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The trainer's toolkit: A practical guide to maximising training opportunities

Emily Baird

In light of the overwhelming pressures we currently face in the NHS, in terms of increasing patient complexity and expectation, set against increasing waiting times and an increasingly resource-constrained environment, it may be all too easy to side-line training. However, with the rallying call of ***'No training today, no surgeons tomorrow'***[1] our trainees, and the generations of patients we will treat in the future deserve better. Already we are seeing trainees approach Completion of Certificate of Training (CCT) with far less experience, as evidenced by lower logbook numbers, and there is a risk of a whole generation of young surgeons being under-exposed and under-trained. So, how do you go about maximising training and stocking up your **'Trainer's Toolkit'** with all you need to support training in the most efficient way possible? How do you ensure your training tools are regularly sharpened? How do you gauge whether you are training to today's standards?

The loss of the firm structure and the reduction in working hours has meant that the days of spending time as a stable team has gone. To make up for this, training must not be thought of as separate from service, but integral to it. This re-framing will allow training opportunities to be realised in the everyday and the appreciation that running a good service leads to good training, which in turn positively feeds back into the service (Figure 1).

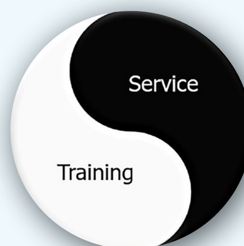

Figure 1: The 'ying and yang' of training and service.

However, the trainee may be unfamiliar to you; rotating rapidly through their attachments, pulled into teams at short notice to cover gaps and often managing multiple clinical areas simultaneously with a bleep that does not seem to stop. Trainers may feel less invested in individual trainees if they have not nurtured them from their earlier days and not been involved in their recruitment, or feel they have no say in the overall direction of travel of orthopaedic training. And with training being under-recognised in terms of time and remuneration in consultant job plans, it is no mean feat to prioritise it on a day-to-day basis, and something personally I struggle with, despite my passion for training. Let us consider an average day at work as an illustration.

The day flows from one clinical activity to another with little time to catch your breath, let alone formal teaching. Grasping the **scalpel** from our trainers' toolkit, here we must dissect out each activity, create space and look for opportunities, (Figure 2).

Trainer tools

Check in. It sounds obvious, but asking how your trainee is before diving headlong into the trauma meeting can take a minute or two, but allows you to appreciate what state the trainee is in. Did their car break down on the way to work? Do they have an unwell child at home? Did they get next to no sleep because they were paged ten times overnight? Are they fasting?

All of these factors will affect performance, and potentially dictate how much supervision and encouragement they need that day, and how much training is possible. Grab the **depth gauge** from your toolkit to sense how they are doing that day (Figure 3).

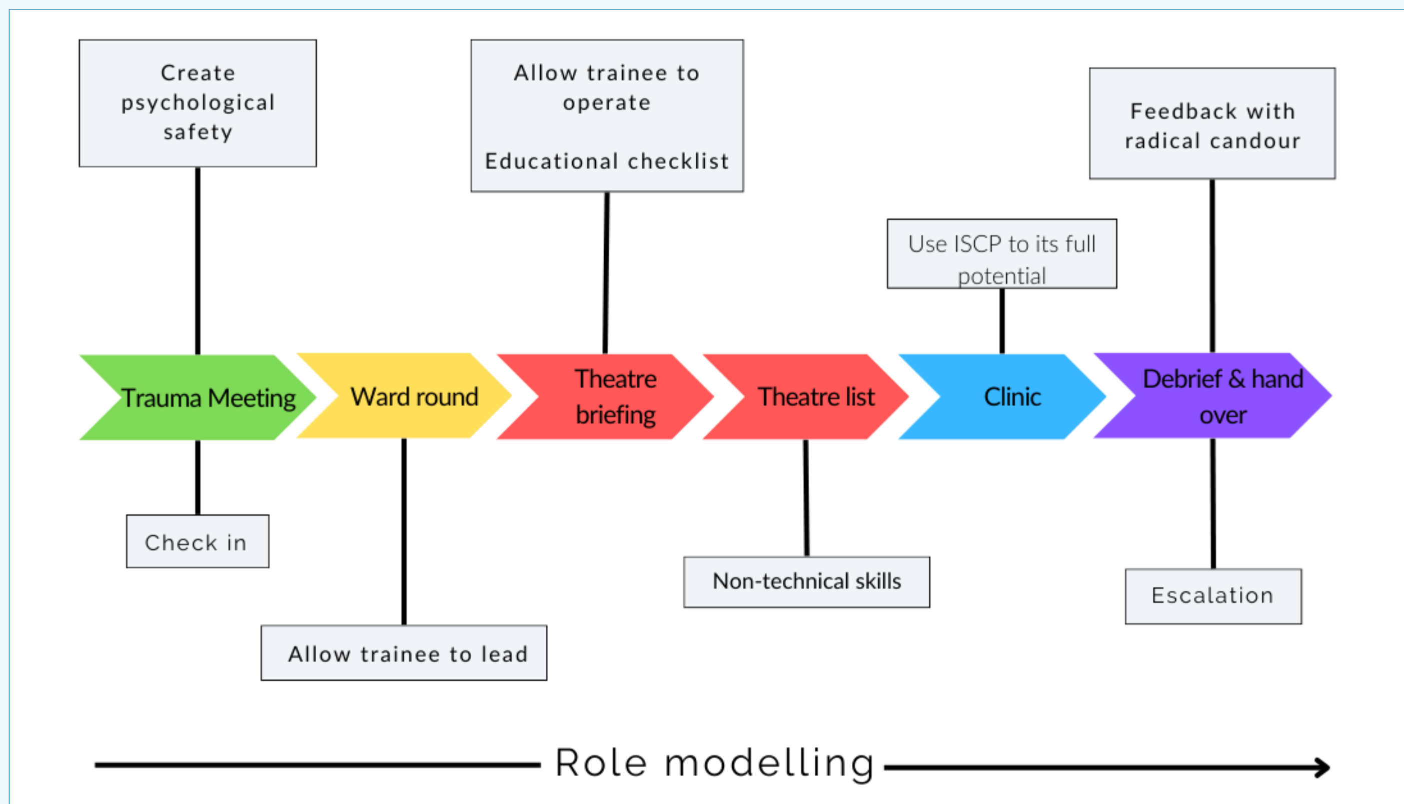

Figure 2: Dissecting out the opportunities of a typical day at work. **Key:** Capabilities in Practice (CiP)[2] **Green:** Manages the emergency take; **Yellow:** Manages ward rounds and the ongoing care of in-patients; **Red:** Manages an operating list; **Blue:** Manages an outpatient clinic; **Purple:** Manages MDT working.

Create psychological safety. Meetings such as the trauma meeting and morbidity and mortality meetings are traditionally hierarchical and transactional and this can be an intimidating environment. Trainers may look upon trainees as less able and less experienced than they were at a similar stage, and even as 'snowflakes' but this is from a place of privilege at the top of the hierarchy and often through the lens of survivorship bias. Trainers may also become accustomed to heated debates over decision-making, but this may be perceived as hostility and lacking a supportive environment. We would all benefit from a more psychologically safe environment to discuss cases robustly, but with civility[3], and seek out the learning points from differing opinions. Grasp your favourite pair of **dissecting scissors** from your toolkit to create safe space to operate and avoid causing harm.

Allow trainees to lead. The end point of training is no longer a time-based phenomenon, but with the new curriculum[2] and in accordance with standards set out by the GMC's *Excellence by Design and Shape of Training* reviews, it has become outcomes-based, with the goal of achieving the competencies of a day-one consultant. As such, trainees no longer 'serve time' as an apprentice, but require an individualised approach. Generic Professional Capabilities (GPCs) need to be demonstrated in a range of Capabilities in Practice (CiP) as evidenced with Work-based Assessments (WBAs) and in the Multi-consultant Report (MCR). Leadership is an essential GPC, often poorly taught and up until recently, usually not assessed. Allowing the trainee to lead the trauma meeting, ward rounds and pre-operative briefing goes against the age-old, hierarchical grain, but serves to trust and allows the trainee to make decisions in a supported environment, developing their leadership style and enhancing performance. So figuratively, **take your tools, hand them over and switch to the other side of the table and observe**, so that you can fill out the leadership section of the MCR with robust evidence.

Allow trainees to operate. Literally hand over your tools! Every trainer has their own 'set-point' of how much of a case they are prepared to 'give away' to the trainee. This is based on many intrinsic factors such as a trainer's own experience and comfort level with the procedure, their engagement with training as a process and their perception of risk. Many extrinsic factors are at play, such as the complexity of the case, time pressures and their assessment of the trainee's competence. The latter in particular is subject to internal bias, and we should all seek to turn our unconscious biases to conscious biases so we can take steps to address them.

Often conversations and decisions about who is holding the scalpel are made whilst scrubbing, but in an ideal world, this should be discussed in advance to allow the trainee to prepare. When that is not possible, for example an urgent trauma case, a useful tool in the box is the **Surgical education checklist**[4] (Figure 4). >>

Figure 3: "On 1-9 of the rubber duck scale, how are you doing today?"

Figure 4: The surgical education checklist.

Ranked operations List (Top 20)

		Total	A	S-TS	S-TU	P	%A	%Sup	Nat Avg %A	Nat Avg %Sup
THR cemented	Total	30	21	9	0	0	70	30	51	47
	CT1/2	0	0	0	0	0	0	0	90	10
	ST3/4	0	0	0	0	0	0	0	55	44
	ST5/6	13	8	5	0	0	62	38	46	53
	ST7/8	17	13	4	0	0	76	24	37	58
THR hybrid	Total	30	19	11	0	0	63	37	54	44
	CT1/2	0	0	0	0	0	0	0	88	12
	ST3/4	0	0	0	0	0	0	0	62	37
	ST5/6	22	12	10	0	0	55	45	51	48
	ST7/8	8	7	1	0	0	88	12	45	52
TKR	Total	28	20	8	0	0	71	29	47	51
	CT1/2	0	0	0	0	0	0	0	87	13
	ST3/4	0	0	0	0	0	0	0	52	47
	ST5/6	21	14	7	0	0	67	33	41	57
	ST7/8	7	6	1	0	0	86	14	39	57

Figure 5: An example of a Trainer's Analysis Report from the e-Logbook.

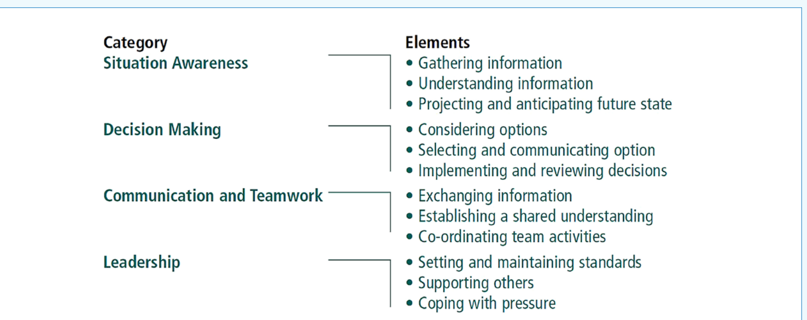

Figure 6: The non-technical skills for surgeons (NOTSS) taxonomy.

Where possible cases should be identified to the wider team as 'training cases' and lists planned accordingly to minimise the occurrence of *"I'm sorry we've run out of time, I'm going to have to crack on with this one…"*.

Hopefully we heed the clarion, post-COVID-19 call of the Joint Committee of Surgical Training (JCST), the Association of Surgeons in Training (ASiT), the British Orthopaedic Trainees' Association (BOTA) and the Confederation of Postgraduate Schools of Surgery (CoPSS) to champion ***'Training anytime, any place, every case – no excuses'***[5] despite the challenges in doing so. You can download your own record of which cases you supervised trainees versus those you perform yourself from the **e-Logbook**[6] (Figure 5), and Training Programme Directors (TPDs) can use this to help in planning rotations to maximise training opportunities.

Figure 7: Radical candour.

Non-technical skills (NoTS) are fundamental tools in your surgical toolkit, and there is growing recognition of their importance at improving surgical outcomes[7]. Trainees are now formally taught NoTS, and these competencies feature heavily in the T&O curriculum[2] and should be assessed just as technical skills are. Although the cognitive skills of situational awareness and decision-making, and the social skills of communication, teamwork and leadership develop with time and experience, few trainers were specifically taught them, and as such it is important to reflect on your ability to teach and assess NoTS. The NOTSS behaviour assessment tool and training system was developed by surgeons using human factors methodologies, and using the taxonomy below, trainers can observe, rate and provide feedback (Figure 6). **Make sure your non-technical tools are as sharp as your technical ones** and consider a masterclass to hone your skills[8].

Give feedback regularly. Normalise everyday conversations about what went well and what didn't, such that the skill of giving honest and appropriately critical feedback is developed with time, and trust between trainer and trainee built up. A good trainer cares about their trainee and is invested in them, but is not afraid to challenge and act with **radical candour**[9] (Figure 7).

Feedback can take many forms, from informal to formal, verbal to written. Ask the trainee what they prefer – often they will be more educationally savvy than you are!

Feedback ideally should be documented contemporaneously on ISCP, as a Work-based Assessment (WBA), post-MCR feedback session or a Journal Note[10]. A practical guide to improving feedback and reflection to improve learning[11] and the BOA's virtual Training Orthopaedic Trainers (V-TOTs) course[12] cover this in greater depth and are highly recommended.

Many trainers do this automatically, and for some it needs to be more effortful. Look around your colleagues, reflect and mirror their positive behaviours, and seek *their* feedback. Many trainers are unaware of the functionality of ISCP and its important place in the Trainer's toolkit.

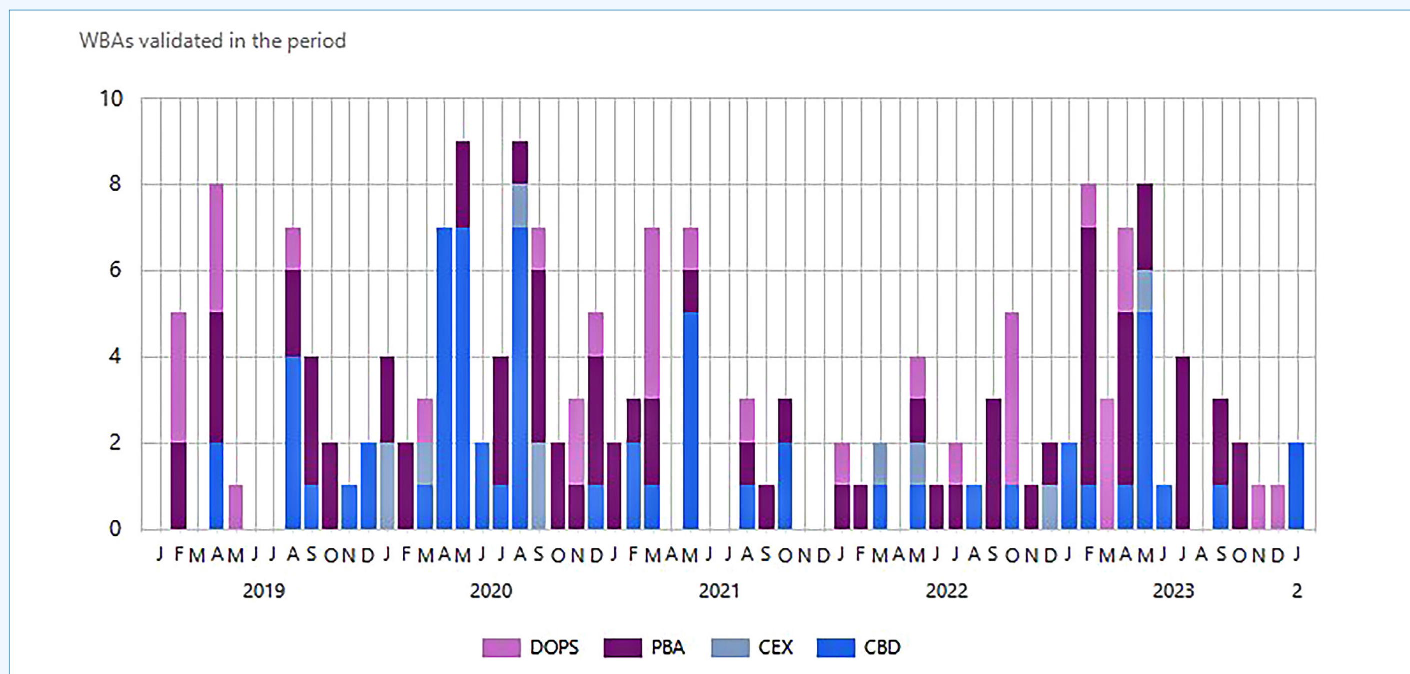

Figure 9: ISCP evidence of WBA completion.

Here you can find space to create your own **Trainer profile** to set expectations for trainees and what they can expect from their time with you (Figure 8), collect data on the number (Figure 9) and timeliness of **WBA completion** (Table 1), and collate feedback from trainees and trainers – all excellent evidence for appraisal and obtaining Recognition of Trainer (RoT) status[13].

ISCP INTERCOLLEGIATE SURGICAL CURRICULUM PROGRAMME

MENU · DASHBOARD · MY TRAINEES · TRAINER AREA · FAQS

TRAINER AREA

This part of the ISCP is intended to allow the collection of evidence by trainers to help them show to the GMC that they are eligible to be recognised as trainers.

EVIDENCE COLLECTION

- Trainer Dashboard
- Trainer Profile
- Assessment Summaries
- Reflective Notes
- Document Library

QUESTIONNAIRES

- Trainee Questionnaires
- Trainer Questionnaires

FIND OTHER TRAINERS

- Search Profiles

Figure 8: The ISCP Trainer's Area.

Escalation. As medics, and particularly surgeons, we feel we need to have the solutions to problems and be the one to personally act to resolve issues. **Sometimes we don't have the correct tool in the toolkit at all.** Trainees lead complex lives, full of challenges, many of them unseen, and trainers need to know where their limits are in terms of being able to adequately support trainees who divulge issues, and when to escalate. If a trainee comes to you **actively listen. Your greatest tools are your ears**. Often acting as sympathetic ear or a sounding board is all that is required, but most trainees will need additional support at some time of training, so reach out to your TPD who will be able to signpost to local resources or refer them on to services such as occupational health, or professional support, wellbeing and development services[14-16].

WBA type	Average days from WBA to submission	Average days from submission to validation	System-wide average days from submission to validation
CEX	28	8	16
CBD	12	5	18
DOPS	18	4	19
PBA	18	6	21
Audit	6	3	14
Teaching	3	5	17

Table 1: ISCP evidence of timeliness of WBA completion.

Role modelling. It is not just what tools you have in the toolkit that matters, but how you use them, and how your trainees go on to develop their own skills and behaviours. Trainers can adopt many roles: educator, coach, manager, advocate, academic, mentor, but running through all of these is role modelling: demonstrating skill, providing feedback and emulating professional behaviour. A great trainer will shape the lives of their trainee, not just in the six months they are working alongside them, but potentially their entire career. We can all remember influential trainers and their impact. Strive, even with the challenges we face on a daily basis, to be that trainer.

I would be fascinated to hear what is in your trainer toolkit, and how we can work together to champion training. Please get in touch and let me know: Emily.baird@nhslothian.scot.nhs.uk or @emilyjanebaird. ■

References

References can be found online at www.boa.ac.uk/publications/JTO.