CREATING AN EDUCATIONAL FACULTY IN TRAUMA & ORTHOPAEDIC SURGERY

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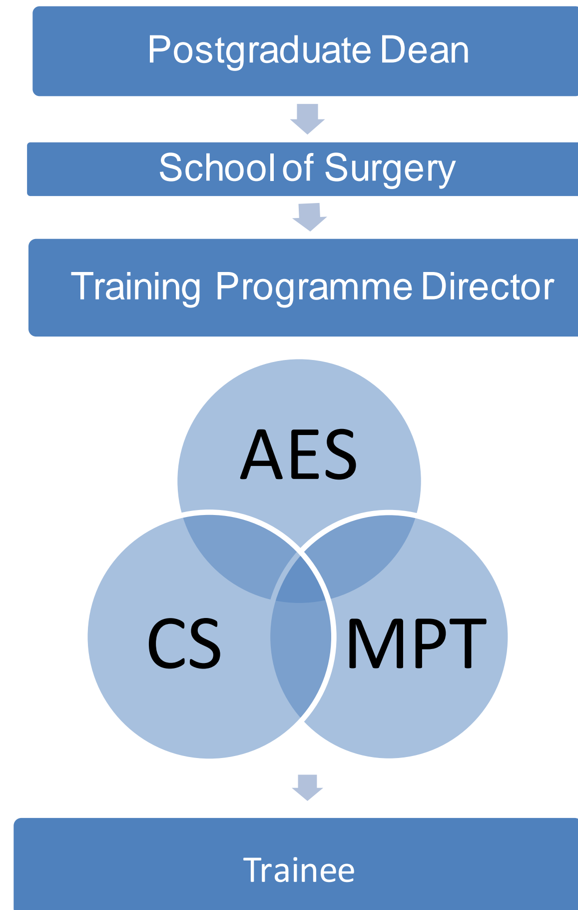
Training Governance Structure



The Ideal AES

- Locally based clinician.
- Interested in teaching.
- Trained in assessment and feedback.
- Mentoring and coaching skills.
- Fair.
- Engages with ISCP.
- Understands the curriculum.

Support for the AES

- 3-4 trainees per AES.
- Time.
- Access to TPD.
- Access to training courses.
- Advice.
- Learning resources.

Role of the AES

- Induction to the unit.
- Establish a professional learning partnership.
- Appraising learning using a learning agreement.
- Checking portfolio.
- AES report.

Checking Trainee’s Portfolio

- WBAs
- MSF
- Logbook summary
- Evidence
- Exam
- Courses
- PDP

WBAs

Assessment blueprint	Knowledge	Clinical	Operative	Professional	Reflective
Audit	*			*	*
CBD	**			*	*
CEX	*	**		*	*
DOPS/PBA + logbook	*	*	**	*	*
MSF	*	*	*	**	**
Teaching	*			**	*
Exams	**	*	*	*	*

* COVERED

** STRONGLY COVERED

Assigned AES Report - Aim

- Provide feedback to trainee to develop future performance.
- Inform the ARCP process.
- Identify strengths and gaps in training performance.

Assigned AES Report - Supervision

- Learning agreements – 1, 12 and 24 weeks.
- Document clinical encounters.
- What the trainee did well and suggestions for improvement.
- Contemporaneous notes.
- Monitor reflective writing.
- Feedback on performance from other members of team.

Assigned AES Report – Writing a Report

- Review notes from the trainee from the clinical supervisor.
  - Knowledge.
  - Technical skills.
  - Judgement.
  - Professionalism.
  - Map year of training to trainee.
  - Strengths and weaknesses.
  - Further development.
  - Sick leave.
  - Any inconsistencies.

“Trainee B has shown himself to be trainable and has progressed. He has achieved a ST3 position which reflects his hard work. He needs to continue his focus on assessments and operative skills”.

“Trainee A had a difficult start to the post, but has made some improvements. His logbook remains weak with only 7 THR/TKR as 1st surgeon. Some of this is explained by annual leave etc, but he assisted far more than he operated. This raises the concern about his technical skills (formally raised by his NCS), but he has not produced evidence to show development here. There is an unvalidated PBA on TKR, with more encouraging comments, but this has not been signed off. He has made some use of the ISCP to demonstrate learning: there were issues with a Cauda Equina Case at the start of the post and he has used the CBDs to show progress here. I am surprised however to see that CBDs have not really been used to explore topics related to lower limb arthroplasty. He has been advised to get a copy of the curriculum and use this as a guide for his learning and reflect this in his CBDs. He was asked to produce 2 pieces of reflective writing - only one was produced and this was not really an indepth analysis. He was also asked to use the NOTTS tool, but has also not done this. His MiniPAT/MSF is generally satisfactory but with some issues on awareness of limitations. Again he has not produced evidence to show that he has looked at this or reflected on it. Overall he has a good knowledge base but his surgical skills, decision making skills and non-technical skills need development. Although he has a number of years behind him at middle grade, I think we need to consider him an ST3. There is much room for improvement, particularly with his engagement with the ISCP and him taking initiative with his own learning & development”.

Thank you