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INTERACTIVE GROUP EXERCISE TO IMPROVE THE CONNECTIVITY BETWEEN PROFESSIONALS AND PATIENTS WITH MENTAL HEALTH PROBLEMS

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Background

North East London NHS Foundation Trust (NELFT) provides an extensive range of integrated community and mental health services for people living in London serving a population of 1.5 million people. Communication between professional and patients with mental health problems can be problematic at times.

Aims

- To help improve connectivity between people.
- Trial a novel method of breaking down barriers of communication between professionals and patients with mental health problems

Method

A small group activity was run for 5 people with two co-facilitators as a part of a larger arts and wellbeing conference.

People were asked to throw a small soft tennis ball for a stranger in the group to catch. The colour of the ball corresponded to a group of questions; red- career focussed question, yellow- lifestyle questions and blue balls – personal questions. A question was selected and answered by the member who caught the ball.

Results

The group consisted of staff who were employed by the trust as well as patients with mental health problems. People appeared to have enjoyed the session from the qualitative feedback received. Feedback from the group included 'fun, light-hearted helps bring you out of your shell' and 'It was very social which I found really helpful with my illness.'

Conclusions

Using small group informal discussion groups using tennis balls to facilitate discussion appear to be well received in this pilot. It is a novel way of improving communication between patients with mental health problems and professionals. Further effectiveness can be evaluated further.

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CROSSING BOUNDARIES: BROAD BASED TRAINING DEVELOPS UNDERSTANDING OF DIFFERENT SPECIALTIES WHICH BENEFITS BOTH DOCTORS AND PATIENTS ~

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Introduction: Patient demographics and healthcare services are changing. In accord with a move towards broader based general training, the Academy of Medical Royal Colleges (AoMRC) introduced the two-year broad-based training (BBT) programme in 2013. The principal aim of our study was to evaluate whether the BBT programme better prepares trainees for the next step in their training compared with those following conventional pathways. This presentation focuses on one key finding, that BBT develops understanding of different specialties (GP, Core Medical, Paediatrics & Psychiatry) which benefits both trainees and patients.

Methods: We adopted a longitudinal, mixed-methods approach collecting data from annual questionnaire surveys (from BBT trainees and comparator groups), focus groups, semi-structured and one-to-one interviews (with former BBT trainees and educational supervisors).

Results: From questionnaire data, BBT trainees were *significantly* more confident than comparator trainees that their training would result in: wider perspectives, understanding how specialities complement one another and application of learning across specialties ($p < 0.000$ Mann-Whitney U).

From focus group data and interviews, it was apparent that experiencing the four specialties fostered greater tolerance and understanding of the pressures and limitations experienced by colleagues in different specialties. Trainees spoke confidently about how their wider perspective and cross-specialty skills equipped them to work with growing numbers of patients with complex health needs. They suggested that BBT experience enabled them to better understand referrals and to tailor discharges appropriately.

Conclusions: Our evaluation benefits from multiple data sources at regular points, following trainees over three years. We can demonstrate a consistent and detailed response which overwhelmingly shows that the BBT programme developed trainees who bring a wider perspective to health care and promote specialty integration. BBT was shown to foster deep understanding of the workings and limitations of different specialties. The generalist outlook is critical to the outcomes of patients with multiple chronic diseases that straddle the boundaries between traditional specialties. Now no longer recruiting in England, BBT may later be judged to have been ahead of its time.

Acknowledgements: We gratefully acknowledge funding from Health Education England via the Academy of Medical Royal Colleges (AoMRC).

References

Ham C, Dixon A, Brooke B. *Transforming the Delivery of Health and Social Care: A Case for Fundamental Change*: The King's Fund; 2012

Moffat K, Mercer SW. Challenges of managing people with multimorbidity in today's healthcare systems. *BMC Family Practice*. 2015;16:129.

9-3

THE GOOD DOCTOR? A STUDY OF MEDICAL STUDENT AND TRAINEE VIEWS USING Q-METHODOLOGY.

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Introduction

The population is ageing, developing multiple co-morbidities and their expectations of healthcare provision are increasing.^(1, 2) There is currently limited research on different stakeholders' understanding of what makes a 'good' doctor. This study aimed to explore students' and doctors' beliefs regarding the 'good' doctor.

Methods

Data were collected during 2015 and 2016 using Q methodology⁽³⁾ and a post-sort questionnaire. Medical students (n=28), Broad Based Trainees (BBT; n=24) and comparator trainees (n=26) completed the process of sorting 40 statements into a forced quasi-normal distribution, from most disagree to most agree. The post-sort questionnaire explored participants' reasoning behind their sorting pattern. Principle component analysis was applied to extract groupings of participants, and the questionnaire responses aided interpretation.

Results

The analysis extracted three distinct groups (loading 58 participants in total) and accounted for 62% of the variance. Both students and trainees (BBTs and comparators) loaded onto all three groups. Across these groups there was consensus that compassion, good communication skills and holistic care are important. The largest group (n=30), the 'patient-centred generalists', valued having a broad-based knowledge and stressed the importance of the patient. The second group (n=14), the 'efficient working doctors', emphasised a sustainable approach to working and valued a good work-life balance. The third group (n=14), the 'specialists', valued in-depth knowledge and mastery of skills.

Conclusions/implications

This analysis demonstrates shared and differing beliefs between these three groups. Both trainees and students shared beliefs that holistic care and interpersonal skills are important. These should be included in curricula. However, what makes a good doctor needs considering in light of the population's changing demographics and the growing need for more generalists.

References

1. Greenaway D. *Shape of Training: securing the future of excellent medical care*: General Medical Council 2013.
2. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *The Lancet*. 2012;380(9836):37-43.
3. Watts S, Stenner P. Doing Q methodology: theory, method and interpretation. *Qualitative Research in Psychology*. 2005;2(1):67-91.

9-4

STUDENTS AS TEACHERS: ADDRESSING ATTITUDES AND BARRIERS TO STETHOSCOPE CLEANING PRACTICES

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Background:

As 4 medical students we observed the ward environment for several days. We realized that despite stethoscopes being an established vehicle for infection, little had been done to address this issue. We therefore decided to look into improving this practice amongst doctors. The aim of this study was to investigate the current knowledge of doctors regarding the importance of this issue and whether we, even as students, could improve their practice through education and removing barriers.

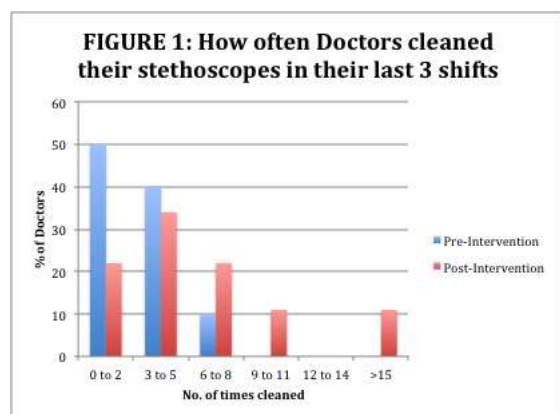
Methods:

A questionnaire gathered baseline information about doctors' knowledge and attitudes towards stethoscope hygiene, as well as barriers to good practice. Following this, a 2 week intervention programme was initiated in 2 wards targeting the main barriers raised. Instructive posters were placed to increase awareness in high volume areas. Ward managers were involved to prompt doctors during ward meetings and cleaning wipes were made readily available. The intention was that this would encourage discussion amongst doctors and increase understanding of the importance of infection control. After 2 weeks, the questionnaire was redistributed to establish any changes.

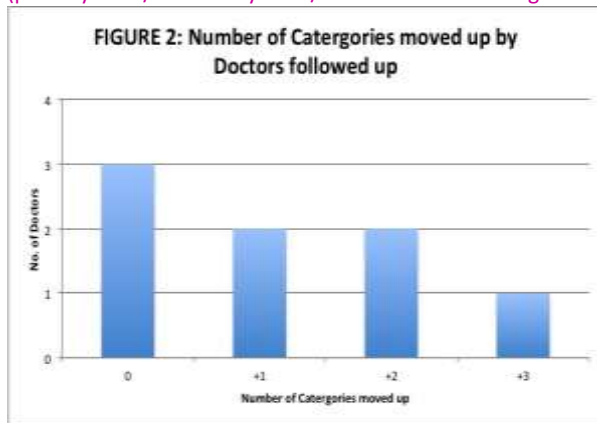
Results:

In the pre-intervention period, 20 doctors were interviewed. All 20 were aware of the importance of stethoscope cleaning, however, 0 cleaned their stethoscope after every patient.

Our implementation did have a positive effect, as fewer doctors cleaned their stethoscopes only 0-2 times in their last 3 shifts (fig.1). From the 8 doctors who were followed up until the post-intervention period, 5 had increased their stethoscope cleaning habits (fig.2).



DEMEC 2017 – abstract poster submission : Category 9: Learning across traditional boundaries
(primary care / secondary care /social care and undergraduate/ postgraduate)



How often doctors cleaned their stethoscopes in their last 3 shifts

Categories:

0-2 times

3-5 times

Discussion:

The fact that not all doctors showed improvement, implies that further underlying issues need to be addressed. Doctors' views on infection control are ingrained early in their career, thus education of stethoscope cleaning should be emphasized earlier on, especially during hospital induction and medical school. Accessibility to wipes should be more consistent and wipes need to be available throughout all the wards. Furthermore, a larger sample of doctors and a hospital wide implementation programme should be warranted due to the mobile nature of a doctor's job.

Conclusion:

Although the intervention specifically addressed the main complaints found by the questionnaire and led to a degree of improvement, some doctors still did not clean their stethoscope after every patient. A wide based approach of early infection control education and increasing resource availability of wipes need to be addressed.

As students, we are at an early stage in our careers, and thus are open to accepting simple changes. Therefore we feel we are well positioned to encourage others to do the same. This project was then chosen over 60 others by our faculty at Imperial College as the winner of the annual Quality Improvement competition, thus highlighting the importance to take the project further.

A COLLABORATIVE APPROACH TO RESILIENCE TRAINING ACROSS MEDICAL AND DENTAL TRAINING

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Introduction Maintaining wellbeing and developing resilience are key skills for doctors and dentists throughout their education with burnout having been identified as a serious threat. The GMC has stated that emotional resilience training should be a key part of the medical curriculum. Northern Ireland is in the unique situation within the UK of having one medical school and one postgraduate deanery. Opportunities exist to develop close working relationships in key areas of educational practice. In 2015, a working group was convened to look at how resilience training is promoted and delivered within the undergraduate and postgraduate educational environments.

Methods The working group is co-chaired by undergraduate and postgraduate lead educators and has invited expertise from trainers, educationalists and other clinical professionals with a background in resilience. Terms of reference for the group's work have been extended to include promotion of resources, quality improvement projects and development of research interests.

Outcomes The group has documented the resilience training offered across medical and dental training in Northern Ireland using a standardised format. Within this process, there has been an opportunity to identify areas for development (transitions from preclinical to clinical and into the Foundation programme), share good practice and consider how this links into other areas of educational practice. The work has informed the content of a joint annual Faculty Development Day. Other outputs have included support for new educational initiatives within undergraduate teaching specifically development of a peer buddy scheme, relevant adaptation of simulation scenarios and enhancement of education on how to give and receive feedback. In addition, there has been development of a generic skills module for Foundation doctors focused on resilience and input to a research project looking at how Foundation doctors have experienced stressful events and to what extent undergraduate training prepared them for this.

Conclusion Development of a joint working group has promoted cross-organisational relationships, understanding and collaboration in the areas of professional well-being and resilience. A focus has been placed on support for career and practice transitions including those leading to full medical or dental registration. Educational approaches have been integrated to encourage complementary designs and spiral learning across the medical and dental undergraduate and postgraduate programmes.

9-6

FIT FOR THE FUTURE: EVALUATING AN INNOVATIVE INTEGRATED COMMUNITY CARE TRAINING POST

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Background

ITPs (Integrated or Innovative Training Programmes) have been recognised as a distinct type of training post for general practice for a considerable time. Previous research has found them to provide an enhanced training experience, often bringing two strands of training together, such as across the primary /secondary care boundary. This poster describes and evaluates a ‘new generation’ ITP post which was piloted in the New Forest.

Summary of work

The post comprised a mix of 2 days a week in general practice and 3 days in community posts. The posts were evaluated using a focus group of trainees and trainers and survey. The evaluation was planned and conducted by two GP trainees who participated in the attachment.

Summary of results

The evaluation aimed to determine if the integrated structure provided a positive educational experience and if it helped to prepare trainees for a career in general practice. Participating trainees and trainers reported that the post was helpful in developing skills and competencies related to community care, but identified some challenges. Responses reflected three key themes:

1. Perceptions of improved quality of training.
2. Feeling better prepared for a career in GP.
3. Better awareness of primary /secondary care system and interface.

Conclusions

ICCs mark a welcome return of ITPs to GP training and can offer a positive experience to trainees in developing their care knowledge and skills. The trainees undertaking this evaluation gained insight into planning and conducting evaluation research.

Take home messages

There continues to be a role for integrated training posts in training, especially with the increasing care complexity. ITPs can add a different dimension to experience in training and could be used more widely.

9-7

BRIDGING THE GAP – PRIMARY AND SECONDARY CARE DEVELOPING TOGETHER WITH TRAINEES IN DIFFICULTY

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Background

Workplace supervisors can find trainees with performance difficulties exhausting but also developmental for their educational skills. Debriefing with educator colleagues on such cases can help formalise the opportunity for reflection and development, allowing events to be discussed in order to share and enhance learning from peers.

Summary of work

HEE Wessex facilitated a series of three half-day action learning sets, over three months, bringing educational and clinical supervisors in primary and secondary care together. Attendance at sessions was encouraged but not compulsory. All participants had supervised a trainee who was not progressing for personal, health, competence or professional reasons.

Summary of results

Evaluation of the sessions indicated overwhelmingly positive responses from both primary and secondary care supervisors. Key themes emerged relating to: support, shared learning, and management planning. The understanding gained from cross-specialty working led to development of 'tools' and resources for dealing with specific areas. Supervisors felt out of their depth when managing poorly performing trainees. The issues encountered were similar in both primary and secondary care; individually they were small but cumulatively added up to a lack of development and poor trainee performance.

Conclusions

Joint, mutually supportive, learner-led protected time for hospital /community consultants and general practice trainers was valued. The ability to discuss the problems with colleagues helped the supervisor's development and assured them that they were handling the situation in the best and fairest way for the trainee.

Take home messages

Mutual, peer group support for supervisors can be beneficial and help to calibrate how they manage situations when dealing with their trainees who are in difficulty.

LEARNING TOGETHER CLINICS: LEARNING AND WORKING ACROSS BOUNDARIES FOR IMPROVED CHILD HEALTH OUTCOMES

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Aims

Learning Together clinics are joint educational clinics run by Paediatric and GP trainees, held within GP Training Practices (see also <http://www.learningtogether.org.uk>). Their aim is to improve outcomes for children and young people (CYP) via experiential joint learning. An evaluation was carried out to test the case for national implementation by interrogating who learnt what and how; and to consider how effective the intervention would need to be (in terms of improved child health) to be considered cost effective.

Methods:

The evaluation looked at quantitative and qualitative data. Data included: 48 semi structured interviews; 65 'Learning Logs' from 75 clinics; programme workshops that featured case discussions; a Quality Improvement Project (QiP) by a GP ST3.

Two researchers completed thematic analysis to map learning. Realistic methodology established how learning may occur.

Cost analysis was used to compare the data from 2014-15 joint clinics and what they displaced in usual training (for both types of trainee) for 353 patients seen in the joint clinics. Using the evidence in NICE guidelines, the results were used to formulate a rubric for the health gain required in a child for Learning Together to be considered cost effective locally. The rubric was applied to patient seen in one practice before and after implementation of the joint clinics as part of a QiP.

Results:

Several learning themes were identified: learning clinical practice; learning how to collaborate effectively); learning about the service or system; teaching/project skills.

Both GP and Paediatric registrars learnt in all major themes and changed practice as a result over 4-6 clinics. However, they learnt in different ways and over different time frames.

Each Learning Together Clinic costs the system £37, less that the cost of one GP appointment. The cost of 6 clinics would be recouped if, as a result, **one** child became symptom free for 2 additional weeks.

The local QiP demonstrated 19 months of additional good health for children with constipation as a result of a set of LT clinics

Conclusion:

The evaluation reveals a complex, interdependent learning platform that is sufficient to change practice and - improve health outcomes for CYP.

We conclude that this model is a 'no brainer' in terms of resource use. We need to change as professionals – this model provides a way of learning how to do that!

USING QUALITY IMPROVEMENT METHODS TO EMPOWER GP TRAINEES TO INTEGRATE PHYSICAL AND MENTAL HEALTHCARE FOR OLD AGE PSYCHIATRY INPATIENTS

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Introduction

People with severe mental illness suffer significant health inequality; they have higher rates of physical ill health than the general population and die on average 15-20 years earlier. In our ageing population, the proportion of frail older people with multiple health problems and complex needs is increasing. Despite this, and the clear interrelation of physical and mental health, the services that are offered to this group are separate and poorly linked. There is a drive for the development of integrated services, as addressed in NHS England's Five Year Forward View and the Royal College of Psychiatrists' report "Improving the physical health of adults with severe mental illness".

Methods

Our innovation is a sustainable trainee doctor led service that provides proactive physical health review and action for functional old age psychiatry inpatients. Using the Model for Improvement, iterative Plan-Do-Study-Act cycles have been used to develop and implement an evidence based framework to guide the review, with reference to the 2016 NICE multimorbidity guideline and validated STOPP (screening tool for older people's prescriptions) criteria for addressing polypharmacy (O'Mahony et al., 2014). The physical health review is led by the GP trainee working on the ward, as a defined portion of their roles and responsibilities for the attachment.

Results

Implementation of the improvement effort has led to a reduction in the proportion of prescriptions of potentially inappropriate medications, as defined by STOPP criteria, and demonstrated in the literature to be significantly associated with adverse drug events. GP trainees leading the intervention are empowered to make independent clinical decisions; it provides transferrable skills through training in practical application of the NICE multimorbidity guideline and approaches to addressing polypharmacy.

Implications

There is national and local acknowledgement of the inequity in access to physical healthcare faced by this vulnerable patient group. Clinical leaders value and support the intervention, and the local culture is such that the ward team are receptive to change and the development of strategies to improve their confidence and competence in managing physical health problems. The intervention is of educational value to GP trainees, with the opportunity to develop skills in managing complexity and comorbidity across traditional specialty boundaries, in line with their training programme learning objectives.

O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P (2014) STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age and Ageing* 44(2): pp.213-8.

9-10

ARE BALINT GROUPS THE ANSWER FOR IMPROVING REFLECTIVE PRACTICES IN FOUNDATION DOCTORS?

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Introduction: Over 60 years ago Dr Michael Balint set up a psychoanalytical reflective group of General Practitioners to study the neglected subject of the doctor, exploring its therapeutic effects and side effects. Introducing Balint Groups to Foundation doctors who are inevitably exposed to life, death, sickness and suffering in the raw, might be useful before either defences of cynicism, dissociation and detachment set in or alternatively burnout, anxiety, depression, psychosomatic illness, substance abuse, take their toll. We conducted a pilot group for Foundation doctors based in the South of the trust and proposed to evaluate this.

Methods: We used 2 questionnaires, 45- item Psychological Mindedness scale (PMS) and a Purpose Designed Questionnaire (PDQ) for Foundation doctors from 3 successive rotations to complete before and after their rotations and compared responses. All responses were anonymous with only the collated results analysed. Qualitative data in the form of free text comments was also collected

Results: About 30 trainees participated with attendance averaging between 11 to 15 sessions. Modest changes in the PMS scores were observed in each of the 5 categories, but a trend towards improved scores in Factors 3 (Access to One's feelings), Factor 4 (Belief in the benefit of discussing one's problems) and Factor 5 (Interest in meaning and motivation of own and other's behaviours).

The PDQs were far more telling. There was a shift towards more participants strongly agreeing that they were more able to voice their opinion in group settings and improved ability to communicate with patients as compared to their peers. The stronger differences however were observed in questions which indicated that more trainees strongly agreed that they were able to use reflective practices in their day-to-day care (62.5% to 96%) and trainees strongly agreeing that they had improved abilities to communicate with patients (15% to 35%). Overall, 83% of the participants felt that sessions were valuable in the overall training experience, 100% found the course facilitators helpful and supportive and 87% would recommend that the Balint groups for Foundation trainees continue

Conclusions: There are several limitations due to the smaller numbers and other confounding factors that may account for changes in scores. Despite the novelty of this experience some participants commented on improved ability to reflect and focus on situations that were emotionally taxing and with some having acquired transferable skills for future. While reflections are considered mandatory in Foundation curriculum, there is growing resentment on either side that they are unstructured, superficial and have distorted original intentions of meaningful reflective practice. May Balint groups be the way forward in our efforts to produce rounded, balanced and resilient doctors for the future?

9-11

GP TRAINEES AS UNDERGRADUATE NEAR-PEER FACILITATORS

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Background

This project was aimed to meet two current educational needs: the persisting lack of medical students choosing general practice as a career in the UK – which has been linked to a lack of GP exposure, and the lack of training opportunities for GP trainees who are interested in medical education.

Summary of work

The local Trainee Committee and Medical School together designed a pilot scheme to work across the undergraduate and postgraduate boundary. Working with an experienced GP teacher, GP trainees co-facilitated seminars for final year medical students on their GP rotation. A training session was held to familiarise trainees with the curriculum and allow them to explore the art of facilitation.

Summary of results

Trainees undertook seminars throughout the year. A rolling evaluation of the scheme was led by a final year GP trainee, and included gathering data on trainees' and GP teachers' experiences. Participants reported that the experience was helpful, but also identified some challenges. We plan to continue the scheme next year and diversify it to give trainees the opportunity to facilitate a wider range of medical student seminars. Our hope is that this will continue to encourage trainees to become involved in education whilst also increasing recruitment into General Practice.

Conclusions

Guided, peer-led teaching can offer a positive experience to trainees and students; For trainees in developing their educational knowledge and skills, and for students meeting positive career role models. The trainee undertaking this evaluation gained additional insight into planning and conducting evaluation research.

Take home messages

This innovative pilot added a different dimension to experience in training for all participants

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A TASTE OF GENERAL PRACTICE (GP): FINAL YEAR GP TRAINEES (GPST3) MENTORING FOUNDATION YEAR 1 DOCTORS

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Introduction:

GP training programmes are struggling to fill posts due to changing career pathways and expectations. The government aspires to increase the GP workforce amidst the current crisis in GP recruitment and retention; initiatives are required to raise awareness and increase relevant GP experience to enable more doctors to make an informed career decision. Trainees may find themselves applying for GP specialty training just 3 to 4 months after completing Foundation Year 1 (FY1), yet there are few GP attachments in FY1.

Methods:

FY1s were given the opportunity to shadow GPST3 trainees in clinical practice. This voluntary scheme showcases life as a GP from a trainee perspective in addition to gaining community clinical exposure. All FY1 and GPST3 doctors working in Wessex since 2015 have been invited to take part following a successful small pilot study in 2014. Thirty FY1 doctors in 2015 and 23 in 2016 undertook the taster opportunity for an average of 3 days in 2015 and 2 days in 2016 (1-5 days). 39 FY1 doctors have signed up to the scheme in 2017. After the taster participants (FY1s and GPST3s) completed an electronic feedback survey, which explores their learning, feedback on the scheme and any change in career choice.

Results:

Response rates for the feedback survey were as follows: in 2015 FY1 (47%) ST3 (57%) reflecting 19 pairings and in 2016 FY1 (52%) ST3 (57%) reflecting 15 pairings. The scheme was positively received by both FY1s and GPST3 mentors. For FY1s 16/26 reported it had changed their view of primary care, 18 stated it had changed their clinical practice, and 7 that they had developed in other ways. FY1s find it helpful to have a trainee's perspective, gaining an overview of what to expect, including opportunities available to them. The GPST3s are enthusiastic about GP, which appeared to 'rub off' on FY1s. 25/30 of GPST3 respondents felt the taster helped them to develop their educational skills. The majority of GPST3 doctors (26/27) would recommend being a near-peer mentor; the majority also expressed an interest in developing an educational role in GP in the future (25/26 respondents).

Conclusions/implications:

Using GPST3 trainees as mentors for FY1 doctors is educational for both groups and can have a positive impact on GP recruitment. The taster demonstrated how varied GP is, and challenged some negative perceptions of primary care. GPST3s gained confidence in their knowledge about GP and greater insight into educational roles.

9-13

BALANCING PROGRAMME FLEXIBILITY WITH FORMAL TEACHING PROVISION IN A PILOT LONGITUDINAL INTEGRATED CLERKSHIP PROGRAMME

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Background

Longitudinal Integrated Clerkships (LICs) offer student-centred learning and quality learning experiences through symbiosis of education with local healthcare provision¹, matching educational theory principles^{2,3}. LICs require flexibility to facilitate the variety of clinical learning experiences on offer, which by nature are unpredictable. This creates a challenge; how to balance flexibility with formal teaching to ensure coverage of the undergraduate curriculum.

Aim

In our pilot Year 4 medical student LIC, need for flexibility created difficulty in organising and providing formal teaching - perceived as an important 'safety-net' to ensure curriculum coverage. Now 6 months into the pilot we wanted to know if we are achieving this balance, and the role formal teaching should play.

Method

All five students undertaking the pilot LIC were asked for their opinions on this topic through a short questionnaire including multiple-choice and free-text responses. The questionnaire was developed through SurveyMonkey and anonymous responses collected electronically.

Results

5/5 responded. All believed LIC provided more flexibility than the existing Year 4 programme. 2/5 believed it offered broader curriculum coverage, 2/5 said it offered the same, with one unsure. All praised LIC flexibility noting it improved "independent learning" and allowed "greater engagement with subject areas". All felt formal teaching was required, but this should be "flexible" and infrequent (once/twice monthly). 4/5 said they would like to request topics, and 2/5 believed attendance should be optional.

Key messages

- Balancing programme flexibility with formal teaching is challenging
- Perceived importance of formal teaching varies between teacher and student

References:

1. Greenhill J, Poncelet A. Transformative learning through longitudinal integrated clerkships. *Medical Education*. 2013; 47(4): 336-339. doi: 10.1111/medu.12139
2. Knowles MS, Holton EF, Swanson RA. *The Adult Learner*. 6th ed. Burlington, MA: Elsevier; 2005.
3. Kolb DA. *Experiential learning: Experience as the source for learning and development*. Englewood Cliffs, NJ: Prentice Hall; 1984.

9-14

ON THE ROAD TO QUALITY IMPROVEMENT: A COMMUNITY OF PRACTICE MODEL SUPPORTING PHARMACISTS-IN-PRACTICE

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Introduction

The benefit of Quality Improvement (QI) Skills in enhancing patient care is widely accepted. Improving Quality Together (IQT)¹ was developed to provide a common and consistent framework of core skills for NHS Wales staff. There is an expectation in Wales that all health professionals undertake Bronze level QI training,¹ which is suitable for staff across every discipline and every level. However, many trained in QI do not apply these skills to their practise. The pharmacist-in-practice (PiP) role is relatively new.² For isolated PiPs, it can be difficult to find time to develop QI skills. A Community of Practice (CoP) has been shown to be an effective way to develop learning through the exchange of ideas with peers.³ We aimed to explore how and in what circumstances being part of a CoP supports PiPs to use their improvement skills to improve their practice.

Method

We used mixed-methods: case reports (n=15), interviews/focus groups (n=45) and online questionnaires (n=27). Qualitative data underwent Thematic Content Analysis.⁴ Quantitative data were statistically analysed in SPSS.

Results

Findings provide insight to challenges and drivers for the translation of QI knowledge into practise for PiPs. In spite of training, limited awareness of Bronze IQT was apparent. Implementation of QI skills was hampered by: workload pressures; disjointed primary care; the PiP not being long in any one GP practice; and patient power to move to practices. However, PiPs' belief in the QI principle and the CoP was strong (62% and 78% respectively). Fostering trusting relationships in GP practices helped to facilitate the use of QI skills. The CoP facilitated networking opportunities which enabled PiPs to learn QI strategies from others.

Conclusions/implications

We suggest that PiPs can use their QI skills when they have the support and leadership of their GP practice together with appropriate training and connectivity with other PiPs which can be developed through the CoP. The CoP provided a professional learning community to meet PiPs' needs. Over time PiPs' knowledge of QI skills and their application to clinical practice increased. It is important not to ignore less easily quantifiable aspects of QI, such as culture, ethos and morale.

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References

1. Public Health Wales 1000Lives (2013) Improving Quality Together IQT Wales. www.iqt.wales.nhs.uk/what-is-iqt
2. RCGP (2015) Strengthening General Practice: Actions for a brighter future for patients in Wales. <http://www.rcgp.org.uk>
3. Boaden R. (2009) Quality Improvement: theory and practice. *British Journal of Healthcare Management*, 15(1):12-16.
4. Boyatzis RE. (1998) Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage.