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Delivery of core medical training: the role of a local faculty group

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ABSTRACT – All physicians who are training young doctors of the future recognise the current challenge of doing this in the NHS. The recently published Temple Report documents the challenge and some of the solutions. For Kent, Surrey and Sussex (KSS) Deanery, one of the responses was to implement a new structure and process at local level – the local faculty groups (LFGs) – to ensure appropriate curriculum delivery. This paper sets out the history, structure and purpose of LFGs, describes what happens during a LFG meeting in both open and closed sessions and presents feedback of learning from two years in action across 11 acute trusts in the South East Coast (SEC) strategic health authority area. The experience of trainers in SEC is that the local faculty group structure and associated processes is one strand in the more effective delivery of education in the current NHS environment.

KEY WORDS: core medical training, educational supervision, European Working Time Directive, local faculty group, trainee progress

Background

All educational and clinical supervisors understand the current challenge of educating physicians of the future to the expectations of the new medical curricula. The Temple Report *Time for training: a review of the impact of the European Working Time Directive on the quality of training* documented all the problems that physicians have recently encountered, in particular the:

- challenges of continuity of care, both service and training with multiple rota and shift systems
- large number of handovers which may or may not be efficient and effective
- traditional models of training and service delivery with wasted learning opportunities in reduced hours and reduced trainer and trainee interactions.[1]

Experiential learning for a young trainee may no longer be from a single registrar and consultant but distributed to a number of different consultants and other middle grade doctors. The overall impact of this on the training of physicians is very difficult to quantify although work by the Royal College of Physicians (RCP) suggests that the UK may be seeing the early effects of working time reductions, such as a reduction in the self-reported total number of procedures undertaken during training.[2]

One of the main messages from the Temple Report was that traditional models of training and service delivery waste learning opportunities in reduced hours. Some of the answers proposed are more consultants, explicit and dedicated time in job plans, the importance of using as many interactions as possible between consultants, senior trainees and more junior trainees as real learning opportunities, for example post-take ward rounds.[1,3–5] However, it is the view in the Kent, Surrey and Sussex (KSS) Deanery that delivering training in reduced hours does not just require a step change in how young doctors are trained and supervised, but also a fundamentally different structure and process at a local level. This is needed to ensure appropriate curriculum delivery, in particular training and assessment of young doctors in an environment where their education is now much more widely distributed.

The structure for doing this in KSS is the local faculty group (LFG) and this paper describes what local faculty groups do for physicianly training, in particular for core medical training (CMT).

The local faculty group: history, structure and purpose

The first LFGs were established in 2005 in KSS to deliver the new foundation programme curriculum. Started as learning sets, developed by the KSS Education Department in every trust, they brought together those doctors who would be the training programme directors and educational supervisors required to deliver the novel new curriculum for foundation training. Crucially the LFGs quickly evolved into the body that made sure at the local level that:

- the curriculum was being delivered
- all educational supervisors were properly involved and trained for their new roles
- the group that would take responsibility for all the foundation doctors in that trust.

Faculty groups started to meet three times a year and all trainees were discussed at each meeting. This meant that problem trainees would be much more easily identified, and the whole faculty who had seen that doctor in any service or educational environment would be fully part of the decision-making process of sign-off, whether for a placement or for the whole year. Furthermore any problems that occurred could be handed on to the next placement clinical supervisor.

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As the Modernising Medical Careers programme then rolled out a new curriculum, core trainees came into a managed educational environment for the first time. The LFG concept was then expanded to involve all the main specialties. The deanery devised the regulations by which every trust had to develop LFGs to ensure that their agendas covered all curriculum aspects and that minutes were produced. Unresolved problems of the LFG were then discussed trustwide at the Trust Local Academic Board which takes responsibility for all educational governance within a single education provider. The regulation controlling the membership, agenda and output of LFGs is called GEAR (Graduate Education and Assessment Regulations).[6] As of 2008, LFGs were implemented for all the main specialties in all KSS trusts.

The main purposes of the LFG in medicine are to:

- maintain standards for curriculum management
- maintain the leadership, management and educational systems that underpin the learning environment
- ensure both of these standards meet General Medical Council (GMC)/Postgraduate Medical Education Training Board (PMETB) and relevant RCP standards

The RCP college tutor will always chair the local medicine LFG. The chair automatically sits on that Trust Local Academic Board as well as on the regional Deanery School of Medicine committee. Other membership of the LFG includes local medical education administrators, all the local education supervisors, clinical supervisors as appropriate, junior doctor (trainee) representation, local human resources representation, local general practice (GP) lead where core trainees are part of GP training, a member of the library and knowledge service and a management representative. Sometimes the local clinical tutor or director of medical education also attends. The membership reflects the fact that service and training are intimately connected.

Some of the key roles of LFGs are summarised in Table 1 but the key points of each meeting are to:

- ensure that every trainee on the programme has been discussed and plans made if progress causes concern in any way
- ensure that minutes are produced that go to both the Trust Local Academic Board and the Deanery School of Medicine
- produce an annual report based on GMC/PMETB generic standards for training which automatically feeds into both the trust and the School of Medicine annual report for the GMC and the RCP.

A local faculty group in action

What happens during a local faculty group meeting?

Open section The meeting is in two sections, the first part being an open session where the chair provides relevant updates from the School of Medicine, the RCP and the deanery. This is an excellent forum for disseminating good regional practice.

Common topics discussed typically might include curriculum updates, regional school quality monitoring visits and related quality management issues, consultant SPA pressures, e-portfolio issues and developments, innovative teaching approaches (including regional training day information), recruitment news and arranging adequate consultant input for annual trainee recruitment.

Table 1. Example of issues covered by the local faculty group (LFG) summarised in the annual report matched against the General Medical Council (GMC) generic standards for training.[6]

Domain	Specific examples LFGs may address during the year
Domain 1: Patient safety	Handover arrangements
	Guidelines on taking consent
Domain 2: Quality management review and evaluation	European Working Time Directive issues
Domain 3: Equality, diversity and opportunity	Specific support for doctors identified as vulnerable
	Adjustment to programmes for doctors with disabilities
Domain 4: Recruitment, selection and appointment	Recruitment support to the deanery and School of Medicine in year
	Involvement in appeals
Domain 5: Delivery of the approved curriculum including assessments	Updating the medicine programme handbook including current educational activities set out against the curriculum
	Opportunities to deliver the approved assessment system
Domain 6: Support and development of trainees, trainers and local faculty	Ensuring that all educational and clinical supervisors have been trained to the standards set by the GMC
	Opportunities for learning around bullying or disciplinary issues
Domain 7: Management of education and training	Clarity on the responsibility of all those involved in the specialty programme.
	Ensuring that all are familiar with the trainee in difficulty policy
Domain 8: Educational resources and capacity	Involvement in simulation
	Knowledge and work of the local career lead
Domain 9: Outcomes	Analysis of outcomes of assessments of exams for local trainees
	Comparatives on benchmarks from across the school or nationally

There is a regular agenda item for trainee representative feedback including a commentary on teaching sessions, such as exam preparation or local and regional teaching sessions. There will be feedback on general trainee supervision and support, ward round arrangements, outpatient attendance for trainees, quality of locums (where appropriate), rotas and ward cover.

Standing items regularly discussed will also include the e-portfolio and how it works locally for trainees and supervisors, workplace-based assessments (WBA), such as ease of arrangement and who is carrying these out, curriculum cover within each specialty department, careers updates and planning for trainees (including preparation for eventual application for higher medical specialty training posts), management and teaching updates.

The agenda will also include trainees' MRCP exam progress and include the timetable and requirements for the trainees' annual review of competence progression (ARCP) process.

Educational supervision updates will also include news on the training requirements for supervisors to ensure that all are appropriately qualified to perform the many roles required of an educational supervisor in the new era of professionalisation of medical education.

The deanery educational adviser will often contribute to many of the discussion areas including careers support and is in a good position to help disseminate good practice as they will usually be involved in several LFGs across the region.

Management input to the LFG includes comment on relevant issues and updates including clinical governance. There is also the ability for any supervisor or trainee (via their representatives) to bring up any issue relevant to education and training within the medical directorate not otherwise already addressed.

This is then followed by a second (closed session) where trainees are not present.

Closed section This part of the meeting is where all CMT trainees, foundation year 2 (F2) trainees in medical posts, GP vocational training scheme (VTS) trainees in medical posts and higher medical specialty trainees are discussed by all those present.

If an educational or clinical supervisor is unable to be present, they will have been asked to provide a written report with relevant feedback on the trainees to be discussed, both the ones they are working directly with and those they may have worked with intermittently over the preceding few weeks (typically, for example, on a post-take medical ward round, in outpatients or opportunistically including during teaching sessions).

In some LFGs, a photograph of the trainee is projected to allow discussion to flow regarding their progress and the LFG administrator documents the feedback obtained from all attendees and integrates this with the written educational and clinical supervisor's reports, where provided, for each trainee.

The chair summarises the feedback documenting the progress of the trainees and any plans and recommendations. This information is recorded and filed both locally and with a copy sent to the deanery in a confidential form. This information helps to inform the ARCP processes locally and centrally.

Any trainee identified as having significant difficulties in their post, progress or in their feedback receives enhanced local support (guided by the LFG chair and usually the trust director of medical education) and, where appropriate, is brought to the attention of the Deanery Trainee in Difficulty Committee, which meets monthly and offers comprehensive additional support and advice to the LFG chair. The whole meeting usually takes approximately two hours.

Learning from two years in action

This section is based on a review of 11 acute trusts (some multisite) LFGs over a two-year period.

Communicating and sharing best practice

One of the most important and beneficial roles of the LFG has been as a central conduit of two-way information between clinicians, trainees, the RCP and the Deanery School of Medicine.

There is marked variability in consultant and trainee representative attendance at LFGs across the region with potential solutions including adjusting the time of the meeting, eg lunchtime or early morning suiting many, and ensuring that written reports from absent supervisors and trainees are provided.

LFGs have improved e-portfolio use and familiarity by sharing problems, solutions and good practice locally and regionally.

Those LFGs which have very active library services (and, eg, pharmacy) support have led to more innovative practice to support trainees locally.

Monitoring and documenting trainee progress

The LFG approach has increased the emphasis on multiple consultant clinical supervisors (and others) support for educational supervisors to prepare comprehensive reports informing the ARCP, which thus strengthens the validity of the evidence presented at the formal deanery ARCP meeting.

In addition, the contribution to general (internal) medicine (GIM) of higher specialty trainees is now formally commented upon by consultants who are not primarily working with them in their subspecialty, but within GIM, and their progress documented, an area that was hitherto not fully addressed.

The above represent one of the most significant achievements of LFGs in trainee support and monitoring across the deanery.

A large amount of experience in dealing with trainee issues has accumulated over the first two years of LFG operation and common problems, with their potential solutions, shared across the region. Thus lack of trainee or trainer engagement, exam difficulties, communication skills difficulties, ill health among trainees and career changes to name but a few issues have all been identified by the LFGs with advice and support to both trainees and their supervisors provided.

Improving quality

The LFG has ensured that the GMC/PMETB survey results are widely discussed and debated with clear action plans involving trainees and supervisors agreed locally. Results of (regular) school visits to trusts are discussed and have led to demonstrable quality improvements. There is regular discussion of the need for and mechanisms in place to ensure that all educational supervisors have received the appropriate training in how to carry out this important role. One local faculty surveys trainees every four months regarding post experience and acts on this to adjust arrangements. LFGs have ensured adequate numbers of trained consultant interviewers have been available for satisfactory CMT recruitment, while championing the recognition of consultant time requirements for these activities in job plans.

Trainee voice

LFGs have placed the trainee voice at the centre of their structure. Trainee representatives all receive specific training, thus strengthening this vital role. There is clear evidence that this has led to a beneficial impact on local CMT programmes and has also addressed and highlighted local clinical governance issues. Trainees are now expected to lead in many areas of innovative practice and to share good practice. Thus trainees now produce a local faculty handbook which covers everything about CMT locally that a trainee needs to know and they also support the local prospectus and website for CMT in their trust.

Curriculum

Increasingly the importance and relevance of the CMT curriculum with mapping to local programmes is discussed at LFGs. This is, in part, driven by the recognition of the need to ensure high quality relevant local programmes to enhance local programme popularity and thus recruitment.

Viewing the curriculum as a central component of CMT has allowed LFGs to develop balanced programmes where previously this was a major challenge and has also ensured that local teaching programmes also map to the curriculum.

LFG discussions and feedback to the Deanery School of Medicine have led to regional school training days covering those parts of the curriculum which are more difficult to address locally yet are essential curriculum components.

LFGs have recognised the importance of ensuring access to other specialties, eg cardiology, intensive care, neurology, renal medicine and so on, to ensure broad curriculum experience and also better information for career choices for trainees.

There are now frequent LFG discussions of WBAs, commenting on the time requirements for both trainees and consultants (particularly as the majority of such assessments will soon need to be carried out by consultants). This has also highlighted the need for specialty registrars (and others) to undergo training in the carrying out of such assessments. The use of CDs to teach assessment techniques has aided this development and also emphasised importance of using free text in feedback comments.[7]

LFG discussions have led to increased completion of WBAs contemporaneously online in the clinical workplace and have also successfully introduced GP trainee WBA methods across departments of medicine.

Difficulties encountered by trainees in ensuring adequate multi-source feedback respondent numbers have been successfully addressed at LFG level.

Regular documentation of the MRCP exam status of trainees by LFGs has further improved programme quality by ensuring that trainees are optimally supported, guided in part by awareness of their exam status.

Teaching and innovation

Innovative practice has been shared regionally, such as trainee representatives using regular text messages and emails to trainees reminding them of forthcoming teaching sessions (locally and regionally) and a novel approach to improving outpatient experience such as online booking of outpatient attendance for trainees who are allowed to choose from a suite of potential clinics, all of which are educationally orientated.

Local teaching 'champions' among trainees has developed from LFGs, resulting in more registrar involvement in CMT teaching programmes. Speakers at local CMT programmes are now sent the curriculum link so as to ensure that their session matches CMT requirements.

LFGs have supported an increasing emphasis on simulation activities (including for practical procedures training) and e-learning, with one LFG requiring that trainees access a minimum of one hour online e-learning weekly.

LFGs have recognised and promoted the importance of non-clinical teaching sessions to include communication skills training, teaching skills, interview/presentation skills, management training and leadership skills.

Clinical governance

LFGs regularly discuss and improve key quality areas such as induction, handover (eg ensuring electronic systems in place), local trainee handbooks (see above), Hospital at Night team functioning, rota gaps, quality of locums, patient tracking systems and many other important clinical governance areas.

The LFGs have enabled regular discussions on rota and local safety issues, with trainee involvement in addressing these as central to success.

Increased weekend workload pressures in some trusts have been highlighted at LFGs and have led to extra support being provided for trainees, resulting in improved patient safety.

Career planning

The LFG has ensured that careers updates and career planning are to the fore for trainees, with clear local careers leads. This has allowed the development of, for example, taster sessions across many medical specialties.

Clinical learning opportunities

The importance of making the best use of everyday clinical encounters, such as ward rounds and outpatient sessions, has been clearly highlighted across all LFGs and has influenced local clinical practice.

Conclusions

There are currently well-documented challenges in delivering high quality education to physicians with the European Working Time Directive and the current NHS service pattern. Meeting this challenge is not easy and will take a multifaceted approach.

KSS Deanery introduction of LFGs of medicine has ensured that a structure is in place to improve the quality management of local CMT programmes with formal recording of the same.

This new approach has greatly improved communications between the RCP, the Deanery School of Medicine, local physicians and, most importantly, with our trainees.

LFGs have led the dissemination of best practice, promoted innovation and facilitated regular updates across the region. These arrangements have strengthened the links with local management so as to promptly address any areas of potential tension or concern relevant to trainees and local services. The LFG structure is one strand to the more effective delivery of education in the current NHS environment.

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