



Society of Academic Primary Care North Conference 2020
Championing the Knowledge Work of Primary Care
Thursday 12th November 2020

CELEBRATING PRIMARY CARE SCHOLARSHIP

Conference Poster Book



In Partnership with The Academy of Primary Care



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE

PARALLEL SESSION A.1 – PRIMARY CARE DELIVERY (10:10 – 11:10)

SESSION CHAIR – Dr Ben Jackson, Director of Primary Care Teaching, Sheffield Medical School, University of Sheffield

SESSION SUPPORT – Pamela Parkinson, Academy of Primary Care, Hull York Medical School

1	Hannah Andrew	University of Sheffield	How GPs think about persistent or 2medically unexplained2 symptoms: a qualitative interview study
2	Andrew Moriarty	Hull York Medical, School University of York	Development of a prognostic model to PREDICT relapse of depression in Primary Care (the PREDICTR study)
3	Win Let Oo	University of Central Lancashire	An audit of risk assessments and management for self-harm and suicide in patients with depressive symptoms at the Reedyford Healthcare Group
4	Balamrit Sokhal Singh	Keele University	Prevalence of fragility fractures and prescribing of medications for osteoporosis in patients with polymyalgia rheumatica (PMR): Results from the PMR cohort study
5	Helen Twohig	Keele University	Development and evaluation of the PMR-Impact Scale (PMR-IS)
6	Joshua Wong	University of Central Lancashire	A standard-based clinical audit on safe prescribing of combined oral contraception at a local GP Surgery



How do GPs think about “medically unexplained symptoms”?

Hannah Andrew, Jon Dickson, Chris Burton



BACKGROUND

Medically unexplained symptoms (MUS) are symptoms which are ‘not attributable to any known conventionally defined disease’¹. Eriksen et al.² suggest that to understand the problem of MUS, we must address the underlying philosophical issues associated with them.

Metaphysics: Do medically unexplained symptoms exist?

Ontology: If they do exist, what are they?

Epistemology: How can we understand them?

Table 1 shows how philosophical approaches were categorised.

AIMS

To explore how general practitioners think about so-called medically unexplained symptoms, both in terms of what they are (metaphysics and ontology) and how they can be known about (epistemology).

Table 1: Categorisation of philosophical positions

	Biomedical model	Humanistic model
Metaphysical position	Monism	Dualism or Holism
Metaphysical assumption	Reductionism, Determinism	Emergentism
Ontological commitment	Physicalism	Organicism
Epistemology	Objective thinking: empiricism, rationalism	Subjective thinking: intuition, values, virtues, narrative reasoning

METHODS

- Qualitative research techniques were used.
- Semi-structured interviews with 6 GPs.
- GPs were contacted through staff lists at the AUPMC, and a notice in the Sheffield-wide NHS GP bulletin.
- Framework analysis.

RESULTS

- All GPs interviewed mixed philosophical approaches to varying extents.
- Two GPs appeared to show a primarily biomedical approach, two a primarily humanistic approach, one an equally biomedical and humanistic approach, and one did not clearly reveal an approach. (See figure 1).
- Several GPs suggested an incongruence of ideas between them and their patients.
- Findings appeared to show the mixing of philosophical approaches may be to ensure explanations are acceptable to the patient, or due to an apparent philosophical ambivalence.

References

1. Fink P, Rosendal M, Olesen F. Classification of somatization and functional somatic symptoms in primary care. *Aust N Z J Psychiatry*. 2005.
2. Eriksen TE, Kerry R, Mumford S, Lie SAN, Anjum RL. At the borders of medical reasoning: Aetiological and ontological challenges of medically unexplained symptoms. *Philos Ethics, Humanit Med*. 2013;8(1):11.

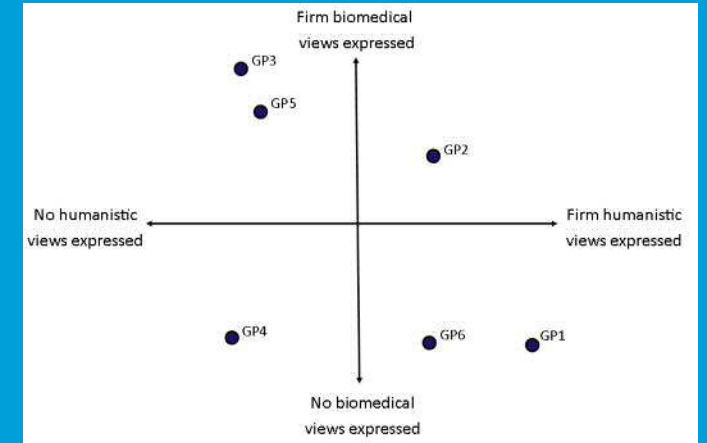


Fig.1

DISCUSSION

Why do GPs mix philosophical approaches?

A pragmatic choice

- The usefulness in framing explanations to the patient
- In order to best understand symptoms
- To ensure explanations are acceptable to the patient

Unconscious switching

- A lack of awareness about philosophy
- The effects of medical culture
- The difficult nature of medically unexplained symptoms

Contact details

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Development of a prognostic model to PREDICT Relapse of depression in primary care (The PREDICTR Study)

Andrew S Moriarty¹, Lewis W Paton², Nick Meader³, Kym IE Snell⁴, Richard D Riley⁴, Simon Gilbody¹, Dean McMillan¹, Carolyn A Chew-Graham⁵

1. Department of Health Sciences and Hull York Medical School, University of York; @A_S_Moriarty; 2. Department of Health Sciences, University of York 3. Centre for Reviews and Dissemination, University of York; 4. Centre for Prognosis Research, Keele University; 5. School of Primary, Community and Social Care, Keele University

Why is this important?

Most patients with depression are managed in primary care

At least 50% of patients relapse within 1 year of first episode of depression

Relapse is a significant concern for people with depression

NICE recently identified depressive relapse as a research priority

What is a prognostic model?

A **prognostic factor** is a variable that is associated with an outcome

A multivariable **prognostic model** combines information about several prognostic factors to produce an individualised risk estimate

Prognostic models for predicting relapse of depression

Our Cochrane Prognosis Review identified 9 previous attempts to develop prognostic models for relapse

8 out of 9 were at high risk of bias

The study at low risk of bias had poor predictive performance

None have had their clinical utility assessed or been implemented in practice

We lack evidence-based tools to guide risk stratification in this area

The PREDICTR Study

We aim to develop a novel prognostic model for to predict relapse within 6-8 months

Prognostic factors include: number of previous episodes of depression; presence of residual depressive symptoms; comorbid anxiety; severity of index episode

We will develop the model using logistic regression in a dataset derived from RCTs and a cohort study (N=1500)

We will explore predictive performance, clinical utility and stakeholder perspectives

Long-term goal is to improve clinical outcomes for patients and facilitate more effective allocation of relapse prevention interventions in primary care



THE COCHRANE
COLLABORATION®

Fig. 1: The logo of the Cochrane Collaboration.



An Audit of Risk Assessments and Management for Self-Harm and Suicide in Patients with Depressive Symptoms at the Reedyford Healthcare Group

Win Let Oo, wloo@uclan.ac.uk
Fourth Year Medical Student, School of Medicine



Introduction

- Over 5 million adults in England are living with depression, with the highest prevalence rates recorded in the North West and North East of England, 12.88% and 11.53%, respectively (NHS Digital, 2019).
- Depression is associated with the highest rates of self-harm and suicide (SH&S) (Singhal, Ross, Seminog, Hawton, & Goldarce, 2014). The impact of SH&S on a family ranges from shock and horror to, blame, secrecy and shame. Survivors may also be negatively judged or self-stigmatise (Cerel, Jordan, & Duberstein, 2008).
- Managing self-harm episodes has a significant financial implication for the NHS (Tsiachristas, et al., 2017). If high-risk individuals are identified and intervened early, it would not only save lives but also potentially reduce financial strains.

Methods

- A retrospective audit was conducted at the Reedyford Healthcare Group in Nelson, Lancashire to evaluate the performance of risk assessment and management of SH&S against the NICE guidelines CG90 for adults with depression.
- The 3 criterion selected to be audited against are as follows:

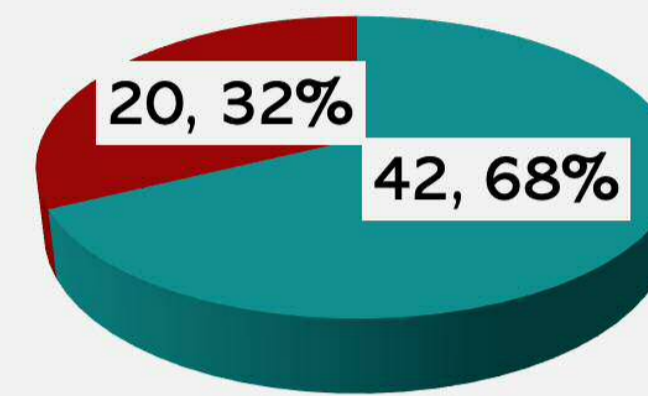
Criterion Code	Criterion chosen from CG90	Target Standards
1.1.4.6	Always ask direct questions to depressed patients about suicidal ideation and intent.	100%
1.3.2.1	If the depressed patient presents with immediate risk to self or others, urgently refer them to specialist mental health services.	100%
1.3.2.4	If the depressed patient is evaluated to be at risk of suicide, consider increasing the level of support e.g. frequent follow-ups.	100%

- Data was extracted from the the Egton Medical Information Systems (EMIS), using the following inclusion criteria:
 - patients aged 18 years or above
 - codes of depression and low mood
 - time frame of 3 months: 13/10/2019 to 13/01/2020

Results

- 62 patients were included in the audit.
- 68% (n=42) were directly asked about suicidal ideation and suicidal intent (Chart 1).

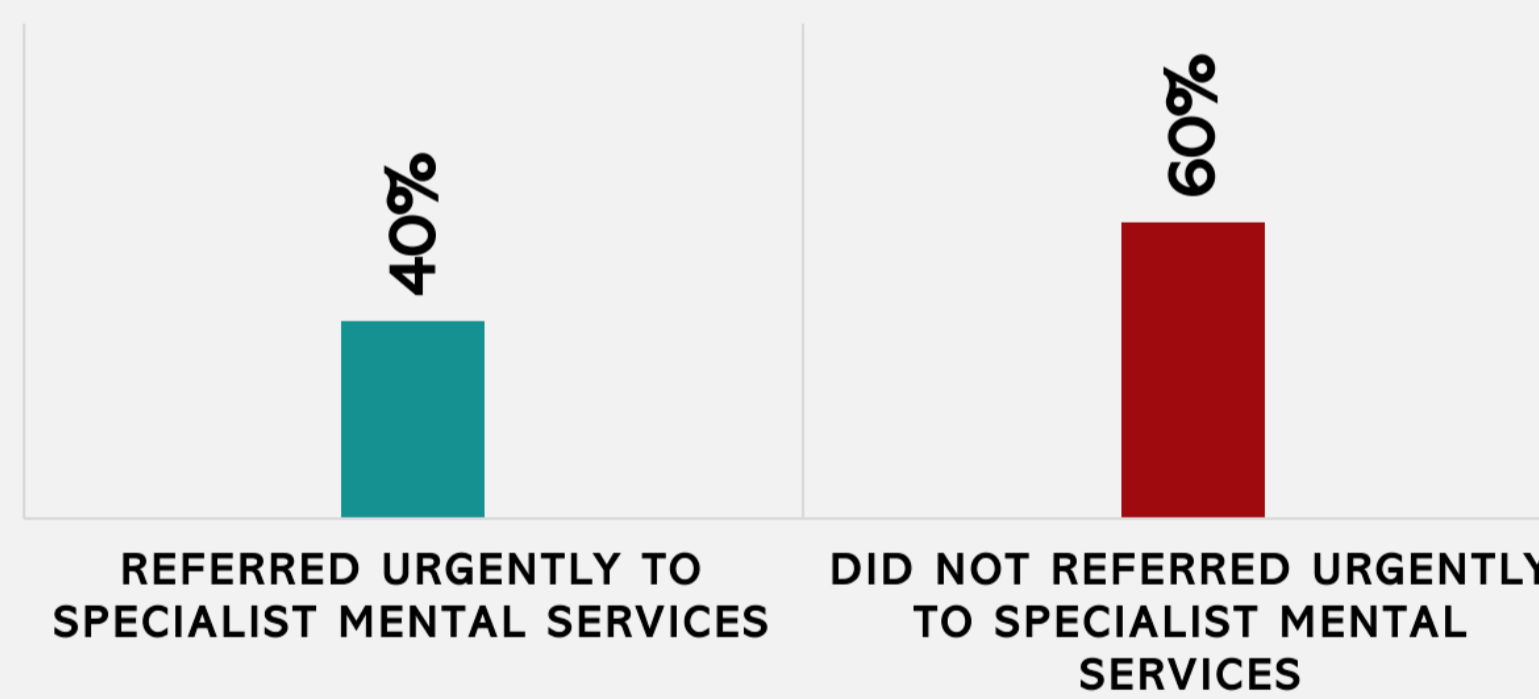
Chart 1: Performance of Risk Assessments for Suicidal Ideation and Intent: Asking Direct Questions



■ Proportion of patients who were directly asked for suicidal ideation and intent
■ Proportion of patients who were not directly asked for suicidal ideation and intent

- 5 of those 42 patients (12%) were found to be at immediate risk to themselves or others, with 3 of them at risk of suicide.

CHART 2. URGENT REFERRALS TO SPECIALIST MENTAL HEALTH SERVICES FOR DEPRESSIVE PATIENTS PRESENTING WITH IMMEDIATE RISK



- Only 40% (2 out of 5) of individuals who were at immediate risk were referred urgently to specialist mental health services (Chart 2). One of them was discovered to have a learning disability and the other had ongoing long-term issues with depression.
- Instead of urgent referrals, the remaining 60% (3 out of 5) of individuals were given contact details for self-referral to crisis team with follow-up appointments in the following two weeks.
- All 3 patients (100%) who were at risk of suicide were given an increased level of support by the practice.

Discussion

- This audit was the first-ever project to be performed on self-harm and suicide risk assessment and management at the surgery. The project shows the importance of risk stratification not just for early interventions to help the patients but also for saving resources of the NHS.
- All patients with depression who are at immediate risk are followed up very well by the practice, usually within the next 2 weeks.
- Early interventions at a primary care level might prevent future acts of self-harm and suicidal attempts. Monitoring risk levels throughout and supporting the patients during a crisis will allow them to feel that they can seek help and they are not alone.
- Within the scope of this audit, it was impossible to identify whether the individual characteristics of the healthcare professionals played a role in enquiring of suicidality.
- Some professionals could have been worried that they might heighten the likelihood of the patient acting on the suicidal ideation when asked about it directly. Some of them could have felt that they did not have the required training on how to intervene nor time if the patients were at very high risk of suicide (Feldman, et al., 2007).

Conclusion

- The assessment of risk in patients presenting with depression is vital and this audit shows that it is not always done in practice.
- The author has not found other published audits on this topic and suggests that this may be appropriate for a national audit, especially with the current concern regarding mental health in the COVID-19 pandemic.

References

- Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The Impact of Suicide on the Family. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 29(1), 38-44.
- Feldman, M. D., Franks, P., Duberstein, P. R., Vannoy, S., Epstein, R., & Kravitz, R. L. (2007, September). Let's Not Talk About It: Suicide Inquiry in Primary Care. *Annals of Family Medicine*, 5(5), 412-418.
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- Singhal, A., Ross, J., Seminog, O., Hawton, K., & Goldarce, M. J. (2014, May). Risk of self-harm and suicide in people with specific psychiatric and physical disorders: comparisons between disorders using English national record linkage. *Journal of the Royal Society of Medicine*, 107(5), 194-204.
- Tsiachristas, A., McDaid, D., Case, D., Brand, F., Leal, J., Park, A.-L., . . . Hawton, K. (2017). General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis. *The Lancet Psychiatry*, 759-767.

Prevalence of fragility fractures and prescribing of medications for osteoporosis in patients with polymyalgia rheumatica (PMR): Results from the PMR Cohort Study

Balamrit Singh Sokhal (speaker) | Dr Samantha L Hider | Dr Zoe Paskins | Professor Christian D Mallen | Dr Sara Muller

Background:

- Polymyalgia rheumatica (PMR) is an inflammatory condition
- PMR is treated long-term with glucocorticoids; this can cause osteoporosis.
- Bone protection medication is advised as prophylaxis.
- Aim was to assess a) factors associated with fractures and b) whether bone protection medication was being prescribed.

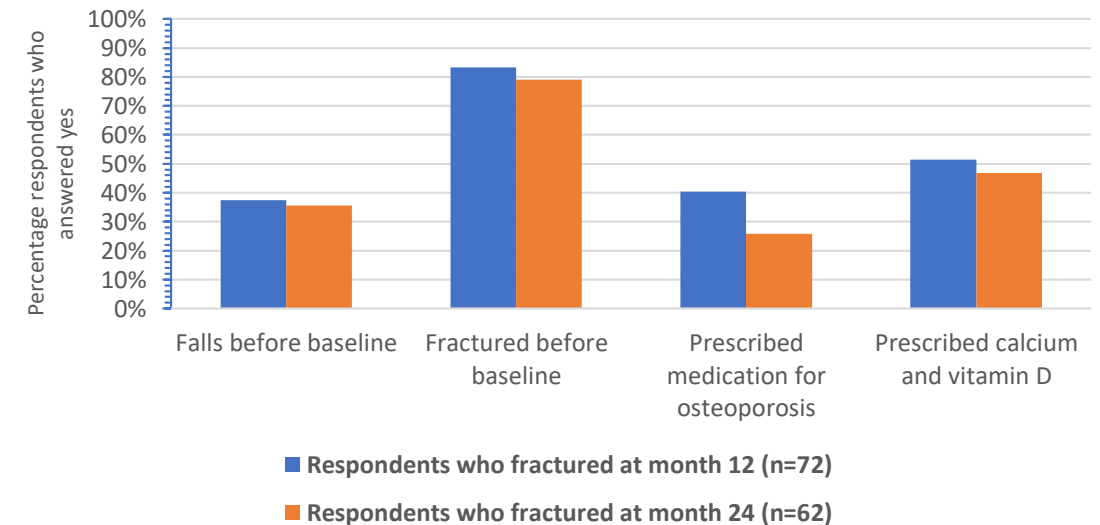
Methods:

- PMR patients responded to a survey at months 0, 12 and 24 which provided information on their prescriptions and fracture history.
- Fragility fractures were grouped as fractures of the hip, wrist or spine.
- Logistic regression models were used to assess association between baseline features and fractures.

Results:

- Prescribing rates of bone protection medication was low.
- Falls were the strongest predictor of future fragility fractures.
- Age, gender and calcium and vitamin D prescription had no association with fractures.

Baseline characteristics of respondents who experienced a fragility fracture at month 12 and month 24



Conclusions:

- Clinicians should consider asking about a history of falls and considering interventions to address falls.
- Further research needed to investigate prescribing habits of GPs around medications for osteoporosis.
- Future studies that explore in more detail the prognosis of PMR patients with previous falls and fractures may be needed as falls are currently not included in FRAX[®] assessments.

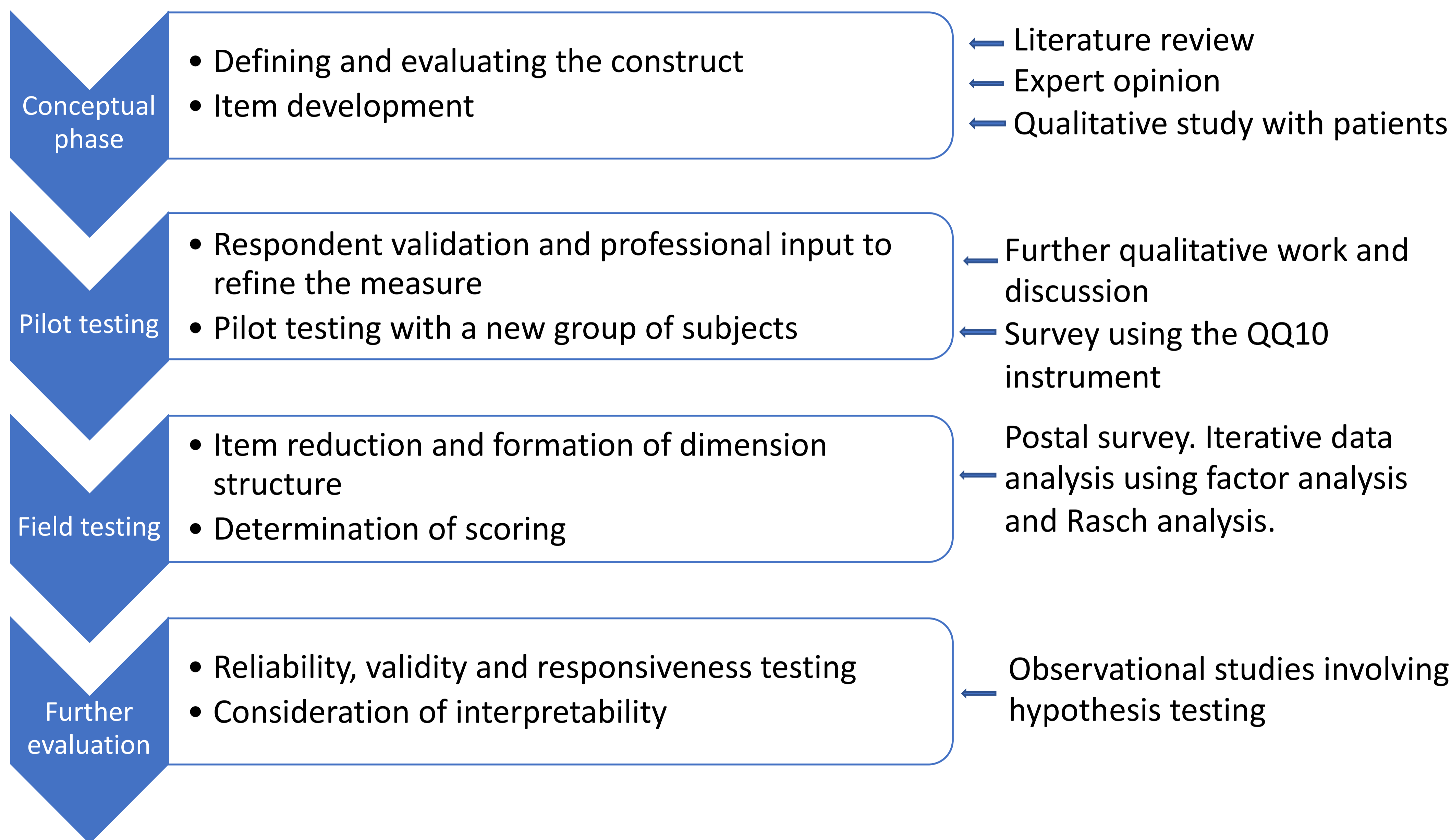
Development and evaluation of the PMR-Impact Scale (PMR-IS)

Helen Twohig¹, Christian Mallen¹, Caroline Mitchell², Sara Muller¹,

1. School of Primary, Community and Social Care, Keele University, Keele, Staffordshire, ST5 5BG, UK 2. Academic Unit of Primary Medical Care, University of Sheffield, Sheffield, UK

PMR is the most common inflammatory rheumatic condition in people aged over 50. It causes pain, stiffness and disability and has a major impact on quality of life. Despite this, there are no validated outcome measures that assess PMR from a patient perspective.

We have developed a patient reported outcome measure (PROM) to assess PMR-related quality of life, **the PMR-impact scale (PMR-IS)**, with scales for symptoms, function, psychological and emotional well-being and steroid side-effects.



The PMR-IS is currently being evaluated to assess its construct validity, test-retest reliability and responsiveness.

Links to related publications: Systematic review <https://doi.org/10.3899/jrheum.200248> Qualitative study <http://dx.doi.org/10.1016/j.pec.2014.12.013> Pilot testing <https://link.springer.com/article/10.1186/s40814-017-0150-y> OMERACT proceedings <http://www.jrheum.org/content/44/10/1515> <http://www.jrheum.org/content/early/2019/03/24/jrheum.181050>

Comments and questions welcome - h.j.twohig@keele.ac.uk.

Helen Twohig is funded by a Wellcome Trust Primary Care Doctoral Fellowship.

This poster presents independent research funded by the National Institute for Health Research (NIHR) awarded to CDM. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

Background

Combined Oral Contraceptive (COC) is associated with increased risks of adverse events such as venous thromboembolism and stroke. Correct prescribing is important to prevent complications associated with its use. The UKMEC and NICE provide national guidance to ensure safe prescribing of COC.

Standards

1. The **UKMEC** evaluates women's risks and assigns them to one of four categories, representing their eligibility for COC use¹.

Category	Definition
1	No restriction for the use of COC
2	Advantages of using COC generally outweigh the theoretical/proven risks
3	Theoretical/proven risks usually outweigh the advantages of using COC
4	Unacceptable health risk if COC is used

Figure 1: UKMEC Category¹

2. **NICE** recommends a thorough assessment at every initial and follow-up visit, which includes blood pressure and BMI measurements, enquiry about risk factors for complications linked to its use, and general pill advice².

Method

This preliminary study reviews COC prescriptions at a local GP surgery and analyses its compliance to national guidelines for safe prescribing.

Using the EMIS database, a retrospective, cross-sectional review of medical notes from 75 patients was conducted. These patients were aged 15-49 years and were prescribed COC between 01/08/2018 and 01/02/2019.

Aims

1. Identify **high-risk** prescriptions (UKMEC Category 3 and 4)

2. Evaluate the documentation of **14 parameters** of risk assessment set by NICE in the latest COC consultation for every patient

Results

Figure 2: Percentage of patients in their respective UKMEC category

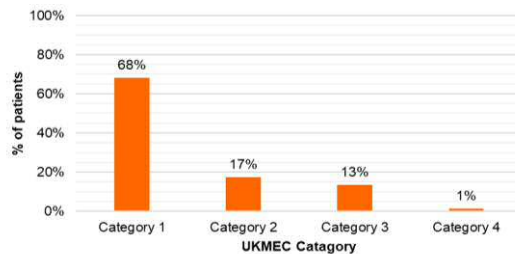


Figure 3: Overall documentation rates of 14 parameters in the risk assessment

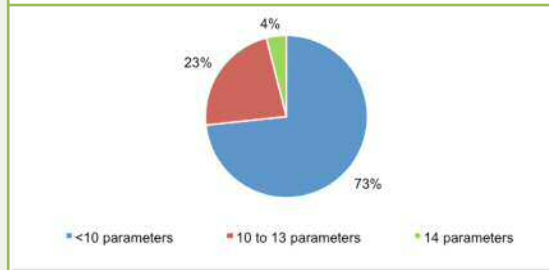
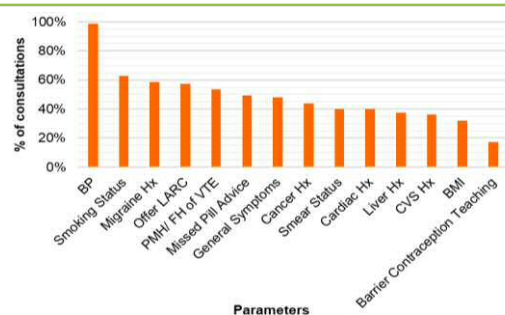


Figure 4: Documentation rates of arranged in descending order of adherence



Discussion and Conclusion

1. This study shows that a proportion of women in the practice were still receiving COC, despite being deemed "unsafe" by the standards. The increased health risks faced by these women are unnecessary, given the availability of alternative contraceptive methods.

2. The practice failed to meet the standards for safe prescribing. Potential reasons for substandard documentation and recommended changes are shown below:

Potential Reasons

Poor understanding of the guidelines

Clinicians' negative attitudes towards a COC template

The perception of a COC clinic as a 'catch-up period' rather than a full risk assessment

Over-reliance on own experiences and the EMIS summary page

Recommended changes

To promote awareness of prescribing safety through posters and staff re-training

To enhance the accessibility of the current COC template

To use pre-consultation questionnaires to allow patients to self-report any symptoms and risk factors before a COC appointment

Such variability in prescribing behaviour may have detrimental health consequences. A re-audit should be performed to measure progress of changes and compliance in future practice.

References

- [1] UKMEC 2016. (2016). Faculty of Sexual and Reproductive Healthcare. Retrieved April 24, 2019, from <https://www.fsrh.org/standards-andguidance/documents/ukmec-2016/>
 [2] NICE: Contraception - combined hormonal methods. (2018). NICE. Retrieved April 24, 2019, from <https://cks.nice.org.uk/contraception-combinedhormonal-methods#lscenario>



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE

PARALLEL SESSION A.2 – MEDICAL EDUCATION (10:10 – 11:10)

SESSION CHAIR – Dr Caroline Sprake, Associate Subdean Primary and Community Care
(Tyne & Northumbria) School of Medical Education, Newcastle University

SESSION SUPPORT – Alison Waring, Academy of Primary Care, Hull York Medical School

1	Achint Bajpai	University of Central Lancashire	Learning and recommendations from significant event analyses of bowel cancer cases
2	James Bennett,	Hull York Medical School, University of Hull	A curriculum review: Evaluating if the HYMS MBBS curriculum is designed to deliver on national guidance for general practice teaching
3	Charlotte Ford	Newcastle University	Exploring medical students' challenging experiences in clinical environments
4	Ameera Iqbal,	Lancashire & South Cumbria NHS Foundation Trust	New roles - Psychology graduates in general practice and community care focusing upon mental health prevention and promotion
5	Liam McHale	Newcastle University	'Just a GP' - exploring the issue of denigration within medicine
6	Michael Harrison	Newcastle University	How does the introduction of a new year 3 curriculum affect future commitment to teach? A realist inquiry of third year GP clinical teachers at Newcastle University
7	Lily Lamb	Newcastle University	The Elephant in the room: Does giving students the opportunity to share their personal experience of an emotive clinical topic have an impact on the subsequent teaching session
8	Katie Munro	Newcastle University	Differences in GP recruitment between medical schools: a quantitative study of FY2 career choices

Achint Bajpai¹, Nicola Cooper-Moss¹, Neil Smith², Angela Dunne², Umesh Chauhan¹
 1. School of Medicine, Faculty of Health and Biomedical Sciences, University of Central Lancashire, Preston, UK.
 2. Lancashire and South Cumbria Cancer Alliance, UK.

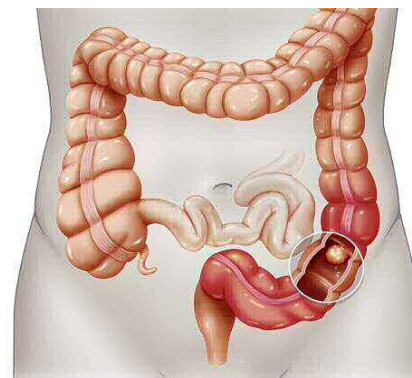
Introduction

Significant Event Analysis (SEA)

- Educational quality improvement approach developed in the mid 1990s in the UK
- Team meeting to discuss and critically assess a significant event, e.g. new cancer diagnosis
- Learning points and recommendations for improving quality of care

Bowel Cancer

- 11% of new cancer cases in the UK (2017)¹
- 2nd leading cause of cancer mortality²



Aims

Improve understanding of the diagnostic pathway for bowel cancer and identify areas for improvement in patient care from a primary care perspective

Methods

Financial Incentive scheme in Pennine Lancashire which asked practices to review bowel cancer cases in the preceding 3 years (Diagram 1).

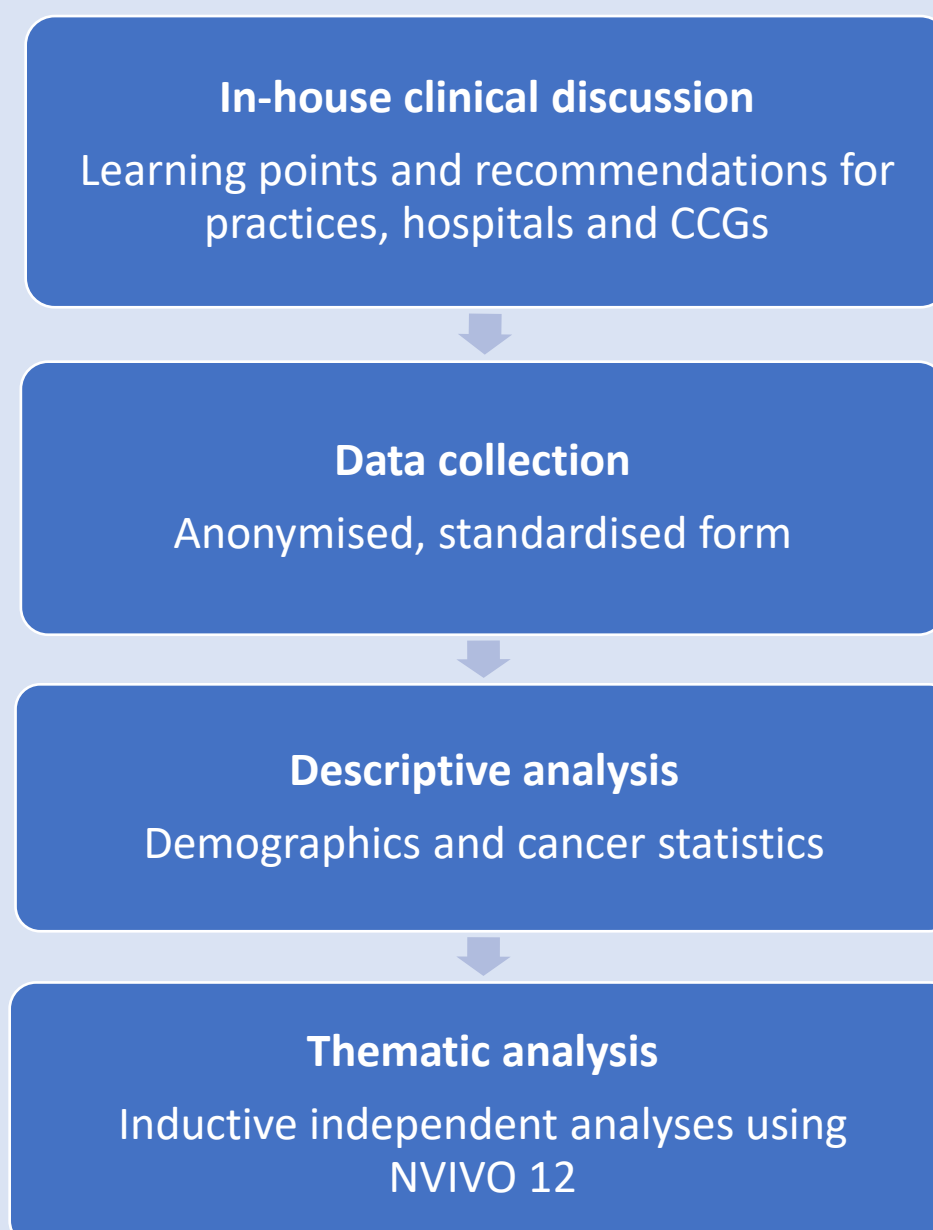


Diagram 1: Data collection & analysis

Results

Participants and patient characteristics

- 53/75 (71%) practices submitted 161 SEA reports
- 86 (53%) were male with a mean diagnosis age of 68 years (SD 14)
- 72 (45%) reported nodal spread and 27 (17%) metastases
- Most patients were still alive (67%) at the time of the SEA meetings

Learning and recommendations for General Practices

Diagnosis

- Increased awareness of diagnostic factors (table 1)
- Building vigilance for atypical presentations (diagram 2)

Table 1: Diagnostic factors for bowel cancer in primary care

Be aware...	
Red flags	Clinical assessment
<ul style="list-style-type: none"> Change in bowel habit Rectal bleeding Iron deficiency anaemia Thrombocytosis ↓appetite/weight 	<ul style="list-style-type: none"> Individualised History of symptoms Family history Abdominal and rectal exam (low threshold)
Beware...	
Atypical presentations	Diagnostic overshadowing
<ul style="list-style-type: none"> Asymptomatic Lack of "classic" symptoms Unchanged bowel habit Younger patients False negative investigations 	<ul style="list-style-type: none"> Haemorrhoids Intentional weight loss Multi-morbidity Repeat presentations

Investigation, Referral and Follow-up

- Lower threshold for 2-week suspected cancer referral
- Faecal immunochemical test (FIT) > younger/atypical
- Diagnostic limitations of computed tomography (CT) scans
- Direct access to scans when endoscopy is inappropriate
- Pro-active follow-up, continuity & safety-netting

"Bowel cancer affects younger patients as well. Patients can feel fairly well/work even with metastatic life threatening cancer"

"Remember to do the FIT test in patients with vague abdominal symptoms"

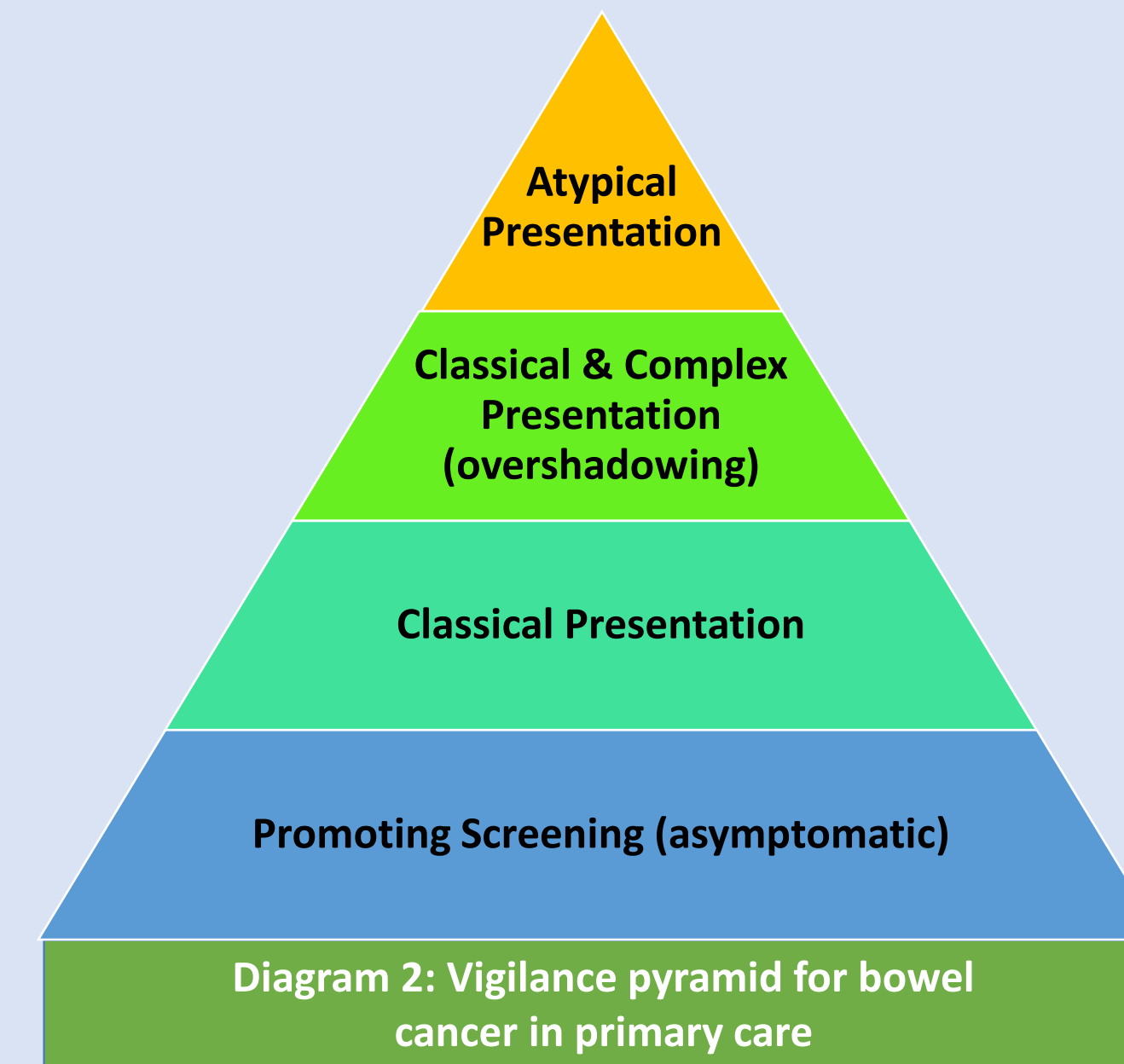


Diagram 2: Vigilance pyramid for bowel cancer in primary care

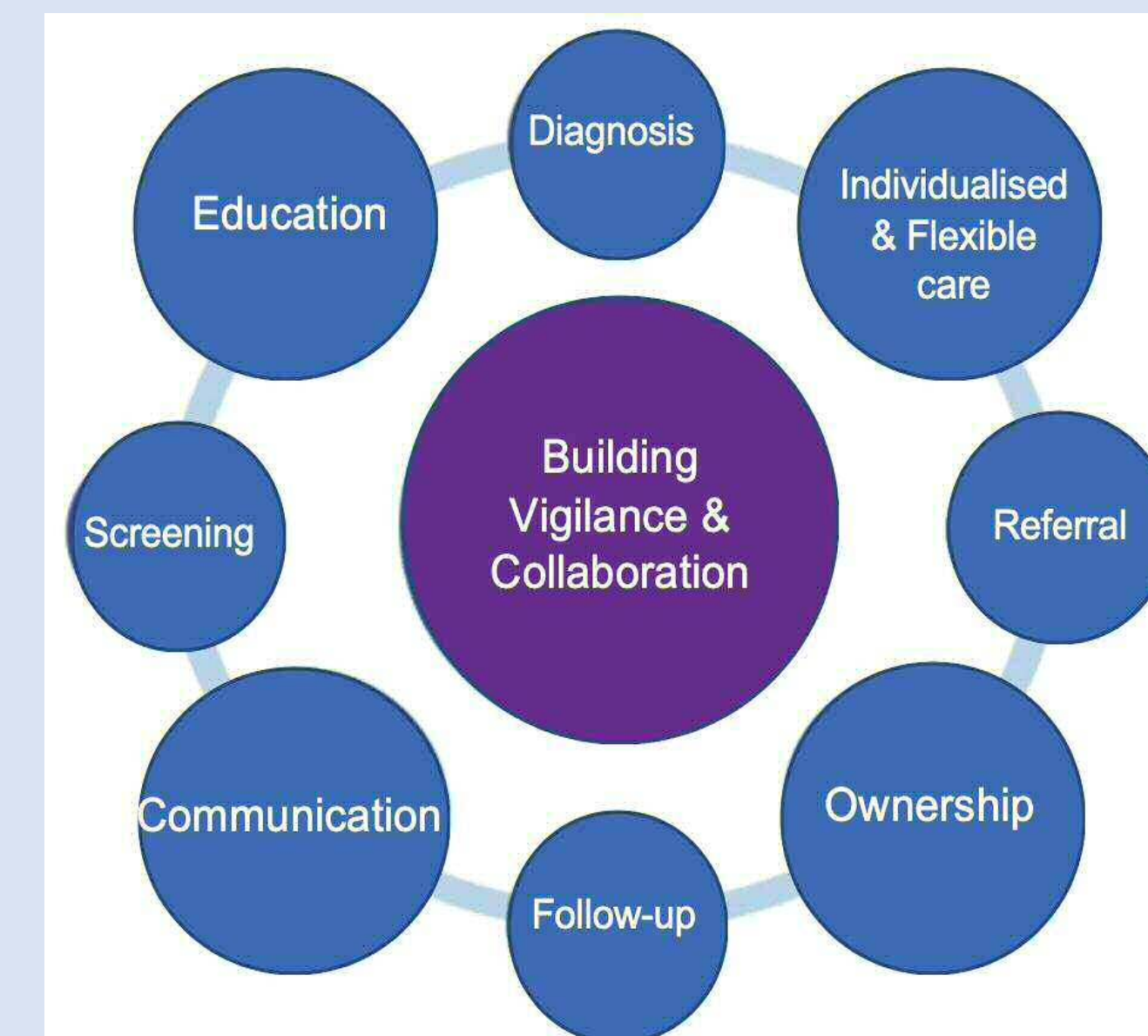


Diagram 3: Summary of main themes

Recommendations for Hospitals

- Radiological access and reduce reporting times
- Ownership of patient follow-up
- Improved communication with patients/GPs

"Continue providing access to CT scans for GPs as this is likely to save lives"

Promote discussion and reflection between primary and secondary care"

Recommendations for Commissioners

Screening

- Promotion & systems for follow-up of non-responders

Education

- Raise patient awareness of symptoms
- Sharing of learning from multi-site SEA projects

Referrals and Communication

- Flexibility with referrals and systems for follow-up
- Oversee effective communication between 1^o & 2^o care

"Advertise and talk about the importance of bowel screening"

"Ensure practices are following best practice to ensure that all 2WW referrals are coded and followed up"

Discussion

Significance

- Findings confirm and provide additional insights to the existing literature on bowel cancer from a primary care perspective.

Key Recommendations

- Utilise learning for assessment and follow-up of patients with varying presentations.
- Support practices in developing systems and protocols.
- Shared ownership and communication between primary and secondary care.
- Peer education and identification of improvements in cancer pathways across primary care networks.

Future Considerations

- Screening, patient education and access to investigations are paramount for improving early diagnosis of bowel cancer, however, a flexible diagnostic approach is required according to the individual circumstances of each patient.
- Further research on the use of SEA for improving cancer outcomes, and the factors influencing system-level change.

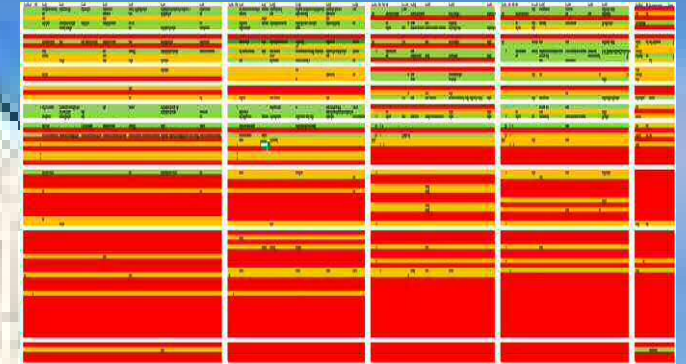
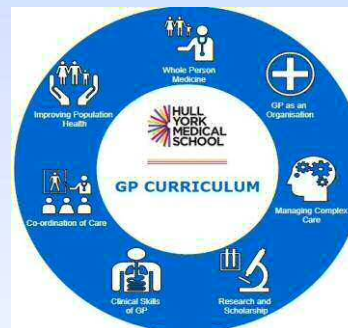
Why review things?

- Primary care is the bedrock of the NHS but it is struggling¹
- GP recruitment crisis - medical schools have a responsibility to act²
- Impact of losing generalist skills in medicine on patient care³
- All doctors need to understand general practice
- Are we educating our students to understand general practice and generalist medicine?

1. Roland M and everington S. Tackling the crisis in general practice. BMJ 2016; 352:i942
2. <https://www.hee.nhs.uk/sites/default/files/documents/by%20choice%20-%20not%20by%20chance.pdf>
3. Reeve et al. Revitalizing general practice: the montreal statement. Annals of family medicine 2018;16(4):371-3

What we've done

- Literature review to identify key national and international documents e.g. Wass, RCGP/SAPC
- Thematic analysis identify a framework of core themes that must be taught
- Applied to formal analysis of curriculum documents
- RAG analysis highlighting areas of strength and possibility to improve



What next?

- RAG – effect of method or real?
- We need to know more
- Semi-structured interviews with students and tutors
- De novo thematic analysis of new data and creation of new framework – had we missed anything?
- Any trends so far?

Medical Students Challenging Experiences in Clinical Learning Environments

Charlotte Ford (c.ford2@newcastle.ac.uk), Dr Michael Harrison, Dr Hugh Alberti. School of Medical Education, Newcastle University.

1) Introduction

Medical students commonly encounter challenging experiences on clinical placement¹. These can affect the learning process, learner wellbeing and satisfaction².

Efforts have been made by medical schools in recent years to address bullying and undermining behaviour¹. Despite this, significant concerns remain locally that challenging experiences are impacting negatively on student learning in clinical environments.

2) Aims:

- 1) Gain an up-to-date understanding of the challenging experiences students at Newcastle University encounter during clinical placement.
- 2) Understand the impact on them.
- 3) Understand student perspectives on the support and education they would find most helpful to cope.

3) Method

3rd and 4th year medical students from Newcastle University were invited to participate via email.

Semi-structured narrative, individual interviews were conducted. Interviews were audio recorded, transcribed and thematically analysed.

Acknowledgements

With thanks to National Institute for Health and Research (NIHR) School of Primary Care Research for funding.

References

- 1) Cook AF, Arora VM, Rasinski KA, Curlin FA, Yoon JD. The prevalence of medical student mistreatment and its association with burnout. *Acad Med.* 2014;89(5):749-54.
- 2) Genn JM. AMEE Medical Education Guide No. 23 (Part 1): Curriculum, environment, climate, quality and change in medical education-a unifying perspective *Med Teach.* 2001;23(4):337-44.

4) Results

- Interviewed: 8 fourth year medical students and 1 third year medical student.
- Figures 1 to 3 display the results. The number of each Figure corresponds to each of the three numbered aims.



Figure 1: What challenging experiences were reported?

Figure 2: What was the impact?

Support and education students perceive to be helpful

Education of staff regarding medical student presence in a clinical environment.

More specialised student support.

Additional communication skills training.

Improved teaching organisation.

Teaching in how to teach.

Improved preparation for clinical learning.

Figure 3 : Support or Education students perceived useful to help them cope more effectively.

5) Discussion

Hierarchy- Students reported situations. They felt:

- unable to challenge doctors,
- were reprimanded,
- or were put on the spot.
- Challenging experiences with patients:
 - issues of consent,
 - difficult discussions with patients,
 - inappropriate behaviour.
- Often they did not feel part of the clinical team.
- Challenging experiences both positively and negatively affected learning, confidence and career intentions.

“Because obviously he’s a consultant and he’s much, much higher up than me on the hierarchy. We were in a room full of other professionals and we were just medical students.”

“It was definitely a speciality I was quite interested in looking into and pursuing and it’s kind of put me off completely.”

6) Conclusion

This study has highlighted types of challenging experiences in clinical learning environments and how these had significant impact on medical students.

We recommend increased active involvement of students in clinical environments, provision of specialised support services, improved and transparent reporting systems for alleged bullying or mistreatment, and further studies exploring perceptions of senior doctors on this subject.

Psychology graduates in general practice and community care focusing upon mental health prevention and promotion.

Ameera Iqbal
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The problem

- ❖ Approximately **40%** of primary care consultations have a mental health component (1).
- ❖ GP's are under significant **time and resource restraints** to meet mental health needs (1)
- ❖ From 2021, PCN'S will be able to use **additional funding** from NHS England to employ mental health professionals

Why it matters

- ❖ Mental health prevention and promotion in primary care has been found to be **cost effective** (2).
- ❖ It is important for the sustainability of NHS services to have an effective workforce in primary care that can deliver mental health **preventative and promotion** interventions.
- ❖ Better integration with the community to **boost resilience** and support community resources is vital for **effective healthcare** (3).

What we can do

- ❖ Offer **1:1 wellbeing** promotion sessions
- ❖ Up to **4 sessions**, each being approximately 45 minutes long
- ❖ **Run a group** that focuses upon the 5 ways to wellbeing ('The Positive Steps Programme')
- ❖ Run **wellbeing promotion sessions** in the community
- ❖ Support local community groups to **normalise** mental health & **promote** positive wellbeing
- ❖ **Increase resiliency** among community members

Who can benefit?

- ❖ **'Pre-caseness/diagnosis'**
- ❖ Those who are feeling **anxious** or struggling in relation to covid-19
- ❖ People who require **specific focused prevention** advice
- ❖ Those whose physical health conditions are impacting upon their mental health.
- ❖ **Everyone!** There is 'no health without mental health'
- ❖ We can work with **any age group**



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Banter or Bashing? Capturing Denigration in the Northern Region



L McHale, A Wood, H Collingwood, H Alberti, School of Medical Education, Newcastle University

1. Background

- The General Medical Council (2012) highlights that doctors should **tackle discrimination** and **respect each persons' skills and contributions**.
- Research by Alberti et al (2017) has shown denigration is a growing concern which may have an influence on recruitment into specialities already under pressure.
- The Covid-19 pandemic has increased pressure across both Primary and Secondary Care services. Primary Care has received its fair share of this criticism in both the national media and on social media, leading to concerns this may compound the problem of denigration that we know was already significant.

2. Aims

To investigate the occurrence of denigration in the Northern Region on an annual basis and promote ways to tackle the issue, in line with GMC Guidance

3. Methods

Data from three surveys has been analysed and compared on an annual basis from 2016 onwards. Assessment regarding any change in prevalence of the issue of denigration was made.

- The **'Your School, Your Say'** survey (YSYS) is distributed to foundation doctors and asks *"So far in your Foundation training have you received any positive or negative comments regarding any choice of speciality?"*
- The **'Career Choice'** survey (CCS) is sent to all medical students in their final year of Newcastle University's MBBS programme. Students are asked *"Have you have heard any positive or negative comments regarding their choice of speciality?"*
- The **'GP Training Scheme'** survey (GPTSS) is sent bi-annually to GP Registrars as a way of collecting feedback on placement experience. It includes the question *"In this post have you had any specific comments made, either positive or negative, about your choice of career?"*

4. Results

- Denigration continues to be experienced by medical students, foundation doctors and GP trainees across the region.
- Negative comments have been experienced in relation to many specialities and is most frequently seen in general practice, followed by medical, surgical and psychiatry specialities.
- Whilst most medical and surgical specialities attract both positive and negative comments, the themes within these does appear to differ.
- The CSS survey suggests a fall in negative comments received compared to previous years

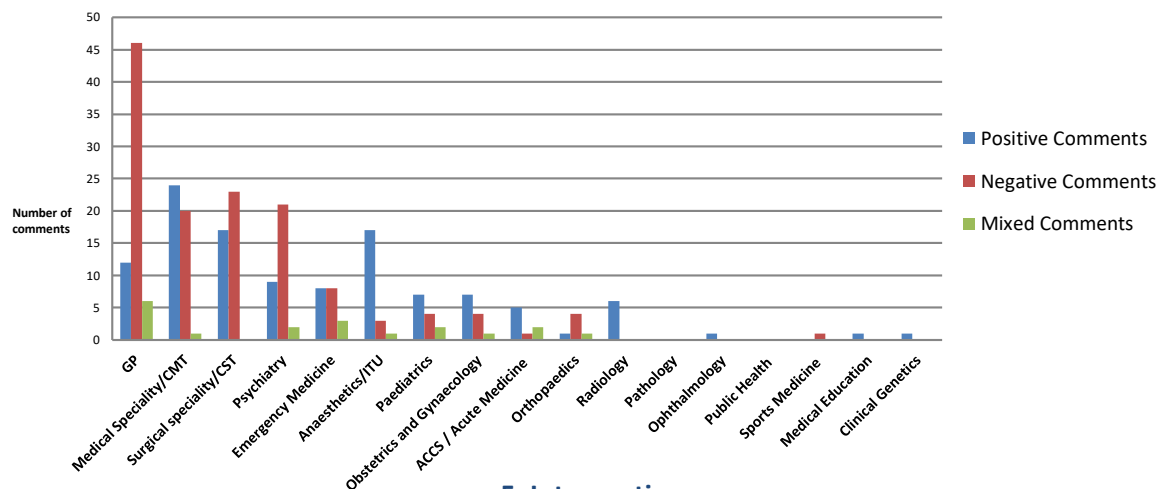
Table 1 - experienced negative comments in relation to a speciality choice (CSS survey)

Option	2018/19		2017/18		2016/17	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Yes	47	38	143	64	144	57
No	78	62	79	36	107	43

Table 2 - Types of comments experienced in relation to speciality choice from the GPTSS survey

Comment type	Aug-16	Feb-17	Aug-17	Feb-18	Aug-18	Feb-19	Aug-19
Positive	83%	83%	85%	0%	92%	85%	87%
Negative	11%	11%	9%	0%	5%	11%	9%
Mixed	6%	6%	6%	0%	4%	4%	4%

Figure 1- 2019 YSYS survey data: comments about chosen speciality



5. Interventions

Over the last 4 years Newcastle Medical School has implemented a number of initiatives in order to reduce denigration of General Practice as a career choice. These have included:

- Introducing an "Informal curriculum" workshop for our Year 4 students to discuss and highlight the issue,
- Implementing a "teaching the informal curriculum/role-modelling" workshop for our teachers at Newcastle University,
- Highlighting the issue within our local HEE training programmes,
- Highlighting the issue locally through local and national publications,
- Tracking denigration comments through the surveys reported in this study.

6. Overall Conclusion

- Denigration is an issue occurring within the northern region and whilst we have no indication to believe this is more problematic here than elsewhere in the United Kingdom, the results remain concerning.
- Some trainees are subjected to negative comments being made regarding their choice of speciality.
- Data from the CSS survey shows that there has been some improvement in the number of negative comments students are exposed to.

Despite intervention inter-speciality denigration persists - what more should be done to address this problem?

How does the introduction of a new year 3 curriculum affect future commitment to teach? A realist inquiry of third year GP clinical teachers



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Background

In western countries, there are trends towards increasing amounts of undergraduate medical education being delivered in General Practice (GP)(1). However, medical schools commonly experience problems with recruitment and retainment of GP clinical teachers (2). Shortages of GP clinical teachers may be a barrier to the expansion of GP teaching in the future. Newcastle University recently introduced its new year 3 GP curriculum, involving an increased quantity of community-based teaching and changes to the roles and responsibilities of GP clinical teachers (Table 1). Such changes have the potential to affect, both positively and negatively, teacher engagement and future teaching commitment.

Method

This study used a realist inquiry, as described by Pawson and Tilley (3). Initially, a candidate theory of how the new curriculum may affect future teaching commitment was developed (Initial Programme Theory (IPT))(Table 2). This was done informally based on personal experience, 'hunches', relevant literature and informal feedback from GP clinical teachers. Subsequent data collection and analysis aimed to confirm, refute and refine the IPT in order to generate a final theory (Programme Theory (PT)). This was done via 10 semi-structured interviews of GP clinical teachers, with use of analytical techniques as per Gilmore et al (4).

Table 2: Initial Programme Theory (IPT)

	Context	Mechanism	Outcome
IPT1	Change in curriculum ie. Increase in teaching required, opportunities to teach core clinical topics	Increased sense of responsibility Increased motivation to teach	Increased personal engagement and interest in third year teaching
IPT2	Opportunity of promote GP more to students	Increased sense of value of being a GP and a GP teacher	Increased personal engagement and interest in third year teaching
IPT3	Increased finances provided for teaching in GP	Increased motivation due to perception of funds	Increased financial benefits for practice

Aims

- This study sought to explore how the introduction of the new year three GP curriculum affects future teaching commitment in year 3 GP clinical teachers.
- It aimed to explain which aspects of the new curriculum increase, and conversely reduce, the future commitment of year 3 GP clinical teachers to continue being involved in year 3 clinical teaching; in what context this occurs; how and why

Results

Table 3 outlines the final PT that arose out of progressive theory refinement during data collection and analysis.

Table 3: Final Programme Theory (PT)

CMO-Cs contributing to final PT	Context (C)	Mechanism (M)	Outcome (O)
CMO-C1: Impact of increased teaching demands	C1- increased teaching demands C2- positive practice teaching ethos, with teaching responsibilities shared across multiple staff members and adequate human and non-human adequate resources for teaching	M1- collective responsibility for teaching M2- mobilization of practice resources (including human resources) M3- reduced personal stress on lead GP teacher	O- practice maintains capacity to meet increased demand from teaching, with subsequent maintenance of personal and practice engagement with, and interest in, third year teaching
CMO-C2: Impact of prescribed lesson plans	C1- prescribed lesson plans with fewer opportunities for patient contact C2- teacher tendency towards controlled causality orientation	M- reduction in autonomy	O- reduced personal engagement, and interest in, third year teaching
CMO-C3: Impact of being given new roles and responsibilities	C1- opportunity to take on new teaching roles and responsibilities, that were previously undertaken by the hospital (enabling increased opportunities to promote GP to students) C2- feeling competent to undertake role or responsibility	M1- increased sense of value M2 increased sense of responsibility	O- increased engagement with, and interest in, third year teaching
CMO-C4: Different opportunities to teach primary care orientated medicine/ facilitate patient contact	C- opportunity to teach generalist/primary care orientated medicine, with focus on facilitating patient contact	M1- increased intrinsic enjoyment and teaching satisfaction M2- fitting with identity of self as a generalist M3- increased motivation	O- increased personal engagement, and interest in, third year teaching
CMO-C5: Impact of increased finances provided for teaching	C- increased finances provided for teaching	M- increased motivation due to perception that remuneration is now adequate to maintain clinical capacity and avoid financial loss	O- increased practice engagement with undergraduate teaching

Acknowledgements

Many thanks to the GP teachers who agreed to participate in the study. Also thanks to Prof Jan Illing and Prof Bob McKinley, who provided additional guidance regarding realist methods.

Table 1: Overview of changes to year 3 curriculum

Additional half day per week in GP from Semester 2
Increased financial remuneration provided for teaching
New roles and responsibilities: <ul style="list-style-type: none"> - Academic mentorship; - Supervision of clinical audit
Change in teaching content- transfer of delivery of teaching of core clinical topics from hospital to primary care
Change in teaching activities: <ul style="list-style-type: none"> • Different opportunities for clinical contact/tutorials; • 'Flipped classroom' used, with pre-written lesson plans for tutorials

Conclusion

- Different teachers are **affected in different ways, influenced by practice and individual contexts.**
- Some parts of the new curriculum result in reduced future teaching commitment, **e.g. prescription about teaching content reduces autonomy in certain teachers.**
- Whereas other aspects of the curriculum result in increased commitment **e.g. opportunities to teach primary care-orientated medicine and facilitate patient contact.**
- **Mechanisms relating to autonomy, identity and sense of value** may be particularly important in facilitating teacher commitment.
- The results allow medical schools to **better understand how GP teacher retention can be facilitated during curricular change.**
- We make recommendations that include **advocating a practice team-based approach to teaching, paying attention to teacher autonomy, and viewing patient contact in relation to primary care-orientated medicine as central to GP teaching.**

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THE ELEPHANT IN THE ROOM: Does giving students the opportunity to share their personal experience have an impact on a potentially emotive teaching session?

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Introduction

As a teacher of MBBS students from Newcastle University for 6 years, I have noticed that in teaching sessions where a more challenging topic is being discussed, such as cancer, neurological conditions or mental health, it sometimes feels as though there is an ‘elephant in the room’, a problem that everyone knows about but does not mention as it is easier not to discuss (Hornby, 2010). Some students seem to disengage, some look visibly emotional, some use dark humour, I feel uncomfortable and the process does not feel holistic or learner centred.

Approach

I undertook a practitioner inquiry to assess an intervention to encourage sharing of personal illness experience. With ethical approval from Newcastle University I adopted a pragmatic methodological approach (Lofthouse, 2014) and asked four third year students to share their own personal experiences of cancer with the group, prior to a teaching session with those students on cancer and palliative care. I then ran a focus group with the students to discuss the impact of the intervention. An independent observer completed a reflective account of the session, and I kept my own reflective log. Thematic analysis (Braun and Clark, 2006) of recorded transcripts was undertaken.

Results

Theme	Examples	
Learning from other's experience 'putting yourself in their shoes'	Hearing other's experience is helpful when you have little experience yourself	'I rely on TV and Youtube as I have had no personal experience of cancer, but hearing other's stories really made me think about the impact on that person and their family'
Appreciating the impact of personal experience	'When I was talking it struck me that actually my experience had impacted on me quite a bit, without me realising'	'It was a nice change to be asked about my personal experience'
Lack of previous opportunities to reflect on personal experience	'Usually when it comes to controversial topics we experience quite the opposite, your experience is actively not discussed'	'I think that has hindered discussion'
Respect for other's experience	'Having time to share made a big difference and helped gauge everyone's levels'	The intervention helped facilitate respect for and understanding of each other
Importance of being comfortable in the learning environment	'I feel comfortable with the tutor and other group members so feel confident to talk about personal experience'	General feeling this intervention would be uncomfortable in a secondary care environment, unless they knew the teacher/ group well
Getting the timing of the intervention right	'I wasn't fully focussed immediately after the discussion, I kept thinking about the experiences of the rest of the group'	'I've managed to detach my emotions from my personal experience, so didn't find it challenging to transition to the next part of the session'
Emotional detachment from personal experience	'I've managed to wall of my emotions, but I think if I hadn't I would have found sharing my personal experience difficult and it would have been hard to go through the rest of the session'	General acknowledgement that if an individual had experienced a recent bereavement that would be hard to share and may affect learning in the rest of the session
Hearing real life cases aids learning	'All I see is the disease, I have no personal experience of cancer, and feel this is a negative for me'	Discussing cases aids with memorising subject matter, provides something to 'hang new knowledge on'
Understanding impact on medical student's family members and that this may affect the student's career choice within medicine	Discussing real cases from a personal perspective aids understanding of the families perspective of healthcare and the health narratives that result from this	'My Nana said don't be a GP- she saw the GP as responsible for killing her husband, she knows I want to be a GP and she no longer speaks to me'
Impact on professional role	Personal experience can impact on how you provide care for your patients	Role modelling of behaviours in teaching sessions that can be carried through to the consultation

Conclusion

A practitioner inquiry provides clarity on what can be done in complex situations (Baumfield et al., 2012). This simple intervention of asking students to share their personal experience of cancer before a teaching session on that topic was positively received, increased student engagement during the subsequent teaching session and aligns with principles of Humanist learning theory (Rogers and Freiberg, 1994; Kolb, 2015).

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Acknowledgements

The author is funded by an NIHR In Practice Fellowship



Figure 1: A word cloud of commonly occurring words during the focus group

Table 1: Emerging themes from the focus group with supporting quotes and examples



Differences in GP Recruitment between Medical Schools: A Quantitative Study of FY2 Career Choices



Katie Munro and Hugh Alberti; University of Newcastle

In 2019 there were 6.2% fewer full time equivalent qualified permanent GPs than in 2015 [1]

Just 9% of trainees chose to enter GP training directly from FY2 last year, falling from 24% in 2012. Now more than ever we need to increase GP recruitment.

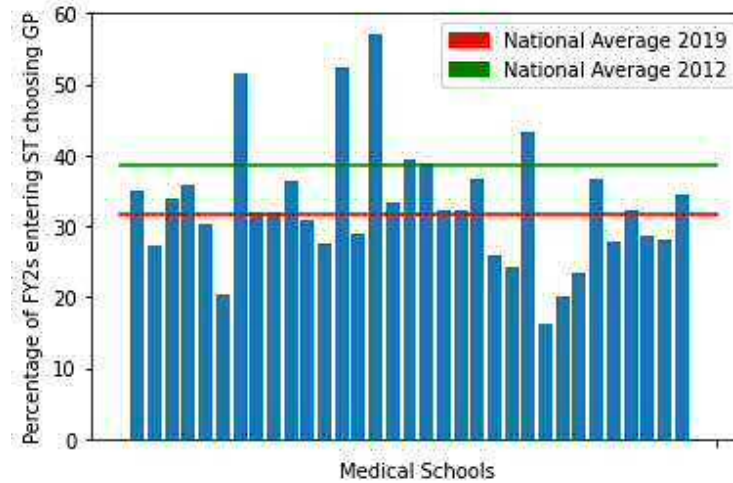
Data published by the Foundation Programme on FY2 career destinations offers an insight into GP recruitment. [2]

Data for FY2 career destinations by medical schools was analysed from 2012 to 2019 inclusive; 2013 was excluded due to lack of data. The proportion of FY2 entering speciality training (ST) choosing GP was looked at to allow year on year comparisons as there is a downward trend in the number of FY2s entering ST directly (down from 68% in 2012 to just 35% in 2019).

The Kruskal Wallis test was performed to determine if there was a statistically significant difference (p value < 0.05 and 1 degree of freedom) between different types of medical schools.

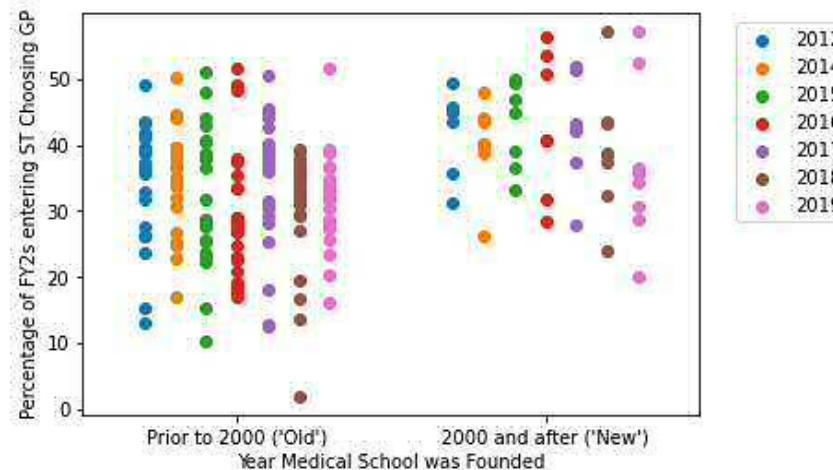
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Variation among medical schools in entry to GP training in 2019

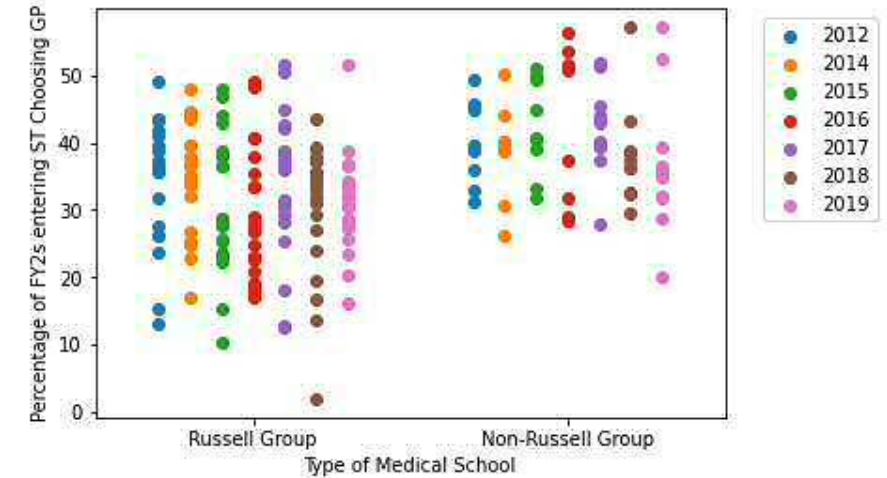


The proportion of FY2s entering ST choosing GP varies widely across all medical school across all years (2019 shown above). The proportion of FY2s entering ST choosing GP has decreased from 38.6% in 2012 to 31.6% in 2019

'New' Medical Schools have higher proportion of FY2s entering GP training



Russell Group Universities have lower proportion of FY2s entering GP training



For every year except 2019 there was a statistically significant difference in the percentage of FY2s entering ST choosing GP between 'Old' and 'New' Medical schools (founded before and after 2000). Similarly a statistically significant difference was found between Russell group and non-Russell group universities between 2015-2018 inclusive.

Further analysis is needed to understand why there is a difference in GP recruitment between different types of medical schools

Previous work by Alberti et al. has shown the amount of authentic GP teaching at medical school correlates with FY2 entry into GP training [3]. Other possible reasons include cultural bias, variations in curriculum and availability of role models.

References:

1. "https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019"
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3. Alberti et al. doi:10.3399/bjgp17X689881



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE
PARALLEL SESSION A.3 – PATIENT PERSPECTIVES (10:10 – 11:10)

SESSION CHAIR – Dr Paul Whybrow, Academic Lead for Health & Society, Hull York Medical School

SESSION SUPPORT – Professor Joanne Reeve, Academy of Primary Care, Hull York Medical School

1	Hassan Awan	Keele University	How do people of South Asian origin with long-term physical conditions understand, experience and seek help for emotional distress? A systematic review
2	Carolyn Chew-Graham	Keele University	Finding the 'right' GP: a qualitative study of the perspectives of people with long-COVID
3	Kate Fryer	University of Sheffield	Co-constructing explanations for persistent physical symptoms: knowledge work in action
4	Victoria Hodges	University of Sheffield	What are the support needs of family carers making health care decisions for people with dementia? a systematic qualitative review and framework synthesis
5	Emily Devoy	University of Sheffield	Parents' lived experience of healthcare for children with long term conditions: qualitative interview study
6	Kitty Worthing	Barts Health NHS Trust	Registration without documentation
7	Anna Kathryn Taylor	University of Leeds	'You know where we are if you need us.' The role of the GP in supporting patients following major pancreatic surgery for cancer: A qualitative study

How do men of South Asian origin with long term conditions understand, experience and seek help for emotional distress? A systematic review

Hassan Awan; Faraz Mughal; Tom Kingstone; Carolyn A. Chew-Graham; Nadia Corp
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INTRODUCTION

- People with physical-mental multimorbidity have poor quality of life and worse health outcomes^{1,2}
- People from ethnic minorities
 - are less likely to recognise symptoms which may represent mental health problems and perceive a need for intervention³
 - may not access available services⁴
- South Asians are the largest minority group in the UK, 4.9% of the population⁵ with a diabetes prevalence of 14% (7% in general population)⁶ and coronary heart disease prevalence 11% (5% in general population)⁷

OBJECTIVES

- *How do people of South Asian (SA) origin with long term conditions (LTCs) understand emotional distress, its nature and causes?*
- *What is the experience of people of SA origin with LTCs of emotional distress?*
- *What help-seeking strategies do people of SA origin with LTCs origin use for emotional distress?*

METHODS

- Systematic searches of 8 electronic databases
- 2,581 unique studies found, 19 included in the review

RESULTS



- Definition by emotion: *I had a lot of tension*
- Emotional and physical link: *I got diabetes because of tension only*
- Poverty: *Poverty causes illness and illness causes poverty*

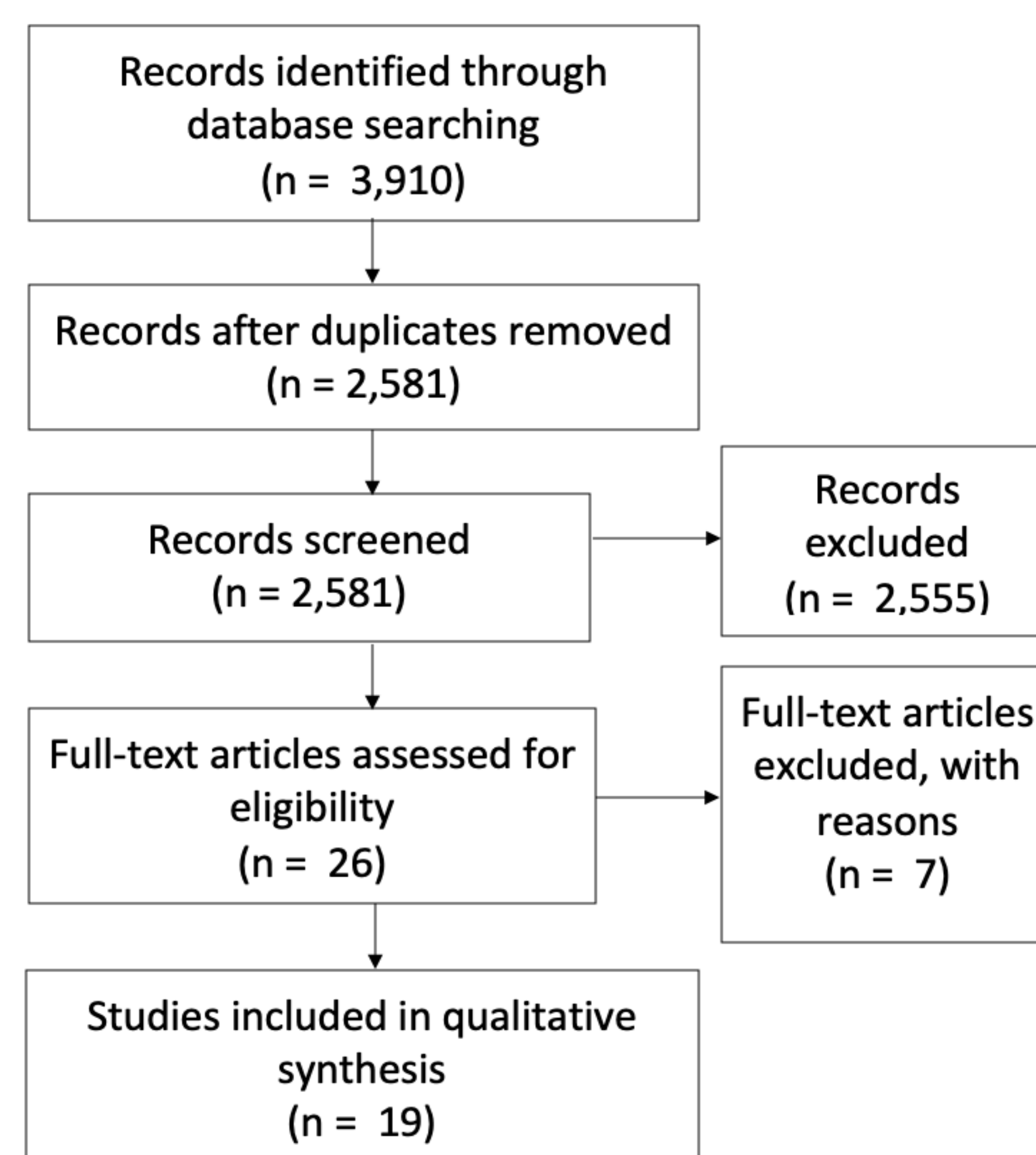
- Distress at diagnosis of long term condition: *And I thought, 'oh my God, it's like the end of me'*
- Acculturation: *Yes in our Indians we take on a lot of tension*
- Male/female differences: *Disappointment vs strong emotion*

- Self-management: *It's your thinking that makes your body feel sick. It's all in the mind*
- Support of friends and family: *When you can count on somebody, even in the back of your mind, you relax*
- Inadequate clinical support: *Doctors are not helping us*
- Higher being: *God will help me*

CONCLUSION

- **People of SA origin with LTCs**
 - Emotional and physical health problems have a complex interaction between each other
- **Practitioners**
 - Clinicians should consider emotional distress when terminology based on emotion such as *tension* and *stress* is used
 - A need for cultural competency in primary care
- **Systems level:**
 - Social determinants of health, in particular poverty, must be addressed to improve emotional distress
- The findings will influence a qualitative study interviewing males of SA origin with LTCs and GPs exploring emotional distress by highlighting key themes from current literature

Figure 1: PRIMSA flow chart





Finding the 'right' GP: a qualitative study of the perspectives of people with long-COVID

Tom Kingstone, Anna Taylor, Catherine O'Donnell, Helen Atherton, David Blane, Carolyn Chew-Graham

DOI:10.3399/bjgpopen20X101143



What's going on?



Methods:

Semi-structured interviews (telephone or virtual platform) with people with long-COVID recruited through social media

Interviews digitally recorded with consent and transcribed

Verbatim

Selective transcribing

Thematic analysis

Findings discussed with people with long-COVID

Long-COVID – 'A new disease'



Findings:

24 interviews

Themes

Hard and Heavy work

Managing symptoms

Accessing care

Living with uncertainty

What is the cause of symptoms?

Is recovery possible?

Finding the 'right' GP

Being believed

Referral for investigation

I really have to pace myself...I have to do a chore, sit down for 15, 20 minutes and then do the next, which frustrates me, it's like peeling potatoes, I can't peel the carrots straight afterwards. P11

My main fear is that obviously the virus is not.... it's new, and I just hope this is not something that is in my body, and it will reactivate you know when I overdo any types of physical or mental activity P13

She just listens a little bit more to what I'm saying and she's much more willing to say, "Of course, we don't really know what's going on because it's a new disease". P 18

Research team

University ethics approval

PPiE / 'experts by experience'

What next?



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[@CizCG](https://twitter.com/CizCG)



Co-constructing explanations for persistent physical symptoms: knowledge work in action

Dr Kate Fryer with co-authors: Professor Chris Burton, Professor Monica Greco, Dr Tom Sanders

Contact k.fryer@Sheffield.ac.uk

Introduction

Multiple Symptoms Study 3 (RCT): Symptoms Clinic

The treatment model has 4
components:

Recognition
Explanation
Action
Learning
(REAL)

Embedded qualitative study to
understand how the intervention
works in practice.

Methods

21 sets of consultation transcripts,
21 participant interviews and 9 GP
interviews were inductively
analysed, drawing on
phenomenology and grounded
theory.

Findings

Training for GPs gives them the ‘tool’ of new and emerging knowledge to use with patients.

Patients respond differently to this information when it is co-constructed with them, rather than receiving it as a pre-prepared monologue.

“so I kind of go through and go ok how am I going to put that, and also adjusting it for the patient’s level of understanding or that kind of thing, so I kind of, I’d kind of sketch out my explanation...but then kind of adapting it to me and that patient” (GP Interview)

The GP facilitates the co-construction in the explanation element by assessing patient’s understanding, and anchoring their explanation to that.

“when I asked you last time about how you understood fibromyalgia you said it’s a primal subconscious part of the brain, and I agree with that, but I want to extend that way of thinking about it” (GP co-constructing explanation with patient)

A successful co-construction between the patient and the GP within the explanation and action elements of the intervention is more likely to engage the patient.

“If I’d gone in for like a normal ten minute appointment and my GP had said try mindfulness, I would’ve said yeah OK, just refill my prescription please...the way that you’d explained it with medical evidence as well, cos I’m a sciencey person, has been really helpful, so it’s made me want to commit to it” (Patient feedback on intervention)

A co-constructed explanation, underpinned by recognition of the patient’s lived experience of symptoms, increases patient engagement.

FUNDED BY

NIHR | National Institute
for Health Research

BACKGROUND

Approximately 700,000 people in the UK provide informal care for some with dementia.

Over 90% of dementia sufferers have at least one co-morbidity

Health care decisions commonly need to be made once the person with dementia lacks capacity to make them

Understanding the support needs of carers facing proxy health care decisions is important for planning and implementing services to best meet those needs

RESULTS

Emotional	Instrumental	Informational
Burden of responsibility <i>'for a time there, I did feel like I was in charge of ending my mother's life.'</i>	Care coordination <i>'it would have been great to have somebody from that point onwards that you could have dealt with like one single person or one single number that you could call and say, "This is happening now. What typically happens here? You know, what, what is a good decision to make here?"'</i>	General population awareness of dementia <i>'I think it would help if there was more public awareness around the gradual deterioration of the mind and the signs to be aware of and when a partner or a child or a sibling needs to intervene quite quickly.'</i>
Decision fatigue <i>'It is probably the practical...everyday decisions...day to day decisions that I have to make...it is very wearing for me...it is very stressful for me...'</i>	Advanced care planning <i>'make sure you know what they wish. So, so that, when they can't make their own decisions, which in dementia can be quite a long time before they die, make sure you know what their wishes generally are.'</i>	Information about disease trajectory <i>'We didn't realise what dementia meant, the implications. . . I think that people who are carers should receive some training . . . told what to expect and what to do, before it happens, not when it happens.'</i>
Support networks <i>'there is "the destruction of one's social life as more people become uncomfortable."'</i>	Carers as experts <i>'they will not really listen to you when you understand the person better than they do'</i>	Dementia-friendly information <i>'asking her very complicated instructions which she just wouldn't be able to interpret and do for them...they weren't adapting the care and the responses'</i>
Loss of control <i>'She said, "My brain's gone", which it has. So I think that's caused more stress, to be honest, because you're thinking to yourself "I'm not being told what's going on"'</i>		Health care professional knowledge <i>'make sure that the staff...have been properly trained, not trained on the job but go through.. . an intensive week.. .give them some idea because they haven't a clue about dementia.'</i>

CONCLUSION / IMPLICATIONS

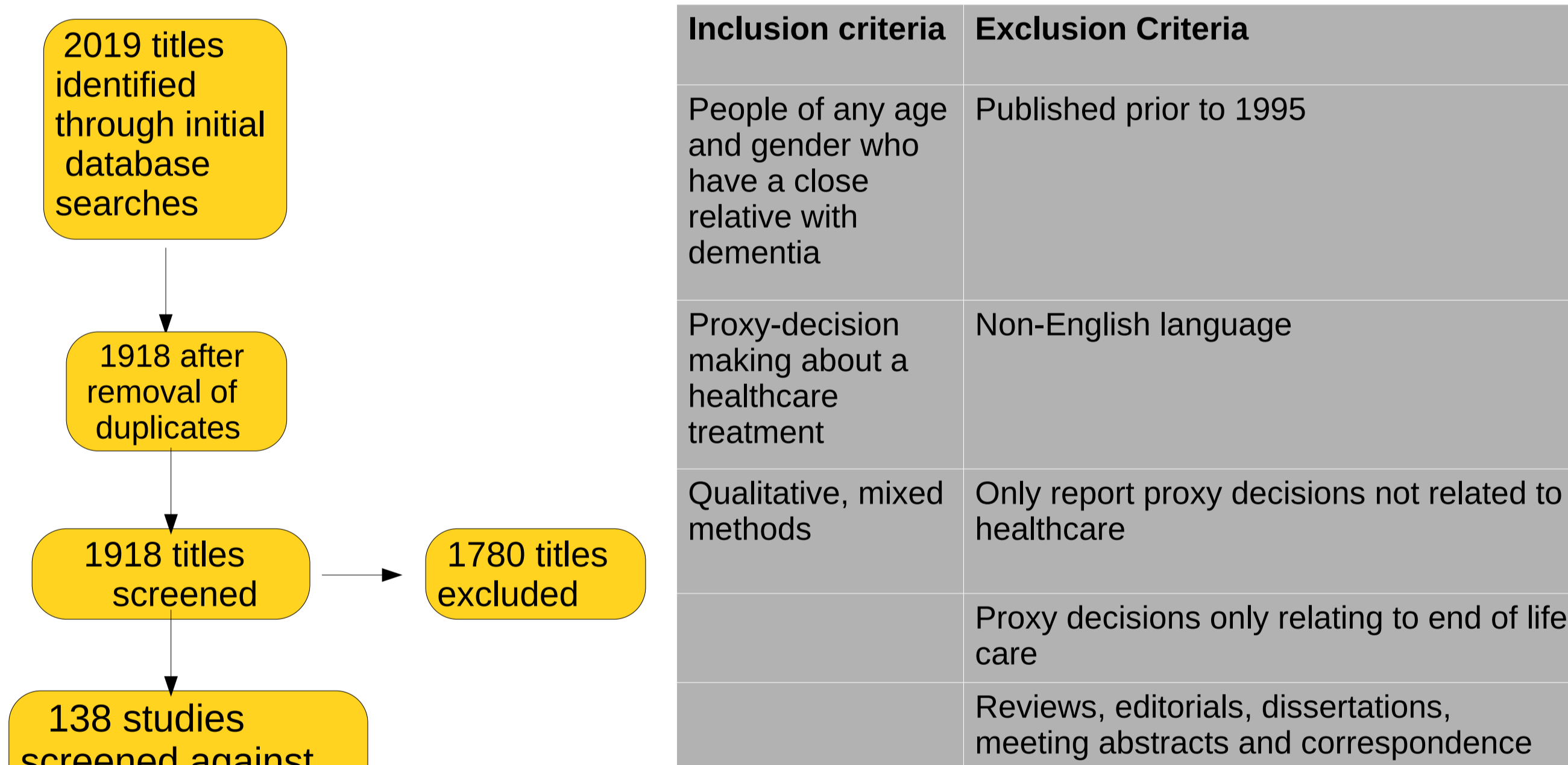
This study provides important insight into the experience of carers making proxy health care decisions for people with dementia.

Provision of a single point of contact, training for carers on the dementia disease trajectory and encouragement to discuss the patient's wishes before they lose capacity are important.

Decisions can feel hugely burdensome. Provision of empathic guidance and emotional support are highly valued

CONTACT: v.hodges@sheffield.ac.uk

METHODS



Framework: Typology of Social Support (House et al 1981)

Emotional, concerning the provision of care, empathy, love and trust

Instrumental, concerning the provision of goods, services and tangible aid

Informational, concerning the provision of information at times of stress which facilitates problem solving

- 14. no qualitative component/no direct quotes included
- 11. not concerning support needs of carers
- 8. not concerning health care decisions

PARENTS' LIVED EXPERIENCE OF HEALTHCARE FOR CHILDREN WITH LONG TERM CONDITIONS: QUALITATIVE INTERVIEW STUDY

BACKGROUND

- 1.7 million children with longstanding illness in England (1).
- Young people in the UK with a long term condition suffer from poor quality of life compared to other high-income countries (2).
- Parents have a pivotal role in the management of their child's condition (3).
- The GP role remains unclear but could be enhanced (3).

AIM OF THE RESEARCH

To gain an understanding of parents' experiences of healthcare for children with long term conditions.

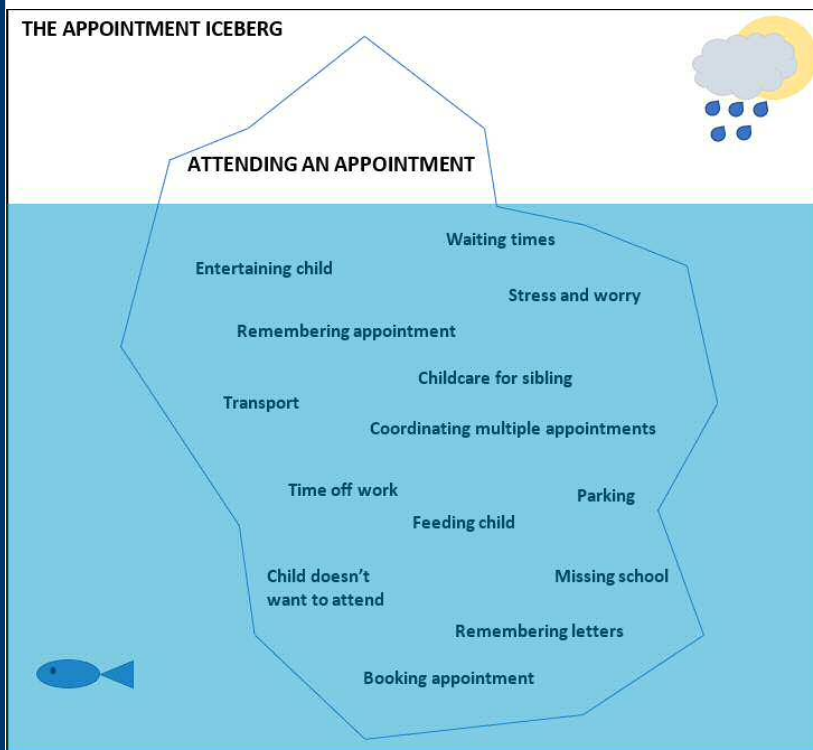
METHODS

- Co-production
- 15 semi-structured interviews with parents of children with LTCs
- Interviews were audiotaped, transcribed verbatim and analysed using the Framework approach

RESULTS

- Meta theme 'complexity of experience' and five key themes:

1. Impact
2. Interactions
3. Experience of Care
4. Feelings
5. Feedback



KEY FINDINGS

- Clinicians should be aware of the complexity of parents' lives
- GPs have a role in signposting parents to appropriate support
- Currently the GP role is less prominent than secondary care
- Parents would like a healthcare professional to integrate their child's care

Authors: Emily Devoy, Dr Joanne Thompson, Dr Jenny Swann

Department: Academic Unit of Primary Medical Care, University of Sheffield

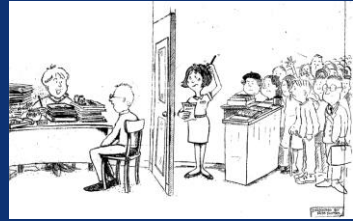
Contact: eedevoy1@sheffield.ac.uk / j.thompson1@sheffield.ac.uk

References:

- 1- NHS (2019). The NHS Long Term Plan. Available at: www.longtermplan.nhs.net
- 2- The Nuffield Trust. (2019). International comparisons of health and wellbeing in adolescence and early adulthood.
- 3- Willis, A., Swann, J. and Thompson, J. (2015). Childhood long-term conditions in primary care: A qualitative study of practitioners' views. British Journal of General Practice, 65(638), e593–e600. doi: 10.3399/bjgp15X686509.

Registration Without Documentation

An exploration of the experiences of GP staff registering patients unable to provide documentation in North East London



Problem

A lack of proof of ID/address remains a barrier to registering with a GP, despite NHSE guidance, and advocacy work by third sector organisations.



The approach

Qualitative research aiming to better understand the process by which registration is refused and factors that operate to influence this.

33 non-clinical GP staff partook in interviews and focus groups.
Narrative analysis using a Bourdeusian framework.

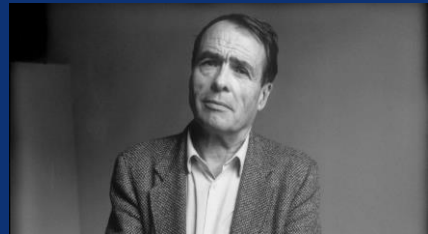


Initial analysis & why it matters

Diversity of practice, but generalised reluctance to register this patient group. Perceived as a burden, suspicious, and not always 'deserving' of care. Participants felt a sense of 'moral' responsibility to 'other' patients and the wider NHS regarding resource distribution

Narratives reflect Bourdieu's 'left and right' hand of the state - duty to provide care in tension with other roles (perceived to be) required by the state. The left hand is the welfare state, and the right policing, justice and immigration control.

Much current work around improving the inclusivity of registration focuses on ensuring staff are aware of guidance, but this study reveals a picture not just of a lack of knowledge of guidance, but a complex set of factors that work to make staff reluctant to register patients without documents.





'You know where we are if you need us.' The role of the GP in supporting patients following major pancreatic surgery for cancer: A qualitative study

Dr Anna K Taylor, Miss Ambareen Kausar, Mr David Chang, Prof Carolyn A Chew-Graham

Email: annaktaylor@doctors.org.uk; Twitter: @Anna_K_Taylor

Managing medications

'I have seven [PERT] with my meals, breakfast, dinner and tea...it's a lot of tablets. And I hate taking tablets... My view is I take the creon because it stops me hurting. Cos if I don't take them, I know I'm gonna get pain.' Charles

'They ran out of the 25,000 [PERT] so they put me on 10,000 but that meant that instead of taking 6 with a meal I had to take 15... So I'd be going through a pack of 100 in two days... but now we've got the normal tablets again it's easier.'
Raymond

'I'm injecting the basal insulin, I'm injecting that twice a day, and the other insulin, I've to inject that every time I have food but before I can eat I've got to work out how many carbs there are in the food and then assess how much insulin I need... life is just hard, it really really is hard.'
Margaret

Psychological support

'After my Whipple I remember thinking "I don't really know where I stand now, whether I see my GP or the oncologist or [surgeon]"' Helen

'The GP says, "oh, you've had a Whipple. Ooooooh, big operation is that". Yeah. They don't really know. They just try and manage it don't they, rather than... what's the word they use? "All we can do is manage your symptoms, it's not up to us to cure them. It's up to your specialist to sort that out." I don't find that very helpful.' Janet

'I was in there a long time, more than the five or ten minutes you're allowed, you know. And he was very supportive and he said 'my door is always open'... I was very depressed at one time... And I would see him quite a lot, it was like once a month. He's a doctor that you can talk to.' Elizabeth



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE

PARALLEL SESSION B.1 – PRIMARY CARE DELIVERY (13:00 – 14:00)

SESSION CHAIR(S) - Dr Tom Blakeman, GP and Clinical Senior Lecturer, University of Manchester
Dr James Bennett, GP Portfolio Fellow, Hull York Medical School

SESSION SUPPORT – Pamela Parkinson, Academy of Primary Care, Hull York Medical School

1	Donna Bramwell	University of Manchester	Reaching the parts that QOF cannot reach: An early evaluation of a General Practice quality improvement initiative in the English NHS
2	Judith Gordon	Abbey Grange Medical Practice / Leeds Teaching Hospital NHS Trust	Communication between specialist genetic services, CCGs and GPs: a service development project
3	Charlotte Harding	Lancashire & South Cumbria NHS Foundation Trust	What works in terms of mental health prevention and promotion delivered in general practice and community settings?
4	Joseph Hutchinson	University of Manchester	Primary Care Networks and health inequality: a policy analysis
5	Paul Pascall Jones	University of Manchester	Enacting infection prevention and control (IPC) in elderly long-term care facilities (LTCFs): a meta-synthesis of qualitative studies
6	Josephine Reynolds	University of Sheffield	The colonial legacy on the social dynamics in global health partnerships
7	Nadja Van Ginneken	University of Liverpool	Experience of implementing and evaluating social prescribing in the North West Coast of England
8	Oliver Wright	University of Manchester	Effectiveness of interventions to improve patient transitions from Secondary to Primary Care: a systematic review and network meta-analysis of randomised controlled trials

Reaching the parts that QOF cannot reach: An early evaluation of a General Practice Quality Improvement initiative in the English NHS

Dr. Donna Bramwell – HOPE, University of Manchester - donna.bramwell@manchester.ac.uk
Prof. Lindsay Forbes & Dr. Sarah Hotham - Centre for Health Services Studies, University of Kent

Introduction

- Rapid evaluation of introduction of new QI activities/incentives into QOF April 2019 - commissioned by NHSE.
- First two QI modules: Prescribing Safety (Lithium, Valproate, NSAIDS) and End-of-Life-care

Objectives

- To describe practice attitudes to the QI modules – how have they been received by practice staff?
- To understand how practices implement the QI modules, what are their experiences and practical challenges in doing so?
- To describe how practice has changed following implementation of the QI modules.

'...with regard to the reasons for doing it I think, you know, they're good reasons because it's for patient safety and for improving services.' DBP002

Methods

- Participants = 25 Practice Managers, diverse sample.
- Data collection = semi-structured, audio recorded telephone interviews.
- Data were analysed using the thematic Framework Method.

Key Findings

- Incentivising QI was received favourably.
- Practices were ready to implement **BUT** negative about additional clinical and managerial time needed to engage.
- Prescribing safety module was easy to implement following previous experience.
- End-of-life module perceived as more challenging.
- Collaborating with colleagues across Primary Care Networks (PCNs) on the modules was working well **BUT** anticipated this could be challenging in the future.
- Tailored approach - local flexibility and influence on subject matter for QI would be good.
- Guidance, business rules and software updates need to be timely.



Communication between specialist genetic services, CCGs and GPs

Gordon J¹, Adlard J², Jewell R², Hayward J³

1- HEE Leadership Fellow in Genomics in Primary Care, Yorkshire. 2- Yorkshire Regional Genetics Service, Leeds. 3- GPwSI in Genetics, Yorkshire Regional Genetics Service

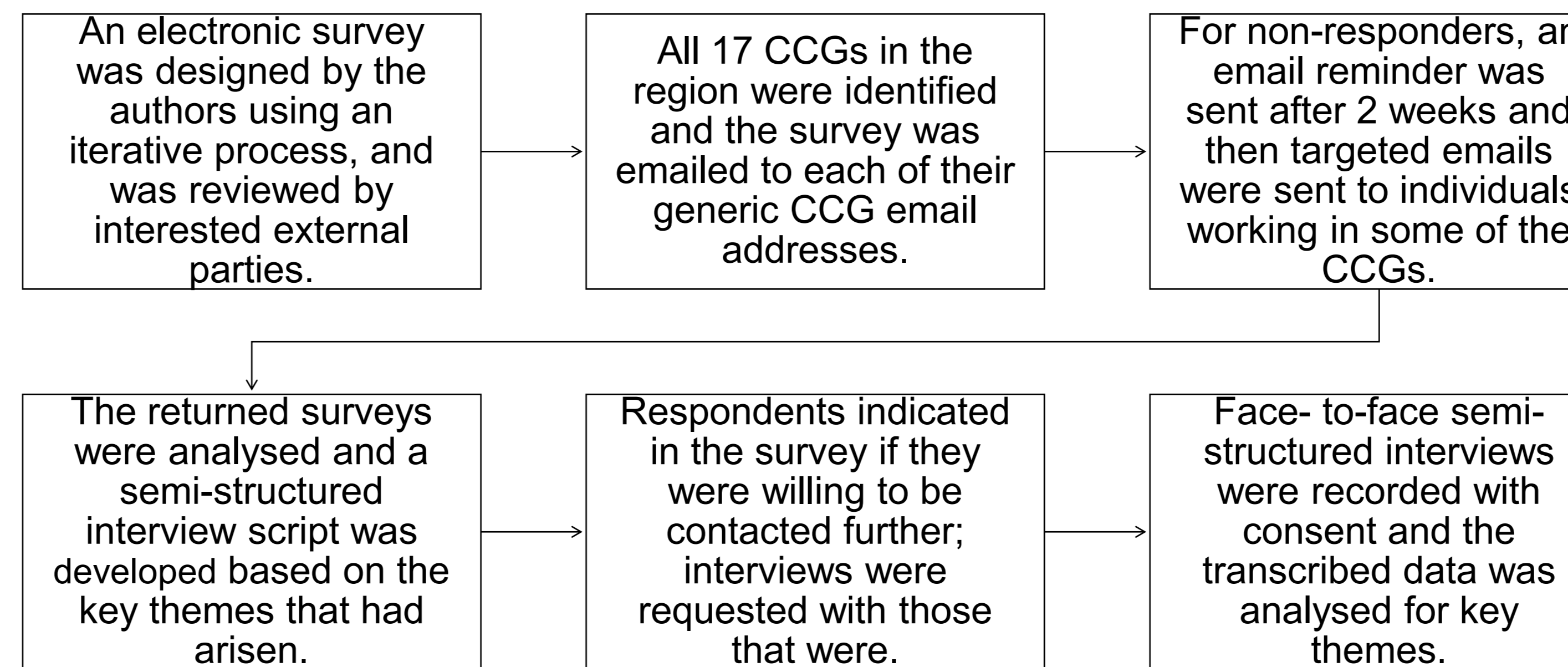
Introduction

- Genomic medicine is a rapidly advancing area and the introduction of the NHS Genomic Medicine Service is likely to bring with it significant clinical and procedural changes.
- General Practitioners (GPs) will need an awareness of these changes and it is therefore important that Genomic Medicine Centres (GMCs) are able to keep GPs supplied with up-to-date information regarding this.
- However, specialist services can struggle to effectively communicate information to GPs as a whole.
- Commissioning Groups (CCGs) have a key role in cascading information to GPs and may provide an invaluable link between the GMCs and GPs.
- With increased public awareness of genomic testing and availability of commercial testing, GPs may also be seeing an increasing number of 'genetics' patients and so it is also important that they are able to access specialist genetics advice when needed.
- In some specialities there has been a shift away from traditional telephone advice to novel electronic approaches and this may be useful in a mostly non-urgent specialty like genetics.

Objectives

- The objectives of this service development project were to get CCGs' perspectives on:
- the best ways to keep GPs up to date with service developments in genomic medicine.
 - the best ways for GPs to access specialist advice from genetics.

Methods



Results - Interviews

"When we've done events...behaviour changes the next week so it's a very effective way of communicating."

"Quick update.. almost kind of drip feeding it in rather than having a full session."

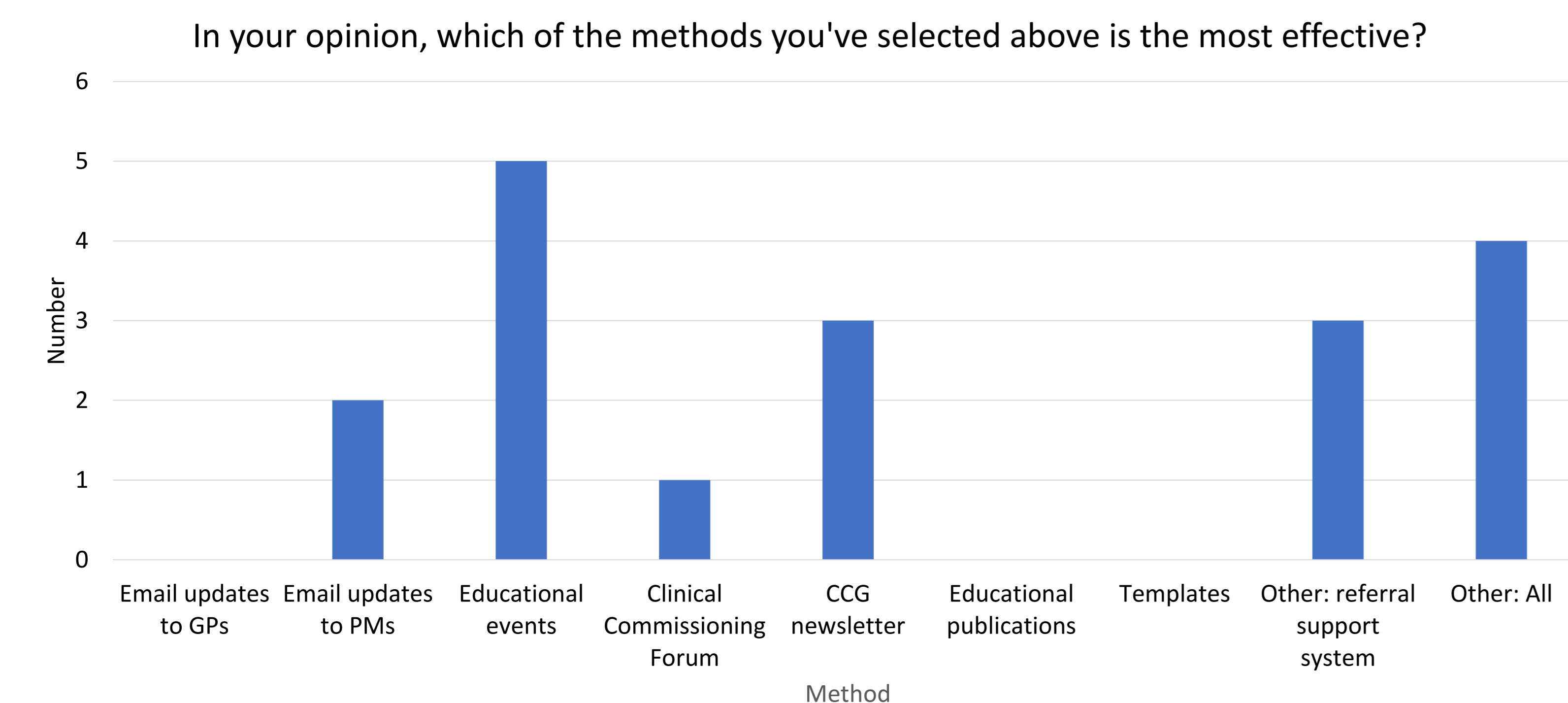
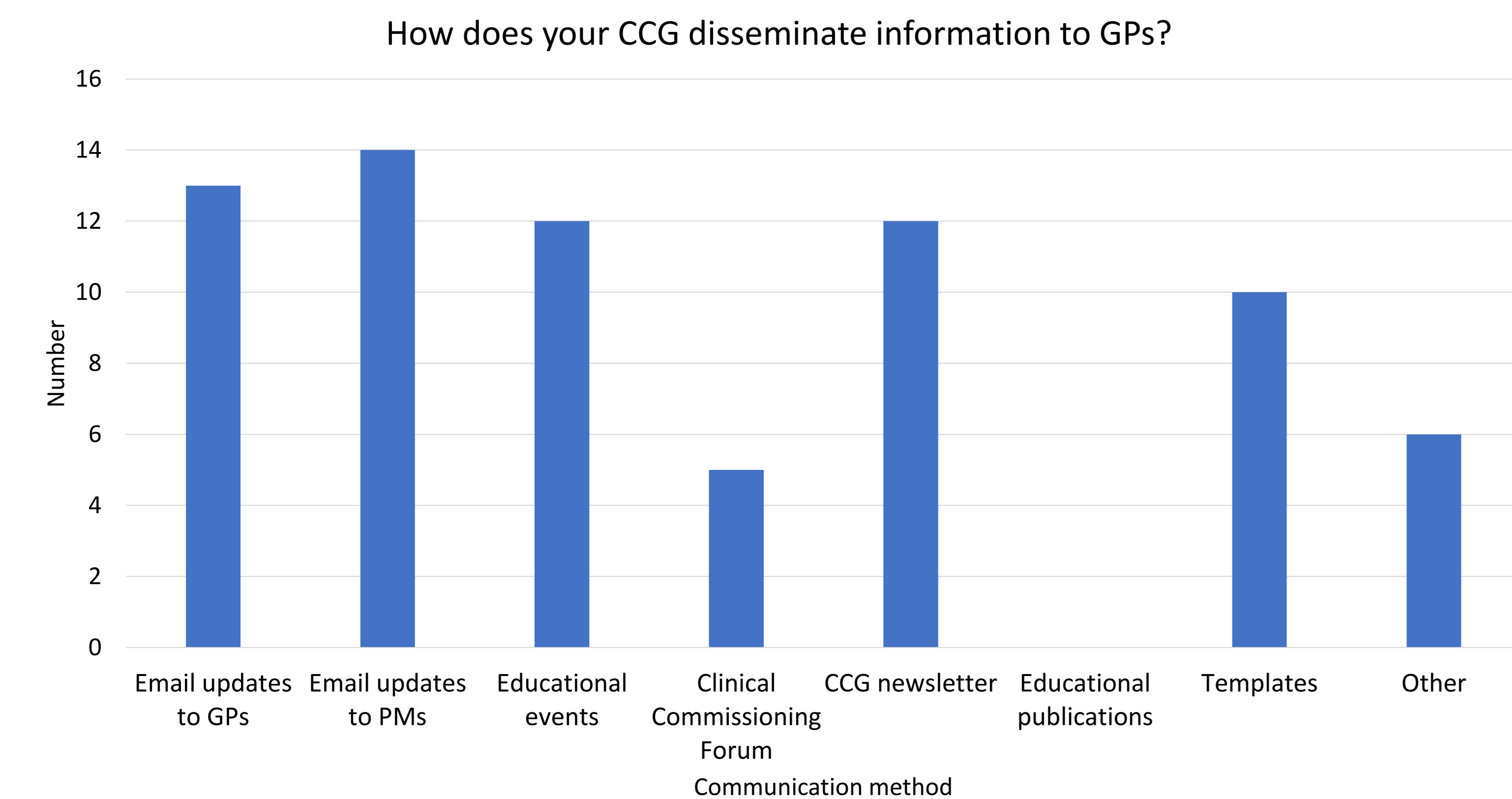
- Educational events were felt to be an effective method of communicating with GPs
- Genetics content in the form of short, practical updates would be useful as part of their established programme of educational events
- Simple updates could be emailed to the CCGs for dissemination to GPs
- All the CCGs had a portal which contained referral criteria and pathway information, as well as management advice and general educational resources. Having genetics information on these would be useful
- Electronic advice and guidance was the favoured specialist advice method for all 3 CCGs

"If there was a dedicated advice and guidance thing that would probably be the best way of doing it."

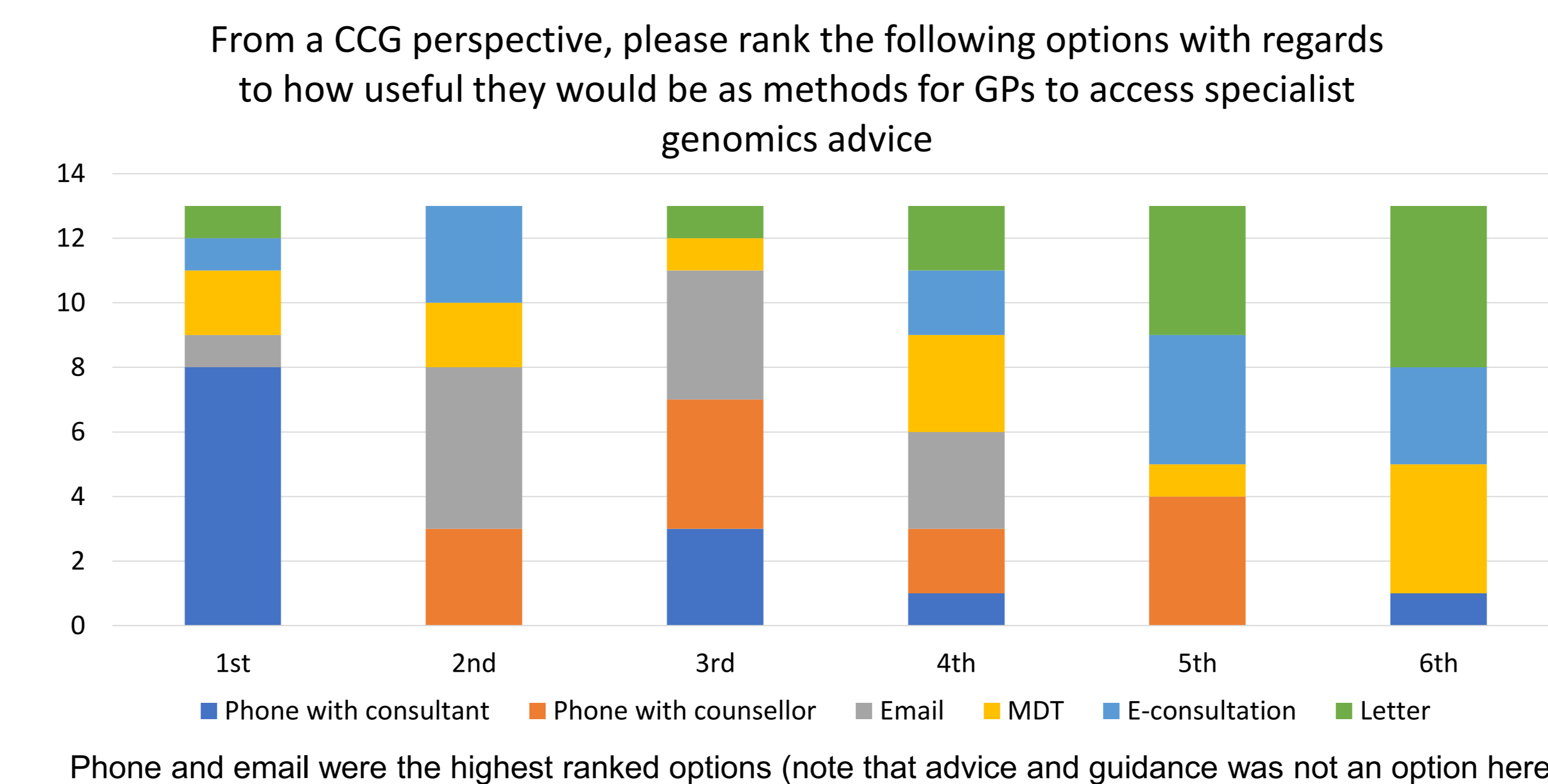
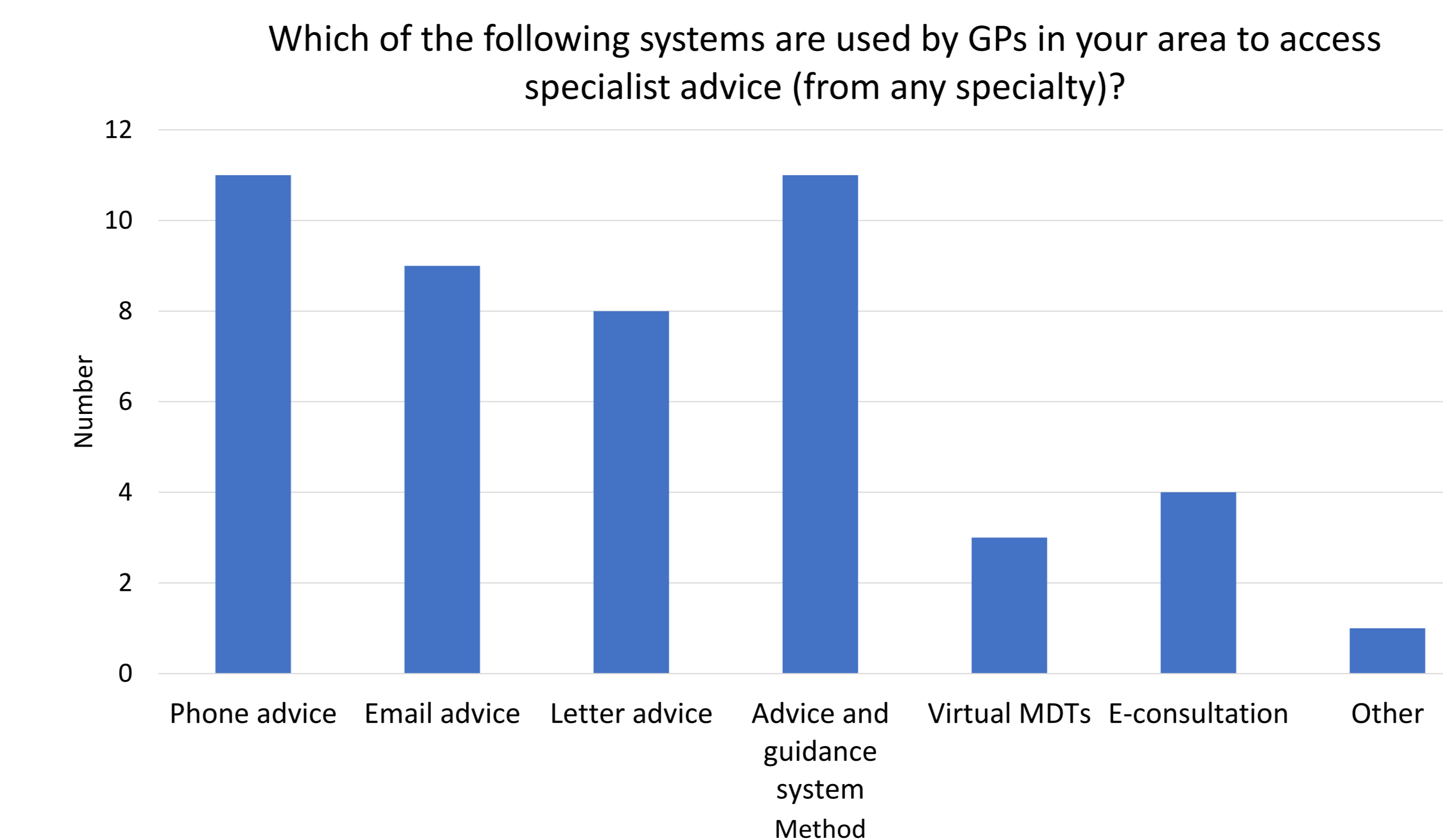
"I'd love to have information from your genetics services on [the portal]."

Results - Surveys

Information dissemination



Accessing specialist advice



Conclusions

- CCGs could be a useful link between GMCs and GPs and already use multiple methods of information dissemination to GPs that GMCs could utilise.
- Educational events are widely used and are felt to be an effective method of communicating with GPs.
- Genetics would be best incorporated as short, practical updates as part of established educational programmes.
- Simple updates can be emailed to CCGs for dissemination to GPs.
- Information on genetics should be made available via existing CCG portals.
- Advice and guidance and email are widely used by GPs and should be strongly considered for use by the genomic medicine service.

References

1. A systematic review of interventions to provide genetics education for primary care. Paneque, M., et al. 89, 2016, BMC Family Practice, Vol. 17.
 2. Primary care providers' perceived barriers to integrations of genetics services: a systematic review of the literature. Mikat-Stevens, NA, et al. 3, 2015, Genetics in Medicine, Vol. 17, pp. 169-176.
 3. Hill, Professor Dame Sue. Genomics for all: From 100,000 genomes to a national NHS Genomic Medicine Service. [Online] 09 2018. [Cited: 15 01 20.] <https://www.geneticalliance.org.uk/wp-content/uploads/2018/10/Professor-Dame-Sue-Hill.pdf>.
- Conflicts of interest: None

What works in terms of mental health prevention and promotion delivered in general practice and community settings?

Feasibility study funded by HEE until May 2021

Charlotte Harding (Charlotte.Harding@lscft.nhs.uk)

The problem

Around 1 in 3 GP appointments involves a mental health component (1) and around 1 in 4 individuals will experience mental health within their lifetime (2), yet only 0.03% of NHS spending is on prevention and promotion activities (3).

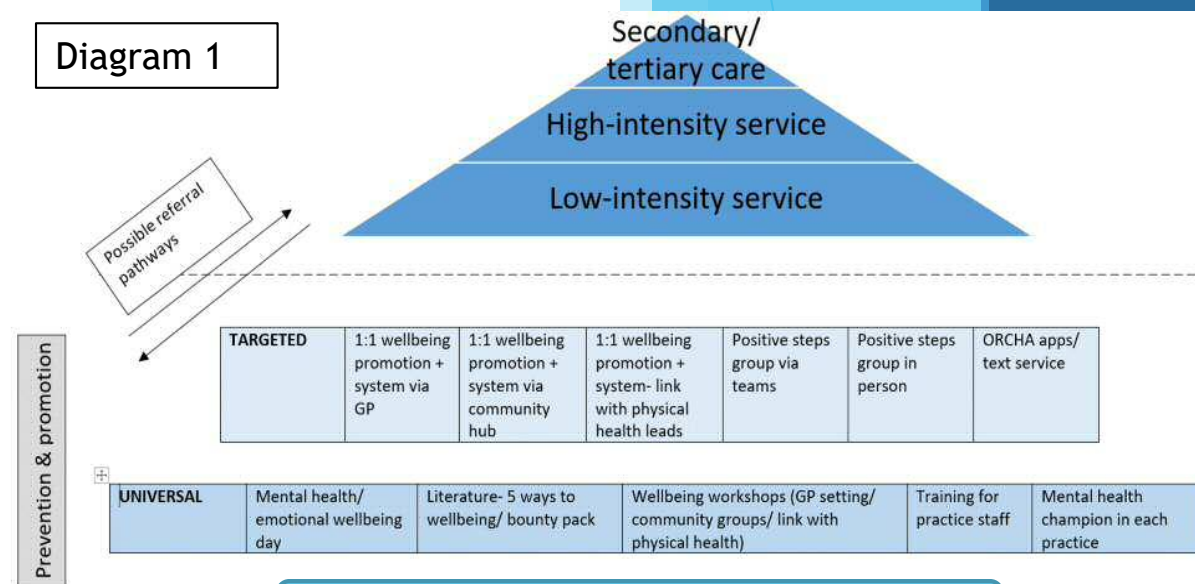
The approach

- 4 Assistant Psychologists working across Burnley and Fleetwood
- APs to provide prevention and promotion interventions to clients ‘below case-ness’
- Interventions delivered in targeted and universal way (Diagram 1)
- APs started seeing patients on the 26th of October

The learning

- There is a clear case for the prevention of mental ill-health and promotion of wellbeing in a primary care setting
- Through communication with services and other staff members in general practice, a vitality of this type of service has been expressed
- It has been challenging to adapt interventions to fit covid guidelines
- Discovering the correct referral process and appropriate clients for the service

Diagram 1



References

- (1) London Strategic Clinical Network for Mental Health (2014). A commissioner’s guide to primary care mental health.
- (2) McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey.
- (3) Mental Health Strategies., 2012



Background

Health inequality is worsening within the UK. Primary care is internationally recognised as a fundamental component of health equity. Primary care in England is being changed through the introduction of PCNs, whereby:

- Practices contractually link
- Service specifications are provided by the network, through practice collaboration
- Funding is increased and provided primarily to the network
- Additional health care roles are introduced into the primary care team

Methodology

Health policy analysis performed as part of a 'mini-dissertation' on my MPH; aiming to identify research questions for my pre-doctoral. This consisted of:

- Literature review of surrounding evidence for PCN implementation
- Cause and consequence health policy analysis of GP contract documentation 2019/20 and its 2020/21 update – Bardach's eightfold path
- Outcome: Development of new research questions

Results

Funding: Significant 14% real terms increase in primary care funding

- Deprivation weighting follows flawed Carr-Hill formula
- Not all funding is deprivation weighted
- IIF follows QoF principles – deprived networks less likely to achieve
- Intra-network funding distribution unknown – some precedent they may support deprived practices

Results

Additional roles/Clinical Director :

- AR harder to recruit in deprived networks, unclear benefit in primary care
- CD incentivised in deprived networks but if ineffective could exacerbate health inequality

Service specification/IIF

- Benefit if HI rhetoric results in targeted specifications – Learning disability IIF implemented

Research Questions

Funding: How are PCNs acquiring and utilizing funding? Variation depending on deprivation?

Additional Roles/Clinical Director: How are they being implemented? Does this differ depending on deprivation? What are they doing in primary care? Interaction with population health and deprivation?

Service Specifications/IIF: How are service specifications and IIF targets being implemented? How do these interact with health inequality?

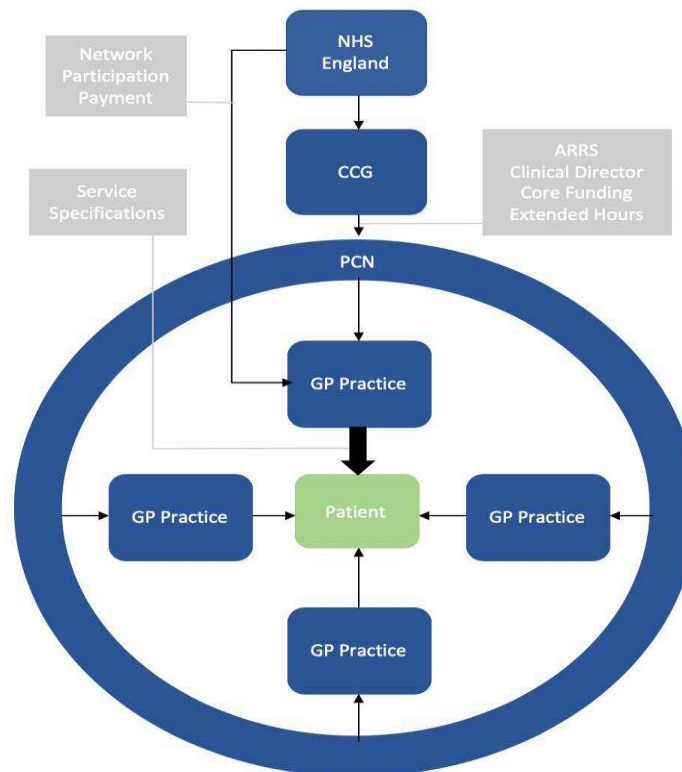
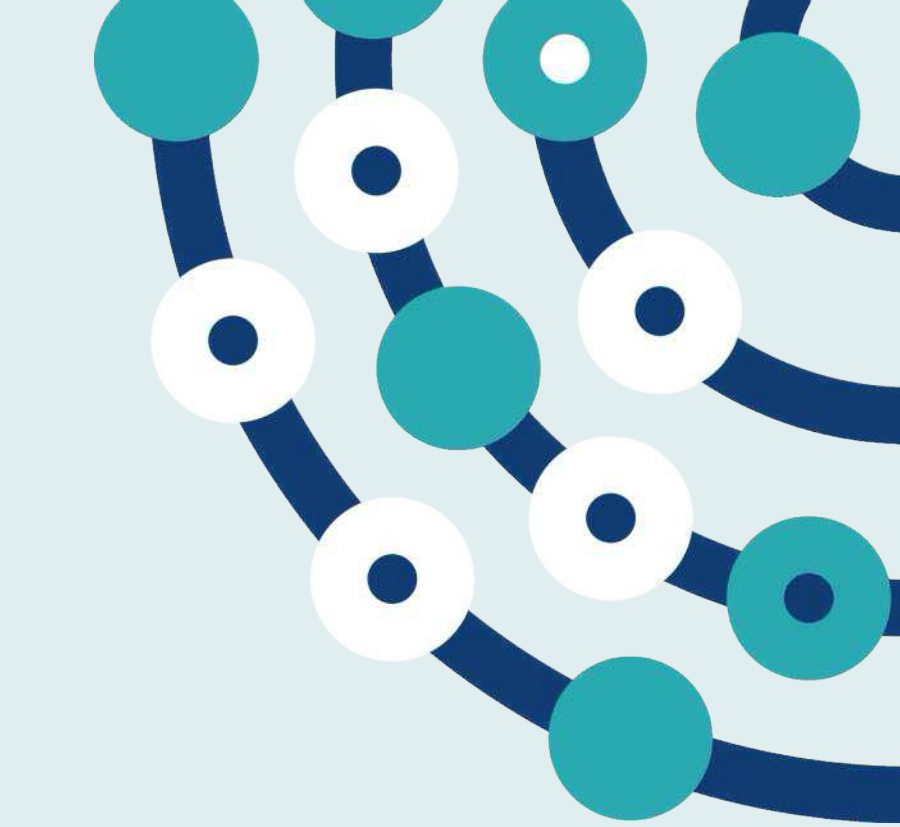


Fig 1: PCN funding flow



The Problem

Specific concerns separate to hospital/private accommodation
 Individual, local and national factors affect spread.
 Residents more likely to be susceptible to infection

To date the experiences of key stakeholders in relation to infection control practices and behaviours in care homes have not been understood in depth

Approach

1. A qualitative meta-synthesis using Noblit's Meta-Ethnography methodology was conducted.
2. We synthesised the findings of these 15 studies into key concepts, assessed where the literature is alike or diverges, and look to move beyond single studies conceptually.

The learning

Findings are emergent
Some take home points:

1. resident and staff behaviour and knowledge, health system design and culture, and interaction between care home and other healthcare settings are contributing factors
2. What works in enacting IPC: Harnessing professionalism and repetitive reinforcement of education messages.
3. organisational and systemic change, rather than an individualistic blame culture focused on those who receive inadequate training, will do better to increase infection prevention and control.

Why it matters

1. As the care home is a specific environment separate from hospital and private accommodation. As such it requires evidence-based infection policy derived from trustworthy research specific to it.
2. The tragic consequences of uncontrolled carriage of infection within care homes and between care home and hospital have been demonstrated during Covid-19 pandemic.

Methodology

Methodology: A qualitative meta-synthesis using Noblit's Meta-Ethnography methodology

- 'Getting started'
- 'Deciding what is relevant'
- 'reading the studies'
- 'determining how studies are related'
- Translating/comparing the findings
- 'Synthesizing translations'
- Presenting the synthesis (1)

No 'one size fits all'
 'A need to select methods which suit: the review aim; the nature, e.g. heterogeneity, and volume of the data to be synthesised; and their resources, such as team size and expertise and the time available' (2)

Results

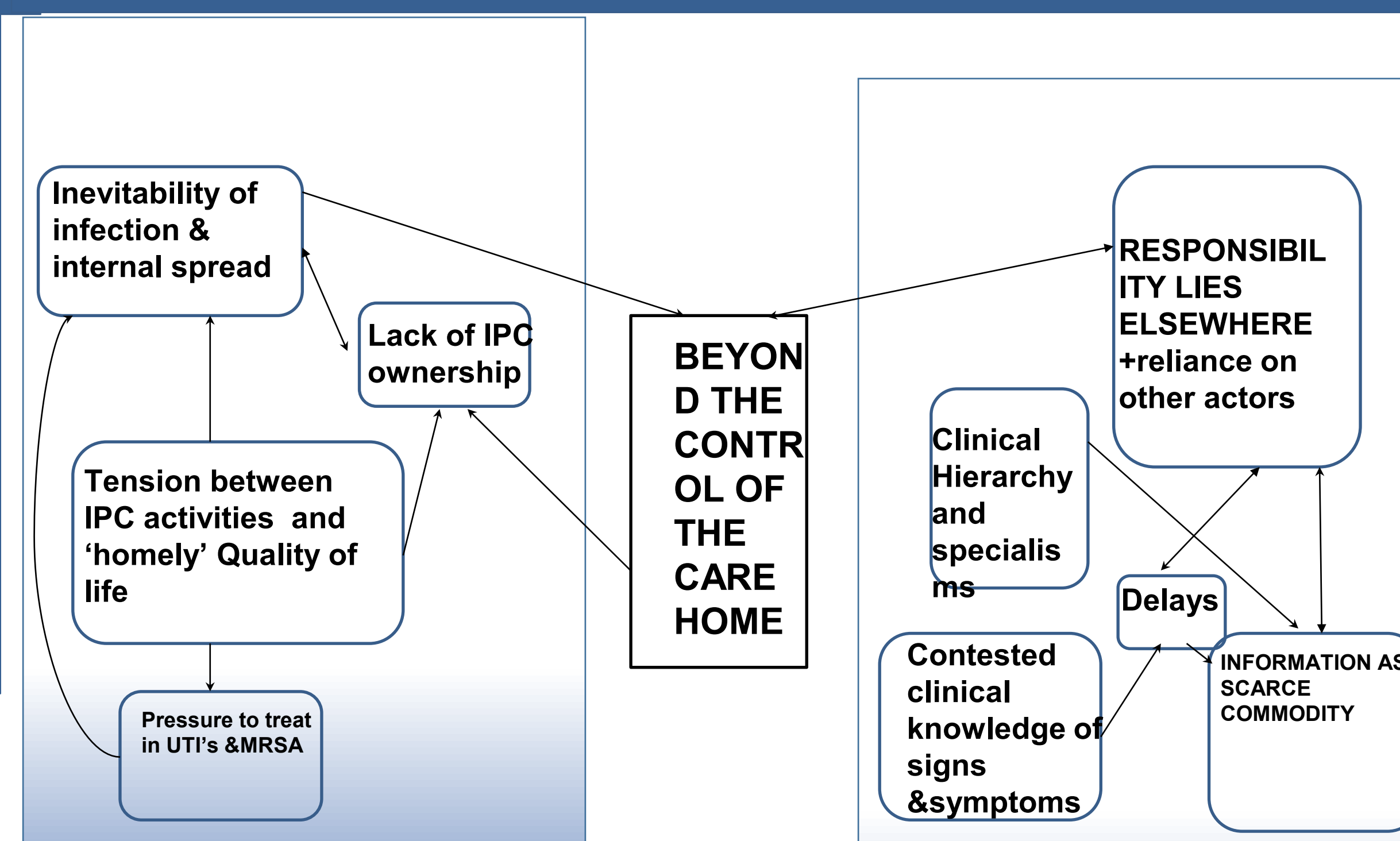


Figure 2: Theoretical relationships between 3rd order concepts derived through the synthesis process (Core concepts in BLOCK CAPITALS)

Analysis is ongoing!- some points of interest.

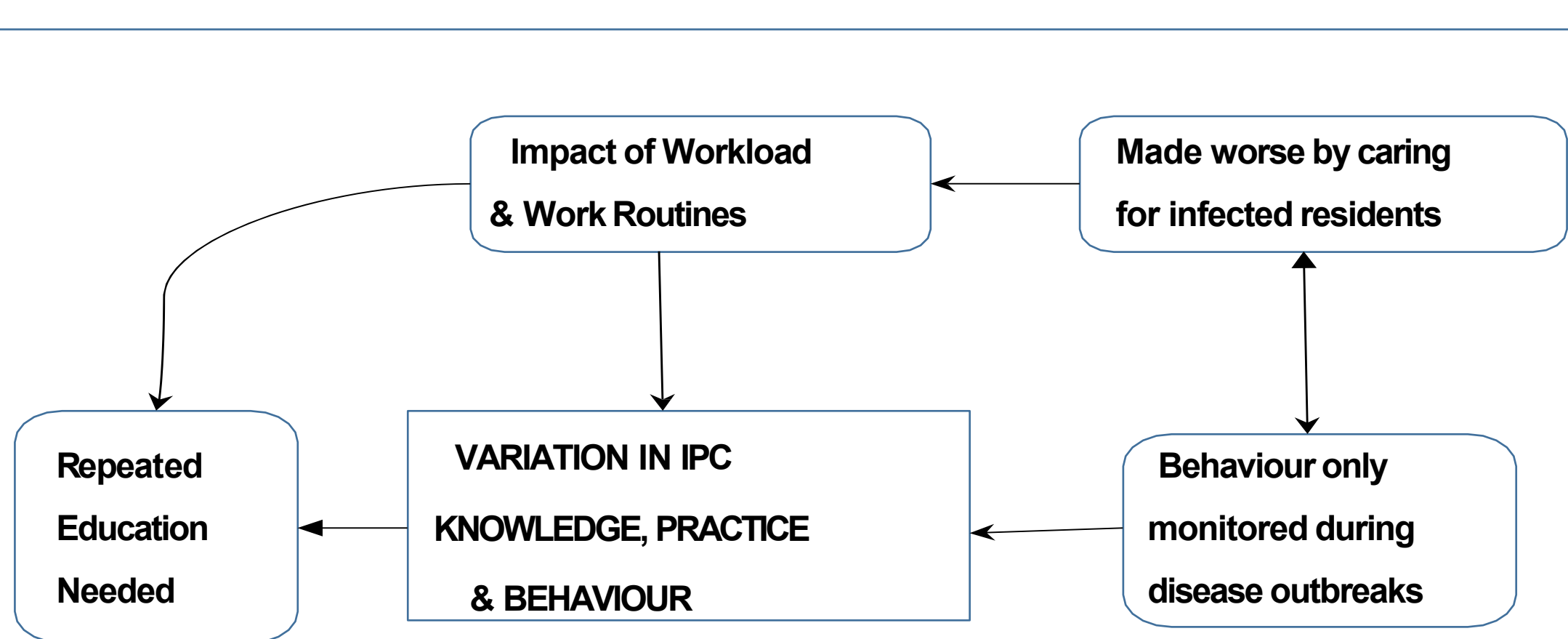
1. Hospital discharge as the principle route of HAI infection in care homes. No surprises, but what can be done about it in a climate where hospitals are increasingly keen to discharge patients from hospital, sometime before it is clinically safe to do so.
2. Care "homes" as an unsuitable environment for enacting IPC.
3. The utility of employing better paid & clinically more qualified staff who would be better equipped to "enact IPC"
4. A moral / ethical challenge around management and treatment in residents who have dementia. Described as "wanderers": difficult to communicate why they need to stay in their rooms etc.
5. The need for residents to take more responsibility and ownership for IPC themselves (but note point 4).
6. More onsite testing, care, diagnosis and treatment needed (e.g. onsite GPs and / or Pharmacists).

Lack of older voice



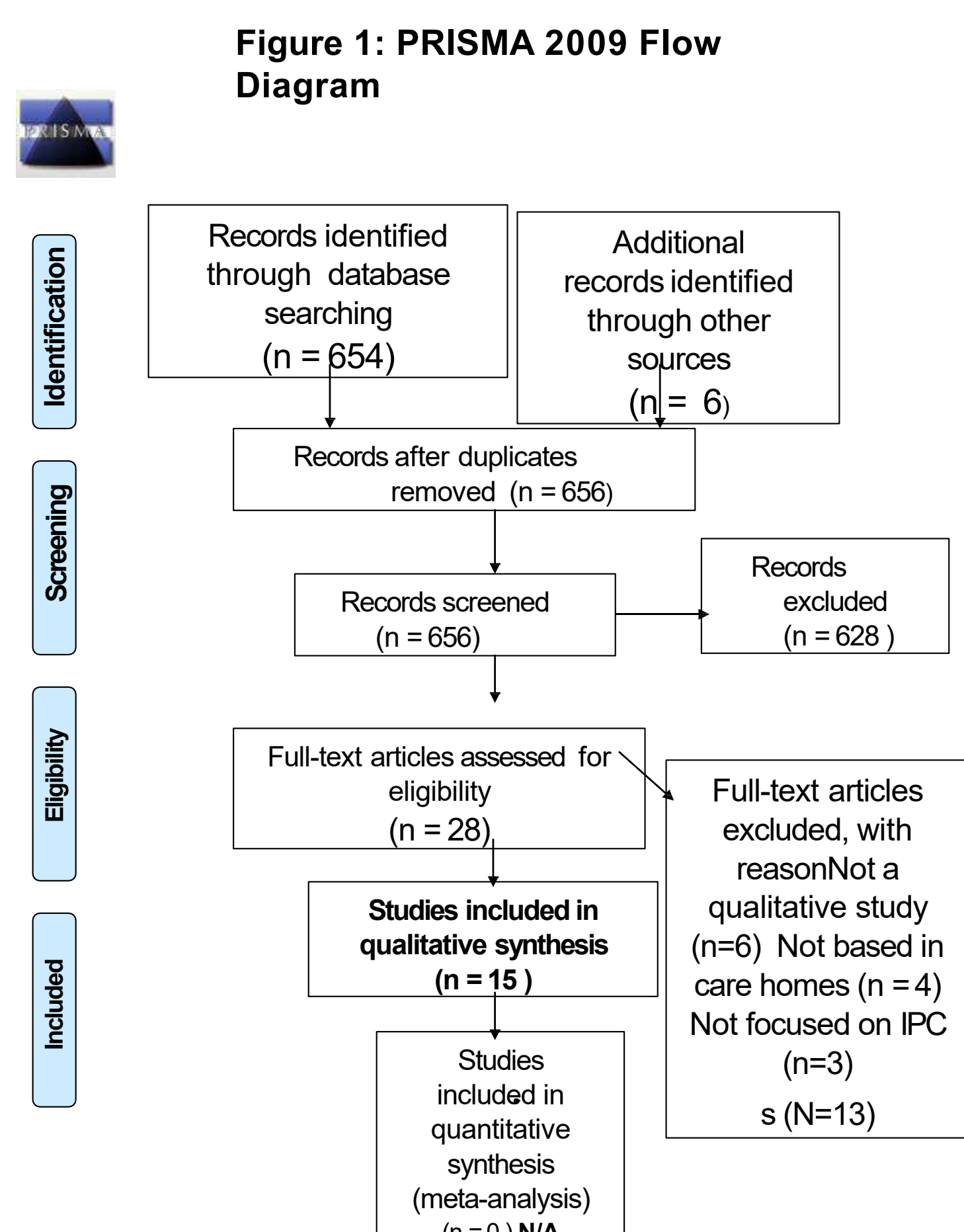
Figure 5: Taken from The Guardian, "Visions of hope" Wed 16 Sep 2020.

1. Arguably a problem across much of research into the health of older people.
2. Noticeable absence across the papers reviewed.
3. Vital for full understanding of the problem at hand!



Limited Opportunities for Harnessing Professionalism in Care Home Staff

Figure 3: Theoretical relationship between synthesised concepts related to care home staff IPC behaviour (Core concepts in BLOCK CAPITALS)



Searched CINAHL, Medline, Embase, PsychINFO and ASSIA (inception to June 2020)

15 eligible studies were identified from 28 which reached inclusion criteria from 652 screened abstracts

"differences in perception of what maximises quality of life led to variation in practice"

"Some GPs felt national guidelines were not applicable to the patient cohort in the residential care facility"

"Lack of ownership of IPC created breakdown in infection control practices and communication"

Example comments from step 4 and 5

This study/project is funded by/ supported by the National Institute for Health Research (NIHR) Greater Manchester Patient Safety Translational Research Centre. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

References

1. Meta-Ethnography: Synthesizing Qualitative Studies (Qualitative Research Methods) by George Noblit (1988-02-01). "Seven Steps"
2. 'A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases', France et al *BMC Medical Research Methodology* volume 19, Article number: 35 (2019)

From: Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G., The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(7): e1000097. doi:10.1371/journal.pmed.1000097

For more information, visit www.prisma-statement.org

The Problem

- As population health becomes increasingly challenging across the world, successful Global Health partnerships seem essential to protect lives; their importance recognised in the Sustainable Development Goals.
- The post-colonial power structures between Global North and Global South collaborators need to be honestly examined.
- Inequitable partnerships may contribute to long-term negative outcomes for Global South countries.



My Approach

- 11 semi-structured in depth interviews with Global Health practitioners studying at London School of Hygiene and Tropical Medicine.
- The aim was to gain insights into the dynamics they had experienced in North-South partnerships.
- Purposive sampling for 'information-rich' cases was employed with sampling for diversity to cover a range in gender, clinical or non-clinical and cultural backgrounds.



The Learning

Three themes were identified:



1. The Global South Self

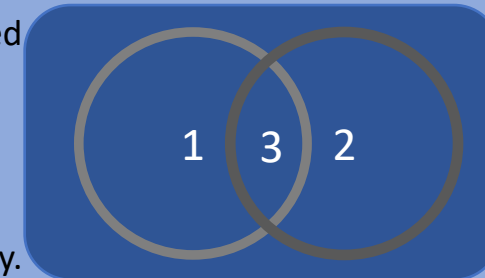
Expressed through forms of resistance, focused on and often denied true 'ownership' and forced to interact in the role of 'the broker' between their community and the GN partners.

2. The Global North Self

Strengthened by the concept of the GS 'other', driven to "help" and "change the world" to perpetuate the 'us and them' mentality, able to act with impunity outside the gaze of GN society, legitimizes it's ongoing interference in GS affairs through a sense of superiority and duty.

3. Symbiotic dependency

The anticipated resource dependency of the GS on the GN. Less expected, the dependency of the GN on the "industry of development" and the interaction with their ex-colonial societies to maintain their superior position on the global stage.



The two forms of self bound by their colonial past. The GS-self seeks space and distance to allow its post-colonial identity to develop. The GN-self clings to the GS as the 'other' in its definition of self and has no desire for separation.

The Key Message

Equity and ownership in Global Health programmes is integral to sustainable success. Now more than ever, it is essential for countries to work together in partnerships with effective and bilaterally acceptable social dynamics. The colonial legacy must be considered and accounted for.



ARC members social prescribing survey

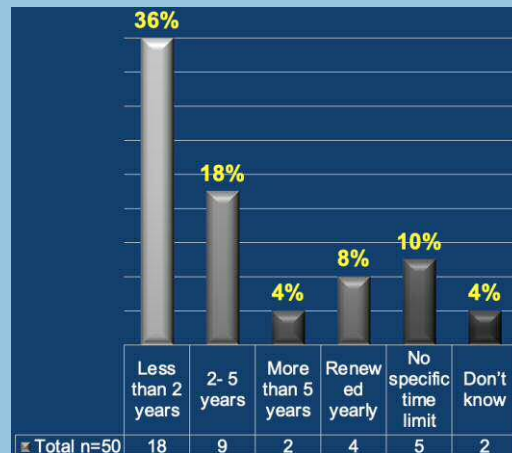
(M Goodall, S Hassan, A Ring, K Abba, N van Ginneken)



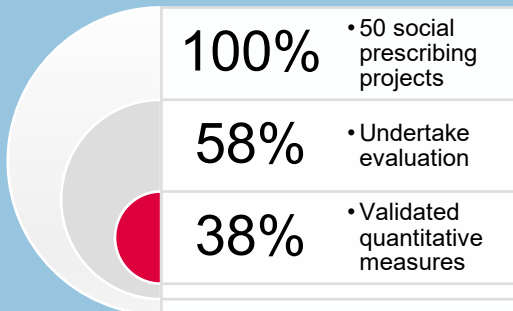
49 responses, 50 projects described

- ❖ 96% urban, 66% rural
- ❖ 80/86% adult/elderly, 32/54% Children/young
- ❖ 66% PPI

Funding



Evaluation

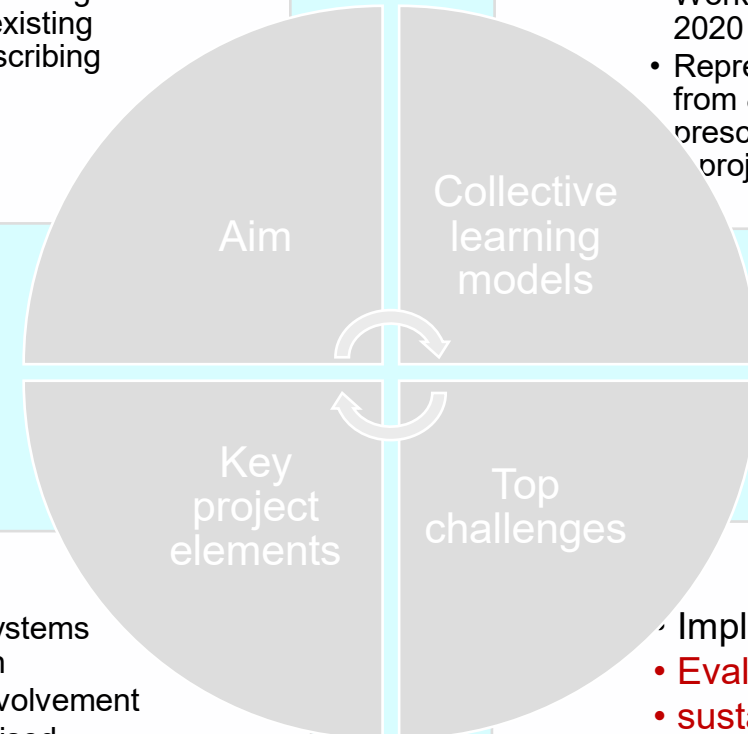


Social prescribing shared learning workshop from CLAHRC projects

(S Hassan, A Ring, K Abba, M Goodall, N van Ginneken)

- Shared learning of new and existing social prescribing initiatives

- Workshop Feb 2020
- Representatives from 8 social prescribing projects



- Whole systems approach
- Public involvement
- Personalised approach

- Implementation
- **Evaluation**
- **sustainability**

Discharge Interventions, Improving Discharge from Secondary to Primary Care, A Systematic Review and Network Meta-Analysis

Tyler N¹, Hodkinson A¹, Daker-White G¹, Keyworth C¹, Hall A¹, Pascal Jones P², Wright O², Blakeman T¹, Panagioti M¹

1) Greater Manchester Patient Safety Translational Research Centre 2) University of Manchester Medical School

Background

>When a Patient leaves hospital after treatment they are Discharged via a standardized "Discharge Process".

This is a crucial period in a Patients Journey as care changes from Secondary (Hospital) to Primary (Community and GP Care)

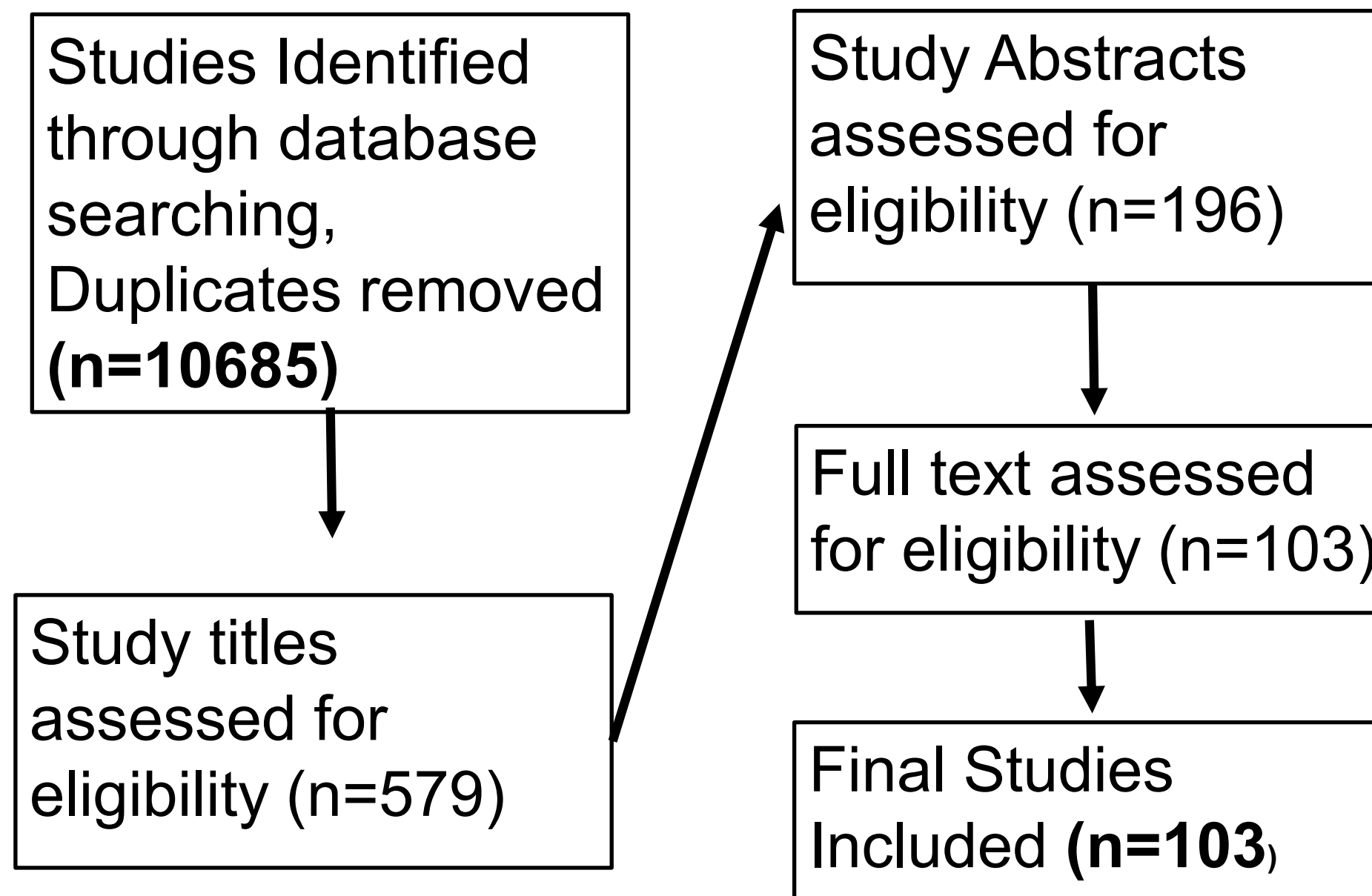
>Mistakes arise during this process in part due to the complexity of multiple independent professionals and agencies working together, and each patient having a unique combination of Medical, Psychological and Social needs.

>20% of discharges are considered sub-optimal worldwide suggesting that this process has scope for improvement (Aeese et al 2017, Coleman et al 2014).

The Question

What types of Discharge interventions are there, and Are they effective at reducing readmission?

Systematic Review



Inclusion Criteria:-

- Randomised Control Trial of a discharge intervention that measured readmission as a primary or secondary outcome.
- The intervention could be pre-discharge, post-discharge or both

Exclusion Criteria:-

- not possible to separate the discharge intervention from a wide range of other interventions
- The Discharge intervention was a small part of a larger intervention
- Interventions that were solely about follow up in the community

Data Extraction and Current Analysis

Grouping Discharge Intervention Types

Improving Communication between care providers and Patients

Post discharge Nurse Home Visits and Reuse: The Hospital to Home Outcomes (H2O) Trial, Auger et al. 2018

Optimizing Medication

A RCT evaluating a pragmatic in-hospital service to increase the quality of discharge prescriptions, Bruhwiler et al. 2019

Educating Patients about their Condition and lifestyle changes

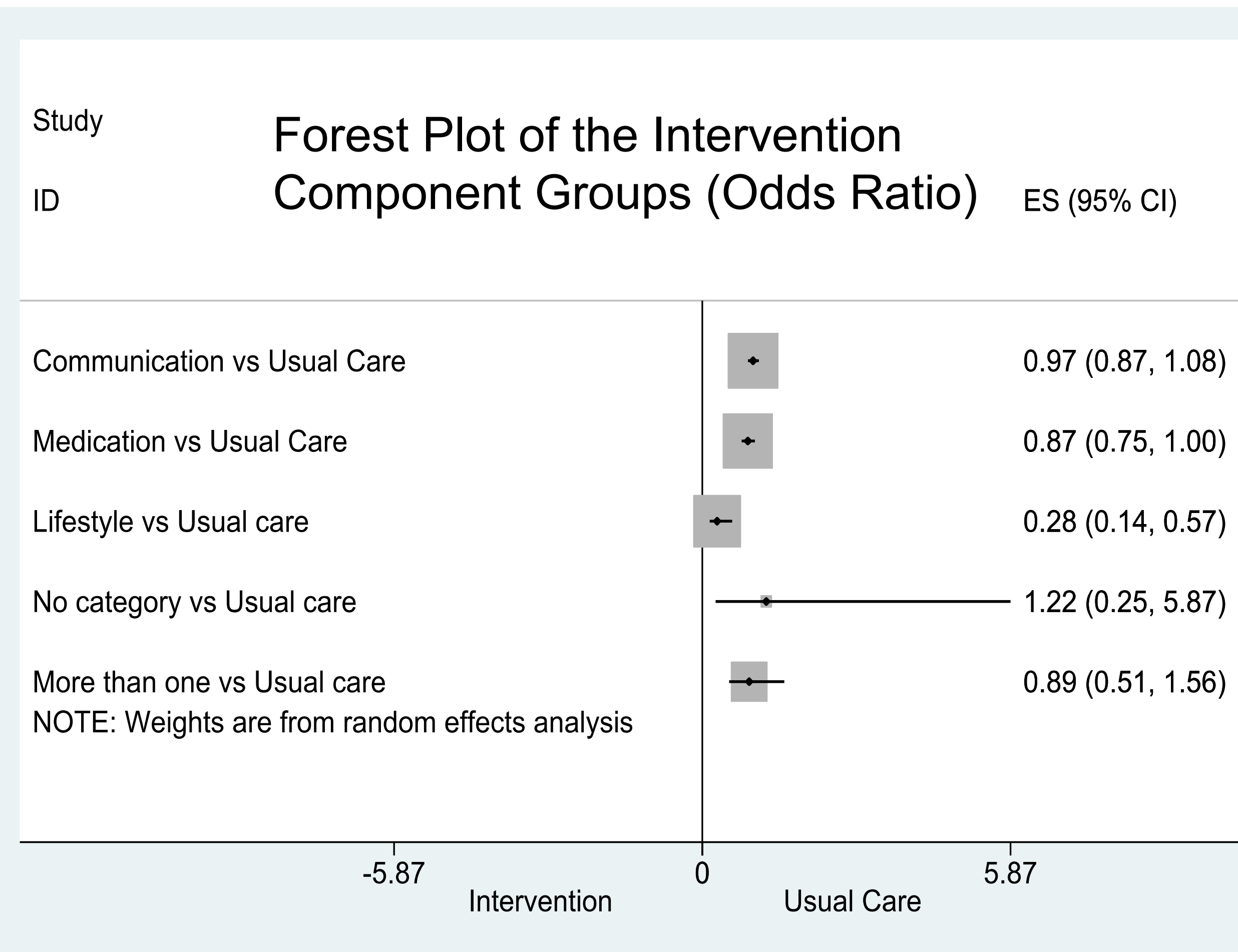
Impact of an Educational Program to Reduce Healthcare Resources in Community Acquired Pneumonia: The EDUCAP Randomized Controlled Trial, Adamuz et al. 2015

Discharge Intervention Odd Ratios against Control

Using 30-day readmission as the outcome we can compare against standard discharge using an **Odds Ratio**.

The **Odds Ratio** here is equivalent to the probability of readmission in the intervention group as opposed to the control group

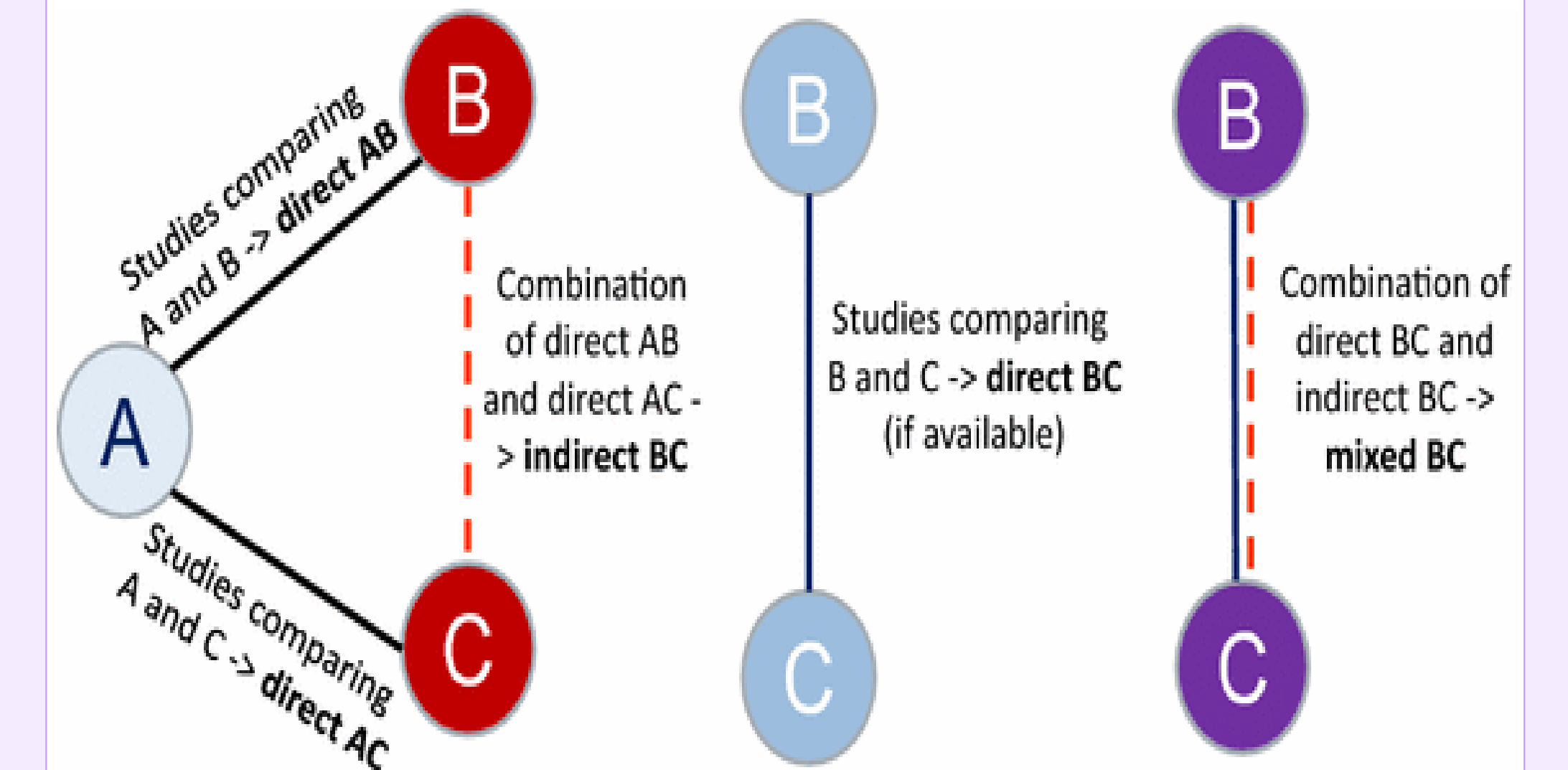
Only 'lifestyle vs. UC' had a significant effect as the 95% CI did not include the **Odds Ratio** of equivalence (i.e. OR=1)



Data Extracted for Further Analysis

- Patient Characteristics (Age, Gender, Ethnicity, Socioeconomic Status, Co-Morbidities)
- Intervention type (Communication, Medication, Lifestyle. Intervention Intensity, Delivery and Uptake)
- Number of Interventions in each study (One, Multiple)
- Primary Outcome (Readmission within a set time period)
- Quality (Sequence Generation, Allocation concealment, Attrition)

Network Meta-analysis



The next step is to compare the interventions against each other using network meta-analysis. Here interventions can be compared by using both direct comparisons of interventions and indirect comparison using a common comparator (I.e Standard Discharge). This will allow for comparison of different interventions directly against each other.

Further Areas to Investigate

> Which Interventions are best compared to each other?

> Which Combinations of Interventions work best together?

> Do different Interventions work better if we look at different measures of outcome (Readmission within 60 days, Quality of Life)?

> Do different interventions work better for certain groups of patients? (e.g. Older Patients, Patients with severe disease)

Impact

Hospital discharge represents the end goal of treatment in Secondary care. By identifying areas at which this process can be improved, Patients are less likely to need readmission and have improved health outcomes.

This study provides evidence that is greater than the sum of its parts and provides a strong basis on which to make future recommendations for Hospital Discharge for all patients.



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE PARALLEL SESSION B.2 – MEDICAL EDUCATION (13:00 – 14:00)

SESSION CHAIR – Dr John Richmond, Clinical Senior Lecturer in Work Based Learning, University of Central Lancashire

SESSION SUPPORT - Alison Waring, Academy of Primary Care, Hull York Medical School

1	Aarti Bansal	Hull York Medical School, University of Hull	How can medical education be optimised to support the development of person-centredness? A realist review
2	Emma Claire Hughes	Manchester University NHS Foundation Trust	Delivery of a Primary Care In-Situ simulation workshop
3	Sushilkumar Keshav Jadhav	University of Central Lancashire	Evaluation of Frailty and Advance Care Planning Documentation in Heart Failure Reviews: A Quality Improvement Project.
4	Deepa Sharma	Lancashire & South Cumbria NHS Foundation Trust	Assessment of palpitations
5	Dr Gillian Shaw	University of Manchester	Hybrid community general practice placements for year four medical students: a pilot study
6	Lara Budwig	Imperial College, London	Combined oral contraceptive pill: Safety and satisfaction at Bassett Road Surgery
7	Ashika Dhondee	Newcastle University	Active Learning in clinical undergraduate GP placements: A qualitative exploration of debrief interactions during parallel surgeries
8	Abdullah Egiz	University of Central Lancashire	An Integrative review of multidisciplinary interventions for heart failure in primary care: Informing the development of a novel delivery model of care within Primary Care Networks - Protocol

How can we optimise medical education for the development of person-centredness? A realist review.

Why this matters?

Gap in our educational strategy?

Explanatory research

Interim findings from thematic analysis



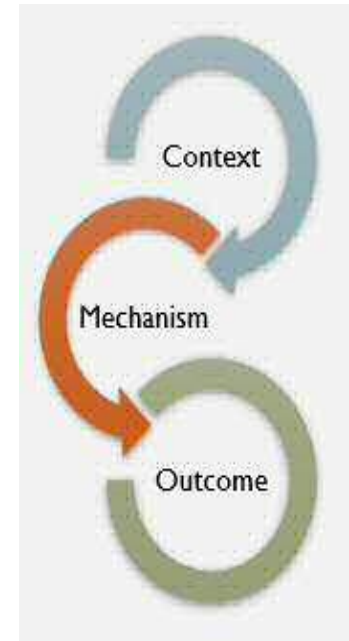
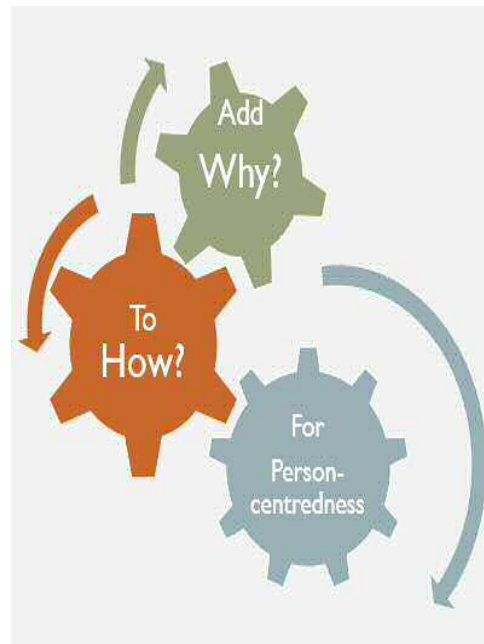
Person-centred approach is central to high-quality care



Decline of person-centred attitudes through medical training



Despite long-established person-centred consultation skills training



Critical engagement with person-centred concepts, knowledge and evidence

Small groups supporting critical reflection on experience

Longitudinal relationships with patients and preceptor

Next steps: Detailed realist analysis

I need ***your help*** to refine theory based on your experience as students, trainees, tutors & course organisers.

Email me to learn more! aarti.bansal@hyms.ac.uk

Simulating Emergencies in Primary Care

Dr E Kilgour, Dr P Horner

Background

50% of GP trainees in South Manchester undertake a 6 month rotation in the Emergency Department (ED) during their training

This rotation accounts for a **sixth** of their overall training to become a GP

It is vital that GP trainees are provided with **educational value** that is applicable to their future career in primary care



Project

Education using **in-situ simulation** is well established in the ED

We aimed to **bridge the gap** between ED simulation and the learning needs of GP trainees by developing a simulation workshop, orientated towards emergency presentations, but based in primary care

A **pilot workshop** was run at a local surgery with trainees participating in 'anaphylaxis' and 'cardiac arrest' simulations, followed by a reflective debrief

Problem

During their rotation in the ED...

69% of trainees attended ≤ 10 weekly GP teaching sessions

69% attended ≤ 10 weekly ED teaching sessions

A rotation in ED should provide GP trainees with the **knowledge, skills and attitudes** relevant to emergency presentations, as set out in the RCGP curriculum

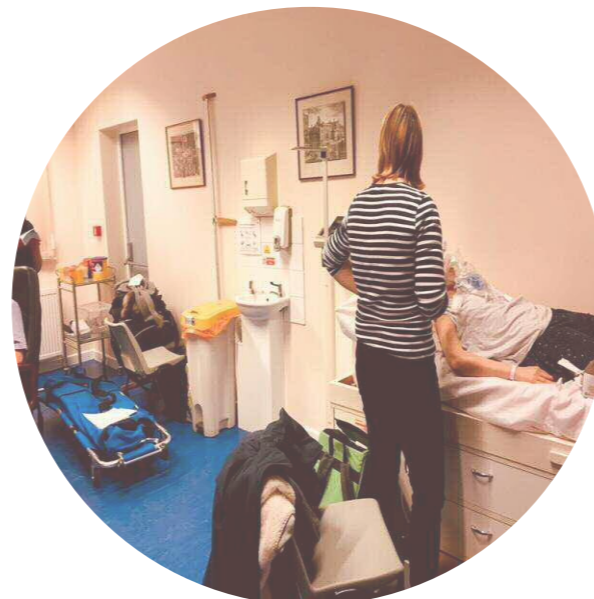
However...

1/3 of trainees did not feel confident in the immediate management of anaphylaxis or cardiac arrest in a primary care setting

1/2 of trainees did not feel confident delivering a shock with an automated external defibrillator in a primary care setting

Aim

To develop a **bespoke educational activity** for GP trainees, orientated towards primary care drawing on the knowledge, skills and attitudes that should be developed during an ED rotation.



Next Steps

The pilot workshop was received very favourably and we plan to repeat the workshop for all trainees rotating through the ED

We will undertake subsequent evaluation using semi-structured interviews and thematic analysis

However, **COVID-19** has introduced challenges relating to the delivery of face to face education so plans are underway to adapt the project to comply with current guidelines

Based on the pilot workshop, we predict that this educational activity will improve the **essential knowledge, skills and attitudes** required to effectively manage emergencies presenting in primary care

Evaluation of Frailty and Advance Care Planning Documentation in Heart Failure Reviews: A Quality Improvement Project

Sushilkumar Keshav Jadhav - The University of Central Lancashire, Preston, UK



Background

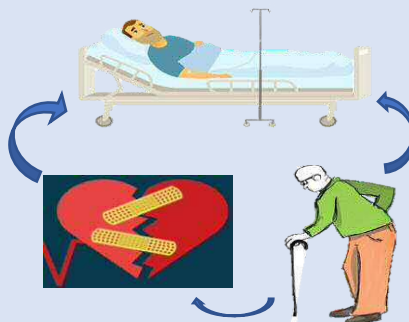
- Around 79% of patients with heart failure (HF) have frailty (Vitale, Spoletini & Rosano, 2018).
- Patients with frailty and HF have increased disability, reduced quality of life, increased hospitalization and increased mortality (Vitale, Spoletini & Rosano, 2018).
- The Ribblesdale Heart Failure Project (RHFP) was initiated in 2017 as a quality improvement project in primary care, to improve the standard of HF reviews. HF, frailty and end-of-life templates created as part of RHFP.
- HF template evaluated by third year medical student in 2019. Frailty scores and New York Heart Association (NYHA) class found to need improved recording (Anderson, 2019)

Aim

- To develop documentation of frailty and advance care planning (ACP) aspects within heart failure and frailty templates on EMIS at Pendleside Medical Practice, Clitheroe

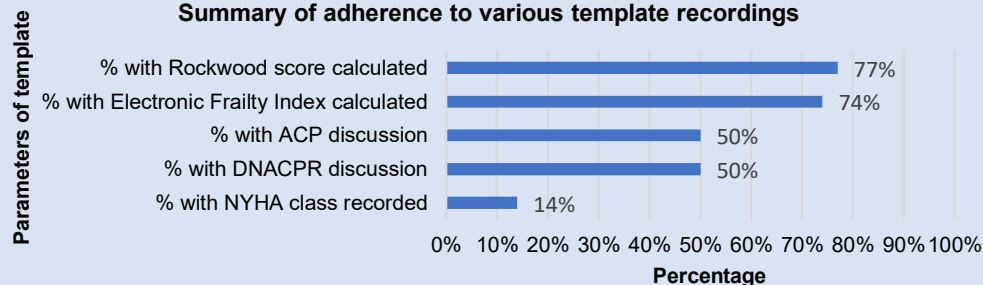
Methods

- First cycle of data collected from 70 chronic HF patients using codes on EMIS, areas to improve found.
- A 'Plan, Do, Study, Act' approach was implemented.
- Nurses taught on how and where to record data on EMIS templates and second cycle of data planned for collection after 2 months.

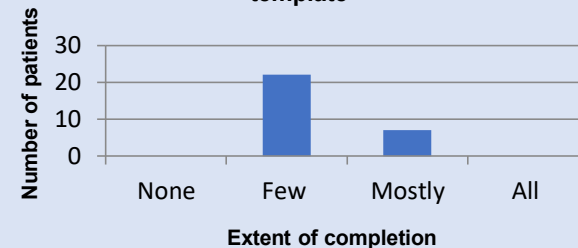


Results

Summary of adherence to various template recordings



Adherence to completion of frailty template



Discussion

- No patients had 100% of the frailty template filled and only 50% had an ACP and/or DNACPR discussion.
- NYHA recording facilitated by adding NYHA class explanation to HF template.
- Recommendation is to explore recording of other areas like DNACPR and more nurse training in using templates.
- Expand this project and create standardized high quality templates to be used across GP practices in UK.
- Find out HF patients needs and incorporate in templates
- Second cycle data not collected due to COVID, however first cycle of data highlights the deficits in recording.

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- Vitale, C., Spoletini, I., Rosano, G.M. (2018). Frailty in Heart Failure: Implications for Management. *Cardiac Failure Reviews*, 4(2), 102-104.
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Acknowledgements

Dr. Lucy Astle, Julian Anderson, admin staff at Pendleside GP practice

Sushilkumar Keshav Jadhav
skjadhav@uclan.ac.uk



INTRODUCTION

Atrial fibrillation (AF) is a tachyarrhythmia characterized by uncoordinated atrial activation due to rapid impulses initiated by the SA node, leading to a decline in atrial mechanical function. AF can be permanent or intermittent (paroxysmal). An estimated population of 1.4 million individuals in England are living with AF, making up 2.5% of the population. AF continues to increase from 40 years of age, is highest in the 75-80-year age group and decreases thereafter. While most patients are asymptomatic, common symptoms include fatigue and palpitations. There is a diagnostic challenge in identifying patients with paroxysmal or asymptomatic AF. In addition, a fivefold increase in stroke risk demands the need for early diagnosis and hence, providing early prophylaxis against thromboembolic events.

AIMS

1. To evaluate the assessment of patients presenting with palpitations
2. to analyse the efficiency of AF detection using patient-controlled ECG devices (such as AliveCore, handheld ECG monitors and smart watches).
3. To develop a pathway to guide the assessment of palpitations in primary care.



Image 1: (a) AliveCore monitor (b) Handheld ECG monitor

METHOD

This Quality improvement project was performed using a plan- do- study- act approach. This poster represents the planning phase of the project which involved the evaluation, assessment and management of palpitations at Pendleside medical practice, Clitheroe. 50 patients (18 males and 31 females) over the age of 50 years presenting with palpitations were carefully selected. P values were measured using the Chi Square test, with expected values taken as the best possible outcome. Chi square values were calculated and entered into a digital P value calculator with 1 degree of freedom.

Figure 1: Patients given ECG and 24 hour Holter monitors

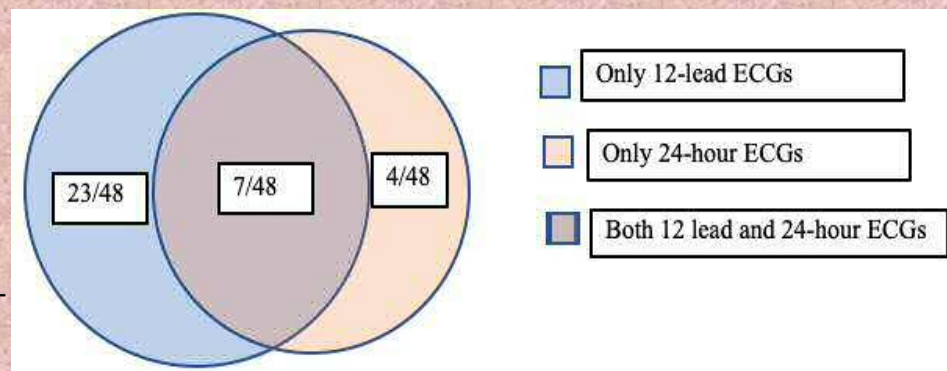


Figure 2: Palpitations cases

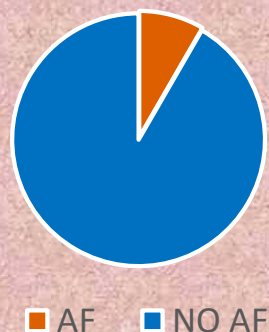
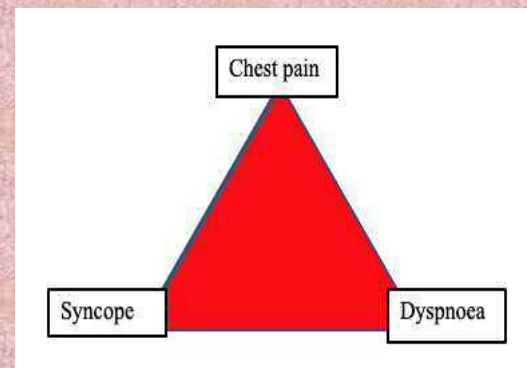


Figure 3: Red Flag symptoms



RESULTS

Positive findings:

- 85% had good documentation of examination skills
- 65% had same day blood tests
- 70% given ECG and Holter monitors (Figure 1)
- AF was detected promptly in 4/48 (8.3%) of the sample and all were immediately referred

Areas needing improvement:

- red flag symptoms were seldom documented: dyspnoea 9/48 (18.75%), Chest pain 3/48 (6.25%), Syncope 2/48 (4.16%)
- only 43% were given a formal diagnosis.
- Pulse rate (41/48) and rhythm (39/48) were not always documented
- Patient controlled ECGs were used in only 7/48 (14.58%), hence its efficacy cannot be elicited, as none of these patients had AF

CONCLUSION

Evaluation of current practice shows current variability and some definite areas for improvement including practicing good documentation strategies, recognising red flag symptoms within the history, performing prompt examinations and investigations in all situations and referring high risk patients in a timely manner. This helps to improve the quality of patient care. It is also ethically important to ensure that all patients are provided with a diagnosis, regardless of the severity of conditions. Therefore, taking this project forward, the proposal is to standardise the pathway, provide education on best practice and standardise use of mobile ECG devices which can support the detection of asymptomatic paroxysmal AF.

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WHAT

Standard- Year 4 GP placement – 20 hours/ week for 4 weeks

Pilot streams – 25% of time is spent in alternative GP lead services

Collaboration with local service providers

WHY

Expose- medical students to the variety of a GP career

Expand- placements for medical students

Recruit the future GP workforce

Hybrid Community Placements; A Pilot Study

WHAT SO FAR

3 cohorts:

7 day access

Federation medicine

Out of hours service provider

THE FUTURE

Expand – cohort volume and variety

Replicate – in year 5

Collaborate- with other institutes

COMBINED ORAL CONTRACEPTIVE PILL: SAFETY AND SATISFACTION AT BASSETT ROAD SURGERY

Lara Budwig



BACKGROUND

Oral contraception is the contraception of choice for women in the UK and the combined pill boasts many benefits. In order to maintain its safety however, the Faculty of Sexual and Reproductive Healthcare (FSRH) state that there should be annual review of patient medical eligibility, as well as an opportunity for patients to explore any concerns they may have and consider other methods of contraception that may suit them better [1].

TARGET CRITERIA

FSRH: patients on the combined oral contraceptive pill should have annual follow-up involving blood pressure (BP) check, body mass index (BMI) check and a discussion about patient satisfaction and alternative methods of contraception.

OBJECTIVES

1. To determine the percentage of patients due follow-up for the combined pill that were followed up within 15 months of their previous pill review.
2. To determine the percentage of follow-ups that addressed the following criteria: BP check, BMI check, discussion about patient satisfaction with contraceptive method and discussion about alternative methods of contraception.

METHOD



A search was done on SystmOne to identify women aged 16-50 at Bassett Road Surgery that were on the pill in 2018 in order to identify patients due follow-up between January 2019 and March 2020.



For the 102 patients due follow-up, the occurrence, timeliness and contents of follow-up were evaluated by manually looking through the clinical notes.



The data was recorded in a spreadsheet, from which the analysis was carried out.

RESULTS

Chart 1. Percentage of patients followed up within each time frame from the previous pill review (n = 102).

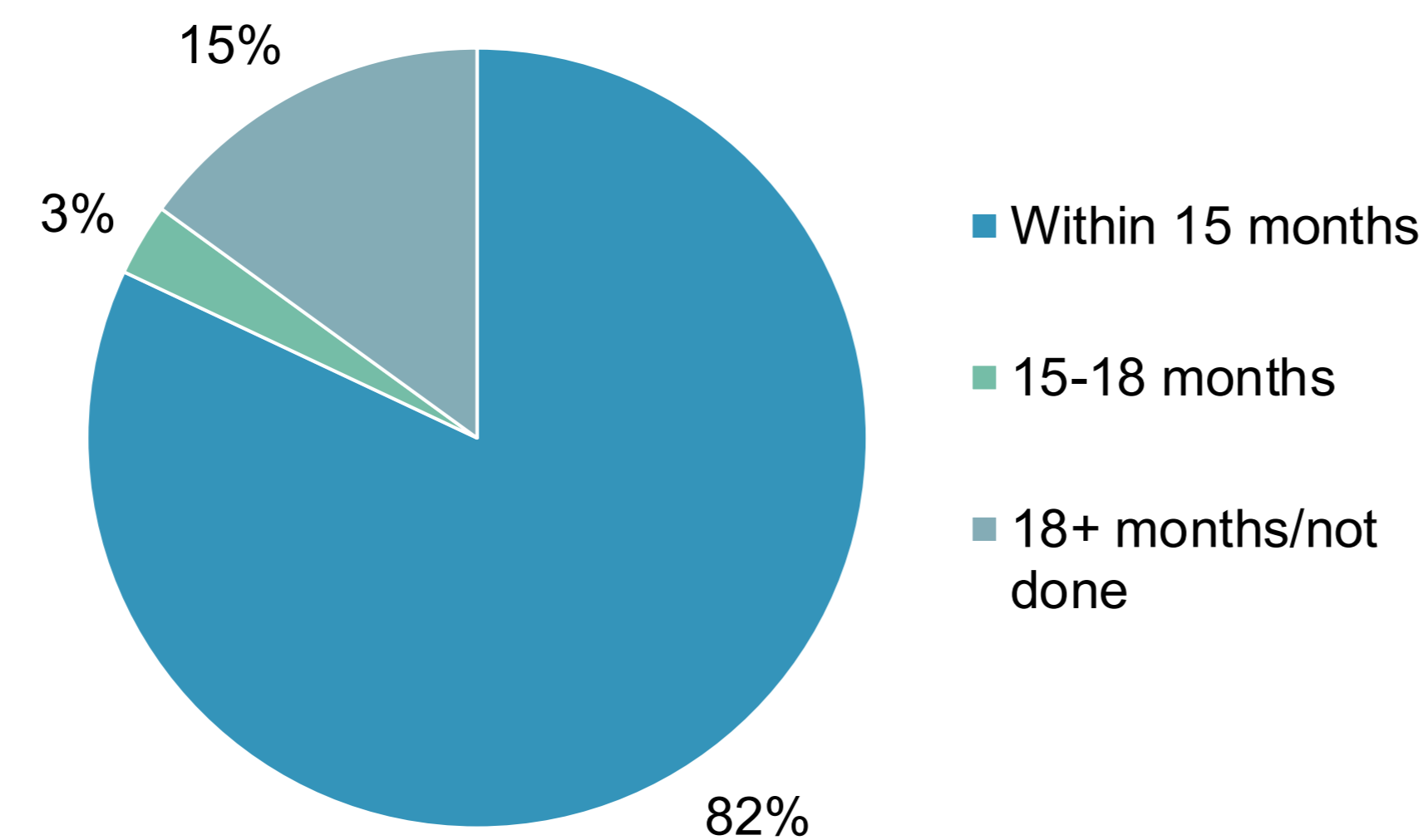
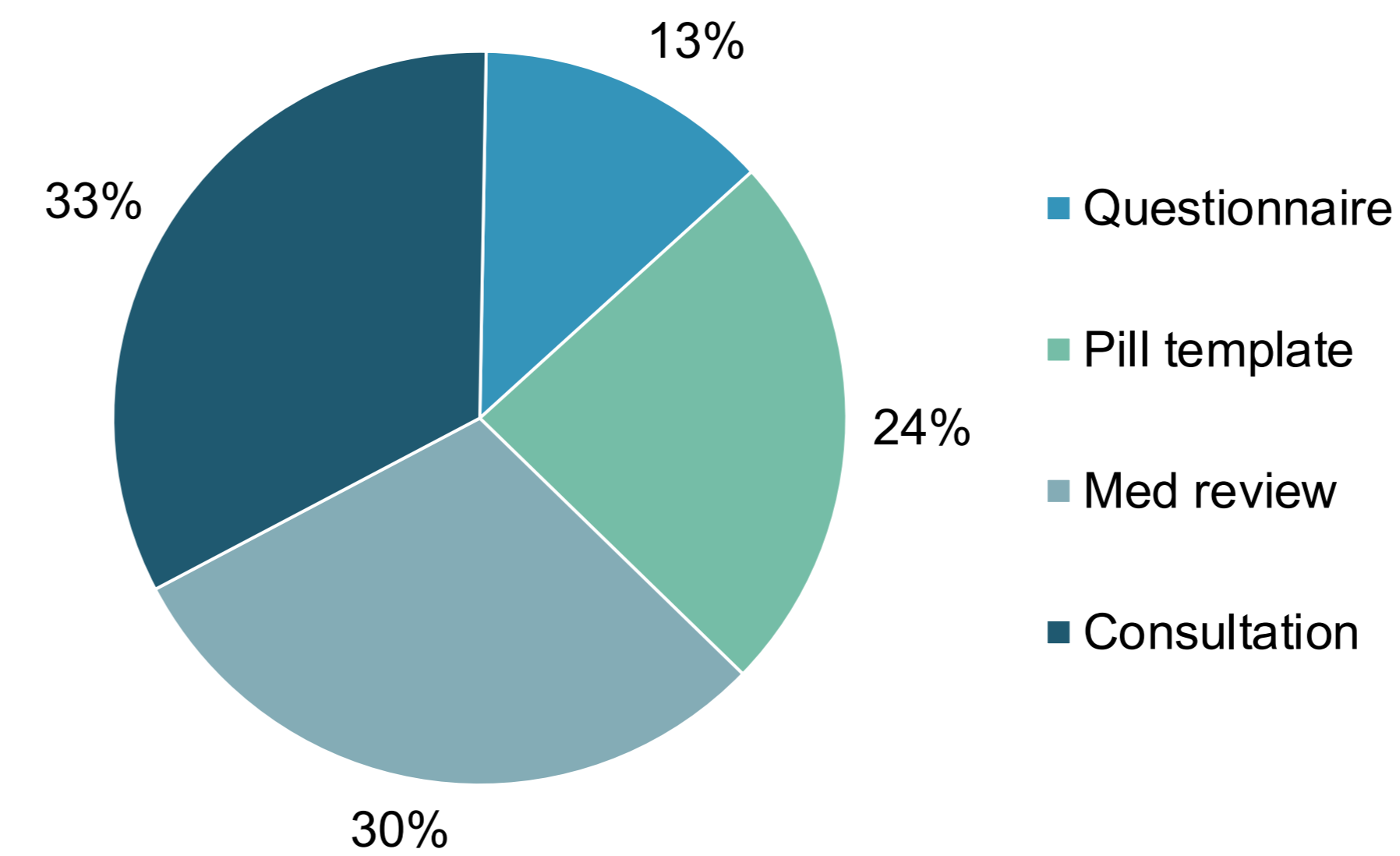


Chart 2. Percentage of patients that experienced each form of follow-up (n = 87).



The overall percentage of follow-ups that included the criteria were as follows (n = 87): BP check (76%), BMI check (38%), discussion about patient satisfaction with contraceptive method (63%) and discussion about alternative methods of contraception (54%).

Table 1. Percentage of general medication reviews (n = 26) and follow-ups within routine doctors consultations (n = 29) that included the four criteria.

	Med review (%)	Consultation (%)
BP	54	67
BMI	12	41
Satisfaction	35	86
Alternatives	19	10

CONCLUSIONS

- Annual combined pill follow-up was achieved for the vast majority of patients, however there was much variation between follow-ups with regard to what was assessed.
- It would be beneficial for the surgery to standardise combined pill follow-up by amending the current patient questionnaire to include all four criteria and solely using this form of follow-up, with manual BP check in the waiting room.
- This system is likely to result in better use of clinician time than the current system since health care professionals would then only need to make appointments for patients who have raised concerns in the questionnaire or whose answers put medical eligibility into question.
- Currently there is no system to alert clinicians that a follow-up is due. Yearly prescriptions of the combined pill would eliminate the uncertainty around whether follow-up is needed since follow-up would then always be required on receipt of a prescription request.

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1. Faculty of Sexual and Reproductive Healthcare. FSRH Guideline, *Combined Hormonal Contraception*. UK:FSRH:2019.

Active learning in clinical undergraduate GP placements: a qualitative exploration of debrief interactions during parallel surgeries

Background

Parallel surgeries are a widely-used teaching tool in primary care medical education for both undergraduate and speciality training. In undergraduate placements learners independently consult, usually without direct observation, then debrief with the GP before the patient leaves. This debrief can vary in format but usually involves a discussion of the learner's impressions and recommendations with the supervising healthcare professional (usually a GP) before agreeing a plan to take forwards in the management of the patient.

There exists a body of literature that describes the essential role of the supervising GP pertaining to providing a learning environment, encouraging active participation of students and setting the boundaries for the interpersonal interactions that occur within the teaching consultation(Park 2015), and also that learning is "enhanced through meaningful encounter with patients"(Pearson 2011) in the GP setting. An Australian paper described the format and purpose of supervisory encounters between GP teachers and speciality trainees, in which the "primary agenda was always developing a plan for the patient."(Brown 2018). This highlights the ever present tension between the delivery of a service and balancing clinical needs against supervisory and learning needs during supervision.

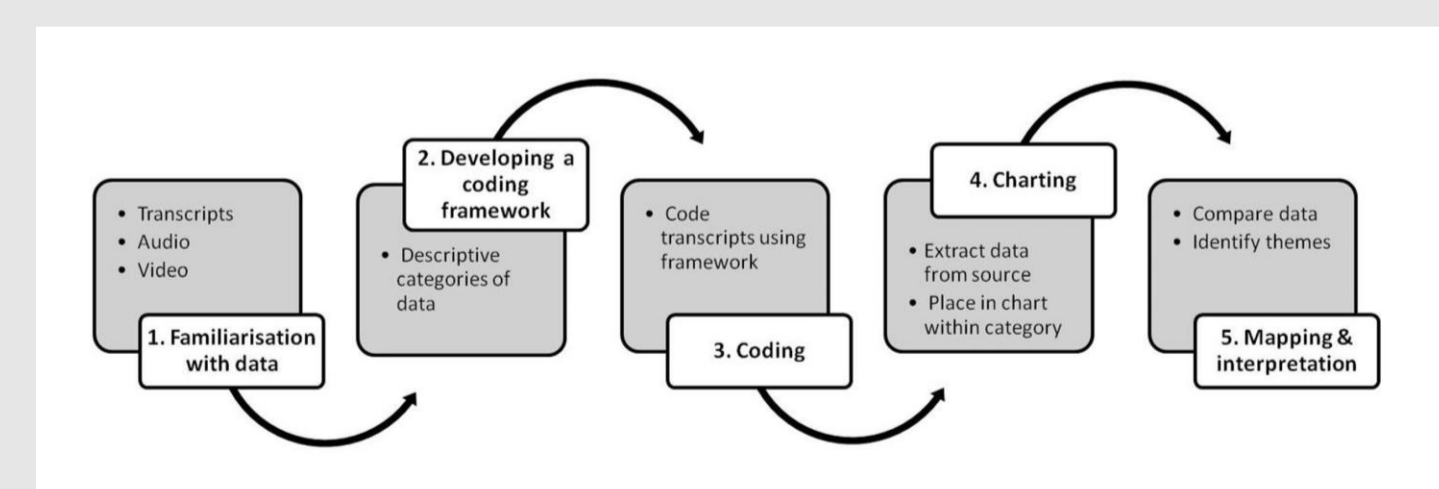
Though the parallel surgery teaching format is a mainstay of clinical supervision in practice, there is no literature that studies its application or use in medical education(Tan, 2018). Given this lack there is no consensus regarding how to approach the supervisory session or what techniques are best to employ within the session.

To explore how GP facilitation shapes these interactions through a process of active participation for patient and student

Approach

The research took a socially situated approach, drawing on the work of Lave, 2019, regarding communities of practice and legitimate peripheral participation. We view learning to be a transformative process in which knowledge is embodied by changing participants as they assimilate the structural characteristics of their community of practice(Lave, 2019). This learning transformation is experiential, but we view this as a physically embodied process, rather than a purely cognitive one. We use the embodiment theory of body pedagogics, which "illustrates how multisensory experience causes embodied changes that become an automatic part of physician expertise"(Kelly, 2019) to describe how peripheral participants can embody knowledge as they learn. "Embodied knowledge is a type of knowledge where the body knows how to act"(Tanaka, 2011) and because of this physically experienced socially situated nature of learning the process can be understood both experientially and observationally.

We used a mixed methods qualitative approach, considering Lave's proposal that the unit of analysis must be a textured landscape of participation(Lave, 2019). Our units of analysis therefore were the subjective experiences of the participants and our qualitative interpretation of the embodied knowledge shown by the video subjects.



audio recorded and transcribed. 14 patient exit questionnaires were completed and e debrief interactions during supervisory clinics (parallel surgeries) across multiple d two camera angles of the consultation, and recording began at the point when the med a consultation with the patient independently first. The recording ended after the GP ics approval was granted, and interview and video data was anonymised.

We analysed the data using an adapted framework analysis based on Ritchie, 1994, which can be visualised in *Figure 1*. Using this framework we incorporated the video data into the framework analysis process as follows: We collaboratively analysed the transcribed interview data, and after the familiarisation and abstraction steps of the analysis we generated a coding framework. We used this coding framework to inform the video analysis during the charting step of the

References

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viewing by multiple researchers, detailed note taking, agreement on major events which were then micro-analysed, and emergent codes. Both interview and

Learning

A total of 15 patients, 5 students and 4 GPs participated. 12 video debrief interactions were recorded, 9 student and GP interviews were conducted and 14 patient questionnaires were completed. From the transcripts 13 initial codes were described, and three categories relevant to the research questions. Of the 12 videos ranging from approximately 10 minutes to 40 minutes duration two were selected as rich data and analysed multiple times to generate the themes, using the three categories from the interview data in the inductive approach to analysis. Once major events and themes were agreed the remaining videos were reviewed without micro-analysis in order to look for divergent themes.

The main codes identified from the categorisation stage of the framework analysis of interview and questionnaire data were as follows:

- Patient**
- GP as the expert
 - Students acted in the role of a doctor
 - Collaborative decision making

- Student**
- Learning by action
 - GP as the active agent
 - Professional role rehearsal
 - Real world environment
 - Recognising the limits of their own capacity

- GP**
- Benefit to patients
 - Encouraging the student to act in the role of a doctor
 - GP as the knowledge keeper
 - Providing a learning environment
 - Seeing students develop over time

After indexing the categories, three major categories emerged that most closely related to transformational learning:

- The active participation of the student
- The supportive learning environment
- The legitimacy of the student

From the video analysis, we observed that the format and facilitation of the parallel surgery debriefs varied widely - from different styles of supervision, to different seat positioning and even disparity regarding if the patient was present during the initial debrief.

- The main themes identified from the analysis were:
- Allowing the student to rehearse the role of a doctor.
 - Contextualising the learning environment.
 - Giving time for the student to respond to a question.
 - Legitimising the student's presence.

- Seat positioning.

These themes are consistent with the model of the 'GP as a broker' previously described in undergraduate medical education in the general practice setting(Park, 2015). We then observed the consequences of these themes when emphasised by the GP facilitator or de-emphasised within the context of the 10-40 minute debrief recordings, which are recorded below:

Domain	When emphasised	De-emphasised
Active participant Allowing the student to rehearse the role of a doctor	<ul style="list-style-type: none">• Evidence of students beginning to embody knowledge, e.g. turning to the computer to look up guidance or prescribe a medication, reaching for an appropriate piece of equipment• Students performed more actions and had more input into management	<ul style="list-style-type: none">• Students adopted a mostly observant role• Students still displayed evidence of focused attention• Rare or no displays of active participation
Encouraging engagement Giving time for the student to respond to a question.	<ul style="list-style-type: none">• Students were able to contribute suggestions or knowledge that were incorporated into the treatment plan and/or explanations• Patient had the opportunity to contribute with clarification or further information• Students displayed more clinical knowledge• Increased physical displays of anxiety by student	<ul style="list-style-type: none">• Students did not appear subdued or anxious despite a quicker pace of questioning or when unable to contribute an answer
Facilitating Seat positioning: dyadic or triadic	<ul style="list-style-type: none">• More engagement by the least active participant in conversations• Examination of the patient was done together by GP and student	<ul style="list-style-type: none">• Comparatively more time with two people interacting at once, sparse evidence of triadic interaction.• Examination of the patient was done alone
Legitimate membership of a community of practice Legitimising the student's presence	<ul style="list-style-type: none">• GP showed trust in student by not retaking history already presented• Students gained rehearsal experience such as giving explanations, opportunities to display process knowledge such as prescription or note-taking	<ul style="list-style-type: none">• The GP took agency, while the student adopted a mostly observant role• Rare or no displays of active participation
Setting the stage Contextualising the learning environment: <ul style="list-style-type: none">• Debrief takes place with the patient present throughout	<ul style="list-style-type: none">• Discussions regarding clinical knowledge were in depth, though no more so than with the patient present.• Students displayed less anxiety related to performance• Student verbal contributions were increased• Increase in role rehearsal	<ul style="list-style-type: none">• The patient didn't have the opportunity to hear their history presented to the GP and give corrections/emphasis/clarification• The student could not ask the patient further questions while discussing differentials• Student verbal contributions were diminished• Decrease in role rehearsal

Other findings

- Structural knowledge was embodied by the patient at various points during the consultation - such as knowing when to move to the examination couch, dress or undress, or wait for the student to perform some action.
- When there were more frequent displays of active participation/embodiment of knowledge by the student, there was also more interaction between the student and the patient
- There was a marked increase in time taken for debrief when the domains of active participation, encouraging engagement and legitimising membership were emphasised

Discussion

Participants from each group described students embodying the structural characteristics of general practice through their legitimate and active participation in parallel surgeries. Our data reinforces much previous descriptive research into the outcomes of benefits and dis-benefits for students, GPs and patients involved in teaching in the general practice setting(Park, 2015), particularly in the domains related to active participation and the environmental aspects of the community of practice.

Both experiential and observational data reinforce the concept that "as an active participant in the consultation, the student is invited to rehearse their role in the consultation by assuming the role of a doctor"(Park, 2015), and that taking action in this way, by the process of doing and living embodied experience, has power and value in the transformation of a learner's knowledgable identity towards the character of the community of general practice.

There was also evidence of conflict pertaining to legitimate peripherality - both in the tension that GPs experienced between providing a service, managing workload and the provision of a supportive- yet stimulating- learning environment for the participant, and also in the practical aspects of allowing learners to rehearse in a legitimate role safely.

A deeper understanding of the complex interactions that take place during workplace supervisory encounters can inform GP teachers of the likely effects of their conscious and unconscious decisions, and improve preparation and delivery of workplace-based teaching.

To our knowledge this is the first experiential or observational exploration of clinical supervisory debrief encounters in depth, and we have barely scratched the surface of the largely invisible curriculum domain of clinical supervision.

We have taken care to avoid viewing knowledgae as separable from changing persons, activities and circumstances, or focusing too closely on the notion of the individual learner. This presented challenges for us to be able to study a complex and ever changing process

BACKGROUND: WHY THIS MATTERS...

- Heart Failure (HF) is a considerable contributor to morbidity and mortality worldwide (Savarese & Lund, 2017).
- HF carries poor prognosis with survival rate 45.5% (95% CI 45.1 - 46.0) at five years (Taylor et al., 2019).
- £2bn (2%) of all healthcare costs in the UK (NICE, 2018).

 There are around 200,000 new diagnoses of heart failure every year in the UK

 People with heart failure are 2-3 times more likely to have a stroke

- Care traditionally provided in secondary care/integrated community HF clinics.
- Multiple co-morbidities and increasing frailty among an aging population requires a holistic, patient-centered approach (Figure 1).

OBJECTIVE

To evaluate existing multidisciplinary community-based interventions for patients with heart failure, to inform the development of a novel model of care within Primary Care Networks (PCNs).

P Adult (>18 years) patients diagnosed with HF (acute and chronic).

I Any HF intervention in a primary, community or integrated care setting.

C N/A

O At least one measure of improvement in quality of care including; (a) hospital admission rates, (b) patient satisfaction, (c) Resource utilisation, and (d) Clinical standards of care e.g. NICE quality standards.

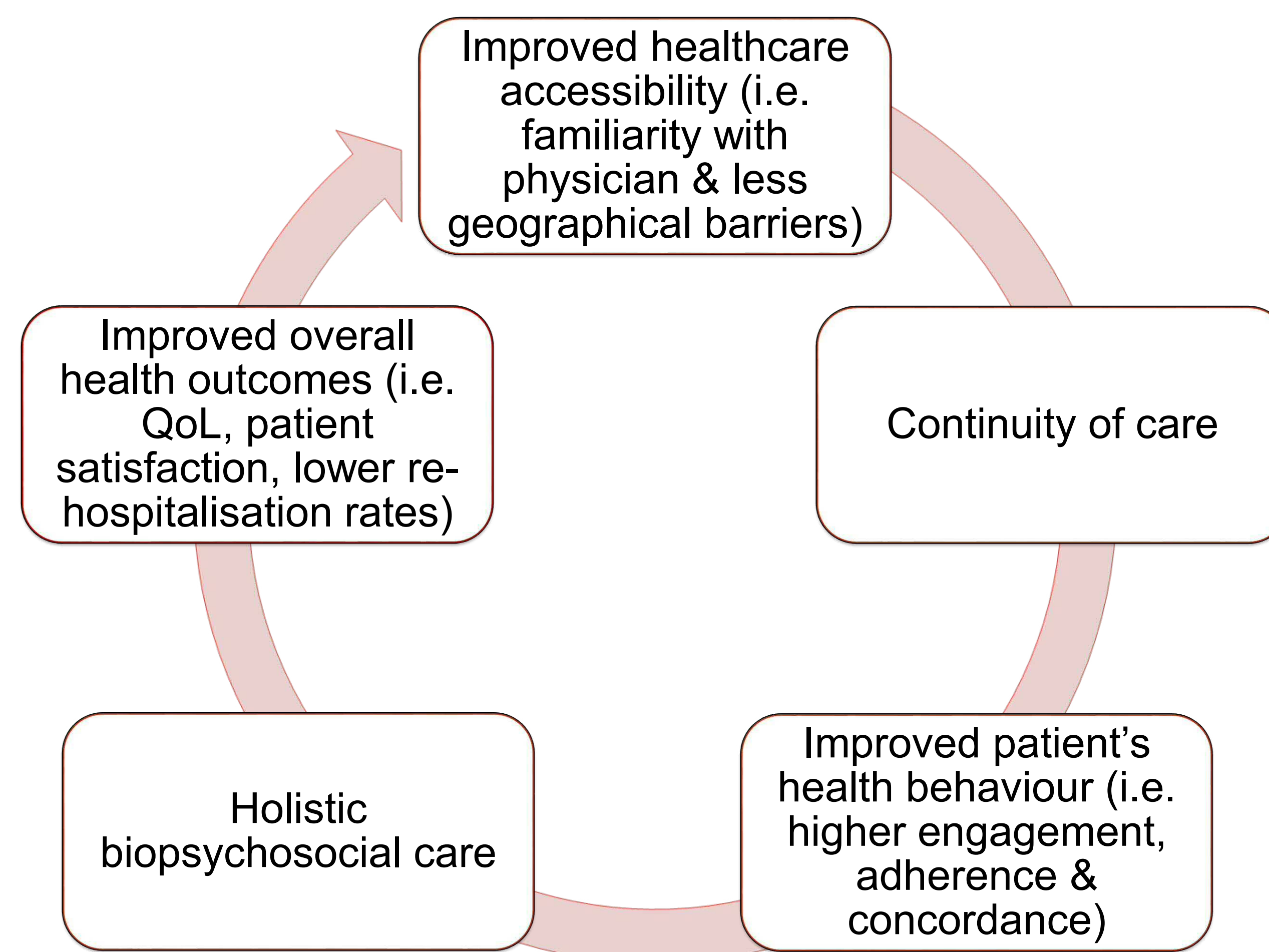


Figure 1: Potential benefits of a Primary care-based HF model of care

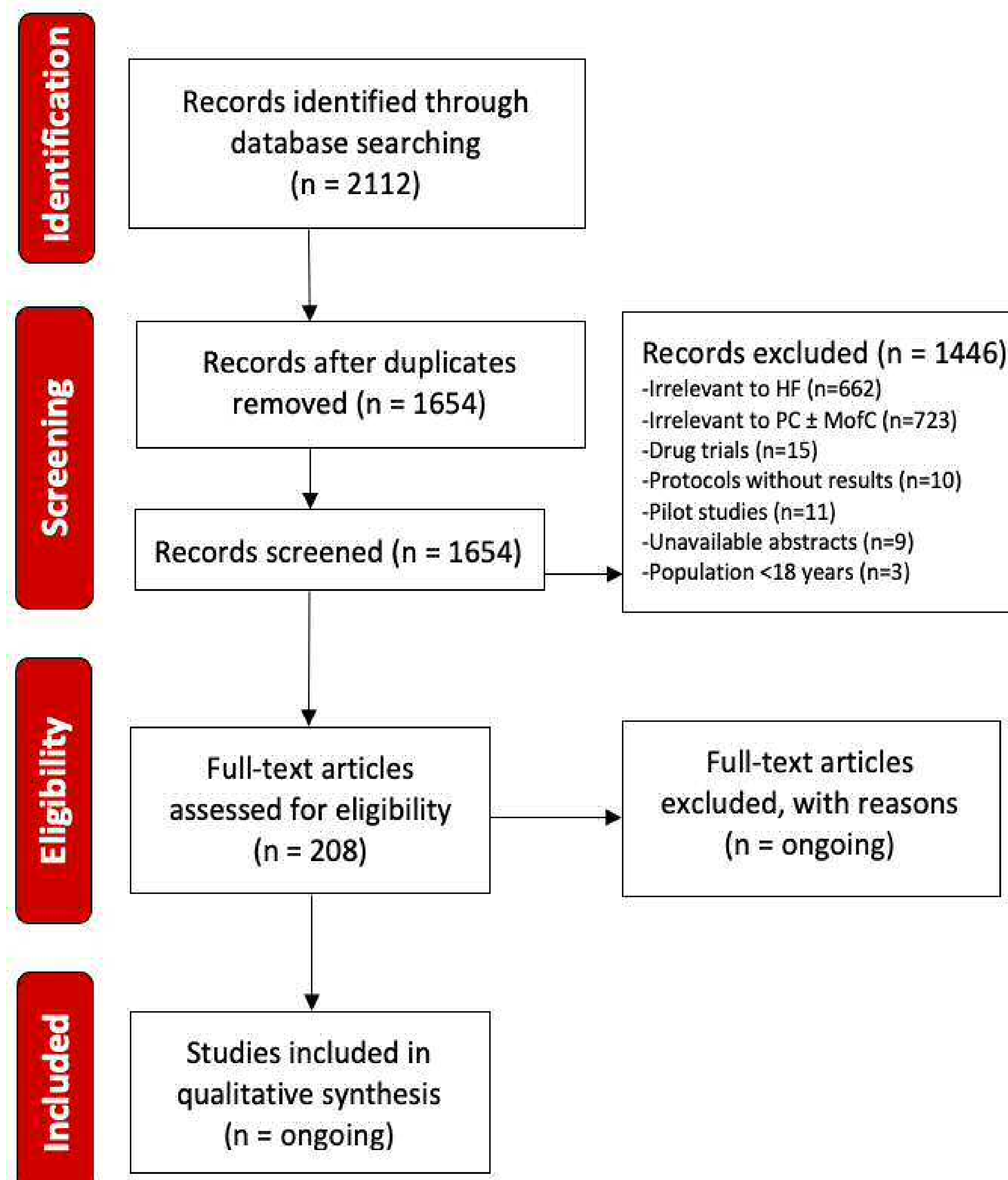


Figure 2: PRISMA flow diagram of the screening stage.

METHODS

SEARCH STRATEGY

- Combined key words for HF and models of care
- Four bibliographic databases: MEDLINE, CINAHL, Embase, and Cochrane.
- All articles independently reviewed by two reviewers (AE & LA/NCM/HO) and disagreements resolved by third reviewer (UC).
- Reference checking (ongoing) and contact of authors.

DATA EXTRACTION

The following data will be extracted by two reviewers (LA & AE):

1. Author, title & publication date
2. Study design & methodology
3. Participant demographics and baseline characteristics
4. Outcomes measured and results

DISCUSSION

Current NICE guidance recommends bi-annual follow-up routine appointments for patient with stable HF (Chaplin, 2019). A substitution of HF care from secondary to primary care appears sustainable, more cost-effective and geographically appealing for patients living nearby a PCN-providing service. However, the need for a solid primary care understanding of HF is of utmost importance for this transition to occur.

WHY WE NEED TO TALK MORE...

The authors would welcome the sharing of experiences surrounding the methodological and clinical approaches for developing models of care for patients with HF.

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- Taylor, C. J., Ordóñez-Mena, J. M., Roalfe, A. K., Lay-Flurrie, S., Jones, N. R., Marshall, T., & Hobbs, F. D. R. (2019). Trends in survival after a diagnosis of heart failure in the united kingdom 2000-2017: Population based cohort study. *Bmj*, 364, I223. doi:10.1136/bmj.I223
- Marshall, T., & Hobbs, F. D. R. (2019). Trends in survival after a diagnosis of heart failure in the united kingdom 2000-2017: Population based cohort study. *Bmj*, 364, I223. doi:10.1136/bmj.I223



CHAMPIONING THE KNOWLEDGE WORK OF PRIMARY CARE
PARALLEL SESSION B.3 – PATIENT PERSPECTIVES (13:00 – 14:00)

SESSION CHAIR – Professor Umesh Chauhan, Professor of Primary Care Medicine, UCLan

SESSION SUPPORT - Professor Joanne Reeve, Academy of Primary Care, Hull York Medical School

1	Rachel Crothers	University of Sheffield	A qualitative study exploring barriers and facilitators to physical activity experienced by 18 to 35 year olds living in Sheffield's most deprived areas
2	Brigitte Delaney	University of Sheffield	Remote asthma reviews: scoping advice and identifying the benefits and challenges from the perspective of professionals and patients
3	Yeyenta Osasu	University of Sheffield	Optimisation of direct oral anticoagulants (DOACs) for older patients with atrial fibrillation: a qualitative study of patient and healthcare practitioner perspectives
4	Dr Claire Sloan	University of York	The 'Behavioural Activation in Social Isolation' Study (BASIL): Modifications of a psychosocial intervention for older adults with multiple long-term conditions in response to COVID-19
5	Nicola Small	University of Manchester	Establishing new methods to utilise patient reported feedback for older people with multiple long-term conditions to increase empowerment (EMPOWER): scoping review preliminary findings
6	Chris Stevens	Keele University	Does occupation predict outcome in conservatively managed carpal tunnel syndrome?
7	Lauren Franklin	Keele University	Work participation in primary care consulters for musculoskeletal conditions
8	Dr Jon Dickson	University of Sheffield	What is primary care epileptology/heurology?

Aim: To explore barriers and facilitators to physical activity (PA) experienced by young adults aged 18-35 living in Sheffield's most deprived areas

Fig.1: Illustration of barriers and facilitators to PA identified from all interviews



Authors: Rachel Crothers (*presenter*), Dr Helen Twohig, Dr Phillip Oliver
Department: Academic Unit of Primary Medical Care, University of Sheffield Medical School
Contact: rncrothers1@sheffield.ac.uk

The Problem

- Inequalities in PA uptake persist between socioeconomic groups; most deprived groups are least active^{1,2}
- Young adults (18-35) are understudied & may hold an opportunity to boost PA engagement in later life^{3,4}

Our Approach

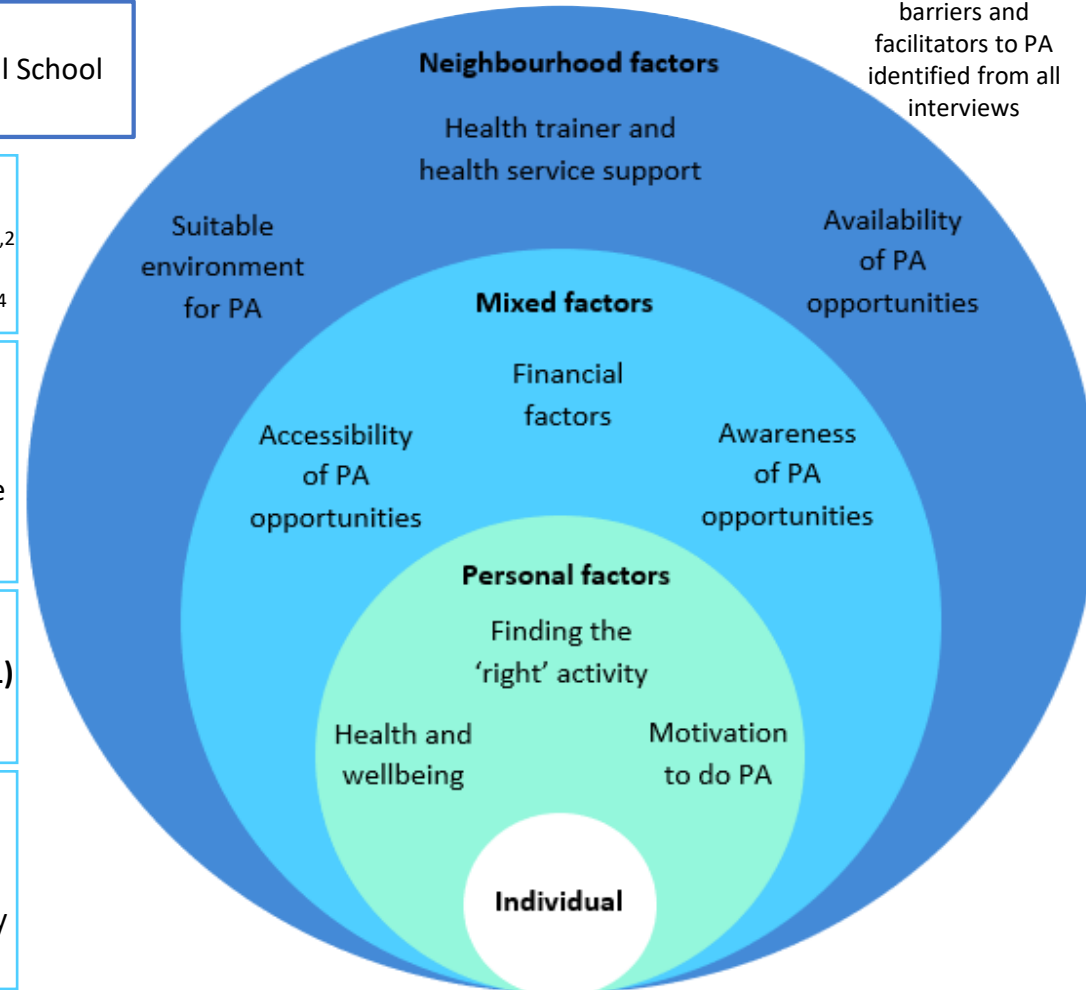
- Qualitative study: semi-structured interviews, analysed by thematic analysis
- Recruited health trainers and lay participants from most deprived quintile nationally based on IMD score
- 1 lay participant & 2 health trainers interviewed before Covid-19 restrictions

The Learning

- Personal, mixed and neighbourhood barriers and facilitators influence PA uptake in this group (see Fig. 1)
- Motivation appears difficult in this population as PA is not able to be prioritised

Why It Matters

- Potential areas to work on include accessibility of activities, enjoyment & PA-promoting environments
- Very limited data in this study - more research needed to inform strategies to boost PA uptake in this key population & **ultimately contribute to tackling health inequities**



“For some physical activity in its broader sense is not a priority... The priority is making sure that there's a roof over their head, the bills are paid and there's food on the table for kids” - Health trainer participant

1. Sport England. Active Lives Adult Survey May 18/19 Report. [Online]. Available from: <https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2020-10/Active%20Lives%20Adult%20May%202019-20%20Report.pdf?AYzBswpBmlh9cNch8TFctPI38v4Ok2JD> [Accessed 8 November 2020].

2. Public Health England. Public Health Profiles: Physical Activity. [Online]. Available from: <https://fingertips.phe.org.uk/profile/physical-activity> [Accessed 8 November 2020].

3. Hirvensalo, M, Lintunen, T. Life-course perspective for physical activity and sports participation. *Eur Rev Aging Phys Act.* 2011;8: 13-22.

4. Telama, R. Tracking of physical activity from childhood to adulthood: A review. *Obes Facts.* 2009;2(3): 187-195.



Remote asthma reviews: scoping advice and identifying the benefits and challenges from the perspective of professionals and patients



Asthma UK Centre for Applied Research



aukcar.ac.uk

@aukcar

@imp2art

Delaney B¹, Barat A², Taylor S², Marsh V³, McClatchey K³, Kinley E³, Pinnock H³ for the IMP²ART group
¹University of Sheffield, ²Queen Mary University London, ³University of Edinburgh

The problem:

- The COVID-19 pandemic has dramatically changed the organisation of primary care, most notably with the move to remote consultations (telephone, video-calls and online). Indeed, prior to the pandemic, over 70% of GP consultations in England were carried out face-to-face, within weeks this figure had dropped to 23%¹.
- It is likely that remote consultations will continue to be a feature of primary care management of long-term conditions beyond the pandemic.

Approach:

- We carried out an online search for publicly available information with Google™ using a combination of the search terms ‘remote consultations’, ‘health care professional’, ‘general practitioners’ and ‘nursing’.
- We convened two group meetings, led by experienced facilitators, with the IMP²ART Professional Advisory Group (PAG) and the IMP²ART Patient and Public Involvement (PPI) group to identify their perceptions of the benefits and challenges of carrying out remote asthma reviews in primary care. The discussions were recorded with consent, and extensive notes were taken.
- Eighteen documents and 12 video resources were identified from 12 difference organisations including NHS, GMC, MDU, BMA, Royal Colleges, Asthma UK, Academia and others. Using content analysis there was a consistency of themes across the documents and videos. The guidance focused on acute consultations only, offering no advice specifically on reviewing long term conditions.



KEY THEMES



The Learning: Following in-depth discussion with PAG/PPI groups, and using these themes to guide us, we were able to gain insight into the perceived challenges and benefits of remote consultations.

PPI Group:

- They felt remote consultations were effective if both participants are well-prepared; it was suggested that the patient be given access to the questions prior to the review and the HCP should have all the pertinent patient information, e.g. medical history/medications etc.
- They felt that remote consultations would be more effective if the patient and HCP already knew each other, for the patient to be engaged in the process.
- They were more cautious about the potential disruption to continuity of care, particularly for long term condition reviews.
- There were concerns raised about inequitable access to the appropriate technology and a number of members highlighted the need to respect patient preference for mode of consultation.

PAG Group:

- They were less concerned about technological issues, drawing on their own experiences of carrying out successful remote consultations during the pandemic.
- They felt that remote reviews offer the potential for the improved management of long term conditions.
- There was a recognition that remote reviews will not be appropriate for a proportion of their patient population and that other options should be available.
- They identified future training needs for practice staff to carry out remote asthma reviews.

Why it matters: Current guidance needs to be adapted to advise professionals carrying out remote asthma reviews in primary care. Patients and professionals were generally positive about remote reviews for asthma, but identified some concerns which will inform the design of review-specific tools for the IMP²ART toolkit.

References:

1. Royal College of General Practitioners. General practice in the post Covid world: challenges and opportunities for general practice 7 July 2020.

Background



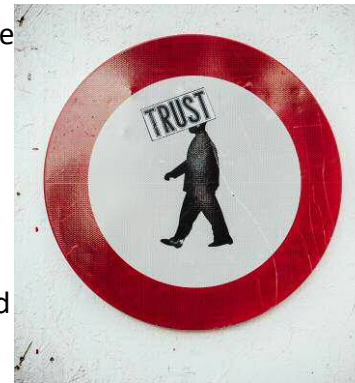
Direct oral anticoagulants are high risk drugs which are increasingly being prescribed for patients with atrial fibrillation. Suboptimal prescribing, adherence, monitoring and ineffective patient education could result in adverse events especially in older adults.

Aim

To understand patient and practitioner perceptions of DOAC optimisation for atrial fibrillation

Patients' perspectives

High level of trust in the GPs expertise was linked to high satisfaction, passivity and low risk perception of DOACs. Information and medication related consultations were unmemorable. Consequently, patients had poor understanding of atrial fibrillation and aims of DOAC treatment



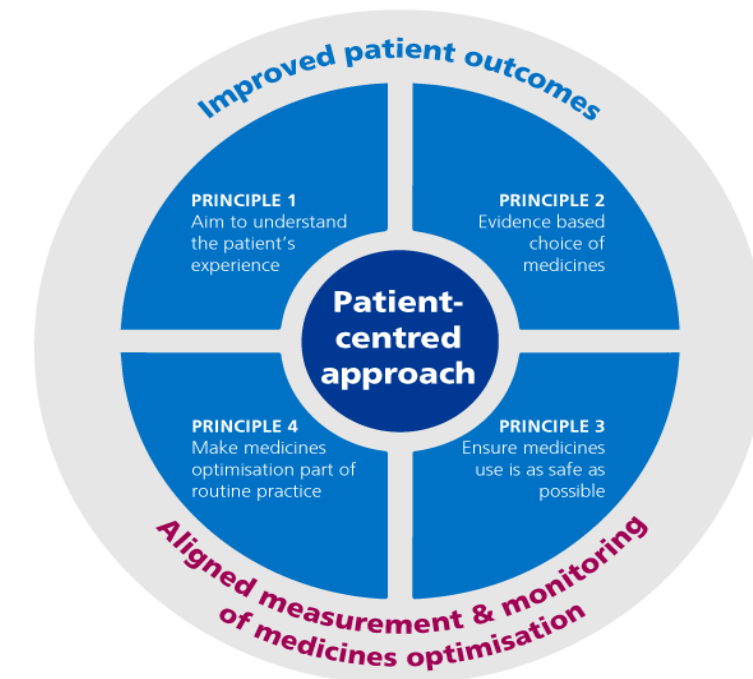
Healthcare Professionals' perspectives

GPs welcomed the innovation to reduce workload, but most did not show excessive concerns about safety compared to pharmacists. GPs valued collaboration with pharmacists although blurred role boundaries, lack of IT integration and poor communication undermined pharmacists' effectiveness at patient engagement in community pharmacies.



Implications for practice

- Improve data integration and information across healthcare systems
- Empower patients in consultations and through co-production of patient information
- Improve patient advocacy
- Optimise GP and pharmacist collaboration

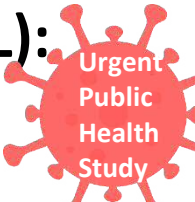


The 'Behavioural Activation in Social IsoLation' Study (BASIL):

BASIL
Behavioural Activation
in Social IsoLation

Modification of a psychosocial intervention for older adults with multiple long-term conditions in response to COVID-19

@BASIL_Research



Presenting author: Claire Sloan¹ **Co-authors:** Dean McMillan¹, David Ekers^{1&2}, Della Bailey¹, Elizabeth Littlewood¹, Samantha Gascoyne¹, Lauren Burke¹, Suzanne Crosland¹, Andrew Henry^{1&2}, Eloise Ryde^{1&2}, Leanne Shearsmith³, Peter Coventry¹, Gemma Travis-Turner³, Rebecca Woodhouse¹, Simon Gilbody¹ and Carolyn A. Chew-Graham⁴, on behalf of the BASIL team

Background

- Older people (OP) with long-term conditions (LTCs) are at particular risk from COVID-19 infection
- COVID-19 restrictions may impact negatively on the mental health of OP
- Risk of depression in OP is increased by around 2-3 times

Aim

The Behavioural Activation in Social IsoLation (BASIL) study aims to prevent or ameliorate depression and loneliness in OP with multiple LTCs by modifying an existing psychosocial intervention (Behavioural Activation within a Collaborative Care framework)

Methods

- Intervention mode of delivery, supporting materials and support worker (SW) training were adapted to specifically consider social isolation and COVID-19 restrictions
- Discussion in a co-design online stakeholder workshop with OPs, caregivers, health and social care professionals and researchers.
- Patient and Public Involvement (PPI) group also met online to discuss intervention materials.

Results/learning

- Intervention modification included: earlier focus on diary planning and linking this with mood monitoring, adding language around social isolation, planning for social contact, supporting older adults to use IT, as well as supporting access to health care,
- Consideration given to finding a functional equivalence for OPs' most valued activities.
- Focus on anxiety with strategies added to manage worry added
- The intervention self-help booklet, which included 'patient stories', the SW manual and SW training were modified
- Modification to recruitment for the pilot study needed.



BASIL Pilot commenced March 2020

Recruitment closed October 2020
n=96

BASIL Pilot trial is ongoing. BASIL+ main trial planned 2020

We need to talk about revitalising patient empowerment in person-centred primary care

Establishing new Methods to utilise Patient reported outcome feedback for Older (65+ years) people With (and affected by) multiple long-term conditions to increase Empowerment: the EMPOWER study

Nicola Small, Brian McMillan, Carolyn Chew-Graham, Peter Bower, Caroline Sanders and Joanne Protheroe

Challenge

- Patient empowerment remains central to ensuring quality person-centred care.
- Yet little is known what empowers this population with complex needs - one size does not fit all.
- Our validated PROM measures patient empowerment as 'a feeling of control' in the self and as a partnership with primary care (see Fig. 1).

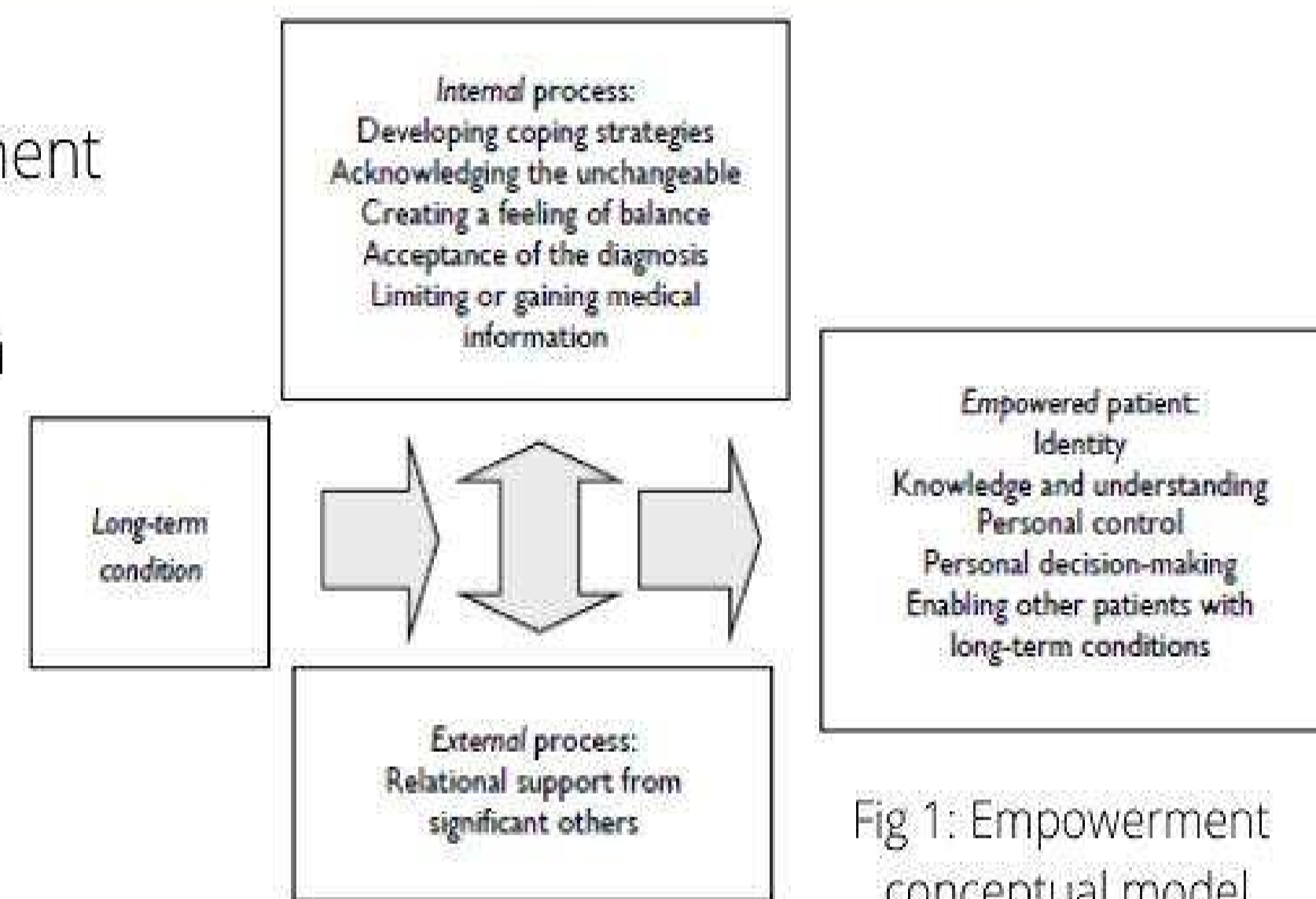


Fig 1: Empowerment conceptual model

Working methods

- Scoping review of PROMs and feedback methods.
- Co-design workshop with critical reflection to inform early digital intervention development and future pilot work.
- Virtual partnership with dedicated 9 patient, public and carer involvement and engagement (PPIE) partners and the wider PRIMER (Primary Care Research In Manchester Engagement Resource) Group @PrimaryCareMcr.

Insights from virtual partnership working

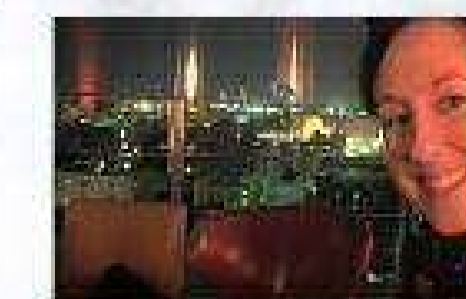
- Embrace what matters to patients and carers, such as, holistic photography or painting, to choose suitable methods to administer PROM to tackle complexity in person-centred primary care.
- Focus on one meaningful activity so a sense of completion is felt (Spoons theory, everything has a process so it can be compartmentalised).
- It is a fluctuating partnership with the self and primary care - one part of this might be empowering other patients and carers to feel in control.
- Identify barriers, such as, language, cultural competency, health literacy and digital exclusion, to explain lower levels of patient empowerment.



Credit: holistic photography ('pansy') by Rebecca and Marie ('Rainbow' and 'Shropshire Hills')

Virtual calling card

Corresponding:
Nicola Small, NIHR SPCR Launching Fellow
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Using Occupation to Predict Treatment Outcome in Conservatively Managed Carpal Tunnel Syndrome: A Secondary Data Analysis

C. Stevens^[1], R. Wilkie^[1], C. Burton^[1]



Keele
UNIVERSITY

Background

Carpal tunnel syndrome (CTS) is a common and bothersome condition causing discomfort and dysfunction of the hand and wrist. In more severe cases, CTS can impact on a patient's ability to work and perform their usual activities of daily living. The onset of CTS is known to be associated with certain occupations but less is known about outcome.

Methods

A systematic search and rapid review of the literature was performed, which identified a gap in the evidence addressing the outcome of conservatively managed CTS, as determined by occupation.

We then performed a secondary analysis of data from the INSTINCTS trial ^[2] (INjection versus SplinTing in Carpal Tunnel Syndrome), which compared the effectiveness of corticosteroid injection to night splitting. In participants who were employed at baseline, we used linear regression modelling to identify if job category predicted (along with other variables) patient reported outcome at 6-months, as measured by the Boston Carpal Tunnel Questionnaire (BCTQ).

This study/project is funded by the National Institute for Health Research (NIHR) School for Primary Care Research.

The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Results

Patients that worked in the sales and customer service industry experienced a raw BCTQ score decrease (positive prognosis outcome, as reported by patient) at 6 months from baseline. This is an exploratory finding due to the small sample size. Sex, symptom duration, high risk employment category, treatment type and age were accounted for in the model.

Medical Relevance

- Carpal tunnel syndrome is the most common peripheral entrapment neuropathy and is known to be a leading cause of long-term work-related disability claims. ^[3]
- Incidence of CTS will continue to increase under current trends.
- There is a need for further research into occupation as a predictor of outcome in CTS.
- It is important that patients receive reliable prognostic information that is applicable to them as an individual. This allows patients to make an informed choice with regard to future treatment.

References

[2] The clinical and cost-effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (INSTINCTS trial): an open-label, parallel group, randomised controlled trial – Chesterton et al, DOI: 10.1016/S0140-6736(18)31572-1

[3] Wellman, H., Davis, L., Punnett, L. & Dewey, R. (2004). Work-related carpal tunnel syndrome (WR-CTS) in Massachusetts, 1992-1997: source of WR-CTS, outcomes, and employer intervention practices. *American Journal of Industrial Medicine*. 45 (2): 139-152.

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Work participation in primary care consulters for musculoskeletal conditions

Background

- Musculoskeletal conditions (e.g. low back pain, osteoarthritis) and mental health conditions are the most common reasons for work loss.
- Whilst primary care data is improving via recording of fit-notes, self-reported information on work absence and productivity is required to estimate its extent and provide information beyond employment rate. Absenteeism describes the time taken off work whilst in employment and presenteeism describes lost productivity at work.
- The new PRELIM initiative links primary care electronic health records and patient-reported data for musculoskeletal health intelligence in defined populations.

Objectives

- To describe the employment rate and extent of being unable to work due to sickness or disability, work absence and productivity loss in consulters for common musculoskeletal conditions in a large local population of England and compare to the general population.

Methods

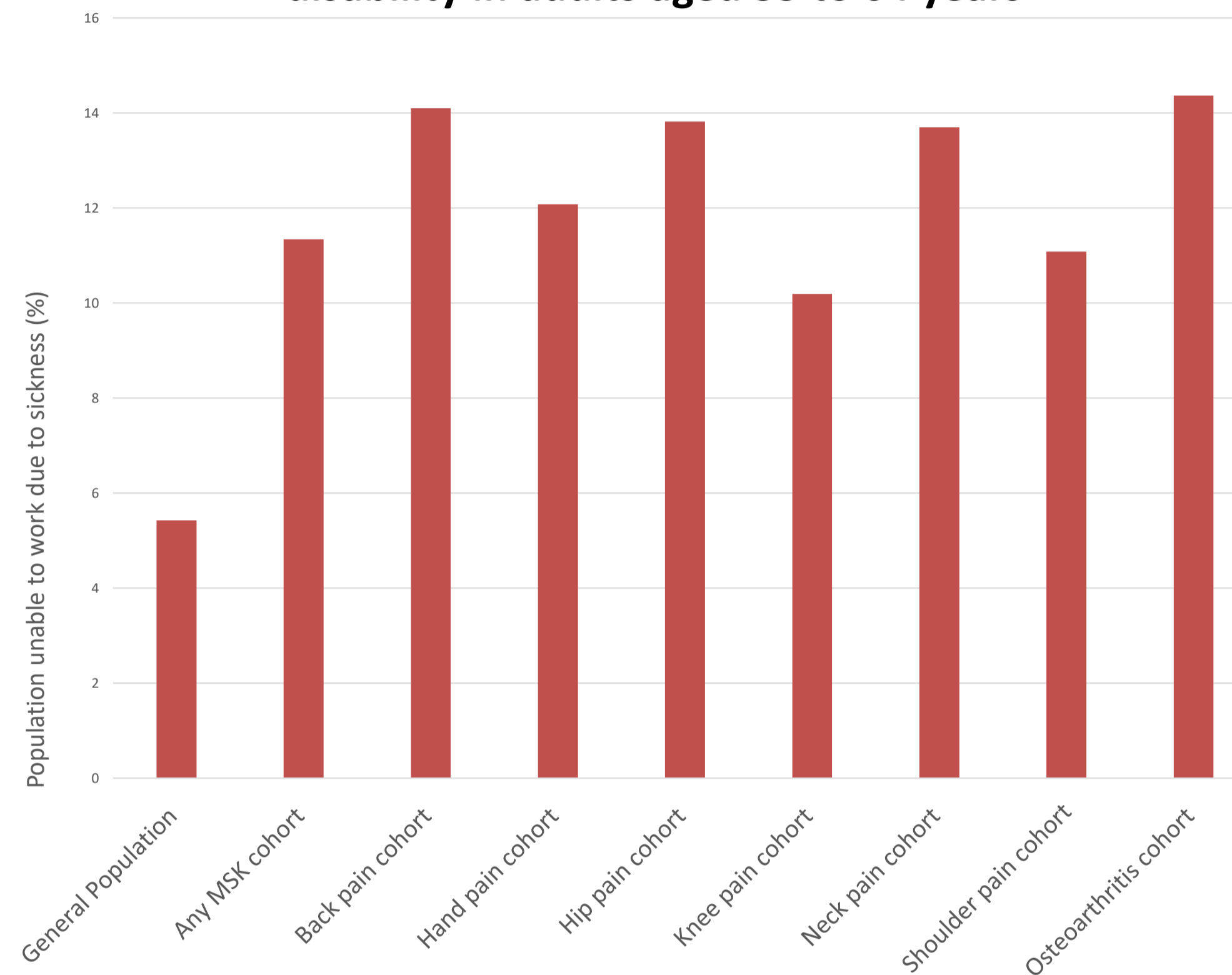
- Cross-sectional postal survey of adults aged 35-64 years, registered with one of 11 general practices in North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs)
- Two groups were invited to complete the survey:
 - (i) All consulters in the previous 12 months for back, neck, hip, hand, knee or shoulder pain or osteoarthritis ('MSK consulters', n=2001), and
 - (ii) A random sample of the registered population from the same practices ('general population', n=2154).
- Employment rate & the extent of inability to work due to sickness or disability was measured using a single item on current employment status. Work absence and productivity were measured using the Work Productivity and Activity Impairment Questionnaire (Reilly et al., 1993).

Statistical Analysis

- Employment rate and the prevalence of inability to work due to sickness or disability, work absence and productivity loss were estimated for the general population, MSK consulters and each musculoskeletal condition.

Lauren Franklin¹, Ross Wilkie¹

Figure 1: Prevalence of inability to work due to sickness or disability in adults aged 35 to 64 years



Key Findings

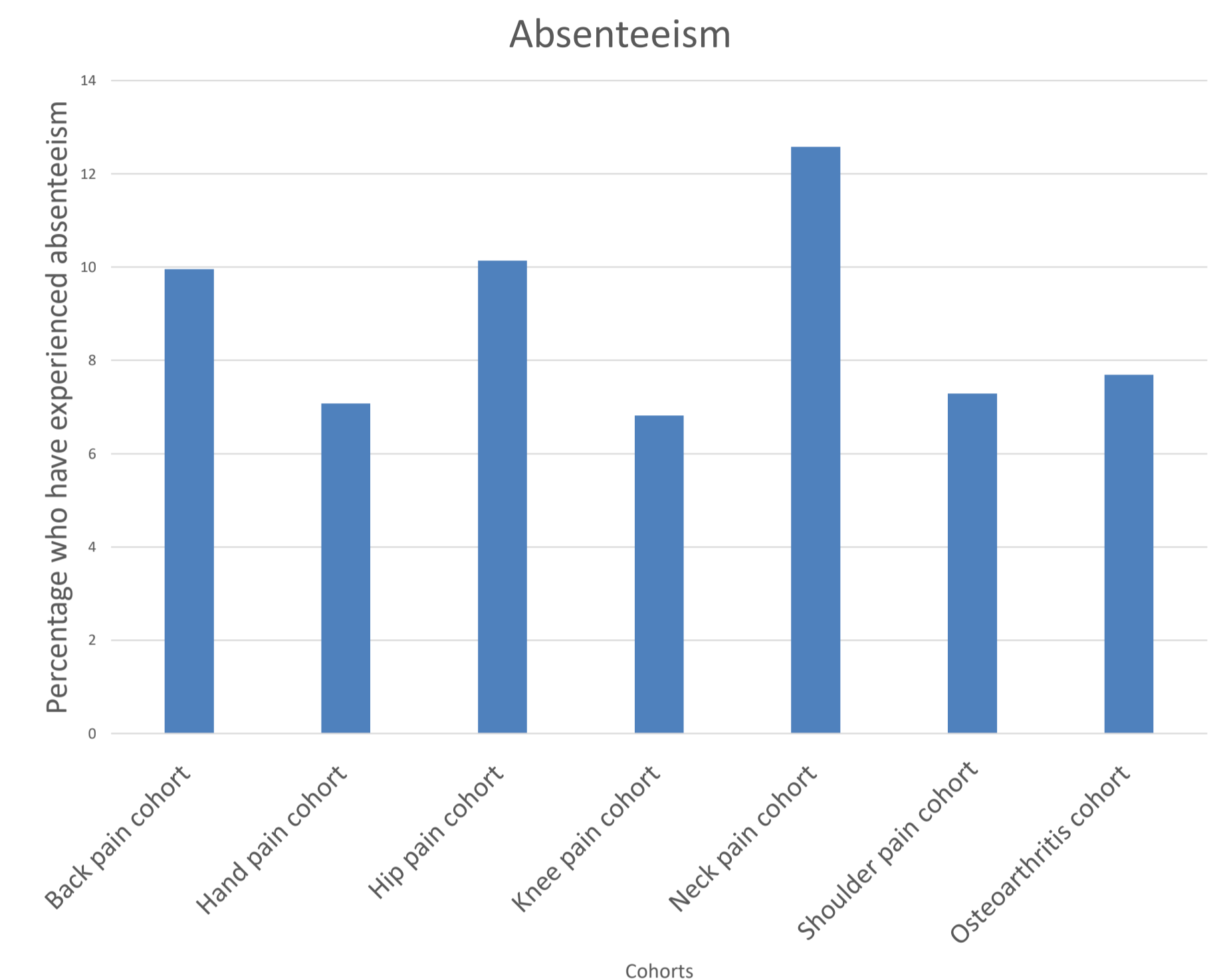
Employment rate & prevalence of inability to work due to sickness or disability

- Employment rate was 77% in the general population and 72% in musculoskeletal consulters.
- Prevalence of inability to work due to sickness or disability was higher in the musculoskeletal cohort than the general population (11.34% cf 5.43% (Figure 1)).
- Among the musculoskeletal consulters, prevalence of inability to work due to sickness or disability was highest for those who consulted for osteoarthritis (14.37%) and back pain (14.10%).

Work absence:

- Of MSK consulters in paid employment, 8.49% reported work absence in the past week, compared to 4.26% in the general population.
- Absenteeism was highest in those who consulted for neck pain (12.6%) and hip pain (10.1%).

Figure 2: Absenteeism compared by musculoskeletal condition



Work productivity:

- 45.1% of those who consulted for a musculoskeletal condition reported a loss in productivity in compared to 28.7% in the general population
- The highest level of productivity loss was in consulters for osteoarthritis (52.4%) and neck pain (47.0%) experienced the highest levels of lost productivity.

Summary and Implications

- Work absence and productivity loss is a significant issue for musculoskeletal consulters.
- The extent of the impact of musculoskeletal conditions on work indicates a need for primary care clinicians to target improving work outcomes for the large number of MSK consulters
- Potential improvements could involve greater linkage with employers and a multidisciplinary approach to reduce the barriers to work participation.

Why I am doing this work?

Many people with epilepsy in the NHS do not get the best quality care
20% of PWE are unnecessarily having seizures
Seizure freedom is the key determinant of quality of life in epilepsy

What I have done?

Focussed on avoidable emergency care as a proxy for failed ambulatory care
Shown that it is the most important neurological cause of unscheduled admissions

Why we need to talk more?

Primary care has an ambiguous and poorly defined role in epilepsy care
Indeed this applies to most neurological disorders: headache, dementia, MND, carpal tunnel syndrome etc
But actually much of good quality care is about expert medical generalism not neurological specialism

- If you'd like to discuss or collaborate, please get in touch by email, thanks, j.m.dickson@sheffield.ac.uk
- There's more on our webpages <https://www.sheffield.ac.uk/medicine/people/aume/jon-dickson>

Open access **Research**

BMJ Open Emergency hospital care for adults with suspected seizures in the NHS in England 2007–2013: a cross-sectional study

Jon Mark Dickson,¹ Richard Jacques,² Markus Reuber,³ Julian Hick,⁴ Mike J Campbell,² Rebeka Morley,⁵ Richard A Grünewald⁶

To cite: Dickson JM, Jacques R, Reuber M, et al. Emergency hospital care for adults with suspected seizures in the NHS in England 2007–2013: a cross-sectional study. *BMJ Open* 2018;8:e023352. doi:10.1136/bmjopen-2018-023352

► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2018-023352>).

Received 5 April 2018
Revised 26 July 2018
Accepted 4 August 2018

ABSTRACT

Aims To quantify the frequency, characteristics, geographical variation and costs of emergency hospital care for suspected seizures.

Design Cross-sectional study using routinely collected data (Hospital Episode Statistics).

Setting The National Health Service in England 2007–2013.

Participants Adults who attended an emergency department (ED) or were admitted to hospital.

Results In England (population 2011: 53.11 million, 41.77 million adults), suspected seizures gave rise to 50 111 unscheduled admissions per year among adults (>18 years). This is 47.1% of unscheduled admissions for neurological conditions and 0.71% of all unscheduled admissions. Only a small proportion of admissions for suspected seizures were coded as status epilepticus (3.5%) and there were a very small number of dissociative

Strengths and limitations of this study

- This study is based on Hospital Episode Statistics (HES) data, which includes all attendances at emergency departments (over 93 million) and all inpatient admissions to hospital (over 42 million) in England during a 6-year period (2007–2013).
- This is the first published study of unscheduled admissions for suspected seizures using HES data.
- HES data use ICD-10 for diagnostic coding facilitating comparisons with other national and international studies where ICD-10 is used.
- We have assumed that HES diagnosis codes are accurate compared with gold-standard clinical diagnoses for epilepsy and seizures but further research is required to confirm this.

<https://bmjopen.bmj.com/content/bmjopen/8/10/e023352.full.pdf>