at King’s College Hospital NHS Trust, winning awards at two South London conferences.

OBJECTIVE:
Our aim was to deliver this programme regionally to CMTs across South London with the intention of improving confidence and addressing trainees’ concerns about transitioning into the role of Medical Registrar.

METHODOLOGY:
This programme is being delivered as a one-day course in four NHS trusts across South London with the following programme outline:

Session 1: Taking referrals from A&E
Session 2: How to manage your team
Session 3: How to manage yourself
Session 4: How to deal with other specialities/giving advice
Session 5: Med Reg nightmares
Session 6: Hospital @Night Handover
Session 7: Careers planning

The trainees completed a pre and post programme questionnaire about their perceptions of training, confidence and career prospects.

RESULTS:
The programme was well received by trainees. Initial results showed that overall, trainees rated the utility of CMT in preparation for the role of the medical registrar as 6/10 (average) whereas they rated the utility of this programme as 8/10. All trainees felt this programme should be a mandatory component of Internal Medicine Training (IMT). Feedback from further four courses is currently pending but will be available by August.

DISCUSSION AND CONCLUSION:
The need for this programme was evident and with the introduction of IMT, we have a duty to prepare trainees in IMT1 and IMT2 to become the Medical Registrar in IMT 3. This programme has been shown to improve confidence and addresses trainees’ concerns about this transition. We hope to deliver this innovative programme as part of pan-London IMT training.
‘UTILISING THE MULTI-PROFESSIONAL LEARNER VOICE TO ENHANCE THE QUALITY OF EDUCATION’ – AN EXPLORATION INTO HOW STUDENTS’ VOICES ARE HEARD

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The aim of this project is to understand how practice placement providers across the Kent Surrey Sussex region collect and use the voices of learners across professional disciplines, to ensure or enhance the quality of the education they are providing.

Whilst structurally its focus is to support medics in training, it remains the responsibility of Health Education England (HEE) to ensure that all healthcare learners are provided with high quality learning environments throughout England, as per their 2019-2020 ‘Quality Framework’. The ability and strength of trainee voice is an essential component of the learning experience, and both its worth and its use is of great importance to HEE. However, there remains inconsistency in the way students from differing professions are supported and how they can share their invaluable insight and feedback. With the continual increase of students undertaking clinical or practice placements as part of their undergraduate or postgraduate studies, it is of the interest of patients, education providers, regulators and workforce planners to ensure the experience learners receive is of the highest standard.

Initially led by networking opportunities available through the author’s Darzi Fellowship, then using a range of explorative methods including; stakeholder events, one to one meetings; targeted emailing etc, the varying approaches used by practice placement sites were collected to feed into the organisation's ongoing strategic programme for ‘Securing Future Supply’. How the placement providers used this student voice was of great interest as it would often contribute to the experiences felt by their current and future student body.

The results of this work are ongoing but initial findings have shown a high use of post-experience feedback surveys that highlight areas of improvement, and appointed (or nominated) practice educators/mentors that support the trainees throughout their placement, addressing immediate concerns as well as facilitating the learning the student is receiving. Other initiatives such as multi-professional faculty groups with student representation or trialling of pastoral educator roles have been created to better support students whilst undertaking practice placement.

The findings will allow for recommendations and sharing of good practice across the region as well as highlight areas where HEE can support placement providers and enhance the quality of education.
INTRODUCTION:
Within recent years patient safety incidents have become an area of scrutiny within healthcare. The concept of the ‘never event’ was devised as a way of managing clinical risk and defining serious incidents. NHS England data analysis has identified that wrong tooth extractions are the most frequent ‘never event’. However this reflects predominantly secondary care activity and consideration needs to be given to increasing unreported patient safety incidents in primary care. Currently there is a lack of awareness of mechanisms for reporting dental patient safety incidents, combined with a culture of fear of reporting due to perceived negative repercussions. Education and training is crucial to raising awareness and changing attitudes within the profession.

METHODS:
We propose a model of leading and educating the profession in patient safety initiatives. This includes participation from key stakeholders to encourage engagement and build local support networks. The education is delivered as ‘road shows’ in each region. This was piloted in one region to evaluate the material and gain delegate feedback. The course used a mixed teaching method of lectures and interactive workshops to generate discussion, and exchange knowledge amongst practitioners.

RESULTS:
The course content encompasses methods for reporting patient safety incidents, human factors and patient safety incident prevention tools. It has also provided an important support hub. Involvement from key pioneers within this field has defined a minimum standard of care and removed the uncertainty for reporting never events.

CONCLUSION:
The patient safety incident road show is a simple, evaluated, tool that can lead education across a wide cross-section of the dental profession. This programme not only provides an educational platform for primary and secondary care dentists, but supports peer networking that allows dentists to seek advice and support from colleagues. It is anticipated as the programme is widely implemented reporting of patient safety incidents will increase, enabling clinicians to learn from errors, as well as create a positive ethos where clinicians work collaboratively together to optimise patient care.
WORKING ACROSS THE EAST OF ENGLAND TO RETAIN TRAINEES VIA SUPPORTING RETURN TO TRAINING

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INTRODUCTION:
A survey sent to all East of England trainees in mid-2017 suggested that following a break, most do not feel prepared to return to clinical training. 50% felt very anxious on their return and that this impacted on patient safety. 70% had not planned their return. Many returned to cover a night shift and felt unsafe to do this. 50% had considered leaving medicine.

METHODS:
Following the national launch of Supported return to training (SuppoRTT) in autumn 2017, we invited all Heads of School, Training Program Directors (TPD), College Tutors, Medial Education Managers and Medical Staffing leads from our 19 acute trusts to a half day workshop to create a return to training policy for our trainees. We ran the workshop four times, building on the discussions from the previous ones.

Key decisions were:
- all trusts agreed that KIT days could be taken in your new trust (with an honorary contract, DBS and OH clearance remaining with the employing trust),
- funding was ring fenced for all returners to be additional to the rota for 2 weeks full-time equivalent on their return
- returners would have access to additional study leave money for relevant courses.
- we would run generic ‘Return to Clinical Practice’ days, with a mixed faculty of trainers and trainees, covering aspects such as ‘wellbeing’, human factors and ‘mentoring’. Childcare would be provided.

We collectively developed online forms to facilitate discussion between the trainee and TPD prior to leaving, prior to returning and 2 weeks post returning. We have worked with all Heads of Schools and trusts to develop specific courses for returners.

RESULTS:
Feedback from trainees (April 2019, n=60) has shown that 60% of respondents had made a plan of how to safely return to training (37% pre SuppoRTT) and 38% of those eligible had used KIT days (12% pre SuppoRTT). 39% had done relevant courses (17% pre SuppoRTT). 26% had used a supernumerary period (0 pre SuppoRTT), and 76% had been able to plan what they did during this themselves. 100% had found this supernumerary period useful. Courses that returners felt would be useful included SIM (56%), courses with other trainees in their speciality (70%) and with other returners (40%). 84% felt that ALS (or equivalent) would be useful.

CONCLUSIONS:
Developing SuppoRTT in the East of England has been a team effort, with trainees, educators and managers involved in the development and implementation of the strategy. Early results are encouraging, and we are now in a phase of further publicity to encourage more widespread use of the support available.
HEETV TRAINING DEVELOPMENT FELLOWS FOR SUPPORTTT: ENGAGEMENT OF A CROSS-SPECIALTY LEARNER GROUP TO DRIVE IMPLEMENTATION OF NATIONAL EDUCATION INITIATIVES

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BACKGROUND:
Supported Return to Training (SuppoRTT) is a Health Education England (HEE) initiative to assist doctors in training back into their posts after long absence. The Trainee Advisory Committee Health Education Thames Valley (TAC) is a trainee representative forum. The trainees meet with the Postgraduate Dean, promoting a mutually beneficial platform for discussion and resolution of educational governance issues. TAC wanted to continue empowering trainees to be involved with the implementation of national strategy.

METHODS:
A private web-based Kanban board was set up to provide opportunity to share documents and sound board ideas whilst people were generically invited to participate via email. Some trainees and non-trainees with specific experiences were targeted as they had previously raised valid issues of concern in this area, to catalyse the group into action. Locally based national appointed fellows for SuppoRTT and those who had been working on associated projects in the area previously were also personally targeted with invites. When most schools had representation a series of web-based teleconferences were co-ordinated to answer questions about the new national strategy and local implementation.

The trainees, over a period of time, self-appointed a group of those who had time and enthusiasm to represent their speciality on the new forum.

The group forged a basic working relationship on the Kanban Board then began face to face meetings. The voluntary contribution of time required was recognised by the Local Associate Dean as HEETV Training Development Fellows for SuppoRTT.

OUTCOME:
A number of highly rated and nationally recognised initiatives have been founded and completed by trainees in this group of 30, with more ideas occurring and legacy building from ongoing recruitment of the recently SuppoRTT’d cohort of trainees. Trainees have gained experience in business planning, funding applications, and leadership as well as gaining experience in working alongside HEE to implement a national policy with local knowledge.

CONCLUSION:
Empowering trainees to be involved in the implementation of national strategy in their locality drives excellence and provides experience of cross speciality collaboration to improve individual, team and organisation issues. This ensures an excellent education, and training opportunities for the next generation.
DEFINING QUALITY ASSURANCE MECHANISMS FOR UNDERGRADUATE PRIMARY CARE

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INTRODUCTION:
Imperial College London Medical School provides undergraduate primary care placements for approximately 320 students in each year of the MBBS. With an ongoing national requirement to increase student exposure in primary care there is a particular need to increase the quantity of primary care community placements and the quality of those placements accordingly. There is however an absence of national quality regulation for undergraduate primary care placements and tutors. We have therefore developed and implemented a number of quality assurance measures to apply to our expanding pool of GP tutors (c1000) and Practices (c800) across North West London and beyond, bringing this all together into one accessible Quality Manual.

METHODS:
Over a period of 2 years, the following key processes were developed:
- New tutors attend in-house training with observed personal feedback
- Ongoing educational development for GP tutors via advanced skills courses
- Faculty Development team visit new teaching practices
- Standardised system for reviewing student feedback including escalations (trigger visits)
- Regular review of national CQC quality assurance practice ratings
- Risk assessments for alternative setting providers e.g. prison settings

RESULTS:
As a result of the above processes, since January 2017:
- 146 new primary care tutors approved and engaged in teaching
- 231 delegates attended our one day teaching course to gain approval
- 28 in person visits to practices carried out to approve new teaching sites
- 18 new ‘alternative’ providers (e.g. homeless shelters and drug/alcohol clinics) approved, increasing opportunities for students to experience wider health inequalities
- 4 separate practices received ‘trigger visits’ following repeated student feedback
- Positive formal student feedback received, impacting the student experience

CONCLUSIONS/IMPLICATIONS:
In the context of an increasing need to provide good quality undergraduate community placements, multiple strands of quality markers have been developed. These have been drawn together in a Quality Manual to provide a coherent framework within which to work, to minimise risk and to provide evidence to external regulators. It is projected that the implications for developing the framework are an improving and ‘safe’, high quality primary care student experience.

DEVELOPING THE ANNUAL REVIEW OF COMPETENCY PROGRESSION (ARCP) APPEAL PROCESS

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In 2007 the Gold Guide was released as a reference guide for postgraduate training. It outlined a process by which trainees could appeal if they disputed a panel's ARCP decision to recommend an outcome 2, 3 or 4. The process of managing appeals was developed locally by each region, with Health Education England's north east office opting to hold focussed meetings based loosely on the model of a Human Resources disciplinary hearing. Several difficulties were encountered with this format and as a result, appeals had become traumatic for all, time consuming and expensive. It was felt the trainee's attention was diverted away from learning, the trainer's attention away from supporting them, and the appeal panel's attention away from the real issues, as they were inundated with data.

A task group took an opportunity to revise the local ARCP appeals process and a new HEE NE policy was implemented resulting in:

- Greater consistency in both appeals and ARCP processes between Schools
- Improved information flow to the Postgraduate Dean's office and resolution of any issue of variance in the process
- More disputes resolved at the review stage
- Fewer appeals, due to a combination of a more effective review, and the use of the proforma, which prompts the trainee to reflect more on their reasons for appeal and asks for evidence to support their claims
- A reduction in the burden of, and time spent preparing and hearing appeals due to:
  - The change in philosophy to one where it is assumed the original panel reached the correct conclusion, that trainers and TPDs are properly trained for the role, are diligent and reasonable and that due process has been followed, unless otherwise proven
  - The focussed approach on addressing the issues logged by the trainee on the proforma
  - Trainees, Trainers and Panel chairs now clearer on their role and responsibilities throughout the process, reducing the stress involved for all
  - A more focussed and more humane process

Whilst appeals should remain as a right of potential redress for a trainee, the time, commitment and the potential stress caused by the appeal process for the various parties concerned should remain in balance. One of the most notable benefits of HEE NE's approach is that the reduction in effort required to prepare management reports, has resulted in HEE NE's faculty and administrators being able to redirect their time towards supporting training and the trainees in a more direct and quality determined way.
HOW CAN WE SUPPORT SUPERVISORS TO SUSTAIN THEIR SKILLS? – REAPPRAISAL RESOURCES FOR CLINICAL AND EDUCATIONAL SUPERVISORS OF FOUNDATION TRAINEES

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INTRODUCTION:
The Academy of Medical Educators (2010) produced a framework for the Professional Development of Postgraduate Medical Supervisors. However, the framework areas suggest potential domains for continued development but do not offer specific resources.

METHODS:
To support clinical and educational supervisors we sought to develop a comprehensive list of resources (regional and nation-wide) in a range of modalities (face-to-face, e-learning and reference). The need for this resource was supported anecdotally based on the experience of the foundation school and a questionnaire distributed across the supervisors in Yorkshire and the Humber.

RESULTS:
The Academy of Medical Educators framework was used to produce a comprehensive resource for supervisors to continue their professional development. Over one hundred potential resources were identified across the seven framework domains.

IMPLICATIONS:
The questionnaire provided an insight into the ongoing development requirements for clinical and educational supervisors. The reappraisal resource will be an important source of information to support supervisors of foundation doctors to maintain their skills. This resource has further potential uses for supervisors of other doctors or trainees themselves given the wide variety of sources.
FUTURE LEADERS’ CONFERENCE 2019: DOUBLING THE DOSE OF LEADERSHIP EDUCATION

Health Education England - Future Leaders’ Programme

INTRODUCTION:
Effective leadership is important for patient care and medical education. However, there is a lack of leadership training and events for doctors and allied health professionals early in their healthcare careers. The Future Leaders’ Conference is an annual event planned, organised and implemented by Leadership Fellows alone. This provides an important opportunity for current Fellows to develop their own leadership skills whilst featuring leadership projects, educating and inspiring future leaders.

METHODS:
The conference was organised by eleven leadership fellows from a wide range of healthcare backgrounds and lengths of training. It was funded by the Future Leaders’ Programme based in Yorkshire. The process involved the development of an online registration process, communicating documents and workshops. Aspiring healthcare leaders had the opportunity to be involved at different levels from submitting a poster, facilitating workshops or presenting a TED-style talk.

RESULTS:
The conference took place on the 25th March 2019 representing six-months of hard work from the committee. It was attended by 180 delegates from organisations across Yorkshire. 94.8% of respondents were very satisfied/satisfied with the conference overall. 95.9% of respondents rated the experience of the online registration process. 90.9% of respondents were satisfied/very satisfied with the content of the conference. The breakout sessions were all extremely well received with the feedback ranging from 81-100% satisfaction. Some themes identified in the qualitative component included “networking”, “inspiring talks” and “opportunity to share leadership projects”.

CONCLUSIONS/IMPLICATIONS:
Delegates came away from the conference with increased knowledge and skills and a willingness to put their new leadership skills in action. Organising the conference was hugely rewarding for the team, allowing us to have a greater understanding of our strengths and weakness as well as how to use our influence. The results highlight the likely need and appetite for leadership events across the UK.
TRAINING EDUCATIONAL SUPERVISORS TO SUPPORT PHYSICIAN TRAINEES RETURNING TO PRACTICE

Rosalyn Hallewell*, Catherine Bryant 1, Andrew Deane 1, Ruth Ruggles 1,2, Jonathan Birns 1,3


INTRODUCTION:
Approximately 10% of postgraduate trainee doctors are on approved out of training at any one time. On their return they often feel lacking in confidence or ‘out of touch’, and there may be a decline in skills. These trainees require enhanced support and concerns have been raised about trainers’ lack of skills and knowledge in this area.

METHODS:
A standardised half-day workshop was developed by an interdisciplinary working party comprising educationalists and healthcare professionals. The aims were: to improve trainer awareness of the reasons and rules for physicians taking time out of training; to provide tools and resources to support educational supervisors of returning trainees; and to improve the confidence and competence of physician trainers supervising trainees returning to practice. A mixed-methods evaluation approach was used to evaluate data from participants before and after training.

RESULTS:
37 educational supervisors attended 3 courses over a 1-month period. Quantitative analysis showed a pre/post-course improvement in attendees’ level of understanding of the processes to support physician trainees returning to practice (t=11.4; p<0.001) as well as their ability to explain the reasons why trainees take time out of training (t=6.6; p<0.001) and the importance of supporting returning trainees for patient safety and staff wellbeing/retention (t=8.5; p<0.001). There was also a pre/post-course improvement in attendees’ awareness of how to manage a trainee returning to practice (t=9.1; p<0.001) and signpost both trainees and trainer colleagues to appropriate resources (t=11.1; p<0.001) as well as an ability to take a leadership role in their Trust/organisation to support returning trainees/develop ‘return to training’ resources (t=8.5; p<0.001). Qualitative analysis of post-course written feedback demonstrated 3 major learning themes: knowledge of ‘what’s available to support returning trainees’, understanding how to best support trainees personally, and how to change culture and improve awareness. Mean rating for the benefit of the course was 86%.

CONCLUSIONS:
A standardised course for educational supervisors supporting physician trainees returning to practice is a feasible educational initiative with objective benefits. This is the first course of its kind and further work in this area would be valuable to establish the potential of providing this on a larger scale.
LUNCHTIME LECTURES FOR ALL!!
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INTRODUCTION:
The Rotherham NHS Foundation Trust has a long history of providing high quality educational events, in-line with our trust values, “Ambitious, Caring, Together.” Our regular Lunchtime Lecture is held every Tuesday during term time and lunch is provided for all attendees. These are 45 minute talks open to all staff within the Trust.

Over time, the lecture programme and speakers became medicine focussed and following a drop in attendance, the Department for Postgraduate Medical Education (PGME) looked at how the speakers, topics and attendees could be more diverse across the Trust in a bid to boost accessibility and attendance.

In 2017, the programme was redesigned, non-medical speakers and external speakers were invited, alongside medics. To further engage with non-medical staff, the winners of the PROUD awards (Trust recognition awards) were invited to speak about their experiences.

The programme is now advertised in PGME, on social media, via our website and on the Trust communication emails.

METHOD:
Data was collected from 56 registers from January 2017 to December 2018. The information collated included; date, topic, speaker, total attendance and attendance breakdown. This was subdivided into; Doctor, Nurse, Allied Health Professional (Pharmacist, Physiotherapist, Occupational Therapist, Dietician), Student (Medical, Physiotherapist, Nurse) and Other (admin, chaplaincy, Biomedical Science).

RESULTS:
After the programme redesign, increasing the variety of topics and speakers, there was a significant increase in the average attendance in 2018 from 36.5 people per lecture to 50.5 people per lecture, a 38% increase. This is also reflected in the greater number of nursing staff, allied health professionals and those from administrative and corporate services attending.

CONCLUSION:
Lunchtime Lectures are a valued resource within the Trust, allowing for continual professional development, networking in a heavy workload environment and supporting our Trust values. It gives colleagues the opportunity to share the learning experience, engage in discussion and promote morale and staff wellbeing. Colleagues see the lecture series as an opportunity to celebrate their successes, promote their service or update staff on the great work taking place within our trust.

Prior to the redesign, the majority of speakers were invited, however now a wide variety of professionals, contact us in order to be involved in the programme, a further indication of its success.
INTRODUCTION:
There are currently 29 secure settings within the NHS England and NHS Improvement Midlands footprint. These include categories B to D, a Secure Training Centre and an Immigration Removal Centre. Each of these secure settings provides dental services to their population. The provision of dental care within secure settings presents numerous challenges. There is very little opportunity for dental teams to interact with one another between different institutions, resulting in their being professional isolation. As part of Health Education England’s Clinical Leadership Fellowship programme, the creation of the first Clinical Leadership Fellow in Prison Dentistry resulted in an opportunity to create a Clinical Network for dental teams working in secure settings across the Midlands footprint. This project has now been completed with the formation of the Secure Setting Dental Clinical Network (Midlands).

METHOD:
A series of conversations were held with dental teams working in secure settings in the Midlands, as well as with NHSE/I Health and Justice Commissioners (East Midlands Team) and Public Health England. From conversations with dental teams working in secure settings, many challenges became apparent including concerns regarding workforce training and induction processes.

Many challenges in the provision of dental care within secure settings require the need for collaborative engagement between different stakeholders. The development of Local Dental Networks with Managed Clinical Networks within NHSE/I Primary Care Commissioning has been shown to be a potential successful model for achieving a clinically-led approach to partnership working. Furthermore, dental teams working in secure settings often feel professionally isolated as the majority operate a single chair service. Hence, there is limited opportunity to share best practice between different establishments and for professional development. A clinical network can therefore be the model environment in which to address challenges faced and support the profession.

Accordingly, a Secure Setting Dental Clinical Network Development Day was held on Saturday 11th May 2019 to introduce the concept of a network to dental teams across the Midlands, and to encourage a clinically-led approach to its development. The overall conclusion was that the formation of this network would be welcome and supported.

CONCLUSION:
The aim of the Secure Setting Dental Clinical Network is to:

- Encourage collaborative engagement and effective partnership working with relevant stakeholders in the provision of dental care in secure settings in order to improve service delivery
- Support dental teams working in secure settings through peer review and networking opportunities. Topics have been set for the next meeting on treatment planning for the prisoner patient with a focus on prevention as this was identified as challenging.
INTRODUCTION: Following a high profile case that took place at Leicester’s Hospitals, the Trust identified issues in communicating organisational messages and advice to the medical workforce. Through a Listening into Action event, it was agreed that the Trust would employ a new Band 5 Communications Officer, focusing on improving communication in Medical Education. This is a unique role within the East Midlands.

METHODS OF WORK: It was apparent that the Trust could have done more to make doctors, especially those returning to work, aware of support available to them. As a result, a communications strategy was devised and presented to the Executive Board. From the strategy it was apparent that the Department of Clinical Education did not have the resources, skills or expertise to effectively realise the strategy. The board therefore agreed to fund a new Communications Officer.

The Communications Officer was appointed in November 2018. The initial aim was to start increasing awareness of Medical Education and the mechanisms already in place to support junior doctors in training. Focus was therefore primarily on increasing awareness through social media and other media outlets to gain more exposure to showcase and signpost. A detailed Communications Plan was created by the Communications Officer underpinning the strategy. There was a review and development of the current communication platforms including the online and paper mediums.

The communications plan then focused on increasing awareness of medical education within the local population through local media outlets. Finally it addressed internal communications through internal magazines, a departmental newsletter, guides to managing medical education and promotional videos.

The Trust introduced the ‘UHL Educator Awards’, organised by the new role, which recognises the hard work, innovation and dedication given to medical education.

In the next 12 months, we will run a full scale media campaign to further improve awareness that UHL is a Teaching Hospital, what this means and why it is a great place to work.

CONCLUSIONS: The new role has resulted in a significant increase in social media engagement increasing from 470 followers (Nov 18) on Twitter to >790 followers (Jun18, see fig.1). This is accredited to specific social media campaigns that focus on key issues. Increased presence on social media has already received positive feedback from stakeholders.

In less than 12 months, we have managed to almost double our social media engagement. Appointing a Communications Officer can have real organisational value. With focused time and expertise it is possible to dramatically improve awareness of medical education, improve engagement and signpost individuals to available opportunities and support.
DELIVERED EDUCATIONAL PROGRAMME FOR FOUNDATION DOCTORS IN THE EAST OF ENGLAND - PILOTING NEW 60 HOURS TEACHING PROGRAMME

Khan Z, Johnson H, Barker H, Banerjee R, Bullock M


All foundation doctors have hitherto been required to attend 70% of generic training to achieve a satisfactory ARCP outcome. The criterion has now changed centrally, in that all Foundation doctors must evidence a minimum of 60 hours of approved direct teaching.

The approval of teaching, and items included has been derogated to the local Foundation Schools. Here within EOE foundation school we are piloting the following programme:

- A mandatory 30 hours [core] directly aligned with core foundation training and curriculum
- Further 30 hours [non core] which can be determined by trainees predominantly from within the comprehensive suggested list

Delivering High Quality Education within Foundation

At the East of England, we have two foundation schools, East Anglia and EBH. Both are keen to promote a culture of learning, education and training within their trusts. Our aim is to achieve excellence in educational provision, with a vibrant programme that allows our trainees to flourish. We have taken note of best practice elsewhere, educational research as well as trainee feedback to devise a programme which is interesting, interactive and covers the depth and breadth of the foundation curriculum. More than half of the taught educational programme is trainee determined according to preference, skillset and future career aspirations - the hub sessions, and additional options.

We hope our foundation trainees will view the educational programme opportunities as part of a wider continuing professional development that will be life long in a medical career. As such, we expect that the topics of the training sessions attended are broad and balanced across the curriculum including both clinical and professionalism elements.

Approximately 1200 foundation trainee within HEEOE foundation school will be piloting out this proposal from August 2019. Booking of the regional Hub sessions (x2 clinical, x1 non clinical for each trainee) will take place centrally in between August - September 2019. Feedback from the trainees, focus groups will be collected. This is a great innovation within the Educational Management and leadership category that will provide a smart sustainable educational programme for our foundation doctors.
DEVELOPMENT OF QUALITY CRITERIA FOR THE ROLE OF GENERAL (INTERNAL) MEDICINE AND ACUTE (INTERNAL) MEDICINE REGISTRAR

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BACKGROUND:
In 2018 the Joint Royal Colleges of Physicians Training Board, acting on behalf of the three United Kingdom (UK) Royal Colleges of Physicians and external stakeholders, developed a set of quality criteria with the purpose of supporting the educational experience of doctors undertaking the demanding role of General (Internal) Medicine (GIM) or Acute (Internal) Medicine (AIM) Registrar. The difficulties faced by Registrars involved in the unselected acute medical take were already well documented, however it was felt that specific and measurable quality criteria would help define how doctors might be better assisted and educationally supported to perform this role.

The criteria\(^1\) comprise a total of 20 quality requirements spread over 3 domains: Ensuring safe and effective care; Creating a supportive environment; Improving Educational Experience. Implementation is being monitored on a UK-wide basis using the General Medical Council’s annual National Training Survey.\(^2\) Baseline data from the 2018 survey is presented.

SUMMARY OF RESULTS:
- High levels of agreement the criteria were being met in hospitals UK-wide was recorded in 4 areas: consultants on call are easily accessible for advice both 'in' and 'out of hours (87%); management of the acute take and out of hours care is effectively supported by multidisciplinary team working (80%); consultants on call generally provide appropriate on site supervision (77%); Educational Supervisors’ GIM curriculum knowledge is good (77%).
- Low levels of agreement were observed in the following areas: able to spend at least half a day per week of protected time to pursue learning opportunities specific to GIM training (15%); trainee representatives are involved in monthly meetings to review service and/or rota difficulties (19%); consultants and trainees are involved in GIM rota design (22%); appropriate calls are directed to the GIM registrar (31%); training and assessment is provided for all essential procedures in the GIM curriculum (38%).

DISCUSSION AND CONCLUSIONS:
The GIM/AIM Registrar Quality Criteria provide an effective way to specify and measure the support provided in the field to enhance the educational experience of doctors undertaking the demanding role of General (Internal) Medicine (GIM) or Acute (Internal) Medicine (AIM) Registrar (Figure 1). Coordinated action from a range of stakeholders is required to improve those hospitals where baseline data suggests the proportion of criteria is being met is very low.

TAKE-HOME MESSAGES:
- Quality Criteria provide a useful tool to support and monitor the educational experience of doctors undertaking the GIM or AIM Registrar role.

REFERENCES:
LEADING THE WAY: A LEADERSHIP AND MANAGEMENT COURSE FOR JUNIOR TRAINEES

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BACKGROUND:
Historically, leadership and management (L&M) courses have been attended by registrars preparing for Certificate of Completion of Training (CCT). Trainees below senior registrar level recognise the importance of L&M, but half feel their training in this area is inadequate. To meet this demand, our Postgraduate Department developed an in-house one day course for junior trainees (FY2-ST4).

METHODS:
The course was comprised of: NHS structure; strategic vision; quality improvement; finance; team roles; medical education, and governance. Attendee’s confidence in their understanding of a variety of L&M domains was self-assessed pre- and post-course using likert scales (1-6) (Table 1). Qualitative data (white-space questions) was also collected.

RESULTS:
17 trainees attended. There was a dramatic improvement in attendee’s confidence across four domains (76.9-142.1%), with more modest increases in the patient safety and quality improvement domains (in keeping with higher baseline confidence).

![Table 1: Summary of the pre-and post-course confidence scores](image)

Analysis of qualitative responses suggested most trainees attended the course to learn about L&M opportunities, NHS structure and to augment their portfolios. It was seen as beneficial to start this process early in their career. 12/13 (92.3%) trainees felt L&M was not adequately covered in their specialty teaching. In keeping with recognised poor engagement2, 8/14 (57%) felt no connection to their current institution, citing frequent rotations and level of administrative work as the main reasons. Trainee feedback was universally excellent. Including theories and strategies for developing their own L&M skills was suggested as an improvement.

KEY MESSAGES:
The appetite of trainees below senior registrar level for meaningful in-house L&M courses is high and few courses are currently meeting this need. Such courses can dramatically increase trainees’ confidence in key L&M domains.

REFERENCES:
INTRODUCTION:
Current medical education and health systems are required to dynamically adapt to shifting external drivers, including changing population demographics and multi morbidity, a greater emphasis on primary care and advances in digital health. To address these drivers there are increasing calls for educators and clinicians to ‘rethink medicine’, promoting the development of reflexive organisations, supporting staff to navigate these changes, fostering innovation and creativity, team morale, cohesion and motivation.

In the last five years in response to these external drivers, our undergraduate primary care academic department has significantly increased the number and types of community placements we offer medical students, resulting in significant change in the size and scope of our work.

To support the team during this period of flux and growth, we developed educational Communities of Practice (eCoPs) drawn from the work of Wenger’s ‘Communities of Practice’ describing ‘groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly’. The eCoPs are non-hierarchical and involve all team members (including students) coming together in small groups to creatively explore their work in the team. The aim of this study was to explore how the eCoP model has supported the team’s professional and personal development over the last two years.

METHODS:
A qualitative approach was employed through conducting voluntary focus groups with team members. Semi-structured questions guided the discussion, which was audio-recorded and transcribed. Thematic analysis was conducted and formal ethics approval was granted by Imperial College.

RESULTS:
Themes emerged around the benefits and tensions of the eCoP model. Benefits included: increased sense of belonging, opportunity and motivation to engage with educational literature. Tensions included uncertainty around leadership within the groups, challenges of ‘forming’ as a group and the balance between creative space and being outcome-driven. We will also present examples of eCoP activities that have taken place over the two years.

DISCUSSION:
The eCoP model can provide an effective approach to management of change in medical education that is transferable to other education and health settings seeking to develop as adaptive education or health organisations.
TACKLING THOSE DIFFICULT CONVERSATIONS IN THE MEDICAL TRAINING ENVIRONMENT

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INTRODUCTION:
The majority of trainees successfully complete a training programme assisted by guidance from their clinical and educational supervisors. Some may fail to progress due to exam failure or for other reasons relating to curriculum requirements. Less commonly, trainees may display unhelpful attitudes or behaviour. Examples might include being rude, dismissive of others, brusque, indifferent to the needs of the team or perhaps being unacceptably slow in discharging their duties. Such issues can sometimes be difficult to articulate and their peers and/or trainers may find it easier not to address them or perhaps they fear the consequences for themselves of a conversation that goes wrong. The training environment of a specialty and regular rotation through other specialties or training locations may also enhance the risk of such issues remaining unaddressed. However to ignore repetition of an unhelpful attitude or behaviour might affect the trainee’s ability to work well within a team which may ultimately impact on the quality of patient care. Early intervention to address such concerns with suitable support is therefore likely to lead to resolution and assist the development of high quality doctors.

METHODS:
HEE EM in association with Dave Thornton (an experienced coach working in the NHS and industry) have developed ‘The Art of an Honest Conversation’ course which seeks to understand the concerns that doctors may have in tacking these tricky conversations supported by a structured and objective feedback model that can where necessary be used as a framework for documenting it. Repeat episodes may require a graded response using the model with a clear message that change must happen and ultimately the consequences for the doctor of not doing so.

RESULTS:
Pilot courses held for trainees and trainers have been very well received. A video is now being developed of the course content supplemented by some acted scenarios in a clinical setting which help to demonstrate the principles of the conversation. It is hoped that this will act as a resource to assist in a wider understanding of how we might approach such conversations across HEE EM.

CONCLUSION:
This work seeks to explore a potentially awkward and perhaps under explored territory in medical training feedback in the hope that this will enhance the ability of trainees and trainers to hold such conversations where needed in order to support the development of doctors in training.
USING THE HEALTH EDUCATION ENGLAND (HEE) MATURITY MATRIX TO ASSESS THE ABILITY OF TRAINING HUBS IN THE EAST MIDLANDS TO MEET THE INCREASED DEMAND IN COMMUNITY TRAINING CAPACITY NEEDED TO DELIVER THE 10 YEAR NHS LONG-TERM PLAN


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**INTRODUCTION:**

In 2014, NHS England published the NHS Five Year Forward View setting out the need to develop and increase the Primary Care Workforce. In response to this, and with additional emphasis on new ways of working, previous success within multiprofessional learning organisations, and Advanced Training Practices, Health Education England East Midlands (HEE EM) commissioned thirteen Training Hubs (THs). Recently, the NHS Long Term Plan (2019) has called for more patient care to be delivered in the community and by a wider variety of healthcare professionals. Their training will be delivered by the THs, so hubs need to develop into Strategic and Transformation Partnership (STP)-facing mature organisations, but are they ready? And how can HEE EM help?

**METHOD:**

The HEE Training Hubs National Steering Group developed a ‘maturity matrix’ for all THs to self-assess 8 domains. These were: Workforce planning, Network and System coverage, Education and Training, Staff Infrastructure, Leadership, Stakeholder Engagement, Governance and Quality Assurance and Financial models. Each domain was categorized according to its preparedness, the first category reflecting very little or no activity, through to the fourth showing maturity and fully-functioning. In March 2019 the matrix was sent to all the THs in the East Midlands. They were invited to mark ‘yes or no’ against the statements. Results were tabulated by STP. Where there was more than one TH per STP, results were amalgamated. Responses were then then classified as ‘red’, ‘amber’ or ‘green’ indicating the degree of ‘readiness’ (RAG rated) and converted to table form.

**RESULTS AND DISCUSSION:**

The summary matrix of responses and generation of a RAG table showed the relative preparedness of each TH. Comparisons could be made both across THs or by domain. THs showed differing levels of engagement and development across our 5 STPS. Whereas nearly all reported good Leadership; Finance, Quality Assurance and Network Coverage were all of concern. In addition, Northamptonshire appeared to be less prepared than the other THs. Discussion of these results at local level resulted in ideas to facilitate ‘maturity’ including inclusion under the ‘Primary Care School’ in order to improve governance structures, dialogue with THs around how to become more involved at local workforce planning meetings, possible solutions to funding and tax concerns, and using the matrix itself for work planning and facilitated debates.

**CONCLUSIONS:**

The matrix and RAG rating allowed HEE EM to scope the degree of readiness that our THs have for the future and to easily decide on where to focus future work and resources.

**ACKNOWLEDGEMENTS:**

HEE maturity matrix: Dr Bob Kirk, Dr Hiliary Diack, Harminder Bains and The National Primary Care Team Health Education England
INTRODUCING PIPS (PEER TEACHERS IN PRACTICE) - A NETWORK FOR NORTH WEST FOUNDATION DOCTORS ENGAGED IN MEDICAL EDUCATION

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Peer teaching is increasingly recognised as an effective teaching tool used widely as a component for Foundation curriculum delivery. In the North West there are over 1800 foundation doctors and nearly all training locations now have some form of peer led teaching. Less attention however has been paid to its utility in teacher training and educational skills attainment. PiPs (peer teachers in practice) is a trainee led initiative, sponsored by Health Education England, designed to promote peer teaching in the North West as well as provide a model for quality in programme design, and training opportunities for foundation leads. This network or community of practice is now in its third year, the main area of work centres around bi-annual events; the “new starters” September inspiration training day and the summer showcase, an opportunity for leads to present and share peer teaching programme design and ideas, to date bringing together over a hundred foundation leads from across the North West patch. As it has been maintained as a wholly trainee led initiative PiPs has also created opportunities for experience in medical education leadership offering foundation trainees opportunities to be facilitators and leads at PiPs events with training and support provided.

Although the PiPs network has been challenged by; barriers to communication with foundation doctors, a paucity of senior support for programmes, mentors and role models, PiPs continues to get excellent feedback from those engaged with it, attending and contributing to events.

To date, evaluation has been largely qualitative and centred around feedback on the training days, the plan for the coming year will be to formally assess the programme and re-orientate the curriculum in order to more effectively support the leads in developing their professional identity as medical educators. We present PiPs as a model for broadening engagement in medical education and supporting early careers development of teaching skills.
INTRODUCTION:
The Revalidation Support Unit (RSU) has developed a programme of Revalidation Quality Assurance Reviews to all Designated Bodies in Wales on behalf of the Chief Medical Officer. This peer review process aims to ensure appropriate appraisal and revalidation management processes are in place for all doctors with a prescribed connection in Wales, including trainees.

Revalidation as a process is now established, therefore, it is the quality of these systems which is under review to drive improvement and consistency. The reviews maintain an educational and formative focus, identifying areas of good practice to be shared as well as areas for development, locally and nationally.

METHODS:
The reviews are peer to peer focussed with representatives from other Designated Bodies taking part in the review team, allowing for learning opportunities across the board.

Prior to each review, available triangulated data is collated which enables the review team to ask targeted questions against a set of quality criteria drawn from GMC guidance.

The review meeting involves exploring with Designated Body leadership and management teams the processes they have in place to support doctors undertaking annual appraisal, including provision for CPD, and how they fulfil the regulatory requirements for medical revalidation.

RESULTS:
All Designated Bodies will be visited over a 2 year period, the review process commenced in February 2018 and to date the RSU has undertaken 11 out of 18 reviews.

Initial feedback suggests that the review process has already had a positive impact on the support structures for appraisal and revalidation, for example of 4 Designated Bodies that were identified as requiring additional professional support and leadership roles, 2 have recruited to these posts and the remaining 2 are in the process of recruitment. This will ensure doctors and Appraisers are appropriately supported, enabling appraisal to remain formative and educational.

CONCLUSION:
The Revalidation Quality Assurance Review process has the potential to facilitate improvements for the medical workforce in Wales. The RSU plan to use the outcomes of the review process to progress an All Wales revalidation programme to promote the sharing of good practice and to develop national strategies to support doctors in meeting appraisal and revalidation requirements.
INTRODUCTION:
As part of its role in quality assurance of medical training, the General Medical Council conducts an annual survey of trainers and trainees. The Trainer survey, part of the National Training Surveys (NTS), consists of 47 questions which are grouped into 11 indicators of quality. In the NTS, outlying poor-performing trusts are denoted by pink and red flags, which can trigger Deanery visits.

By focusing on red flags, providers often neglect the wealth of information contained elsewhere in the NTS. Surrey and Borders Partnership NHS Foundation Trust did not receive any pink or red flags at trust level. However, we were keen to use the comprehensive data in the NTS to improve training. We analysed each question to create a workshop to engage trainers in discussion about improving the experiences of trainers and trainees.

METHODS:
Our analysis of the NTS used data from the online reporting tool to calculate the scores that were obtained for each question in the 2018 NTS. A question was discussed at the workshop if it performed poorly relative to other questions in the indicator; to provide useful information; or to clarify ambiguity. Indicators where interesting comparisons can be drawn between the views of trainers and trainees were also discussed. The 90-minute workshop was led by the Leadership and Education Fellow and Director of Medical Education. Attendees were subsequently sent an online survey.

RESULTS:
The workshop consisted of an introduction to the NTS; group discussion on which indicators were felt to be important, good- or poor-performing; discussion of specific questions; and a review of feedback from trainees.

12 questions and 3 indicators (Handover, Supportive environment, Rota design) were discussed. 11 questions were chosen for poor performance, which sought to contextualise the results within the experience of attendees. 8 questions were chosen to provide information, such as resources and current initiatives. 3 were chosen to clarify ambiguity. Many questions met several criteria.

17 attendees responded to the online survey. 64.7% agreed or strongly agreed that the NTS asks questions that are important for them. 76.5% agreed or strongly agreed that the NTS can be used to improve the trainer experience.

CONCLUSIONS:
The NTS can be used to structure a workshop that trainers feel can improve their experience. Our strategy demonstrates the value of analysing the NTS dataset intelligently to engage trainers in improving training.
A MODEL FOR IMPROVING POSTGRADUATE MEDICAL EDUCATION USING THE GENERAL MEDICAL COUNCIL NATIONAL TRAINING SURVEYS

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INTRODUCTION:
As part of its role in quality assurance of medical training, the General Medical Council conducts an annual survey of trainers and trainees. The Doctors in training survey, part of the National Training Surveys (NTS), consists of 70 questions which are grouped into 18 indicators of quality. In the NTS, outlying poor-performing trusts are denoted by pink and red flags.

By focusing on red flags, providers often neglect the wealth of information contained elsewhere in the NTS. Surrey and Borders Partnership NHS Foundation Trust did not receive any pink or red flags at trust level. However, we were keen to use the comprehensive data in the NTS to improve training. We analysed each question to create a plan of action to improve the quality of training.

METHODS:
We used data from the online reporting tool to calculate the scores for each question in the 2018 NTS. Taking into account the impact of year-on-year changes in the content of the survey, we examined the score, change from 2017 to 2018, and difference between the score and indicator mean to identify poorly-performing questions. Other questions with clear potential for further improvement were also highlighted. A plan of action was produced by the Leadership and Education Fellow and Director of Medical Education.

RESULTS:
29 actions were identified. The most common were to ensure that information (e.g. job descriptions, professional opportunities, procedures for raising concerns) was accessible to trainees (8 actions); liaise with other teams (e.g. Human Resources, Safety team) (6); discuss issues with or provide information to trainers (5); discuss with trainees to contextualise survey results within their experiences (4); and ensure that information was delivered at induction (3).

To implement these actions, we conducted a workshop for trainers and held feedback meetings with trainees. 76.5% of trainers (13/17) and 88.5% of trainees (23/26) surveyed following these respective events agreed or strongly agreed that the NTS can be used to improve the training experience. A presentation on making the most of the placement was added to trainee induction and was rated excellent or good by all respondents (28/28). Posters were also produced to disseminate information.

CONCLUSIONS:
The NTS can be analysed to create a plan of action with elements that trainers and trainees feel can improve their experience. Our model demonstrates the potential for using NTS data to plan quality improvement in training.
INTRODUCING A SYSTEM FOR IDENTIFYING AND SUPPORTING TRAINERS IN DIFFICULTY

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INTRODUCTION:
Supporting and empowering educators is one of the quality domains in the Health Education England Quality Framework. This includes “an auditable process for identifying, supporting and managing educators whose performance or conduct falls below the expected standard”. At the level of trusts and deaneries, there is considerable variation in how this is managed. Despite guidance from the National Association of Clinical Tutors on how to support “Trainers in difficulty”, it remains a challenge to identify them at the outset. Most providers rely on reactively responding to concerns as they arise, rather than proactively identifying trainers who might benefit from additional support. At Surrey and Borders Partnership NHS Foundation Trust, we have introduced an Annual Post Quality Meeting, which aims to collate information from various sources to identify educators requiring support.

METHODS:
The Annual Post Quality Meeting is attended by the Director of Medical Education and Locality tutors. This is in addition to responding to concerns that have emerged throughout the year. Data on each post is presented from trainees’ End of Post Survey (EOPS), the General Medical Council National Training Surveys (NTS), informal feedback, complaints, and feedback given at Local Faculty Groups. Each post is rated as Red, Amber or Green on the basis of this data, as well as any practical concerns such as the supervisor leaving the trust. Trainers graded as Red or Amber were supported by a face-to-face meeting with the Director of Medical Education and Locality tutor to discuss the concerns and agree an action plan.

RESULTS:
From 2016 to 2019, 366 posts were reviewed. 91.0% were rated as Green, 6.6% as Amber, and 2.5% as Red. Feedback from the EOPS was the reason for 42.9% of posts being rated as Amber and 43.8% of posts being Red. In many cases, other feedback corroborated the grading decision. No post was graded Amber or Red on the basis of the NTS. Support provided to trainers has included clarification of supervision requirements, information on specialty curricula, sharing of helpful resources, and clarification of education time commitment in job planning.

CONCLUSIONS:
An Annual Post Quality Meeting collating information from various sources can be employed to proactively identify trainers who might benefit from additional support. Data from internal surveys and feedback, rather than the NTS, gives specific information that is more appropriate for this process.
INTRODUCTION:
As part of its responsibility in quality assurance of medical training, the General Medical Council (GMC) conducts the National Training Surveys (NTS), an annual survey of doctors in training. Outlying poorly-performing trusts are denoted by red flags. In 2015, 67.7% of trusts receiving red flags for the quality of handover were mental health trusts (MHTs). This dropped to 50.0% in 2016, after 54 MHTs all improved their handover scores. While this survey data would suggest a dramatic improvement in the quality of handover in 2016, the NTS evolves year on year, so changes in the survey could explain the apparent improvement. We explored whether this was indeed the case.

METHODS:
Each indicator in the NTS is composed of certain questions, with their average score forming the overall indicator score. Changes in the set of questions, wording of questions, wording of answers and scoring of answers in the Doctors in training survey were reviewed from 2012 to 2016 using the NTS online reporting tool. We compared acute and MHTs in Health Education Kent, Surrey and Sussex (HEKSS) to examine the impact of any changes on scores in handover.

RESULTS:
From 2012 to 2015, the handover indicator was composed of two questions on handover before and after night duty. Trusts were awarded a maximum score for “an organised meeting of doctors and nurses”, with “an organised meeting of doctors”, “phone or email communication”, “informal” and “none” scoring lower. In 2016, these questions were removed and replaced by three questions that asked whether trainees agreed or disagreed with statements regarding MDT involvement, continuity of care between shifts and between departments. This change had a disproportionate effect on MHTs. The twelve HEKSS acute trusts scored on average 71.85 in 2015 and 69.89 in 2016 (change of -1.96) while the three MHTs scored on average 49.69 in 2015 and 70.36 in 2016 (+20.57). There was little change in scores from 2012 to 2015.

CONCLUSIONS:
From 2012 to 2015, handover was evaluated using questions that the GMC recognised were “prescriptive about what constitutes an effective handover”, more concordant with the practice in acute trusts and disadvantaging MHTs. With the change in questions in 2016, MHTs enjoyed a vast improvement in their handover scores, which was not due to any material improvement. This reminds us of the need to review the methodology and content of the questionnaire when interpreting the meaning of survey results.
INTRODUCTION:
In the General Medical Council National Training Surveys (NTS), poor-performing trusts in the lowest quartile of their benchmark group are denoted by pink and red flags. In the 2018 NTS for Foundation Year One (FY1) doctors in Psychiatry, Surrey and Borders Partnership NHS Foundation Trust (SABP) received pink flags for Teamwork, Induction and Adequate experience; and a red flag for Rota design. Despite training 12 FY1s from four acute trust partners, the scores for SABP were calculated using the surveys of only 3 trainees from one acute trust partner. Scores for the other FY1s were attributed to trainees’ affiliated acute trusts, even though SABP is the provider for Psychiatry placements. We sought to recalculate our scores to take into account the views of these other trainees.

METHODS:
SABP hosts FY1s from Ashford and St Peters’ Hospitals (ASPH), Royal Surrey County Hospital (RSCH), Surrey and Sussex Healthcare (SASH), and Frimley Health (FHFT). We combined the scores for FY1s in Psychiatry from these trusts and SABP to calculate a score more representative of the overall training experience for FY1s at SABP. The scores were compared to the lower quartile limits for the benchmark group to determine whether pink and red flags would be given.

RESULTS:
Scores for Teamwork, Induction and Adequate experience were available for SABP, RSCH and SASH, but not for FHFT and ASPH due to insufficient numbers of respondents. We were able to reclaim 6 missing FY1s to give a score contributed by 9 of our 12 FY1s. Scores for Rota design were only available for RSCH and SABP, allowing calculation of a score contributed by 6 of our 12 FY1s.

Our recalculations improved all the scores for SABP: Teamwork from 52.78 to 71.53, Induction from 60.00 to 79.44, Adequate experience from 62.50 to 73.61, and Rota design from 25.00 to 45.83. None of the revised scores received pink or red flags.

CONCLUSIONS:
Although mental health trusts host foundation doctors from acute trusts for Psychiatry placements, the NTS does not always attribute the responses for foundation doctors to the mental health trusts. This reduces the validity of the system used to identify outliers and quality assure foundation Psychiatry training, and also reduces the validity of results for acute trusts. We are liaising with the GMC and local Health Education England office to ensure that our trainees are correctly assigned to us in subsequent surveys.
IMPROVING MULTISOURCE FEEDBACK FOR TRAINERS AT THE LOCAL LEVEL

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INTRODUCTION:
With the General Medical Council (GMC) recognising educational and clinical supervisor roles, and the introduction of an annual Trainer survey in 2016, there has been a renewed focus on ensuring that educators are supported in their roles. Appraisal of their performance as educators is an important part of this, as stated in the GMC’s ‘Promoting Excellence’ and Health Education England’s Quality Framework. Consultant appraisals require reflection on feedback from patients and colleagues, but there are few well-established systems for providing structured feedback for trainers on their educator role. We describe our innovative system for improving multisource feedback (MSF) for trainers, in collaboration with a technology partner.

METHODS:
Since 2013, Surrey and Borders Partnership NHS Foundation Trust has conducted a semi-structured end of placement survey of trainees for quality assurance of posts. Many models for gathering such feedback exist, but to our knowledge, none allow the use of trainee feedback for both quality assurance and MSF for trainer development. We therefore adapted our survey, adding items on supervision such as ‘punctuality and reliability of supervisor’ and ‘availability of supervision’. In the first two years, the MSF reports were generated manually, placing a time burden on the Education Department, but collaboration with a technology partner has allowed automisation of the process in the third year. More recently, a new format for the reports was introduced to improve clarity and show benchmarking data. Trainers were asked to rate the new MSF reports through an online survey.

RESULTS:
35 trainers responded to the survey. 82.9% had a very positive or somewhat positive first reaction to the reports. 76.5% rated the reports as being of very high or high quality. 97.2% rated the reports as being extremely, very, or somewhat useful. Trainers felt that the reports most helped them to reflect on their overall performance as a supervisor, to identify specific areas of the training post that need improvement, and to provide evidence for appraisals, job planning, and Clinical Excellence Award applications.

CONCLUSIONS:
MSF reports that trainers find useful and of high quality can be produced from local data collected through a rolling trainee survey. This enhances local training quality data and reduces the administration time for trainers, allowing more time for their role as educators.
FOUNDATION PROGRAMME EDUCATION – A JOURNEY THROUGH MOVING FROM TRADITIONAL CLASSROOM TEACHING TOWARDS MORE HANDS-ON, SELF-DIRECTED LEARNING IN EAST OF ENGLAND DEANERY

_C Liu*, G Winnett, H Barker, R Banerjee, Z Khan, H Johnson_


INTRODUCTION:
To achieve educational excellence, the East of England Foundation School has taken an innovative approach by introducing an interactive educational program for the Foundation trainees, which complements the more traditional generic teaching program (such as weekly lectures) to cover both clinical and professional elements across the foundation curriculum.

METHODS:
The program consists of the following:
1. **Trainee-selected regional hub days**
   Half-day events are held in 4 hubs across the region with a broad range of clinical and non-clinical sessions covering:
   a) Clinical and professional aspects of medicine, surgery, emergency medicine, obstetrics and gynaecology, general practice, paediatrics, psychiatry, etc. which the candidates can choose from
   b) Non-clinical days to explore professionalism, ethics and other aspects of modern medicine
   c) Aspects of career development, offering trainees insight into specialty training
   These are highly interactive sessions, including group discussions, practical skills and simulation.

2. **Simulation training:**
   A variety of simulation based events delivered locally by each Trust to enhance trainees’ learning:
   I) High-fidelity simulation: in the form of real-time simulated clinical scenarios of management of acute illnesses (e.g. deteriorating patient) with emphasis on human factors and communication skills
      Feedback: effective, useful, well-liked, improves their confidence
   II) Virtual reality (VR) simulation: we are excited to introduce an innovative learning opportunity – VR simulation for all foundation trainees in the region from August 2019. VR simulation can bridge the gap between theory and practice by immersing the learner in a realistic, dynamic, complex setting and has been effective in surgical training and improves patient outcomes.

CONCLUSION:
Since August 2018, our successful pilot of hub days has shown this to be an excellent resource with very positive feedback. The hub events will be fully rolled-out from August 2019: each trainee will be expected to sign-up to at least 2 clinical and 1 non-clinical event to ensure a flexible, balanced experience. We aim to make all dates available centrally on the Deanery website from August 2019 to increase uptake by trainees.
GPWER THE NEW NAME FOR GPSI: DEVELOPMENT FOR AN ACCREDITED GENERIC FRAMEWORK

Johnny Lyon-Maris. Kamila Hawthorne, Geoff Payne, Chantal Simon, Mat Lawson

BACKGROUND:
This framework describes a generic set of principles to underpin the governance of General Practitioners (GPs) with Extended Roles (GPwERs) formally known as GPSI. As the standard setter for general practice, and with its role in professional development, the RCGP is uniquely positioned to develop standards for extended roles working in collaboration with relevant specialties. With a UK wide remit, the RCGP can transcend national health systems and support consistency across the four countries of the UK.

SUMMARY OF WORK:
The framework describes; 1. Overarching principles for the development of specific frameworks, which describe the knowledge, skills and competencies required of a GP to practise in a particular scope of extended practice 2. Inform operational guidance on a national and sector-specific level 3. Support commissioners and employers to shape appropriate governance processes 4. Describe how initial competence in an extended role should be demonstrated 5. Explain a process of RCGP accreditation for GPwERs, delivered to RCGP standards 6. Describe how continued competence in an extended role will be demonstrated once initial accreditation has been achieved.

OUTCOMES:
This framework provides the generic principles necessary for safe delivery of extended roles in primary care. Those roles are activities beyond the scope of GP training and the MRCGP and contracted outside of normal general practice.

CONCLUSIONS:
The RCGP feels that accreditation of some extended roles is necessary because of: Patient needs Patient Experiences Patient Safety Effective and efficient resource utilisation New Ways of Working Recruitment and retention.
THE GP RESILIENCE PROGRAMME: KEY THEMES

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BACKGROUND:
The current climate in primary care can see GP practices not only negotiating challenging care issues, but also difficult team relationships and planning for the future. Pausing to review and work on such issues in a protected away day or meeting can be a powerful experience for teams (either key people managing the practice or the whole practice team), and one that can lead to positive change and quality improvement.

Sessions are facilitated by two experienced education practitioners and comprise expert-led issue recognition and small group learning.

SUMMARY OF WORK:
An evaluation and review of the process was undertaken and feedback from the 10 practices participating in the scheme was gathered in order to identify common issues and opportunities for change. These were identified through the use of structured activities. Six themes were identified.

SUMMARY OF RESULTS:
Issues looked at in these sessions have included: team building, communication, understanding the impact of change (resilience of teams), planning ahead and implementing change, exploring new solutions to challenges (learning from difficult situations). Partnerships have in addition looked at succession planning, major changes (mergers and splits), recruitment, federation, leadership and decision making. Feedback indicated the value of expert input for helping practice teams manage difficult issues, the value of expert having protected time to discuss and review team issues and dynamics and sessions striking a balance between learning /reflecting on practice and making changes to practice.

CONCLUSIONS:
The poster will describe and share the facilitation process and its impact on primary care teams, and report the results and outcome of the evaluation in more detail.
WHAT IS A GP?

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BACKGROUND:
The role of the GP has changed dramatically and there is often poor understanding of this role by trainee doctors working prominently in hospital settings, and allied health care professionals in the community. In this research we seek to understand these perceptions. The lack of understanding of the GP role creates a barrier to multidisciplinary working and affects patient outcomes.

SUMMARY OF WORK:
Medical students, foundation doctors, GP trainees, GP supervisors and everyday GPs completed a questionnaire exploring their views on the key purposes of the GP and the origins of these views. It was also completed by nurses, physiotherapists, pharmacists and paramedics working in community-based roles allied to General practice.

FINDINGS:
The findings have enabled educators to support those working in GP to feel satisfied in their workplace and appropriately fulfil their role. Perceptions varied between different allied healthcare professionals, depending on the facet of general practice they were most exposed to within their role. Variation between all doctor categories was demonstrated, with established GP presenting a most holistic perception of the role, and with more junior colleagues citing a more medical model focusing around managing medical conditions.

CONCLUSIONS:
Medical schools and foundation Programmes need to educate students further to enable them to develop a more accurate perception of the scope of the GP role. This is vital in ensuring ongoing recruitment into General Practice in the UK. Other Healthcare professionals working alongside GPs in new primary care community roles should also receive education focussed on helping them to work more symbiotically with GPs.
CELEBRATE YOUR TRAINEES!

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Entry to the Emergency Medicine training programme remains attractive and competitive but has a 25% attrition rate. The doctors and allied professions work in highly pressurised environments, experiencing high levels of stress and burnout.

Against this backdrop, in 2017 inauguration of the East Midlands Emergency Medicine Conference (EM2C) by the school of emergency medicine was designed to celebrate, motivate and showcase the achievements of all emergency medicine trainees across all disciplines.

The inaugural one day conference proved to be massive success with over 250 delegates representing educators, trainees and 6th form students aspiring to a career in emergency medicine. Trainees submitted over 100 posters across the Paediatric, Emergency & Acute Medicine, Major Trauma Care and Quality Improvement domains. Regional simulation teams, some lead by trainees performed live simulations. Trainees were selected for oral presentations of their posters and the best presentations and simulations rewarded. National and local keynote speakers complimented EM2C.

The unprecedented success of EM2C was reflected in the feedback requesting future conferences. Trainees highlighted EM2C served as a platform to network, share good practices, ideas and discuss innovations in Emergency Medicine. More importantly the trainees felt relaxed meeting their educators and peers at various stages in their training in an informal setting that re-ignited their desire to succeed in their training.

EM2C has been delivered annually since 2017 and continues to remain the focal point in the training programme. The authors believe the annual celebration of achievements has directly lead to successful retention and recruitment of trainees.
LESSONS LEARNED FROM LEGAL CHALLENGES TO THE SYSTEM – CRITICAL APPRAISAL AND REVIEW BY CO-EDITORS OF THE GOLD GUIDE (REFERENCE GUIDE FOR POSTGRADAUTE SPECIALTY TRAINING IN THE UK)

Professor Jane Mamelok*, HEE Postgraduate Dean & Lead Dean for the Gold Guide
Dr Aileen Sced, Gold Guide Co-editor, Ian Steele, Gold Guide Co-editor

INTRODUCTION:
In recent years, there has been an increasing trend for litigation and legal challenge to the governance and operational management of postgraduate specialty training programmes across the United Kingdom (UK) as the rules around decision making have become more prescriptive. Critical decisions about trainees’ progression in specialty training have become “high stakes” and for some career limiting, affecting livelihoods. Therefore, it is important to ensure that career critical decisions are defensible and consistent; and that trainees can challenge in an open and transparent way.

In preparing for Gold Guide version 8 due publication in 2020, the Gold Guide team have had the unique opportunity to review legal cases, how they impact upon and drive improvement in decision making by Postgraduate Deans and their support teams. This presentation summarises the learning and development of resources for cascade across the system.

METHODS:
- Legal challenges relating to UK postgraduate specialty training and UK Foundation Training Programmes have been reviewed by the Gold Guide team.
- This includes employment tribunals (where relevant elements of specialty training are referenced e.g. quality of clinical /educational supervision); judicial reviews and high level ARCP appeals (for the purposes of this review high level has been defined a significant legal input/representation by any party).
- Cases have been critically appraised to identify the main issues tested and subject to legal challenge, the outcome and any changes or improvements as a result.
- Outcomes were subject to thematic analysis using a grounded theory approach to group themes for development.

CONCLUSIONS AND IMPLICATIONS:
- The preparation and management of cases subject to legal challenge was variable across the UK. Those areas with experience have developed more comprehensive systems and had greater access to legal support.
- Currently, there is no mechanism for feedback and sharing of experiences following challenging cases.
- Current Gold Guide has areas that are ambiguous which could be improved in GG8 reducing inconsistency.
- This has led to development of a resource bank of real time scenarios including guidance for managing ARCP panels, appeals and decisions tested by legal challenge with training packages available for local delivery; resulting in consistency and equity across the UK, reducing litigation and training costs.
A UNIQUE OPPORTUNITY TO CHANGE THE PROFESSIONAL SUPPORT AND WELLBEING OF JUNIOR DOCTORS WITHIN THE EAST OF ENGLAND DEANERY: EXPERIENCES FROM TWO YEARS OF THE MENTOR FELLOWSHIP PROGRAMME

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INTRODUCTION:
The East of England deanery of Health Education England is unique in that it since 2017 it has hired two part-time mentor fellows (local trainee doctors) to help establish mentoring and give every trainee the option to access a mentor within the deanery. Since the introduction, the mentor fellowship has led to the establishment of regular training courses, a mentor training package and the rise of a number of new mentoring schemes within the region.

METHODS:
We review the successes, as well as the challenges and limitations of the mentor fellowship. We discuss the experiences the mentor programme has brought to the fellows and how it has impacted their own profession development, as well as the wider impact of the roles in the region and the support it provides for local mentoring schemes.

CONCLUSION/IMPLICATIONS:
Mentoring fellowships are a unique approach to increasing awareness of the role of mentoring in modern medical education and to help establish mentoring programmes. This can be achieved in a range of ways from providing a support infrastructure and training for mentoring leads and mentors, providing local mentor support, marketing mentoring as a professional support tool at local education events and encouraging active involvement of local training programme directors and educational supervisors.
INTRODUCTION:
Mentoring is used in a range of industries and can harness untapped potential amongst junior and senior staff. There is increasing need for support and development amongst doctors, however this aspect in increasingly undermined within an increasingly stretched health care system with both shortage of time and money.

METHODS:
We will outline a step by step guide on how to go about creating and launching a mentoring scheme. We run this as a half-day course and take on feedback from this as well as support potential mentor leads in establishing and launching new mentoring schemes. We will review the many challenges faced (that are common across many mentoring schemes trying to launch) and potential solutions that have been successful. We also discuss succession planning and how to transition to a new mentor lead.

CONCLUSION/IMPLICATIONS:
Setting up a scheme can be challenging and difficult; but is a rewarding experience. Having a structure and information governance framework is key. The challenges in getting schemes off the ground are common to many specialities and a range of different approaches can be taken with regards to time, money and administrative help. Planning succession early can help keep momentum and prevent droop within a newly established scheme.
A NOVEL PILOT FOR CORE TRAINEE PERSONAL DEVELOPMENT IN PSYCHIATRY: OUTCOMES AFTER 12 MONTHS

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BACKGROUND:
Sussex Partnership Trust is a large mental health trust on the south coast of England which has psychiatry trainees from the Kent, Surrey and Sussex deanery. The trust medical education team tracked and observed positive results of a number schemes offering enhanced professional development. They also recognised the lasting impact of the trust’s higher trainee leadership programme on the medical workforce.

Sussex Partnership devised and developed a “Core Trainee Plus” post for 4 trainees a year to work 60% clinically and 40% in an area of special interest. This scheme was supported by the Deanery and no extension to core training was required on completion of this post. This has been running since August 2018.

METHODOLOGY:
Core trainees who had undertaken the trainee plus post were asked about their experiences of the rotations. Trainees in their first year of training were asked their views on potentially undertaking “plus” posts in more senior years.

RESULTS:
Four trainees have undertaken six month “Core Trainee Plus” posts. When given free range for their own special interests, two trainees have chosen medical education and two trainees chose leadership. The trainees found they were given more responsibility for personal planning than their peers and were allowed to develop their own projects. In education, the trainees contributed to teaching at undergraduate, postgraduate and masters level. They also produced novel programmes such as post graduate mentoring schemes and training for mental health nurses, doctor’s assistants and health care assistants. Within the leadership trainees, there was a focus on longer term projects with the ability to produce business proposals and contribute to critically appraising projects within the region. The leadership trainees had regular meetings with senior decision makers including the Chief Medical Officer (Medical Director). All trainees felt that the post added significant personal development to their training without impacting on their clinical needs. Several of their projects are ongoing after the post finished and continue to contribute innovate solutions for challenges within the trust and deanery. The more junior doctors described the possibility of undertaking the post in the future as making them feel valued and recognised for their work. However, some disagreed with the competitive nature of limited posts and wished for greater clarity on the selection criteria.

DISCUSSION:
This project enabled Sussex Partnership Trust to develop educators and leaders for the future at a more junior level of training. It allowed for the growth and development of these trainees with relative freedom and personal responsibility ascribed to the trainees. It has encouraged a culture of innovation from the junior medical workforce which has had a positive impact on trainees of all levels. The project intends to continue for the foreseeable future to continue fostering a culture of change and improvement.
THE INTRODUCTION AND OUTCOME OF THE SPIRAL LEADERSHIP PROGRAMME IN OPHTHALMOLOGY IN LONDON
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INTRODUCTION:
The Spiral Leadership Programme in the London Ophthalmology training was introduced in 2016 by Fiona O’Sullivan the former Head of School. This model was based on the Healthcare Leadership Model developed by the NHS Leadership Academy and is made up of 9 dimensions which are all linked to a series of leadership behaviours (1). The aim of this initiative was to prepare trainees for the leadership and management roles that is required once they are consultants which is often an area that trainees feel is absent from their training programmes (2, 3). As a result of the success of this model, the spiral leadership toolkit was shared across London for all specialties in 2018 (4).

METHOD:
In 2019 all ophthalmology trainees were expected to undertake two leadership activities and to write a reflection on these tasks to upload to their e-portfolio in order for them to achieve a satisfactory ARCP. To encourage the trainees to undertaken useful projects for their personal development (rather than it be a ‘tick box’ exercise) the London School of Ophthalmology awarded prizes at their yearly conference for the best projects and reflections in each domains. We noticed an increase in number of submissions and an improvement in standards of projects from 2018 to 2019. This year we had 18 applications for prizes and these involved projects ranging from procurement initiatives, shadowing chief executive officers, setting up training for allied health professionals in extending roles, reducing inpatient risk by auditing compliance with ophthalmology medication and developing protocols to improve patient care. The spiral leadership toolkit allows the trainees to learn from experiential learning, i.e. on the job with the support of a supervisor. The material is integrated horizontally and vertically between years of training where it is revisited at increasing levels of complexity at the trainee’s progress through their training as they connect new learning to old learning. Spiral learning was originally describe by Brunner and as the trainee becomes more experienced the supervisor can descaffold instruction allowing them to become more independent (5, 6).

CONCLUSION:
The spiral leadership toolkit has become embedded into ophthalmology training and seems to be approached with enthusiasm by our juniors as highlighted by the quality of projects undertaken in the last year.

ACKNOWLEDGEMENTS: Fiona O’Sullivan

REFERENCES:
TEACH IN TEN: FLEXIBLE TEACHING IN A TRAINING POST

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Teaching within training posts is often cited as an area for improvement on feedback from junior doctors, as described in the National Training Survey 2018. There are several factors impacting upon regular ward-based teaching including time pressures, workload upon the ward and staffing difficulties. The aim of this project was to increase the frequency of organised teaching on a paediatric ward by developing a culture of sustainable and flexible micro lessons that could be utilised across a variety of wards or clinical based settings and specialities. The key principles deployed included: making more teaching explicit and visible, utilising peer assisted learning (PAL), delivering micro lessons in the clinical environment, developing teaching skills through micro teaching and using regular simulation as an aid to traditional teaching.

By utilising PAL with trainees, we also hoped to stimulate higher level processing of information during the preparation phase of the teaching materials, and fostering more of a cognitive and social congruence between teachers and learners. The teaching sessions were designed as micro lessons as a way of delivering key information in short segments. This is a clinical teaching method that also acts as a way of teaching knowledge and skills by reducing the complexity of teacher training. Research has shown that in-situ simulation can reinforce desirable individual and team behaviours, improve technical proficiency, identify active and latent system issues and catalyse change in clinical care systems with improved clinical outcomes.

We used a central poster to advertise and promote the micro lessons, as well as acting as a sign-up sheet and a record of the sessions, their length, and the time at which they took place.

Feedback questionnaires were used to gather pre and post project cycle changes focusing on teaching confidence, knowledge of paediatrics, satisfaction with teaching knowledge and quality and satisfaction with teaching opportunities and simulation training.

Flexible micro lessons were subjectively and quantitatively well received as a useful way of promoting and maintaining regular teaching in a busy inpatient setting. The teaching sessions lasted around 10-15 minutes and mainly occurred at handover times.

Building a teaching culture helps foster improved training satisfaction, teaching and training skills and improved education and patient outcomes. There are many aspects to developing sustainable teaching but regular micro lessons and in situ simulation are two aspects that we have seen having a positive effect on trainees and the department.

These techniques also have the benefit of being transferable across many clinical departments, opening up the possibility for more unified, trust wide teaching and training focused clinical departments and hospitals.
BE WISER ABOUT YOUR SUPERVISOR – IMPROVING EDUCATIONAL SUPERVISION ACROSS SOUTH LONDON
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INTRODUCTION:
All postgraduate medical trainees require a named Educational Supervisor (ES) for each placement, appropriately trained, responsible for the overarching management of educational progress.

HEE south London took a proactive approach to improving the GMC National Training Survey (NTS) results in the educational supervision domain – in partnership with the Local Educational Providers (LEPs) and the trainees.

METHODS:
A focus group of south London trainee representatives was conducted in December 2018, to gather understanding of the role of an ES from the trainee perspective.

To support this work, we produced a document drawing upon national materials (Gold Guide, GMC and NACT UK) summarising the key roles and responsibilities of educational supervisors for HEE London.

This information was combined and distilled into an infographic which has been shared across our network and nationally.

The product was promoted via social media and at conference presentations as part of the #bewiseraboutyoursupervisor campaign.

FURTHER WORK:
We continue to engage with our LEPs and trainee representatives to increase awareness of the key role of the relationship between a trainee and their ES in maximising their learning and training experience.
INTRODUCTION:
The Confederation of South London Local Education Providers (CoSL) is a collaborative forum with a mission to enhance quality and strengthen the network delivering medical and clinical education in south London.

CoSL brings together the Health Education England (south London) team with the medical education leaders from the ten acute and mental health Trusts in the sector to discuss common areas of concern, good practice, and opportunities for collaboration.

The group of approximately 40 members meet six times a year with a set agenda plus invited items (an example agenda will be included in the poster).

Membership of CoSL
- Postgraduate Dean, Health Education England working across south London
- Deputy Deans, Health Education England, south London team
- Senior Medical Education Lead (DME or equivalent) and Management Lead (Medical Education Manager) from each LEP;
- Trainee representatives from the South London Trainee Network Executive Committee
- Management and Administrative staff from HEE London teams including: Local Office, Healthcare Education Team and Quality, Patient Safety and Commissioning Team

METHODS: Achievements from CoSL include:
- Key to CoSL is the platform for relationship building and networking to share concerns and good practice in the essential task of stakeholder engagement
- Early raising of risks for projects such as specialty programme changes to ensure smooth joint working such as the transition from core to internal medical training
- Responding as a network to the challenges presented from the GMC national trainee survey
- A forum for dissemination of good practice within the network, showcased at an annual COSL conference
- Establishment of a South London Trainee Network
- A space for the many fellowships across south London to present the work they do to support quality of education and training
- A forum for discussion for wider system changes and workforce transformation, with key influencers invited to attend

FURTHER WORK:
We have had interest from other local area teams and have shared our model in order to spread this novel method for joint working across the whole medical education system in a geographical area.
THE STATE OF PHYSICIANLY TRAINING IN THE UNITED KINGDOM

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INTRODUCTION:
Recent reports highlight concerns around the state of the National Health Service (NHS) being underfunded, under-doctored and overstretched (1). This potentially impacts on the quality of training and patient safety. This report aims to objectively evaluate the current state of quality of physicianly training provided within the United Kingdom (UK) and crucially provide an evidence-based benchmark for future comparisons.

METHODS:
Data from six key quality datasets across 29 physicianly specialties and three sub-specialties in the UK were analysed by specialty and region. Data from each was mapped against the General Medical Council (GMC) themes for standards of postgraduate medical education and training (2). A thematic analysis was done to identify factors affecting quality of training.

RESULTS – Four major themes identified:
- Rota gaps in acute medical specialties affecting workload.
- Imbalance of service delivery of General Internal Medicine (GIM) affecting specialty training experience.
- Smaller specialties - issues with curriculum delivery and sustainability.
- Single specialty - issues meeting particular curricular requirements and commissioning.

The first two themes affect the majority of acute medical specialties and have a significant negative impact on all the GMC themes and have the potential of affecting patient safety. The latter two themes affect a smaller number of specialties with more specific issues affecting the learning environment and curriculum delivery.

CONCLUSIONS:
This report has made judgements based on analysis of six key datasets. The findings provide an evidence-based benchmark for the current state of quality of physicianly training in the UK. It supports the literature around the NHS challenges and being a junior doctor in the current climate with increasing service pressures compromising the quality of training.

TAKE-HOME MESSAGE:
- First report to examine multiple quality datasets and map these against the GMC themes for postgraduate medical education and training to provide an evidence-based benchmark.
- Findings highlight increasing pressures of acute medical specialties due to the rota gaps and imbalance of service delivery of GIM affecting the specialty training experience.

REFERENCES:
DEVELOPING AN APPROACH TO NATIONAL QUALITY ASSURANCE OF PHYSICIANLY TRAINING IN THE UNITED KINGDOM

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INTRODUCTION:
The Joint Royal Colleges of Physicians Training Board (JRCPTB) improves patient care by setting and maintaining standards for the highest quality of physician training in the UK. We aimed to evaluate the current quality data around postgraduate medical education of physicians and identify core data sources that will inform the state of physicianly training.

METHODS:
A quality management audit involving key internal and external stakeholders revealed 62 data sources available to the JRCPTB to inform the quality management process. Out of these six key ones were consistently mentioned.

RESULTS:
These included: GMC National Training Survey (NTS), Annual Review of Competence Progression (ARCP) outcomes, Membership of the Royal College of Physicians (MRCP) Exam data, Royal College of Physicians Higher Specialty Trainee Workforce Census/New Consultants Survey, Penultimate Year Assessments (PYA), and Monitoring visit reports.

DISCUSSION:
The key quality indicators from each dataset were identified and mapped to the GMC themes for standards of medical education and training, which enabled detailed analysis of various components of the quality of training. Data was analysed by specialty and region to produce the State of Physicianly Training Report in the UK.

CONCLUSION:
This approach provides a national quality assurance framework for physicianly training by using multiple quality datasets mapped against the GMC themes and standards for postgraduate medical education and training. It enables a systematic method of evaluating the quality of postgraduate medical training and provides an evidence-based benchmark for future comparisons.

TAKE HOME MESSAGES:
• National quality assurance of physicianly training in the UK developed using analysis of six key quality datasets by specialty and region.
• Key quality indicators from each data source mapped to the GMC themes and standards for postgraduate medical education and training to produce the state of physicianly training report.

REFERENCES:
DOES OVERSEAS DELIVERY OF THE CLINICAL YEARS OF A GMC-APPROVED UNDERGRADUATE CURRICULUM DISADVANTAGE STUDENTS IN UK CLINICAL EXAMINATIONS? IMPLICATIONS FOR TRANSNATIONAL MEDICAL EDUCATION COLLABORATIONS

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INTRODUCTION:
The UK government plans to remove the cap on international medical student numbers. International educational collaborations hold promise for additional recruitment, but few UK medical schools have experience beyond in-programme student transfers from the International Medical University. Notable exceptions include St George’s Cyprus programme and Newcastle’s Malaysia campus. The poster reports on an innovative collaborative programme - the BM(EU) - between the University of Southampton and a German healthcare provider.

The first BM(EU) cohort enrolled in 2013 and graduated in 2018. Student admission and selection processes are the same as Southampton’s standard school leaver BM5 programme, except BM(EU) applicants must prove both English and German language proficiency. Both programmes are quality-assured by the General Medical Council. For two years the cohorts study together in Southampton, differing only in their clinical context. In Years 3-5 BM5 students undertake clinical placements in Wessex but BM(EU) students’ placements take place in Hesse, Germany. BM(EU) students learn clinical medicine in the German language and culture but undertake major clinical assessment (OSCEs) in Southampton in a British context. BM(EU) graduates carry out Foundation Year 1 training at Klinikum Kassel (overseen by the Wessex Deanery) to complete full GMC registration.

METHODS:
We compared BM(EU) and BM5 student performance in clinical examinations. For this, we aggregated available OSCE results as follows (n of BM(EU) students given in brackets):

- Y3 exams in 2016/17/18, total n=473 students (62).
- Finals exams in 2018/19, total n=282 students (36).

Our analysis shows no significant differences between the exam performance of the BM5 and BM(EU) cohorts, either in Year 3 or in finals.

CONCLUSIONS / IMPLICATIONS:
Our findings indicate that clinical experience overseas does not disadvantage students in UK clinical examinations. The BM(EU) model shows that UK learning outcomes can be met abroad. Moreover, the model could be scaled and/or replicated elsewhere and in other health care professions.

The BM(EU) has brought significant benefits for the Faculty, staff and home students as well as the German placement providers. The challenges include recognising differences in health care systems, staff development and cultural differences in priorities and management.

ACKNOWLEDGEMENTS:
We would like to recognise our partner organisations within the Gesundheit Nordhessen Trust, namely Kassel School of Medicine and the Foundation School at Klinikum Kassel and the various placement sites. We would also like to acknowledge the collaboration with Wessex Deanery and are grateful for the support of the General Medical Council, which has performed regulatory visits annually between 2012 and 2019.
SINGING IN THE WORKPLACE

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We have introduced singing into the workplace. An established chorus director (Tim Briggs) comes in to direct and sing with staff, patients and parents, employed as a contractor by the trust.

Successful health and well-being interventions seem few and far-between and our experience of singing with staff and patients has been hugely uplifting. Staff describe "walking taller" (and request shifts on the days when singing happens)

We started in 2017 with a singing course for staff, offering an hour a week for 10 weeks and leading up to a performance in the trust Christmas show. This was repeated in 2018 and we now hold a range of regular weekly sessions with different staff groups and with varying content. In all of these, the emphasis is on having fun while singing and preparing to sing.

The singing course carries on with a group of staff learning 3- or 4- part harmony arrangements (an hour a week after work). We have performed for staff at trust shows and we go onto the wards to sing for patients. There is a less formal lunchtime group who work on shorter pieces and well-known songs (for half-an-hour). This was requested by clerical and administrative staff and that group now comprises a range of staff from across the trust - including support services, psychology & physiotherapy.

We realised that nursing staff struggled to reach the organised sessions, so we now go onto one of the wards every Thursday lunchtime for half an hour and sing with whoever is available. Staff can be accessed immediately if there is a problem. These sessions attract attention from patients and parents, who are welcome to come and join in.

Singing is known to benefit health and it has proved to be a flexible and effective way to engage staff. Although the benefits are hard to measure, staff describe the "uplift" from joining in with the sessions - and return the following week for more...

As senior clinicians, modelling the importance of our own health and well-being to other staff is crucial and singing offers a very simple way to do this. All the singers are "equal", so in any group the clerical/support staff, allied health professionals and medical staff can interact as peers.

Junior doctors haven't been regular attenders at the sessions and we believe this is due to timing (530-630 or 1230-1pm). Sessions are being planned and advertised in the junior doctors’ mess.
UNDERSTANDING NORMAL – INTRODUCING NORMAL CHILDHOOD HEALTH, GROWTH AND DEVELOPMENT AS PART OF A SPIRAL CURRICULUM PREPARES STUDENTS FOR CLINICAL CHILD HEALTH BLOCKS AND FUTURE CAREERS

Dr Alice Roueché, Dr Chloe Macaulay

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INTRODUCTION:
Exposure to paediatric medicine in medical school has always been limited. As the required curriculum content grows across all fields of medicine it can be increasingly challenging to ensure that students get adequate child health teaching. No matter what the destination specialty is, every doctor has a responsibility to understand and manage child health. Every patient was once a child and many adults live as survivors of childhood illness. King's College London has recently implemented an innovative new undergraduate curriculum within GKT medical school. We have used this opportunity to revisit the child health content and ensure that students experience a spiral curriculum with stepwise exposure to child health topics across the programme instead of a single intensive child health placement.

METHODS:
Prior to 2017 GKT medical students were only exposed to child health in a combined child health, dermatology and ageing block in year 4. Actual child health clinical exposure was very limited. As part of a review of the whole undergraduate curriculum the case was made for more exposure to child health, resulting in a longer 4th year placement dedicated to child health. The clinical placement is by necessity focused on childhood illness but we felt that this needed to be preceded by an understanding of normal child health and development. A new clinical block had been devised for year 2 entitled Human Development to cover pregnancy and genetics. We were able to adapt this to include growth and development from conception to adulthood. Students are now exposed to these topics through taught content and clinical placement early on in their learning. This knowledge is then built upon in a spiral manner through the rest of the programme, including GP placements and their 4th year child health block. OSCE and progress test assessments have been adapted accordingly.

RESULTS:
The student feedback for the new Human Development block has been very positive. The students value the earlier clinical exposure and their OSCE performance has demonstrated that their learning has been put effectively into practice. We are in the second year of this programme so have not yet seen the students come through to their year 4 Child Health block but we anticipate seeing better preparedness for the placement and an improved baseline understanding of the normal child.

CONCLUSION:
We have successfully introduced a new spiral approach to the child health curriculum for undergraduates at KCL. Students value the teaching and we believe that this will be of benefit to them whatever medical career paths the take. Our next steps are to link across to other blocks in the programme, such as Long Term Conditions, to ensure that child health and adolescent transition feature in these and enable students to develop a whole life-course approach to medicine. With an increasing understanding of epigenetic influences and social determinants of health we believe this will make for doctors better equipped for the challenges of modern medicine.
THE TUTORIAL IS DEAD: LONG LIVE THE TUTORIAL

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AIMS & BACKGROUND:
To explore how and why supervisors vary the structure, modalities used and location of the tutorial, an established educational activity utilised in primary and secondary care to educate a professional life-long learner.

Historically tutorials have been topic based with less consideration given to the setting. The current format needs adapting for the new generation of trainee (Generation Y—‘Millennial’s and Generation Z—‘Digital Natives’).

SUMMARY OF WORK:
General practitioner (GP) supervisors completed a questionnaire about their tutorials exploring what modalities are used, the location and rationale for variation in structure/place. A multi-specialty medical educationalist workshop was subsequently held gaining a wider perspective of the tutorial. Collated data was distributed to the GPs, sharing ideas and validating the varied personalised approach.

FINDINGS:
During tutorials, GP supervisors (n=21) utilised: YouTube (52%), eLearning (58%), shared tutorials (>1 trainee present) (81%), role-play (81%) and “other” practice member(s) (53%). Alternative settings included: trainee in the “consultation” seat (86%), trainee’s room (71%), coffee/other room (29%), café/restaurant [ensuring confidentiality] (52%), supervisor’s home (43%), walking (67%). The structure and venue varied to address challenging issues/trainee and for variety. In the multi-specialty professional workshop (n=32), the GP’s (1/4) had varied their tutorial style and location unlike hospital doctors. At the end of the session all appreciated the benefits and felt empowered to adapt future tutorials.

CONCLUSIONS:
Tutorials require a personalised approach, addressing the wider picture of training (including the ‘hidden curriculum’), developing ‘softer skills’. Alternative settings can help manage challenging issues, provide variety, incorporate new technologies and enable learning needs to be addressed.
THE IMPACT OF A WORK-LIFE BALANCE (WLB) ASSESSMENT ON DOCTORS’ CONTINUING PROFESSIONAL DEVELOPMENT AND PERFORMANCE

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BACKGROUND:
Clinician wellbeing, stress and burnout have been the focus of increasing research activity in recent years and is an area of educational development for intervention/support. This is in recognition of the impact of clinician health and wellbeing on performance, and caregiving ability for patients. There is a growing body of literature around medical student and trainee experiences, however less in relation to post-qualification experience and support as part of continuing professional development.

SUMMARY OF WORK:
The present work sought to embed an opportunity for reflection on GP health and wellbeing in the appraisal discussion. A series of questions concerning work-life balance (WLB) (n.26) were added to an online appraisal portfolio to gather information on the impact of clinical work on GPs and allow users an opportunity to think about this in relation to their own experience. Appraisees’ views of the value of these questions was also evaluated using a qualitative approach.

This work presents findings from data gathered and reflection on the value of this opportunity by appraisees.

SUMMARY OF RESULTS:
1046 GPs provided information on aspects of their work-life balance. Descriptive analysis of the data indicated that there was a blurring of boundaries between the two, where home life activities would be impacted by work demands, and areas where there was ‘work leakage’ for example working through lunch. Further statistical analysis is underway to identify deeper trends and relationships within the data.

88% of participants found the WLB questions useful for reflection, in particular to think more deeply about different aspects of WLB, and to compare their answers with their peers. The questions served to surface issues the participants were aware of, and for some, to prompt change or the intention to change.

DISCUSSION AND CONCLUSIONS:
The appraisal discussion presents a golden opportunity to reflect on the demands of clinical work and their impact, as well as to support positive behaviour change. GP health and wellbeing should form an area for discussion in appraisal, beyond the standard requirements of a health declaration. The appraisal interview can act as a driver for change.
NORTH WEST SCHOOL OF ANAESTHESIA RETURN TO WORK COURSE: RESULTS OF 6 YEARS HELPING DOCTORS RETURNING TO PRACTICE AFTER A PERIOD OF ABSENCE


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INTRODUCTION:
There are many reasons why doctors may undertake a period of absence from practice, including ill health and parental leave. Returning to work is a stressful time for doctors and, unless properly managed, could have patient safety implications. In 2012 the Academy of Medical Royal Colleges produced a document highlighting the importance of a good procedure for doctors returning to practice1. In response to this, the North West School of Anaesthesia developed a multifaceted ‘Return to Work Programme’, one aspect of which is a day-long ‘Return to Work (RTW) Course’. The course delivers workshop and simulation sessions, supported by a webpage which we populate with up-to-date guidance, important research articles and summaries of important changes to clinical practice. Increasing demand for places on the course has necessitated the frequency of courses be increased from biannually in 2013 to 4 times a year currently. We now cater for anaesthetists returning to work from Core Trainee to Consultant Level, and with a diverse set of reasons for absence. Following the 2016 Acas junior doctor’s contract agreement, Heath Education England has committed to develop their ‘Supported Return to Training (SuppoRTT)’ strategy2 which promotes existing good practice. We therefore present the results of 6 years of our own initiative.

METHODS:
Following each of the 13 courses we have run to date, we collected post-course feedback using a 5-point Likert scale describing how strongly the attendees agreed with 12 statements, e.g. This training has increased my confidence. We also collected free-text comments and suggestions for improvement.

RESULTS:
One-hundred per cent of attendees agreed or strongly agreed with the statement ‘I am satisfied with the training I have received today.’ Of all attendees, 99% agreed or strongly agreed that ‘This course will increase patient safety and quality care’ with 1% neutral. Ninety-nine per cent agreed or strongly agreed that ‘This training has increased my confidence.’ Free text feedback included the statement, “It [the course] has made me less fearful of RTW. It has also helped me identify areas of weakness and have an action plan for my KIT days and RTW”

CONCLUSIONS:
The RTW course is a successful and valuable part of the North West School of Anaesthesia RTW programme. We would encourage other specialty schools to develop similar bespoke programmes of work to support their doctors returning to practice after a period of absence.

REFERENCES:
INTERNATIONAL GP RECRUITMENT – AN EVALUATION OF THE STRUCTURAL, EMPLOYMENT AND EDUCATIONAL ASPECTS OF THE PROGRAMME AND THE IMPLICATIONS FOR FUTURE WORKFORCE INITIATIVES.

Shears, M-R

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INTRODUCTION:
Recruitment to the primary care workforce is a priority as identified in the King’s fund report “Closing the Gap” (2019). International GP recruitment is considered a short-term answer to workforce shortages. To streamline and support this process the national initiative to recruit 2000 international General Practitioners (GP) was announced in July 2017. To date (May 2019) approximately 120 GPs have been recruited. National and local networks were set up to deliver this programme. Reviewing the strengths and weaknesses of the structure of this recruitment initiative is relevant to plans for future workforce drives. This study evaluates the effectiveness of the learning and communication between and within these organisations.

METHOD:
The Delphi method was used to ask all the members of the Kent Surrey and Sussex International GP recruitment delivery group about their understanding and experience of the programme. Two rounds were collated by email. The responses were grouped under three themes: structure of programme, employment and educational perspectives.

RESULTS:
The findings suggest a responsive, knowledgeable and motivated network supporting the programme. It raises questions about the roles and responsibilities of different organisations, the ongoing communication and value for money.

CONCLUSION AND IMPLICATIONS:
Future initiatives could learn from the international GP programme and its cost, by developing transparency, clarity and reviewing resources at all levels.

ACKNOWLEDGEMENTS:
The Kent Surrey and Sussex International GP recruitment delivery group, Richard Weaver and Professor Hilary Diack.
INNOVATIVE TRAINING AND RECRUITMENT PROGRAMME IN SURGERY

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'BHR Academy of Surgery' is an innovative training and recruitment programme initiated by the surgical division at the BHR NHS trust to recruit, train and retain junior doctors from across the world and help support the vital NHS services. Prior to the introduction of the programme with the prevailing shortages in staff numbers, there was a heavy reliance on locum staff and frequent gaps in rota. This was an issue with regard to patient safety and departmental expenditure.

With looming recruitment crisis in the NHS, we designed a successful teaching and training programme to attract junior doctors in July 2018. We started a trust wide 2-year, FY2 and CT1 equivalent, surgical training programme (Basic Surgical Training). The trainees spend 6 months in 4 specialties of their choice within in General surgery/ENT/ Orthopaedics/ Urology/ Emergency departments. The training programme consisted of 4 rotations in relevant specialities within the hospital for the total of 2 years.

We have recruited 25 doctors to this programme. The majority of the trainees are qualified overseas, with doctors from around 9 different countries. The first rotation started in October 2019 and they have moved on to the second rotation in April 2019.

The programme lead for this project is actively involved in designing the programme and also managing the recruitment & training aspects. There are dedicated educational and clinical supervisors and each trainee has an allocated AES and CS.

The programme encompasses supervised training activities including clinics, theatres and teaching sessions that was included in the rota. The training programme also includes fully funded 2 year MSc programme (distant learning) linked to UK university, to be completed during this rotation.

The trainees are encouraged to complete work place based assessments on a regular basis, which is supervised and monitored. The aim is to help them take MRCS and gain eligibility for higher surgical training application. These trainees attend the weekly departmental teachings delivered by junior doctors and consultants. They have a mandatory monthly Academy of Surgery teaching schedule for half a day, which is supported by the higher surgical trainees. We have conducted MRCS teaching courses for these doctors and few trainees have already taken MRCS part 1. We have also scheduled an ATLS course within the trust, for these trainees in July 2019.

These trainees meet once monthly with the programme lead to discuss their progression and other training issues. There is a planned ARCP in October 2019 and the first batch of trainees would complete their 2-year rotation in October 2020, with the certificate of completion from the BHR Academy of Surgery.

This has been a successful initiative with all the rota gaps in the surgical division being covered with substantive doctors. The locum spend is drastically reduced. The continuity and quality of care is self-evident with significant improvement in the morale of deanery trainees in the surgical division. The estimated cost saving is £480,000 for 2 years, as calculated by the divisional finance team. The difference made in the day-to-day activities is phenomenal. The frontline emergency department staff, nursing staff and para-medical staff has expressed wide support for the programme. The hospital benefits from a stable and enthusiastic work force who contributed immensely to daily functioning of the hospital.

There is a plan to expand this programme with rotation involving the neighbouring trusts. We are in discussion to establish BHR Trust as the hub for this training programme and recruit more doctors to rotate to neighbouring hospitals. This would greatly help the NHS hospitals in the region at the time of significant shortage of junior doctors across the country. This would also give platform for world class teaching and training in surgery within the NHS.

ACKNOWLEDGMENT:
Surgical team and staff at Barking, Havering and Redbridge University Hospital Trust
WHAT DO STUDENTS HAVE TO DO WITH MEDICAL EDUCATION LEADERSHIP AND MANAGEMENT?

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INTRODUCTION:
PsychED UP is a teaching course for third-year medical students, supported by a Health Innovation Network Small Grant. This two-tiered project aims to teach challenging, extra-curricular topics in psychiatry, whilst, training medical students as Peer Facilitators (PF) and Trainee Psychiatrists (TP) as expert educators. It is important for medical students to acquire skills in medical education leadership and management, however, opportunities to pursue these avenues during medical school are lacking. PsychED UP established meaningful roles to develop such skills.

METHODS:
Inspired by its predecessor course (Extreme Psychiatry), PsychED UP was designed and delivered collaboratively by TPs, PFs, actors and service users. The PFs were involved in content creation, identifying impactful teaching methods and adapting clinical scenarios.

The seven-week course ran twice over the year and each weekly session began with large group teaching followed by small-group simulated patient roleplays. The small groups were co-led by one PF and a TP, who provided structured, dynamic feedback and received personal feedback from mentor observation. The course was iteratively developed and in addition, PF’s attended the end of year evaluation session and offered reflections on their experiences.

CONCLUSIONS:
The PFs were integral to the team: leading and managing the sessions; keeping the group to time; and, troubleshooting to ensure sessions ran smoothly. Additionally, the PFs encouraged participation, promoted equal opportunity, developed effective relationships with the TP and provided sensitive, targeted feedback. PsychED UP also empowered PFs to personally develop and utilise qualities integral to medical careers such as leadership, management, communication, and evaluation skills. Themes that emerged were learning about the nature of successful teams and development of leadership values:

“The relationship between the group and its leaders determined the productivity”
“To achieve a harmonious working environment, we began by developing mutual respect and setting boundaries”
“Leading by example was important”
“Each individual has an essential role, yet no individual could function without the others- the team is greater than the sum of its parts.”
“The supportive nature of the team inspired confidence, whilst providing vital reassurance of knowing where to turn to if need be”
“This multi-disciplinary team support network is highly reflective of the hospital environment”

In conclusion, medical students are vital to medical education. Opportunities for leadership positions not only improve their professional skills to produce better future doctors but also improve the content and running of medical education programmes.
IMPROVING OUR LEADERSHIP CULTURE, DEVELOPING FUTURE LEADERS AND SPREADING HIGH QUALITY LEADERSHIP AMONGST OUR CLINICAL AND EDUCATIONAL SUPERVISORS ACROSS HEALTH EDUCATION EAST OF ENGLAND

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INTRODUCTION:
Research confirms the importance of first line supervisors in determining the behaviour, performance and engagement of individuals in their work. It highlights the impact of supervisors on trainees learning and professional development, including how they respond to challenges; and the importance of supervisors’ pastoral role in giving meaning, purpose, instilling values, and creating environments where a culture of learning and development thrives. Despite this knowledge the training and development offered to educators lacked consistency of content, limited accessibility, and confusion around competency achievement or training progression.

The results of this approach were inconsistencies in the quality of education and clinical supervision together with individuals who felt under-skilled and vulnerable.

In addition, applications for senior leadership roles within education and training have reduced. At the latest appointment to the role of Deputy Postgraduate Dean, only one application was received. The reasons are clearly multi-factorial, yet a clear development strategy to support individuals to identify and obtain the required knowledge, skills and experience to apply for such opportunities was required.

AIM:
• an educational leadership strategy which would provide the opportunity for educators to develop and update their skills and gain demonstrable competencies to enable clear career progression
• career opportunities within education and development to facilitate the provision of quality candidates prepared to practice within higher educational roles

METHOD:
A tiered approach to educator development was designed, with a competency framework, and opportunities for development of skills at face-to-face contact days provided by hubs at Higher Education Institutes and Trusts across the region, blended with an easy access e-learning package.

The contact days have continuing professional development points awarded as a means of external quality assurance and to benefit the development and appraisal of the educator. To encourage widespread adoption of the programme, the entire provision is free to the educator. Opportunities for further development, masterclasses, bursaries and job opportunities are advertised through the network and shared at events. A complete web page re-design enabled easy-access information, on-line bookings and directions to all learning opportunities for each tier of educator.
QUALITY IMPROVEMENT OF THE EDUCATION AND TRAINING OF EDUCATORS ACROSS HEALTH EDUCATION EAST OF ENGLAND. A STRATEGY FOR CURRICULUM DELIVERY TO DEVELOP CLINICAL AND EDUCATIONAL SUPERVISORS

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INTRODUCTION:
The General Medical Council (GMC) national training surveys report that “The majority of doctors in training are satisfied with the standard of ... supervision they receive”; yet also found that the majority of trainers felt they would benefit from further training and support.

Development of clinical and educational supervisors in East of England fell to the individual, or the individual trust. The result was training in silos with different standards in primary and secondary care, and between trusts. We decided to standardise a curriculum of generic supervisor skills and deliver training across all specialties, primary and secondary care for the entire region.

METHOD:
The curriculum was determined by identifying essential elements required by the GMC, the Academy of Medical Educators (AoME) Professional Standards Framework and the Committee of General Practice Education Directors Guidance for Deaneries on educational standards.

The curriculum supports educators by following the same format at each level of training and by encouraging learning locally.

The first step is to gain the theoretical knowledge of supervision delivered by completing specifically selected modules from e-Learning for Health mapped to AoME standards.

The second and third steps are face-to-face teaching days; step two focuses on academic aspects of medical education and supervision and is delivered by one of our three medical schools. Step three concentrates on practical aspects of supervision and is delivered at one of five Health Education England (HEE) hubs across the region by a local faculty of clinical educators from primary and secondary care. For consistency across the region, the same curriculum and standard mapped educational content for academic and HEE days is delivered, regardless of the provider.

Contact days have continuing professional development points for external quality assurance, and for appraisal of the educator. We require completion and return of standardised evaluation forms.

CONCLUSION:
Our aim this year was to develop and pilot the strategy. We have delivered 6 academic days and 3 hub days, with more planned this financial year. The days have been fully booked within days of opening; we have waiting lists and are booking in to 2020. We have trained 180 educators so far with a plan for 450 this year; our goal is to train 1000 per year, achieving 5000 trained educators across the region in a 5 year cycle. We have excellent feedback from delegates.
AN EVER INCREASING NUMBER OF MEDICAL STUDENTS – UTILISING RESOURCES AND THE MULTIDISCIPLINARY TEAM

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INTRODUCTION:
The introduction of a new curriculum at our affiliated medical school aimed to expose students to clinical areas in more specialties earlier in their undergraduate programme. This placed 2nd year medical students in Paediatric and Women’s Health departments which previously only hosted 4th year students. We report how we utilised the multidisciplinary team in order to accommodate increased numbers of students in a busy teaching hospital.

The new curriculum sees 160 students from Year 2 and 120 from Year 4 rotate through our hospital. This brings with it obvious challenges: we had to be judicious in using resources to provide adequate exposure to clinical cases and a good learning experience, while ensuring clinical areas are not overcrowded.

METHODS:
• We identified the needs of 2nd year and 4th year medical students to be different. Students in their early training period need to become familiar with the hospital environment and introduced to concepts of communication, history taking, patient journey and teamwork as opposed to 4th year skills such as clinical examination and focus on pathology.
• In order to maximise learning opportunities we identified clinical areas that year 4 students were not attending. We directed students to shadow nurses, midwives and allied health professionals.
• We communicated with nurse managers, midwifery practice leaders and matrons to ensure students were known to be coming and made welcome. Posters highlighting the difference in clinical needs and learning objectives between Year 2 and 4 students were placed in clinical areas.
• We paired clinical exposure with afternoon tutorial-based teaching to consolidate learning.

RESULTS AND DISCUSSION:
Qualitatively our students have consistently mentioned nurses and midwives as ‘most useful staff members to spend time with’. Students have also given excellent feedback for the afternoon tutorials.

Our block leads have personally reviewed student feedback after each rotation and made changes Likely due to this iterative approach, student feedback has increased throughout the year from an overall score of 3.82/5 to 4.14/5.

In comparison to the three other blocks run for Year 2 students, our ‘Human Development’ block remains in the top two in student feedback. We believe this is down to the model of focusing on history and communication skills, utilising allied professionals and consolidation tutorials. We would recommend utilising this model for early year’s clinical training.
IT'S ALL ABOUT THE MONEY: LINKING QUALITY OF EDUCATIONAL SUPERVISION WITH FINANCIAL ACCOUNTABILITY

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INTRODUCTION: There is a perceived lack of transparency and accountability for the financial education tariff received for undergraduate and postgraduate medical training in local education providers (LEPs). There is a need to demonstrate how funding is used to deliver training to produce a highly trained medical workforce equipped to work in the future NHS.

The national tariff is standardised across all Trusts for undergraduate and postgraduate training. More detail on the tariff funding will be included in the poster.

The HEE London team have undertaken a work programme, working with LEPs in south London to define and collate appropriate data to provide assurance that appropriate resources are available to support the training environment. The aim is to embed an annual review of funding utilisation in partnership with LEPs. Six guiding principles have underpinned this work. Transparency, fairness, flexibility, policy and regulation, value for money and continuous improvement.

METHODS: Dr Jo Szram, Deputy Postgraduate Dean and Emma Bailey, Associate Workforce Transformation Lead met with each LEP in south London (10 in total) Present at the meetings were the medical education teams and representatives from medical staffing and finance. There was a general discussion around their LEPs approach to utilising tariff funding. During the course of the meetings with LEPs, areas of focus were better defined.

OUTPUTS: Through the discussions, many examples of good practice were identified. A set of metrics has been established to identify areas requiring improvements with the use of tariff. One of the key metrics is dedicated educational supervision time in job plans with funding directed to departments to appropriately support this time.

Next steps are to embed this into an annual process of reporting and supporting LEPs to work on problem areas.
INTRODUCTION:
Health Education England (HEE) supports various fellowship programmes for trainees across South London i.e. Darzi fellowships, Chief Registrars, medical education fellows, leadership and transformation fellows, and more recently education and clinical leadership fellows. These are generally one year in length, following which the fellow returns to full time clinical practice with little or no contact with the HEE London team.

We created the concept of a fellows’ network which is a structured framework to ensure fellows have access to resources and opportunities to facilitate further development. It is also a forum to maintain support for and disseminate information on the work that they had carried out during their fellowship year.

METHODS:
Feedback was gathered from past fellows across south London with a 50% response rate with the following agreed benefits of participating in such a network:
- the opportunity to receive coaching post fellowship from senior leaders
- receiving information on how to maximise opportunities for presenting and publishing work
- being part of an on-going peer support mechanism
- support when returning back to training, engaging with Trusts on the leadership and management experience that the individual is bringing with them to their new organisation
- Benefit to HEE south London in creating a “think tank” of fellows to consider and work on contemporary issues in medical training, as part of “reverse” keeping in touch days
- opportunities targeted to this experienced group, such as participating and driving medical education research projects

FUTURE PLANS:
We have created and are facilitating a structured annual programme of events such as action learning sets, keynote speakers and team-based action research, gathering feedback in real time to ensure the delivery of a high-quality talent management programme.
NO MONEY FOR AN EDUCATION FELLOW? THINK AGAIN

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INTRODUCTION:
In many medical schools, students are gaining earlier clinical exposure. While there are clear benefits to this, there needs to be adequate education faculty in place to deliver high quality clinical teaching to increased student numbers.

CURRENT CHALLENGES:
- Time: Both consultants and junior doctors are often facing challenges of busy clinical work. This means even those with a keen interest in teaching can struggle to allocate time.
- Variable teaching standards: Without consistent education faculty and well prepared tutors it is difficult to provide high quality clinical teaching.
- Funding: At the same time, rota gaps mean out of hours clinical service at middle grade level can be hard to cover and trusts may spend significant amounts on locums.

CREATING A BUSINESS PROPOSAL:
- In our middle grade rota in 2014 – 2015 we identified that we were spending about £70,000 a year on middle grade locums trying to fill out of hours cover.
- We put forward a business proposal to employ a middle grade doctor whose primary daytime role will be to deliver undergraduate and postgraduate education but will be on the on-call rota.
- Given that recruitment of middle grade doctors with full clinical commitments is often difficult to fill, we postulated that the role of Education Fellow could be a way to attract candidates who are keen to develop their skills in education.
- We made the case for hiring a middle grade to provide out of hours cover as better value for money and a longer term solution than locum cover, while also increasing our education faculty.

RESULTS:
- We were given funding to hire one full time middle grade doctor with 50% of time dedicated to teaching and 50% commitment for clinical duties and on-calls.
- While student feedback from our department is multifactorial, we have experienced highly rated student feedback consistently from both year 2 and year 4 medical students. Multiple students in every rotation have put our Education Fellows forward for ‘teaching excellence awards’.

CONCLUSIONS:
Education Fellows are highly useful members of education faculty within teaching hospitals. There is benefit to students, the trust and the individuals completing the fellowship. We would recommend for departments to strongly consider putting forward business proposals for Education Fellows. We recommend using this model of out of hours cover as a feasible way of making it financially viable and appealing to decision makers.
INTRODUCTION:
Leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: followers within the leader’s own organization, and influential players and other organizations in the leader’s wider external environment. (Goodwin, 2006, p 22)

Within the medical profession, leadership is being recognised as a key aspect to deliver efficient and effective high-quality care to patients. With new programmes available through the NHS, and a direction of change seen with the implementation of leadership, it is of the utmost of importance that the dental profession is kept on board with the forward face thinking of the ongoing transitional change. The Dental Leadership Fellowship posts provided by Health Education England Midlands and East (HEE) have allowed dentists to become directly part of leadership roles within early stages of their career with a unique interlink with local professional networks and trusts around Midlands and East. With the healthcare industry facing daunting challenges, leadership is required at all levels in order to support improved transformation. Irrespective of the setting in which a dentist may work at, leadership should be incorporated into everyone’s current practice. This will help to aid improvement within working environments, patient care provision and morale within the profession.

METHODS:
The Dental Leadership Fellow Alumni (DLA) was founded by the 2018-2019 Dental Leadership Fellows and supported by HEE. It supports the idea for a robust development process to continue to develop and retain future and current influential leaders while providing mentorship for the next generation of fellows within the dental profession. This is critical in contributing to the delivery of the NHS Long Term Plan in order to ensure that effective leadership can provide changes immediately rather than delaying for the future.

RESULTS:
Monthly meetings and strategic planning, with the addition of close working relationships with HEE and the NHS Leadership Academy, has resulted in the contribution of creating a robust curriculum for future Leadership Fellows. With the use of technology and social media, innovative leadership workshops and webinars the Dental Leadership Alumni is fast expanding. Future events are on the horizon to support effective leadership within the dental profession, and the NHS as a whole, at both undergraduate and postgraduate levels.

CONCLUSION:
The Dental Leadership Alumni has created a sustainable networking platform to provide support for past, current and present Leadership Fellows. This is in order to further enhance engagement and awareness of leadership to support the NHS Long Term Plan and workforce development. As the alumni network develops, the importance of leadership within medical education is highlighted with the emphasis placed on the implementation of current change for future benefit.
INCREASING THE NUMBER OF PRE-REGISTRATION NURSE PLACEMENTS IN PRIMARY CARE

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BACKGROUND:
High numbers of nursing staff in primary care are set for retirement in the next five to ten years. The loss of these clinicians with substantial experience, presents workforce challenges for the long-term sustainability of primary care. There is a need for investment in student nurses’ education to promote experience and to generate interest in careers in primary care nursing.

SUMMARY OF WORK:
Strategies include promoting the image of primary care at careers events and roadshows to increase the understanding of the role of general practice nursing and available career opportunities. I have been working in a specific area to increase the number of pre-registration nurse placements to attract newly-qualified nurses into general practice, supported by preceptorship programmes.

RESULTS:
Analysis of data suggests that students want placements in primary care and when they have had placements have then considered general practice as a first career destination. Further in-depth qualitative data from student nurses and host training practices about the placement process, supervision and learning have allowed an evaluation of the placements.

DISCUSSION:
Building relationships with and supporting healthcare professionals within a specific geography to lead and support the development of education for the non-medical workforce is vital to increasing the number of pre-registration nurse placements in primary care and to boost workforce numbers. Evaluation data indicates that placements work well and offer benefits to the student nurse and host practices. The poster will present these findings.

CONCLUSION:
Before the current generation of GPN’s start retiring, the flow of nurses into primary care needs to increase so that expert knowledge and skills can be passed on, and the workforce sustained. There is a need to transfer more care from hospital to primary and community settings and this can only be done if there are staff to deliver this care and both these settings need to be positive learning environments to nurture learning.
STUDENT EXPERIENCE AND THE BENEFITS GAINED FROM WORKING AS A MULTIDISCIPLINARY COLLABORATIVE TO DELIVER MENTORING IN ORDER TO DEVELOP TRANSFERABLE SKILLS IN MEDICAL, DENTAL AND VETERINARY MEDICINE APPLICANTS.

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INTRODUCTION:
The WHO emphasises the importance of a One Health approach, where multiple specialities work together to achieve better health outcomes. Medic Mentor is a social enterprise that utilises this principle by bringing together members from across different healthcare disciplines at all levels of training to mentor students as young as high school age. Through our merit based national School Ambassador Programme, we aim to support future healthcare leaders by mentoring them to develop the transferrable skills required to enter into University, (courses being Medicine, Dentistry or Veterinary Medicine) and beyond into their healthcare careers.

METHODS:
School Ambassador students (aged 12-17) were invited to attend a multidisciplinary meeting to be mentored on transferable skills. The mentoring was organised by members of each of the three specialties who came from mixed professional and undergraduate backgrounds. The day focussed on presentation and communication skills where the teaching was delivered through a mix of lectures and small group sessions to a cohort of 64.

RESULTS:
Feedback forms were sent out via email and 14 out of the 67 (20.9%) students responded. This feedback was given in the form of 5-point rating scales and free text comment boxes. All students who responded found the teaching either extremely useful or very useful. From the feedback, it was apparent that the application of difficult communication skills through learning how to break bad news was the most useful section of the day.

DISCUSSION:
Feedback given both verbally on the day and online was overwhelmingly positive. However, we have noted a number of areas for improvement for upcoming workshops which we have already instigated. Largely this is a greater focus on small group mentoring. Alongside this, we are striving to improve our response rate for the upcoming six school ambassador meetings in order to yield a greater picture of how our mentoring through a small group, multidisciplinary approach improves pupils’ skillsets.

CONCLUSION:
These transferrable skills workshops allow the development of not only the students but also the mentors acting as facilitators of learning. This creates a mutually beneficial relationship between student and mentor, pushing each member of the collaborative to develop their own transferable skills. The recent feedback has shown the benefit of an inter-professional approach to mentoring and will play a large role in the future development of upcoming meetings.
INTRODUCTION:
The General Medical Council National Trainee Survey (GMC NTS) is carried out yearly to monitor training experience across the UK and has a high uptake. Its relevance is not uniformly recognised, with issues around sample size, granularity and wording of the questions. Nevertheless, it is used by Health Education England as one of the cross-programme measures of quality and prompts interventions to departments with poor scores. A discussion at a regional meeting on the reaction to ‘red signals’ led to this more systematic exploration on the value of the survey at improving performance.

METHODS:
The publicly available database\(^2\) of the GMC NTS converts the trainee survey results into a colour scheme, ranging from Green, Light Green, White, Pink, Red, Yellow and Grey. Yellow and Grey are provided for incomplete or not enough trainees, for that indicator. Red indicates, the average score and its confidence interval, fall within the bottom quartile, whilst Green on the other end indicates, the average score and its confidence interval, fall within the top quartile.

In our example case, the number of red scores were summated per department and the department with the highest number of reds in 2016 was selected for improvement. Several innovative interventions such as; reorganising the senior staff to allow better access to educational opportunities, better supervision and introduction of a teaching programme, were put in place.

RESULTS
The 2017 GMC NTS results demonstrated the positive correlation between the effect of identifying a struggling department and the result of these timely interventions.

Taking this a step further, applying the student’s T test demonstrates a statistically significant difference (probability of 0.038) between the average scores within this same department from 2016 to 2017.

CONCLUSION / IMPLICATIONS
The GMC NTS tool is currently in widespread use within the management of medical education, and there is a lack of information available with regards to its use and impact at individual trust levels. We have looked at a particular department at one site, which has scored poorly in 2016, according to the GMC NTS. Put in place multiple innovative interventions, and then used the GMC NTS results from 2017, to assess the effects of these interventions. Furthermore, the results from 2018 are encouraging, with zero red scores in this particular department and indicates sustainability of these interventions.

REFERENCES:
1 Bring on the Reds – an Alternative Guide to the GMC Trainee Survey (date viewed 17/06/2019)
A PILOT ONLINE PLATFORM OF RESOURCES FOR TRAINEES RETURNING TO CLINICAL PRACTICE FOLLOWING MATERNITY LEAVE

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BACKGROUND:
Taking time out of clinical practice is associated with both a depreciation of trainee confidence and clinical skill. It is now widely recognized that taking time out of training is a common and normal event for trainees. At any one time up to 10% of trainees are out of programme, accounting for approximately 5000 doctors. Of those out of programme, the largest subgroup (40%) is trainees on maternity or parental leave.

Health Education England (HEE) has invested heavily in optimizing the transition back to clinical practice via their Supported Return to Training (SuppoRTT) Programme. One risk factor for prolonged lack of confidence following return to clinical practice is lack of access to tailored educational material. Previously collated feedback also highlighted difficulties due to lack of information about a defined return to training process, lack of knowledge about KIT days, worries about childcare arrangements and striking a healthy work-family-life balance.

INTERVENTION:
Here we present a pilot online platform designed by one of the HEE clinical SuppoRTT fellows specifically for trainees returning to clinical practice following maternity leave. The platform provides information about the specific return to training process for each deanery and a menu of generic and specialty specific courses for returning trainees. In addition to this a summary of new clinical guidelines and ‘hot topics’, as well as a wealth of wellbeing resources, childcare tips and an interactive peer-mentoring function are included.

30 specialist trainees from the schools of paediatrics, anaesthetics and trauma and orthopaedics piloted the project. These trainees had access to the platform from December 2018 onwards and returned to work between February and May 2019.

CONCLUSION AND DISCUSSION:
100% of those who completed the feedback questionnaire stated they would recommend the platform to a friend. 50% of users stated that their confidence had improved as a result of the resources available on the platform and 92% said they had found new information that they had not come across elsewhere. We discuss the opportunities and challenges involved in rolling out the platform on a national level.

* (Please note further feedback data is still being collected and will be available for the finished poster in December).
ASSESSING THE IMPACT OF A DEDICATED ROTA CO-ORDINATOR AND E-ROSTERING ON ROTA GAPS IN A LARGE TEACHING HOSPITAL

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INTRODUCTION:
Filling medical rota’s, particularly out of hours, is a notoriously difficult task across all hospitals. Often there are various unfilled posts within these rotas, known as ‘rota gaps’, increasing the workload on the remaining staff and sometimes impeding on patient care. Various techniques are used to co-ordinate rotas in an attempt to optimise shift cover. The general medicine department of a large teaching hospital in London employed a dedicated junior doctor rota co-ordinator and implemented a new web-based rostering software to facilitate this process.

METHODS:
Rota gaps were assessed in the same 3-month period for 3 consecutive years preceding the appointment of a junior doctor rota co-ordinator in the general medicine department as well as the same time period in the year after this change. These gaps were segmented by staff grade and shift type in order to identify changes within the department.

RESULTS:
A total of 96 rota gaps were identified across throughout the time periods studied, with a majority of rota gaps falling on night shifts (54). The staff grade found to have the most gaps were specialist registrar posts (65). There were an average of 29 rota gaps identified in the years preceding the introduction of a rota co-ordinator, dropping to 9 gaps in the 3-month period following this. All staff grades and shift types experienced a fall in the number of rota gaps.

DISCUSSION:
The introduction of a rota coordinator combined with new software was associated with more than two-thirds reduction in rota gaps across all staff grades and shift patterns. This meant significantly increased medical cover for patients, particularly out of hours, improving patient safety. We would strongly advocate for this role to be an essential part of all general medicine teams.

Figure 1 - Rota gaps identified per year, categorised by staff grade and shift type
CONSIDERATION OF PERSONAL SPECIAL CIRCUMSTANCES IN THE ALLOCATION OF TRAINEES TO SPECIALTY TRAINING PROGRAMMES

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Following feedback that the recruitment process into specialty training did not consider applicants’ personal circumstances, a review was undertaken to look at ways in which increased flexibility could be implemented.

The Special Circumstances process was introduced to specialty training in 2017. This allowed for applicants who met the eligibility criteria to apply for recognition of their special circumstances, allowing for pre allocation to a region of choice at the point of offer. To be eligible, applicants must:

- Have a personal medical condition or disability where continued care or treatment in the current region is an absolute requirement; or
- Be the primary carer for someone with a disability, as defined by the Equality Act 2010

Applicants are required to submit evidence of their eligibility which is reviewed by a single national panel, regardless of the specialty of application. The eligibility panel will decide whether the evidence submitted meets the criteria. Applicants have the right to appeal and the opportunity to submit new evidence. The decision of the appeal panel is final.

Applicants who have their special circumstances approved will be pre allocated into their preferred region, providing that they rank highly enough at interview to be made an offer in any of the appointing regions.

In the first two recruitment years following implementation (specialty recruitment 2017 and 2018), 157 applicants were approved through the national special circumstances panels, 79 of whom were pre allocated to posts in their preferred region. Of these, 26 would not have been allocated to their preferred region based on their selection score alone. 2019 data is currently being analysed.

Feedback from applicants has been positive and the data shows that it has made a difference to applicants with very exceptional personal circumstances.

Using feedback from applicants and recruiters, the process is constantly being reviewed and refined.
EVALUATION OF A NOVEL PEER-LED APPROACH TO ASSESSING THE LEARNING ENVIRONMENT ON CLINICAL PLACEMENTS

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INTRODUCTION:
Quality control ensures that doctors in training (DiT) and medical students (MS) receive high quality training during clinical placements. This occurs from departmental level to national level processes such as the GMC’s National Training Survey, and data evaluation is usually undertaken by educationalists.

This project takes a novel approach to evaluating the quality of the learning environment on placements, whereby data gathering and feedback is ‘peer-led’ by a team of DiT and MS.

METHOD:
A medical and a surgical department were identified in which to pilot the project. A team of assessors was assembled, consisting of a specialty registrar, a post-Foundation level Teaching Fellow and two medical students.

A framework for assessing the learning environment in a department was designed, and a mixed-methods qualitative approach was taken.

Anonymous questionnaires were completed by students and DiT on placement. The learning environment was explored in greater depth via semi-structured interviews using an iterative approach. MS and DiT were interviewed by the assessing team, as individuals or groups depending on accessibility. Results were fed back to the department in written form and by verbal presentation.

RESULTS:
14 DiT and 7 MS were surveyed across two departments. A numerical rating 0-4 was assigned to each department using questionnaire data, with a higher score reflecting a better learning environment. The surgical score from DiT and MS were 3.1 and 3.0 respectively, and the medical department scores were 3.2 and 3.4. Key findings from the surgical department included post-CT1 doctors reporting a better learning experience than Foundation doctors, including project and e-portfolio support. Formal departmental teaching was viewed positively, but would be improved by consultant presence. Positive findings from the medical department included good access to clinics and study leave, with an overall positive learning culture. However, no regular departmental teaching was on offer.

CONCLUSION:
Peer-peer project design and interview leads to a richer understanding of the strengths and weaknesses of a clinical placement than standard questionnaire based approaches. Focussed recommendations on how to improve a clinical placement are likely to result in meaningful change, and the departments will be re-visited to evaluate the impact of this process.