**Focus group 20-5-14**

**Summary of themes**

**Limiting factors**

Room space: almost universal – limits most practices.

Nearly all practices have no clinical space free to accommodate additional learners.

Some solutions suggested but need for infrastructure investment likely

Eportfolio

Multiple eportfolios not attractive, esp among those who do not find them a useful learning approach: for some this is a ‘deal breaker’

Managerial/Admin time

Practice Managers are stressed. Increased trainees necessitates careful workforce planning and scheduling with increased workload for PMs

**Tensions**

Patient access (from increased trainee workforce)

**vs** continuity of care (from multiple short term posts and taking trainers away from their clinical workload)

Joint learning (peer support, atmosphere, informal learning, teaching each other, efficiency of joint tutorials and shared learning)

**vs** need for 1:1 (esp for Trainees in difficulty, role modeling, making a ‘global judgment’ and eportfolio work)

Workload (overall practice clinical workload contributed to by most learners)

**vs** trainer workload (and how this is renumerated/compensated within practices and from trainer grants which must be sufficient). Need for team approach, pooled resources and sharing training.

Interprofessional learning (benefits of improved communication and workforce development eg practice nurses)

**vs** real concern re educational delivery (different needs, different ethos, different outcomes and different contribution to workforce within practice ie what is in it for our practice?)

**Key conclusions:**

Educational management appears a bigger challenge than Educational delivery, tho adapting how learning takes place (esp joint tutorials) is necessary with multiple learners.

Generally, trainers express cautious enthusiasm and interest for more trainees, allowing for the barriers described as above.

But need for caution in determining an optimum number of learners is not exceeded, to ensure all stakeholders’ (inc patient, learner, manager, trainer, other clinicians) experiences not damaged thereby.

**Transcription of post it notes**

**Educational Management**

Room space!!

Physical space – consultation rooms

Room space!

Room sharing and timetabling can be tricky

Pressure on space.

Resources of practice: time/room/finances

Rooms, tutorial sessions, grants

Space

Rooms

Practical aspects of space

Space – accommodating extra learners

Constrained by space

No room – clinical, reception or admin!

Expansion and extension of premises needed almost before expansion and extension of training

Premises! Would love more trainees but no room. Happy to extend training for one trainee.

How likely is this to be properly funded? Not very?!

Fear: will extra trainees drain scarce resources?

IPE: Registrars “give back” in terms of appointments – other learners don’t necessarily. Trainers justify the time spent training

Positive – ultimately good leading to better community services

Space/Time/Paperwork for Practice Manager/Supervision…

Managerial time: Rotas/Study Leave/Tutorials/Supervision

Pressure on admin systems

Headache for Practice Manager: timetabling etc

Need for additional administrative staff

I think we need a trainers workshop for the practice managers of training practices to support each other and work out the educational management

Tension with other commitments in practice ie appointments

Time constraints

Need to redesign the teaching week, extra time for tutorials and supervision

Trainer time

More effort to ensure all trainees progressing satisfactorily

With lots of trainees being part time – opportunities for job sharing

More pooling resources between practices

Emotional: how will pushed practices cope with supervision?

Emotional: Exciting in principle as long as not pushed upon us

Good opportunity (for a new trainer)

Welcome change to have regular trainees

Do we have enough trainers?

**Educational Delivery**

Communities of practice have higher proportion of learners

Partners working as a team to educate

Potential to increase learning models: registrars teaching each other without trainers

Good for registrars: peer support, supports trainers

Need dedicated 1:1 time which is hard to find if learners outnumber trainers. Good if enough trainers.

Joint tutorials successful mix of joint/individual important

More group tutorials. Larger trainee pool to learn from

Lots of positives in terms of >1 in terms of peer learning and support

Trainees like having peers in practice and we like having two at a time

Costs (reduction in 1:1 training relationship) vs Benefits (tutorials with multiple learners can be stimulating)

Will it result in less 1:1? Temptation to teach all together (and pros of that)

Joint tutorials: positive for topics: more interesting. Negative: planning tricky – more experienced registrars closer to AKT more involved

Joint tutorial. Joint surgery

121 tutorials

Challenges of differing educational needs

Different styles required for different trainees?

Diverse training requirements with impact on trainees, trainers and practice generally

Educational delivery: we have multiple trainees: FY2/ITP/Reg. More? What is our limit? How is this judged? Experience for trainees? What is lost? What is gained?

Attitude: is forcing medical students who don't want to be a GP a good idea?

Patient experience if too many trainees?

IPE

Anxious re other professions/IP training; how to deliver

Shared learning with nurses/pharmacists? Worries me: Can’t address specific needs in each group.

Multi vs Uni Professional learning

**Focus Group:**

**Transcription of issues raised in discussion**

Fear – concern about ‘forcing’ a higher proportion of medics into GP. We may end up with people who don’t really want to be GPs. This could make training harder.

Lots of positives. Trainees support each other.

Challenge of finding 1:1 time for trainees when needed.

How much 1:1 is enough?

A balance (needs to be found) between increased support from learning together vs decrease in 1:1 training relationship

“Couldn’t offer more…would have to drop something else”

Eportfolio input very time consuming. Would be impossible to do more.

Not do-able with only one trainer’s allowance

Workload: multiple trainees may help.

Trainees in difficulty may generate increased workload

May be problematic if patients perceive most appointments are offered by trainees

Impact on continuity of care potentially detrimental: Is there an optimum number. How would we know?

Maybe 1:1 supervision is a luxury we can’t afford?

Practicalities: trainees would need to be flexible: days worked, room pressures, space is a major limiting factor

Administrative burden eg for PM

Anxieties about multi-disciplinary learning – concern that learning needs may not be addressed

Achieving balance between Uni and Multiprofessional learning.

Patient story based learning is most effective for IPL

“Group tutorials work very well”

trainees at different stages

need to prepare

likely to be a maximum number beyond which tutorials may be useful

Observed surgeries and shared consultations – reduced opportunities with multiple trainees

Debrief after surgery difficult with > 2 trainees at a time

Impact on “global assessment” discussed

-could this be diluted with multiple trainees?

-e.g. ways in which trainees ask for support during surgery

-and indirect feedback e.g. from patients

-and informal feedback from reception/admin staff

Issue of how multiple trainers manage multiple trainees

-agreed to be more manageable than having one trainer supervising multiple trainees

(NOTE HACKNEY – only two practices have a single trainer)

“A community of trainers managing a community of trainees is quite appealing”

Ratio of trainers to trainees: 1:1 agreed to be ideal; 1:1 maximum

So more trainers needed in many practices if trainee numbers are to increase

Possibility of Hub and Spoke model

-concerns expressed about model of supervising a trainee in a remote location

-universally felt to be undesirable

-“completely at odds with old-fashioned apprenticeship”

Issues of renumeration: needs to be adequate

More trainers needed!

Eportfolio requirements are a major barrier to taking on more trainees

Space: universal limiting factor

Premises “More space!!”

Need for building estates and investment in GP infrastructure

Some space issues can be overcome by “hot desking”

Who should do this? The trainer/partner or the learner (easier to move if you know the systems in the practice but may have more books/equipment to store etc)

Room sharing needs good management of rotas, stocking and filling of rooms in consistent way so all rooms the same and TIDINESS essential!

Down side is “lose the personal touch” and different experience of “belonging” to a workplace if you do not have a room with your name on the door.

Other options include

Tutorials or administration conducted outside the practice e.g. at home – different feelings expressed about this. Would free up clinical work space

use of technology e.g. Skype

Expanding the time spent in Half Day release, less learning/tutorial time needed at practice? Different views expressed on this

Hub and Spoke model: not liked, cannot supervise trainees remotely; why would hub trainers get involved?

TIDs: cannot do joint tutorials

Managers: impact on them ?develop a supportive peer group to share ideas and workload

One model currently used is an Educational Administrator (shared between two practices for 2-3 days per week) to plan and schedule and manage all learning (inc med student)

More trainees = more work for Practice managers

Patients: Very positive feedback, nil concerns re seeing trainee; some patients find it hard when the learner leaves after a year

Patients benefit from more appointments (access) longer appointments (as learner has longer time) and a happy trainer/team!

Trainers pulled away from clinical workload to supervise more: some concerns around impact on continuity of care

Recognition of current tensions between expectation and desire for provision of continuity of care (enhanced by contemporary priorities eg over 75s named doctor) and access (where trainees contribute to number of appointments offered) “we are never going to be what they want us to be” “It is like the M25 – you can build as many lanes as you like, they will all be used” “There is no need for us to be constantly available, I think complete continuity is impossible nowadays”

Workforce planning: if trainee numbers not consistent year to year, this is hard

Pregnancy and maternity leave a common feature of training years making work force planning and tutorial planning difficult: learners not in synch.

Trainees do contribute to workload and service commitment

Other learners eg IPE would be harder to justify to partners/colleagues.

Concerns re IPE: different ways of thinking e.g. nurses are taught to be “risk avoidant” whereas GPs manage and embrace risk.

Who would the supervisor be to a nurse learner?

Peer learning: role modeling eg medical students taught by registrars

Multiple learners take issues to each other and self-support

Multiple learners are ‘vibrant’ and influence the atmosphere in the practice

Team involvement with debrief and learning essential

A balance needed

Joint tutorials and debrief possible and do have benefits (sharing ideas, learning from each other, efficiency of time)

Some 1:1 essential, for needs of eportfolio and esp if TID

Renumeration: has to be adequate “They can’t keep adding into the pot and expecting more and more”

Different models used currently to share debrief: common theme is 2 x appointments ‘blocked’ during one session to enable support for learner

“Expansion creep” is ok but as long as numbers not excessive as there are downsides for stakeholders