A need for hospital based postgraduate teaching programmes in dermatology

A Bonsall
Department of Dermatology, Aberdeen Royal Infirmary

Background
Following the closure of the specialised dermatology ward in Aberdeen, dermatology patients are now admitted to designated beds on a general medical ward. Their clerking and immediate care is delivered by junior trainees on medical rotations, with experienced dermatology staff based in outpatient areas.

Dermatology has had a low priority in medical education\(^1\). Clinical exposure for junior trainees may be infrequent. It was felt likely that the junior staff would not feel confident in dealing with dermatology inpatients, and that a ward-based teaching programme may improve their experience.

Methods
Between August 2015 and April 2016, ward-based junior medical staff were surveyed at the start and end of their 4 month attachments, to assess their prior knowledge of dermatology, and the impact of the teaching programme alongside their clinical experience.

Results
Respondents were \(n=12\) at the start and \(n=17\) at the end. None had any postgraduate clinical experience in dermatology.

Results continued

![Junior doctors' confidence in assessing and managing dermatology inpatients](image)

**Conclusion**
More specialised dermatology wards across Scotland are expected to close. Despite the high prevalence of skin disease, many foundation, core and GP trainee junior doctors lack confidence in assessing and managing dermatology patients.

Shared wards provide an opportunity for these junior doctors to gain experience, and teaching programmes encourage their engagement by increasing their knowledge and confidence.

**References:**
1. How can dermatology services meet current and future patient needs, while ensuring quality of care is not compromised and access is equitable across the UK? The Kings Fund, March 2014, www.bad.org.uk
Use of a DOPS Assessment Tool for Candidate Evaluation after an Ultrasound Guided Central Line Insertion Workshop

K Hill¹, D Silcock¹, F Burns³, S Jeffrey², S Chaudhri²
¹Queen Elizabeth University Hospital, Glasgow  ²Royal Alexandra Hospital, Paisley

Introduction
The National Institute for Health and Care Excellence (NICE) guidelines from 2002¹ recommend that real time ultrasound guidance should be used to insert internal jugular central venous catheters. Initial training in a simulated environment before supervised practice on patients is recommended to minimize patient morbidity².

We have established a half-day ultrasound guided central line insertion workshop programme comprising short lectures and small group practical stations to train our junior medical staff. We then developed a DOPS (directly observed procedural skills) assessment at the end of the course to provide candidate feedback. DOPS assessments are well established in the medical training framework and are a tool to provide supportive learning³.

Method
We developed a DOPS tool focusing on key components of safe practice with emphasis on the ultrasound guided intravascular needle and guidewire insertion components of central line insertion. There were ten stages for the candidate to complete -

1. Correctly sets up u/s machine ready for scanning using vascular, depth and gain settings
2. Orientates probe correctly
3. Identifies site of intended needle puncture by tissue movement
4. Identifies needle tip correctly
5. Follows course of needle to vessel by following needle tip
6. Knows how to tell whether dot seen is tip or shaft of needle
7. Identifies needle within vessel
8. Aspirates to confirm vessel placement
9. Identifies intravascular placement of guidewire in plane
10. Identifies intravascular placement of guidewire out of plane

The candidate was observed and scored by a faculty member using a specific mark scheme. Zero, one or two points were awarded at each stage with a maximum score of 20/20. Two points were awarded if the candidate completed a stage without guidance, one point if some prompting was required, and zero points if it was not completed despite guidance.

Results
52 candidates with no previous formal training in ultrasound guided central line insertion completed the DOPS at the end of the workshop. 47/52 (90%) candidates scored at least 17/20. 24/52 (46%) scored 20/20, completing all 10 stages without prompting (figure 1).

Most points were lost in setting up the ultrasound machine and following the needle tip accurately to the vessel (figure 2).

Discussion
We have demonstrated that a structured standardised training programme comprising the key components of ultrasound guided central line insertion can result in key competencies being achieved in a majority of participants.

In order to further improve the DOPS results, we intend to further develop the effectiveness of this training by incorporating mastery learning principles⁴ in order to optimize performance.

Objectives
Our objectives in using the DOPS assessment tool were to

• Evaluate if our course adequately taught key components of central line insertion to candidates
• Provide the candidates with feedback on their progress.

References
¹http://www.nice.org.uk/guidance/ta49
²http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programme/resources.
³GMC Workplace Based Assessment: A guide for implementation
⁴BMJ Qual Saf 2014;23:749-756
How Trainees Can Help Us Be Better Trainers
Baggaley A1, Maple N2, Danielle L2, Gardner WT2, Cadzow A1, McHardy K1.

Introduction and Aims
We aimed to use Trainee opinions (both undergraduate (UG) and postgraduate (PG)) in an interactive workshop entitled “How Trainees Can Help Us Be Better Trainers” at the inaugural NHS Grampian Medical Education Conference to stimulate discussion and improve practice as medical Trainers.

Methods
A questionnaire asking six multiple-choice questions was distributed to final year medical students (n=125) and Foundation Year doctors (n=40). The questions covered GMC requirements for Trainers, methods of effective learning, feedback on trainers, star quality in trainers and learner feedback. The same questions were posed to the Trainers (n=22) attending the workshop; they were asked to respond using coloured cards, which were counted. The results generated from the Trainees were used to compare against the answers provided by the Trainers and to stimulate discussion in the workshop. Medical students, a trainee and clinicians active in training facilitated the discussion. Four months following the workshop, attendees were asked to provide some reflective feedback via e-mail.

Results
The data provided great starting points for discussion in the workshop and there was ample interaction with the trainee and medical students present. Feedback was overwhelmingly positive with over 90% of attendees rating the workshop as ‘good’ or ‘excellent’.

Discussion point
What do you feel is the most important QUALITY in a TRAINER?

“Trying to motivate, challenge and inspire!”
“Providing a learning environment to allow trainees to learn the job they will be doing in the future.”

Feedback
• “I will tend to empower trainees for reflection in future”
• “…highlighted the benefit of training from the people directly ahead of you in your career path.”
• “I really enjoyed the Q&A session with the statistics of trainee perspectives from the questionnaires you had done with trainees.”

Discussion and Conclusions
Trainers welcomed the involvement of Trainees in the workshop, and the large number of questionnaire responses collected from UG and PG generated powerful discussion. The use of Trainee feedback to inform and improve Trainer development is simple and reproducible, and aids change in practice among Trainers. Workshops of this kind would also contribute towards GMC requirements for Trainers to provide evidence that they are meeting standards.
Facilitator feedback on a user friendly guide to inform foundation teaching sessions in NHS Lothian

Introduction

“The [Foundation Programme] Curriculum is intended to be used by foundation doctors and deliverers of their education”[1]. This is topic headings, but there is no specific guidance for what should dictate the content of teaching sessions for FY doctors. The curriculum is designed to be delivered over the course of 2 years in a variety of settings using different methodologies. Due to geographic distribution in NHS Lothian, foundation teaching is delivered on 4 different sites by a wide range of facilitators. Until 2015 there was no continuity in the teaching programmes between sites, leading to a lack of standardisation and foundation doctors getting different experiences of varying relevance. The 1 hour lunchtime sessions are now mapped entirely to the Foundation Programme Curriculum using its learning outcomes, attempting to address these issues. This has, however, created a new set of challenges. Informal feedback has suggested that some facilitators struggled to relate their topics to these outcomes and desired further guidance. We wanted to address this issue and gather formal feedback on this.

Methods

We devised a document to supplement the learning outcomes. This was to help inform facilitators of the suggested content of their sessions and relate their sessions to the learning outcomes more easily. We invited facilitators to take part in semi-structured interviews to understand their views on the teaching sessions, the learning outcomes and our new guidance.

Results

We emailed 44 facilitators of foundation lunchtime teaching sessions and successfully organised to interview 7 over a 3 month period.
Of those interviewed all (7/7) were aware of the foundation programme curriculum, however just 1 facilitator was aware of which learning outcomes they were supposed to be delivering in their session, with 2 more stating they would look them up in preparation.

<table>
<thead>
<tr>
<th>Mean Likert satisfaction responses (1= very unsatisfied, 5= very satisfied)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning outcomes (n=6)</td>
</tr>
<tr>
<td>Learning outcomes and new guidance (n=6)</td>
</tr>
</tbody>
</table>

What do you think about this new guidance alongside the original learning outcomes?

- “It’s more prescriptive so it’s clearer what is to be covered”
- “Works well in the context of original learning outcomes”
- “I like the phrasing”
- “That is what I covered”
- “It’s useful as it’s more practical advice”
- “It’s a reassurance that I’m doing the right thing”
- “It is a helpful differentiation between the context/learning outcomes and the content of sessions”

Key Messages

The foundation curriculum is not specifically designed to guide teaching sessions so using it in this way has created issues with delivery.
Having additional guidance on this has increased facilitator satisfaction in guiding content for foundation programme teaching sessions. Facilitators are not always aware of how their sessions map to the foundation programme curriculum so having a document that lays this out ensures deanery wide standardisation of the lunchtime teaching programme.

Brief Ward Tutorials Are Effective at Improving Staff Knowledge & Confidence of Safe Insulin Administration

J Hofer, J Bridson, M Cowan, J-A Gabbott, L Irvine, H Jones, R Li, W Morley, all Dept. of Medicine of the Elderly, Royal Infirmary Edinburgh

Background

Episodes of hypoglycaemia and to a lesser extent hyperglycaemia contribute to inpatient morbidity and mortality with hypoglycaemia being associated with decreased conscious levels, falls, stroke

• Nursing staff expressed a lack of confidence surrounding insulin.
• A questionnaire found that understanding was lacking in identifying different types of insulin and their effects, and correct administration techniques.

Innovation

• We developed a 15 minute interactive tutorial for nursing staff. This conveys key information, and can be provided on the ward without the need for computer/projector or any specific set-up. Two laminated cards were used to highlight local protocols.
• The tutorial was delivered during the normal working day.

Evaluation

• A baseline questionnaire administered to nursing staff in an acute Medicine of the Elderly ward in the Royal Infirmary of Edinburgh
• A tutorial was delivered to 20 staff over a 2 week period during the working day.
• Following the tutorial repeat questionnaire was completed, along with feedback form.
• Overall rating of the tutorials was “excellent” by 95% of attendees.
• The confidence of attendees increased dramatically, in all areas
  • Insulin administration (80% more confident)
  • Types of insulin (100% more confident)
  • Hypoglycaemia management (90% more confident)

Results

<table>
<thead>
<tr>
<th>Knowledge area</th>
<th>% correct before teaching</th>
<th>% correct after teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insulin preparation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invert vial</td>
<td>32%</td>
<td>57%</td>
</tr>
<tr>
<td>Inject air then withdraw</td>
<td>43%</td>
<td>93%</td>
</tr>
<tr>
<td>Avoid use of cartridge – we use vial</td>
<td>59%</td>
<td>79%</td>
</tr>
<tr>
<td><strong>Insulin types</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognising short acting names</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Appearance of short acting (clear)</td>
<td>57%</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Insulin administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After injection wait how long before withdrawing the needle</td>
<td>50%</td>
<td>93%</td>
</tr>
<tr>
<td>Use of pts own pen if incapable of self administering</td>
<td>59%</td>
<td>100%</td>
</tr>
<tr>
<td>When to give short / mixed insulin in relation to food</td>
<td>59%</td>
<td>86%</td>
</tr>
<tr>
<td>What angle to inject through skin</td>
<td>39%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1 Knowledge about insulin improved after a short tutorial

Conclusions

• Knowledge improved in several areas covering insulin preparation, types and administration.
• This shows that a quick intervention with minimal time/resource requirements can rapidly improve staff knowledge and subsequently improve patient safety.

References

• Time allocated as part of Clinical Development Fellow Programme in NHS Lothian (J Bridson & M Cowan)
• Advice sought from Janet Barclay (Diabetes Specialist nurse) when designing the teaching session
Mentalizing skills in generic mental healthcare settings: can we make our day-to-day interactions more therapeutic?

H Welstead (SpR)1, J Patrick (Consultant)2, T Russ (Consultant)2, Gary Cooney (SpDr)1, C Maclean (Psychologist)3 and A Polnay (Consultant)3

1 = Lansdowne Psychotherapy Service, Glasgow; 2 = Royal Edinburgh Hospital; 3 = State Hospital, Carstairs

Introduction

A third of psychiatric outpatients and over 50% of inpatients are estimated to fulfil the criteria for personality disorder (PD). Caring for these patients is experienced as emotionally challenging by clinicians1-3, making it hard to maintain a stance towards them that is therapeutic. Negative attitudes towards PD are associated with poorer outcomes in patients4,5.

A pilot study by Polnay et al in 20156 showed that a brief teaching intervention in Mentalization-Based Treatment (MBT) skills improved core psychiatry trainees’ understanding of mentalizing and along with that their attitudes to personality disorder. In order to test if this finding is replicated in a larger sample and if it generalises to other professional groups, we conducted a before-and-after study of 76 mental healthcare staff who underwent a 2-day course in MBT skills.

Methods

Study participants: doctors, nurses, psychologists and allied healthcare professionals within NHS Lothian. Once a clinical team was identified by the course leaders (in some cases, teams self-selected), all members working in that service were invited to take part in the training.

Intervention: Mentalization-Based Treatment Skills (MBT-S) training, developed by the Anna Freud Centre in conjunction with MBT Scotland, and delivered in 4 sets of 2-day courses in 2014 and 2015.

Outcomes: self-report questionnaires were completed at baseline and post teaching programme.

- 1) outcome: Knowledge and Application of MBT Questionnaire (KAMQ)*
- 2) outcome: Attitudes to Personality Disorder Questionnaire (APDQ) **
- Data on professional groups was collected for 3 of the 4 courses.

Data were entered into MS Excel and analysed using R for Windows 3.2.3. Missing items at baseline were assumed to be missing at random and the mean score among all responders for that item was entered. For missing end-of-programme items, baseline values were carried forward.

Results

All 76 healthcare professionals who attended the first day of training were included in the analysis. 7 participants did not attend the second day of training and did not complete follow-up questionnaires.

There was a mean increase in KAMQ scores of 12.6 points (95% CI 10.4-14.7) from baseline to end-of-programme:
- Mean KAMQ score at baseline: 102.5 (SD=9.4).
- Mean KAMQ score at follow-up: 115.1 (SD=10.0).

There was a mean increase in APDQ scores of 3.9 points (95% CI 1.4-6.4) from baseline to end-of-programme:
- Mean APDQ score at baseline: 147.9 (SD=14.5).
- Mean APDQ score at follow-up: 151.8 (SD=14.7).
- 22 APDQ scores worsened.

Doctors and psychologists had better baseline KAMQ scores when compared jointly to nurses, but their APDQ scores increased to a lesser degree after the teaching compared to nurses (see Table 1).

Table 1. Linear regression model including fixed effect for job category and interaction between job category and time. Doctors and psychologists were entered jointly to nurses, but their APDQ scores increased to a lesser degree after the teaching compared to nurses (see Table 1).

**APDQ**

<table>
<thead>
<tr>
<th>Joba</th>
<th>Jobb</th>
<th>Joba*Timeb</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2.0</td>
<td>0.9</td>
<td>-2.9</td>
</tr>
</tbody>
</table>

Table 2. Linear regression model including fixed effect for job category and interaction between job category and time. Doctors and psychologists were entered jointly to nurses, but their APDQ scores increased to a lesser degree after the teaching compared to nurses (see Table 1).

Discussion and conclusion

To our knowledge, this is the largest quantitative study to evaluate the impact of MBT-S on clinicians. We found that MBT-S training improved mental healthcare professionals’ knowledge and application of MBT to a statistically significant degree. This supports Bateman’s contention4 that effective MBT skills can be gained through limited additional training.

Attitudes to PD improved overall to a lesser degree. In 22 cases, the APDQ scores worsened. While this may represent a genuine worsening of some participants’ attitudes towards PD, it is more plausible that this reflects participants’ increased awareness and acceptance (i.e. mentalization) of negative feelings towards patients. For clinicians, this is likely to be helpful as it allows them to reflect on their responses, and makes them less likely to ‘act on feelings in a counter-therapeutic way’6.

Doctors’ and psychologists’ APDQ scores improved less than nurses. Our data points to doctors and psychologists having higher baseline APDQ scores, so it may be that we are seeing a ‘ceiling effect’. In the context of previous research6, we think the salient point is that this intervention appeared effective for professional groups other than doctors in training.

Study limitations:
1) the internal validity of a before-and-after study is lower than designs that incorporate a control group
2) we note the need to establish what constitutes clinically relevant change for our outcome measures, as opposed to statistical
3) we note the need for follow-up beyond the intervention to investigate whether effects persist.

Conclusion

Recent UK health policies have urged mainstream mental health services to be more responsive to the needs of individuals with PD.7,8 Our findings suggest that MBT-S might be an effective way to respond to this need, and one that is accessible to a range of professional groups.
Not Just The Intubator In The RSI

Dr D Moore • Dr Z Hutcheson • C Paton • Dr F Burton
Hairmyres Emergency Department & Kirklands Medical Education and Training Centre, Lanarkshire, UK

Introduction

In the Emergency Department (ED), Rapid Sequence Induction (RSI) is a relatively infrequent but extremely important skill. Not only does it involve the intubator, but at least two, preferably three skilled assistants. Each must be confident in their role to make the RSI as safe as possible.

We became aware this was not the case in our department and sought to change this.

Methods

Following an update to our RSI checklist and introduction of an equipment mat, staff in the ED were invited to attend an Emergency Anaesthetic Assistants course run locally by a faculty from the hospital in which they worked. A total of 36 staff attended one of the two training days organised.

Pre-course they were issued a questionnaire requiring them to select between “Strongly agree,” “Agree,” “Neutral,” “Disagree” and “Strongly Disagree” for statements regarding their ability and confidence in assisting.

Immediately post course participants were asked to respond to the same questionnaire and we intend to issue the questionnaire again at three months to evaluate retention of skills and confidence.

Results

There were a number of questions that showed a significant improvement in confidence post course.

• 39% of staff felt confident in applying cricoid pressure pre-course vs 100% post course
• 33% pre-course felt able to prepare induction agents and emergency drugs and understood the role of opiates in RSI. This rose to 94% post course
• 56% were aware of the RSI checklist pre-course vs 100% after.
• 71% of staff had confidence in their abilities and knowledge to questions pertaining to difficult airways and failed intubation drills pre-course vs 87% post course

When asked post course how the knowledge and skills they had gained would transfer back into the department staff said:

“I now feel more competent to be involved with RSI, and realise the importance of good communication.”

“I feel more knowledgeable and confident to assist and set up equipment”

“I feel more confident in intervening if things are not going to plan.”

“I found this training event very helpful and effective. I feel much more confident in assisting in the event of an RSI.”

<table>
<thead>
<tr>
<th></th>
<th>Pre course</th>
<th>Post Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confident in applying cricoid pressure</td>
<td>39%</td>
<td>100%</td>
</tr>
<tr>
<td>Able to prepare induction agents and emergency drugs and understand the role of opiates</td>
<td>33%</td>
<td>94%</td>
</tr>
<tr>
<td>Aware of the RSI checklist</td>
<td>56%</td>
<td>100%</td>
</tr>
<tr>
<td>Confident in abilities and knowledge regarding difficult airways and failed intubation</td>
<td>71%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Conclusion

There was a significant improvement in participant’s confidence and ability to assist in an RSI following the course.

We plan to run this course again, consolidating newly acquired or refreshed skills back in the department with the aid of simulated scenarios so that we can ensure that the team are confident in their roles and make the RSI as safe as possible.

For the future

In situ simulation is an emerging teaching strategy which is gaining momentum and has a strong focus on collaboration and patient safety. Importantly, as discussed by Barbeito et al., it has been shown to be effective in identifying system vulnerabilities giving the opportunity for patient safety improvement.

We want to bring simulation into the department to allow us to practice in a real environment with the real multidisciplinary team. We are looking forward to building relationships with our colleagues in and out of the department and are seeking other areas we can improve upon to provide a safe RSI.

Acknowledgments

Many thanks to Dr S. Hearns, Dr D. Inglis, and Dr A. Rafferty for sharing their resources to allow us to proceed. Many thanks also to staff of Hairmyres Emergency Department who took part in and facilitated the RSI.

References

INTRODUCTION:
Surgical education and training is aimed at producing competent surgeons with the knowledge and skills to enable independent practice. This is achieved in numerous ways and various time frames. Drivers for changes such as the European Working Time Regulations and patient safety concerns have led to competency-based training. There is limited research comparing training standards and competency.

This poster highlights the differences in surgical training between the United Kingdom, Europe and the United States of America.

AIMS:
1.) What are the different durations and competencies required for the completion of training?
2) What are the different experiences, competencies and perceptions of current trainees? Are trainees ready to practice independently by CCT?

METHODS:
Literature regarding general surgical training in the USA, UK, rest of Europe and Australia were obtained. Up to date publications by the Joint Committee on Surgical Training, Accreditation Council for Graduate Medical Education, American Board of Surgery, Royal Australasian College of Surgeons and European Union of Medical Specialists were reviewed[1-4]. Both quantitative and qualitative evaluation were performed.

Themes from the above publications were used to develop a questionnaire. This was piloted with 4 general surgical trainees in the UK. Invitations to participate internationally were distributed electronically by email. All data was collected between 15/2/15 – 15/4/15 and stored in an online questionnaire system (http://www.quicksurveys.com).

RESULTS:
There are vast differences between both the length of training and requirements for CCT between countries as seen in Chart 1.

The UK has the longest training with at a minimum of 10 years following graduation. USA trainees may go straight to a 5 year surgical residency programme directly after graduating.

The UK requires the greatest total number of procedures and is the most comprehensive in specifying numbers of individual procedures. In contrast, Australia and USA ask for an ‘acceptable spectrum and complexity of cases.’ Across the rest of Europe, qualifications are legally equivalent and mutually recognised, yet vary greatly.

A total of 158 responses from 15 countries were collated as seen in Figure 1. Due to small number of responses from individual countries in Europe, these have been grouped together for future analysis (but exclude the UK.) The demographics and mean weekly activity of trainees in sessions (1 session = half day) are displayed in Table 1 and their perceptions of training in Chart 2.

72.1% of trainees agreed that the DURATION of training was sufficient. This was greatest in the U.S.A at 85.8% compared to 60% in the U.K.

59.8% of trainees thought they would be prepared to practice independently at the end of their training.

CONCLUSIONS:
There are large difference in duration and the curriculum required to complete general surgical training globally.

Although the duration of training in the USA is shortest, most of its trainees felt their duration of training was sufficient. The majority of trainees also perceived their training provided enough operative autonomy and case volume to produce competent surgeons. This highlights the importance of quality of training as well as quantity.

There is much too be learnt from one another globally to improve standards of training and produce competent surgeons worldwide.

References:
Thank Goodness It’s Friday!

Evolution Of A Trainee-Led Paediatric Education Programme

L Bertram*, J McGill*, A Orr, A Dall & S Joseph
Royal Hospital for Sick Children, Edinburgh

* authors contributed equally

AIM: to develop an education programme for paediatric trainees.

The Royal Hospital for Sick Children (RHSC), Edinburgh has run a trainee-led paediatric teaching programme for the past six years. The programme continues to develop and adapt to trainee requirements through quality improvement methodology. A recent trainee survey demonstrated high satisfaction and defined areas for improvement.

2010 2011 2012 2013 2014 2015

RCPCH 2010 curriculum mapped

Biannual meetings of lead trainees with Associate Director for Medical Education

Individual session feedback

Regular audit cycles

Didactic to interactive style

Planning for reprovision

2014/15 survey of trainees

Results below

RESULTS

• 26/36 (72%) trainees at RHSC (or those able to videoconference in) responded to survey (42% ST1-3; 58% ST4-8).
• High satisfaction overall.
• 23/26 (88%) rated topics as “relevant to training needs”.
• 63 “best things about teaching” vs 32 “worst things about teaching”, e.g.

- GMC National Training Survey 2015 – regional teaching score “significantly above the national score in benchmark group”.

CONCLUSIONS

The teaching programme has evolved to:
• Gain higher scores year-on-year for regional teaching in annual GMC National Training Surveys.
• Foster a sense of community.
• Advance educational management and leadership skills amongst paediatric trainees.

Current and future improvements in response to feedback include:
• Teachers encouraged to increase interactive content (e.g. smartphone voting, case studies, practical sessions).
• Sessions on quality improvement, leadership and management (e.g. “HEADSTART” course).
• Creation of “paediatric oracle” – teaching library on Medical Education Directorate website (www.med.scot.nhs.uk) – provides a flipped classroom model and improves access to teaching topics.
• Sessions on adolescent medicine as part of reprovision for the new hospital in 2017.
• More simulation teaching sessions.

REFERENCES
http://www.med.scot.nhs.uk/Pages/default.aspx
http://www.gmc-uk.org/education/national_summary_reports.asp

METHODS

An anonymous survey of paediatric trainees attending teaching in 2014/2015 was conducted. As part of this survey, trainees were specifically asked to comment on the three best and worst aspects of teaching.

RESULTS

• 26/36 (72%) trainees at RHSC (or those able to videoconference in) responded to survey (42% ST1-3; 58% ST4-8).
• High satisfaction overall.
• 23/26 (88%) rated topics as “relevant to training needs”.
• 63 “best things about teaching” vs 32 “worst things about teaching”, e.g.

- GMC National Training Survey 2015 – regional teaching score “significantly above the national score in benchmark group”.

CONCLUSIONS

The teaching programme has evolved to:
• Gain higher scores year-on-year for regional teaching in annual GMC National Training Surveys.
• Foster a sense of community.
• Advance educational management and leadership skills amongst paediatric trainees.

Current and future improvements in response to feedback include:
• Teachers encouraged to increase interactive content (e.g. smartphone voting, case studies, practical sessions).
• Sessions on quality improvement, leadership and management (e.g. “HEADSTART” course).
• Creation of “paediatric oracle” – teaching library on Medical Education Directorate website (www.med.scot.nhs.uk) – provides a flipped classroom model and improves access to teaching topics.
• Sessions on adolescent medicine as part of reprovision for the new hospital in 2017.
• More simulation teaching sessions.

REFERENCES
http://www.med.scot.nhs.uk/Pages/default.aspx
http://www.gmc-uk.org/education/national_summary_reports.asp
Social media – the way forward for global promotion of a career in General Practice?

Duncan R, Lints A, Kelly M, Haining R, Colville E.

General Practice (GP) in the UK currently faces a recruitment and retention crisis\(^1\). There is mixed evidence as to the effectiveness of marketing in promoting a career in GP\(^2\).

NHS Education for Scotland (NES) has run two Social Media Campaigns to promote GP – one for GP training recruitment and one to advertise the Welcome Home project. This poster aims to summarise the results from these campaigns.

GP training: There continues to be difficulties in filling GP training posts in Scotland, especially in remote and rural areas\(^2,3\) but there is evidence to suggest that promotion can help influence trainees’ choices about where to train\(^3\).

A Facebook campaign was run for ten days shortly before the closing date for GP training recruitment round 1 in 2015. It was identified that as well as UK trainees, there was the possibility of attracting trainees from the EU, with the Netherlands, Germany and Malta having similar GP systems.

A Facebook advertising campaign was run with adverts linking through to the Scottish Medical Training (SMT) GP landing page.

Audience targeting:
- Attended named UK, Dutch, German or Maltese Medical Schools
- Medical Student
- Attends UK foundation schools
- Aged 22-28
- Interests: medicine, GP, Scotland

Results:
- 67,291 people reached
- 945 click through sessions in 10 days to SMT landing site
- Overseas campaign generated 64% of the click through sessions
- Web sessions on SMT GP landing page up by 32% on the same period in the previous year
- Nine extra applications to round 1 in Scotland compared to the previous year

Welcome Home: a project aimed at helping UK trained GPs currently working overseas return to Scottish General Practice.

A Facebook advertising campaign was run in August – September 2015 targeting prospective returning GPs in Australia, New Zealand and Canada.

Audience targeting:
- Ex-pat
- Attended named UK Medical Schools
- Previously worked in the NHS
- self identified as a GP
- Attended UK foundation Schools
- Medical qualifications
- Aged 32-55

Results:
- 20,261 people reached
- 730 click through sessions to ‘Welcome Home’ landing page
- cost per click of £0.65
- 81% of web sessions on the NES ‘Welcome Home’ landing page during the campaign originated from Australia, NZ and Canada
- Media coverage in Australian medical and government websites
- Evidence of peer to peer discussion about returning to GP in Scotland

Conclusion:
Facebook campaigns have generated interest and click through sessions to NES websites. Further research is required to gauge the effect this has on recruitment and returner rates.

References:
\(^3\) Green P. The effect of a blog on recruitment to general practitioner specialty training in the north of Scotland. Education in Primary Care. 2014;26:113-115.

© NHS Education for Scotland 2016. You can copy or reproduce the information in this document for use within NHSScotland... educational purposes. Use of this document for commercial purposes is permitted only with the written permission of NES.

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on 0131 656 3200 or email altformats@nes.scot.nhs.uk to discuss how we can best meet your requirements.

Published by NHS Education for Scotland May 2016.
To help tackle the GP workforce crisis, the Scottish Government has supported a national campaign to attract GPs back into practice. This included:

- Investing in and fully funding the Scotland GP Returner Programme
- Introduction of the Scotland Enhanced Induction Programme and the Welcome Home project

The Retainer Scheme has long been a family friendly way to return to or continue in General Practice and continues to be available, now with more secure funding.

This poster aims to review these ways to return to Scottish General Practice and assess the impact that government input and NHS Education for Scotland (NES) work has had on the numbers undertaking these programmes.

### Programme Details

<table>
<thead>
<tr>
<th>Programme</th>
<th>Number of GPs in post 2013-14</th>
<th>Number of GPs in post 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retainer</td>
<td>126</td>
<td>104</td>
</tr>
<tr>
<td>Returner</td>
<td>~5</td>
<td>13</td>
</tr>
<tr>
<td>Enhanced Induction</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

### Important factors influencing progress:

- Regular meetings of regional advisors to discuss progress and specific cases ensuring a consistent approach across Scotland
- Work on publicity with Facebook campaigns and improvement in the website with addition of personal stories

### Conclusion:

- Since 2015, dedicated government funding and a coordinated approach by NES throughout Scotland, has provided an increase in numbers of GPs in the Returner and Enhanced Induction programmes.
- Although the Retainer Scheme still employs many GPs, numbers are declining. This may be a reflection of practices now offering more flexible part-time working options.
- Guaranteed funding is crucial for the ongoing success of these projects and more work is needed on publicity and assessing their long term effects.
Introduction
GP trainees in South East Scotland are encouraged to arrange study days in their base GP practice whilst undertaking hospital placements. It is presumed that this helps trainees to re-orientate themselves to their primary care career focus, but little is known about what activities trainees undertake during these days and what trainees and educational supervisors feel are the main benefits of these days.

Method
Electronic surveys were distributed to 153 current ST1 and ST2 GP trainees and 179 educational supervisors using Questback survey software. An additional survey was sent to 88 ST3 trainees asking them to reflect on their experiences of attachment days whilst undertaking hospital placements and the impact of these on their senior training.

Results
The surveys received response rates of 45%, 50% and 52% for ST1/2, ST3 and Educational Supervisors respectively.

Are attachment days perceived to be useful?

It is clear that both trainees and educational supervisors feel that attachment days are a useful aspect of GP training whilst in hospital posts: 84.4% of trainees and 96.7% of educational supervisors feel that the days are either somewhat useful or very useful.

Do trainees get to contribute to the content?
34.1% of ST3 trainees and 42.4% of ST1/2 trainees reported no involvement in the planning of the attachment days. Across all groups of, the majority of respondents reported that the trainee was consulted regarding the format of the day and their ideas taken into consideration. Only a small number (13.6% ST3; 8.5% ST1/2; 2.2% supervisors) indicated that the trainee got to plan the day.

What elements of attachment days are most useful?

There is agreement between trainees and educational supervisors that joint surgeries and tutorials with the named educational supervisor are the most useful aspects of attachment days. All suggested components were thought to be useful to the trainees’ overall development as a GP.

What are the benefits of attachment days?

More time in GP is always FAR more relevant than hospital work! (Trainee, ST3)
Can help focus what you should be learning from your current job. (Trainee, ST1)
Time to think like a GP – community orientation! (Ed. Supervisor)
Important to maintain links with your trainer and your practice. (Trainee, ST3)
Chance to reflect on current role, debrief from hospital, and review and feedback on portfolio. (Ed Supervisor)
Pick up warning signs of a stressed registrar early, build rapport and trust. (Ed. Supervisor)

Conclusions
South East Scotland trainees and educational supervisors feel that attachment days to GP whilst in hospital placements are useful to the trainees’ overall development as a GP. There may be benefit in suggesting that trainees have more involvement in the planning of these days, to maximise educational benefit, and in offering templates for attachment days in order to broaden the range of educational options available.

Acknowledgement: I would like to thank Heather Peacock (GP Unit, Westport) for helpful discussion regarding the content of the questionnaires and her comments on their first versions.
Optometrist progress and patient outcomes at the Lothian Optometry Teach and Treat (LOTT) clinic

Ah-See KL 1, Tochel C. 2, Cameron D. 2, Gupta A. 3
1 Ninewells Hospital, NHS Tayside. 2 NHS Education for Scotland (NES). 3 Princess Alexandra Eye Pavilion, NHS Lothian

BACKGROUND and AIM

2006: Revised Scottish General Ophthalmic Services expanded to include comprehensive eye examination appropriate to patient needs
2010: Lothian Optometry Teach and Treat (LOTT) Clinic opened to facilitate optometrist training to meet new duties and contribute to increasing burden on outpatient services (ISD ref)

Present audit: To investigate the performance of the LOTT clinic in terms of patient outcomes and satisfaction, and optometrist experience.

LOTT CLINIC OUTCOMES

Methodology:
Collection of outcome data for all patients seen at 3 LOTT clinics between 18th March 2013 and 18th March 2014.

Results:
Clinic outcomes, n=701

<table>
<thead>
<tr>
<th>Admitted for IP/VacANCY treatment</th>
<th>26.56%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to another doctor</td>
<td>2.43%</td>
</tr>
<tr>
<td>Listed for IP/VacANCY treatment</td>
<td>6.71%</td>
</tr>
<tr>
<td>Discharged</td>
<td>49.50%</td>
</tr>
</tbody>
</table>

HOW DOES LOTT WORK?

- Daily weekday clinic
- Consultant ophthalmologist to supervise/lead
- Up to 4 optometrists training
- 3 examination rooms
- Video examination room
- OCT/visual field room

SOURCES OF LOTT REFERRALS

- General, medical retina and glaucoma queues from e-triage
- GP
- Optometrists
- Self-referral

PATIENT SATISFACTION

Methodology:
Questionnaire survey offered to all patients attending LOTT over the course of one calendar month (October to November 2014)

Adapted from NES questionnaire 1

40 respondents of 75 patients attending LOTT. 17 Males; 23 females. 50% of patients were over the age of 60 years.

OPTOMETRIST EXPERIENCE

Methodology:
Self-assessment questionnaires distributed to 7 participating optometrists (out of 9) at 2 different time points:
1. On joining LOTT (0 sessions completed)
2. After completing ≥16 sessions
Changes in responses quantified (eg. for a given domain, a change in response from “good” to “very good” was given a score of +1)

All optometrists recorded overall improvements in their subjective performance following LOTT training

Optom ID | A | B | C | D | E | F | G
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall change</td>
<td>+1</td>
<td>+14</td>
<td>+17</td>
<td>+9</td>
<td>+3</td>
<td>+1</td>
<td>+2</td>
</tr>
</tbody>
</table>

Frequency of responses per domain

<table>
<thead>
<tr>
<th>1=very poor</th>
<th>2=poor</th>
<th>3=fair</th>
<th>4=good</th>
<th>5=very good</th>
<th>6=excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance to your needs</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection of cases</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands on experience (SVO, FB removal, OCT)</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical teaching style of facilitators</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoyability of sessions</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of teaching presentations/group teaching</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency of clinic</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall satisfaction with LOTT</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CONCLUSIONS

- High volume of patients seen and managed within LOTT, contributing to reduced burden on outpatient services
- Positive experience for both patients and training optometrists
- Innovative clinic facilitates the expansion of optometrist practice to improve community ophthalmic care.

References: