

Appendices: Assessment of the Impact of CPD Case Studies

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CASE STUDY

1. Advanced Life Support Group

1. INTRODUCTION

Advanced Life Support Group (ALSG) was founded in 1990 and became a registered charity in 1992. ALSG is known as a high quality clinical education designer and is a world leader influencing and providing life saving training for everyone responding to medical emergencies.

Each of the 23 course packages has been developed in recognition of identified training needs within particular specialties or settings. The course packages are all developed by representative clinical working groups supported by the ALSG educators and ALSG development team

2. SETTING & LOCAL CONTEXT

All of the packages are based on a blended learning approach and are standardised, evidence-based, structured and quality assured. The courses are delivered by a network of 9,500+ recognised instructors who have all been selected and have completed a structured training programme.

The core elements of the package are on-line learning, a course manual, standardised teaching and assessment materials and an organisation package. In addition, for on-going CPD, delegates can use an on-line learning environment to access revision 'e-scenarios', updates and question forums. Candidates retain access to this for four years following their course, at which point they should then recertify. Course instructors are provided with development topics in medical education and access to relevant papers and resources. They also recertify every 4 years.

The areas covered by the courses are emergency paediatrics, obstetrics, safe transfer, child protection, major incidents, acute medical emergencies and human factors. The courses are aimed at a wide range of healthcare professionals from medical and nursing students to senior consultants. They are also developed or adapted for diverse groups across many cultures and settings.

3. NATURE AND DELIVERY OF CPD

ALSG courses are primarily aimed at secondary care, in particular emergency medicine, anaesthetics/ICU and paediatrics. The pre-hospital courses are relevant to GPs. The uptake of the ALSG courses is widespread, as can be seen from the number of attendees at individual courses below. These numbers reflect the total number of delegates, not just doctors:

- Advanced Paediatric Life Support (APLS) – 60,264

- Paediatric Life Support (PLS) – 29,721
- Pre-hospital Paediatric Life Support (PHPLS) – 1,817
- Major Incident Medical Management and Support in the Hospital setting (HMIMMS) – 2,796
- Major Incident Medical Management and Support at the Scene (MIMMS) – 14,218
- Managing Obstetric Emergencies and Trauma (MOET) – 3,802
- Pre-hospital Obstetric Emergency Training (POET) – 60
- Acute Medical Emergencies (MedicALS) – 1,008
- Safe Transfer and Retrieval (STaR) – 1,164
- Paediatric and Neonatal Safe Transfer and Retrieval (PaNSTaR) – 472
- Child Protection Recognition and Response (CPRR) – 3,045
- Child Protection in Practice (CPIP) – 1,437
- Strengthening Emergency Care Programme for Developing Nations – 2,773

4. IMPACT

Impact is measured by administering questionnaires to all candidates 6 months after completion of the training. :

- 86% of respondents from the APLS course had put the skills that they had learned on the course into practice and 76% of those commented that the skills they had learned were very or extremely useful
- 100% of respondents from the MOET course had put the skills into practice and 87% commented that the skills they had learned were very or extremely useful.

ALSG also have anecdotal feedback from the same questionnaires. Examples of feedback from the Advanced Paediatric Life Support course (APLS):

“Was on ward as only doctor present when a post op child had a cardiac arrest. Had it not been for the skills I learnt on the course the 5 minutes until the dedicated arrest team arrived could have been the difference between the child living (as he thankfully did) and having a negative outcome”.

“4 year old child came to A&E fitting, although I still got senior help as I would have previously I felt much more confident assessing ABC stabilising the child”.

“I have been involved in respiratory arrest recently. I used the systematic approach I learned in APLS course which was extremely useful and saved the patient's life”.

Examples of feedback from the Managing Obstetric Emergencies and Trauma course (MOET):

“Led a case of major PPH on labour ward with an excellent outcome for the patient. The opportunity during the course to lead a team was useful for this scenario”

“In managing a patient with APH where although others thought that because the blood pressure was OK everything was fine, where as I recognised the gravity of the situation and started early fluid resuscitation. In the next reading her blood pressure collapsed and since I had got two large bore IV access, we were able to manage the patient effectively”

5. BARRIERS

The key barriers identified were time and money— access to study leave for both the candidates and the instructors can make it difficult for them to complete the on-line learning and also to attend the face-to-face course. Increasingly some candidates and instructors have to cancel at the last minute because of pressures in the work environment e.g. having to cover colleagues who are sick or deal with particular surges in demand in the emergency department setting.

Time can also be a problem for those developing course packages and CPD activities – all of the clinical working groups are volunteers and they are very busy. They recognise the value of the training and are very generous with their time, but there are limits.

Based on the 6 month follow up feedback, it is thought that candidates, in the main, do have the opportunity to implement the learning. The exception to this is likely to be the major incident courses, because major incidents, thankfully, are rare. Feedback from candidates of the major incident courses report that they use the skills to teach others within their department.

6. LESSONS LEARNT

Standardisation of courses is important as it helps with familiarity across a multi-disciplinary and multi-specialty team and ensures that there is a common language and a common understanding of the safe, structured way of dealing with an emergency.

Candidates sometimes come back after completion of a course with further questions. In order to meet their needs an on-line question forum has been developed. On-going access to the experts allows those implementing their learning to check back if they have any issues that arise when they put their skills into practice.

Pressure of work means that candidates have less time available for training. A blended learning approach has been introduced to many of the courses to shorten the face-to-face element, which also reduces cost and the time needed away from the workplace. The face-to-face course focuses much more on the practical skills and practise simulations which cannot be replaced by on-line learning.

Feedback suggests that candidates would like to have the opportunity to undergo practise simulations more regularly. Consequently, on-line 'e-scenarios' have been set up to go some way towards accommodating this.

Courses have been adapted to meet the needs of Trusts for on-site delivery. Trusts can train as many people as they like for a fixed fee. This gives them the advantages of standardised training packages that are regularly reviewed and updated as evidence changes. It also gives their employees the benefits of internationally recognised certificates and transferable qualifications.

(For further information about this case study please see <http://www.alsg.org/uk/Attend>)

CASE STUDY

2. Coeliac prescribing Guidance: MyHealth Strensall

1. INTRODUCTION

This initiative was developed in 2010 by a single GP as part of his ongoing CPD. He identified a need to update and implement local guidance for coeliac prescribing. Gluten free foods have been available on prescription but national guidance produced in 2010 indicated that some foods such as biscuits, cakes, cake mixes, luxury bread, cereals and ready meals were all readily available from supermarkets, are not considered essential to the diet and as such should not be prescribed on FP10s. Further to these guidelines, it was felt necessary to assess the prescriptions of all patients on the Coeliac register within the Practice. One of the principal reasons for doing this was to reduce practice prescribing costs.

2. SETTING & LOCAL CONTEXT

The setting was a large general practice (MyHealth), North East of York with 17,600 patients across four premises. This CPD initiative was undertaken by a single GP in a practice setting but impacted on both Practice colleagues and patients. There were 49 patients on the register with Coeliac disease.

3. NATURE AND DELIVERY OF CPD

The CPD itself took the form of an audit of patient prescribing conducted in December 2010, followed by a review of good practice (based on recommendations on the Coeliac Society Website), revision of local guidance and a follow up audit of prescriptions. The aim of the audit was to reduce prescribing costs by ensuring that no luxury items were prescribed and no patient should exceed their monthly quota of gluten free food. A computer search to identify patients with the condition was carried out and then individual patient notes were scrutinised and any necessary changes to medication made. Each patient had their records annotated to display clearly how many units they were entitled to and each scripted item was shown as a number of units. All patients were written to warn them of forthcoming changes to their prescriptions. Information leaflets sent to patients were based on information sourced from the Coeliac Society website. All patient notes were reviewed to show the correct unit dosage so that all subsequent prescriptions would be correctly written and dispensed.

4. IMPACT

As a result of this initiative all affected patients had their prescriptions updated in accordance with revised guidance and all GP colleagues were made aware of the change in guidance. In total of the 49 patients registered with the practice with Coeliac disease, 29 were in receipt of 'luxury' items. As a result of the audit, 39 had their repeat prescriptions amended and were sent both a letter and an information leaflet. All patients now have a label attached to their notes indicating the number of units they are entitled to under the latest guidelines. This has proved beneficial for both patients and receptionists as it is now extremely clear how many units an individual patient is getting on prescription. A follow up audit conducted in September 2011 shows a significant improvement in meeting the prescribing guidelines; just one person was in receipt of a prescription for a disallowed product and there was a slight slippage in the quantities of prescriptions in a minority of patients which has been re-addressed with both patients and staff. One of the main reasons for conducting the audit was to reduce costs on behalf of the PCT and this seems to have been achieved.

The new guidance and the results of the audits were communicated to partners at business meetings and other members of staff both by email and by team meetings.

5. BARRIERS

Most patients acknowledged the necessity of restricting the 'luxury' products and the number of prescription items given the current financial climate. Nevertheless a small number remained resistant to the change.

On trying to rationalise the prescribing and reduce the volume of prescription items, it became apparent that some of the prescription items were only available in fixed pack sizes which meant it was impossible to make dose adjustments in some cases.

The practice also tried to rationalise the number of products which were available for prescription. However from the patient perspective it was important to have a choice. For example, some patients wanted to be able to choose 6 items from a total of 20. The Practice is complying with their wishes but this can lead to complicated screen views on the computer system for Practice staff.

6. LESSONS LEARNT

The project was a lot of work for one individual to take on and has led to more work than anticipated. With hindsight it would have been possible to delegate different aspects of the work to other members of the practice team.

(For further information about this case study please contact Dr Mark Stenton – Mark.Stenton@gp-B82080.nhs.uk)

CASE STUDY

3. COSBART: Salford Royal NHS Foundation Trust

1. INTRODUCTION

This initiative was developed in 2005 following a number of critical anaesthetic incidents involving patients undergoing surgery. In response the Trust, which has a strong reputation for patient safety asked all Consultants to undertake Advanced Life Support (ALS) training. The ALS course is only undertaken once every three years and is aimed at acute coronary emergencies rather than emergency anaesthetic scenarios. The anaesthetic department therefore decided to develop their own in-house course: **CO**n**tinuing S**cenario **B**ased **A**naesthetic **R**esuscitation **T**raining, known as COSBART. Following a review of critical incidents, the course was designed to provide Consultant Anaesthetists with more frequent training in relevant resuscitation scenarios such as hypoxia, blood loss, failed intubation, and drug reactions. Each year every consultant member of the Anaesthetic Department spend a session in a Simulator Suite which is equipped with manikins to rehearse their responses to a variety of typical anaesthetic emergency scenarios which could occur during surgery such as:

- Can't intubate, can't ventilate scenario
- Anaphylaxis
- Pre-eclampsia.

2. SETTING & LOCAL CONTEXT

This is an initiative designed for secondary care aimed specifically at Consultant Anaesthetists but is also delivered to Intensivists and locum Consultants. All Consultant Anaesthetists are obliged to undertake the training.

3. NATURE AND DELIVERY OF CPD

The course borrows freely from the ALS group and the resuscitation council and has two elements:

- Essential (CPR) skills such as defibrillator safety, demonstration of BLS, knowledge of VF & pulseless VT ALS algorithms and the ability to perform rapid cricothyrotomy.
- A selection of anaesthetic specific emergency scenarios which are managed in real time.

- A selection of discussion based scenarios (Non-CPR) which should all be covered at least once every three years.

The scenarios are split into CPR and non-CPR with four people allocated to each group. Course delegates work through a scenario in real time without any briefing as to what the scenario might be about. Each scenario is followed by a team debrief. The debrief period provides an opportunity for feedback and reflection. Once a candidate has successfully completed a scenario, they should then be able to facilitate the same scenario. This means that Consultants take it in turns to facilitate different scenarios. Ultimately all staff undertake and subsequently run both individual scenarios and complete courses.

The scenarios take place within the simulator suite and involve the use of manikins and other equipment. Courses take one PA (Programmed Activity) of clinical time and are run every two months for 6-8 people, with 48 places available per annum.

4. IMPACT

It is difficult to quantify the impact of the training since critical anaesthetic incidents being trained for are very rare and so it would not be possible to measure a difference in the number of critical incidents. Nevertheless there are a number of qualitative outcomes; Consultants feel more comfortable in dealing with emergencies in surgery as they are better equipped to work through the protocol having rehearsed their response in their training. Those in receipt of the training say they are happier dealing with critical incidents and are better at managing them. Actually working through emergency scenarios in real time means that Consultants have rehearsed a practical exercise rather than just having a theoretical knowledge of the correct procedures. This hands-on approach is likely to lead to deeper learning than theoretical learning alone. Respondents also noted that the course was useful in providing evidence for appraisal. The course is very cost effective to deliver with an in-house cost of roughly £35 per head.

"It makes you practice drills that you would never do normally. When a situation arises, you are fresh, having actually performed 'it' just a few months before."
(Consultant Anaesthetist, Course participant 1)

"We are all singing from the same hymn sheet". (Consultant Anaesthetist, Course participant 2)

"The use of real time scenarios embeds the information better; you might know what to do theoretically but working through it means you know where everything is".
(Consultant Anaesthetist, Course participant 3)

5. BARRIERS

In terms of barriers, one challenge has been to bring clinicians together to undertake the training on a regular basis and it has sometimes been difficult to persuade colleagues to attend the course. Initially courses were one day long and encompassed the whole department but it became

increasingly difficult for the Trust to release this many people from clinical duties at the same time. Courses now cover a smaller number people (6-8) and are run every couple of months. Consultants have to use time set aside for clinical governance in order to undertake the training.

6. LESSONS LEARNT

Three key lessons learnt were identified:

- The process of training can expose weaknesses and not everyone is happy to put themselves in that situation
- It can be difficult to persuade people to give up their time to contribute to the course. In theory everyone should have a go at facilitating the scenarios but not everyone is willing.
- Simplicity and repetition is preferable to complexity.

There have been discussions around rolling the training out to other professions such as Operating Department Practitioners (OPDs) in a multi-disciplinary scenario but as a whole there is a feeling that not all Consultants would feel comfortable training in a multi-disciplinary setting. Delegates welcome the easy learning environment where they feel free to ask questions; there is a sense that this might be lost in a multi-disciplinary setting.

The scenarios used in the COSBART course have evolved over time and have been modified to take account of changing guidance. COSBART authors reflect on critical incidents as they arise and develop new scenarios to incorporate these situations if they are appropriate and participants can suggest new scenarios on an ongoing basis. The Trust has recently started to take child patients and so the course authors are planning to develop some paediatric scenarios. In addition Salford Royal is now part of a major trauma network and they would like to develop some major trauma based scenarios in the future.

The COSBART authors have set up a website (<http://www.cosbart.org/default.htm>) where scenarios can be downloaded for use by Trusts elsewhere. Staff from other Trusts can join the COSBART course at Salford for a fee of £50 and Consultant anaesthetists from the North West have been invited to attend the course.

“Simplicity and repetition is preferable to complexity”. (Course organiser)

(Please contact Dr James Palmer at <http://www.cosbart.org/default.htm> for further details about this case study)

CASE STUDY

4. Community DVT Clinical Pathway: NHS South Gloucestershire PCT

1. INTRODUCTION

The Protected Learning Time (PLT) events, from which this specific CPD emerged, have been running since 2003. Originally organised and managed by South Gloucestershire PCT, the local CCG will now be responsible for these, and are committed to continue the PLT's, using it as a platform for sharing information about clinical pathways such as the Community DVT clinical pathway as well as more general information sharing about the changes in the NHS etc.

2. SETTING & LOCAL CONTEXT

This is delivered in primary care, aimed specifically at General Practitioners.

3. NATURE AND DELIVERY OF CPD

The CPD is a half day event, delivered monthly. Topics for the sessions are decided by an annual audit of the 26 GP practices in the CCG, where they are asked to identify their specific needs. These are ranked and the most highly ranked form the basis for the PLT programme. There is an expectation that there are two representatives from each practice will attend three PLT events per year.

The sessions are designed to be interactive and are led by one or more speakers.

4. IMPACT

Like many of the CPD educational events that are organised by this PCT, the CPD session was led by a General Practitioner and Clinical Nurse specialist, as the organisers believe that peer-led learning enables the attendees to relate to those who are providing the training if there is more of a focus on primary care. The GP for this session was from GP Care, who provides the Community DVT Service which is part of the new Community DVT Clinical Pathway.

The DVT session focussed specifically on the management and risk assessment of patients with who are considered to be a high DVT risk. This included how to arrange the variety of tests that patients with DVT need; blood tests, either at the practice or in hospital, scans etc and information about the pathway for patients who fit the criteria for referral into the Community DVT service.

Following a short presentation, there were break-out sessions around the table where attendees were encouraged to ask questions around things like implementation, management, referrals etc as well as sharing experiences of how to manage patients with DVT.

“...never just a lecture that you go and sit and listen, always a two way process.”
(Associate Director for Clinical Governance)

Feedback from the session indicates that GPs felt it would improve their practice and performance, particularly by alerting them to new services that they might not have previously been aware of. There is an implicit expectation that GPs return to their practice and share what they have learnt during practice educational meetings, therefore cascading the knowledge and information to their GP colleagues and the wider practice team.

Community DVT programme which covers South Gloucestershire and North Bristol has seen hospital attendances reduced by 8,000+ over the last three years has seen. The CPD is only part of this initiative but it is believed that the CPD has had a noticeable impact on referrals;

“DVT CPD – that has had a major impact on ensuring that the pathway is followed It does have impacts on changing behaviour once people are aware of the service”
(GP, Participant 1).

5. BARRIERS

The greatest barrier was attendance at the CPD – The majority of practices send at least one GP to the training sessions, but some of the smaller practices struggle to attend. Organisers try to send out training dates well in advance to help smaller practices plan around the sessions they wish to attend.

Presenting a new service such as this, which some GP practices may not have been aware of can have the effect of increasing patient activity in practice, through the time investment needed to explain the new pathway to patients, discussion of the treatment options and time spent on subsequently managing the onward referral of treatment – all of which may impact on staffing levels.

However, as GPs have implemented their learning and become more familiar with the Community DVT clinical pathway, the extra time involved is minimal;

“in terms of extra time for consultation, it’s only added on about an extra 5 minutes”.
(GP, Participant 2)

“it’s been quite easy to implement what was learnt on the training day, especially because we can see the patients have a better quality of care, they’re seen quickly and locally which is better for them, and better for us because we can see the results”. (GP, Participant 2).

The close relationship that the GPs in this region have with GP Care has been instrumental in enabling GPs to put their learning into practice;

“if we have any queries, we can always ring the DVT centre – they are quick to answer, and because they deliver their service really quickly, we feel really encouraged to use it”. (GP, participant 2)

6. LESSONS LEARNT

The organisers have learnt to be very assertive and specific about what they expect from the session,

“can’t be any ambiguity, if the speaker’s not clear then that can impact on the session”. (GP organiser).

Delivering learning in practice is essential, with relevant local information which is going to help GPs in their immediate day-to-day practice rather than at some point in the future, with an emphasis on improving patient care.

“I’d like to think it’s a more streamlined and up-to-date practice in general practice, using the most up-to-date care pathway, patients are managed better.” (Associate Director for Clinical Governance)

Building good relationships with care providers, such as GP Care can be beneficial. GP Care have worked together with the PCT to deliver the training, and have worked with local GPs to ensure that GPs are confident when referring to the community DVT clinical pathway. Part of this initiative has been to seek GP opinions as to how the service could be improved; *“we have been able to feed in, helping to tweak the service.” (GP, Participant 2).*

The close relationship that the GPs in this region have with GP Care has been instrumental in enabling GPs to put their learning into practice;

“if we have any queries, we can always ring the DVT centre – they are quick to answer, and because they deliver their service really quickly, we feel really encouraged to use it”. (GP, Participant 2)

(For further information about the Community DVT Clinical Pathway CPD, please contact Tracy Cabbage, Associate Director for Clinical Governance, NHS Bristol at Tracey.Cabbage@sglos-pct.nhs.uk)

CASE STUDY

5. Dementia Education: Bath PCT

1. INTRODUCTION

In 2010 the South West Health Authority offered some funding to support GP Education and Training. It was felt there was a need to improve Dementia Education in the region, particularly with respect to the overall national dementia strategy, and the requirement for PCTs to publicly publish their plans to implement the strategy. Some of the key drivers of this strategy are pushing the targets to improve early diagnosis rates in primary care, how to refer into the memory services and also about raising awareness of the services available in the community. A multi-disciplinary team meeting was held with GP educators and representatives from the PCT, psychiatry, Research Institute for Care of the Elderly (RICE), and the voluntary sector to look at what sort of education was needed, as well as sending out a questionnaire to all GPs, adapted from the Educational Needs Analysis questionnaire developed by EVIDEM. Key areas highlighted included making the diagnosis, early diagnosis and diagnostic tests. There was a lot of interest in medication, what to expect from treatment, starting and stopped, and dealing with agitation and difficult behaviour, as well as interest in finding out more about pathways, shared care information and support services in the community.

2. SETTING & LOCAL CONTEXT

This was set in primary care, with a multi-disciplinary approach. The training was aimed at local GPs, and was delivered by a geriatrician from RICE, a consultant psychiatrist from the Avon & Wiltshire Mental Health Partnership Trust, and the GP Educator.

3. NATURE AND DELIVERY OF CPD

The training was delivered over two events; A GP educational evening and at GP Forum Plus. The GP educational evening was attended by GPs who had chosen to attend, therefore were self-selecting. It was explained that educational events are often held in the evening to enable GPs to attend, because of the difficulties that attending a day-time event might bring, i.e. finding locum cover etc.

GP Forum plus is a commissioning day, held monthly on a Wednesday afternoon. All practices are expected to send a representative due to the business nature of the meeting, but there is always an educational component as well. It was felt that that this does ensure that the educational component provided does reach a wider audience, as some of the GPs may not choose to attend an educational event held outside practice hours.

The GP Educational evening was facilitated by the GP Educator. These events are available to be viewed on the Bath Education Trust website for all members to access.

The Geriatrician's presentations focussed on how to identify memory problems, the difficulties associated with early diagnosis of dementia, signs to look out for, when and how to refer into the memory clinics. The Consultant Psychiatrist's presentation was about managing behavioural and psychological symptoms of dementia.

The GPs were also signposted to the Dementia Web portal, www.dementiawebath.org.uk which was set up by a charity called The Guideposts Trust. This site is useful for sufferers of dementia and their carers; it provides, for example, information around further support and advice, and it is considered to be a useful resource for clinicians as well.

4. IMPACT

With the target to improve early diagnosis of dementia in primary care, there was a concern that GPs might not have the necessary expertise to diagnose, mainly because they see relatively few cases a year, perhaps 4 or 5. It was felt that the focus of this CPD, being on early diagnosis, would help increase the confidence of GPs, and provide knowledge to help them identify symptoms that could indicate early dementia.

GPs will have a clearer understanding of when and where to refer, knowing what the correct pathway is, but also knowing there are things that can be accessed, such as the mini mental state tests to help manage a patient who may simply have memory loss or may be in the early stages of dementia.

“One of key messages, they're keen to see people as early as possible so that has changed practice. It helped me clarify when I should go down the RICE route rather than the mental health route, helped on that front.” (GP participant)

GPs will have more understanding around treatment and drug use – having a clearer understanding of the realistic expectations of current medication for dementia, and understanding how medications work and being able to pass that information on to patients and their carers. Importantly not just to focus on medication, but how to manage the patient's future and understand what the diagnosis may mean to the patient and carer. GPs will have a clearer understanding of what best to prescribe, if medication is appropriate.

From a participant's perspective, it was felt that the events offered;

- A better understanding of the drugs that are prescribed for people suffering with dementia, in particular when to prescribe and the realistic expectations around the different drug therapies, which can be passed on to the patients and their carers.
- An increase in confidence about knowing when to refer patients to the services available, such as the Memory Clinic, e.g. lowering the threshold about when to get the memory clinic involved.

“I've think I've had one patient since then that I referred to the memory clinic that I wouldn't have done at that stage – I referred earlier. To be honest, we don't see many new diagnoses, which is one of the challenges in general practice” (GP participant)

- An increased awareness of what is available and what work they do in the memory clinics and in mental health, increasing confidence in the consultation, increasing awareness of why the patient is being referred and what they might get out of it.

“It has increased my confidence, having an increased awareness of what is available and what work they're doing, it makes you more confident in the consultation as it makes you more aware of why you're sending the patient where you're sending them and what they might get out of it really.” (GP Participant)

GPs who attended the evening learning event were asked to evaluate the session in terms of learning objectives and relevance. Twenty-five of the 50 GPs who attended the evening session completed evaluation forms:

- 23/25 felt their learning objectives were met
- 24/25 felt the sessions were relevant to their needs.

Dementia Education is very new, so too early to get any idea of impact on service, but it is expected that prescribing pattern might change; increased access to medications and a reduction overall in anti-psychotic use.

“I think it's to give them a realistic view and more confidence, but not easy because it's quite a difficult thing, and they're busy doing thousands of other things. So the patients will benefit from a more understanding GP who feels more confident about how to manage”. (Geriatrician)

5. BARRIERS

A number of barriers were mentioned; time – not only in terms of participating in this CPD but the time that might elapse between a GP doing the CPD and having a patient presenting with early onset dementia, prescribing barriers, keeping skills updated - together with the sheer volume of information that GPs deal with.

There was an agreement that the relatively small number of patients that present to GPs with early onset of dementia can be problematic, due mainly to the lapse between an event like this and seeing a patient who might have dementia.

The visibility of GPs, with a special interest in dementia, who are well known in the local GP community is a particular resource for support and information for GPs to call on, should they have any uncertainties about diagnosis or management of dementia, or require clarification around some aspect of the diagnosis. This is encouraged by the strong tradition of collaborative working that exists in this area. In addition they are planning to develop practice clusters (5 practices per cluster) which will help as they will be encouraged to have their own debates around what is important in dementia.

Prescribing barriers are more difficult to overcome as it is in the guidelines that only specialists can initiate the prescribing but gaining a more in-depth understanding of the medications is deemed to be beneficial to all.

6. LESSONS LEARNT

Getting people together who are interested in dementia is relatively easy, but the challenge is reaching those people who might be not be able to attend or have no real interest in dementia. The

GP forum plus has been instrumental in overcoming this to some extent, with the inclusion of an educational component at every meeting, therefore reaching a wider audience.

"I was most certainly aware during my recent presentation it was predominantly younger trainees, which I think is great, an excellent change to influence future practice but I'm also aware that there are a large group of GPs who I don't get to have any contact with. For those people who are there....it's likely that they will go away with increased confidence, at least to be clear to say what to families and what to prescribe and what to avoid. I think this will have a positive effect on practice". (Consultant Psychiatrist)

Taking a collaborative approach has encouraged more understanding between specialties, i.e. for a specialist to understand how difficult it is for a GP to manage a myriad of conditions, therefore gaining an understanding around how to pass information on to GPs in the most appropriate way. This collaborative approach has encouraged more regular interactions between the specialists and GPs, in order to ensure that they have a system that works best for everyone; specialists, GPs, patients and carers.

"Giving information in a more appropriate way, you really do need regular interactions between the specialist and the GP, that's part of it, that there's an interaction, so you try and make sure that what you're doing is what everyone wants, the patient, the family, the GP and the specialist so that we get something that works for us as best we can". (Geriatrician)

It is essential that reflective learning forms are available on the Bath GP Education website, which prompt GPs to not only think about what they learnt but how to implement their learning in their day-to-day practice, as well as a prompt to feedback their learning to colleagues in practice, either formally or informally to ensure the information cascades down.

"One of most useful things was pointing out the resources that were available, for carers etc, especially Dementia Webb that's available, I run the practice internet at my practice and I have put a lot of links onto that." (GP participant)

It is anticipated that this CPD will extend to all practice staff, not just GPs and there are plans for all members of the practice staff to attend two open visits at RICE to gain some understanding of what is available and what happens when patients are referred.

"Collaborative approach has paid dividends for us, getting the right people and discussing the training, what is the best way of doing this, comes back to our local strategy". (PCT)

"The education must always be aimed at what is relevant for the jobbing GP, and it must always be locally relevant." (GP educator)

(For further information about the Bath Dementia CPD please contact Dr Nicole Howse, GP Facilitator at nicole@drhowse.co.uk)

CASE STUDY

6. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR): Southend University Hospital, South Essex PCT, and South Essex Partnership University NHS Foundation Trust (SEPT).

1. INTRODUCTION

This project was stimulated by the NHS East of England SHA's 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) Initiative and was driven locally by the South Essex PCT. The project aimed to give a consistent approach to DNACPR across the region which will therefore allow portability of the decisions across care settings in line with best clinical practice. The SHA developed initial drafts of a DNACPR form, patient information and policy guidance. The form is supposed to travel with the patient although the decision is also recorded in the Summary Care Record so that others can access this information. At PCT level a partnership was established with all the relevant services including the ambulance service with a view to obtaining a singular approach to implementing this initiative.

2. SETTING & LOCAL CONTEXT

The CPD delivered as part of this initiative covered both Primary and Secondary Care services. Training was delivered in a variety of settings across the PCT area including Southend Hospital, Basildon Hospital, the local ambulance Trust, GPs and local care home and hospices. This CPD was not an isolated educational initiative; it was part of a much larger change management programme across the whole patch.

3. NATURE AND DELIVERY OF CPD

The training aimed to make doctors comfortable with making DNACPR orders. A co-ordinated approach was taken to ensure joined up working between the services. A dedicated palliative consultant was appointed to work with different elements of the services and the same consultant ran three educational sessions in January 2012. Overall 40 GPs across the South Essex PCT area participated in the training, with the intention of delegates cascading the training to the rest of the practice.

The sessions were not compulsory and were two hours long. The sessions were timed to run at different times on different days of the week to enable GPs to attend. The training itself was a mixture of didactic teaching combined with discussion and dealing with different scenarios. The sessions covered advanced care planning including DNAR/CPR decision making, 'best interest' and how the form can be used to share information on the decision made. The course adhered to the Gold Standard Framework.

An e-learning package has also been developed by local clinicians to support all healthcare and care home staff who may be involved in making DNACPR decisions.

4. IMPACT

On completion of the CPD, the doctors are required to complete an evaluation form. They are asked to describe how the CPD has affected their practice and how their new knowledge/skills may have benefited patient care. Participants are encouraged to write a reflective account of their learning and how they have implemented it.

All the Trusts & GP surgeries in the region can now use the same standardised DNACPR the form and ambulance staff are happy to transfer patient with the form. More consultants and GPs are willing to address the issue of DNACPR using the simple form.

The End of Life Register in the community shows a significant increase in the number of DNACPR orders issued. In the last 9 months of 2011 there were 99 DNACPR orders made and in the first six months of 2012 there were 230 DNACPR orders. The DNACPR orders made for patients who have subsequently been discharged into the community as well orders made by GPs so this change reflects the result of CPD activity in both Primary and Secondary Care.

At PCT level, the end of life commissioner hopes to see a reduction in unnecessary hospital admissions including unnecessary or avoidable admissions to A&E in the longer term.

"There are benefits from everybody's perspective" (End of Life Facilitator)

5. BARRIERS

A number of different barriers were identified including:

- The training was not compulsory so some GPs did not attend and in the hospital older doctors were less likely to attend the training sessions.
- Single handed GPs were less likely to implement their learning; they are less likely to want to take a decision they might consider to be risky and they have no one to discuss their difficult decisions with.
- An initial barrier was the coloured form produced by the SHA. Many general practices do not have access to a colour printer and this would mean they had to order the form rather than just being allowed to print the form themselves as and when they needed it. The PCT negotiated with the other partners that the form could be any colour as long as it was filled in appropriately and relaxed the rules to allow the GPs to print the form themselves.

- At a later point the SHA issued a revised form which was produced in triplicate with carbon copies for the GP, the hospital and the patient. Again this meant that the form could not be printed in general practice.
- It can be difficult for GPs where clinically DNAR may be inappropriate and there are divisions within the patient's family.
- In the hospital setting, there has been a problem with junior doctors not obtaining a second signature from a senior colleague. To rectify this, nurses on the ward will become responsible for ensuring that second signature is obtained.

6. LESSONS LEARNT

A number of lessons learnt were identified across the different services:

- The shared form itself provides a framework within which different healthcare professionals can operate with confidence.
- Those doctors that turn up at optional educational events tend to be those that are most interested in the topic and those that may require training do not attend. With the advent of Clinical Commissioning Groups (CCGs), they anticipate that the CCGs will be in a better position than the PCT was to encourage GPs to attend the training in the future and to implement their learning.
- The process of setting up a DNACPR and sharing this information with others has to be kept as simple as possible and anything too complicated will hinder compliance.
- GPs require ongoing support to implement the initiative successfully. The local palliative care consultant will work closely with those GPs requiring support.

“Different GPs have different levels of confidence and some need more support than others, particularly the single handed GPs” (End of Life Commissioner)

(Please contact Dr Patricia Ahlquist (pahlquist@doctors.org.uk) for further details about this case study)

CASE STUDY

7. Educational Leaders Course: Northern Deanery

1. INTRODUCTION

Development of the course came from an invitation to tender from the Northern Deanery to develop a leadership programme for leadership in medical education. It was designed as a bespoke course, in collaboration with the Durham Medical School and Durham Business School, and was aimed at senior medical trainers, including medical directors and deputy medical directors. The aim of the course was not to train how to teach but how to lead and manage others that are doing the teaching.

2. SETTING & LOCAL CONTEXT

This was designed for secondary care aimed at senior medical trainers, eg consultants, medical directors. The participants choose to attend therefore is a self-selective group.

3. NATURE AND DELIVERY OF CPD

The course is a series of workshops and event spread over a four-month period and comprises eight full day events/modules. Four of the days are delivered by the Medical School and four days are delivered by the Business School. Current NHS guidance on leadership is incorporated into the materials, and it is very much an NHS model.

The themes of the modules delivered by the Medical School are:

- Assessment – how to know how effective training has been, how to measure outcomes and looking at areas around measuring validity and reliability (described as the most useful single session). Revalidation is often discussed here, in terms of validity and reliability which generates a lot of discussion.
- Where's my jetpack? – a vision of the future, the use of new technology; new teaching methodologies, simulation etc.
- Safe Practice – evidence based practice, dealing with errors etc
- Research – how to incorporate and interpret research

The themes of the modules delivered by the Business School are:

- Introduction – personal positioning, personal leadership, emotional intelligence, the nature of leadership in the NHS.
- Project Change Management – looking at the NHS, current changes and styles of leadership within the NHS
- Leadership skills – models and roles of leadership styles
- Developing and Improving team performance – how people work as a team, the theories and methodologies

The participants are also offered the opportunity to work towards a certificate from the Chartered Management Institute. This is self-funded – about half of the participants have chosen to do this, and it is formally assessed, e.g., the reflective diary all participants are expected to keep is assessed formally for the certificate.

The resources for the course are placed on the virtual learning environment at Durham University, which all participants have access to.

4. IMPACT

It is very difficult to measure the impact of an intervention like this, due in some part to the nature of the positions which many of the attendees hold, where day-to-day problems and issues can deter putting what has been learnt into practice. However, the success of the particular CPD depends on the participants putting their learning into practice almost immediately and the course organisers felt it was important to 'brand' the course. Participants have a distinctive ring binder, designed to sit on their shelf and is instantly recognisable for the participants as their 'big book of management. The folder holds all the course materials, together with their own personal reflections (in essence an aide-memoir), which they would use if a problem came up which had been covered during the course. Participants were also encouraged to keep an action log, where they would record things that were going to change, together with a date to implement that change.

Although no funding was received to do any follow up work, the organisers carried out a 12 month evaluation, interviewing some of the first cohort, reflecting the importance of this;

"...used tools from the course...developed a plan of action and processes to help with certain tasks...continues to use the things learnt and monitor their effectiveness"
(Feedback from course evaluation)

In the short term, it is anticipated that the participants will be better in their local leadership roles, as well as enabling the gradual development of a cohort with the skills, knowledge and awareness of the importance of supervision, of training which, it is hoped, will have a positive impact on recruitment. Again, the 12 month evaluation interviews reflected this;

"...have taken on a new role since doing the course. More involved with assessing students and measures used. Have been able to implement change in the curriculum" (Feedback from course evaluation)

In the longer term, the expectation is that the participants will go on to hold influential posts in their area, e.g. leading education in their own trust or in their speciality area, with an understanding of the importance of training such as this. They will also have a greater understanding and knowledge of how organisations work and how change might occur, drawing on the skills and training that have developed as a result on participating on this course.

“It’s a word of mouth thing, it’s an influence, we are gradually developing a group of people who have a higher level of knowledge and experience, pot of knowledge and group work, task and finish groups and all that sort of stuff” (Course Participant 1, Consultant Haematologist)

There is also some filtering down into the teaching of the more junior doctors, i.e. Foundation doctors, or first post doctors, i.e. ST1/2, in essence, those starting at the bottom of the continuum of professional development.

“Being able to feed the leadership things that we’ve learnt into that programme has been beneficial to another group so it’s helped us enormously” (Course Participant 2 – Consultant Anaesthetist)

5. BARRIERS

Four main barriers were identified:

- Time: Seen as one of the primary barriers. The majority of participants are consultants, medical or clinical directors, with the expectancy that the demands of these roles should take priority over training. There is a feeling that some trusts are beginning to recognise the importance of leadership training, with recognition that this should be built into educational roles but there is a perception of paying lip service to this.
- Finance: budget holders have to be sure that funding participation on this course will be beneficial to the trust. However the hope is that many of the cohort who have been on the course will go on to achieve positions of authority therefore they will have an understanding of the importance of leadership management and training (at all levels) which will benefit the organisation as a whole.

“there is a tension in medicine between service delivery and good training, so that often expressed itself as being a threat to training budgets, so that was a significant barrier they faced” (Course Director)

- Organisational barriers, in terms of the positions held [or not held] within the organisation by participants, were cited in the interviews, particularly with reference to being in a position to begin to implement learning;

“I think the major thing is to actually be in a position where you are able to do it straight away, if you’re trying to develop people ideally they already have to be in the role to be able to put the stuff into action. Had I been without a decent management responsibility in the organisation it probably would’ve been tricky to actually learn

some of the things without being able to try it straight away.” (Course participant2, Consultant Anaesthetist)

- Cultural barriers; acknowledging that there are people who are resistant to change and will resist being actively managed or who do not want to engage. Skills and training learnt from this CPD enabled participants to recognise those individuals and to use their training to begin to foster change;

“... the whole point of going on the course is to be able to encourage people to become active followers as opposed to disengaged and actively not following” (Participant 2– Consultant Anaesthetist).

6. LESSONS LEARNT

The approach to training – the traditional didactic lecture approach is not suitable for this type of training. There has to be a mix of group discussion, interactive role-play with contributions from the participants.

An application process is now in place to ensure that participants are already in roles that would enable them to begin to implement the training they have received immediately. Previous participants are invited to recommend people who they have identified as having the ability to influence change (due to their position in the organisation) to apply for this training.

The lack of an ‘output’ was seen as being a potential weakness of the training, unless the participants chose to work towards a Chartered Institute of Management certificate, which was voluntary therefore not all participants chose to do so. Participants are now required to develop a QI (Quality Improvement) project during the course.

Understanding that this type of leadership training will show some impact in the short-term, but it is expected that the real benefits will become more apparent over time as some the participants begin to move into leadership roles within their organisations and begin to influence change.

“longer term, influence leadership of education... to increase the importance of supervision, for training, and it’s hoped, for the long term, for the region, if it became known that we are good with trainees...we attract good people to come here, if you get good trainers, you get good trainees following.” (Course participant 1, Consultant Haematologist)

(For further information about this case study please contact Professor John McLachlan, Associate Dean, Durham Medical School at j.c.mclachlan@durham.ac.uk)

CASE STUDY

8. Essential Knowledge Updates: RCGP

1. INTRODUCTION

Since its inception, the RCGP Professional Development Board has overseen and co-ordinated the development of a range of innovative educational resources for GPs to ensure that they have access to high quality CPD products to support their learning needs, career aspirations and to help them to meet their CPD and revalidation commitments. Essential Knowledge Update (EKU) was the first e-learning resource to be produced by the RCGP and has proved to be one of the College's most successful educational products.

There is a constant need for GPs to keep up to date with new information as it becomes available such as the latest NICE guidelines and Essential Knowledge Updates is an e-learning programme designed to meet this need.

2. SETTING & LOCAL CONTEXT

There are roughly 22,000 doctors logging onto the RCGP online e-learning environment where there are wide range of bespoke modules available. This CPD programme is aimed solely at GPs.

3. NATURE AND DELIVERY OF CPD

The aims of the EKU programme are to:

- provide GPs with a quick and accessible way of updating their knowledge on new and changing information relevant to the GP specialty and encourage effective application of that knowledge in clinical practice to enhance their skills and patients' experience
- enable GPs to meet previously identified and unrealised learning needs in relation to new and changing knowledge and information relevant to general practice
- be a key element of a GP's annual CPD folder that can be self-accredited or accredited by peer review
- contribute, in due course, as part of the managed CPD scheme to the provision of evidence of a GP's learning and application in their personal portfolio for revalidation purposes.

The EKU programme deliver a regular and concise synthesis of the most important new and changing information in a series of online modules. They are based on a rigorous and continuous literature search of the preceding six months taking into account NICE guidance, gold standards, research papers and articles of relevance and importance to general practice. At the end of each section there are suggestions for improving practice, audit and links to other sources.

Approximately 8,000 GPs undertake each six month session. The six month courses run over three years. The courses and assessments are free to all PCGP members, associates in training, and GP foundation members. Each online learning update is supplemented with a Podcast to add to the learning experience.

4. IMPACT

At the end of the six month period doctors undertake 50 questions in a multiple choice question format. This is an open book test. GPs are told their mark relative to others in the top quotient. The e-learning module produces Challenge Benchmarking Graphs so that GPs can compare their scores with others. The Updates Challenge allows doctors to capture any learning or service needs in their Personal Development Plan (PDP) and will also recommend further reading. A clinical scenario is also made available allowing doctors to demonstrate that they have assimilated, or already know the information in the Update item. Doctors can demonstrate their learning if they can show how they have implemented their learning in the practice.

Doctors can choose to undertake the Challenge before working through the Updates to provide them with a baseline before learning.

Feedback on the Update programme (based on a star rating and an online questionnaire) indicate a high level of user satisfaction. All participants are asked to give examples of things they would do differently having completed the Knowledge Challenge. Some of the responses given are set out below:

“Do a full blood count earlier in menorrhagia”.

“Use different analgesia in low back pain”

“Be more confident with substance abuse problems “

“Increased confidence to diagnose bronchiolitis”

“Increased awareness of red flags in children”

“More confident in asthma management”

“Better information to patients re: smoking cessation”

“More aware of the issues around prescribing varenicycline”

“Take on board the latest guidelines re UTI in children and the timing of further investigations”

“Telephone triage of back problems”

“Referral of children with UTI”.

5. BARRIERS

It is suggested that older doctors are less likely to engage with e-learning than younger doctors. In addition older doctors are not used to having to demonstrate learning whereas younger doctors are very familiar with this process.

Some of the doctors undertaking the Challenge have complained that they are not told specifically which questions they have failed but the feedback is deliberately constructed in this way to ensure a broad focus.

6. LESSONS LEARNT

Originally a pass or fail system was employed with a pass mark of 70%. This was reviewed and given the focus of the Updates was for CPD purposes rather than providing a qualification, it was decided to remove the pass or fail system and instead a benchmarking system was established to allow GPs to compare themselves with others.

The RCGP are constantly looking to improve the Essential Knowledge initiative and in the future would like to develop further interactivity.

(For further information about this case study please contact the RCGP at eku@rcgp.org.uk)

CASE STUDY

9. External Quality Assessment Scheme: Pathology

1. INTRODUCTION

Traditionally slide clubs and slide circulations had always been part of the education of histopathologists and the first External Quality Assessment (EQA) Schemes built on this in a more formalised system. Professor Furness in the early 1990s developed a computerised system to record and analyse results for the UK Renal EQA scheme and this acted as a blueprint for other schemes. The program he developed (using an OMNIS database system) recorded case details, organised circulations and allowed organisers to enter participant's results. It provided a system to calculate frequency of each answer and then to distribute personal analyses to individuals. It also enabled "poor performers" to be identified and monitored.

2. SETTING & LOCAL CONTEXT

EQA schemes are aimed at pathologists across the UK. There are a variety of different histopathology schemes including specialist and general schemes; intended for specialist and general Pathologists, respectively. Specialist schemes include gynaecological, urological, renal, dermatopathology. In total there are over 15 schemes and they are all hosted on the website of the Royal College of Pathologists. The UK Uro pathology scheme started in the early 1990's but it lapsed in late 1990's. In 2006 the scheme was restarted by Dr Mayer and it has grown from just over 100 participants to over 300 today. This slide-based U.K. National Scheme is open to all practicing Consultants and is aimed at those with a specialist interest in Uro pathology. The scheme is overseen by the British Association of Urological Pathologists (BAUP) and the scheme SOP's have been approved by the RCPATH EQA Steering Committee. An outline of the scheme can be found at [Histopathology EQA](#) and also at the [British Association of Urological Pathologists \(BAUP\)](#).

3. NATURE AND DELIVERY OF CPD

Most pathologists participate in multiple EQA schemes, the precise scheme undertaken will depend upon their specialist interests. The two compulsory specialist EQA schemes are Breast and Bowel Screening (this is true but it is also worth stating that as part of the peer review process it is a requirement to demonstrate that the clinical leads in a particular cancer area participate in relevant EQA schemes). There are usually two circulations of slides per year for each EQA scheme (Figure 1).

In each circulation pathologists participating in the scheme are sent a set of slides for diagnosis together with a clinical history and any additional investigations performed at the time of the original diagnosis. They are asked to report on them independently. The results are collated and compared with peers anonymously.

Interpretative schemes in histopathology differ from EQA schemes in other disciplines e.g. clinical chemistry where there is a single numeric score which can be marked. Furthermore, schemes use different methods to define an acceptable diagnosis, some using an 'expert panel' of pathologists who agree on suitability of a case and on a diagnosis prior to the circulation, and others using a consensus approach where the acceptable diagnosis is agreed at an open meeting of the participants. The decision-making around each slide is not 'black and white' and needs to be debated in each case by a group of pathologists. There can be multiple reasons for discrepant diagnoses e.g. variations in staining quality of sections, lack of diagnostic material in a given section (which is particularly a problem when using small biopsies) and additional clinical or pathological information used to make the original diagnosis that was not provided by the submitting pathologist. These must all be taken into consideration when deciding whether a case is suitable for scoring. Most schemes predefine a percentage level of agreement for all cases and if there is less than this level of agreement of responses then the case is not used as a scoring case

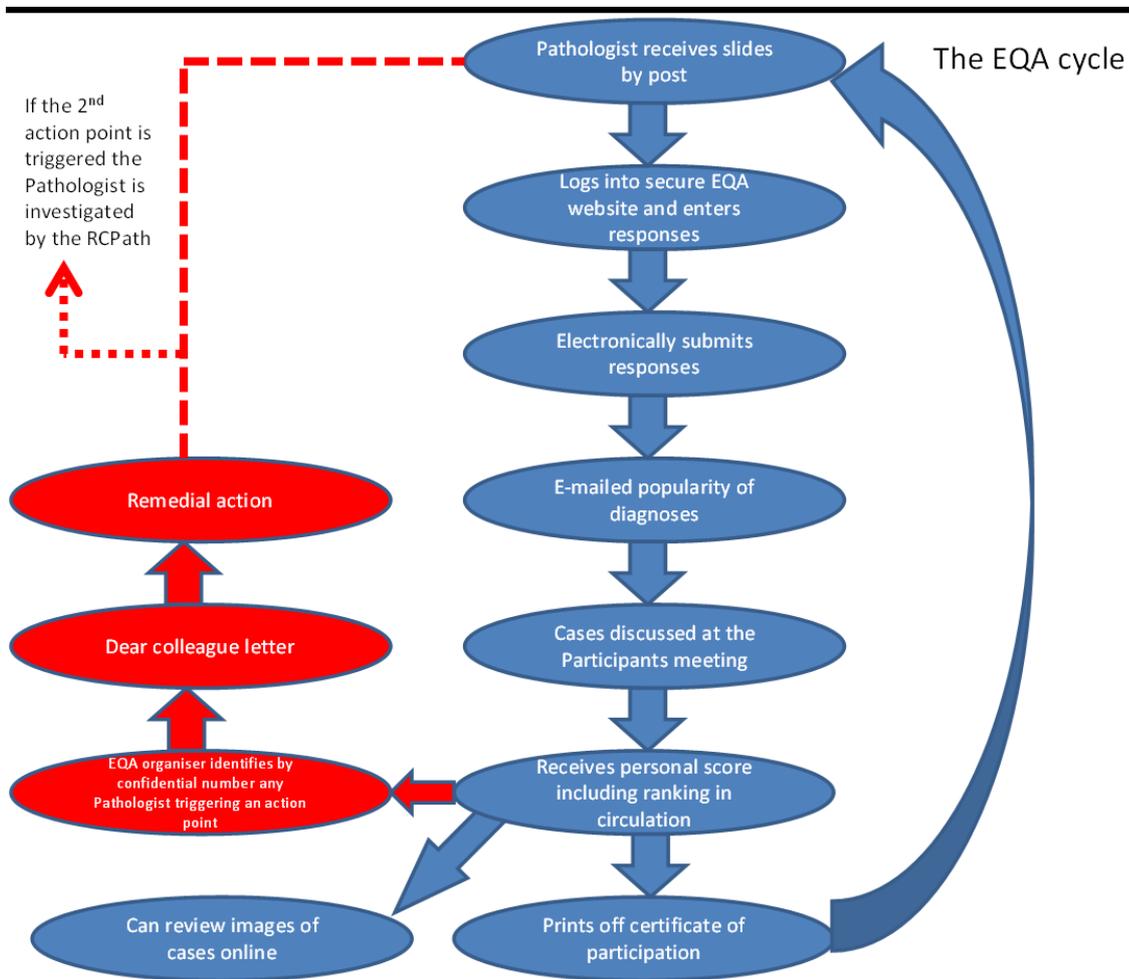
4. IMPACT AND DELIVERY OF CPD

Because of the interpretive nature of histopathology it can be difficult for Pathologists to get feedback in the same way as other specialities. EQA schemes are primarily educational. However, they also allow each member of the scheme to anonymously receive their own personal score which they can compare with their Peers. This can be useful information for formulating career development plans and in planning continuing professional development.

Schemes also need to have a mechanism of ensuring Patient safety through defining poor performance. Most schemes use the definition of a score in the bottom 2.5% (some use centiles) in 2 out of 3 consecutive circulations as sub-standard and this triggers the 'first action point'. If a doctor falls into the bottom 2.5% in any 2 out of the next 3 circulations then the 'second action point' is triggered and the Pathologist is investigated by the Royal College of Pathologists. It is the experience of the longest running EQA schemes that the triggering of the second action point is a very uncommon event and it is well recognised that low scores in EQA do not necessarily equate to a 'dangerous' Pathologist. There can be multiple reasons for low scores including excessive daily workload. It is also noteworthy that EQA schemes have not been independently validated for the identification of poor performers and their function primarily is educational.

According to the Royal College, Pathologists also use the EQA schemes to inform their appraisals and expect it to also inform their revalidation in the future.

Figure 1: The EQA Cycle



5. BARRIERS

There are a number of problems with running an EQA scheme in pathology. Historically slides have been sent direct to the pathologists by post. These slides can get lost or broken. The schemes require large numbers of duplicate slides but sometimes diagnostic features can change as further slides are sectioned (particularly in small biopsies). Digitisation and electronic circulation of images offers an alternative to circulating glass slides and is being increasingly employed by some schemes, but image quality and speed of download of images in many Trusts are on-going challenges. Furthermore, many Pathologists are uncomfortable with diagnosis from digital images as this does not replicate normal practice.

6. LESSONS LEARNT

Anonymity of participants and confidential feedback are founding principles on which EQA schemes were developed and are important to ensure the continued participation in the EQA schemes.

Example of a case used in the EQA scheme

Chromophobe renal cell carcinoma is a variant of kidney cancer that has a different prognosis to other types of renal cancer and it is important to diagnose this correctly. The tumour has characteristic morphological features and expresses particular proteins, which can be detected using a technique called immunohistochemistry.

These tumours are relatively uncommon so an individual Pathologist may go a considerable amount of time before seeing one. Examples of these tumours have been used in several of the Uropathology EQA slide circulations and there has been improving diagnostic agreement over time {see Table 1} suggesting there is genuine educational value from participating in the scheme.

Table 1

| Chromophobe RCC | | | | |
|------------------------|-------------|------------------------|---------------------------------|-------------------------------|
| Diagnostic agreement % | Circulation | Number of participants | Alternative diagnoses proffered | Immunohistochemistry provided |
| 83.9 | A4 | 120 | 5 | Yes |
| 95.1 | B14 | 120 | 4 | Yes |
| 95.7 | D38 | 143 | 3 | Yes |
| 96.4 | H95 | 228 | 8 | Yes |
| 99 | I108 | 255 | 2 | Yes |

Although Pathologists tend to prefer to make diagnoses from the circulated glass slides, there is a web-based virtual microscope hosted by Leeds University which allows the Pathologist to refresh their memory of the case at their leisure and can be annotated retrospectively after the circulation closes to emphasise important diagnostic features, making it a valuable educational resource for Consultants and trainees.

(For further information about this case study please contact Dr Jon Oxley at Jon.Oxley@nbt.nhs.uk)

CASE STUDY

10. The Frontier Programme: London Deanery

1. INTRODUCTION

The Frontier Programme aims to facilitate CPD for Staff grades, specialty doctors and associate specialists (SASG) primarily and subject to availability of funds, other middle grade doctors as well. In 2008 the Department of Health allocated funding to Deaneries across the country specifically for CPD for SASG doctors. Frontier is the work stream within the London Deanery which formulates, commissions and delivers targeted CPD. It aims to ensure that:

- CPD needs of SASG doctors are adequately met
- Funding is used efficiently and effectively
- SASG doctors are actively involved in identifying their own further development needs
- Local education providers are supportive towards SASG doctors in accessing CPD activities
- CPD serves to improve career prospects and patient care
- Lifelong learning becomes a core component of SASG careers
- Closer professional links are forged between all stake holders such as local education providers, Royal Colleges, faculties, and the London Deanery in improving CPD for SASG doctors.

2. SETTING & LOCAL CONTEXT

CPD delivered by the Frontier programme is aimed at all SASG and other middle grade doctors within the London region. The programme works in many ways. For example;

- Sponsorship of CPD for individual doctors who can apply for funding for specific CPD online.
- Provision of Frontier study days for organisations. These days offer an educational session with CPD points on a topic chosen by the Trust, allowing doctors to focus on their own specific learning needs.

- Secondments in areas of practice which may require the doctor to attend sessions in another setting where they can learn the skills under an expert supervisor. Frontier supports such arrangements by funding back fill for locum cover.

Doctors are encouraged to apply to their own trust first for funding before applying to the Frontier Programme.

3. NATURE AND DELIVERY OF CPD

All doctors applying for funding for CPD from the Frontier Programme need to show that the CPD is in their Personal development Plan and they must have a supervisor who will support their application. They need to demonstrate links to organisational objectives as well as personal objectives. In particular applicants are asked to show how the CPD will contribute to patient care and how it will relate to the four domains of good clinical practice:

The CPD might be delivered by the Deanery itself; alternatively it might be provided by an external provider such as a Royal College.

4. IMPACT

To be eligible for support from the Frontier doctors are required to demonstrate how the CPD will contribute to organisational objectives and patient care as well as personal objectives. On completion of the CPD, the doctors are required to complete an evaluation form. They are asked to describe how the CPD has affected their practice and how their new knowledge/skills may have benefited patient care. Examples of how the CPD undertaken has changed practice are given below:

“I feel more confident to see, examine and treat those cases where I had difficulty earlier. Also this course has given me an initiative and foundation to prepare for upgrading exams like Dip GUM which is vital for career progression” (Course Participant 1)

“I am now more confident and capable of independent working within a multi-disciplinary team”. (Course Participant 2)

“Improved my clinical knowledge” (Course Participant 3)

In terms of impact on the organisation and patient care:

“Long unnecessary waiting times for potential patients are reduced because I am able to see complicated cases and make decisions yet take a quick second opinion if required.” (Course Participant 1)

“My patient care and skills are definitely better”. (Course Participant 2)

“Better and safer care”. (Course Participant 3)

“Improved communication with colleagues and patients”. (Course Participant 4)

“This has a direct impact in the working environment... More patients are seen in a timely manner”. (Course Participant 5).

In terms of impact on the wider team:

*“Will impart this knowledge to my colleagues during clinics and teaching sessions”
(Course Participant 3)*

A Director of Medical Education for a large Mental Health Trust reported on a leadership skills course provided by the Frontier programme on their site for 25 staff grade doctors. This CPD was offered in addition to the Trust leadership programme. She noted that in the past there has been a reluctance on the part of staff grades to get involved in QIPP. They have now seen a huge increase in getting involved in managerial roles. Benefits of the CPD were identified at two levels:

- Benefit to the individual - doctors have made requests to take on new leadership roles in their job plans to be allowed to undertake a management role or quality improvement. Delegates also had the opportunity to network with each other.
- Benefit to the organisation – At a strategic level in terms of improving the quality of services which in turn has a beneficial impact on patients. The training is also considered to be very cost effective.

5. BARRIERS

SASG face barriers to undertaking CPD within their own Trusts, not least the lack of funding for this activity. The funding of the Deaneries is supposed to overcome this problem. The organisers of the Frontier programme identified lack of adequate educational supervisors as one of the main barriers.

“SASG doctors require the support of an educational supervisor and to a large extent this is dependent upon the good will of other doctors. It is a time consuming role and not everybody is willing to take this role on.” (SASG lead for CPD at the Frontier Programme).

6. LESSONS LEARNT

Implementation of learning is encouraged as applicants are asked to reflect upon how the CPD will impact on their practice when they apply for sponsorship.. Following good practice of reflective analysis, Frontier encourages the applicants to write a reflective account to demonstrate the impact of their learning on themselves, the wider organisation and on patient care.

“SASG are a valuable group of doctors. With revalidation commencing from 2013, all doctors have to prove that they are fit to practice and up to date. This requires investment of time and resources. While other groups have training and CPD embedded in their training or development programmes, middle grades need support to access CPD” (SASG lead for CPD at the Frontier Programme).

(For further information about this case study please contact Dr Naila Kamal on Frontier@londondeanery.ac.uk)

CASE STUDY

11. Medicines Management: James Paget

1. INTRODUCTION

The James Paget Hospital was asked to make improvements to its medicines management following a visit by the CQC (Care Quality Commission). The training aimed to minimise the risk of drug errors in the prescribing and dispensing of drugs in a hospital ward setting.

2. SETTING & LOCAL CONTEXT

This CPD initiative was aimed at hospital doctors within a single acute Trust and was made mandatory training for all doctors and nurses. Nurse prescribers also received training on the prescribing aspects. Senior nursing staff were also trained and they in turn delivered the training to other nurses.

3. NATURE AND DELIVERY OF CPD

The CPD was developed in-house and delivered to doctors of all grades across the whole Trust. Five key aspects of prescribing were covered by the training:

1. Legibility; this included the use of capital letters written in indelible ink, avoiding the use of abbreviations (such as “u” for units), and avoiding the alteration of prescriptions and rewriting them instead.
2. Antibiotic prescribing; this recommended confirmation of the indication for and duration of antibiotic use.
3. Stopping and starting drugs. This aspect covered how doctors should communicate the stopping and starting of new drugs on the chart to ensure clarity and avoid confusion, including explaining why a drug had been stopped.
4. Omissions. This included communicating the reasons for omitting a prescribed drug with an emphasis on minimising the number of omitted drugs and justifying omissions appropriately.
5. Reconciliation of medicines when a patient arrives in hospital to ensure that they are in receipt of the appropriate treatment.

The course leaders reviewed all recent guidance to ensure that best practice was adhered to. The implementation of the learning was supported by the development of a new drug chart which was designed to reinforce or prompt the key issues. For example, the new drug chart has a box on the front of it which prompts the doctor to conduct the reconciliation of drugs when the patients first arrives and formally document it within the drug chart. The training was made compulsory for all doctors and 301 doctors were trained over a two month period in 2012. The drug chart also captures a sample of each doctor's signature so they can be cross referenced to prescriptions. The drug chart was revised twice during the training period, with opportunities for users to feedback using a dedicated email address.

4. IMPACT

All prescribers in the Trust were trained in medicines management. As a result of this initiative all affected patients had their prescriptions updated in accordance with revised guidance and all GP colleagues were made aware of the change in guidance.

Regular audits were established to monitor the implementation of the medicines management training. A number of consultants were selected at random and six patients were sampled for each Consultant. Data was collected for the audit from the patients' drug charts and Health Care files. The audits focused on a number of key criteria indicated in the table below.

| Criteria examined in the medicines audit | |
|--|---|
| Medicines reconciliation | Alterations made |
| Recording of intentional changes to medicine | Use of old drug charts |
| Prescribing of antibiotics | Omissions and reasons given |
| Recording of indications for 'as required' medications | Communication of stopped drugs including signatures and reasons given |
| Legibility | Drugs prescribed with non-daily dosing |
| Accuracy of dose recording | |

An analysis of the audit data over time shows a reduction in prescribing errors and an overall improvement in compliance. When the CQC carried out their follow up visit, they found that their concerns about medicines management had been addressed. The course organiser has noted that there is an ongoing need for training in this area as new staff arrive and there are plans to roll out the training to the new tranche of junior doctors who will join the Trust in the summer.

"These initiatives resulted in an improvement which seems to have been sustained"
(Consultant Gastroenterologist, Course organiser)

5. BARRIERS

Initially the course organisers experienced difficulties in achieving high levels of attendance. The Trust response was to work with both Clinical Governance and the line managers of those who had not attended to ensure the CPD was undertaken. Some of the more experienced doctors expressed cynicism towards the training and could not always see the need for it. There were some stragglers that were resistant to undertaking the training and some of these had to be trained on a one-to-one basis. The trainers were able to emphasize the CQC requirements for the training to encourage

attendance. The audit department also implemented a number of initiatives to encourage implementation of the learning and compliance, including:

- Issuing weekly key messages to all prescribers about the standards expected.
- Developed a 'task force' who undertook visits to the wards to review compliance and speak directly with prescribers
- Expanded the task force to become a multi-disciplinary team who selected areas reviewed a sample of drug charts. A Consultant was included in each team. The involvement of Consultants in this process meant they were better able to understand the nature and the scale of the problem and to tackle the issue when teaching junior doctors as well as making changes to their own practice.

6. LESSONS LEARNT

With hindsight the course leader was aware of the huge amount of time taken to design and deliver the course on the scale required. The course organisers found that routine documentation can be used to support both the implementation of learning and also audit the implementation itself. In this case the drug chart was re-designed to act as a prompt to implement actions which had been covered by the CPD. The drug chart was also used to capture this implementation and so could also be used to monitor the take up.

Initially the audit was carried out at ward level, however the Clinical Governance team found that where the data showed a lack of compliance it was difficult to do anything about this with only ward level data. They recognised that in order to persuade doctors to change their prescribing behaviour they needed to be able to present them with individual based feedback. The second audit round was changed to collect data at the level of individual doctors which enabled the Trust to tackle the behaviour of individual doctors. By focusing the audit at individual doctor level, they were able to give direct meaningful feedback to doctors about their own prescribing behaviour and the risks to patients where this fell short. This action had a direct impact on compliance and demonstrates the power of benchmarking.

(For further information about this case study please contact Dr De Silva at anups.desilva@jpaget.nhs.uk)

CASE STUDY

12. Mental Health Law Training Programme: Leeds and York Partnership NHS Foundation Trust

1. INTRODUCTION

Leeds and York Partnership NHS Foundation have developed and delivered a series of mental health training courses delivered through the Andrew Simms Centre, a provider of regional and national conferences, workshops and seminars, in the fields of mental health and learning disabilities.

2. SETTING & LOCAL CONTEXT

The courses have gained in reputation so are now attended by professionals from across the UK. A key factor in developing this reputation has been the role played by known experts in the field such as Dr. Tony Zigmond (The Royal College's lead for mental health law reform), who come together to provide a Mental Health Law multi professional training team including clinicians and social workers.

"Dr Zigmond is a tour de force and a very good teacher." (Course Participant)

The programme of courses has evolved over the years to reflect changes in the legislation. The following table outlines the number of trainees attending these courses over the last two and a half years. This list omits additional one off courses run by the team.

| Course | 2012 (6 months) | 2011 | 2010 |
|---|-----------------|------|------|
| Mental Health Law update | 98 | 62 | 21 |
| Approved Clinician induction | 31 | 55 | 55 |
| Section 12 Induction with Deprivation of Liberty Safeguards | 37 | 55 | 45 |
| Deprivation of Liberty Safeguards | 14 | 14 | 14 |

The courses are attended by a range of professionals however the majority are doctors.

3. NATURE AND DELIVERY OF CPD

The team develop courses to respond to the changing landscape of mental health legislation and the four courses outlined below are part of the core programme and supplemented by additional courses.

- ***Approved Clinician induction***

A two-day course, approved by the East Midlands and Yorkshire Regional Advisory Panel, which is designed to deliver the necessary training to those who are able to demonstrate the required competencies and wish to take up the role of Approved Clinician.

- ***Mental Health Law update***

A one-day refresher course accredited by the East Midlands and Yorkshire Regional Advisory Panel as a refresher course for Section 12 approved doctors and Approved Clinicians and is valid for those attending from other parts of England. It is also designed to deliver the regulatory requirement for annual further relevant training essential for Deprivation of Liberty Safeguards (DoLS) Mental Health Assessors. The course provides an update on statutory changes as well as significant case law.

- ***Deprivation of Liberty Safeguards***

All professionals caring for or treating adults who lack capacity to decide about their care need to be aware of the legal framework and the implications for their practice. In particular Section 12 approved doctors and Approved Mental Health Practitioners need to understand when to use the Mental Health Act and when to use the Mental Capacity Act. This course is designed to deliver Module 2 of the Royal College of Psychiatrists' DoLS Mental Health Assessor Training Programme for Section 12(2) approved medical practitioners.

- ***Section 12 Induction with Deprivation of Liberty Safeguards***

This course has been accredited by the East Midlands and Yorkshire Regional Advisory Panel for practitioners requiring approval for the first time under Section 12 of the Mental Health Act and is valid for those attending from other parts of England. It also fulfils the requirements for approval as a DoLS Mental Health Assessor (Module 2 of the Royal College of Psychiatrists' DoLS Mental Health Assessor Training Programme for Section 12(2) approved medical practitioners). It provides an interactive forum for discussion of the practicalities and ethics of using mental health legislation and an opportunity to discuss potential clinical dilemmas. It aims to equip trainees with the essential knowledge for day to day implementation of the Act.

"I really liked the pleasant colleague to colleague style and the new detail conveyed." (Delegate)

"Excellent presentations and facilitators and broken down into manageable components." (Delegate)

“All speakers were excellent, with very well formulated case studies. A dry subject made extremely digestible” (Delegate)

4. IMPACT

The courses have the following stated training objectives:

- ***Approved Clinician induction***
 - Understand the main provisions of the Mental Health Act 1983 as amended
 - Understand more clearly the role and responsibilities of the Approved Clinician and appreciate the roles of other key professionals
 - Apply to be included on the Approved Clinician register (subject to meeting the other requirements to become an Approved Clinician)

- ***Mental Health Law update***
 - Apply to renew Section 12 / Approved Clinician approval through the trainees local approvals office
 - Demonstrate further relevant training to continue to act as a DoLS Mental Health Assessor
 - Understand recent statute law and appreciate the effects of recent case law
 - Discuss how these changes could affect practice.

- ***Deprivation of Liberty Safeguards***
 - Understand the main features of the relevant Mental Health and Mental Capacity legislation
 - Become familiar with the mechanisms of deprivation of liberty authorisations
 - Understand the roles of the professionals involved in deprivation of liberty authorisations
 - Feel more confident about applying the legal framework to everyday work

- ***Section 12 Induction with Deprivation of Liberty Safeguards***
 - Apply for or renew your Section 12 approval through your local approvals office
 - Act as a Mental Health Assessor for the Deprivation of Liberty Safeguards (subject to successful S12 approval)
 - Understand current developments in mental health legislation.

The perceived impact of the courses is that they may increase the number of section 12 approved doctors and robust training in this area should ensure that patients are only detained only when legally and ethically necessary and all the legal requirements are fully met. S Services should also become safer with fewer legal claims arising from patients being detained under the Mental Health Act.

“I don’t know how I could contemplate starting my SpR rotation without completing this course” (Delegate)

“The vignettes, particularly illustrating situations where it could go either way, and capacity applications were very helpful in boosting my interest in these clinical situations to serve patients better.” (Delegate)

“Knowledge of the CTO rescindment and automatic tribunal is important.” (Delegate)

“An enlightening and interactive course, extremely helpful for understanding case law” (Delegate)

5. BARRIERS

Advertising and promoting the courses was something of an issue in the early days but is less of a challenge now as the courses have become more established and built a reputation. The courses now have a reasonable Google rating so may be picked up by web searches.

For those delivering on the course finding the time to train alongside other work commitments can be something of a challenge.

Much of NHS Psychiatric services are delivered via Integrated Care Pathways (ICP's) which are structured pathways that the majority of patients presenting with mental illness will follow during their treatment. The structured nature of the care can be a barrier to implementing changes in the light of learning from CPD.

A major barrier to change is the multi agency involvement in delivering psychiatric care – the funding available from Local Government for patients can be an issue in respect of change and service improvements.

The Trusts CPD service ensures that events are provided locally and it is responsive to requests for specific issues to be addressed. The study leave budget for Consultants within the Trust is fairly generous in that it is adequate for Consultants to access the CPD which they feel is appropriate.

6. LESSONS LEARNT

Key lessons learnt were identified:

- Having a known expert has helped to increase the credibility and popularity of the course.
- There are strong established relationships across the multi disciplinary team which a strength.
- The course is delivered through an established training centre which supports and coordinates the practical arrangements.
- The course has evolved and developed over time to reflect both the current landscape and legislative framework but also taking on board feedback from course evaluation.
- The courses use combined educational modalities combining didactic approaches with vignettes which provide genuine recognisable and practical examples.

- It is very difficult in Psychiatry to see if an individual's CPD has had an impact of how care is delivered as much of the treatment of patients suffering from mental illness is system based rather than procedure based. The evidence base for Psychiatry is a 'bit thin' and there is a feeling of there being 'nothing new under the sun' when it comes to treatments etc. Much of Consultants CPD activity serves to reassure, install confidence etc. that how they are treating their patients is the same as everybody else is.
- The biggest influence on patient outcomes is the relationship between primary and secondary care and the interaction between these bodies and the other organisations i.e. Local Government involved in providing support etc. to the patient.

"Really enjoyed the case vignettes session - very thought provoking and informative." (Delegate)

(For more information contact Nick Brindle on 0113 3055553)

CASE STUDY

13. Mental Capacity Act: South Essex Partnership Trust (SEPT)

1. INTRODUCTION

In February 2011 new case law came from a Court of Appeal Judgment that required all psychiatric units to review the way in which incapacitated compliant psychiatric inpatients were being kept in these units. The case was that of *P and Q (also known as MIG & MEG) v Surrey County Council* [2011], which concerned two sisters, aged between 18 and 19, who had substantial and permanent learning disabilities. They both lived in some sort of care setting in the community and lacked capacity to consent to these placements and, as they were not free to leave and under continuous supervision and control, it was argued by their official solicitor that they were being deprived of their liberty

In summary the Judge made it clear that hospitals that were authorised as ‘detaining institutions’ were to be distinguished from homes of carers or nursing homes. Essentially if you are not free to leave the latter, you are not necessarily being deprived of your liberty. But if you are not free to leave a detaining institution, such as a psychiatric hospital, then you probably are being deprived, regardless of whether you are objecting to being there or not. The East of England’s Regional Implementation Network (RIN) for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) drafted guidance on how this new case law should be interpreted and implemented in all psychiatric settings. The guidance emphasised that if a patient who lacks capacity is not free to leave in the psychiatric inpatient setting, then they are being deprived of their liberty and the service provider will need authorisation to do this, either under the Mental Health Act (MHA), 1983 (if they are objecting) or DOLS (if they are compliant).

SEPT took the guidance on board and decided that the best way to implement this would be through an action plan which focussed on a change in policy in relation to DOLS and an intensive training programme across the whole of the organisation. SEPT manages many psychiatric hospitals and units, consisting of a total of 28 psychiatric wards as well as forensic units and community hospitals with many more inpatient wards. Initially SEPT focused on implementing the policy only on the psychiatric wards as this is what the new case law and guidance specifically related to. The action plan reflected this and stage 1 was therefore aimed at training the multi-disciplinary teams working in these settings, such as doctors, nurses and other support staff.

An audit was completed all of SEPT’s inpatient settings which showed that older peoples, learning disabilities and rehabilitation wards would be most at risk of non-compliance with this new case law

and guidance, as they had the highest number of patients who lacked capacity. Highlighting the high risk areas ensured that the training action plan targeted these wards first. It also generated baseline data that could be compared to data gathered during and after the implementation of the training and new policies to ensure that it was done effectively. The audit further highlighted that the staff of these wards also needed refresher training around the Mental Capacity Act (MCA) 2005.

2. SETTING & LOCAL CONTEXT

All doctors who act as responsible clinicians on psychiatric inpatient settings were included in the first stage of the training action plan (targeted specifically at inpatient settings). Other doctors, such as community consultant psychiatrists, staff grade doctors and doctors acting as Section 12 doctors under the MHA and/or DOLS were also included in the lecture style and CPD training sessions described below. SEPT employs approximately 200 doctors and about half of these doctors have already been included in the training action plan. By the end of this financial year, all doctors will have had some CPD training around the MCA, DOLS and related case. The training is being extended to all the General Practitioners in the South of Essex.

3. NATURE AND DELIVERY OF CPD

Stage 1 of the action plan's training section commenced in October 2011. The following training methods were used:

- One-to-one sessions with some members of staff to offer intensive support and training by working through every case on their ward to demonstrate how the MCA and new guidance on DOLS might apply to each one of these cases. This method was mostly used with ward managers, doctors and senior members off staff on high risk wards. In some cases they would then cascade this training down to other ward staff.
- Interactive group sessions with no more than 5 members of ward staff, during which they received refresher training on the MCA and how the new guidance on DOLS might be applied. This was often arranged by the ward managers for their staff after they themselves had the initial one-to-one sessions described above.
- Larger training sessions were also arranged on wards for groups of between 10 and 15 members of staff at a time, especially on the lower risk wards where the aim was more to raise awareness than to change existing practice.
- Lecture style training sessions were further offered outside of the wards, but aimed at particular groups, such as the doctors. One of the trainers visited the doctors' weekly education session to raise awareness of the changes in law.
- Other CPD training sessions were also used to explain the new case law, such as those targeted at staff that may be assessing under the DOLS and related legislation. These CPD sessions included those for Approved Mental Health Professionals (assessing under the MHA), Section 12 Approved Doctors (assessing under both the MHA and DOLS) and Best Interest Assessors (assessing under DOLS).

By the end of March 2012, all the work on the high risk wards was completed and some work had already commenced on most of the moderate to lower risk wards. Various training sessions had been completed at this stage.

4. IMPACT

The impact of this training action plan to date is clearly measurable through data collected via audits and other SEPT information systems. The implementation of such an intensive training action plan increased SEPTs combined MCA and DOLS activity by 101.18% from March 2011 to March 2012.

There was also a significant increase in activity recorded within 2011/2012 since the implementation of the training action plan in October 2011 - MCA activity rose by 194.52% and DOLS activity rose by 600% after implementation in October 2011.

The risks of potentially unlawful deprivations are now fully addressed. Other benefits of implementation included:

- Providing evidence to CQC that the Trust had a robust plan in place to achieve compliance in relation to MCA, DOLS and consent to treatment.
- Providing re-assurances to SEPT's PCT commissioners that they have policies, procedures and an action plan in place for assessing capacity appropriately and to ensure that they do not deprive any person unlawfully in their inpatient settings.
- Training staff from various disciplines in relation to the necessary MCA/DOLS legislation that may apply on inpatient settings.
- Building the reputation of SEPT.

5. BARRIERS

Implementing any new legislation via training requires a change in current thinking and practice. It is important to manage this change alongside the implementation of the new legislation and policies. Doctors, and all the other professionals affected by these changes, all needed additional time and support to process the changes and think about how they could implement it in practice. This process had to be led by the doctors and others affected.

"We had to consciously refrain from implementing the action plan in a way that was too descriptive or too driven by targets and risk management."(SEPT course organiser)

This was hard to do at times, as the changes were driven by a change in case law and by guidance issued at regional level, which was seen as a burning platform to drive the implementation of the action plan at an incredible pace.

"we had to constantly stop and reflect on how it was being implemented to ensure that we were not just delivering a training programme, but also a process through which all affected could be involved and supported to make the necessary changes in their everyday practice in a way that was acceptable to them, whilst still being compliant with the law".(SEPT course organiser)

6. LESSONS LEARNT

The success of the action plan is evident from the significant increase in MCA and DOLS activity, has been largely due to the training being intensive, flexible and adaptable to individual need. They have been able to provide a much more hands on approach and offer one-to-one support. The course organisers believe that other methods of training, such as e-learning, has its benefits, such as helping staff keep up to date, but does little in terms of managing that initial change in thinking and practice, nor does it give staff the opportunity to reflect ideas off others or to discuss how any proposed changes may be applied to individual cases. Face-to-face training and follow up support was thought to require more resources, but it was felt that it had definitely led to better outcomes, such as embedding learning into practice.

(For further information about this case study please contact Elmari Bishop from South Essex Partnership Trust (SEPT) on Elmari.Bishop@sept.nhs.uk)

CASE STUDY

14. Musculo-skeletal Pathway: Sheffield PCT

1. INTRODUCTION

Spinal pain is one of the most commonly seen conditions in primary care. Whilst the majority of cases clear up within six weeks, a significant proportion (3-10%) go on to develop chronic back pain. The main risk factors for developing chronic back pain are psychosocial factors, such as fear/avoidance of movement, depression, and 'catastrophizing attitude' towards the pain. However many GPs fail to acknowledge the psychosocial issues affecting their patients. Referrals to secondary care surgical spinal teams at baseline were around 100 per month with a conversion rate to surgery of 20%. This initiative combined face to face training sessions for doctors and physiotherapists with the development of a musculoskeletal website for doctors. The overall aim of the initiative, developed in 2008, is twofold:

- To support best practice for clinicians and
- Best practice for patients.

A key aim was to generate more appropriate referrals for back pain and reduce the number of inappropriate referrals. GPs were trained to make a more thorough assessment of the patient including psycho-social factors, to use a back screening tool known as the Keele StarT Back Musculoskeletal Screening Tool to help stratify risk of chronicity (an evidence based, simple 9 question tool, designed for use in primary care). The tool enables the GP to allocate the patient to one of three risk categories from low to high.

GPs were trained to make a more thorough assessment of the patient including psychosocial factors, to use the StarT screening tool, information on NICE guidance including agreed patient pathways, and to risk assess the patients. Alongside the educational component of the initiative, the course authors also developed the website provides much of this information for GPs together with a section for patients where they can complete the screening tool for themselves.

Before the GP training could commence, the course authors had to work with partners across the health community to agree a local pathway and create a specification for a physio-led spinal team that would act as the first point of referral from primary care. They requested that all non urgent spinal referrals pass through these teams as opposed to direct referral to hospital surgical spinal teams. They then developed patient information leaflets, assessment tools, and education materials for professionals. The website (www.sheffieldbackpain.com) was developed to act as a hub for all this

information for both professionals and patients, and to assist with implementation of the pathways in parallel to the face to face training.

2. SETTING & LOCAL CONTEXT

This is a joint initiative which spans both primary and secondary care; the stakeholder group included primary care, physiotherapy based in community care, secondary care (orthopaedics, rheumatology, neurosurgery, radiology and chronic pain), patient representatives from Arthritis Care and management. The CPD was delivered to GPs in primary care. The stakeholder group developed a local consensus to agree on the best evidence and developed the new patient centred, patient pathway and agreed on information to be displayed on the website. Approximately 5-6,000 patients a year with spinal pain in physiotherapy.

3. NATURE AND DELIVERY OF CPD

GPs were invited to two city wide 4 hour events held on 13th and 28th September 2012 with 330 doctors attending each event. The new patient pathway, referral process and website were launched at the two CPD events. GPs were trained to:

- make a more thorough assessment of the patient including psychosocial factors,
- use the StarT screening tool,
- use information on NICE guidance including agreed patient pathways, and
- conduct risk assessment of patients.

The training itself was a mixture of plenary sessions and breakout groups where GPs could choose to attend workshops covering foot & ankle, shoulder, knee, spinal, osteoporosis, hand and elbow. The sessions were delivered by a wide range of experts from Primary, Community and Secondary Care. The sessions started with a call for clinical champions and ended with a debate on whether GPs need financial incentives to change their referral practice. The face to face CPD was supported by articles in the GP Bulletin.

4. IMPACT

GPs attending the CPD events were asked at the end of the event how the CPD would change their practice. An excerpt from this feedback received at the second CPD event is shown below:

- Will use appropriate referral pathways (9)
- Will use website (14)
- Will use STARTback tool (6)
- Will use blood tests for osteoporosis (1)
- Will phone foot and ankle service for advice (1)
- Will request standing xrays for foot and ankle problems (1)

- Will update technique on knee examination and history taking (2)
- Will re-assess my approach to how I undertake joint examinations (2)
- Better identification of red flags (3)
- Will use x ray to diagnose shoulder pain (2)
- Will change approach to Vitamin D management (1)
- Will review shoulder injection technique (1).

What matters the most here however is the long term implementation of the learning. An audit of spinal referrals made by GPs was completed in 2010. As a result of this the spinal pathway was amended. The assessment tool was made mandatory on the basis of the lack of compliance shown in the audit data.

The adherence to the new pathways ensures that the majority of patients (95%) are referred having received a bio-psychosocial assessment. This allows easier triage to appropriate treatment from the first physiotherapy appointment. The use of the assessment tool combined with the new pathway has led to more appropriate and targeted therapy, together with more efficient treatment. Anecdotally the physiotherapists believe that patients make further progress in the same timescale.

A recent review of all orthopaedic referrals to secondary care in Sheffield shows a drop of 20% over the last two years. Whilst it may not be possible to attribute all of this change to the educational initiative, it is likely that a large part of the drop is due to this initiative. Referrals to secondary care are now supposed to be made via physiotherapy only. Direct referrals to secondary care from primary care have dropped substantially – saving on average 80 new appointments per month. This has the result of halving the number of patients referred to surgical teams and has resulted in surgical conversion rates increasing from 20% to 50%. It has also allowed faster access to surgical treatment for patients in severe pain.

The website has also been a success, being used equally by professionals and patients alike. It has attracted wide usage with an average of 200 users per day. The website encourages self-care and patients have reported that they have found the website helpful and have used it to follow exercise instructions.

5. BARRIERS

The main barriers facing the organisers were:

- Obtaining consensus amongst all the interested parties across all services in agreeing a new patient pathway
- Non-attendance at the CPD events by a minority of GPs
- Compliance with the training. In some cases compliance was only partial.

6. LESSONS LEARNT

A challenging aspect of this project was to achieve a consensus between different parties including general practitioners, the acute teaching hospital and the community provider. The development of the website proved to be a very good way of gaining consensus between a range of different groups by encouraging individuals to focus on and commit to a number of different issues. The actual process of developing the site stimulated debate and cohesion within the stakeholder group. The process of bringing people together and developing an initiative across a large city with multiple partners requires strong leadership, ideally involving one or two lead clinicians partnered with a managerial lead.

There was limited resistance to attendance at the training events but overall attendance at the CPD events was good. This was thought to be due, in part, to the fact that doctors understood that they needed to attend the sessions if they were going to be able to access the spinal pathway in the future. However it might have been helpful to hold some sort of follow up for those GPs that did not attend the main CPD events.

The third barrier which arose was compliance with the training. Initially feedback collected after the first training event showed that only 20% of doctors in primary care were using the screening tool. To overcome this lack of take-up, the steering group agreed to make the use of the StarT screening tool compulsory at referral. This had the desired effect but caused logistical problems for the community provider. The community provider acted as the filter for all referrals to secondary care and was asked to 'bounce back' all referrals without the results of the screening tool to the GPs. However this had implications for the revenue flow of the provider and their ability to handle renewed referrals. The initial implementation of the 'bounce back' policy led to an increase in waiting times as the system adjusted but overtime the waiting times have reduced. The community providers also noted an ongoing need for the education of new GPs.

Overall the reaction from GPs has been positive but some have been resistant to the imposed changes. Implementation of the learning was facilitated by:

- Making the website available to support GPs and patients including information leaflets for patients, assessment tools, referral form and educational materials
- Publishing supporting articles in a GP Bulletin
- Issuing fliers/posters and cards for use in practices
- Letter and email reminders
- Providing a further launch event
- Ongoing support from the community provider who provide education to GPs showing a lack of compliance.

The spinal pathway was expanded in 2011 to include neck pain and the website has been expanded to include hip and knee, foot and ankle, hand and elbow, and shoulder (See www.sheffieldachesandpains.com). There are plans to re-audit the initiative on a regular basis and to extend the data collection to include patient outcomes for referred patients. (For more information about this study please contact Dr Ollie Hart on olliehart@yahoo.co.uk).

CASE STUDY

15. Practice Based Small Group Learning: NHS Education for Scotland

1. INTRODUCTION

Practice Based Small Group Learning (PBSGL) is an approach to Continuing Professional Development (CPD) for General Practitioners (GPs) that originated in McMaster University in Canada in the late 1980s and is managed by the Foundation for Medical Practice Education (FMPE), a not-for-profit organisation based at McMaster University. The model has been adapted in other parts of the world for general practitioners, practice nurses and others as a way of driving evidence into day-to-day practice and closing the gap between current practice and best practice. The project is based on peer-facilitated small groups of practitioners from either neighbouring practices or based within the same practice coming together at a time to suit them to address topic-specific modules. The aim is to provide a supportive learning environment where participants can maintain and enhance professional knowledge and competence, and use educational approaches and material, which are focused on evidence, learner-centred and practice based.

PBSGL has three key objectives:

- To identify gaps between current practice and best available evidence
- To encourage reflection on individual practice
- To promote changes in patient care by identifying areas for change and discussion on overcoming barriers to change. Key to this is the completion of a Commitment to Change instrument in the form of a log-sheet at the completion of each module.

2. SETTING & LOCAL CONTEXT

In 2001 the Director of Post Graduate Education the North of Scotland Deanery of NHS Education Scotland visited Canada on sabbatical and made an assessment on the suitability of PBSGL for general practice in the UK. Following positive evaluation of an initial pilot of five groups in the West and North of Scotland in 2003/ 04, a decision was made to roll out PBSGL across Scotland in 2006 for general practitioners and practice nurses

There are now over 130 groups and approaching 1200 members. This represents a quarter of Scottish GPs and the numbers are growing. PBSGL has also been used as part of the educational programme in GP Specialty Training in all four Scottish Deaneries since 2009 and has since been adopted by other

deaneries in the UK. The method has also been adapted for Pharmacists and other primary care professionals. There are a small number of PBSGL groups in other parts of the UK.

The NES PBSGL team has a close relation with, and a formal memorandum of understanding with the FMPE.

3. NATURE AND DELIVERY OF CPD

Each PBSGL group consists of between five and twelve GPs (or a mixture of GPs and nurses) that meet on a regular basis. Groups discuss real patient problems, and the evidence to solve these cases. The problems, the evidence, patient leaflets and websites are all combined in specially-prepared "modules" - which are available to all groups. Key to the success of PBSGL is participants moving from discussing the problem cases that are presented (problem based learning) to using this as an opportunity to identify similar problems and challenges from their own practice (practice based learning). The peer-facilitator has a crucial role in this. Training and support is provided for a facilitator for each group and the role of the facilitator has been found to be key. The important role of the facilitator impacts on group dynamics, individual learning, and the continuing life of the group. They undertake a unique "summing up" at the end of the PBSGL meeting including the crucial elements of commitment to change and addressing barriers to planned change, which helps drive the learning into clinical practice.

Groups come together in different ways but at this stage of the project's evolution the news of PBSGL spreads by word of mouth and groups form in that way.

There is a broad choice of modules that groups can study which cover a wide range of common conditions. A list of the available modules is available on the NES PBSGL webpage at: <http://www.gpcpd.nes.scot.nhs.uk/pbsgl.aspx>. Groups can cover as many modules as they like - the only restriction is time. Groups commonly meet every four to six weeks, with the arrangements being left to the discretion of the individual group. Some groups meet by webcam or video conference - this is particularly popular in remote and rural areas.

Initially modules were adapted from the Canadian modules to make them appropriate for Scottish use - a process referred to as "tartanising" but from 2010, there has been an increasing commitment to the production of UK specific modules. New modules are produced at a rate of 12-14 per year and currently approximately 50% are Canadian modules that are tartanised before being added to the library. The remainder are UK-produced lead by the NES PBSGL module production team and it is anticipated that over time an increasing proportion of the modules will be UK-produced. These home-produced modules are proving very popular with groups.

Each participant pays an annual fee (currently £120) which gives access to the modules and funds the training of facilitators and administrative support. For most group members, PBSGL forms a large chunk (often the majority) of their CPD activities. PBSGL is a valid form of education to declare for appraisal and revalidation purposes.

4. IMPACT

A study of the initial PBSGL pilot examined the effectiveness of the approach in addressing the gap between evidence-based practice and clinical practice and in participants' understanding of the effectiveness of small group functioning. Five small groups in geographically disparate parts of Scotland undertook a 12-month pilot of PBSG learning. Evaluation of the pilot suggested a positive change, particularly in participants' understanding of how to interpret medical evidence, of their skill in interpreting medical evidence, in their ability to apply evidence to day-to-day practice and in their confidence in interpreting evidence. This study informed the wider roll out of the approach.

"I consider evidence more now in day to day practice." (Participant 1)

"Practicalities of applying evidence into normal practice have improved."(Participant 2)

"The use of small groups supplied with expert information can be useful at extracting what is important for day to day use." (Participant 3)

A qualitative study was undertaken to explore the perceptions and experiences of PBSGL participants to gain an understanding of how PBSGL learning achieves its success. The study found that the small group format is an important factor in the success of the approach, along with the role of the facilitator. Other factors include:

- The strong need among general practitioners to update their skills and compare their practice with that of peers
- The inclusive nature of the small-group environment
- The importance of creating a learning environment that is the right balance between being not too cosy but not too threatening
- A recognition of the learning power of the group members instead of invited experts.

The findings highlight the importance of a learning environment conducive to learning and change, one that is based on honesty, openness and a willingness to acknowledge ignorance as a precursor to learning. A dominant finding was that participants stated that they had applied some learning to their practice. They reported a general increase in awareness of conditions and also confidence in treating them. Some cited specific benefits.

'The module on falls was very good and I now regularly employ the "Get Up and Go" test to enable me to assess mobility and balance.' (Participant 2)

'We've changed the way we deal with urinary tract infections. We used to get the lab to test all patients with symptoms; now we ask them to bring a urine sample for a dip-test. If it is positive, we give antibiotics, and only if the symptoms persist, do we send samples to the lab.' (Participant 3)

Commitment-to-Change strategies used as part of CPD programmes have been found to influence changes in the clinical practice of health professionals. The PBSGL programme includes a Commitment to Change instrument. A study examining the meaning that learners ascribe to their statements of intention to introduce changes in their practice revealed that for some participants commitment is

too strong a word to describe their intention. Some did feel that they were committing to the changes that they identified at PBSGL meetings however sometimes commitments were constrained by the ability or power of the individual to implement change in that particular area. Where change was within the power of the individual they seemed motivated to implement it.

“I feel that I am making a commitment . . . The whole point of going along to [PBSGL meetings] . . . it is obviously [an] educational experience, but it is also to change practice, to improve patient care.” (Participant 4)

“I don’t like making commitments, especially if I’m not going to be able to keep them. Commitment is a strong word, you feel fully committed. But again, if we’re going to the meetings and we’re going to gain by it, and we’re wanting changes, we need to commit to a certain amount or level of activity. . . . Although you would like to see changes, you may not be able to follow through because of constraints within the practice. So it is very conditional because of the other people involved, the practice as a whole.” (Participant 2)

“I would say I have sincere intention to make the change and would like to say I’m committed to doing so. Obviously, feasibility of introducing changes has to be discussed with the rest of the team and agreed . . . Getting the appropriate forum for discussion may be more tricky.” (Participant 1)

“I take away things that will improve my practice; then yeah, I will make the changes. I would feel that it would be wrong to realise that I could be doing something better but not do it better. The way I work, I have the flexibility and resources to implement things.”(Participant 3)

This study also explores the factors that influenced the decision of PBSGL participants to introduce practice changes, and the process of implementing change in clinical practice. Receiving new information through the module has been a significant factor in motivating change. All participants in the study were able to identify at least one change to their practice.

“The first module emphasised the importance of asking elderly patients about any over-the-counter medications they take – I now do this routinely, whereas I did not previously. The Colitis module brought up the importance of checking colitis blood tests in anaemic patients – I now do this, whereas I didn’t previously. The Dizziness module introduced new information for me regarding exercises for patients – I have discussed this with our Practice physiotherapists, and am much more aware of the usefulness of such treatment.” (Participant 2)

“I found the equipment in the practice needed updating. I did come out of that meeting [on patient safety], and I did make a request, and they [GPs at work-place] have addressed two parts of the equipment. I now have a new ECG machine and a new nebuliser.” (Participant 4)

A research study aimed to explore GP Specialty Trainees' perspectives of the impact of PBSGL on curriculum needs, preparation for independent practice, and facilitator learning. Findings were arranged in four main areas:

- Learning as a group was appreciated at this career stage, and group membership should consist of trainees at a similar career stage, as this supports psychological safety
- PBSGL helped in locating a 'one best way' for future care planning, but was also used to find alternatives to trainees' current approaches
- Discussion during PBSGL helped GPSTs devise plans for how they would handle patients in the future
- Some facilitators moderated their involvement for the perceived benefit of the group.

The study concluded that learning is experienced in a very unique way for GPSTs, and the views of the cohort are formed on the basis of the delicate stage in their career. Aiding the transition from structured education into independent practice is a more immediate need for GPSTs than curriculum needs.

5. BARRIERS

Evaluations identified barriers to the delivery of PBSGL as the lack of trust among partners in practice and the lack of confidence of participants in their own skills as a facilitator. The key element of training and continuing support for peer facilitators is a major focus for the NES PBSGL team.

Module materials prepared in Canada may not fit with UK guidelines and studies have found it to be important that materials are adapted where necessary. This issue is being addressed with an increasing proportion of UK-produced material by the NES PBSGL module production team.

6. LESSONS LEARNT

Key lessons learnt were identified:

- The crucial importance is of learning with peers rather than from experts who impart knowledge. In the PBSGL participants build from their own knowledge base. An expert coming in does not result in the same kind of learning experience. The approach enables participants to share their lack of knowledge and starting from this point enables deep learning.
- Has been good for engaging a large number of GPs.
- The content is broad and the participants choose areas of interest.
- Learning is delivered in “bite size chunks” which is a helpful approach.
- The process of working together in the group is valuable.
- The rapid implementation of PBSGL for GPs in Scotland suggests that successful CPD interventions can be successfully translated between different countries. Through active collaborative efforts, programmes and materials that have been developed for use in one medical environment can be successfully adapted for use in another country.
- Videoconferencing is under-utilised as a method of delivering CPD to remote and rural GPs. This project indicates that small group work in general can be delivered across a videoconference link to good effect.

- A study of multi disciplinary PBSGL showed a number of benefits. Respect shown for different roles and perspectives enabled participants to be open about gaps in their knowledge and to ask questions. A mutual keenness to understand the perspectives of and learn from the other profession emerged as a key ingredient for learners to feel that their learning needs were met. The learning process in the groups came close to transformative learning with changes in perspectives, acquisition of new knowledge and increased self-esteem.

(For further information about this case study please contact Dr Ronald MacVicar at ronald.macvicar@nes.scot.nhs.uk)

CASE STUDY

16. Practice Leaders Programme: Entrusting and Enabling General Practitioners to Lead Change to Improve Patient Experience: South Central SHA in partnership with Oxford Deanery

1. INTRODUCTION

This programme was developed in 2008 by South Central SHA in partnership with the Oxford Deanery and focuses on practice-level service change as a means of improving patient care and developing leadership skills. The aims of the programme are to promote and support change in leadership thinking and practice, facilitate practice-led service improvement, support career development, support CPD and contribute to the development of extended GP specialty training.

2. SETTING & LOCAL CONTEXT

The programme has run a total of three cohorts to date. The first cohort commencing in 2008 comprised a total of 19 GPs based in Milton Keynes and included both newly qualified and experienced GPs. Milton Keynes was selected because of its relative social deprivation and underperformance in national quality indicators. Upon completion of this cohort the programme received an International Institute of Healthcare Improvement award.

The second cohort was thematic and ran from 2009-10, focusing on new solutions for unplanned admissions to hospital across Oxfordshire. This group comprised a combination of doctors and primary care staff with a total of 16 participants.

The third cohort commenced in 2010 and focused on rethinking local solutions in preparation for GP led commissioning of health care across Buckinghamshire. This cohort was jointly funded by the commissioning group. This group had 30 members and was more diverse than previous cohorts including some lay members who were recruited as they were identified as local opinion leaders.

3. NATURE AND DELIVERY OF CPD

The programme is built on a bi-weekly action learning set and individual coaching with each participant completing a project focusing on improving patient care. The action learning sets

supported the design, delivery, and evaluation of the quality improvement projects. Sets consisted of groups of between six and eight people and were facilitated. Initial meetings of the set were used to build trust within the group and foster a willingness to be open to new ideas by creating a thinking environment and developing listening skills. Subsequent meetings contained elements of theory delivered by the facilitator alongside a more typical action learning approach with content responding to the expressed needs of the participants. Elements of theory included:

Introduction to service improvement models, change management, social marketing, health economics, Lean thinking, leadership skills, neuroleadership, Mythodrama, presentation and communication skills, report writing, patient perspectives, Myers Briggs type indicator, team leadership, chairing groups and meetings, public involvement, NHS structures, policy development, and process mapping.

The framework is summarised as:

- Start the journey (term 1). Understand, identify personal development needs, define service improvement project, discover a vision of a future culture that motivates individuals to change behaviour, set challenging goals and plan the big steps toward the goals and start the first small steps.
- Evolve, lead, deliver (term 2). Think in new ways focused on solutions, develop leadership competencies, experience transformational leadership and deliver service improvements.
- Complete the journey (term 3). Complete and sustain service improvement, further develop leadership competencies, evaluate the programme, cultural change and personal competencies, share insights and reflections, produce report and celebrate achievements.

At each learning set, participants agreed on actions and reported back on outcomes at the following meeting. The learning sets were also used for discussions and presentations on individual projects.

Each participant was given access to eight telephone coaching sessions from an independent coaching company. These sessions were used to identify personal success criteria and personal goals which could then be fed back into the action learning sets. At the end of the year participants described their personal journeys and project successes at a major presentation.

The concepts and evidence underpinning the programme were based on narrative medicine, neuroleadership and complex adaptive systems theory. The aim was to frame thinking away from linear and diagnosis-based problem solving and knowledge acquisition towards solution-focused vision, goals and planning, knowledge creation and application.

4. IMPACT

Specific evaluation of the first cohort has taken place and then a broader evaluation was rolled out across the programme more generally. Medical Leadership Competency Framework self- assessment forms were completed before and after the first cohort and demonstrated a statistically significant improvement in scores at the end of the programme for 79 out of the 80 areas covered in the assessment.

Other elements of the evidence used to evaluate the cohort included evaluation forms completed at the end of each learning set, service improvement project reports and reflective accounts, focus group

transcripts, programme handbooks, videos of presentations, programme documentation and correspondence.

As the cohort progressed, participants' reflective accounts changed showing recorded knowledge being transferred into practice. The service improvement projects provided an opportunity for participants to put theory into practice and the success of this approach encouraged all participants to feel confident in leading and implementing further improvement projects in current and future roles. All participants have gone on to take up leadership roles since completion of the cohort.

"I now know that I have the skills to lead change and improve care, and the confidence to get my voice heard." (GP Milton Keynes)

"Challenged my ideas and made me think in different ways." (GP Milton Keynes)

Participants reflected upon a realisation of why previous attempts to instigate change had been successful and understood how to engender success in future projects.

"Taught me how to get things done." (GP Milton Keynes)

All participants reported sharing knowledge and learning with Practice colleagues. Participants had also been able to draw on the knowledge and experience of the course leaders and other participants and the sets were viewed as a safe environment in which to share, explore and test new ideas in an experimental way.

Participants were asked to express views about leadership at the start of the course and some felt that they did not have the ability to lead but their reflective accounts showed an increase in confidence of ability to lead and to sustain improvement work throughout the life of the programme. Apprehension was also expressed over the prospect of delivering a service improvement at the start of the programme, however reflective accounts showed feelings of professional and personal achievement as a result of their implementation. Learning outcomes were defined as:

- Increased understanding of the importance of prior research for fully understanding the nature of the project being undertaken
- Increased understanding of the necessity of collecting data to provide an evidence base to be able to measure change
- Greater self awareness
- Increased confidence
- Recognising the importance of team support to facilitate service improvement and understanding how to achieve this
- Excitement about the improvement of patient services
- Eagerness to achieve greater patient involvement in future practice change.

"I am now involving patients much more." (GP Milton Keynes)

Projects chosen by the initial cohort for service improvement were varied and included:

- Improving patient access through physical redesign
- Off site medical archiving
- Improved information for and communication with patients
- Introduction of web based and on line check in
- Appointment reminders by text
- Online repeat prescribing
- Formation of new patient groups
- Development of health promotional material
- Redesign of chronic disease management systems
- Establishment of an obesity treatment service
- Becoming a training Practice
- Introduction of internal performance management for doctors
- Expanding the role of practice nurses
- Establishing a nurse led minor injury treatment service
- Reorganisation of Practice administration to increase time for staff patient contact
- Increasing investment in staff training across the Practice.

The projects chosen by the second cohort focusing on unplanned admissions included:

- Reducing delayed transfer of care to zero for Oxfordshire
- Improving patient access to appointment systems
- Enabling patients to support themselves through knowledge about direct access services, community support and healthy living
- Alternatives to visiting GP or A&E for dental pain
- Improving communication between A&E and primary care
- Education about services
- Improving the integration of walk-in centres into the healthcare system
- Design, development and implementation of a new clinical and operational information system.

The broader evaluation of the programme identified that participants from the second cohort now hold executive roles with consortia and those from the third cohort are leading clinical pathways, leading localities, linking with other organisations, demonstrating improved leadership competencies and improving patient care.

“The programme has had a significant impact on me, personally and professionally; it has changed the way that I approach my role as a GP and the way that I interact with my colleagues. It has empowered me to effect change in a system in which I had come to feel I had little, if any, sphere of influence.” (GP Oxfordshire)

“I have started work to reopen the clinical redesign project that “failed” for me four years ago and have encouraged the local GPs to think “beyond budgets” within medicines management.” (GP Buckinghamshire)

“Professionally I use the skills and theory from this programme daily. When implementing change I have become aware of models of improvement, change management and neurolinguistics of leadership. This I try and use when making even small changes in professional capacity. I think this makes changes I make more structured, hopefully more useful and sustainable.” (GP Oxfordshire)

5. BARRIERS

There were some challenges experienced by lay participation in the programme both in terms of process and outputs. There was a lack of understanding of the pressures of primary care and some entrenched views and expectations about knowledge. There was also a lack of sustained motivation to play a role in driving change. This must, however be balanced against the advantages of gaining a multidisciplinary perspective.

In the current landscape there is an expectation that service improvement needs to happen quickly and using the programme to facilitate and mobile change is time consuming.

6. LESSONS LEARNT

The programme creates space for participants to think about and experience thinking like leaders and to be able to build on this in a safe environment. It also offers a direct link between educational processes and outcomes as after completing the programme the educational intervention, its impact and sustainability, is evident.

Established GPs were more ready to learn and engage with the programme than the newly qualified GPs however the newly qualified GPs demonstrated an increased confidence to actively contribute to the development of their Practice which would inform their career decisions.

“A Practice would have to be willing to support me as a future leader, not just treat me as a working GP.” (GP Milton Keynes)

The initial cohort identified the value of partnership and the value of the programme which included a broad range of participants. This learning was taken forward to the subsequent cohorts.

“I think that it would have been better if we could have learned with non- GP colleagues who are also trying to improve the quality of care.” (GP Milton Keynes)

Cohorts two and three included other professionals. This diversity was perceived as a positive move and meant that the groups were able to explore issues from a multi disciplinary perspective. It enables participants to gain insight into the structures and processes in other organisations, speedily dismisses ideas that would not work and explore alternative approaches to achieving objectives.

It was important that participants chose a service improvement project that they could influence and which enabled them to reflect the benefits of their skills and learning from the programme. It was also important that the nature of the project enabled progress to be measured.

The programme has consolidated and evolved over time and adapted to take on a more multi disciplinary perspective. Ideas for moving forward include utilising the concept of disruptive innovation which would encourage an even more diverse approach to gaining different perspectives by working with different disciplines.

For further information about this case study please contact Marion Lynch (email@marionlynch.com) and Nigel McFetridge (nigel@changedthinking.com).

CASE STUDY

17. Reflective Practice - Bristol Association of Sessional Doctors (BASD)

1. INTRODUCTION

With the introduction of GP appraisals and revalidation BASD recognised that locums and sessional GPs need some extra support to fulfil all the criteria that are required for a GP to gain revalidation.

BASD saw the main difficulty arising from the nature of being a locum or sessional GP, an 'independent doctor', ie they often work in isolation and, unless they are in a practice for a long-term cover such as maternity cover, they often don't feel integrated into the practice.

The nature of sessional and locum work means that many of these GPs have little or no contact with other GPs in the practices where they are working.

"I tend to get booked by a Practice Manager, go into the Practice and I might see one of the doctors for a minute, just to say hello." (Locum GP, attending Reflective Practice afternoon)

Unlike salaried GPs or partners, Locum GPs seldom have the opportunity to attend practice meetings, either educational or business, or have informal discussions or chats over coffee or lunch where GPs might seek advice or discuss concerns etc with their colleagues. The more formal practice meetings are often the conduit through which all manner of issues can be discussed including clinical, educational, significant events, and revalidation/appraisal.

2. SETTING & LOCAL CONTEXT

This is set in primary care, aimed at sessional and locum GPs. It is facilitated by BASD and is free of charge.

3. NATURE AND DELIVERY OF CPD

The Reflective Practice afternoons are held once a month. GPs sign up to attend, but there is no compulsion to attend. There is no set agenda for these afternoons, the content being determined by the attendee, the aim being to provide a safe environment where the GPs can bring a whole range of issues/concerns/needs to be discussed.

These can range from;

- educational needs and how best to meet them,
- educational opportunities,
- sharing top tips
- revalidation and appraisal
- clinical
 - discussing case studies
 - managing difficult patients
 - significant events

There are a number of locum GP appraisers locally, some of who attend the Reflective Practice afternoons so they are able to answer questions and concerns around appraisal and revalidation.

4. IMPACT

The Reflective Practice CPD has a different perspective to the more educational CPD events that GPs can attend, therefore the impact is more difficult to measure in terms of hard outcomes, although the successful revalidation of locum and sessional GPs who attend this CPD will attest to the long-term impact of the Reflective Practice afternoons.

A locum GP who regularly attends the Reflective Practice afternoons describes these *“as substituting the kind of meetings we would have had in Practice.”* (Locum GP, Participant)

As the content of the Reflective Practice afternoons are GP led, the agenda is determined by any issues or concerns that the GPs want to discuss with colleague in the same position. As well as providing reassurance, *“knowing people are in the same boat”* (Locum GP, participant), the GPs are in a position to be able to meet their appraisal requirements.

The group provides an opportunity to discuss challenging cases and significant events, enabling the participants to share their views and experiences, taking a problem solving approach and encouraging reflection, which can be difficult for a GPs working in isolation.

A key component of the group is that it is seen to be a safe, supportive environment; the GPs attending ranging from newly qualified GPs to GPs who, for example, may be retired but wish to continue working, therefore the mix of experience can give the less experienced GPs in the group the opportunity to voice concerns or apprehensions, benefitting from the years of experience and knowledge that is present in the group.

“ [the afternoons] seem to be very useful, they keep you in touch with other doctors...to help you have a sounding board for your own worries and to present cases and so on, which is very useful.” (Locum GP, participant)

GPs can question their own practice or learn how other GPs deal with difficult cases or situations,

“It could be a clinical problem that they’re faced with, a clinical issue that haven’t been able to diagnose or manage...they can get advice from colleagues...it may simply be simply reassurance that something is difficult and open-ended so it can reduce stress.” (BASD facilitator)

5. BARRIERS

- Time: This is highlighted as being a particular problem, again due to the nature of locum and sessional GP work, i.e. required at short notice.
- Small number of attendees: The groups, on average, are between 5-12 in number, with a core group of participants. This can have a dual effect – small groups work well in terms of allowing everyone to participate and have a voice, but conversely there is likely to be a lack of new ideas. As one GP said

“It’s very worthwhile, it’s really supportive. I wish more people attended but if a lot more people attended it wouldn’t work as well, it would be too big. (locum GP participant)”

6. LESSONS LEARNT

Whilst numbers are quite small, with about 60-70 GPs attending in the last 2.5 years, the Reflective practice afternoons have acted as a platform for other group activity in the area, such as local study groups which are run separately to the Reflective Practice afternoons, and BASD will be starting a First Five group this coming Autumn which provides mutual mentoring support, educational support and career advice for newly qualified GPs.

As the Reflective Practice afternoons evolved, BASD recognised that there was a need to formalise the groups to enable the GPs who attended to gain CPD hours. Notes are now taken and distributed to the attendees, who can now provide evidence of how they are spending their education time, which can be added to their portfolio.

The Reflective Practice afternoons will continue for as long as the locum and sessional GPs see a need for them as BASD recognise their importance

“there is a need for it...given me evidence that locum doctors are quite isolated and they absolutely do need some kind of group forum activity so they can talk through issues, just from a mental health point of view, if you’ve had a really difficult day, with no opportunity to talk through these things with colleagues, I think you can come unstuck.” (BASD facilitator).

CASE STUDY

18. Regional Course for the Royal College of Psychiatry Exams: Cornwall Partnership NHS Foundation Trust

1. INTRODUCTION

The purpose of Membership of the Royal College of Psychiatrists (MRCPsych) examination is to assess as many attributes of a good psychiatrist as possible, as fairly as possible in order to prepare and select potential consultant and senior psychiatrists. Clinical exams should assess skills- multiple skills: assessing patients, taking histories, examining mental states, summarizing assessments to colleagues, making a diagnosis, ordering appropriate investigations, deciding on management plans incorporating biological, psychological and social interventions, and demonstrating the ability to communicate these plans to patients, carers and professionals.

The Clinical Assessment of Skills and Competencies (CASC) is the relatively new clinical exam at the end of the MRCPsych process. To describe the examination format, candidates are presented with consultation scenarios known as 'stations', in which a specialist actor role-plays a patient, the patients' relative, or a colleague professional. This happens under the scrutiny of a College examiner. Two CASC circuits are completed on the same day. One circuit consists of eight individual stations of seven minutes with a preceding one minute of preparation. The other circuit consists of four pairs of linked stations, giving 16 stations. Here the stations each last ten minutes with an additional two minutes of preparation time. For the linked stations, each station is marked independently, so that performance in one of the linked pairs does not influence the other station's mark.

The current pass rates for this exam hover around 35% thus being a difficult, costly and complex exam to pass. A major weakness observed by CASC examiners is the inability of candidates to probe deeply into the signs and symptoms with which patients present. Given the lack of preparation material, a local consultant decided to develop a workbook (known as the Cornish CASC workbook) and a later DVD to assist those wishing to undertake the exam within their Trust.

2. SETTING & LOCAL CONTEXT

This CPD is almost entirely focused in secondary care and is aimed at psychiatrists wishing to undertake the Royal College of Psychiatry exams. However a course is planned for interested GPs later in 2012.

3. NATURE AND DELIVERY OF CPD

The workbook was designed for use individually, in study groups or in larger “mock exam” workshops for candidates. Following on from the workbook, the organisers decided to also develop a two-volume DVD package with each DVD covering 180 minutes.

“It was felt that it would be useful if candidates could actually ‘see’ and learn, as a picture is worth a 1000 words.” (Course leader)

The DVD project involved a range of practicing psychiatrists (College CASC examiners, clinical tutors, training program directors, consultants and ST4-6s (post membership trainees)) taking on linked CASC scenarios drawn from our Cornish CASC workbook as candidates. 12 different candidates each appear in 12 linked stations (20 minutes each) covering a range of examples used in exams (the common and the tough ones). Professional actors play the patient and relatives so convincingly that quickly one is drawn into the consultation, observing as the candidates face demanding situations.

Following the 20-minute CASC station, each station performance is professionally critiqued by separate panels which involve at least four consultants of whom at least one is a Royal College CASC examiner in a 10-minute interactive discussion for each linked station. The idea is to highlight what a consultant would do in an exam station. The discussion panel comments on what has been done well and identifies possible areas of improvement with reference to the actual exam.

The DVD highlights the essential element of preparation for such exams i.e. self-assessment and rehearsal. They assist with learning to manage performance anxiety, testing depth and breadth of knowledge. The need to focus active attention on the consultation is highlighted rather than becoming lost in a catalogue of interrogation. The DVD demonstrates that there is not necessarily a single correct answer and provides help to the trainee to experiment with techniques to find out what feels right. It also shows the value of recognizing and rehearsing using different vocabulary with different roles. They show that while succinct professional language would be quite appropriate for a professional discussion, talking to a “patient” or a “relative”, requires the trainee to be accessible without being patronizing.

4. IMPACT

The course organisers believe that where candidates have used their CPD material, the pass rates have improved from 35% to 50 – 60%. Over 150 copies of the DVDs have been sold to private individuals and to various medical school and NHS Trust libraries across UK and internationally (e.g. Kuwait, Singapore, New Zealand, Egypt, Hong Kong). All income generated goes to the Trust’s Continued Professional Development fund to facilitate training needs for the Trust doctors.

The DVD set has been the winner of the ‘highly commendable’ award in the Digital and Online Resources category of the British Medical Association (BMA) book awards 2011. The Trust also won the Royal College of Psychiatrists Southwest Division Innovation Award 2011 for their work with the DVD.

Below are examples of feedback from users:

"I must say that the picture and sound qualities are exceptional. The quality of each interview is an eye opener. The feedback by the panel is invaluable - shows what the examiners really appreciate - calm, control - seen as confident and therefore "passable"."

"Just to echo what the others above have said about the good picture and sound quality and the professional approach in getting the DVDs done. The interviewing and communication styles have been good."

5. BARRIERS

Four key barriers were identified:

- With regard to any such new project initial seed funding is required. Grants from various agencies were required at different stages
- Time – It's important that participants especially senior medical staff believe that the time provided for this project is productive and has value.
- Credibility – Any new project once completed requires credibility for promoting the products. It has taken 8 years to develop the Cornish CASC brand. Focus has been on collecting feedback, especially any critical feedback to help improve future products.
- Dissemination is linked to credibility. Various networks, in particular, widely used psychiatric trainee forums such as 'super-ego café' have been supportive. The webmaster allowed free advertising of the projects as the profits are fed back to the NHS.

6. LESSONS LEARNT

Developing the DVD in addition to the workbook has enhanced the overall learning package and made it more accessible to doctors including overseas doctors who have to sit the same examination.

(For further information about this case study please contact Dr Rohit Shankar on Rohit.Shankar@cft.cornwall.nhs.uk)

CASE STUDY

19. Gwent Respiratory Education Project: Aneurin Bevan Health Board

1. INTRODUCTION

This is a multi disciplinary joint working project between Aneurin Bevan Health Board and GlaxoSmithKline. The project which ran from February 2011 to March 2012 aimed to enhance the management of COPD to a standard of care defined by NICE with the objective of improving quality and productivity in the management of patients with COPD across the Health Board.

The project was designed to support:

- The promotion of disease prevention and the earlier identification of patients with COPD through healthcare professional education
- Accurate diagnosis and classification of disease with access to high-quality information
- Prevention of COPD exacerbations through improved patient review and appropriate use of medications in line with NICE guidelines, and
- Improved quality of COPD referrals to secondary care and community teams.

2. SETTING & LOCAL CONTEXT

One of the key drivers for this work was that COPD was a target area for the Health Board and it was felt that a multi-disciplinary approach was needed to bring about improvement in this area. There was at least one doctor involved from every participating Practice along with a larger number of practice nurses.

Another enabling factor for this project locally, was a momentum for exploring more fruitful collaboration with the pharmaceutical industry.

All 92 primary care Practices across Aneurin Bevan Health Board were invited to participate in the project and a total of 43 signed up initially with 41 Practices completing the project.

The project was overseen by a project steering group with representation from primary care, secondary care, pharmacy, Aneurin Bevan Health Board and GlaxoSmithKline.

“This project has been used as a test case for Aneurin Bevan Health Board and has undergone high scrutiny. The Joint Working Framework gave a strong foundation for ethical application of the project.” (GP respiratory champion and project lead GP)

3. NATURE AND DELIVERY OF CPD

The training was delivered by a third party and the educational material was based on National Institute for Clinical Excellence (NICE) guidelines. The content of the educational programme had an emphasis on doing simple things well and included:

- Spirometry and diagnosis
- Appropriate prescribing
- Checking inhaler technique
- Patient self management

For the more formal training sessions, the focus of the training was directed towards the practice nurse role with doctors’ education being less central. However some of the doctors participated in Practice based mentoring sessions.

4. IMPACT

Of the 41 Practices completing the project data has been collated for a total of 38 practices. Three of the Practices could not supply data due to IT incompatibility or had no agreement for extended use of data.

A baseline, interim and final audit was collated in each Practice using the POINTS Audit software (delivered on behalf of GSK by Quintiles). Each Practice reviewed their performance report and planned appropriate actions.

In addition to this a lead COPD GP and/or nurse from each participating Practice, who ran a respiratory clinic in their respective Practices were responsible for reviewing their COPD population based on NICE COPD guidelines for standards of care.

The data shows that the number of COPD patient reviewed within the Gwent Patient Educational Project area shifted from 59% NICE standard patient reviews to 89% (key data recording is a composite score of annual review (25%) exacerbations (25%) breathlessness (25%) and Spirometry FEV1 (25%) from each patient consultation).

Health care professionals identified that their knowledge had increased significantly across the following areas:

- Detailed history
- Accurate spirometry
- Asthma or COPD
- Disease stage

- NICE adherence
- Management of breathlessness
- Recording exacerbations
- Management of exacerbations
- POINTS system
- Appropriate referral
- Appropriate secondary care
- NICE COPD implications.

Patients' understanding of their lung condition has increased. Patients were asked for their level of understanding before and after their latest lung check up. 46% said that their understanding was high before their latest check up and 85% said it was high after their latest check up. 11% said their understanding was low before their latest check up and none said that their understanding was low after their last check up. In addition 77% of patients are leaving their COPD review with increased knowledge about what to do if their symptoms get worse.

Recording of exacerbations has increased from 23% to 77% and Practices are able to identify and support patients based on their exacerbation rate. There was also an increased recording of self management plans and CAT scores.

83% of patients received inhaler technique checks during their review and 100% of patients have received inhaler training.

5. BARRIERS

This was the first time Aneurin Bevan Health Board had worked with the pharmaceutical industry to deliver a programme in Primary Care, consequently there was very detailed discussion with GSK and clinicians to develop the formal business case using the ABPA guidelines. This was agreed by the Health Board Chief Executive. A particular concern identified related to the management of any governance issues arising throughout the programme, this was addressed by the development of a Governance Group.

Another barrier was the time involved to deliver the project as for the participating practices there was a significant time commitment involved with staff having to take time out from the practice. A more flexible approach to learning may have reduced the impact of this barrier.

6. LESSONS LEARNT

Key lessons learnt were identified as:

- Having a programme with momentum and direction as opposed to serial one off events was a valuable and focused approach.
- To deliver care as teams it is important to learn as teams and to understand respective roles etc.

- Another feature was learning across the primary secondary care interface, so again in order to successfully manage patients along integrated pathways, the education needs to encompass the different players along the pathways.
- Evaluating patient outcomes as part of the programme was a real driver and motivator.

“The project generated a lot of interest, particularly with regard to understanding how this new way of working between the NHS and the pharmaceutical industry can lead to improved patient outcomes and the impact of working together to develop further skills in primary care.” (GSK)

(For further information please contact Dr Liam Taylor, Assistant Medical Director at Liam.Taylor@wales.nhs.uk)

CASE STUDY

20. Robotic Surgery: St Georges Hospital, London

1. INTRODUCTION

Chris Anderson is a Consultant Urologist in Laparoscopic Urology, Oncology and Andrology at St Georges Hospital. In 2000 he trained in laparoscopy for prostate cancer in Leipzig. This training in laparoscopy acted as a stepping stone for his robotics training both in the skills that he acquired and the training methods used. He was attracted to robotics as he felt it offered an advance on laparoscopy in terms of technology and capability as it is more akin to open surgery, more intuitive and addresses many of the challenges of laparoscopy.

In 2002 he undertook a fellowship in Detroit at the Henry Ford Hospital where some of the first robotics cases in the world were undertaken. Realising that robotics was a thing of the future, especially in urology, he used the contacts and relationships developed in Detroit to build a platform for mentorship for himself and a number of colleagues at the London Clinic where they trained between 2005 and 2007.

In 2008 St Georges acquired a robot through contacts that Mr Anderson had made at the London clinic and this has facilitated him mentoring colleagues in urology and supporting the use of robotics in other departments.

2. SETTING & LOCAL CONTEXT

This case study focuses, in particular, on the role of mentoring in specialist areas of CPD in Secondary Care, but also looks at some of the challenges faced by innovators and early adopters in acquiring training and creating opportunities to put the training into practice.

3. NATURE AND DELIVERY OF CPD

Mentoring plays a pivotal role in the development of new surgical skills and where training is in a highly specialist area or an area relating to new technology that is not well established, finding suitable mentors can be challenging. This challenge will always be at its greatest for early adopters - those wanting to develop skills at an early stage in the development of the innovation.

Robotic surgery is a relatively new development in the UK. It was developed by the United States military with the objective of enabling surgeons to operate on wounded soldiers from a safe distance.

The robot was not used in this way because it was not sufficiently portable but in the late 1990s it was adapted for the operating theatre and began to be used in the USA and Germany.

At an early stage Mr Anderson saw the potential of robotics and identified this as an area for his professional development prior to robotic surgery being introduced in the UK.

“I predicted that robotics would have a huge impact in urology.”(Course Leader, Acute Trust)

He built on relationships already established in the USA and Germany which enabled him to gain experience observing and assisting in robotic surgery and these contacts came to the UK to mentor him and two other surgeons who were also developing in this area.

Whilst undertaking laparoscopic training in Germany Mr Anderson was involved in the development of a modular training plan. This approach involved dividing the operation up into twelve modules with five degrees of difficulty. Trainees would build experience at a certain level and also build experience at each of the different stages before moving on to a higher degree of difficulty. A more experienced surgeon was always on hand to step in. He used this approach with his own training in robotics.

“We applied this approach to robotics. We never put any patients at risk, the operation never took more than five hours and if we were struggling with any aspect the more senior person would take over.” (Course Leader, Acute Trust)

Mr Anderson undertook his UK training at the London Clinic at a time before robotics was established in the UK. The Freemasons’ decided that they would fund two robots in the UK and St Georges was involved in developing a business case for this funding. Although St George’s was unsuccessful, the process of developing a business case helped to galvanise thinking about robotics. A year later Mr Anderson became aware that the London Clinic was upgrading their robot and realising this presented an opportunity he put forward a case to rent the old robot which was accepted by both the hospital and the company that owned the robot. This was possible because Mr Anderson had already trained in robotics and his contacts and relationships meant that he was aware of the second hand robot becoming available.

“I could hit the ground running. I’m not sure we would have got it going if I didn’t have the training and hadn’t known about the spare robot.” (Course Leader, Acute Trust)

Mr Anderson has gone on to mentor others in urology but has also seen potential for robotics to be utilised in other areas of surgery such as gynaecology, ENT, cardiac, colorectal and general surgery.

4. IMPACT

Robotic surgery at St Georges currently includes prostate, bladder, renal and pelvic lymph node removal in penile cancer patients. It is much less invasive than open surgery as it only requires very small incisions in the body, therefore, patients benefit from faster recovery, less blood loss, less post-operative pain reducing the need for pain killers and very good outcomes.

Although the surgeon sits at a console away from the patient and the operating 'arms' of the robot, the technology allows for very precise surgery to be performed. The console's 3-D monitor can magnify the surgeon's view by 10 - 12 times, aiding them to more easily identify vital anatomy such as delicate nerves and blood vessels. This helps to minimise the trauma to sensitive areas of the body - particularly important with procedures such as prostatectomy.

Mr Anderson commented that published research on outcomes for robotics often don't show significant differences in outcome with open surgery but this may be because they tend to use high volume centres for studies. Recent audit data from St Georges comparing open surgery for prostate and renal cancers with robotics over the last 8 years shows some significant differences. The blood transfusion rate for robotics is 3% compared to 33% for open surgery. The median hospital stay for open surgery is five days and for robotic surgery 70% go home on the following day. For partial nephrectomy the median hospital stay is seven days for open surgery and two days for patients of robotic surgery. The audit also showed that robotics is cheaper for nephrectomy and partial nephrectomy on a case for case basis not including the cost of the robot which is a capital expenditure. This means that outcomes are better for lower costs. Mr Anderson noted that the cost of the equipment is not factored in to other types of surgery but that there is a tendency to do this with robotics which means that economic comparisons can be misleading.

The work undertaken at St Georges has shown a marked improvement in outcomes for patients:

- Reduced trauma to the body
- Less blood loss and need for transfusions
- Less post-operative pain and discomfort
- Minimal need for pain killers
- Shorter hospital stay.

These outcomes have helped to reinforce the value of robotics and have given credibility to this approach to surgery within the hospital.

"St Georges believe that robotics is part of the vision."

(Course Leader, Acute Trust)



5. BARRIERS

One of the challenges faced by Mr Anderson as an early adopter of robotic surgery has been to develop the interest and motivation necessary to influence change as people are commonly resistant to change. The unsuccessful case study to bid for funding was helpful in that it enabled a case for a robot to be prepared, focusing on the advantages of robotics without having to focus on the costs.

This helped to shift attitudes and made it easier to promote the case for renting a robot further down the line. The successful outcomes achieved once the robot was being used have further helped to shift attitudes and gain credibility for robotics.

Mentoring has resource implications in terms of both cost and time. Mr Anderson self funded his almost all of his own training in robotics, receiving only a small scholarship from the British Urological Foundation which contributed to the cost of one of his Fellowship visits. There was a particular challenge in arranging funding for mentors to come over to the UK to supervise cases with one of the mentors having to cover his own travel costs to the UK.

Another significant barrier for the mentors coming from outside the UK is the requirement to apply to the GMC for a licence to practice. This licence lasts only for a period of six weeks and has to be reapplied for once the six weeks has lapsed. For mentors returning regularly to the UK this created frequent bureaucracy and there were examples of licences not being processed in time which prevented mentoring from proceeding. There is also no system in place to facilitate the GMC understanding or recognising when someone applying for a licence is a world expert. This is different to the systems in Europe where it is at the discretion of the Professor of the department to decide based on the expertise and professional standing of visiting person which makes things considerably easier.

“Every time (albeit only a few months apart) the mentors had to do a new full submission {for their GMC licence} with original documents, literally taking framed documents off the wall in some cases!” (Course Leader, Acute Trust)

The hospital also has bureaucratic requirements which create barriers for visiting mentors. They have to create an honorary contract and undertake tests for Hepatitis B and C, HIV and have CRB checks. In some cases they are required to be up to date with vaccinations such as rubella and smallpox. Quite a few NHS hospitals don't recognize results from other NHS hospitals.

“I personally have often been in the position where I have been asked to help at some hospital with mentoring .The bureaucratic nightmare begins there and in many cases bloods have had to be taken by their own labs!!” (Course Leader, Acute Trust)

Before coming into theatre overseas mentors have to go to occupation health and have bloods taken.

“The visiting mentors are truly incredulous at the red tape and often insulted by the process, particularly with the lack of recognition of their own laboratories' test results.” (Course Leader, Acute Trust)

Mr Anderson has mentored consultants at St Georges and one who is now fully trained is himself mentoring others. One of the challenges of mentoring is that operations takes longer when training and mentoring and this can often cause surgery to run late or the last case of the day can be cancelled which in turn creates tensions and is in conflict with hospital performance targets.

Due to restrictions in the UK, all trainee surgeons who are learning laparoscopy or robotics have to go to Europe for wet lab training (which usually involves operating on anaesthetised pigs). NHS trusts do not appear to sponsor this and funding is always an issue with people either paying for themselves or

small amounts of money coming from pharmaceutical or instrument companies to help fund their training.

When adopting a new surgical technique such as robotics it is not only the surgeon who requires training. Anaesthetists, nurses and theatre staff also require training to be able to work alongside the surgeon. Staff from St Georges trained at the London Clinic and a nurse from the London Clinic came to St Georges but this element of the training was not very structured or resourced:

“They were slow at learning because they were learning by osmosis from each other. This resulted in some delays in operating schedules.” (Course Leader, Acute Trust)

6. LESSONS LEARNT

Key lessons learnt were identified:

- A significant amount of energy and personal drive has been required to bring about the adoption of robotics at St Georges.
- The mentoring role has been pivotal to developing skills.
- Training for doctors needs to be structured in order to ensure that it is carried out ethically and is clinically safe. The modular approach developed offers a framework for this.
- It is not necessary to train large numbers of surgeons in this technique. Because of the effort and commitment involved, it would be helpful to hand pick people who would be most likely to have the drive to succeed.
- Other staff working in theatre also need comprehensive training which should be budgeted for.
- There are training centres in Europe where whole teams can be trained at reasonable cost. Surgeons and nursing staff are trained in parallel.
- In low volume centres it takes considerable time to gain the necessary experience to become proficient and it is important that people do not train and mentor people before they are ready. In the USA surgeons would perform in the region of 50 operations before starting to train or mentor in that particular operation.

(For further information about this case study please contact Mr Chris Anderson on chris.anderson@stgeorges.nhs.uk)

CASE STUDY

21. Snakes & Ladders: Great Ormond Street Hospital for Children NHS Foundation Trust

1. INTRODUCTION

Snakes and Ladders is an innovative approach to the delivery of CPD in the form of role play enactment to present a story around the patient journey and went live in September 2002. One of its key aims was to help junior doctors understand the patient perspective, but because it was delivered by and to a multi-disciplinary audience, it ended up driving much broader service improvement. Although it is now ten years since it was first launched, it had a powerful impact on a wide range of health care professionals.

2. SETTING & LOCAL CONTEXT

This CPD initiative took place in a tertiary care setting (Great Ormond Street Hospital) but representatives of other parts of the NHS including secondary and primary care, also benefited from this project.

3. NATURE AND DELIVERY OF CPD

For an 8 month period, the Grand Round was replaced once per month with an enactment of a patient journey along a care pathway from birth through to end of life. A professional role play company was used to deliver the story with occasional walk on parts for real staff. The role play centred around a child/adolescent with cystic fibrosis and covered a number of themes including:

- Drug error
- Conflict
- Ethical decisions
- Consent and issues about emerging autonomy
- Communication breakdown and
- End of life.

The patient experienced poor communication between secondary and tertiary care, drug errors, enrolment in a clinical trial, ethical issues around consent and end of life care. Each episode was

enacted by professional role players in front of a multi-disciplinary audience which included everyone from the CEO to medical secretaries and clinical staff from all backgrounds. The audience sometimes included clinicians from other hospitals as well as GPs from the local community. The aim of the project was to support organisational development

4. IMPACT

The monthly episodes were well attended and staff were very engaged with the story. The story line was not fully scripted and the actors were able to contribute to the decisions made. As a result of the programme there were two main outcomes:

- Reflections from the audience on ways in which it had changed their personal practice and encouraged them to think more actively about service improvement from a patient perspective. Some of this took place immediately following each episode but individuals and groups continued to reflect on the issues.
- A number of working groups were set up to look at some of the issues emerging from the story. Some policy changes were made including reviewing the prioritisation used within the bed management strategy, and improving communication with external teams. Particular attention was paid to how information about children stepping down to secondary care was communicated.

As the story evolved, it received a lot of attention and generated considerable debate. The patient's story was written about by the Press Office and published in the Great Ormond Street Hospital magazine, the intranet and the external website. Articles were published in the press including the Health Services Journal and the story was turned into a book and a DVD.

5. BARRIERS

The barriers to the project were minimal. There was some initial resistance to losing a Grand Round each month, but this fell away as the project developed. The monthly events motivated staff to want to do something about problems they had seen and think about service improvement.

6. LESSONS LEARNT

The project had an enthusiastic multi-disciplinary project team which included doctors, nurses, the Head of Medical Education, the Press Office, Deputy Chief Nurse, Head Pharmacist, the PALs lead, a patient representative and a professional role playing company who supported the project throughout. Although the main themes and key events were planned in advance, they were able to tweak each episode by adding in topical issues informed by the local PAL service and real events as they occurred. This made the role play more real. Whilst the storyline could be criticised for focusing too much on negative events, this was a deliberate move in order to encourage the audience to understand the patient perspective and find solutions to the problems.

It is helpful to have a facilitated discussion with the audience immediately following each enactment to elicit views and opinions and support reflection.

Finally, a long term project of this nature requires a considerable commitment and investment of time and planning to make it a success.

“Negative aspects of the service were highlighted in order to focus on the solutions”.

(For further information about this case study please contact Dr Hilary Cass on hilary.cass@rcpch.ac.uk)

CASE STUDY

22. Spotting the Sick Child: North Tyneside

1. INTRODUCTION

The development of this CPD arose from a meeting in London in 2009 where Dame Sheila Shribman (The Paediatric Czar) was speaking, the focus of which was looking after sick children and how it could be improved. It was felt that some CPD training in this area could be developed in North Tyneside with GPs, with the focus being twofold: to improve the quality of the provision that general practice provides in the locality for sick children and to begin to have an impact on the number of inappropriate admissions to hospital by trying to reduce them.

2. SETTING & LOCAL CONTEXT

This programme is set in general practice, initially with the Engage Health CCG (11 Practices) set in North Tyneside.

3. NATURE AND DELIVERY OF CPD

This is a web-based model, 'Spotting the Sick Child', and was developed with the aid of the local Paediatric Commissioner. The content is based on the most common childhood referrals to hospital (using national and local evidence), and further refined from looking at baseline hospital data in 2009; for example, how do children end up in hospital, what are their pathways of admission, what they are admitted with, and the origin of the admission. The web-based CPD takes about 3-4 hours to complete. Initially, in 2010, one GP in each of the 11 Practices in the Engage Health CCG completed the training, but the majority of the GPs in the Engage Health CCG have now completed the training. A DVD has also been produced which can be used as a refresher for GPs who have done the training.

4. IMPACT

The priority of the CPD was initially to up-skill GP who, although they see children every day, may not have done any 'paediatrics' since their training which could be as long as 25 years ago. As a GP commented:

"children aren't little adults, they're children and that might sound daft but it's not, you can't apply all the same principles to children that you do to adults when you're examining them." (GP participant)

A key element of this CPD is to try to ensure that paediatrics stays in General Practice, rather than following a more European model of specialist paediatric family practitioners for children up to 18 years old, therefore upskilling is essential, particularly with regards to spotting a seriously sick child. As the GP organiser said

“we don’t see loads of really sick children, we see unwell children so I think it’s got to have a positive impact and then it’s a snowball positive impact, because you’re better educated, you provide better care, you’re less reliant on the secondary care services.” (GP Course Organiser)

Following the use of this intervention in year one, when comparing the referral figures of the Engage Health CCG with a neighbouring CCG, they were able to see a 7% decrease in activity, compared to a 1% increase in activity of the neighbouring CCG where none of the GPs had participated in the Spotting the Sick Child CPD.

The second year of the intervention showed that the results from the CCG which hadn’t participated in the Spot the Sick Child CPD, remained the same, whilst referral figures for the Engage Health CCG showed a 4% decrease in activity.

Both the GP organiser and the Paediatric Commissioner believed this to be due to the intervention. However they felt that more could be done to capitalise on these results, and to test whether or not it is the CPD intervention that is influencing the decrease in referral activity from participating practices.

As well as developing this CPD, they have designed two booklets, with the most common childhood ailments for 0-5 year olds and 6-18 year olds together with a pathway of what services are available locally and when to use these services. They used resources such as best practice documents from, for example, the Royal College of Paediatrics and Child Health and the NHS Confederation to design these booklets.



Front cover of the 0 – 5 years booklet



Front cover of the 6 – 18 years booklet

A social marketing approach was used to help increase knowledge and awareness for patients and practitioners across the CCG, therefore the booklets were sent out to all patients with children in the Practice in which the course organiser is a partner (list size about 1500). These were sent out in March 2012, with a covering letter explaining how to use the booklet. The GPs in the Practice also have copies of these in their surgery. When a GP sees a child with a common illness that is in the booklet, they are encouraged to use the booklet in the consultation.

"I find the page with the illness on, look at the symptoms with the patient and ask them if they have looked at the booklet...this allows families to feel confident about using the booklet as we use it with them." (GP participant)

Anecdotal feedback from parents suggests that the booklets have been received positively. At the same time, the Paediatric Commissioner looked at peaks of activity data for common illnesses, such as rotavirus which has peaks in March and November, again sending a mailshot to parents of children, explaining that this virus is very common, what the symptoms are and how to treat the illness.

"we know that 80% of kids that are unwell are looked after by their parents..... if we can make that 80% of parents who look after their kids really well up to 82/83% ...we're much less reliant on those other services and it's much more appropriate." (GP Course Organiser)

In order to evaluate the impact of the CPD, either in isolation, or combining the CPD with the booklets, they are currently carrying out a pilot which will end in March 2013.

- Engage Health will continue with the CPD training, with GPs being encouraged to use the DVD as a refresher, together with the booklets.
- Care First (another CCG grouping) are receiving the Spot the Sick Child training, but will not be using the booklets.
- A further group of Practices, who have not been offered the training or the booklets, have agreed to take part to act as the control group, on the understanding that they will receive the training as soon as the pilot has finished.

"idea is, at the end of the year, if you just do Spot the Sick Child training, we can get a 3,4,10% reduction in appropriate admissions, in addition we get x,y,z so the GP feels more confident etc. If enhanced, might be a 5% stretch on that?" (Paediatric Commissioner)

5. BARRIERS

Time is cited as being one of the key barriers initially, the interactive web-based programme taking about four hours to complete. GPs who found this particularly difficult were encouraged to do this in 'chunks':

"doing this in bite-size pieces made it much more manageable." (GP participant).

Engaging GPs has been a barrier; particularly the GPs with many years experience, and some of whom are sceptical about the value of this kind of training, as they were unsure as to what value this CPD could add.

Seeing the positive results of this CPD, particularly the hard data in terms of decreased referral rates, has been the turning point in encouraging the majority of GPs to do the training, and use the knowledge, in particular, GPs who have a more evidence-based focus;

“Having the figures presented to us, showing a reduction in referrals showed us that the training was worth doing as it does seem to make a difference.” (GP participant)

These findings have also been significant in encouraging GPs to participate in the training and to implement their learning;

“I can’t believe what an impact we can make...I have set a template up on my PC so that every time I see a child, this pops up and I follow it through.” (GP participant)

Access is also an issue. This CPD potentially increases the number of children coming to see GPs, therefore GPs have to be sure they have the space and capacity to see the children.

6. LESSONS LEARNT

Getting GPs who are interested in paediatrics to do the training has been easy, targeting the hard-to-reach group who feel competent and confident in assessing children’s needs has been more difficult. There was some funding from North Tyneside PCT, which was available for the course organisers to use to give a financial incentive to encourage Practices to get involved. The early positive results have enabled a degree of peer pressure, with other GPs wanting to show the same results, so it is important to share success.

Involving the Paediatric Lead in Practices is crucial; not only to encourage GPs to do the training, but to provide support when GPs are implementing their learning in practice. This has led to a number of training Practices including this CPD in their induction packs for new GPs.

Awareness of the time taken to complete the web-based programme has led to the development of a DVD which is less interactive and more didactic, but covering the same learning points. It is anticipated that this will also be used as a ‘refresher’ for GPs to supplement their training.

Including all Practice staff in some of the training to get the most impact, i.e. around the booklets, is essential, particularly receptionists and other staff who have the initial contact with the patients.

“If [Practice staff] they’re aware of the booklets...they are really aware of what these booklets contain, they can say to patients, have you got your booklet, have you had a look here, and yes, I can put you in touch with a doctor and that’s what we want to foster, not the oh dear, you’re not well, you must go to the hospital.” (Course Organiser)

The organisers also thought it was important to involve other children’s services such as School Nurses, Health Visitors and colleagues in secondary care to:

“Get this message across, so instead of the first port of call for a sick child being A&E, you contact your primary health care team first.” (Course Organiser)

Sharing the early success of this particular CPD and its potential impact on referral activity, in order to encourage a wider uptake of training, is important and there have been a number of events across the

region with presentations to groups of up to 30 GP Practices. They have involved the GP Advisor for the whole Tyne region in these events, who is keen to roll this CPD out across Newcastle.

(For further information about this case study please contact Dr Jane Wetherstone on jane.weatherstone@nhs.net)

CASE STUDY

23. Training the Trainers, Faculty Development: Northumbria Health Care NHS Foundation Trust

1. INTRODUCTION

This is a Trust initiative to assist consultants to deliver quality training to junior doctors. There was an appreciation of the difficulties of attending external CPD, so they established an in-house, three-year rolling programme to cover all the relevant areas, keeping trainers up-to-date with the knowledge and skills required to supervise and train junior doctors.

There was also an understanding that people need to be supported in their training role for a number of reasons:

- inducting new consultants into good educational practice
- changes in medical education (i.e. introduction of foundation, e-portfolio, curriculum changes)
- changes in organisational structures and educational infrastructures

There was an awareness of the anticipated introduction of GMC standards for trainers, quality assurance and performance. Although this was not a pre-requisite at the time of developing this CPD, there was an understanding of the need to have their trainers ready to be accredited in order to continue training for a time in the near future when this will be a requirement.

There was a keenness to run the courses at a local level in order to reflect local needs. For example, the trust have F1 doctors in Emergency Care which some trainers may not have had experience of, so training can be directed to reflect this.

2. SETTING & LOCAL CONTEXT

This CPD is designed for Secondary Care trainers, the majority of whom are consultants, who are involved in the training of junior doctors.

3. NATURE AND DELIVERY OF CPD

This is a rolling programme over three years, which consists of a half-day event every two months. Subjects covered include:

- Assessment
- Teaching
- Managing doctors in difficulty
- On the job teaching and assessment tools
- Culture change
- Role modelling and mentoring

The subjects are scattered, each session having completely different topics, the intention being that the same sessions are not delivered at the same time each year. It is anticipated that trainers will attend at least one event each year that will help them to develop their skills.

The sessions are designed to generate discussion, with a high level of interaction. The format is usually a short presentation (with few slides) and handouts, for example, discussing scenarios, sharing experiences.

4. IMPACT

The anticipated introduction of GMC standards for trainers was one of the driving forces behind the development of this CPD, with an awareness that the Trust need to ensure their trainers will meet the quality standard that gaining accreditation to train will demand. The aim of the CPD is to provide trainers with up-to-date knowledge, not just in clinical areas, but also to have an understanding of the changes in the educational models that have occurred in recent years, which will be different to the education models that many of the trainers will have experienced.

“most people felt their knowledge in the area had improved, or at least knowing how to access the knowledge, because things are changing all the time, in terms of training.” (Participant 2, Consultant Anaesthetist)

The emphasis of the CPD is to encourage trainers to think about the importance of training and their training role; being an effective role model, and how this influences how they set up their clinics, their ward rounds and their small group teaching sessions as well as giving them the skills to deal with doctors who are in difficulty.

Measuring the impact of this type of CPD is difficult, as it is essentially learning transfer, with no certainty that the learning transfers to meaningful changed behaviour. However the Faculty are confident that they are doing well, with good feedback from the GMC survey and the NHS QA standard. They see the high levels of recruitment into the Trust being a measure of success.

In the future, numbers of trainers gaining accreditation will be a measurable outcome of the success of this training.

5. BARRIERS

Time and job plans were initially seen as being the main barriers to participation on the course but the Trust is keen to see this work so there has been a willingness to work together to build in time for trainers to attend. Clinical pressures can still impact on attendance but the nature of the delivery of the training helps with this. It is anticipated that it will be a Trust requirement for supervisors to attend one training session to continue to be a supervisor.

“attendance may improve, sometimes you have to have an absolute requirement, a target to meet.” (Course organiser)

There was an agreement that attitudinal barriers are the most significant barrier to putting the learning into practice and that these are often the hardest to break down, making it potentially difficult for the participants to implement what they have learnt on the course:

“A lot of people don't like it [change], don't value it.” (Participant 2, Consultant Anaesthetist)

The participants, however, are clear that the CPD has provided the skills and training to enable them to begin to break down the barriers, for example around reviewing trainees;

“There's been changes in the way we organise the training, how people are aware of these roles. We now meet up once a month in our department, to talk about all the trainees. Traditionally, it was mainly are there any problems?...., but now we systematically review every trainee once a month in an open forum... we've managed change and people seem to be behaving a bit differently.” (Participant 2, Consultant Anaesthetist).

6. LESSONS LEARNT

The added value of this CPD is the support network that has developed; providing a forum for trainers to meet colleagues from across specialties, with a wealth of experience from junior to more senior consultants. Perceived as a safe environment where trainers can question their own practice, learn from other people's good and bad experiences, as well as providing contacts for trainers to 'fall back on'.

“ I think the most valuable thing is the networks you establish is a non-threatening environment, to question your own practice, to learn from other people's nightmare scenarios as well, because a lot of the sessions are refresher areas, and because a lot of the people are quite senior people a lot of it is what have you experienced, what was the difficulty, how did you deal with it, I think that's probably the most useful thing.” (Participant 1, A&E Consultant).

Providing feedback to the trainer/supervisors via the sessions has developed into an important aspect of these CPD training sessions, which is perceived to be of considerable value to the participants:

“The knowledge, getting feedback, that what you're doing is ok, and what you're doing is quite a difficult situation to manage but I know other people are in the same boat as me, I know that I'm not on my own, that's a nice thing to have insight into. You practice independently as part of a big organisation and knowing that you're doing ok is valuable feedback... You come back and think I'm doing an OK job because I'm not getting feedback from elsewhere in terms of quality of my supervision so I think that was a really useful feedback for me as a participant.” (Participant 1, A&E Consultant)

Involving all managers at strategic and administrative level can be useful – it gives them insight into what teaching involves and they can provide insight into problems such as on-call and how that can impact on training.

(For further information about this case study please contact Dr Chris Tiplady, North East SHA at Chris.Tiplady@northeast.nhs.uk)