

Signposting GP trainees to relevant learning opportunities in hospital posts: the Super-condensed Curriculum Guide

MeiLing Denney
South East Scotland deanery

Abstract

UK three-year GP specialty training programmes consist of 18 months in hospital posts and 18 months in general practice. Within the hospital setting, clinical supervisors of GP trainees may have difficulty determining which learning opportunities available within the post are most relevant to training for a future career in general practice. Feedback from GP trainees has indicated that there is a lack of consistency in hospital posts regarding relevance of training for general practice.

The aim of the project was to provide support to the hospital supervisors in order to improve the overall quality of hospital posts in GPST programmes and their relevance to General Practice training, and to provide guidance to GP trainees to target their learning most effectively within each specialty post to improve relevance to future career. The deanery set out to develop a tool, the Super Condensed Curriculum Guide (SCCG) consisting of a set of documents created for a specialty with involvement from stakeholder groups. It was intended that this guide would stand alongside the relevant part of the GP curriculum. A programme of familiarisation and initial training for clinical supervisors was delivered. Take-up of the clinical supervisor training sessions was not uniform. Following favourable initial feedback from trainee groups and clinical supervisors across the region, the guides were developed for the remaining specialties in the programme.

Trainees were also informed about the guide and how it might help focus their learning in a hospital post. Feedback from trainees across the specialties was positive, but more needs to be done to engage clinical supervisors across the range of specialties. This will improve the utility of the tool, help to guide the clinical supervisor in their teaching, and make sure each post is as educationally effective as possible.

Problem

Successive trainee survey reports conducted by the GMC and a number of other surveys conducted by the Royal Colleges throughout Scotland and the UK have highlighted difficulties within medical training, which have the potential to undermine the future provision of high quality and safe patient care. The impact of the European Working Time Regulations and the resulting lack of continuity of care and fragmentation of clinical teams are perceived to threaten the quality of training and learning opportunities experienced by all doctors in training (Clarke, 2014), although an earlier study showed this was not the case with the limit of 80 hours per week (Moonesinghe, 2011). In general practice speciality training the problem is exacerbated by speciality consultants' difficulties in fully appreciating the curriculum competencies required to be a GP (Bedward, 2011), and the differences in the needs of GP registrars to other specialty trainees. This is not surprising, given that general practice has changed beyond recognition since the establishment of GP training in the 1980's and even since modernisation of GP training in 2007 (Patterson, 2013), and that consultants rarely have significant exposure to the scope of practice of a GP. In Scotland the deanery conducts its own surveys, and gathers evidence from GP trainee focus groups for the purpose of evaluating the posts within the GP specialty training rotations. The results of these indicated that, as in other parts of the UK, GP trainees in hospital posts felt that training needs did not meet the requirements of the GP curriculum, and were overridden by service requirements. Thus they felt that a significant proportion

of the learning and experience that they gained had little relevance to their future role as a general practitioner.

Background

Trainees progress by achieving defined competencies and standards set by the Royal College of General Practitioners, which has a comprehensive published curriculum that is regularly updated to reflect innovations in clinical practice. Nevertheless the size of this curriculum, originally 900 pages in length, has proved daunting for many trainees, and despite being aware of its existence, trainees rarely refer to the curriculum during the course of their everyday work (RCGP 2007, Riley 2011). Within each section of the curriculum are embedded Intended Learning Outcomes to guide trainees in their learning, and these cover a variety of areas including primary care management, person-centred care, specific problem-solving skills, community orientation, and psychomotor skills.

GP Specialty Training is currently a three-year programme in which trainees will usually only experience three specialties in 18 months of hospital placements. The remaining 18 months in General Practice has to give the trainee adequate exposure to and training in General Practice as well as meeting all the competencies described in the RCGP curriculum and fulfilling assessment requirements. All SE Scotland programmes offer six months in General Practice in ST1, leaving the remaining 12 months in ST3 to meet all requirements necessary to achieve CCT once the hospital

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component of training is complete. It is therefore vital that the time in hospital placements is used productively, with relevant training provided for a future career in general practice.

The RCGP has made the case for an extended and enhanced GP training programme, citing as one of the concerns being insufficient exposure of trainees to some important curriculum areas, such as mental health, child health, and public health areas (Gerada C, 2013). In the meantime, given the time constraints imposed by the three-year programme, maximising the learning opportunities for trainees would seem to be a sensible idea.

Baseline measurement

GMC requirements mean that we need ongoing assurance that posts and programmes have the potential to meet the requirements of the RCGP curriculum. A variety of sources of information help to provide this information. These include post-placement questionnaires, individual feedback statements from trainees, information from the GMC visit, and feedback from GMC questionnaires (GMC, 2013). This has indicated a lack of consistency across the region, with some posts receiving much more positive feedback than others in terms of perceived value as training posts for general practice (GMC, 2013).

To find out if similar guidance documents existed within the UK GP training, other Deanery websites were scanned for the existence of similar work, and if not available on the website the relevant deanery was contacted for further information. Although some guidance had been produced for trainees by a very small number of deaneries, there was nothing that met the requirements of the proposed project.

Design

We wished to produce a document to support hospital units in the delivery of the RCGP curriculum for GP specialty training. The initial idea was to have a one-page guide to prompt them to think of any changes that might be necessary to make these posts more relevant for training towards a future career in general practice. We also wished to be able to signpost the GP specialty trainee more effectively to key learning opportunities available in specific hospital posts, to maximise relevant learning and curriculum coverage. The project team created a single sheet learning map showing possible learning opportunities relevant to general practice within a particular hospital specialty, with specific areas designated to show where these opportunities might lie, e.g. core themes, acute and chronic problems, community, technical skills, etc. To do this, the most recently updated versions of the relevant sections of the GP curriculum were consulted, and the team contacted local sources for information on the hospital specialty post. The learning map was referred to as a “blobbogram”, and was compiled by the associate adviser responsible for GP training rotations (HP), a training programme director (MLD), and a GP educational fellow (ET). A feasibility pilot was to be carried out solely on medicine/medicine for the elderly for six months, and after review the project would be rolled out to all specialties within the training programmes.

It soon became clear that it would be helpful if not essential to involve the relevant hospital colleagues in that post, not only to get their input regarding the learning opportunities, but also to get their buy in. We therefore involved the relevant clinical supervisors for that module, GP educators, and trainee representatives. It was felt that making the resource available through the deanery website (Virtual Learning Environment) would make it accessible to trainees and clinical supervisors at any time, and provide an easy means of disseminating updated versions to both groups.

Strategy

We planned to analyse questionnaire feedback from trainees on hospital posts to establish if there was a need for the creation of the guidance documents, evaluate any existing tools in Scotland and UK, and build on work done if relevant. If we found nothing already in existence suitable for the purpose, we aimed to create a practical tool to support the delivery of the RCGP curriculum, using rehabilitation medicine as the starting point. Piloting would involve testing the tool from February to August 2012 with that specific specialty, and following the results of the pilot in September 2012 we would make any necessary revisions. After this we would extend the methodology to cover all remaining ten specialties within the programme, re-test, and run a full pilot using input from all specialties involved between February to September 2013. To engage with clinical supervisors beyond those involved with the pilot, we planned to offer training sessions to all clinical supervisors in December 2012. We would continue evaluation using questionnaires with clinical supervisors and trainees (created by SWO) in September 2013, and use the results of the evaluation to develop and roll-out further training sessions for clinical supervisors in December 2013. GP trainees and educational supervisors will be kept informed and involved through electronic bulletins, information on the deanery website, and through workshop discussions.

PDSA Cycle 1. The SCCG tool was developed and shared with the clinical supervisors and tutors for rehabilitation medicine. The idea was to demonstrate specifically where each of the elements mapped to the RCGP curriculum can be applied. It was then shared with trainee representatives, and feedback on the guide obtained. After this it was clear that the learning map (“blobbogram”) should sit within a package to include other guidance for trainee and CS. Following this, a confidence rating scale that the trainee could complete before the meeting was included and the basic guide was then expanded to include recommendations for use of the tool and guidance for educational review meetings and their timings. The guide also set out roles and responsibilities of both clinical supervisors and trainees during the hospital placement.

PDSA Cycle 2. This first SCCG tool was then shared with others and evaluated informally through clinical supervisor, GP educator, and trainee groups. The feedback from both CSs and trainees was incorporated into a revised version. This now became a pack, containing an introduction to the SCCG with instructions regarding its use, a flowchart with timelines giving roles of CS and trainee within and around the meetings, a specialty-specific visual learning map with common colour codings for all specialty posts, and a trainee confidence rating scale relating to that specialty.

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PDSA Cycle 3. The revised version now showed what additional learning opportunities could be accessed during that post that links to another specialty. For example, paediatrics in an obstetrics and gynaecology post, psychiatry within a medicine of the elderly post.

Following this, similar SCCG guides were created for all other specialties in the GP rotations. Anecdotally it became apparent that SCCGs were not being used in practice, and that contacting CSs by email and alerting them to the existence of the guides was insufficient. Whilst having the relevant CSs being very involved and satisfied with the development of the tool, this approach would not be practical for time and resource reasons for all subsequent guides.

PDSA Cycle 4. Clinical supervisor training sessions were therefore organised in December 2012/January 2013 to which all CSs were invited. However, not all CSs attended, a few specialties being well represented, and some specialties not at all.

PDSA Cycle 5. Trainees were then approached as a group to take the guides to their CS and encourage their use. The training session materials for CSs were further developed. In December 2013/January 2014 the CS training sessions were offered again. There was no negative feedback from these sessions, but take-up was low, and there were still specialties where no CS had attended the training.

Results

The intended outcomes were to facilitate the development of specialty training posts with respect to future GP career and curriculum coverage, create a tool and training package to enhance the current learning opportunities provided in the hospital posts, and improve the delivery and understanding of the RCGP curriculum whilst in the hospital component of GP training. The surveys sent out took these intended outcomes into account.

We surveyed all our GP trainees in hospital posts (N=119) on the use of the SCCG. Response rate was 45% with 54 trainees completing the questionnaire. Of these trainees 38.9% were in ST1, 14.8% were ST1.2 (second year in a 4 year programme), 46.3% were in ST2 (second year in a 3 year programme or 3rd year in a 4 year programme). Out of the trainee respondents, 52.8% had used the Super-Condensed Curriculum Guide in their current post, but 11.3% had never heard of it. 64.3% had initiated the use of the Super-Condensed Curriculum Guide themselves, and the remainder were divided equally between those whose clinical supervisor had initiated it and those where the initiation of use had occurred jointly. 53.6% of trainees felt that their clinical supervisors were informed in the use of the Super-Condensed Curriculum Guide, 28% were not aware of it and indifferent as to whether to use it or not, and 17.9% were not aware of it but happy to use it. No clinical supervisors were perceived to be not keen on using it. 50% of trainees felt that the confidence rating scale part of the guide was useful or very useful in identifying their learning needs, 50% felt it was somewhat useful. 41.7% of trainees felt that the confidence rating scale part of the guide was useful or very useful in the developing of an action plan, 50% felt it was somewhat useful, and

8.4% felt it was not useful. Thinking about the learning map, 50% felt that this part of the guide was useful or very useful in creating a discussion around their learning needs, and 50% felt it was somewhat useful. 71.4% converted their action plan into a PDP, the remainder did not. Finally, when asked how useful the Super-Condensed Curriculum Guide was overall in signposting learning opportunities in their current post, 17% said it did to a large extent, 8.7% said to some degree, 39.1% felt it neither did nor did not, 34.8% felt it signposted these very little, and 6.5% not at all.

92 clinical supervisors were e-mailed a survey and 38% responded (n=35). Supervisors were from a broad range of specialties. 37% of respondents used the guide. About a third of all supervisors said they were not aware of it. 75% of clinical supervisors found that the guide was very useful or useful in creating a discussion of learning needs and the development of an action plan; 25% found it somewhat useful. A lesser percentage, 65%, found it useful in signposting learning opportunities of the post, 66% in enhancing understanding of the GP curriculum, and 45% in recognising the learning needs of GP trainees.

Lessons and limitations

We learnt several lessons from carrying out this project: design and implementation of any new product takes time. It is essential to involve the stakeholders, both in the design and the implementation of a new project. Communication with stakeholders has to take place for each stage of the process. Too much paperwork in a variety of places is confusing - combining guidance in one document minimises confusion and increases the likelihood of them being used together and appropriately. Whilst training sessions prove useful for those clinical supervisors who attended them, it was not easy to reach those who did not attend. Better engagement with individual specialty departments at the design stage may have improved uptake of places on the training sessions.

The findings illustrated that blocks for using the SCCG were lack of awareness by trainees and supervisors. Trainees found they were able to understand the usefulness of a guide to the learning opportunities that they should be able to cover in a particular specialty post. As less than half of those in ST1 had been informed about the guide face-to-face, it was perhaps surprising that many in ST1 and ST2 had heard of it. Trainees found the guide useful in identifying their learning needs, in signposting learning opportunities for them and in the development of an action plan. The majority used the action plan in their PDPs. The guide also enhanced their understanding of the GP curriculum. About half of the trainees who completed the survey used the guide. The use of the guide was largely initiated by the trainees suggesting that trainees' awareness of the guide is a major facilitator for its use. Clinical supervisors reported the major block to not using the guide was lack of awareness - about half of clinical supervisors were aware of the guide. Those that were aware of it initiated its use. Most clinical supervisors found it useful in facilitating a discussion of learning needs and developing an action plan, signposting learning opportunities within the post, and enhancing their understanding of the GP curriculum.

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The relatively small number of people involved in communicating and involving the stakeholders was a limitation, and the limited amount of time available was a further constraint. Questionnaire return rate could have been higher, particularly for clinical supervisors. Evaluation would ideally include looking at long-term outcomes such as enduring knowledge and skills, and improved patient outcomes, but this was not possible within the study period. Due to the small numbers involved overall it was not possible to determine whether or not the results varied significantly between clinical supervisors in one specialty more than another.

Conclusion

Given the relatively short time for specialty training for general practice, and service requirements for any particular post, there is a need to signpost trainees to the most relevant learning opportunities within any hospital specialty post on their rotation. Many trainees feel daunted by the size of the GP curriculum, and a guide that highlighted local opportunities such as specialised clinics, community teams, and particular patient groups was found to be helpful. The guides and their embedded learning maps gave structure to the planning and review meetings between clinical supervisor and trainee. Within the guide there is also a confidence rating scale for trainees to complete prior to their first meeting with the supervisor to inform their action planning. We did not ask specific questions about this in the survey, but anecdotally it appears that this is felt by both trainees in supervisors to be very useful. It might be useful in the future to survey opinions about this specifically.

The Super Condensed Curriculum Guides were created to help clinical supervisors and trainees in a particular hospital post. Their use could now be extended into a general practice setting where trainees who have missed particular specialties from their hospital-based training could use them to focus discussion with their GP Educational Supervisor on how any identified deficiencies could be met. This generic tool has application beyond general practice, not only across a variety of medical specialties, but also across the range of Allied Health Professionals within the UK.

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Declaration of interests

Nothing to declare

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