Induction - helping trainees settle into their practices

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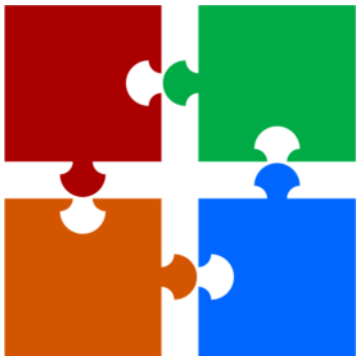
Introduction



Do you remember your first days starting out in General Practice? In many respects, it resembled a birth. We arrived tightly holding onto our new doctors' bags into a strange world. Here, consulting was so different to what we had been used to in hospitals. We thought we had to know everything and our trainers wondered would we survive. Those trainers comforted us with a "towels and hot water" approach and brought us to their way of thinking and doing. They might not have called it an "Induction" but nonetheless their methods worked enabling us to tackle what was a challenging time.

What then was it in their approach that helped us survive and would it still work for our trainees today? To answer these questions, we must first look at the meaning of induction and what it is that we are trying to achieve through it.

What then is Induction? What's it purpose?

An induction is simply a process you use to help integrate a trainee into their new role and the organisation (in this case, the practice) as a whole. Many of you have been 'inducted' yourselves and will recognise some of the components of induction:

- Processing some necessary details
- Introducing the trainee to new surroundings & letting them know where everything is
- Informing the trainee about your organisation and how it works
- Apprising the trainee about their job – what's really involved, what's involved on a day to day basis, what's expected of them etc.
- And ensuring the trainee will be safe in the workplace (including things like health and safety information, fire safety etc...).

BUT if we step back a little and look at the overall picture, it's more than just that! **And this bit is important:**

- It's the opportunity for developing a really good trainer-trainee relationship
- And if you get that right, it's the stage where you can start motivating new trainees
- It's the time when you can start developing an initial set of learning and educational needs of the trainee (and thus start developing a personalised learning plan for them)
- As well as enabling them to settle into your practice, find their bearings and thus become productive and efficient team members over a short period of time.

So, induction is more than just about helping new people survive the first couple of weeks. Think of the latter bullet list as the overall aims and the former as the objectives (see Chapter 4: Powerful Hooks - aims, objectives and ILOs).

Come on! Is induction really necessary?

You might be wondering "*Is induction really necessary? Come on! I was thrown in at the deep end and it didn't do me any harm*".

Throwing people in at the deep end is not good practice because:

a) It's ineffective meaning it takes longer for the trainee to settle in.
b) More mistakes are made by the trainee that could have been avoided (and will cause you, the practice and the trainee unnecessary frustration)
c) Experience might improve confidence but not necessarily competence. Good induction will allow trainees to make mistakes so they can be corrected (and thus learning to take place): without fear of retribution.
d) Some trainees will end up leaving their new jobs or change careers at an early stage (and perhaps making a wrong life decision).

So yes, you have a professional responsibility to provide induction to your trainees.

Did you know?

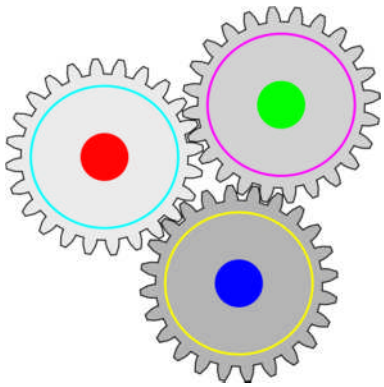
It is becoming an increasingly legal requirement for employers to provide induction (by the way, health and safety is a non-negotiable legal requirement). You might think of yourself as the trainer, BUT don't forget that your practice is also the employer (not the Deanery!).
Research also tells us that induction also makes good business sense (1) for your practice. Failing to provide good induction is seriously false economy.

How long should induction last? Is 2 weeks enough?

It's common for trainers and books to usually refer to a specific 2 week course termed an induction program. But we think that sort of thinking is misguided…. They're missing the point!

The usual induction programme should be seen as **the initial phase of an integration programme**: providing particular needs and ongoing support that trickles throughout the period of time the trainee is with you.
So, we can say induction is really complete when the trainee becomes fully integrated into the practice. You can't put a timescale on this: it's different for different individuals. That's why you need to be flexible: some trainees will require more input than others. You get some idea of this if you create an environment in which you encourage the trainee to **ask questions and engage in dialogue**.

Induction in terms of process and content



So now with the basic stuff out of the way, we hope we're both on the same wavelength. Let's move onto the more practical side of going about induction. To make this easier, it's best to split induction into two bits – that of:

- **Process** – the way one might go about induction covering things like some core principles and the different methods one might use
- **Content** – the actual make-up of induction

If you find terms like process and content difficult, think of it this way: let's say you've got a little car building project you'd liked to have a go at. The way you build that car is the process, and the actual components you'll need to make it is the content. Any clearer?

Some tips on the induction process.

This is what our own trainers may have found wrapped in the towels that came with the hot water. The ultimate aim of trainee induction is **to foster a learning environment and encourage learning** (2).

But how do we actually foster a learning environment?

- You have to **get to know each other.** Learn about each other's lives and backgrounds. Some trainers go out for a relaxed 'chilled out' lunch/dinner with their trainees. Seriously, try it. Whatever method you use, do spend time on this: it's often the first point where dialogue is created and questions encouraged.

- A good induction always has to be **trainee focused albeit trainer led**. Its principles are based on the **trainee's educational needs**, many of which are generic (3).

- But induction is not just about showing the trainee you're going to try and meet their educational needs. It's also about **demonstrating a true investment in them as a person** (as opposed to an employee or trainee). Don't you feel good when someone shows real interest in you as an individual person?

- Whilst the trainer's role is to plan and structure the induction, the practice's role is to deliver it. Remember, you don't have to do everything yourself: you'll burn out otherwise. By **getting others involved**, you're establishing a **practice ethos towards training**: where GP training is seen as a practice activity not merely 'something only to do with the trainer.'

- And to carry on with that note, induction is best delivered as **practice based tasks**: where the trainee is inducted via a series of learning events delivered by different members of your practice organization. And that means **involving loads of different**

people including reception staff: why not ask them to CREATE as well as deliver a session? Offer them your hand of guidance. Many will find it enjoyable, rewarding and developmental (and again, truly feel part of the GP training process).

- A good induction program always **involves lots of contact with the practice team**. So make sure you plan your introductions and the tour of your practice as early as possible. Organizations depend on its team members working together and for that to happen, relationships need to form. And don't assume the trainee will automatically make good relationships. Some are very shy and introverted: so design an induction which helps to make it happen. Consider briefing your colleagues early on, even before the new trainee's arrival. Nominating someone (you or the practice manager) ensures that the trainee has assistance to settle in quickly. Introduce them as early as possible: may be by welcoming them at a practice meeting, during the tour of the building or by going around specific groups. However you do it, do it early.

- One of the most crucial people to involve is **the practice manager**. If your practice manager shares the **same vision, energy and devotion** towards GP training right from the beginning as you, you can almost guarantee the rest of GP training as a delightful, rewarding and headache-free activity.

- If possible, try and involve the outgoing trainee in some way in the induction process for a new trainee.

- Make sure you issue an **induction training plan** to the new starter and all those involved so everyone is aware what is involved, who is involved and when. Again, this encourages a practice approach towards training. It also tells the trainee about what to expect and helps them 'buy into' the process.

- **Be available** to hold the trainee's hand. Many trainers take their family holidays during the month of August when new trainees start. This can really wreck a good induction period and can make it difficult for a bond to form between trainer and trainee (and it creates tension with your other work colleagues who often have to pick up the pieces). So, make sure trainees are looked after properly and not left on their own to work things out and remember: **first impressions count!**

- No doubt some of the stuff one has to cover in induction is going to be dry. But try, where possible to **be creative, add variety and use different formats** to nurture interest, excitement and dynamism. Use a mixture of teaching methods like the typical 'chalk and talk' classroom-style training to encouraging the trainee to go away and find out for themselves. Just to give you more of a flavour, you might also consider:
    - Sitting in with different people (and possibly swapping roles)
    - Doing specific tasks rather than simply observing or shadowing
    - Setting some background reading assignments

Special Areas to consider

When developing an induction plan for the following groups of people, some things need to be borne in mind:

International Medical Graduates

- Language difficulties
- Cultural differences
- Attitudinal problems (which may stem from cultural differences)

Disabilities

- Extra sensitivity
- Identifying barriers like
    - What form of assistance is required to make the job easier: remember, people with disabilities can work as effectively as their able counterparts. And often, the changes required are small and relatively effortless.
    - A lack of confidence
- Job coaches – people who will work with the employer and the new employee during the induction process identifying barriers and addressing them effectively (contact local disability service for more information).

Feeling a little exhausted? Take a break and then come back when you're feeling a bit more refreshed.

Scene: A trainer's meeting somewhere in UK

Dr Newt Donohoe (ND) is talking to Dr. Ben wise (BW), an experienced GP trainer. Newt is a new trainer and was Ben's registrar only 10 years ago.

ND: *GP Training has changed a lot since I was a registrar with you.*
BW: *I know, have you heard the one about a trainer and a trainee walking into a building?*
ND: *No, what happened?*
BW: *The trainer got hurt!*
ND: *Very good, It often seems like the trainees always know where the door is and we trainers are playing catch up all the time.*
BW: *It sure does*
ND: *I mean, I don't remember "induction programs" and the like. I've my first ST3 coming in the next month and I'm a bit apprehensive about it.*
BW: *Well, if you have time for a coffee, we could talk about it?*
ND: *That'd be great – like old times eh, those impromptu coffees in my registrar year.*

(Both trainers are now seated with their coffees)

BW: *I know there's a lot of jargon. But really the starting point to induction is planning and structuring it.*
ND: *Does this take a lot of time to do? We're so busy with the QOFs.*
BW: *Tell me about it, I don't know where general practice will end up...don't get me started on that. But I suppose with all these changes in GP training, we have to look at the induction of trainees again. I planned it over several hours, set up a practice meeting and discussed my plans with the team. I haven't had to spend as much time with planning since then.*
ND: *Well, how should I go about starting?*
BW: *Simple -* ***Involve the practice team and you'll definitely need your practice manager on board for this one.*** *If you do this, the trainee will think the first couple of weeks all so natural. What's more, once you've done it, you can draw on your planning again for your next trainee. Start with putting together an induction pack.*
ND: *An induction pack? Tell me more…….*

Induction – the nitty gritty (the content)

Okay, to recap, the induction program should include the following elements:

- **General training** relating to your organisation, including things like structure, history, values and the philosophy behind why you train
- **Mandatory training** like health and safety and other legal or essential areas
- **Job training** relating to the role that the new trainee will be performing
- **Education & learning training** covering areas like 'giving and receiving feedback' and an exploration of **personal strengths and development wishes** so that the trainee is seen as an individual rather than a name or function
- **Evaluation**, detailing where evaluation fits in, including evaluation of the induction programme itself.

We can describe the content and how we use it as a series of three links in a chain. We'll look at each link in turn and then put it all together again. We're hoping this approach will help to structure this section and therefore make it easier for you to understand.

The 1st Link – Planning and Structure

A good stating point is to prepare an induction pack. What we include in our induction pack is listed in the table below. We find it comprehensive but you may wish to include or remove items. We download the templates for each of these components from the Bradford VTS website (4) and adjusted them to suit. We send the contents to the trainees before they arrive.

Induction Pack example

(courtesy of www.bradfordvts.co.uk)

For each of the things below, we're NOT going to provide you with examples or templates; it would take up far too much space. However, there is a comprehensive set of templates and examples that you can use and modify from the Bradford VTS website:www.bradfordvts.co.uk (click on "training map for GP" on the homepage). Also your local deanery or other nearby local training practices may have more relevant material for your region (they often do!).

Contents	Notes	Suggested Responsibility
Introductory letter and request for certificates	It's good to make contact with the trainee before they start. Send them a welcome letter and any other information that can be sent beforehand. This is also a good way of breaking up the information overload that often happens during the induction period.	Practice Manager
Registration on performers list	Trainees should have done this themselves	Practice Manager
Training Grant Application Form	Deanery may have separate procedures	Practice Manager
Employment contract	Does your local deanery have one?	Practice Manager
Educational contract	Local deanery may also provide a suggested template	Trainer but Practice Manager to send out
Proposed timetable for induction programme	You need an induction programme tailored to the individual trainee. Involve your practice manager. Things like sitting in with doctors, nurses, reception, pharmacy etc need to be incorporated into the plan.	Practice Manager
Practice Booklet and or Practice website reference		Practice Manager
Learning needs assessment questionnaires	More details below.	Trainer but Practice Manager to send out
Trainee Inventory	A trainee inventory is basically a checklist of tasks that should be achieved within the first few weeks of starting GP.	Trainer but Practice Manager to send out
Practice Inventory	Another checklist to make sure you and your training practice have got everything sorted ready to take on your next trainee.	Trainer but Practice Manager to send out

Okay, now let's talk a bit more about each of these in turn.

Employment Contract and Employment Law

As an employer, you can agree your own contractual terms with your trainee, provided you comply with certain statutory rights (8). In the UK, the main employment legislation is the Employment Rights Act 1996 and employers must also protect the health of their employees (2).

The deaneries have a major role and usually address pay issues, pension, part time working, allowance and expenses. Trainers should know the statutory rights relating to hours and holidays, maternity rights, parental leave, sickness and invalidity. You are also involved in relation to discrimination issues and health and safety (2).

Our practice uses a statement of terms and conditions of employment. We also include health and safety in our inventory. We delegate employment issues to the practice manager and liaise closely with the deanery. The BMA provides a framework for a written contract of employment for GP specialty trainees and this is also a useful resource (5).

Education contract

The purpose of this is to outline what both the training practice and the GP trainees are signing up to. Contracts vary but their primary aim is to make explicit what the trainees can expect in their training from your practice and what is expected off them in terms of their education.

An Educational contract should cover things like:

- Practice based teaching - times and methods
- Supervision of training
- Study leave (entitled to 30 days, including day release),
- Out of hours arrangements (determined by Work Based Placed Assessment (WBPA)),
- Business/practice meetings (when the trainees attend),
- Half day or day releases and
- Performance review (linking in with WBPA, assessments and reviews).

Other areas covered may include trainees' appointment times and tasks expected during training including audit and guideline reviews, career guidance and out of practice teaching arrangements.

We would highly recommend putting an educational contract in place because it sets out right from the start what is expected from each and makes sure you're both on the same wavelength. It reduces the chances of difficulties later on because you both have a clearer understanding. It's also helpful when there are difficulties with trainees because quite often

the difficulty will relate to a breach of one of the expectations. There are several types of educational contract templates on www.bradfordvts.co.uk . We prefer the ones written in less formal language as they are friendlier and less frightening for trainees.

The Timetable

The timetable follows on from the education contract. There are two timetables you will need to develop

a) An induction time table outlining what's going to happen in the new couple of weeks
b) A regular timetable - outlining surgery times, tutorials, day release commitments and on call arrangements once the induction period is over.

Use the timetable and the education contract to secure protected time for looking at the e-portfolio, doing work place based assessments. An example of each of the two timetables is provided below to help illustrate this further. Take a look at it closely to see what's going on where. Seeing well thought out timetables like these is also very reassuring to the new trainee, and helps make a very positive impression about their new place of work.

INDUCTION TIMETABLE WEEK 1

	WEDS	THURS	FRI	MON	TUES
AM	**8.30-10.30 am** **practice manager** *greetings, practice tour and meet others* **10.30-12** **with trainer** *introductions, why we train, the practice etc.*	**8.30-10.30** **Dr. Krishnan** Sit in surgery Discuss: why patients come to see the doctor* **10.30-11.30** **Sitting in the waiting room** & then discuss with Dr. Krishnan*	**8.30-10.30** **Dr. Sandhu** Sit in surgery *Discuss: how did consultation style differ from yesterday* **10.30-11.30** **Visit Pharmacist** *What happens to a prescription**	**8.30-11.00** **With trainer** *Developing a learning plan; reviewing e-portfolio* **11-12** **Free Time** *To collect your thoughts and mingle**	**8.30-11.30** **Dr. Bamber** *Sit and swap surgery*
	12-1 lunch with trainer	Visit with Dr Krishnan	Visits with Dr Sandhu	Visits with Dr Lunat	No visits – get to HDR on time.
	LUNCH				
PM	**1-3** **with trainer** *learning styles, training needs analysis, feedback principles, ethics, , responsibility, educational contract.* **3-5** **practice manager** *employment contract, check certificates, get personal details, health, safety & fire, confidentiality*	**1-3.30** **Practice In House Teaching** *We call it PLT (practice learning time)* **4-6** **Deputy practice manager** *Learning how to use the computer system**	**1.30-3** **Nurse Jenkins** *What do nurses do? ** **3-4** **Coffee Break** **4-6** **Deputy Practice Manager** *The patient medical record system – getting to grips with EMIS**	**1.30-5** **District Nurse Stockdill** *What do district nurses do? * Go on visits with them.* **5-6** **With trainer** *How's it going?*	*1-5pm* *HALF DAY RELEASE* *(Bradford Royal Infirmary)*

**Use specific task sheet in conjunction with this activity – www.bradfordvts.co.uk has many under the "training map for GP" section – click on "first month of training" and then look under "sitting in with different members of staff"*

REGULAR TRAINEE TIMETABLE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	**8-9pm** *practice meeting* **9-1050** *Tutorial time: COTs* **1050-1pm** *Surgery* **CS: Dr. Mehay**	**9-11** *Surgery* **11-1130** *Debrief* **CS: Dr. Kumar**	**9-11** *Surgery* **11-1130** *Debrief* **CS: Dr. Bamber**	**9-11** *Surgery* **11-1130** *Debrief* **CS: Dr. Mills**	**8.30-10.30** *Tutorial time: CBDs* **10.30-1200** *Surgery* **CS: Dr. Mehay/Dr. Khan (alt weeks)**
	NO VISITS (baby clinic)	1 VISIT ONLY	1 VISIT ONLY	VISITS	VISITS
LUNCH					
PM	**1.15-2.15** *Baby Clinic with Dr. Mills* **3-5pm** *Surgery* **5-5.30** *Debrief am & pm* **CS: Dr. Khan**	*1-5pm* *HALF DAY RELEASE* *(Bradford Royal Infirmary)*	**1300-1400** *Weds Group Tutorial 1 hr (Bradford Royal Infirmary)* **3-5pm** *Surgery* **5.30-6pm** *Debrief* **CS: Dr. Mehay**	**1-3.30** *Practice Protected Learning Time Session* **4-6pm** *ADMIN time*	**3-5pm** *Surgery* **5.30-6pm** *Debrief am & pm* **CS: Dr. Mehay/Dr. Khan (alt weeks)**
	Days marked with COT/CBD may be replaced by other educational methods eg RCA, PCA, Gask's PBI etc CS=Clinical Supervisor				

One of the important things about the regular trainee's timetable is the inclusion of debrief time. This is time where trainee and one of the doctors in the practice quickly go through surgeries to make sure the trainee is clinically on the right track, has not made mistakes and to iron out problems where identified.

Back to Drs. Newt Donohoe (ND) & Ben wise (BW) – how are they doing?

ND: Are there any references I can use to draw up the induction pack?

BW: Yes, the Bradford VTS is a must see with a template for most things in the induction pack and your deanery may have plenty to offer. Again, check out the Bradford VTS website. You can use its templates freely.

ND: I'm also a bit worried about employment law, anything legal always scares me?

BW: I know. ***The deanery recruits the trainee but you are the employer*** *so in essence you have legal responsibilities. Your practice manager and the team need to understand this and draw on their experience that they already have as employers. The most important thing is to work closely with the deanery especially on things like sickness leave.* ***The deanery needs to know about this about it as it may affect the trainee's training.***

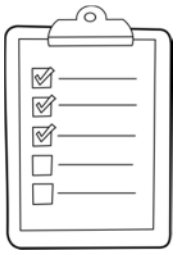
ND: Right and when I have the pack ready, when should I contact my new trainee? I remember meeting up with you before I started.

BW: Well, the trainee may already be in a practice and it might be difficult for him to come and see you before he starts, but you do need to contact him before he arrives. I usually phone the trainee a month or so before he arrives.

Trainee Inventory

As mentioned above, an inventory is a **list of fundamental tasks.** Not everything in the inventory needs to be checked off within the first week. It might take several weeks: in this way, it avoids overloading the trainee during the first few weeks whilst ensuring vital areas are covered. The purpose of the inventory is to check AND address basic areas of trainee induction. These include

- orientation,
- computer and administration,
- clinical and
- educational areas
- An Initial consultation helper pack



Many of the tasks are common to all trainees: so you should be able to use the inventory again and again for future trainees whatever stage of training they are at.

We use an inventory available on the NIMDTA website (6). Click on the F2 induction document and you'll find the inventory on page 10.This inventory was standardized for foundation doctors and contains over 100 tasks. We tend to use it in its complete form as a checklist for all trainees, regardless of their stage in training. Tip – consider using it to help draw up your own inventory.

The most important thing about the trainee inventory is not just to see it as just a tick box exercise. Address those difficult areas it identifies.The BMA (7) also provides guidance for trainers if trainees find the cultural environment unfamiliar to them in their new practice.
Here are some things the trainee inventory should include:

PRACTICE MANAGER'S CHECKLIST

- Tour of the building including fire exits, emergency equipment, coffee/tea, kitchen, toilets, noticeboards, other sites, parking and of course their room.
- Introduction to other practice team members.
- A bit about the practice and the practice leaflet.
- Health and safety information.
- Fire safety information.
- Other practice policies and procedures that affect the trainee like absenteeism, lateness, sick leave, security policy and confidentiality.
- Job description & work contract – an explanation of terms and conditions

ADMIN/RECEPTION

- Basic training on things like the telephone or computer system.
- Showing the trainee pigeon holes, letter trays and forms.
- Dictating letters – equipment, how to dictate and so on.

TRAINER'S CHECKLIST

- An overview of the practice – mission statement, goals, values, philosophy and history.
- Trainee's duties – and how they fit with the structure of the practice.
- Expectations, standards and current priorities – cover things like lateness, doing their educational homework!
- Feedback – going through the principles of giving and receiving feedback.
- Learning styles self-assessment.
- Training needs analysis and the development of personal objectives and goals.
- Opportunities for self-driven development.
- Ethics, integrity, corporate social responsibility.
- Training support, assistance, mentor support – where to go, who to call, who to ask for help and advice.
- Training review sessions – dates etc.
- Educational contract.
- Initial training plans after induction and starting 1-1 coaching.

The Practice Inventory

You should also try and develop a practice inventory: a set of fundamental tasks that need checking off AND addressing; this will ensure **your practice is ready to take on the new trainee.** There may be overlap with the trainee inventory. It should include things like (again, this is not an exhaustive list):

PRACTICE INVENTORY

- Preparing the trainee's consulting room,
- Checking consulting/examination equipment required
- Have surgeries been blocked off for the couple of weeks and then set at appropriate intervals?
- Have video surgeries been block booked?
- Has both trainee and trainer been 'released' and 'protected' for induction?
- Have trainer-trainee weekly tutorials been booked
- Has the induction plan been circulated to everyone involved?
- Updating the library
- Checking the IT equipment – computers, internet access and video recorders
- Sorting out keys, smart cards, practice system usernames and passwords
- A dedicated pigeon hole for letters etc. for the trainee
- Nominated partner for looking after the trainee when the trainer is away (annual/study/sick leave etc.)

The Second Link – your induction in action

The Initial contact

Many trainers benefit from contacting the trainees early. It makes the trainees feel wanted and will lighten workload later when the trainees actually start. Some even go out for a meal together to "break the ice": and they swear by it!

Your aim is to tailor the induction to the individual trainee. We often ask the trainees to identify their own needs and worries and then choose appropriate objectives from this. You might consider contacting their previous practice manager and trainer to ensure there are no difficulties (2) and help determine what they feel you need to focus on.

Later, you will have access to the trainee's e portfolio to review previous clinical supervisor reports and /or educational supervisor reviews to identify any additional issues.

The trainees arrive

This is when a well prepared trainee and practice inventory pays dividends. A nice additional touch is to have the trainees' name on their consulting room door. It gives them a sense of ownership and worth. We delegate the delivery of the tasks to different members of the practice team and much of the first days are occupied with this. As mentioned earlier, if you do use an inventory as part of your induction, NIMDTA have a detailed one on their website (6). You might consider adapting it for your own use. In any case, make it the trainees' responsibility to ensure the tasks are covered and don't forget to ask them to countersign any inventory and keep a copy.

We think it might be helpful at this point to mention the contents of our Initial Consultation Helper Pack that we give our trainees. You might think of other resources for your trainees.

- Local support agencies.
- Local Hospitals & Consultants & Referral guidelines.
- Local Phone numbers.
- Map/Guide of the area.
- Practice Policies, Procedures & Protocols.

Dr Newt Donohoe (ND) and Dr. Ben wise (BW) are now discussing the arrival of Newt's new trainee

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ND: *Do you have a specific timetable for the first couple of weeks?*

BW: *Well, yes, I simply adapt the generic timetable, that I made in the Induction pack. On the first day, I take the trainee and use the induction pack as the basis for discussion. I ask Cathy, our practice manager, do you know her?*

ND: *No, I don't think so*

BW *Of course you wouldn't. She started after you left, she's excellent, and anyhow, I ask her to take the trainee for an introductory session on the first day. After that, we meet up and structure the remainder of the induction.*

ND: *I'd be worried; I'd be left with a trainee with no identified needs and say a week or two to fill, or worse, a trainee with so many needs and I wouldn't be able to take the time out from seeing patients to address all his needs.*

BW: *Ah, the worst case scenarios. It has never happened to me, but even if it did, you'll have the*

resources to cope.

ND: What resources?

BW: You see, I have already asked each member of the team to deliver a session. Remember, I have done this as part of my planning. GPs in joint surgeries, nurses – that's practice, treatment room, district nurses and health visitors in joint clinics and or visits, practice manager in administration and so.

ND: Does, this not disrupt the running of the practice?

BW: No, it fits in with what the team is doing and anyway it's a chance for the team members and the trainee to get to know each other. It works really well.

ND: Is there not a danger the trainee will be bored with all this and just going through the motions?

BW: Well, I suppose, but there are ways to stop that happening …

ND: Hold that thought, I just need to make a phone call, are you okay for time?

How to fill the Sessions

- Sessions with trainer might involve
  - Agreeing ground rules
  - Learning more about the trainee and his needs (learning, attitude and personality)
  - Addressing essential learning needs first
  - Joint surgeries
  - Shadowing trainer
- Practice manager and administration team sessions addressing administration and inventory (Detailed)
- Joint surgeries with other GPs in the practice
- Joint clinics and visits with other members of the wider primary care team.
- Trainee Surgeries
- If appropriate, trainees seeing patients on their own might compliment Kolb's four stages in the learning cycle of experience, reviewing, concluding and planning (9).
- Social aspects

(Newt returns from making his phone call)

ND: So you were saying about keeping the trainee interested?

BW: Ah yes, the key is through making the sessions dynamically active based learning sessions – by that I mean setting tasks for each session. I often link it in with the e portfolio.

ND: I'm not sure I understand.

BW: Well take a session where the trainee does a joint surgery or observes a non trainer consulting. Ask the trainee beforehand to identify what the GP does well, what surprised him etc. You can write your own tasks, but they should challenge the trainee to reflect. ***Or set an independent task****. There's loads of different task sheets on the Bradford VTS website to give you more of a flavour.*

ND: Can you give an example of what you call it – an independent task?

BW: Well, you could give the trainee a questionnaire to complete which requires him to talk to people about things other than work.

ND: Sounds like a good idea, do you ever use any of the sessions for the trainee doing surgeries on his own?

BW: Usually a few, but only a few patients at a time. It's a balance and depends on the trainee and his stage of training. In any case the inventory and needs assessment usually throws up plenty to do.

ND: I think I'm getting an idea of how things might go, but I still have a few concerns about aspects of the induction pack….but first would you like another coffee, mine's done.

BW: I'll get these….

We think there are some specific areas worth mentioning at the start of an induction programme.

Ground rules

We think trainers should generally develop their own ground rules. It helps reduce misunderstandings later on (10). When deciding on these rules, discuss them first with the trainees and thus gaining their perspective and ownership. Keep a record of them.

You can address some of the ground rules through the educational contract (assessments, learning log etc) and inventory. Others though deal with attitude and behavior and do not easily fit into an educational contract. They are better discussed. Decide for example if you want to discuss such things as prompt starting of surgeries or informing the trainer or practice manager prior to leaving premises etc. Take your time on deciding what you want to discuss. If you wish to raise the issues relating to dress code, do it sensitively and don't discriminate with respect employment law.

Giving and Receiving Feedback

We also find it's an absolute must to talk about the rules behind receiving and giving feedback. By doing this, you prevent feedback from going wrong. Trainees are less likely to become defensive or blame others if they know feedback is being given to help them become even better rather than in a punitive manner. See chapter 14 for more details on feedback.

Assessing the trainee's preferred learning style, attitude and personality

Including a learning styles self-assessment questionnaire or a multiple intelligences self-assessment questionnaire within the induction process also helps to 'draw out' strengths and preferences among new starters.

There is also a range of attitude and personality questionnaires which can help trainers relate to the trainees. Ensure that new starters are given control of these self-tests - it is more important that they see the results than the employer. Conducting a learning styles assessment also helps the trainer to deliver induction training according to people's preferred learning styles. Chapter 10 has lots more stuff on learning and personality styles.

Assessing trainee's knowledge and skills

We suggest reviewing the trainees' e portfolio and in particular their curriculum coverage. This helps in completing a learning plan. We know we keep going on about the Bradford VTS website, but there's a curriculum self assessment tool there that the trainees can use to specifically map out strong and weak areas (on the home page, click nMRCGP then click AKT and you'll see it there under the downloads section). It's really worth getting them to do it.

The Learning Plan

This helps you plan for the year ahead. WBPA is a major component of this. We find it helps to discuss how e portfolio log entries are managed, including the quantity and quality (type of

reflection expected etc). You may wish to include this in the educational contract. As trainers, you want your trainees to engage in the process and if they don't, it leaves your training open to question.

The Learning plan really helps in tailoring it to their needs and is particularly good for planning tutorial topics especially the early tutorials. We often find this concerns aspects of emergency or primary care issues such as the "doctor's bag", "sick notes" or "how GPs solve problems?" Some trainers ask their trainees to structure tutorials on cases or random cases.

Consider discussing work based assessments and perhaps preparing for future examinations Again the Bradford VTS is a valuable resource for the suggestions.

The final part of the conversation…

(BW arrives with the coffees)

BW: *Newt, those concerns?*

ND: *Well, ground rules, are they really necessary, I mean these trainees are professionals, adult learners and all the rest?*

BW: *Trust me, Newt if your trainee leaves early some day and hasn't told anyone, can you blame him? No, it's best to be up front from the start.*

ND: *I suppose, but the questionnaires, are they really a priority?*

BW: *The learning styles ones?*

ND: *Yeah, and the attitude and personality ones?*

BW: *I wouldn't call them a priority, but I use them because they help me understand the trainee and how to pitch my teaching. Remember, induction is about encouraging learning and these tools are there to help. The trainees always enjoy completing them and learning about themselves. It also gives you an idea about their weaker areas which you might want to consider opening, exploring and strengthening.*

ND: *But I'm not sure, I have the skills to interpret them.*

BW: *I know what you're saying. But they are straight forward enough. Why not start with the Honey and Mumford questionnaire. If you think it is a learning need, you could consider a course or discuss them at a trainers' meeting.*

ND: *I might just do that. Tell me, Ben how much time do you give your trainee? I mean I think I pestered you when I was a registrar during my induction.*

BW: *Newt, I'm glad you asked me that, because a trainee who questions plenty never concerns me. My door is always open during his training but particularly in the first couple of weeks. Otherwise, I don't think I should be training. Talking to the trainee is important, plenty of contact.* ***It's the trainee who doesn't question, doesn't seek advice is the one I worry about.***

ND: *Do you always take the trainee for dinner during the induction, just like you did for me?*

BW: *Mostly but not always. I always make a point of doing lunch with the trainee once or twice during the two weeks. The dinner one,, well, if I do, I either involve the practice team, but holidays and such can sometimes not make this possible. The other option is to invite the trainee and his partner out with you and your partner, but again your trainee might not have a partner. You'll have to judge that one yourself. Other trainers prefer to leave this to later in the year.*

ND:: *Ben, as always you have been really helpful.*

BW: *It's been a pleasure; now tell me how Jane and the kids are getting on?*

The final link in the induction chain – Evaluation

When the first few weeks are over and the dust has settled, you should ask your trainees for feedback. Trainee questionnaires are available, which are validated. (Check the Bradford VTS again). Otherwise you could structure your own. These can help improve the programme for your next trainee.

We think induction training is a continuously evolving and improving process. But evaluation doesn't just stop there. Consider also seeking feedback from the staff, who have helped provide the induction training. And don't forget to discuss the results with other members of your team, with particular reference to praising people personally who have done well.

Summary

In this chapter we looked at the aims and objectives of induction, the process and the contents involved and at ideas on how you might link it altogether. At the start of the chapter, we also questioned whether or not our own trainers' approach all those years ago would work today. After all, our trainers' consulting door "was always open", and there was much good in what they did.

But General Practice continues to evolve as has the need for reviewing how we induct our GP trainees. We hope that this chapter will help provide some ideas and resources for you to build on the" blanket and hot water approach". Best of luck with it!

Valuable web sites

- http://www.bradfordvts.co.uk/ (click on "training map for GP" on the home page)
- http://www.nimdta.gov.uk/general-practice/foundation-year-2/fy2-induction-pack/

A sample of some of the resources on our website

- The way a trainee develops – Maslow
- Various learning needs assessment tools – GP curriculum, TISA, Manchester etc.
- Things to discuss – practice matters, educational matters
- Various task sheets – sitting in with the Dr, why do patients go to see the Dr, how to doctors problem solve, the pharmacist, the health visitor etc.
- Feedback handout for the trainee

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