

How to create capacity and space to deliver medical undergraduate education in your practice and within the Federation area

Teaching capacity

To increase GP placement capacity new models of supervision in the primary care setting need to be implemented.

Intensive supervisory models with 1:1 teaching may be burdensome for GPs with full 'waiting rooms', and this model limits the number of students able to attend the practice.

Other possible supervision models to assist in addressing student placement capacity:

Group supervision and group learning activities

Peer supervision/self-directed learning in clusters

Interprofessional supervision

Requirements to facilitate this:

-sub-deanery to 'cluster' practices and therefore students for peer supervised/self-directed learning

-group activities scheduled into the existing clinical GP attachments

-faculty development through activities and consultation of readily available resources to develop knowledge and skills on group supervision and interprofessional supervision organized and offered by sub-deanery

Engaging other health care professionals/management/administrative staff in teaching

For maximum impact teaching practices can consider setting clear learning objectives for the planned sessions with other health care professions focusing on role, collaboration, specific skills etc. Try to take it from 'observing' to 'contributing'.

Educational Triad : 'Observing provides breadth, rehearsing provides depth, contributing confers legitimacy'

Some examples (see also examples of time schedules for fourth- and fifth-year placements):

Practice Nurse:

-student to prepare his/her session by reading the guidelines (eg. asthma/COPD/hypertension)

- student to look at QoF requirements (population manager)
- student to link in with PN before he/she joins a chronic disease management clinic to ask any specific questions that were generated from above
- student to observe 1-2 reviews
- student to conduct under supervision 1-2 reviews

Nurse Practitioner:

-fifth year: to collect information from records/talking to patient about 'why does the patient present?' (away from bio-medical model) and discuss with NP before contacting patient together with management plan incorporating patients' ICE

Social Worker:

- identify one patient/family (from MDT meeting list)
- student to speak to GP/DN/SW/other HCP involved and of course family/patient and get involved in care plan
- discuss with SW what their role is in this particular case and how they conduct a care assessment
- present at (virtual) MDT meeting

Mental Health Worker/FPC physiotherapist:

Joint telephone/FTF or VC consultations with Mental Health Practitioner/First point of contact Physio. Mental Health/MSK presentations to Primary care- data gathering/setting up management plan

GGP

Student to identify 5 patients who normally would be dealt with by General Practice Pharmacist. Student to set up proposal for re-consolidation and review of medication. Student to discuss with GGP. Student to ring/VC/link in with patient (3-way with GGP if applicable) to check adherence, discuss management plan etc. - feedback by GGP.

Sessional GPs

It can be challenging to find time to teach. A viable option could be offering a sessional GP (or other HCP) to get engaged in your practice-level delivered UG education, A local sessional GP could have an interest/expertise in medical education. Offering him/her a session in which they share their patient contacts with a student could be a way to attract a sessional GP to your practice and for the sessional GP

to build up a portfolio. SUMDE payment creates the financial space to do this (1500 pounds for three weeks fourth year, 1200 pounds for two weeks fifth year)

Space in your practice to deliver UG

Direct (face-to-face or virtual) interaction with a patient/carer/family is highly valued as a learning method by students and can be very impactful to learn a variety of skills, professionalism and reinforce or expand knowledge.

Limited space (inadequate premises) and the need for physical distancing at present can be limiting factors to let student conduct their own consultations or let them shadow/actively observe consultations.

Below are some suggestions on how students can get a rich educational experience with direct patient contact and problem-based learning as an underlying principle within these restrictions. Although we still want the students to experience 'the chaos' of real practice they can be 'tasked' with some specific recurrent daily primary care activities and use these as the base of their learning.

-Student can link in or conduct a consultation with supervision remotely on or off site (see '3 way consulting')

-Student could collect initial information (data gathering skills) by looking at the presenting complaint, use of past medical records and ringing/Texting patient. The student could discuss the initial working diagnosis after this data collection with his colleague student. The tutor can then meet with student(s) (virtual if preferred)- discuss their differential diagnoses, set up a management plan which the student can then discuss (under supervision by 3 way consulting if appropriate) with the patient. Other HCPs can use same structure.

-student to view results or Tasks- student to set up plan and contact patient