

Fellowship Report

Introducing and Evaluating the Structured Learning Programme (SLP) Pilot

Dr Mahwish Usman

Introduction

Taking on this fellowship role gave me the opportunity to help introduce the Structured Learning Programme (SLP) pilot into GP training, at a time when expanding training capacity was a genuine strategic priority but the appetite among trainees and trainers for yet another new initiative was, understandably, limited. Looking back over the year, the experience has taught me as much about leading change in a large, dispersed system as it has about the educational content of the programme itself. This reflection focuses on three strands of the fellowship that stand out most clearly to me: the difficulty of getting the programme off the ground locally, the value of connecting with colleagues leading similar work nationally and regionally, and the process of designing and introducing a new module on adolescent health.

Early Challenges

As a team of fellows and Programme Directors, we underestimated, at the outset, how much resistance an innovation introduced with good intentions can meet simply because of timing and framing. The SLP was introduced into an environment where trainees were already juggling portfolio requirements, workplace based assessments, exam preparation and clinical duties, and where trainers were similarly stretched. Presenting a new structured programme, however clinically relevant its content, was always going to be read initially as an addition to an already full plate rather than a genuine alternative to existing demands.

In practice, this played out in several ways. Some trainees questioned, reasonably, why they were being asked to complete written reflections and poster tasks that duplicated work they were already doing for their portfolios. Others were anxious that time spent in structured modules was time not spent in clinic, generating consultations, tutorials and workplace based assessments they needed for ARCP. As a team, we found ourselves fielding a good deal of scepticism in early sessions, not because the module content was poor, but because trainees could not yet see how it fitted into the wider picture of what they were required to demonstrate. Trainers, too, were cautious, unsure whether SLP participation would be recognised as equivalent to protected teaching time or seen as separate to it.

There were practical barriers as well. Early sessions were hampered by broken links, unclear instructions and inconsistent use of the digital platform, which undermined confidence in the programme before the content itself had a chance to prove its worth. Between us, the fellows and Programme Directors spent a disproportionate amount of early fellowship time troubleshooting access issues and chasing clarity on logistics rather than focusing on educational design, which was frustrating but also instructive: a programme's credibility is often won or lost on these unglamorous operational details long before anyone judges the quality of the teaching.

What helped, gradually, was our team being honest with trainees and trainers about where the programme was still being worked out, rather than presenting it as a finished product. Framing early sessions explicitly as a pilot, and actively asking for feedback on what should change, seemed to shift the tone from compliance to genuine collaboration. It also meant that when the formal evaluation later confirmed exactly the concerns trainees had been raising informally, namely workload burden, duplication with portfolio requirements, and anxiety about reduced clinical exposure, we were not surprised, and we already had a working relationship with participants that made it easier to have constructive conversations about what needed to change.

Looking back, I think the difficulty of this initial phase was not really a failure of the programme's design so much as a predictable consequence of introducing structured change into a system that was already running close to capacity.

Trainees and trainers were not resistant to the idea of structured learning in principle; they were resistant to anything that felt like it was being imposed on top of an already unsustainable workload, without a clear account of what it would replace. That distinction, between resistance to change itself and resistance to poorly sequenced change, is one we did not fully appreciate as a team until well into the fellowship, and it has shaped how I now think about introducing any new initiative into a training environment.

Connecting Nationally and Regionally

One of the most valuable parts of the fellowship was stepping outside my own local training programme and connecting with people doing similar work elsewhere. I made contact with Dom Patterson, who leads the SLP work nationally within the NHS, and this relationship proved genuinely useful rather than simply symbolic. Being able to describe what was and was not working locally, and to hear in return how the national picture was developing, gave me a much clearer sense of which of our local difficulties were generic teething problems shared across every site piloting the programme, and which were specific to how we had implemented it locally and were therefore within my control to fix.

That conversation also helped me understand the strategic reasoning behind the programme in a way that was hard to appreciate from the trainee and trainer point of view alone: the drive to expand training capacity nationally, the intention that structured learning modules should eventually substitute for rather than add to existing training activities, and the recognition, even at a national level, that digital infrastructure and clarity around evidence requirements were recurring weak points. Knowing that these were acknowledged, live concerns nationally, rather than something unique to our failure to implement the programme well, was genuinely reassuring, and it gave me more confidence raising them upward rather than assuming I simply needed to try harder to make the existing model work as designed.

I also connected with colleagues in the West Midlands, who were running their own version of the SLP pilot. This was, in some ways, even more useful than the national conversation, because it was practical rather than strategic. We compared notes on which modules had landed well, how they had structured facilitation, and how they were handling the tension between structured learning time and protected clinical exposure. Seeing how another region had sequenced their modules and handled trainer engagement gave me concrete ideas I could adapt locally, rather than having to solve every problem from first principles. It also underlined for me how much unnecessary duplication of effort happens across training programmes when regions are not talking to one another: a great deal of what West Midlands had already learned through trial and error, we were in the process of relearning independently.

These conversations, taken together, changed how I approached the rest of the fellowship, and directly shaped the case for a new adolescent health module, which I go on to describe below. Rather than treating our local pilot as a standalone project to be judged solely on its own local feedback, I began treating it as one node in a wider, evolving national effort, which made it easier to be honest about weaknesses without feeling that doing so reflected badly on my own leadership of the project.

Developing the Adolescent Health Module

The existing SLP modules (Clinical Reasoning, ENT, Genomics, Men's Health, Paediatrics and Planetary Health) covered a good deal of curriculum ground, but adolescent health stood out to me as a notable gap. Paediatrics as delivered tended to focus on younger children, and modules aimed at adults did not really address the particular communication, consent and safeguarding challenges of consulting with teenagers. Given how often this age group presents in general practice with problems that sit awkwardly between paediatric and adult services, such as mental health, sexual health, chronic disease transition, substance use and safeguarding, it felt like a genuine curriculum gap rather than an optional extra.

Designing the module from scratch was a useful test of everything the evaluation later confirmed trainees valued and disliked about the programme as a whole. I deliberately built it around case based discussion and role play rather than didactic content or written tasks, having already heard clearly from trainees that these were the formats they found most engaging and most transferable to clinical practice. I tried, as far as possible, to design outputs that could double as portfolio evidence rather than sitting alongside it as extra work, mindful of how strongly duplication had come through as a source of frustration elsewhere in the programme. I also kept a close eye on workload, deliberately avoiding poster tasks or repetitive written reflection, both of which had already been flagged as low value, resented activities in other modules.

Recruiting and briefing facilitators for the module reinforced something else the evaluation later confirmed: facilitation quality, not just content, is what makes structured learning land well. I spent time briefing facilitators not just on the clinical content but on creating the kind of supportive, extending discussion trainees consistently said they valued: facilitators who could draw on wider GP experience and encourage genuine reflection, rather than simply working through a fixed slide deck. Piloting the module with a small group first, before wider rollout, let me iterate on pacing and content based on real feedback rather than assumptions, which felt like a much better use of the limited goodwill trainees had left for yet another new module by that point in the year.

Reflecting on the Evaluation Findings

Reading the combined evaluation findings once the pilot had run its course was, in some ways, a confirmation of what I had already been hearing informally throughout the year, but it was still useful to see it laid out systematically. The strongest positive theme, clinical relevance, and the value trainees placed on facilitation and peer supported learning, matched exactly what I had prioritised in designing the adolescent health module, and it was genuinely gratifying to see those design choices reflected in what trainees said mattered most to them across the programme as a whole.

The challenges identified, namely reduced clinical exposure, workload burden, duplication with existing portfolio requirements, variable value between modules, and technical/organisational barriers, were also exactly the issues I had encountered in trying to introduce the programme locally. Seeing them formally evidenced, rather than anecdotal, strengthens the case for the recommendations that came out of the evaluation: that future development should focus on integration rather than addition, that low value activities like posters and repetitive reflective exercises should be reduced or removed, and that digital infrastructure and the link between SLP participation and ARCP evidence needs to be much clearer than it currently is.

If I were starting the fellowship again, I would try to have these evaluation informed principles in place from the very first session, rather than arriving at them through a year of iteration and informal feedback. I would also push earlier and harder for the technical and organisational issues to be resolved centrally, since so much of trainees' early scepticism was rooted in a poor first experience of the platform rather than in the educational content itself.

Personal Learning and Next Steps

Beyond the specifics of the SLP pilot, this fellowship has changed how I think about introducing change into medical education more broadly. I have learned that credibility with trainees and trainers is built through visible responsiveness to feedback, not through polished initial design; that national and regional networks are worth investing time in early, not treated as an afterthought once local problems have already become entrenched; and that operational and technical details, however unglamorous, can make or break trainees' willingness to engage with genuinely valuable educational content.

Alongside the SLP pilot, I also designed a board game and companion interactive quiz app for GP trainees, covering clinical, pathology, medication, patient explanation and case management themes. I have since presented this resource to trainee groups in Southampton and Thames Valley, and the positive response reinforced for me how much trainees

value engaging, interactive formats over more traditional teaching methods, a lesson that fed directly into how I approached the design of the adolescent health module.

Going forward, I intend to keep the relationships I have built with Dom Patterson and with colleagues in the West Midlands active, both to continue benchmarking our local implementation against the wider national picture and to contribute what we have learned, particularly through the adolescent health module, back into that national conversation. I plan to refine the adolescent health module further in light of the evaluation recommendations, aligning its outputs more explicitly with portfolio and workplace assessment requirements, and to advocate locally for the wider recommendations around reducing duplication and clarifying the link between SLP participation and ARCP evidence.

I intend to utilise this experience to further enhance my own career in medical education. I am currently undertaking the GP Prospective Trainers course with postgraduate certification, alongside the ILM Level 5 leadership qualification, both of which will support my continued development as an educational leader.

The pilot has demonstrated real educational value; the work now is making sure that value is not undermined by avoidable implementation problems as the programme moves from pilot to established practice.