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2018
Year 4 GP Teacher Workshop Report

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"I really enjoyed chatting to other teachers and finding out what different practices are doing"

Organisers
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Year 4 GP Teachers' Workshop report

Engineers' House, Clifton, Bristol
Tuesday 23rd October 2018

Morning			
8.30	**Coffee and registration**		PHC team
9.15	**Welcome and Introduction to the day** Review and update of year 4 Primary Care Teaching		Lucy
10.00	**Mental Health** - teaching, update, assessing risk	**MB21 Year 4** – *what will it mean for your teaching?*	David Barbara
11.05	**Coffee**		
11.35	**MB21 Year 4** – *what will it mean for your teaching?*	**Mental Health** - teaching, update, assessing risk	David Barbara
12.40	What has **Research at the Centre for Academic Primary Care** ever done for us?		Matt
13.00	**Lunch**		
Afternoon			
14.00	Sharing best teaching practice		Small groups
15.10	**Tea**		
15.25	Patient centred teaching (consent and feedback) Involving allied health professionals in student teaching		Barbara Lucy
16.25	**Q&A**		Lucy and team
16.30	**Home**		

Speakers and facilitators

- Lucy Jenkins, MB16 Year 4 lead
- Barbara Laue, GP lead for MB16 Year3, Co-chair for MB21 Year4
- David Kessler, GP in South Bristol and Reader in Primary Health Care
- Matt Ridd, GP and Reader in Primary Health Care. COMP 2 Unit lead
- Dr Jessica Buchan, MB21 year 2 lead, previous year 4 lead

Year 4 GP Teacher Workshop report

I am very grateful to the GP teachers who attended and contributed with enthusiasm and expertise to the 2018 workshop. There was a wide range of teachers both in terms of geographical distribution and teaching experience.

The primary focus was to update, interest and inspire our year 4 GP educational community – to share knowledge and ideas which we can take back to our practices and to ensure that the teaching continues to be rewarding and fun. In the PHC department, we are aware of the current pressures in primary care and want you to be able to continue teaching and for it to be enjoyable rather than an added burden. We also act on feedback from yourselves and the students to maximise the experience for all concerned.

In view of this, a large part of the day was taken up with a review of the current course, updates such as the portfolio and sharing top tips. We also discussed how we can make our teaching more patient-centred – considering feedback and consent and how we can involve our allied healthcare colleagues in teaching. Read on for more about these and look out for the resources which are in the process of being developed to help you encourage and train your colleagues in this.

Dr David Kessler and Becky Mars gave an informative and thought-provoking talk on mental health with a focus on risk assessment and self-harm/suicide.

Barbara Laue ran a session on MB21, the new curriculum, now in full swing in its second year. Year 4 is being developed and this was an excellent opportunity to share plans and get thoughts from our GP teachers.

Our teaching department sits alongside the research part of Academic Primary care in Bristol, so it was great to hear from Matt Ridd about local research and how our practices can get involved.

Thank you to all our contributors and for allowing us to share their slides.

Please do read on for more information and if you have any queries or concerns, please do get in touch

With all best wishes

Lucy Jenkins.

Lucy Jenkins, GP and clinical teaching fellow (year 4 element lead).

Lucy.jenkins@bristol.ac.uk 0117 9287224 (Tuesdays only) or contact PHC as above

GP teacher feedback from the workshop

"I really enjoyed chatting to other teachers and finding out what different practices are doing"

"as a new year 4 teacher, learning about the practicalities of placement planning was really useful"

"good to have some time and headspace to really think about the student needs and how we can best accommodate them and make them feel part of the team"

"it felt like a good balance of general info about the course, sharing tips on specific issues (especially planning student led surgeries) and some other interesting bits too"

Feedback was that the workshop overall was enjoyable and helpful, with everyone feeling they had a clearer idea of the course, new ideas for placement planning and teaching and an awareness of pending changes. The mental health session was felt to be both interesting and of use for clinical practice. The research session as interesting and informative – though possibly less relevant to your day to day teaching.

As ever, the most popular session was the sharing top tips, so we hope to expand this next year as it always runs out of time!

We asked what teaching topics you would be interested in for future workshops. See below for these and we will be sure to cover in 2019 workshop!

- Helping students develop consultation skills
- I would attend different year group teaching
- More idea sharing and practicing giving feedback
- More ideas on Mental health teaching
- If possible, having the session earlier in the academic year before the placements would have been useful

Next year's workshop will be held earlier – but it cannot be before placements start as this would be during the summer holidays)

In terms, of what support you would like from Primary Care, top of the list was teaching resources for allied healthcare professionals (coming in the Spring and see later in this report for more info). A few participants commented that it was good to hear about and look at the resources on the top table that are all available on the website (see below for a list of these) and would use these more in future as well.

Another request was for specimen timetables ahead of MB21 year 4 – the curriculum for this year is work in progress but we acknowledge your requests for more information and will make this available as early as possible.

We were pleased to read that the majority of you are logging on to the PHC website and reading the newsletter.

Update and review of teaching

Update for MBChB

- Admissions process changes – now using UKCAT entrance exam, and MMIs (mini medical interviews) with no UCAS personal statement
- Gateway student scheme – now in year 3 – pre-medical school year- part of widening participation so that students who have potential to become doctors but do not meet the academic entry criteria to apply direct to Medicine.
- GMC Outcomes for Graduates - replaced 2009 Tomorrow's doctors- 40% bigger – we are in the process of mapping all our Learning Objectives
- Improving scores in National Student Survey – above average for overall satisfaction with the course (88%), especially improved in feedback and student support
- New curriculum MB16 now in its second year – more later!
- Progress test - longitudinal feedback-oriented assessment where the whole medical school sit the same test together at regular intervals.
- GPs in a number of senior Medical School roles
    - Sarah Purdy — Head of the medical school
    - Andrew Blythe — Director of MB16
    - Trevor Thompson — Head of primary care teaching (and now Professor!)
    - Rupert Payne — Lead for prescribing

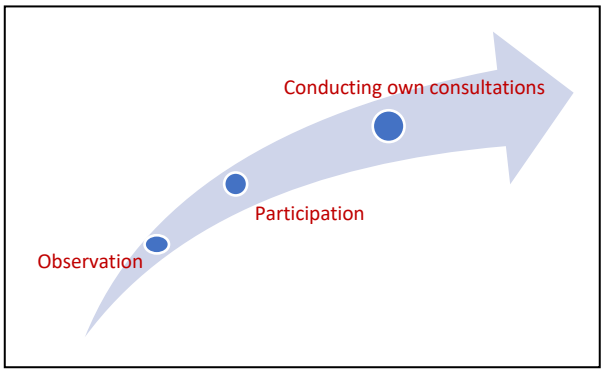
Year 4 in MB16

Sept- Nov	Nov-Jan	Feb-Apr	Apr-June	June	July
COMP1 Child Health & Public Health	PPC –Psychiatry and perioperative care	COMP2 Primary Care Care of Elderly & Dermatology	RHCN; Obstetrics & Gynae	OSCE & Written Exams	Student Selected Component

Essential information

- COMP2 is one of 4 x 9-week long teaching blocks in year 4
- Students have 4 weeks in primary care for which they are expected to have 30 sessions in practice
- The other half of the block is spent in secondary care in Medicine for Older People
- Dermatology teaching is mostly spread throughout the block (dates sent through in advance). This is done during the middle week in Bath
- There is central teaching at the beginning and end of the block (consultation skills seminar, lectures and Disability workshop)

In practice



Aim to send draft timetable in advance
Induction and learning needs analysis day 1
Students should spend 2/3 time with a GP

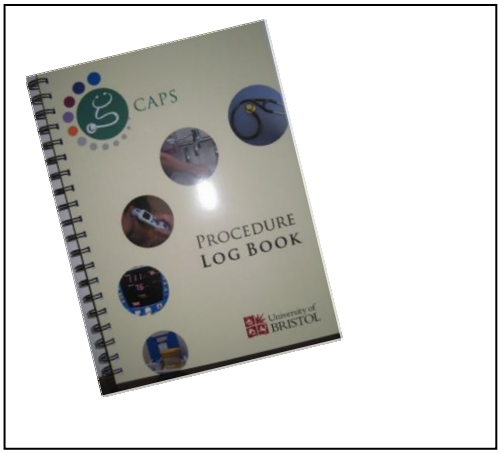
- Initial observation with active participation
- Then observe student doing at least 5 consultations and give feedback
- Then student to consult alone then you review and see together
- Use observation templates and learning logs
- Aim for a student led surgery (see templates)

Other learning activities

- Practical skills
- Visits
- Tutorials 2 minimum
- Sitting with other GPs
- Practice meetings
- Longer interviews
- with invited patients
- Home visits
- Out of hours
- Self-directed learning - GP paperwork time!
- Time with other primary health care team members
- Teaching session from ST 2/3
- E-learning

Remember practical skills and prescribing

Practical skills	Examination
BMI Urine-analysis Blood glucose Peak flow Blood pressure Pregnancy test Temperature Intramuscular injection	Respiratory Cardiovascular Abdominal Neurological Fundoscopy ENT Rectal Musculoskeletal
<u>Prescribing</u> Use of BNF Risks and benefits of giving medications Know at least one medication for each of the core problems including side effects Compliance. Discuss medication reviews 10 stages of prescribing Preparation for PSA	



Support and resources for GP teachers

- Year/academy leads and administrators.
- Primary Care website – see next page
- GP Teacher guidebooks
- GP Teacher workshops and workshop reports
- Newsletter
- Blackboard
- Twitter

Resources on the website

https://www.bristol.ac.uk/primaryhealthcare/teaching/teaching-in-practice-by-year/four/

- GP teacher guide
- Student study guide (lecture notes)
- CAPS logbook
- Portfolio

- Tutorial templates (Prescribing, domestic violence, substance misuse, spotting cancers)

- Attendance Concern form
- Student concern form

- Example 4-week placement timetable
- Attendance and payment form
- Patient feedback form

- Template for student led surgery
- Consultation observations and feedback forms (long and short forms. OSCE marking schemes are based on these)
- Guide to run a student led surgery

For your personal development and CPD

- Year 4 practice feedback form
- Student record form
- Reflective teaching template

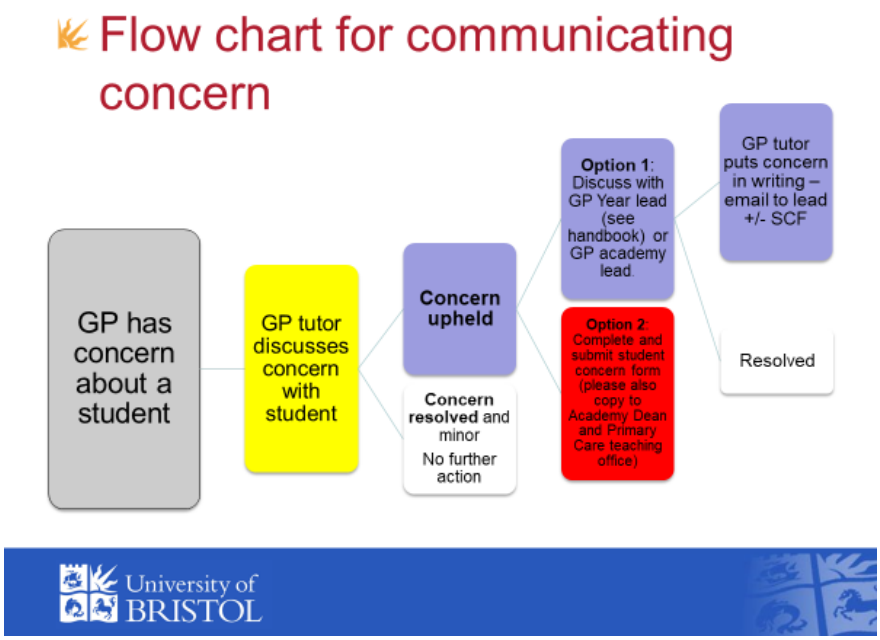
Portfolio **new for 2018-19**

- As for other year 4 units
- Student held document
- Sample available on the PHC website

Unchanged: The learning needs analysis and consultation log that were previously in the student's study guide are now part of this portfolio

New: One observed primary care consultation (documented in CaPS logbook)

- GP sign off at end of 1st/2nd 4 weeks
- Handover comments
- Check + confirm completion (A+P form at end of block)



Any concerns – please discuss with your Academy GP lead or Dr Jenkins as necessary and before completing a form - thank you

Top tips

What will you take away from this session?

- Start writing name of student on whiteboard to welcome at work when they start
- Persuade partners to allow students to consult more when they are supervising
- To schedule students to sit in with more different GPs
- Will make sure they are aware of the potential for stressful/upsetting experiences and to let me know if they have any difficult experiences
- Prepare students for difficult consultations
- If possible get student name on door
- Ensure student log in
- Get the student to write up notes more often

Teaching experience – what works

- 'Learning by doing' is very important
- 'Some' direction is useful
- Opportunistic learning is important
- Moving students from 'rote' questioning to working hypothesis informed questioning
- Summarising is a good tool for focusing further questions and making sense of the information gathered so far
- Dual working – taking in the history and clinical reasoning
- Pattern recognition, 'illness scripts'
- Get them through that 'Clunky' stage of learning when students don't quite have enough information and experience
- Mixed approach – some student consultations need to be observed and some alone
- Be flexible- i.e. check in the morning what Nurse has on. 30-60min long activities are fine

- Push more for diagnosis, use OMP=one-minute preceptor model – 'framing' it for patient and student
- Structure plus trying things out
- Learning needs to be 'bite sized'
- Learning from videos
- Embrace a practice culture of teaching
- Student led surgeries are really popular and a great learning opportunity

Teaching in practice – Teaching tips

Logistics

- Designated timetable
- Template for teaching
- Organise other teaching – pharmacist, BDP sessions etc
- Delegate the organisation of the timetable
- ¾ time with lead GP
- Remember the tutorial templates
- Ensuring that the student consults with appropriate patients – initially new or acute problems. Try to avoid the patients knowing which GP is supervising

Getting to know the practice, becoming a member of the team

- Induction
- ½ hour with practice manager
- Sitting in with reception
- Session with every doctor
- Photos – put student up too (with permission) – ask on 1st day
- Student name on whiteboard for patients

Getting to know your student

- Invest in getting to know more about them
- How did they get into medicine? medical family?, gap year?, career plans?, hobbies
- Share something about you – roles, how you got into GP, how you juggle work/home etc
- Address the emotional side of medical work, patients and their stories can upset us, patient stories may link with personal upsetting experiences, for example having experienced a bereavement or split up of parents etc
- Make sure that your student knows that you are there to support them
- Know what resources are available to students if they need help
- Take them home for lunch, out for curry or bring cake!

Wishlist – we are working on these!

1. Concise information material that can be used to informed other GPs and allied health professionals re the needs of Year 4 students
    a. What have they learned already?
    b. What can they do?
    c. Teaching expectations
2. Training up practice champions to inform whole practice team about teaching opportunities in the different years, what the task is, how to get involved, remuneration
3. Document comparing teaching tasks in Years 1-5 for MB16 and MB21, serving as concise information

Year 4 in MB21

<u>Please note:</u> Up to half of the students will be returning from intercalating between Year 3 and 4 and Finals will be at the end of Year 4.

Brief summary of rationale for Year 4 structure and draft outline of plans

Learning outcomes

Year 4 is the 'lifecycle year' in which students will be studying topics from conception to death. It aims to prepare students well for finals and the embedded assistantships in Year 5.

By the end of Year 4 students should be able to demonstrate the following

- Competent history and examination for all systems incl. mental state and for children and pregnant women
- Effective consultation skills in a range of situations incl. with patients with learning difficulty, disability, frailty, memory loss, approaching the end of their life, with patients from a range of cultural backgrounds and those needing a translator, and with colleagues.
- Wide range of knowledge of common conditions, presentations and situations and their management
- Professionalism in their behaviour and learning approach
- Making patient safety and wellbeing a priority

Year 4 schematic

Students will be studying in 2 academies, one central one out of Bristol, 18 weeks/ academy.

<table>
<tr><td colspan="7">36 weeks teaching</td></tr>
<tr><td rowspan="11">Central introductory day to Year 4</td><td colspan="3">Academy 1</td><td colspan="3">Academy 2</td></tr>
<tr><td colspan="3">18 weeks</td><td colspan="3">18 weeks</td></tr>
<tr><td colspan="3" rowspan="4">Complex Medicine for Older People
Life limiting illness and end of life care</td><td>6 weeks</td><td>6 weeks</td><td>6weeks</td></tr>
<tr><td>RHCN</td><td>MH</td><td>CH</td></tr>
<tr><td>CH</td><td>RHCN</td><td>MH</td></tr>
<tr><td>MH</td><td>CH</td><td>RHCN</td></tr>
<tr><td colspan="3">Academy 1</td><td colspan="3" rowspan="2">3 streams of students rotating through these specialties</td></tr>
<tr><td colspan="3">Academy 2</td></tr>
<tr><td>6 weeks</td><td>6 weeks</td><td>6 weeks</td><td rowspan="4">18 weeks
Complex Medicine for Older People
Life limiting illness and end of life care</td><td>4 weeks</td><td>4 weeks</td></tr>
<tr><td>RHCN</td><td>MH</td><td>CH</td><td>Finals</td><td rowspan="3">Finals Resits</td></tr>
<tr><td>CH</td><td>RHCN</td><td>MH</td><td rowspan="2"></td></tr>
<tr><td>MH</td><td>CH</td><td>RHCN</td></tr>
<tr><td colspan="3">3 streams of students rotating through these specialties</td></tr>
<tr><td colspan="6">GP & community placements, 1 day per week throughout the year</td></tr>
<tr><td colspan="3">GP practice 1</td><td colspan="3">GP practice 2</td></tr>
</table>

RHCN	**Reproductive health and Care of the Newborn**
MH	**Mental Health**
CH	**Child Health**

Key innovations

- Longitudinal integrated clerkships (LIC) in 'Complex medicine' and Primary Care with continuity of tutor
- Long-term follow up of patients with conditions relevant to the Units and ILOs
- Integration of learning in primary and secondary care
- Substantially increased time spent in CoE/end of life specialities

Longitudinal integrated clerkship in Primary Care/Community

A longitudinal clerkship in Primary Care integrated with secondary care and with learning opportunities in community settings and services should provide our students with the benefits and positive outcomes that have been described for integrated LICs in the education research literature:

- Better scores in clinical performance examinations and internal medicine examinations[1,2]
- Higher percentage of core conditions covered [1,2]
- Students more consistently described opportunities for growing into the doctor role compared to students in block placements[3]
- More likely to choose General Practice for further training[3]

A LIC in Primary Care/com. should help students with the following learning outcomes

- Learn about the whole spectrum of conditions and their management
- Better understanding of the lived patient experience
- Better understand the patient journey
- Gain insight into the role and needs of carers
- Learn about and contribute to 'patient safety'
- Gain insight into how primary and secondary care work together
- Further develop their clinical skills and become confident and flexible learners
- Build confidence in their clinical judgement and managing uncertainty
- Learn about self-care

Organisation of learning in Primary Care and associated community settings

- Structured apprenticeship style learning under supervision.
- Two students per practice during each of the LICs
- Students will be based in two GP practices, one in each academy (18 weeks/acad.)
- Students will have 1 day/week=2 sessions in Primary Care and associated com. settings.
- These sessions will be on Wednesdays.
- Students will consult with patients on each of their GP/com. days plus menu of learning options
- Students will be allocated **patients for long term FU** at the start of each GP clerkship.

Consultations with patients

- On each of those days students will be consulting with patients. The number of consultations will increase as they gain experience and progress through the year. This means that by the end of their second GP LIC students will be consulting for 2 hours on each of their GP/com. days, seeing 6 patients.
- They will be seeing **unselected patients**. Students will be expected to learn about the problems those patients present. This will mean that some of that learning is directly relevant to the RHCN Unit while they are studying in that Unit, for example patients presenting with a new pregnancy or with PMB or vaginal discharge. Some learning will not be directly relevant to RHCN, i.e. urinary symptoms in male patients.
- Other opportunistic learning experiences (this list is not exhaustive): time with practice pharmacist, local pharmacist, other health care professionals, school nurses, home visits, urgent visits, meetings (clinical, SEA, end of life, PHCT etc), repeat prescribing activities, dealing with results and letters etc
- 'Unscheduled' learning such as this will be supported by a **virtual medical school** – all learning objectives and materials available online for students and teachers in all years.

General thoughts about changes from small group discussions

- Wish I had been taught like this when I was at medical school
- Definitely see advantages of longitudinal learning
- Think it will increase the number of students wanting to do GP
- Increased exposure to GP positive for recruitment and finance
- Opportunity for more teaching as part of regular post to improve portfolio nature of job
- Would it be helpful for GP student teachers to have their own support group?
- Will have to reinvent how we do our teaching
- Going to be interesting! Need to change the way we do things massively due to change in days
- Capacity an issue
- Daunting
- Finals in Year 4 will mean that students will focus on exams rather than learning in GP
- More change – change in timetables and the way we work/practice

Consultations

- Sitting in with another student not always helpful
- Students could both be seeing patients in the morning, one in the first half, the other in the second half of the morning
- Easier sell to others to just have one student sitting in

Authentic tasks

- Reviewing discharge letters
    - With pharmacist
    - Looking at prescribing
- Follow up patients who have been discharged
- Long-term conditions – spend 20 minutes with patient
    - List of things to be looked at
- Audits
- Results on EMIS

Case based learning

- Professional discussions
- Tutorials
    - Could be cluster tutorials shared with other practices
    - Maybe once a month

Mental health. Self-harm and suicidal behaviour

This session was given by Dr Becky Mars, Research Fellow specialising in self-harm and suicide and Dr David Kessler, an academic GP whose research focuses on the treatment of anxiety and depression in primary care. It covered the topics below and stimulated a lot of discussion and learning points to support our daily GP work. If you have any questions please contact becky.mars@Bristol.ac.uk or let me know if you would like copies of her slides.

Self-harm is common, dangerous, usually a coping strategy and not necessarily associated with a mental health problem. It is not just part of certain sub-cultures 'goth / emo' etc or a teenage phase. Repetition is common. Around 30% still self-harming as adults.

- It is one of the commonest reasons for A+E attendance
    - over 200,000 each year
    - around 1500 in Bristol (but estimated 25,000 in community)
- 2014 Adult Psychiatric Morbidity Survey
    - 6.4% of 16-74-year olds reported having self-harmed
- rise of SH is increasing over time – particularly for teenage girls. In a GP study over 600 practices – 68% rise between 2011 and 2014
    - 5.4% reported past year suicidal thoughts
    - One in four 16 to 24-year-old women reported having self-harmed at some point; about twice the rate for men in this age group

For SH, NICE guidelines recommend...

- 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm
- The intervention should be tailored to individual need, and could include cognitive behavioural, psychodynamic or problem-solving elements.

Types of treatment include

- Cognitive Behavioural Therapy
- Dialectical Behavioural Therapy
- Problem solving therapy
- Family Therapy

Top tips

- Minimise harm:
    - ice cubes, elastic bands, pen
    - advise re alcohol and drugs
    - wound dressing/tetanus/first aid
    - reduction of dispensed medications
    - diaries

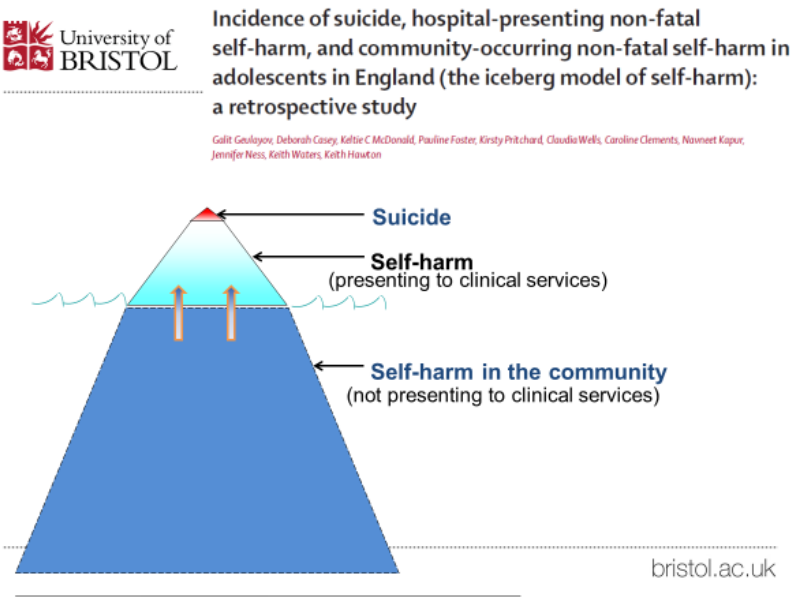
Identify help:
Professional/non-statutory orgs, GP carer/friend/supporter

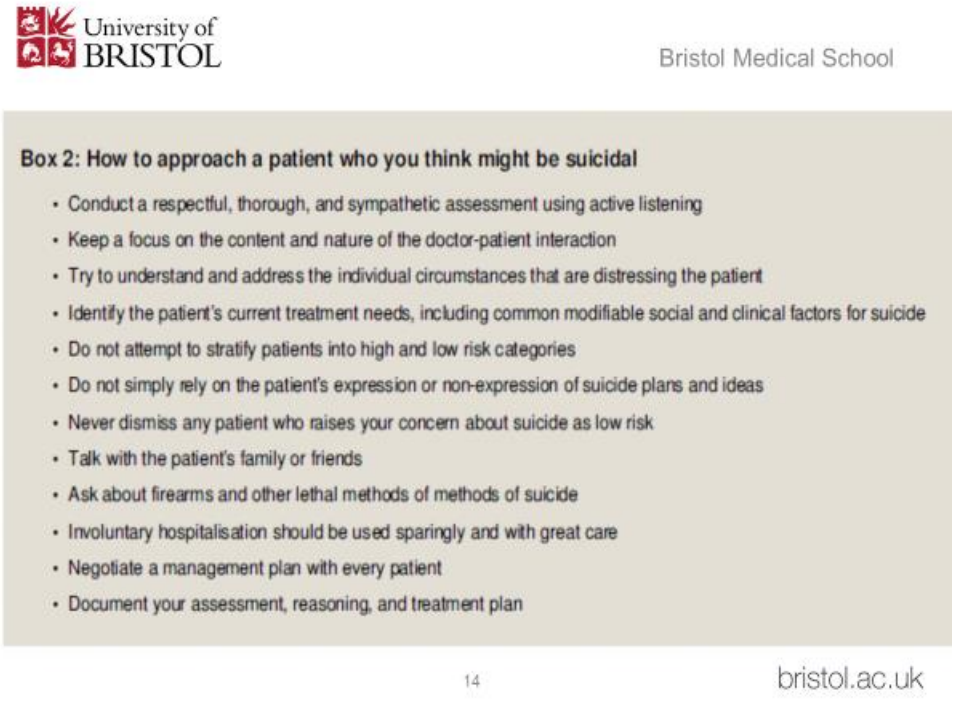
Risk of suicide with SH

- SH is the strongest known predictor of suicide:
    - Risk of suicide up to 100x times higher amongst those who have self-harmed
    - Almost half of all people who die by suicide have previously self-harmed
- Systematic review of 177 studies (Carroll et al, 2014; Plos one)
    - Risk of repetition after 1 year 16.3%
    - Risk of suicide after 1 yr. =1.6%. 3.9% after 5 years

Risk assessment tools

These scales are usually checklists that can be completed by a clinician or sometimes the service user. They are designed to give a crude indication of the level of risk (high or low) of a particular outcome, most often suicide. NICE advise against using these to predict future SH or suicide or to guide discharge decisions. They can support an individualised risk assessment: comprehensive psychosocial assessments of the risks and needs that are specific to the individual should be central to the management of people who have self-harmed.



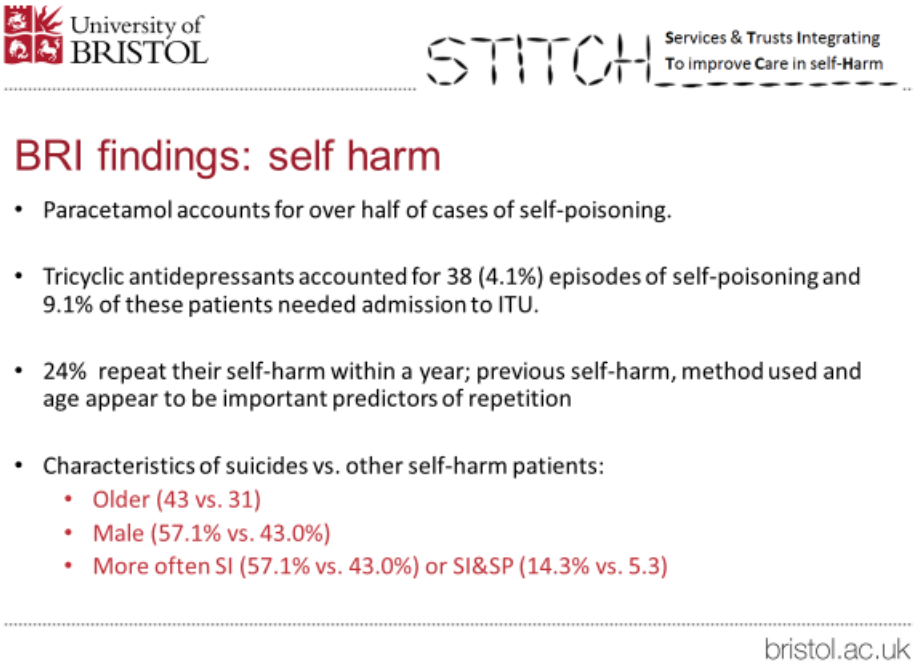


What can we teach our students??

- How to ask about DSH
- Not to avoid asking or difficult questions
- Individual risk assessment without over reliance on scoring tools
- Finish consultations on a positive note
- Be aware of own attitudes and stigma around DSH
- Hand responsibility back to the patient
- Safety net and planed follow up
- Think about stigma*

*Attitudes held by clinical staff towards people who harm themselves, together with their knowledge about self-harm, are likely to be important influences on their clinical practice

Local research



Few other tips

60million SSRIs prescribed/year/England

See the table in the appendix for toxicity of various ADs

Sertraline remains first line for combination of efficacy and low toxicity
NB. Lofepramine is safe in OD but relatively ineffective
Fluoxetine can safely be used under 18, normal dose from age 14

IAPT – see 1million people/year in the UK

Kooth, from XenZone is an online counselling and emotional wellbeing platform for children and young people https://kooth.com/

Research in the Centre for Academic Primary Care

In this presentation, Matthew Ridd, GP and reader in Primary Care talked about the who, what, what, where and why of CAPC: more info at http://www.bristol.ac.uk/capc

How is primary care research different?

Other research
- Disease/system-focused
- Drug-focused (new)
- Efficacy

Primary care

- Person-focused
- Non-drug, old drugs or alternative drugs (CAM)
- Effectiveness (pragmatic)

We reviewed different research designs and the process from start to end thinking about where does it all come from and why does it take so long? We also considered different ways to become involved as and what the barriers to this (unholy trinity of time, money and paperwork!)

What do you know about research?

Qualitative
- Interviews
- Focus groups
- Ethnography

Quantitative
- Cross-sectional
- Case-control
- Cohort
- RCTs

Different ways to engage

Practice (CRN)
- Sessional
- Level 2
- Level 1
- Associate
- Commercial

Individual
- Surveys
- Interviews
- Mail-outs
- In consultation recruitment

Current studies

Maybe you or your practice have contributed to or heard about these?

DUTY. What is the best way to diagnose a UTI in children presenting to primary care with an acute illness? Hay et al. Ann Fam Med 2016; 14: 325

Cross sectional study of 3036 children 3 months-<5 years who were unwell. They assessed symptoms & signs and MSU (clean catch & nappy pad). Of a total of 2740 (90%) samples, 60 (2.2%) had a proven UTI.

Features that supported this were:
- Previous UTI, increasing pain/crying on passing urine, increasingly smelly urine, abdominal tenderness on examination
- Absence of severe cough, increasing clinician impression of severe illness, normal ear examination
- Dipstick leukocytes, nitrites, and blood

Another interesting study evaluated **eConsultations. Banks et al. BJGP 2017**
A free eConsult pilot was carried out in 36 GP practices (396,828 patients) in BNNSG. Analysis was via mixed methods - web analytics, survey, EMR review and interviews

The results showed that eConsultation rates were low – 2 per 1,000 patients/month

- 60% Mon-Fri. 70% 7 am-5 pm. 82% 25-64 years

The reasons for these were:

- 23% administrative
- Outcomes were:
  - 38% F2F
  - 32% telephone

The authors concluded that it works best for simple enquiries, such as test results or advice for ongoing conditions, and eConsults cannot replace face-to-face consultations in complex situations.

BATHE. Santer, Ridd et al. BMJ 2018; 361: k1332

A further study discussed found no evidence of clinical benefit from including emollient bath additives in the standard management of childhood eczema.

The 3D Study:
Improving whole person care

- RCT, 33 GP surgeries (1546 patients)
- Adults, 3+ LTCs
- Usual care
- Intervention
  - Dimensions of health
  - Depression/MH
  - Drugs (polypharmacy)

↑ experience of patient-centred care

But not
↑ quality of life or
↓ burden of illness or treatment

Salisbury et al. Lancet 2018; 392: 41

So, in conclusion, what has Research at the Centre for Academic Primary Care ever done for you (us)?

We discussed how we all need research for our teaching – both postgraduate and undergraduate; without supporting research (directly or indirectly) we won't know what to tell our medical students, trainees or know ourselves what to do! Also, the importance of research to influence guidelines, CCGs, etc to reflect real-life primary care and maintain/build the standing of the profession. And finally, for sustainability – of general practice and the NHS (how to more with less – efficiency, stop prescribing things that don't work) etc

Patient centred teaching

We discussed a fourfold method to ensuring patients are aware of students being present and giving them a number of opportunities to consent or decline.

What we need to do and when:	**How:**
Publicise that we are a teaching practice	Consider information on website/leaflet or in the waiting room
Advise patients at booking	All consultations where students are present should be clearly identified in advance so that patients can be advised of this at booking (this may need special action for appointments booked online)
Remind at check in	Either via the check in machine or a sign at reception/by the machine or the receptionist can advise the patients. It's a good idea to have an explanatory sheet that the receptionists can hand to each patient; if your patients sign in on a touch screen it may be helpful to put a message alongside it asking patients to see the receptionist on arrival. See below for the sheet that receptionists hand out at Portishead Medical Group.
Confirm when calling the patient	GPs or other allied team members doing teaching need to check that the patient is aware there is a student present and confirm their verbal consent - before they are in the room with the student. (Gold standard is to document in the notes that a Medical student was present)

We considered the use of a letter like the one below to give to patients on arrival to further inform patients. This is available in the GP teacher guide.

Medical Students

XXXXX surgery is a teaching practice, which means that from time to time we have medical students here on placements of up to 4 weeks long. We greatly appreciate our patients helping us to teach these student doctors. ***There is a medical student at the practice at the moment, working with the doctor you are waiting to see****. You should have been told about this at the time you booked the appointment, and again when you arrived here today. The consultation may take one of 3 forms:*

1. *The student may be "sitting-in" with the doctor, observing your consultation. He/she may be asked questions by the GP during the consultation.*
2. *The GP may be "sitting-in" with the student. In this case the student will be leading the start of the consultation, with the doctor present in the room. Please try not to talk to the doctor until he/she joins in the consultation. At the end of the consultation the GP will confirm your diagnosis and treatment and will answer any questions that you may have.*
3. *You may be invited to see the student on his/her own before seeing the GP. In this case, the student will listen to your problem, may examine you, and may suggest a diagnosis and treatment plan. The student may not get everything right but this will not be the end of your consultation. The student will explain everything to the GP in your presence. This will give you the opportunity to correct anything and will give the GP the opportunity to ask you extra questions and possibly examine you again. The GP will then give you his/her diagnosis and suggest some sort of treatment. If the student made a different diagnosis or suggested a different treatment then the GP will explain why this is not right for you. Students learn a huge amount from this experience and most patients find it helpful too.*

If you would prefer not to see a student at all, please let the receptionists know so you that you can be booked in with another doctor, or with the same doctor at a different time.

Finally, we and the students would like to thank you very much for helping us with this important teaching. Our student feedback is overwhelmingly positive, and this is largely due to our very helpful patients! ***We can't do it without you!***

We also thought about ways to get feedback from our patient and possibly give feedback to them. We concluded that sharing the fact that patients are teachers too, and often experts in their own condition would reinforce the patients' enthusiasm to help with teaching and possibly benefit their self esteem and general outlook that day.

We discussed ways of asking the patients for feedback on how the student consulted. This is powerful feedback and can be requested informally at the end of the encounter or more formally using the university central patient feedback form - available at https://www.bristol.ac.uk/primaryhealthcare/teaching/teaching-in-practice-by-year/four/

We thought about applying the 'Friends and Family' test to our student doctors and discussed how we may need to guide patients to feedback on specific areas for constructive useful information. One GP always asks the patient to tell the student what they think makes a good doctor- invariably the response involves listening and patient centred care, but again very powerful for the students to hear this direct from a patient.

Involving allied health care professionals (AHCPs) in our teaching

The focus of this session was to enable our GP teachers to be able to harness all the possible teaching supports and opportunities for students in our practices. We wanted to consider the advantages of involving allied healthcare professionals in teaching, whilst being aware of possible disadvantages….and feeling able to embrace the challenges!

The long-term outcome will be a PHC protocol and resources for your allied healthcare professionals to use. We plan to develop a teaching resource that you can use for a short teaching session with your AHCPs to increase their enthusiasm, confidence and competence in teaching - hopefully available by the Spring. Watch this space!

From the GP teacher guide

"*In year 4 students learn about the art of general practice as well as clinical and consultation skills. For this reason, we ask that the lead teacher is a qualified GP. Trainees and other health professional can deliver some sessions and teaching but the bulk of the consultations that students observe or have observed should be with an experienced GP. "*

Who is teaching?

A questionnaire was sent to all 106 GP practices, within the footprint of Bristol Medical School, who are involved in the supervision of our year 4 medical students.

They were asked to identify allied health professionals (AHPs) who had supervised medical students during the month-long clinical placement at their practice

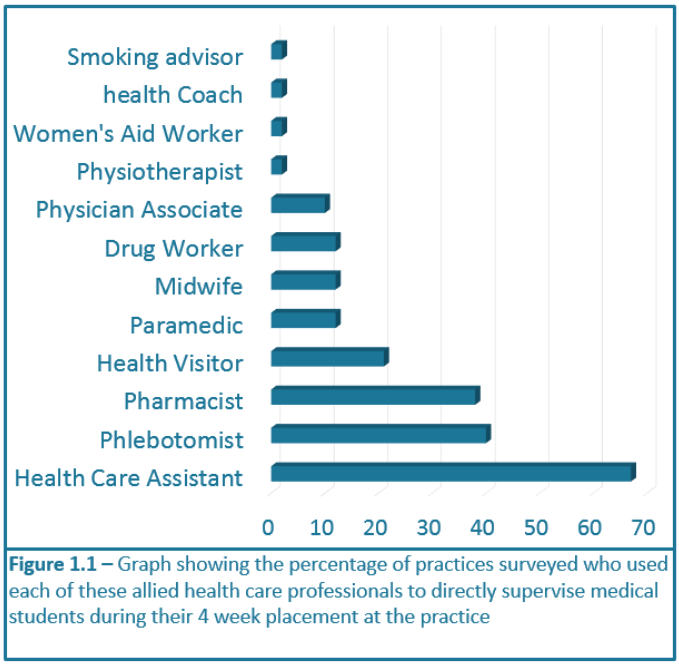
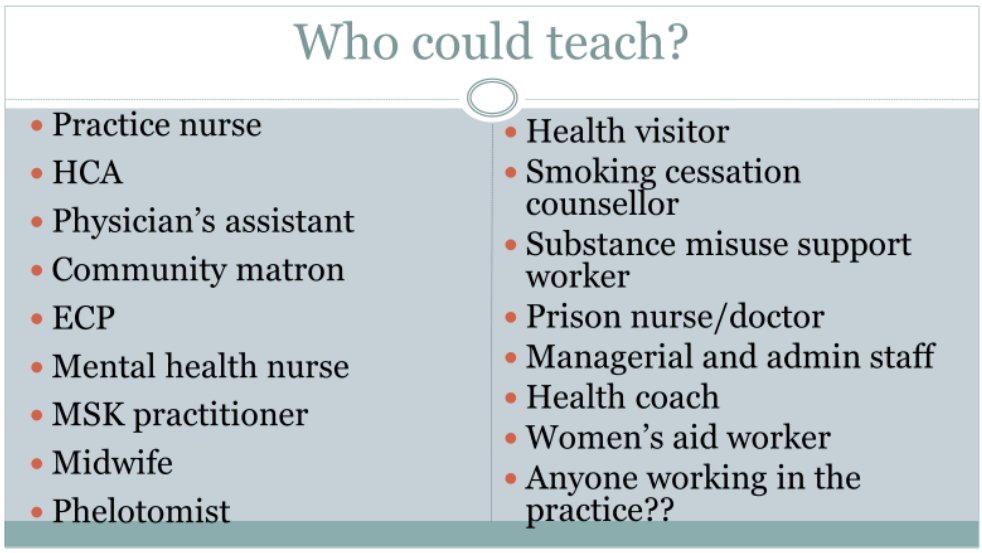


Figure 1.1 – Graph showing the percentage of practices surveyed who used each of these allied health care professionals to directly supervise medical students during their 4 week placement at the practice



Benefits for students

- Need to learn that patient care is increasingly dependent on collaboration of interprofessional healthcare workers and teams
- More people to say hi and chat to in the staff room!
- Enables student variety in their day and wider range of experience
- Can complement learning e.g. focus on reasoning and knowledge vs communication and collaboration skills
- AHCPs often better experienced in some fields. E.g. may be essential in a practice where most asthma management is done by the Nursing team
- Practical skills (CAPS logbook)
- Better insight into other professions
- Do not feel burden too or get bored of lead GP

Benefits for lead GP and the practice

- Frees up GPs for other duties – clinical, admin, managerial. A break from the student!
- Enables approaching clinical teaching like patient care as a team effort
- Sharing of knowledge in the MDT benefits patients and promotes productive working relationships
- Embrace teaching potential of other AHCPs
- Enables them to give student a broader experience

For allied healthcare professionals

- Same as for teaching GPs - personal satisfaction, new skills, fun, professional development
- Feel part of practice teaching team
- Insight into medical training
- Opportunity to formalise their roles in order to recognise their experience and expertise
- Opportunity to influence Tomorrow's Doctors

Challenges

- Perception that GP is main teacher
- Complex timetabling
- Time and service pressures
- Lack AHCP confidence – some need persuasion to take students

- Lack ‘teaching’ skills
- Need adequate supervision
- ? Concerns about indemnity
- Student perceptions?
- Ability to given good feedback
- PHC – do our efforts to improve clinical teaching focus too much on individual GP teachers?

How?

- Enthuse and train AHCP – resources coming! Will be online, can be printed and pinned up in surgery.
- Hope to develop presentations that you can use to train up your AHCPs
- Workshops for AHCP
- Ensure students meet all team members early so AHCP feel part of teaching team
- Consider core problems and learning opportunities
- Adhoc experiences vs planned learning
- Remember to block time out when possible
- Remember can do ½ session
- Some timetables will have sessions scheduled early on, others will review on that morning e.g. see what is booked into treatment room, arrange student to attend for specifics
- Can do tutorials on relevant topics e.g. asthma management, Minor Illness
- Ensure AHCP feel confident and prepared
- Need clear lines of supervision, for student- overall GP teacher is supervisor for both

Clarification regarding indemnity

Following the Secretary of State for Health's decision to possibly introduce a state backed indemnity scheme for GPs from early 2019 the landscape regarding indemnity has been uncertain so here is some clarification from work done by Trevor Thompson and Ciaran Conway. This advice will be updated when appropriate.

- PHC research direct with Medical Defence Organisations – MDOs all in agreement that a student under supervision by a GP is covered vicariously by the GP's indemnity.
- There is an expectation that practices inform their MDOs that they are teaching.
- MDOs cover GPs doing student training/educational work but not ‘practice business’
- The GP teacher retains overall supervisory role if student is with an allied healthcare professional e.g. practice nurse or HCA
- The fall- back is the university’s public liability insurance. This *liability insurance is to cover the University’s “business” of education and research, but this does include an extension to cover the personal liability of students in connection with the business; in this case they are undertaking an educational activity.* i.e. students do have secondary indemnity to cover situations were they to do some harm that isn't covered by the MDOs in the course of legitimate supervised practice

In practice: e.g. for flu vaccs
a) make sure students are fully briefed by a doctor around issues arising (principally vaccination reactions)
b) know exactly where to go for help from a *doctor*
c) are practically supervised by the nurse/HCA in charge – someone who has been trained in the procedure

- d) ensure students self-identify as such and usual patient consent

Appendix 1 – from mental health lecture

BJPsych The British Journal of Psychiatry (2010) 196, 354–358. doi: 10.1192/bjp.bp.109.070219

Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose

Keith Hawton, Helen Bergen, Sue Simkin, Jayne Cooper, Keith Waters, David Gunnell and Navneet Kapur

	Both genders	
	Rate ratio (95% CI)	Relative toxicity index[a]
TCAs		
Amitriptyline	8.6 (7.8–9.5)	1.0
Clomipramine	12.5 (8.9–17.0)	1.4
Dosulepin	23.3 (21.4–25.2)	2.7
Doxepin	22.5 (14.1–34.0)	2.6
Imipramine	12.8 (8.3–18.9)	1.5
Nortriptyline	11.0 (3.6–25.5)	1.3
Trimipramine	14.2 (7.8–24.3)	1.7
All seven TCAs	13.8 (13.0–14.7)	1.6
SNRI: venlafaxine	2.5 (2.0–3.1)	0.29
NaSSA: mirtazapine	1.9 (1.1–2.9)	0.22
SSRIs		
Citalopram	1.1 (0.8–1.4)	0.12
Fluoxetine	0.3 (0.2–0.5)	0.03
Fluvoxamine	0	0
Paroxetine	0.3 (0.1–0.5)	0.03
Sertraline	0.4 (0.2–0.8)	0.05
All five SSRIs	0.5 (0.4–0.7)	0.06

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