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Primary Care

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A1.1

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Title of your work: How GPs think about persistent or “medically unexplained” symptoms: a qualitative interview study

THE PROBLEM:

Approximately 45% of patients have at least one medically unexplained symptom (MUS) and they therefore represent a large portion of GP workload. The exact causes of MUS are uncertain and while a range of plausible mechanisms exist, they are often referred to as ‘medically unexplained’. Philosophical positions inform how doctors think about disease, and in cases with no identifiable pathology their philosophical worldviews become particularly important. The objective of this research was to explore how GPs think about medically unexplained symptoms, both in terms of what they are (metaphysics and ontology) and how they can be known about (epistemology).

YOUR APPROACH:

Qualitative research techniques were used. Six thirty-minute semi-structured interviews with individual GPs were recorded. Eligible GPs were contacted through staff lists at the Academic Unit of Primary Medical Care (AUPMC), and a notice in the Sheffield-wide NHS GP bulletin. Transcripts were analysed using a framework approach.

THE LEARNING:

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. Findings appeared to show the mixing of philosophical approaches may be a pragmatic choice in order to improve outcomes, or that it may be unconscious.

WHY IT MATTERS:

If GPs have such different philosophical worldviews, this may affect the acceptability of explanations to them and have implications for education on MUS. However, this research suggests that the approaches to understanding MUS developed within the AUPMC had been acceptable to GPs regardless of their apparent philosophical worldviews and had given them the tools to legitimise their patients’ experiences. Additionally, understanding philosophical worldviews and pragmatically using philosophical approaches may enhance the clinical skills of GPs.

A1.2

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Development of a prognostic model to PREDICT Relapse of depression in primary care (the PREDICTR study)

The problem

Most people with depression are managed in primary care. After a first episode, approximately half of patients will experience a relapse, and this risk increases for each subsequent episode. There is uncertainty about what factors are associated with an increased risk of relapse (some established factors include adverse childhood events, previous episodes of depression and residual symptoms). Combining several prognostic factors within a multivariable prognostic model can result in improved individualised risk predictions. The goal of this programme of work is to develop a primary care-based prognostic model to identify patients at increased risk of relapse.

The Approach

We have carried out a systematic review and critical appraisal of existing prognostic models. Using a dataset drawn from seven primary care-based RCTs and one longitudinal cohort study, we will now use logistic regression to develop a statistical model to predict risk of relapse within 6-8 months after reaching remission. Focus groups and interviews with patients and primary care professionals, along with a PPI group, will provide additional information about the acceptability and feasibility of the model.

The Learning

We identified nine existing prognostic models designed to predict relapse of depression. All were either developed in studies assessed to be at high risk of bias or had poor predictive performance. There is a need for improved risk predictions for depressive relapse in primary care.

Why it matters

The longer-term goal of this study is to develop a clinical tool, to be implemented in general practice, to support clinicians to identify patients who are at increased risk of relapse. This could allow for more targeted allocation of relapse prevention interventions to the individuals who need them most. Ultimately, we aim to improve clinical outcomes and quality of life for patients, as well as facilitating more targeted use of NHS resources in primary care.

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

The Problem

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 also 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.

My Approach

A retrospective audit of 62 patients presenting with depressive symptoms over 3 months was performed at The Reedyford Healthcare Group, a practice of 11,000 patients in Nelson, Lancashire. The audit was to evaluate the performance of risk assessment and management of SH&S against the National Institute for Health and Care Excellence guidelines for adults with depression. Two criteria were included with associated standards of 100%:

1. All patients with depression should be assessed for suicidal ideation and intent by asking direct questions.
2. A patient presenting with significant risk to self/others should be referred to specialist mental health services the same day, as soon as possible.

The Learning

42 patients were asked direct questions about SH&S. 2 patients presenting with immediate risk were urgently referred to specialist services. The results indicated that the practice could improve, and a quality improvement approach has been planned.

Why It Matters

The assessment of risk in patients presenting with depression is vital. 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 national audit. This is particularly prudent with the current concern regarding mental health in the COVID-19 pandemic.

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A1.4

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Reducing inappropriate antibiotic prescribing for patients with acne vulgaris.

THE PROBLEM: What is the problem/issue/challenge that your work is tackling

Inappropriate antibiotic prescribing is defined by prescriptions that are the; incorrect choice, duration, dose or are not indicated. When prescribed inappropriately, the risk of avoidable antimicrobial resistance increases. Prescribing incentive schemes and public health agendas have prompted the practice to undertake a quality improvement project.

YOUR APPROACH: what are you doing to explore/understand/address the issue – what methods are you using?

Quality improvement methodology was used to achieve the aim of reducing inappropriate antibiotic prescriptions for acne vulgaris by 10% by November 2020. Both clinical and non-clinical staff were surveyed to aid in root cause analysis. Patients' notes were audited according to their diagnosis, antibiotic choice, dose, duration and appropriateness for a 3 week period. An e-mail was sent around with the current guidelines and another 3 week period was audited.

THE LEARNING: what are you finding, noticing, learning from the work?

Cycle 1 showed, 5/14 patients (35%) were prescribed antibiotics inappropriately. Cycle 2 showed, 2/12 patients (16%) were incorrectly prescribed antibiotics, creating a reduction of over 50%. We can observe that our intervention has completed our aim.

WHY IT MATTERS: why does an SAPC North attendee need to find out more about your work?

We intend to perform multiple PDSA cycles implementing interventions identified from our survey e.g. not putting antibiotics on a repeat prescription or informing patients they must come back for a review after a certain period of time to review their antibiotics. We hope this will encourage other healthcare practitioners to present the idea at their own practices and carry out their own quality improvement projects.

A1.5

SAPC Abstract Submission (300 words):

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Title:

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

The Problem:

Polymyalgia rheumatica (PMR) is one of the commonest indications for long term glucocorticoid (GC) treatment, which can lead to an increased risk of osteoporosis and subsequent fragility fractures. Guidelines recommend calcium and vitamin D supplements and anti-resorptive agents as treatment. The association between medication for osteoporosis and fracture experience in patients with PMR has not previously been examined.

Your Approach:

652 people with an incident diagnosis of PMR responded to a baseline survey. This cohort gave information on their general health, sociodemographic characteristics and their experience of PMR. Participants completed further questionnaires at 1, 4, 8, 12, 18 and 24 months. Data on fractures and the prescriptions were collected at 12 and 24 months. For this work, fragility fractures were defined as fractures of the hip, wrist or spine. Logistic regression models were used to assess the association between baseline characteristics and fractures at 12 and 24 months. Analysis was conducted unadjusted and adjusted for age, gender, reported medication use and falls history.

The Learning:

Fewer than 50% of respondents were ever prescribed treatment for osteoporosis. Being prescribed treatment for osteoporosis was associated with a reduced incidence of fragility fractures at 24 months (adjusted OR 0.28 95% CI 0.10-0.80), but an increased incidence at 12 months (adjusted OR 2.10 95% CI (1.3-3.48)). Falls before baseline was the factor most strongly associated with fragility fracture at 12 (OR 2.35 95% CI 1.35-4.12) and 24 months (OR 1.91 95% CI 1.05-3.49) when unadjusted for previous fractures. Calcium and vitamin D prescription, gender and age were not significantly associated with fracture outcome.

Why It Matters:

More needs to be done to encourage adherence to prescribing guidelines. Further studies need to address reasons for non-adherence to guidelines and the effects of long-term GC treatment for PMR.

Abstract submission for SAPC North 2020

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Title: Development and Validation of the PMR-Impact Scale

The problem:

Polymyalgia rheumatica (PMR) is a heterogenous condition, causing pain, stiffness and disability in older adults. It can be challenging to diagnose and manage and patients report feeling that their condition is poorly understood by healthcare professionals. Measuring the impact of PMR and its treatment from the patient's perspective is important, yet there are no validated outcome measures to support patient and clinician decision-making.

The approach:

We have developed a patient-reported outcome measure (PROM) to assess PMR-related quality of life. The development process involved qualitative interviews, iterative item development and application of classical and modern measurement theory methods. The construct validity, test-retest reliability and responsiveness of the resultant PROM, the polymyalgia rheumatica-impact scale (PMR-IS), are currently being evaluated.

The learning:

The qualitative study highlighted the mismatch between 'textbook' PMR and experiences of participants – stiffness was longer-lasting than the classical 'morning stiffness' and marked functional impairment and 'weakness' were described. The difficult balance between managing side effects of medication versus symptom control was apparent and many described mood disturbance, fear and a sense of vulnerability. A long-list of items for the PROM was developed from this data.

Field-testing involving 250 participants, allowed item reduction and formation of dimension structure. The PMR-IS has four domains – symptoms (pain, stiffness, weakness, fatigue), function (9 items), psychological impact (4 items) and steroid side effects (10 items). Scores are presented individually for each domain.

The evaluation study recruited 200 people from primary and secondary care. Participants completed the PMR-IS, the modified Health Assessment Questionnaire (mHAQ) and the Short Form-36 (SF-36) at baseline and then the PMR-IS, the mHAQ and a series of anchor questions 2-6 weeks later. Data analysis is underway.

Why it matters:

A PROM to measure PMR-related quality of life will enable the assessment of what truly matters to people with PMR to be incorporated into research into the condition and ultimately improve person-centred care for PMR.

A1.7

Presenting Author: Joshua Wong, University of Central Lancashire MBBS 5, tsiwong@uclan.ac.uk

Title: A Standards-based Clinical Audit on Safe Prescribing of Combined Oral Contraception at a Local GP Surgery

The Problem:

Combined Oral Contraceptive (COC) is associated with increased risks of adverse events such as venous thromboembolism. Correct prescribing is important to prevent complications associated with its use.

The UKMEC and NICE stipulate that clinicians should perform a risk assessment during every COC consultation, which includes clinical measurements and enquiry about risk factors.

Methods:

This audit 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. High-risk prescriptions described by the UKMEC were identified. 14 parameters of the risk assessment set by NICE (e.g. blood pressure measurement) were studied.

Findings/ Learning:

The practice failed to meet the standards for safe prescribing. 14% of patients were prescribed COC, despite being classed as high-risk. There was substandard documentation in 13 parameters. High-risk prescriptions may lead to adverse events; therefore, alternative contraceptive methods should be recommended. The lack of documentation might further lead to legal litigation.

Why it Matters:

Although this was a small-scale project, issues raised here could help suggest improvements in future practice nationwide. Reasons for substandard documentation include clinicians' negative attitudes towards a 'COC template', prioritisation of a COC clinic as a 'catch-up time' rather than a full risk assessment, poor understanding of the guidelines and components of a COC consultation, and over-reliance on own experiences and the EMIS summary page.

Several changes were recommended to ensure safe COC prescribing. They include posters and staff re-training to promote awareness of prescribing safety, the use of pre-consultation questionnaires to allow patients to self-report any contraindications and symptoms before a COC appointment, and enhancing the accessibility and simplicity of the current COC template to guide future risk assessment.

Word Count: 297 (excluding headings)

SAPC North 2020 Abstract

Learning and Recommendations from Significant Event Analyses of Bowel Cancer Cases

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The problem

Bowel cancer is the second leading cause of cancer-related mortality in the UK. Early diagnosis provides opportunities for intervention and improved survival. Significant Event Analysis (SEA) is a well-established quality improvement approach for learning from new cancer diagnoses. This project aimed to improve understanding of the diagnostic pathway for bowel cancer and to identify areas for improvement in patient care from a primary care perspective.

The approach

General Practices across Pennine Lancashire were invited to undertake SEAs of one or more bowel cancer cases from the preceding three years as part of an incentivised scheme. Anonymised data were collected on a standardised form. Practices provided learning outcomes and recommendations for the practice, hospital and local Clinical Commissioning Groups (CCGs). 53/75 (71%) practices submitted 161 reports for descriptive and thematic analysis.

The learning

86 (53%) patients were male and the mean age at diagnosis was 68 years (SD 14). There was a central theme of “building vigilance and collaboration” between and within general practices and secondary care. “Building vigilance” pertains to recognition of complex and atypical presentations of bowel cancer, while accounting for diagnostic overshadowing and having a reduced threshold for 2-week suspected cancer referrals. “Building collaboration” emphasises timely follow-up, ownership of care, and clear communication between primary and secondary care. Access to screening and investigations are paramount for improving early diagnosis, however, a flexible diagnostic approach is required according to the individual circumstances of each patient.

Why it matters

These findings confirm and provide additional insights to the existing literature on bowel cancer from a primary care perspective. Practices should be supported in developing protocols for assessment and follow-up of patients with varying presentations. The range of cases from multi-site SEA should be utilised across Primary Care Networks for peer-peer learning and identification of Network-wide improvements in cancer pathways.

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Title of your work

A curriculum review: Evaluating if the HYMS MBBS curriculum is designed to deliver on national guidance for general practice teaching

Abstract (max 300 words) using the following headings

- **THE PROBLEM:** What is the problem/issue/challenge that your work is tackling

The Wass report summarised why General Practice matters, and so why we must pay attention to recruitment, training, and retention of GPs at all career stages. There is particular emphasis on the roles and responsibilities of all medical schools to address the issues at the root of this problem. What is also apparent both within General Practice and more widely is a loss of 'generalist' skills in medicine.

HYMS vision is to be Exceptional, Innovative, Visionary and Pioneering, which needs to be reflected in our curriculum. To continue to support current and future workforce development, we need to ensure that we prepare our students for general practice and educate them about medical generalism.

- **YOUR APPROACH:** what are you doing to explore/understand/address the issue – what methods are you using?

We have designed a two-stage approach to evaluate our curriculum. Stage one involved analysis of key national and international documents and produced a set of codes organised into a framework based upon core themes. We compared each written learning objective against our novel framework and so generated a map of general practice teaching across all 5 years of study in the MBBS programme.

- **THE LEARNING:** what are you finding, noticing, learning from the work?

Stage one highlighted areas of teaching strongly represented in the formal curriculum, including person centred care, communication skills and reflective practice. It also identified areas with possible room for improvement such as the hidden curriculum, generalist medicine and methods of delivery. This mapping has enabled us to focus on areas of the curriculum which appear under-developed for our ongoing evaluation. We are now in the process of stage two, where we are engaging students and tutors in semi-structured interviews. The data from these interviews is being analysed using a modified framework approach.

- **WHY IT MATTERS:** why does an SAPC North attendee need to find out more about your work?

All medical schools and clinicians involved in education have a responsibility to address the issues affecting General Practice recruitment. Our methods so far may be transferrable to other schools and will be of interest to anyone who wishes to explore this issue further.

A2.3

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Exploring Medical Students' Challenging Experiences in Clinical Environments

The Problem

Previous studies suggest that students experience challenging situations in clinical environments. Despite attempts to address issues such as bullying and denigration, concerns exist that challenging experiences are impacting negatively on learning. This study sought to gain an up-to-date qualitative understanding of the challenging experiences that medical students are encountering in clinical environments; their perceived impact and the nature of support and education that would enable students to cope more effectively.

Our Approach

This study used a qualitative approach in keeping with the interpretivist research paradigm. 3rd and 4th year medical students were invited by e-mail to participate. Individual interviews of nine students were conducted using a semi-structured guide. Students were asked about experiences relating to both primary and secondary care placements. Data were thematically analysed using the Braun and Clarke model.

The Learning

Participants reported challenging experiences, centred around three themes: hierarchy, challenging patient situations and not feeling part of a team. Whilst these occurred in all clinical settings, they were found to be more common in hospitals. Being reprimanded and humiliated were felt to reflect an ongoing underlying hierarchical structure. These experiences impacted student learning, career intentions and confidence. Students made suggestions for support and education, including provision of specialised support services, better teaching organisation and improved preparation for clinical learning.

Why it Matters

This study highlighted the nature of challenging experiences that students encounter. Our results suggest that hierarchical structures within healthcare settings, alongside students not feeling part of the clinical team, may have a significant, detrimental impact on students' learning and speciality choice. Our study further emphasises the importance of optimising the learning environment and active student participation to enable students to learn effectively. We also recommend the provision of more specialised student support services and a zero-tolerance approach to bullying and mistreatment of students.

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Title:

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

Abstract**The problem –**

Approximately 40% of primary care consultations have a mental health component (1). However, there remains a huge disparity between money spent on preventing physical and mental health problems in primary care (2). From 2021, PCN'S will be able to use additional funding from NHS England to employ mental health professionals directly (3). GP's are under significant time and resource restraints to meet mental health needs (1). Psychology graduates could potentially fill this gap as an underused resource.

The approach –

The primary aim of this evaluation is to assess the feasibility of delivering mental health prevention and promotion strategies in a general practice and community setting by psychology graduates. Two Assistant Psychologists will work across these settings. The evaluation aims to understand if this workforce can feasibly deliver such mental wellness approaches and build resiliency within community members.

The learning –

The timing of this work is advantageous given the rise in mental health issues following the COVID-19 pandemic (4). There is also a growing recognition of the significant gap in mental health prevention and promotion support in primary care (5). Such interventions, delivered by mental health/psychology professionals working with primary care has found to be extremely cost effective for people with poor mental health (5). Recruitment for the current project proved straight forward, given the vast number of psychology graduates who are looking for Assistant Psychologist roles.

Why it matters –

Economic modelling has shown that many mental health preventative interventions are outstandingly good value for money over time (6). Finding an effective workforce who are able to work in a primary care setting and deliver mental health preventative interventions matters to patient care and the sustainability of NHS services. Better integration with the community to boost resilience and support community resources is vital for effective healthcare (7).

Word count – 299**References –**

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A2.5

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Title: *'Just a GP' – exploring the issue of denigration within medicine.*

Abstract (max 300 words) using the following headings

THE PROBLEM: Whilst some argue competition between specialities is a 'time old tradition' we explore if it conceals a wider issue. Through our recent work, we have found denigration is occurring within the Northern Region and strongly feel that we must work towards having a state of 'professional respect' between specialities. With some specialities, including General Practice, facing issues relating to recruitment, understanding how denigration may be having an impact is of great importance.

YOUR APPROACH: Since 2016 we have adopted a mixed method approach to exploring the issue of denigration within the region, exploring the experience had by local medical students and junior doctors. We included questions relating to denigration within routine evaluation surveys and conducted focus groups annually to observe for any trends. This work initially focussed solely on denigration towards General Practice, we recently welcomed the opportunity to extend the scope as it is our opinion that a better understanding of this issue is essential in order to progress towards its elimination throughout the NHS.

THE LEARNING: It has been noted that the issue of denigration is ubiquitous, with few specialities spared. However, the themes that have emerged in comments made about different specialities do differ, with General Practice and Psychiatry being perceived by some as 'second rate' career options. The fact that both students and doctors early in their training are experiencing this phenomenon is of particular concern due to the potential impact on speciality recruitment.

WHY IT MATTERS: Despite intervention, denigration remains an issue and more needs to be done to address the problem. We hope by showcasing our work, we can continue to inspire others consider how they could inspire change. The response we have received so far has been encouraging, the ongoing Covid-19 pandemic has resulted in significant pressure on our organisation which could potentially further increase the strain on inter-speciality relations.

Abstract SAPC North 2020

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Title of work: 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

Abstract

The problem

The recruitment and retention of General Practice (GP) clinical teachers are problematic for medical schools and may be barriers to the expansion of undergraduate primary care teaching. Newcastle University recently increased the amount of teaching delivered in GP in year three as part of wider curricular reform. Feedback has suggested dissatisfaction amongst some GP clinical teachers since the changes were introduced.

Your approach

This study applies the realist philosophy of science using realist inquiry. It seeks to understand which aspects of the new year three GP curriculum affect future teaching commitment, in what contexts this occurs, how and why. As a starting point, a candidate theory of how the new curriculum may affect future teaching commitment was developed. Data collection and analysis then used semi-structured interviews of ten GP teachers, using analytical techniques consistent with realist principles, to refine the candidate theory and generate a final Programme Theory.

The learning

In certain contexts, some aspects of the new curriculum result in reduced future teaching commitment, e.g. increased teaching workload negatively affects commitment if a GP lacks practice support. Other aspects of the curriculum result in increased commitment e.g. opportunities to take on certain new roles and teach primary care-orientated medicine. Numerous mechanisms are identified, including alterations to autonomy, sense of responsibility and value. Different GP teachers are affected in different ways, influenced by practice and individual contexts.

Why it matters

This study explains how curricular change may affect teacher engagement and commitment, thus improving our understanding of factors that affect GP teacher retention and retention. We make several recommendations, including: a whole practice team -based approach to undergraduate primary care teaching as the norm; paying attention to maintaining teacher autonomy; consideration of the future role of the GP teacher; and efforts to strengthen teacher identity and connectedness.

(299 words)

Abstract for SAPC North 2020

Presenting author: Dr Lily Lamb, Newcastle University, lily.lamb@newcastle.ac.uk, @drlilylamb

Title: 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.

Abstract:

The problem:

I have been 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.

The approach:

I undertook a practitioner inquiry to assess an intervention to encourage sharing of personal illness experience. With ethical approval from Newcastle University I 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.

The learning:

Thematic analysis of the transcripts from the focus group identified several themes including the value of learning from discussing personal experience and lack of previous opportunities to do so, and of the importance of personal illness experience in development of the professional. The observer and teacher logs reflected the enthusiasm and high level of engagement from students during the teaching session following the intervention.

Why it matters:

A practitioner inquiry provides clarity on what can be done in complex situations (Baumfield et al., 2012). This simple intervention was positively received, increased student engagement and aligns with principles of Humanist learning theory (Rogers and Freiberg, 1994), (Kolb, 2015). I hope the others involved in primary care medical education research particularly in the area of professional development would be interested in this project.

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

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Co-author: Hugh Alberti; Newcastle University (hugh.alberti@newcastle.ac.uk)

Problem:

Despite government promises to deliver 5000 extra full time GPs by 2020 there were 6.2% fewer full time qualified permanent GPs in 2019 than 2015.

Now more than ever we need to increase GP recruitment. Just 9% of trainees chose to enter GP training directly from FY2 last year, falling from 24% in 2012 [3]. Uptake of FY2s entering speciality training (ST) has similarly decreased from 68% in 2012 to 35% in 2019 [3].

Approach:

Data published by the Foundation Programme since 2012 offers an insight into GP recruitment [3].

The Kruskal Wallis test was performed to determine if there was a statistically significant difference between different types of medical schools.

Learning:

The proportion of FY2s entering GP training directly varies widely across all medical schools across all years: for example, in 2019 the percentage of FY2s entering ST choosing GP ranged from 16-57% [3].

Based on a p value less than 0.05 and 1 degree of freedom; for every year except 2019, there is a statistically significant difference in the percentage of FY2s entering ST choosing GP between 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.

Why this matters:

The data shows that there is a difference in GP recruitment between different types of medical schools. Possible reasons include cultural bias, variations in curriculum and availability of role models. Alberti *et al.* have shown the amount of authentic GP teaching at medical school correlates with FY2 entry into GP training [4]. Further analysis is needed to understand exactly why different medical schools differ in the number of FY2s choosing a career in GP.

References:

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SAPC North 2020
Abstract application

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Title:

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

Abstract (300 words):

The problem:

People with physical-mental comorbidity have a poorer quality of life, worse clinical outcomes and increased mortality than those with physical conditions alone.

People from some ethnic groups are less likely to recognise symptoms which may represent mental health problems. South Asians (SAs) are the largest minority group in the UK, and are more likely to have long-term conditions (LTCs) such as diabetes and heart disease. This systematic review synthesises studies that explore perceptions of emotional distress in, and help-seeking by, SAs with LTCs. *Emotional distress* encompasses distress which can cause significant suffering but not be diagnosed as a mental health problem.

Our Approach:

Eight databases were searched for qualitative studies exploring emotional distress in SAs with diabetes or coronary heart disease, within primary and community care settings worldwide. 3,910 studies reduced to 2,581 after de-duplication. Two reviewers separately undertook title and abstract screening. 27 studies were included for full text screening and 20 in the review. Data extraction occurred independently; the CASP checklist was used to review the quality of the papers. Thematic synthesis was undertaken and GRADE-CERQual to assess the overall strength of evidence.

The Learning:

SAs with LTCs defined emotional distress in non-medical terminology such as tension and stress, even when diagnosed with conditions such as depression or anxiety. They described a strong link between emotional distress and physical illness. Acculturation was a prominent theme. There were some differences between men and women's experiences. Participants did not find medical services useful, and instead sought help from other areas such as faith groups and family and friends.

Why it matters:

The review provides a greater understanding of SAs' conceptualisation of emotional distress in the context of physical LTCs, leading to improvement in the recognition and management of emotional distress. This study has the potential to influence policy-makers and commissioners about service provision for this patient group.

A3.2

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

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The problem

An unknown proportion of people who had an apparently mild COVID-19 infection in Spring 2020 continue to suffer with persistent symptoms, including chest pain and palpitations, shortness of breath, muscle and joint aches and pains, paraesthesia, headaches, cognitive impairment ('brain fog') and fatigue. Post-acute COVID-19 (or 'long-COVID') seems to be a multisystem disease, and people struggling with these persistent symptoms are referring to themselves as '*long-haulers*'.

Approach

University ethics approval gained. Qualitative methods with semi-structured interviews to explore the perspectives of people with persistent symptoms following COVID-19 infection. Participants were recruited through advertisements on social media. Interviews were conducted by telephone or video platform, were digitally recorded, and transcribed with consent. Thematic analysis was conducted utilising constant comparison techniques. People with experience of persisting symptoms contributed to study design, documents for ethics application, data analysis and interpretation of findings.

The learning

We report analysis of 24 interviews. The main themes we will report include: the 'hard and heavy work' of enduring and managing complex and changing symptoms; needing to find answers; the hard work of accessing care, including investigation of symptoms and exclusion of serious pathology; living with uncertainty, helplessness and fear, particularly over whether recovery is possible; the importance of finding the right general practitioner (GP) who provides the understanding, empathy and support needed; and, finally, recovery and rehabilitation - what help is out there?

Why it matters

Post-acute COVID is a new syndrome, with people struggling with symptoms which are complex and unexplained. That doctors were initially unaware of the problem and uncertain how to respond, impacted on patients. People with post-acute COVID need to be believed and require their GPs demonstrate empathy, but also consider what investigations or referrals are needed. In addition, GPs should offer long-term support and monitoring to this patient group.

299 words (including headings)

A3.3

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Social Work, Education and Community Wellbeing, Northumbria University

Title of your work:

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

Abstract (max 300 words) using the following headings

THE PROBLEM: What is the problem/issue/challenge that your work is tackling

Patients with persistent physical symptoms often make repeated GP visits, the outcome of which are unsatisfactory for both the patient and the GP. Evidence suggests that a mismatch in understanding between the patient's experience and the doctor's models of illness is an important factor in this.

YOUR APPROACH:

Multiple Symptoms Study 3 is a multi-centre trial of an Extended-Role GP intervention for patients with PPS. Using knowledge from previous research into how GPs communicate with patients with PPS in general practice, we designed an intervention which contains the following elements: Recognition, Explanation, Action and Learning (REAL). Embedded in this is qualitative research to understand how the intervention works in practice. Consultation transcripts and participant interviews are inductively analysed, drawing on phenomenology and grounded theory.

THE LEARNING:

Analysis so far has revealed the importance of a successful co-construction between the patient and the GP, within the explanation and action elements of the intervention. The recognition element of the intervention is an important part of the co-construction, and we have identified other enablers and barriers to creating a co-construction within this context. For example, anchoring explanations in the patients existing knowledge enables a successful co-construction, whereas challenging patients thought processes too early in the intervention can be a barrier to co-construction.

WHY IT MATTERS:

A successful co-construction appears to be an important precursor of patient's willingness to engage in strategies that may help to manage their symptoms, and therefore has implications for the delivery of care to these patients. GPs may be able to use this knowledge as a tool in their own practice, to enhance their communication with patients with PPS.

A3.4

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Title

What are the support needs of family carers making health care decisions for people with dementia?: a systematic qualitative review and framework synthesis

The problem

Approximately 700,000 people in the UK provide informal care for someone with dementia.¹ Dementia is known to be one of the most stressful and difficult conditions to care for.²

As an individual with dementia's ability to make complex decisions declines, carers are often required to be involved in proxy decision making about health care.

Approach

We conducted a systematic review of qualitative studies which addressed the research question. The review protocol is registered on PROSPERO. Qualitative synthesis followed the structure established by Noblit and Hare.³,

The Learning

Support needs of carers fall into 3 established categories⁴ which provided a framework for our synthesis⁴; emotional, practical and informational.

Emotional needs include recognition of decision fatigue, the burden of taking responsibility for a loved one's health and wellbeing, loss of normal support networks and the need for opportunities to share their experiences.

Practical needs include a desire for continuity of care, a preference for empathic guidance from health care professionals and the importance of being encouraged to make advanced decisions whilst the person with dementia has capacity. Health care systems are complex and help to navigate them is important.

Information needs include receiving information that is clear, appropriately paced and timely.

Information about disease trajectory was commonly lacking. Carers also described a lack of awareness of dementia among health care staff

Why it matters

GPs will frequently be in a position to offer support to carers who are involved in making health care decisions for people with dementia. Understanding what the support needs are and how best to meet them could improve outcomes for the carers and the people with dementia.

1. <https://www.dementiastatistics.org/statistics-about-dementia/prevalence/>

2. Prevalence and Impact of caregiving: A detailed comparison between dementia and non-dementia caregivers, Marcia G Ory et al, The Gerontologist Vol 39, No 2, 177-185

3. Noblit G, Hare R. Meta-ethnography: synthesising qualitative studies. Newbury Park, CA: Sage Publications; 1998 'the seven stages' of a meta-synthesis.

4. House J.S. (1981) Work stress and social support. Addison-Wesley, Reading, MA

A3.5

It is intended as a call to arms..and to the profession as a whole.

Though i suspect not to some of the luddites (academic or clinical)

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Title of the work:

Parents' lived experience of healthcare for children with long term conditions: qualitative interview study.

ABSTRACT:

THE PROBLEM: There is a dearth of literature concerning how parents of children with long term conditions (LTCs) experience and manage their child's care. While GPs could be the coordinators of care, very often parents bridge the gap in communication between primary and secondary healthcare.

This study aims to gain an understanding of parents' experiences of healthcare for children with long term conditions.

THE APPROACH: In this qualitative study, co-production was used to ensure public involvement and authenticity of the research. Fifteen semi-structured interviews with parents of children with LTCs were carried out. The interviews were audiotaped, transcribed verbatim and analysed using the Framework approach.

THE LEARNING: The analysis revealed a meta theme 'complexity of experience' and five key themes: Impact, Interactions, Experience of Care, Feelings, Feedback.

Having a child with an LTC is ongoing and relentless. Relationships within the family can become strained, but are also a key source of support. Parents see themselves as having a major role in coordination and communication between healthcare teams, to ensure consistency of care. Parents' viewed the GP role as small in comparison to secondary care: often limited to prescribing medication, onward referrals and providing support. Consultations can be seen as an iceberg where attending the appointment is visible but the constant and complex demands of the illness, the child, and the family remain hidden.

WHY IT MATTERS: This research describes in depth the everyday complexity of parents' lives. Clinicians should be more aware of the challenges parents face and the benefits they report of appropriate support when offered it.

A3.6

Presenting author: Dr Kitty Worthing, QMUL @kitdempsey

Co-authors: Dr Megan Clinch, Professor Anita Berlin, Dr Pooja Seta, Dr Isa Ouwehand, QMUL

Title of your work: Registration without documentation

Problem

Despite NHS England guidance that patients without access to proof of address or identification should be able to register with a GP, research shows those without documentation are often refused registration. Third-sector organisations have been working to support patients to register and provide training to GP staff, however, staff's experience of new patient registration processes has never been explored. This on-going qualitative study aims to better understand the process by which registration is refused and factors that operate to influence this. It explores non-clinical GP staff's: 1) experience of and current practice regarding patient registration 2) perceptions of patients without documentation and obstacles to their registration 3) ideas of how to improve access for this group of patients; aiming to produce recommendations that are sustainable and acceptable.

Approach

Thirty-three participants across three boroughs in North-East London have taken part in focus group discussions or individual interviews. An initial thematic analysis, utilising Pierre Bourdieu's theory of power and practice has been undertaken and will be subject to participant checking before the analysis is completed.

The learning

Key emerging themes that engender reluctance to register patients without documentation include: perceived lack of clarity of national guidance, perception that this patient group represent increased financial, clinical and administrative burden on the practice, concerns regarding patient & staff safety and illegal activity, concerns regarding specific legal or statutory requirements and duties and a sense of 'moral' responsibility to other patients and the wider NHS regarding resource distribution.

Why it matters

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. Specific issues that need to be addressed include: a perceived lack of clarity of NHS England's registration guidance, perceived increased administrative and financial pressure specific to GP practice relating to the registration of certain patient groups, and unanswered questions about the responsibility of individual non-clinical staff regarding new patients. More broadly, analysis of the data using a Bourdieusian framework also aims to contribute to an improved understanding of how individual interactions both reflect, and serve to reproduce health inequalities.

Abstract

***'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**

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The Problem

Pancreatic cancer is the 10th most common cancer in the UK, and 10-15% patients undergo pancreaticoduodenectomy. There is limited research reporting the experiences of patients living with pancreatic cancer, and minimal specifically focusing on the role of the GP. However, GPs are key in enabling effective coordination of care for people living with life-shortening conditions, and identifying unmet support needs which negatively impact on patients' lives.

The Approach

Ethical approval was obtained. Semi-structured interviews were conducted with patients who had undergone pancreaticoduodenectomy for pancreatic or distal biliary duct cancer at a specialist hepato-pancreatic-biliary centre in Northwest England. Interviews explored participants' experience of the diagnostic process, life after surgery, and sources of support. Data were analysed thematically using constant comparison.

The Learning

Analysis of 20 interviews is reported. Participants described immense treatment burden, challenges navigating the healthcare system, and uncertainty of the role of the GP in their ongoing care. They recognized that GPs may have little experience with patients who have had a pancreaticoduodenectomy. However, they felt that GPs should be proactive and could play a vital role in offering support. Participants expressed a wish for support post-operatively, but found that asking for help was difficult. Participants felt they would value greater recognition by GPs of both physical and psychological sequelae of major pancreatic surgery, and the impact on their families.

Why It Matters

Patients may be reluctant to ask for psychological support post-operatively, and are often unsure who to ask. Therefore, an awareness of both physical and psychological sequelae is crucial in order for GPs to proactively offer such support, and enable more effective liaison with secondary care.

Understanding the impact of cancer on quality of life is vital in enabling the development of improved support interventions.

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Reaching the parts that QOF cannot reach: An Early Evaluation of a General Practice Quality Improvement Initiative in the English NHS

- ***THE PROBLEM: What is the problem/issue/challenge that your work is tackling***

The 2018 review of the Quality and Outcomes Framework (QOF) found that its narrow focus on recording of multiple single processes and outcomes may not promote delivery of holistic, patient-centred care, limiting the role of professional judgement. One of the subsequent reforms to the QOF was the introduction of incentives for quality improvement (QI) activities for particular patient groups – in 2019-20 people at end-of-life and people taking certain medications i.e., valproate, lithium and non-steroidal anti-inflammatory drugs. In this presentation we report on a study commissioned by NHS England to examine how the first two QI modules have been received by practice staff, their experiences in implementing them and the practical challenges they faced in doing so. This will inform further implementation of QI modules.

- ***YOUR APPROACH: what are you doing to explore/understand/address the issue – what methods***

We conducted 25 semi-structured, telephone interviews with practice managers between July and November 2019. We asked questions exploring experiences and perceptions of implementation of the QI modules. Interviews were audio-recorded and transcribed. Data were analysed using the Framework Method.

- ***THE LEARNING: what are you finding, noticing, learning from the work?***

Despite delays caused by late release of business rules and templates, practices were generally accepting of the principle of incentivising QI. Practices reported that the prescribing safety module was straightforward to implement being already experienced in this. The end-of-life module was perceived as more challenging because of the lack of indicators of good quality care and the need to survey patients and carers at a sensitive time. Participants also indicated that collaborating with colleagues across their Primary Care Networks (PCNs) on the modules was working well, although anticipated that this could be challenging in the future.

- ***WHY IT MATTERS: why does an SAPC North attendee need to find out more about your work?***

This work will be of interest to all general practice staff engaged in QOF implementation and researchers examining quality improvement in primary care. This work is important because the findings are reported directly to NHS England to inform future policy developments.

B1.2

Presenting author:

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Title

Communication between specialist genetic services, CCGs and GPs: a service development project

Abstract

The Problem

Genomics services are advancing rapidly. Development of these services must allow for effective information dissemination to, and communication with, primary care. However, specialist services can struggle to effectively communicate information to GPs as a whole.

The Approach

We developed an e-survey to assess Clinical Commissioning Groups' (CCGs) mechanisms of information dissemination and General Practitioners' (GPs) access to specialist advice. All 17 local CCGs were invited to participate. A semi-structured interview script was developed for face-to-face interviews.

The Learning

82% of surveys were completed. CCGs disseminated information to GPs mostly by emails to practice managers (100%) and GPs (93%), educational events (86%), and CCG newsletters (86%). Overall, educational events were identified as the most effective method and emails to GPs relatively ineffective. The most common methods for GPs to access specialist advice were phone (79%) and electronic 'advice and guidance' (A&G) systems (79%). Phone and electronic advice were the preferred options for a new genetics advice service.

Three respondents consented to interview. All felt that short, practical updates on genetics (rather than a full dedicated session) would be useful at their educational events. All had website portals for referral information, on which they felt genetics content would be useful. Simple updates could also be emailed to CCGs for dissemination via newsletter. Electronic A&G was the favoured specialist advice method.

Why It Matters

Short, practical educational sessions could be used to share genetics updates. Simple updates could be emailed to CCGs (for inclusion in newsletters/emails to practice managers) or uploaded onto CCG portals. Electronic advice methods, such as A&G and email, should be considered in genomic medicine service development.

It is hoped that the findings from this project can be combined with similar work taking place looking at GPs' views and help to inform new service specifications for genetics services.

B1.3

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Title:

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

Abstract

The problem

There is a vital need for mental health prevention and promotion work and a requisite for a stronger research base. Around 1 in 3 GP appointments involves a mental health component (1) and statistics suggest that 1 in 4 individuals will experience mental illness in their lifetime (2). Although there is a push for 'parity of esteem' and a recognition that there is no health without mental health, prevention and promotion activities account for less than 0.03% of NHS spending on mental health (3). The covid-19 pandemic means the case for change is stronger than ever, as many report needs relating to their emotional wellbeing.

The approach

Assistant psychologists will provide mental health prevention and promotion activities across two communities with an aim to reach individuals below 'caseness'. Interventions will be delivered in a targeted (one to one wellbeing sessions and group work) or universal way (e.g., wellbeing days, literature, wellbeing workshops, training and mental health champions).

The learning

There is a wealth of organisational and government guidelines and position papers available that make 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. Working alongside the changing covid-19 guidelines has been challenging but adaptations have been made e.g. online group.

Why it matters

Mental health prevention and promotion work matters. If more is not undertaken, it is predicted that by 2026 providing services that meet mental health demand will become unaffordable (5). This work will help to strengthen the research base for preventative strategies. This work aims to provide an effective and meaningful service for individuals, reduce pressure on GPs and waiting lists for other mental health services.

Word count- 300

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B1.4

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Primary care networks and health inequality: a policy analysis

Abstract

The Problem

Health inequality is worsening within the UK resulting in reduced life expectancy in low-socioeconomic groups. Good primary care is internationally recognised as a fundamental component of health equality. Primary care in the UK is being altered through the introduction of primary care networks (PCNs), whereby geographically contiguous GP practices are funded to contractually align. Therefore, it is important to understand how PCNs will influence health inequality, which I assess here.

Your Approach

An analysis of the GP contract agreement, its update and surrounding documentation was performed. Initially a literature review was undertaken followed by an assessment of the contents, outcomes and trade-offs of the policy, utilising adapted principles from Bardach's eightfold path for policy analysis. The focus of this analysis was an assessment of the funding formula, additional roles reimbursement scheme (ARRS) and service specifications to evaluate the probable interaction with health inequality.

The Learning

There is government intent to increase primary care funding through PCNs, however there are underlying flaws. Aspects of the funding mechanism lack inequality weighting and when it is applied, the flawed Carr-Hill formula is used. PCNs control the distribution of funding within the network, which may not be according to deprivation. Much of the funding is through the ARRS, which introduces new healthcare professionals into primary care. These have minimal evidence supporting their implementation, which is similar to concerns regarding the clinical director. The service specifications are broad but some focus on disadvantaged groups, such as the learning disabled, indicates potential inequality improvements.

Why it Matters

Addressing health inequality is vital to improve population health, therefore understanding and improving the policies we work within is essential. This analysis identified key areas to focus upon during my pre-doctoral study of PCNs. This will help refine their implementation to most effectively address health inequality.

B1.5

Enacting infection prevention and control (IPC) in elderly long-term care facilities (LTCFs): a meta-synthesis of qualitative studies

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The problem

Individual, local and national factors make the care home setting susceptible to infectious diseases. The Covid-19 pandemic has highlighted longstanding complexities in preventing and controlling carriage of infection between care home residents and staff. Increased susceptibility to infection of residents makes infection prevention and control a key issue in reducing mortality and complication rates from infectious disease in the older population. 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

A qualitative meta-synthesis using Noblit's Meta-Ethography methodology was conducted. Multiple databases were searched from inception to June 2020 including CINAHL, Medline, Embase, PsychINFO and ASSIA. Fifteen eligible studies were identified from 28 which reached inclusion criteria from 652 screened abstracts, on the basis of relevance and trustworthiness. We synthesised these 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 but early analysis identified a range of factors influencing infection prevention and control including resident and staff behaviour and knowledge, health system design and culture, and interaction between care home and other healthcare settings. The findings suggest that 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. There is a absence in the literature of residents voices.

Why it matters

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. Our findings point towards organisational changes to prevent and contain infections including Covid-19.

B1.6

Presenting author: Josephine M K Reynolds, AUPMC University of Sheffield, josiereynolds11@gmail.com, @drjosiereynolds

Title of your work:

The Colonial Legacy on the Social Dynamics in Global Health Partnerships

Abstract (max 300 words) using the following headings

THE PROBLEM: The Global Health field is increasingly challenged on an unprecedented scale, requiring global collaboration. Collaborative efforts commonly take place under the concept of partnerships between Global North (GN) and Global South (GS) countries. However, the most *acceptable* model for Global Health partnerships is a topic of intense debate. Postcolonial theorists warn of historic power dynamics perpetuating negative outcomes for the GS and highlight the challenges of achieving equitable North-South partnerships on the backdrop of colonialism. Global Health practitioners from both GS and GN backgrounds have important insights into the social dynamics of these partnerships therefore understanding these is crucial to achieving acceptable global health partnerships.

YOUR APPROACH: This study used qualitative semi-structured in-depth interviews with eleven Global Health practitioners studying at London School of Hygiene and Tropical Medicine to gain insights into the dynamics they had experienced in North-South partnerships. Non-random 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 within the study findings. It became clear that both the GS and GN relied on one another in a form of 'symbiotic dependency'. This brought the two forms of self together, both bound by the colonial past. The GS-self predominantly seeks distance from the oppressive dominance of the GN to allow space for its self-identity to be defined. Conversely, the GN-self clings to the GS 'other' as core to its self-identity and shows no desire to seek separation.

WHY IT MATTERS: 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. Former colonial powers have a duty to reckon with their past and its impact on contemporary Global Health.

B1.7

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Title: EXPERIENCES OF IMPLEMENTING AND EVALUATING SOCIAL PRESCRIBING IN THE NORTH WEST COAST OF ENGLAND

Abstract

THE PROBLEM:

Whilst social prescribing (linking patients to health and wellbeing resources) is not a new construct, it has been earmarked by the 2019 NHS Long Term Plan to address health inequalities and promote health and resilience, through a person-centred approach. Evidence remains scarce for what types of social prescribing and wellbeing activities are effective and feasible for which types of population. Our approach focusses on enquiring amongst current organisations across the North West Coast Applied Research Collaborative (ARC-NWC) to learn about current challenges and opportunities organisations with regards to design, implementation, evaluation and sustainability.

APPROACH:

A mixed methods approach included conducting 1/ a 'shared learning workshop' amongst eight programmes that were under the CLAHRC (predecessor to ARC) complemented by document analysis of these projects, and 2/ a survey across ARC members and their collaborators across the NWC.

THE LEARNING:

The workshop attendees felt the key important features for good programme implementation and perceived effectiveness were a/ a whole system approach, i.e. the interrelationship of working in partnership and collaboration with different stakeholders; b/ public engagement and involvement; and c/ using a personalised approach. Challenges identified included difficulties of capacity and engagement and adherence of stakeholders and referred people; technical, resource and financial challenges of evaluation; and the lack of sustainability of programmes due to short term funding. The survey information on 50 projects highlighted the breadth of different models to deliver social prescribing. Sustainability was also a concern, (poor financial and statutory body support and rising demand). Evaluation was weak; 58% of programmes did any form of evaluation, of which only 38% use validated quantitative measures.

WHY IT MATTERS:

Understanding the current processes and challenges will lead to further collaborative research to strengthen evaluation, build on important models of co-development and address issues of sustainability.

B1.8

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Effectiveness of interventions to improve patient transitions from Secondary to Primary Care- A Systematic Review and Network Meta-Analysis of randomised controlled trials.

The Problem: Patient discharge from secondary care to primary care or social care is a crucial transitional point in the patient journey. It is estimated that one in 5 patients experience sub-optimal care at discharge worldwide resulting in avoidable readmissions or patient harm. Several international trials have tested interventions to improve the safety and efficiency of patient transition from hospitals to primary care or social care settings. However, it is unclear whether these interventions are effective, and which patient groups are most likely to benefit by which types of interventions.

Approach: A systematic review with network meta-analysis is being performed. Several databases were searched from inception to March 2020 including Medline, Embase, Cinahl PsychINFO and Central. The primary outcome is 30-day patient readmission rates. Following title/abstract and full-text screening, 103 randomised control trials which tested different transitional interventions from secondary to primary/social care were identified. Interventions were mainly classified into four types, communication, medication, lifestyle and multicomponent.

The Learning: Via Network Meta-analysis we can see which interventions are effective at reducing readmissions as opposed to usual care. We can also compare the interventions against each other to see if a certain intervention category is more effective. Preliminary results suggest that transitional interventions are moderately effective in reducing hospital admissions compared to usual care. Additional analyses are ongoing and directed towards looking at comparisons between different types of interventions and different patient populations within each intervention to see if the observed benefits are dependent upon specific intervention contents and patient characteristics.

Why it matters: The results of this study can be used to inform healthcare professionals and policy makers on which interventions work best at reducing hospital readmissions and which types of interventions should be prioritised during health care transitions for different patient groups.

B2.1

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Title: How can medical education be optimised to support the development of person-centredness? A realist review.

The Problem

Person-centred care (PCC) is considered central to the delivery of high-quality care. Yet current evidence points to an erosion of person-centredness in medical students as they progress through training. This is despite the long-established delivery of person-centred consultation skills training in medical schools. We query whether there are gaps in our educational strategy in developing person-centredness.

Your Approach

Education is as a complex intervention with multiple component parts and a variety of potential outcomes depending on the interactions between multiple factors. A realist review, which focuses on explanation (how, why and in what circumstances does an intervention lead to desired outcomes) is particularly suited to investigating complex interventions. The output of realist research is a programme theory with explanations in the form of Context-Mechanism-Outcome (CMO) configurations. These CMO configurations, which are a form of generalisable knowledge, seek to explain in what contexts, certain mechanisms trigger to generate outcomes of interest.

The Findings

At this interim stage of analysis, we have identified three key themes which suggest that person-centred values, beliefs and attitudes may be supported by:

1. Critical engagement with the knowledge, concepts and evidence that underpin the theory of person-centred care.
2. Critical reflection on clinical practice that supports self-awareness and transformative learning.
3. Clinical experiences which allow for the development of relationships with patients and preceptors.

Why it matters

It is imperative for patient care that we understand how we can optimise medical education to support a person-centred approach. We are particularly keen to involve undergraduate and postgraduate medical educators, medical students and GP trainees as stakeholders in this research to test emerging theory with lived experience. Come and find out how these findings can be used to inform, develop and evaluate existing educational strategies.

B2.2

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Title of your work: Delivery of a Primary Care In-Situ Simulation Workshop

Abstract (max 300 words) using the following headings

THE PROBLEM: What is the problem/issue/challenge that your work is tackling

Education using in-situ simulation is well established in Emergency Medicine (EM) and focusses on the management of emergency presentations in secondary care. Many GP trainees hold posts in EM and may struggle to grasp the relevance of such simulation programmes to their future career.

This project aims to deliver bespoke teaching that bridges the gap between EM topics and the learning needs of GP trainees, by developing an in-situ simulation workshop orientated towards emergency presentations in primary care. It aims to demonstrate the relevance of the skills that trainees develop during a rotation in EM and expand on these in a primary care context.

YOUR APPROACH: what are you doing to explore/understand/address the issue – what methods are you using?

A pilot workshop was run at a local practice. Trainees participated in 'anaphylaxis' and 'cardiac arrest' simulations, followed by a debrief reflecting on their reactions and understanding in order to meet intended learning outcomes. Pre- and post-workshop questionnaires were completed.

THE LEARNING: what are you finding, noticing, learning from the work?

Participants enjoyed the workshop, felt it was applicable to their work environment and improved their confidence in dealing with emergency presentations in a primary care context. The debrief provoked in depth discussion, helping them to reflect on how to improve their performance in future.

As the pilot workshop was received so favourably, we aimed to repeat the workshop and 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. Plans are underway to adapt the project to comply with current guidelines.

WHY IT MATTERS: why does an SAPC North attendee need to find out more about your work?

Based on the pilot workshop, we predict that this project will improve patient care by refreshing essential knowledge and highlighting vital latent safety errors. In the future, we aim to deliver these workshops to other primary care based staff, providing an opportunity to re-visit basic life support skills in a familiar environment using their own equipment.

ABSTRACT

THE PROBLEM

This quality improvement (QI) project was a continuation of an audit completed in 2017, which found lack of standardization in the evaluation of heart failure (HF) patients. Therefore, a HF, frailty and end-of-life template was created to improve assessment of HF patients. The audit found several deficits in template usage by practice nurses, especially low recording of lifestyle advice and frailty. Therefore, this project aimed to further assess deficits in recording and increase utilization of at least the HF and frailty template.

MY APPROACH

The project was conducted at Pendleside Medical Practice in Clitheroe. Data was collected using the Egton Medical Information Systems (EMIS) software, from 70 patients identified as having chronic HF. Main parameters investigated were: Patients having New York Heart Association (NYHA) classification, Clinical Frailty Score (CFS or Rockwood score), electronic frailty index (EFI) score, advance care plan (ACP) and Do Not Attempt Resuscitation (DNACPR) recorded and the extent of template recording for each patient.

THE LEARNING

Areas needing improved recording was the HF template (41% had no questions filled), frailty template (76% had few questions filled), NYHA status (14% recorded), CFS (77% recorded), EFI (74% recorded) score, care plan discussion (50% recorded) and DNACPR discussion (50% recorded).

WHY IT MATTERS

The project demonstrated that frailty and end-of-life aspects required further recording and standardization, with regards to frailty scores, falls, care plan reviews and NYHA class. In addition, lifestyle and functional status recording needed improvement. Therefore, this project has significant implications for primary care. Frail and elderly individuals comprise a majority of HF patients, so inadequate documentation can cause reduced quality of management for many. In addition, not managing frailty and the needs of HF patients, inevitably leads to increased and prolonged hospital admissions, adverse quality of life and early mortality (Vitale et al, 2018).

REFERENCES FOR ABSTRACT

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B2.4

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TITLE: ASSESSMENT OF PALPITATIONS

Abstract

The problem: Atrial Fibrillation (AF) is associated with a fivefold increase in stroke risk (Adderley, Ryan, Nirantharakumar and Marshall, 2018). AF can be asymptomatic and transient but may commonly present with palpitations. Cardiac causes contribute 43% of all patients with palpitations (Weber & Kapoor, 1996), the most common being AF. This determines the substantial need for early diagnosis and providing early prophylaxis against thromboembolic events.

My approach: The assessment of palpitations requires a structured approach with attention to history, examination and investigations. This retrospective case review involved evaluation of the assessment of palpitations against NICE guidance in 48 patients at Pendleside Medical Practice, Clitheroe. In addition, use of a patient-controlled ECG device over regular 12 lead ECG and Holter monitors was evaluated.

The learning: The results showed variable documentation of history and examination findings. Good documentation of examination skills (85%) and performance of same day investigations (65% had same day blood tests, 63% given ECG and Holter monitors). AF was detected promptly in 4/48 (8.3%) of the sample and all were immediately referred. Patient controlled ECG was used in only 7/48 (14.58%), hence its efficacy cannot be elicited. It was found that red flag symptoms were seldom documented: Dyspnoea 9/48 (18.75%), Chest pain 3/48 (6.25%), Syncope 2/48 (4.16%). Furthermore, only 21/48 (43%) were given a formal diagnosis. Pulse rate (41/48) and rhythm (39/48) were not always documented. Therefore, improving documentation strategies and promptly recognising and referring patients with red flag symptoms can improve quality of care.

Why it matters: Studies have shown that 20-30% of patients with ischemic stroke have undiagnosed AF in the background. (Kirchhof et al., 2016) It is also important to rule out red flags and associated non-cardiac causes. Therefore, due to the complex nature of assessing palpitations, a quality improvement project is indicated to improve and simplify the existing pathway to ensure high diagnostic accuracy.

B2.5

SAPC Abstract Submission – Hybrid Community Placements

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Title of your work: Hybrid Community General Practise placements for year four medical students; a pilot study
Abstract (max 300 words)

- **THE PROBLEM:**

Firstly, general practise is a broad and varied career. A contemporary GP CV is often brimming with experiences in special interests, bespoke service delivery and time spent in both scheduled and unscheduled care. Community medical student placements traditionally occur within a practise. Students gain experience of the traditional partnership model, the roles of allied professionals and special interests. However, exposure to unscheduled care is somewhat limited. Secondly, the diverse and forever changing workload and commitments within general practise can sometimes cause issues in securing a quantity of quality placements

- **APPROACH:**

University of Manchester year four medical students undertake a four week block in general practise. Students allocated to a hybrid block spend 75% of their time in their designated surgery and 25% in unscheduled care.

There are two streams within the pilot study 1/ seven day access (7DA) 2/ Out of hours (OOH) service providers. Those allocated to OOH will spend four hours per week rotating through the different services available such as base triage, treatment centres, bespoke services and mobile home visiting.

Those allocated to 7DA will attend an out of hours extended hours surgery weekly

Feedback will be obtained from the students and the tutors involved to draw conclusion and comparison.

- **THE LEARNING:**

To date, one block is operational in the 7DA stream. The feedback so far has been positive. Students offered the OOH stream have been enthused. By the time of conference, feedback would have been obtained from both students and tutors in both streams.

- **WHY IT MATTERS:**

If successful, this pilot will provide supportive evidence to expand the student experience. It is hoped that this would influence the future career choices of students and encourage more into General practise. Expansion of placements into unscheduled care providers would increase the volume of available placements.

B2.6

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Combined Oral Contraceptive Pill: Safety and Satisfaction at Bassett Road Surgery

THE PROBLEM: During a placement at Bassett Road Surgery in Leighton Buzzard, inconsistencies in the timeliness and content of combined pill follow-up were detected. This audit was carried out to investigate the safety of current combined pill prescribing and to explore whether patients are being prescribed the optimal method of contraception for them.

YOUR APPROACH: A SystmOne search identified women aged 16-50 at the surgery that were due follow-up between January 2019 and March 2020 (n = 102). The occurrence and timeliness of follow-up were assessed, along with the following Faculty of Sexual and Reproductive Healthcare criteria: blood pressure (BP) check, body mass index (BMI) check, discussion about patient satisfaction and discussion about alternative methods of contraception.

THE LEARNING: 82% of patients were followed up within 15 months of their previous pill review (n = 102). The percentage of follow-ups that included the criteria were as follows (n = 87): BP check (76%), BMI check (38%), patient satisfaction (63%) and alternative methods (54%). It is important to note that there is no system to alert clinicians that a review is due and that follow-up takes on multiple forms: patient questionnaire with manual BP check, pill check template, within a general medication review and within a routine doctor's appointment. The latter two forms showed considerable variation with regard to the components assessed.

WHY IT MATTERS: Bassett Road lacks a robust system to ensure that follow-up occurs annually and in full for every patient, and it is likely that other practices also fall short on providing follow-up for this reason. It would be beneficial for all primary care centres to standardise pill follow-up through the use of a patient questionnaire that covers all the criteria and manual BP check. Yearly prescriptions would also eliminate the uncertainty as to when follow-up is needed.

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

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The problem

Parallel surgeries are a widely-used teaching tool in primary care medical education for both undergraduate and speciality training. In undergraduate placements students independently consult, then debrief with the GP before the patient leaves. Though this teaching format is a mainstay of clinical supervision in the UK there is no literature that studies its use in medical education. The aim of this study is to explore how these workplace-based debrief interactions shape learning.

Approach

We used a mixed methods qualitative approach, drawing upon Wenger's situated learning theory (Lave and Wenger, 1991). Sampling was purposive, and interviews of 5 students, 4 GPs and 14 patients were recorded and transcribed. Videos of their debrief interactions across multiple clinical consultations in four different GP surgeries were obtained. IRAS ethics approval was granted.

Interviews were categorised using framework analysis. We used preliminary themes from the interviews to guide a 'whole to part' inductive approach to video analysis (Derry 2010). This involved multiple viewings by multiple researchers and agreement on major events and themes. Our analysis focused on participant experiences. These were interpreted and categorised as 'embodied cognition' of video subjects (Streck, 2014)

Learning

Format and facilitation of the parallel surgery debriefs varied widely. The main domains that affected the active learning of the student were:

- Allowing the student to rehearse the role of a doctor.
- Contextualising the learning environment for the student (including where the debrief took place).
- Giving time for the student to respond to a question.
- Legitimising the student's presence.
- Seat positioning: dyadic or triadic.

All of these domains had an impact on the major events of the consultation and the active learning embodied by the student.

Why it matters

A deeper understanding of the complex interactions that take place during workplace supervisory encounters can inform GP teachers decision-making, improve preparation and delivery of workplace-based teaching, and maximise opportunities for patient-based learning in this setting.

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B2.8

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Title of your work A systematic review of existing primary care and community-based heart failure services, to develop a new model of care within Primary Care Networks: A study protocol

Abstract

THE PROBLEM: Care for patients with HF is traditionally provided within secondary-care integrated community heart-failure clinics where heart-failure specialist nurses (HFSNs) provide care in community clinics or patients' homes. This model is not ideal because many patients prefer to seek HF care with their GP practice with which they are familiar. However, the quality of care provided in primary care is often variable and below the standard of care provided by HFSNs. Patients with HF often have co-existing comorbidities. As a result, holistic patient-centred care is required to tailor care plans meticulously. Hence, our belief that primary care is a much suitable healthcare tier compared to secondary care alone.

YOUR APPROACH: We aim to conduct a systematic review of existing primary care and community-based heart failure services, to develop a new model of care within Primary Care Networks (PCN). The primary outcomes will be measuring improvement in HF outcomes of care, particularly in primary care settings. This includes examining the standard of care, the cost-effectiveness of primary care-based HF services, rehospitalisation rates and patient satisfaction.

THE LEARNING: Current NICE guidance recommends bi-annual follow-up routine appointments for stable CHF patients. A substitution of HF care from secondary to primary care seems sustainable, far 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 IT MATTERS: The management of chronic heart failure (CHF) comprises considerable costs accounting to 1-2% of all healthcare costs which are estimated to be around 1-2% of all healthcare costs. These costs are mainly attributed to long-lasting re-hospitalisation rates. These figures are subject to increase due to the nature of an ageing population, further increasing the pressures on the secondary care system as well as increasing the costs attributed to HF care.

B3.1

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Title: A qualitative study exploring barriers and facilitators to physical activity experienced by 18 to 35 year olds living in Sheffield's most deprived areas

THE PROBLEM

Physical activity (PA) can help prevent and manage many noncommunicable diseases and their risk factors. Health inequalities persist in England; those in lowest socioeconomic groups are most likely to be inactive. Activity in young adulthood can predict engagement with PA in later life. This study examines influences on PA in deprived young adult populations.

OUR APPROACH

This qualitative study used semi-structured interviews with health trainers (HTs) and lay participants (LPs), recruited from the most deprived quintile nationally based on Index of Multiple Deprivation scores. HTs were recruited from a community development charity and LPs through community organisations and exercise sessions. Topic guides were derived from literature review and public involvement group findings. Data were analysed using thematic analysis.

THE LEARNING

One LP and two HTs were recruited before recruitment ceased due to the Covid-19 pandemic. Four themes which influence PA behaviours were common to all interviews: 1) Individual internal factors: health, self-confidence and motivation; 2) Lifestyle and personal circumstances: finances, commitments and daily routine; 3) Local environmental factors: crime and availability of comfortable environments for PA; and 4) Local neighbourhood facilities: availability and cost of PA opportunities. Both HTs highlighted a fifth theme, outlining the HT role in encouraging client motivation. PA uptake in this population appears affected by barriers and facilitators at individual and neighbourhood level, findings concordant with existing literature.

WHY IT MATTERS

Lack of data limits ability to draw conclusions from this study. PA motivation appears low in deprived areas as PA is unable to be prioritised around family and financial commitments. PA opportunities may have limited availability and accessibility in these areas. Implementing community regeneration schemes, subsidising exercise costs and expanding HT services may improve PA uptake among deprived young adults. However, this important area requires further research before recommendations can be formed.

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

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The problem: COVID has seen remote consultations (telephone, videocalls, and on-line) in general practice becoming the norm; these are likely to be a feature of primary care management of long-term conditions beyond the pandemic.

Approach: We carried out an online search, identifying guidance using a combination of the search terms 'remote consultations', 'health care professional', 'general practitioners' and 'nursing', the results of which would inform the development of a toolkit for remote asthma reviews in primary care. We held discussions with the IMP²ART Professional Advisory Group (PAG) and Patient and Public Involvement (PPI) group to explore their perceptions of the benefits and challenges of carrying out remote asthma reviews in primary care. Discussions were recorded with consent, and notes made.

Web-based guidance was identified from NHS sources, GMC, BMA, MDU and Royal Colleges. Resources were both document and video format with a consistency of themes. Key themes included practical advice on using technology; ethical/legal issues; communication strategies; planning and patient selection. The guidance focused on acute consultations only.

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

The PPI group felt remote consultations were effective if participants are well-prepared but were more cautious about potential disruption to continuity of care, digital inequity and highlighted the need to respect patient preference for mode of consultation. The PAG were less concerned about technological issues, but identified future training needs for practice staff to carry out remote asthma reviews.

Why it matters: Current guidance can 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.

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Presenting author: name, affiliation and contact details (including email, twitter handle)

Co-authors: name, affiliations and email addresses

Title of your work

Abstract (max 300 words) using the following headings

- **THE PROBLEM:** What is the problem/issue/challenge that your work is tackling
- **YOUR APPROACH:** what are you doing to explore/understand/address the issue – what methods are you using?
- **THE LEARNING:** what are you finding, noticing, learning from the work?
- **WHY IT MATTERS:** why does an SAPC North attendee need to find out more about your work?

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Optimisation of direct oral anticoagulants (DOACs) for older patients with atrial fibrillation : a qualitative study of patient and healthcare practitioner perspectives

The Problem

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

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

The Approach

Maximum variation sample of patients, aged ≥ 65 years with atrial fibrillation, GPs, practice based pharmacists and community pharmacists were recruited. Semi-structured, face-to-face, taped individual interviews undertaken in 2018. Six stage thematic analysis was undertaken facilitated by NVivo software (V12).

The Learning

Thirty-two participants were interviewed comprising 10 pharmacists, 6 GPs and 16 patients aged between 67 to 89 years. Greater satisfaction and preference, including lower perceived risk was associated with DOACs over warfarin. Operational failures in primary care including overworked GPs, poorly integrated computer systems between healthcare settings, and communication gaps were reported by GPs and pharmacists to hinder optimisation of DOACs. GPs assumed that medication information and patient education would be provided by the initiating healthcare professionals from other healthcare settings and they often expected pharmacists to bridge this gap during medication reviews and the new medicines service. However, patients preferred relational continuity with their doctors over other healthcare professionals such as the community pharmacist. Consequently, patients' understanding and knowledge about atrial fibrillation and DOAC therapy were found wanting.

Why it matters

This study shows a gap in the safe care of older patients receiving high risk drugs like DOACs in primary care. Healthcare professionals and patients perceive DOACs as low risk and this impacts on how healthcare is provided and received. Patient engagement and co-production of medication related information with healthcare professionals could facilitate patient education. Furthermore, improving healthcare work systems such as the integration of computer systems to provide seamless communication across various healthcare settings could promote medicines optimisation.

B3.4

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Title: The 'Behavioural Activation in Social IsoLation' Study (BASIL): Modification of a psychosocial intervention for older adults with multiple long-term conditions in response to COVID-19

The problem

Older people (OP) with long-term conditions (LTCs) are at particular risk from COVID-19 infection. In addition, COVID-19 restrictions could impact negatively on the mental health of this vulnerable population in which the risk of depression is already increased by around 2-3 times. 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) for delivery with this group.

Approach

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

Learning

Intervention modification included diary planning and mood monitoring, with consideration given to finding a functional equivalence for OPs' most valued activities. An increased focus on anxiety was thought to be needed, with strategies added to manage worry. The method of contacting potential study participants, online and telephone delivery considerations, language around social isolation, planning for social contact, supporting older adults to use IT, as well as supporting access to health care, all required agreement at the co-design meeting. The intervention self-help booklet, which included 'patient stories', the SW manual and SW training were also modified.

Why it matters

This work enabled the rapid modification of an existing intervention for use within a new Urgent Public Health trial, focussed on addressing mood and social isolation in older adults with LTCs during COVID-19. Given the importance of maintaining positive mental health during the pandemic, this work would be of interest to health service researchers as well as clinicians and organisations working with older adults.

Funding acknowledgement

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B3.5

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Title of your work

Establishing new Methods to utilise Patient reported feedback for Older people With multiple long-term conditions to increase EmpoweRment (EMPOWER): scoping review preliminary findings

Abstract

- **THE PROBLEM:** What is the problem/issue/challenge that your work is tackling
Patient empowerment remains central to ensuring safe and efficient *person-centred care*. However, little is known about how to empower older people with multiple long-term health conditions and complex needs to express their needs in primary care. Better use of patient reported outcome measures (PROMs) could enable measurement of feelings of empowerment. Research is needed to test the feasibility of this model in practice. Recent research indicates interventions that are evidence-based, person-centred and utilise digital methods have the potential to advance empowerment in practice.

- **YOUR APPROACH:** what are you doing to explore/understand/address the issue – what methods are you using?

A scoping review of UK primary care literature incorporating publications identified through core research databases, reference lists, grey literature and consulting experts in the area.

Complimented with partnership working with members of the patient and public involvement and engagement group (PRIMER) at The Centre for Primary Care and Health Services Research at Manchester, to ensure the early development work is person focused.

- **THE LEARNING:** what are you finding, noticing, learning from the work?
Preliminary results from early work examining how PROM feedback can be, or is used in primary care, with older people with multiple long-term conditions will be showcased with the virtual SAPC community. We will also share how we co-created our aims for the review, and how we established our approach to patient and public involvement and engagement for the EMPOWER study to demonstrate how we formed a meaningful virtual partnership during the pandemic.

- **WHY IT MATTERS:** why does an SAPC North attendee need to find out more about your work?

Virtual attendees will learn of themes that support or hinder feedback of empowerment for older people with multiple long-term conditions of relevance to clinicians and researchers in primary care who struggle with the challenge of using feedback to drive change.

The next steps to the EMPOWER study will be outlined, including the co-design of the ingredients of a new person-centred intervention, in partnership with PRIMER. Insights from this work will be placed within the wider context of person centred care research theme at Manchester which may be of interest to attendees.

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Title of your work: Does occupation predict outcome in conservatively managed carpal tunnel syndrome?

Abstract (300 words max)

THE PROBLEM:

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.

YOUR APPROACH:

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 (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).

THE LEARNING:

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.

WHY IT MATTERS:

- 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 (Wellman et al., 2004).
- 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.

B3.7

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Title of your work

What is primary care epileptology/neurology?

THE PROBLEM: What is the problem/issue/challenge that your work is tackling

Neurological disease is no more complex than many of the chronic diseases which are managed largely by primary care such as diabetes and COPD. Furthermore, the complexity brought about by comorbidity so often seen in epilepsy such as depression, anxiety, cerebrovascular disease and frailty make our generalist skills especially pertinent. Nevertheless, primary care has been in the grip of an unjustified neurophobia for many decades. With support, education, and accredited training the potential of primary care in neurological care is huge.

YOUR APPROACH: what are you doing to explore/understand/address the issue – what methods are you using?

In my research I use qualitative, quantitative and mixed-methods to take a health services perspective on neurological care. My current work includes an NIHR funded grant on emergency care pathways after a seizure, a big-data project looking at prescribing of anti-seizure medications and a mapping review of the role of GPs in epilepsy care. In my clinical work, I work as a GP with a special interest in epilepsy in Sheffield Teaching Hospitals epilepsy clinic. I am a member of the ILAE GP Society (International League Against Epilepsy) and I am a member of the NICE Epilepsy Guideline Update Committee. I was the Chair of the recently published National Clinical Practice Guideline for Convulsions for paramedics.

WHY IT MATTERS: why does an SAPC North attendee need to find out more about your work?

Our Unit in Sheffield has a vibrant theme on neurology and neuroscience, we work closely with the internationally renowned Sheffield departments of SCHARR and SITRAN we would be delighted to hear from colleagues in SAPC who wanted to collaborate on neurology projects. Headache, dementia, epilepsy, Parkinson's disease, cerebrovascular disease would all be in scope and we'd be delighted to hear from you.

B3.8

Title: Work participation in primary care consulters for musculoskeletal conditions

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PROBLEM: The impact of musculoskeletal conditions on work is a common reason for consultation to primary care. Whilst primary care electronic health records provide information on the issue of fit notes, employment status and the extent of work absence (time taken off work whilst in employment) and presenteeism (lost productivity at work) is unclear in consulters for musculoskeletal conditions. The aims of this study were to describe employment status in primary care consulters for common musculoskeletal conditions aged 35 to 65, the extent of absenteeism and presenteeism and how these levels differ by condition.

APPROACH: Data was used from the PRELIM initiative, a cross-sectional study of adults aged ≥ 35 years registered with one of eleven general practices in North Staffordshire or Stoke-on-Trent clinical commissioning groups. Analysis included responders to a survey who (i) consulted primary care in the previous 12 months for one of seven common musculoskeletal conditions (back, neck, hip, hand, knee or shoulder pain or osteoarthritis (n=2001)) and/or (ii) belonged to a general population sample (n=2154). Employment status was measured using a single item. Work Absence and Productivity was measured using the Work Productivity and Activity Impairment.

LEARNING: Employment rate was lower (76.3% cf 70.7%) and levels of absenteeism (4.7% cf 8.5%) and presenteeism (28.7% cf 45.0%) were higher in the general population to those who consulted for a musculoskeletal condition. Consulters for OA had the lowest employment rate (61.0%) and highest level of presenteeism (52.40%), whereas neck pain showed the highest rate of absenteeism.

WHY IT MATTERS: 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 consulters with musculoskeletal conditions. This will may involve greater linkage with employers and a multidisciplinary approach to reduce the barriers to work participation.

SESSION X: Writing a Research Question Masterclass

Abstracts for this session described early stage ideas being worked up by participants. Ideas were presented to an expert panel for discussion and development.

Josie Reynolds : Evaluating a new BAME focused dementia service

Racial inequalities in health can no longer be ignored. The Black Lives Matter movement has ignited a renewed sense of momentum to tackle such injustice across the world. Dementia is a condition which has vast implications on individuals, their families and wider society. Black, Asian and Minority Ethnic (BAME) groups experience delayed or absent diagnosis in Dementia and barriers to accessing support services.

The UK's ageing population means that this is a rapidly worsening situation – with the proportion of BAME people living with dementia set to double within the next 10 years. Health services are currently framed around the norms of the white majority and BAME populations are greatly under-represented in dementia research.

In Sheffield, a network is being set up to create a specialist BAME dementia service which will be co-produced to be more reflective of BAME communities and therefore directly address their needs.

A realist evaluation of this new intervention would help to understand how, why and in what circumstances this specialist BAME dementia service impacts on BAME people living with dementia and their carers in Sheffield.

I hope the panel can help me consider whether the question is manageable; whether realist evaluation is the approach to use; and how best to seek funding.

Jung Yin Tsang: Building an informatics system targeting inappropriate polypharmacy in primary care

Polypharmacy is an international patient safety challenge, broadly defined as the use of multiple medications in a single patient. Its prevalence continues to rise, driven by aging, multimorbidity and numerous single disease guidelines. Medications carry obvious benefits as treatments, yet polypharmacy is linked to several adverse consequences including adverse reactions, unplanned hospitalisation and death. The challenge is to distinguish appropriate polypharmacy from inappropriate polypharmacy, where the combination of risks outweigh the original intended benefits of treatment. Current approaches are limited in their identification of patients with inappropriate polypharmacy and do not reliably take into account patient views.

Research question: Can an informatics system targeting polypharmacy in primary care, incorporating a polypharmacy risk score and patient input tool, enhance prescribing appropriateness by improving shared decision-making between patients, carers and health practitioners.

The research will aim to develop an informatics system targeting inappropriate polypharmacy in primary care, incorporating a polypharmacy risk score and patient input tool. This will build on preliminary work to date, upgrading an existing informatics system built on evidence surrounding medication safety, audit & feedback and behaviour change theory. The polypharmacy risk score will be established by developing and validating a clinical prediction model using large databases of electronic health records (Clinical Practice Research Datalink – CPRD), accounting for individual factors such as age and comorbidity. The patient input tool will be co-produced with patients and carers, through a series of workshops and testing of prototypes. This will be designed to capture patient views to enhance decision making during polypharmacy medication reviews. Subsequently, the informatics system will be piloted in five general practices for six months in a mixed methods feasibility study.

I hope the panel can advise to improve the clarity and brevity of the research question.