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Appendix I: Meeting Agenda

Appendix II: Posters by Academic Fellows

Appendix III: Previous Academic Fellows
Participants

Harry Ahmed, Foundry Town Clinic and Cardiff University
Madeleine Attridge, Cardiff University
Swarna Bhat, Ynysybwl Surgery
John Bligh, Cardiff University
Simon Braybrook, Butetown Medical Centre
Geraldine Buckley, Welsh Government
Alison Cooper, Cardiff University
Freya Davies, Cardiff University
Glyn Davies, White Rose Medical Centre
Huw Davies, Keir Hardie Health Park
Adrian Edwards, Cardiff University
Meirion Evans, Cardiff University
Susan Evans, Cardiff University
Karen Gully, Welsh Government
Steve Harries, Ashgrove Surgery
Helen Houston, Cardiff University
Ruth Hussey, Welsh Government
Jonathan Richards, Cwm Taf University Health Board
Naomi Stanton, Cwm Gwyrrd Medical Centre
Kevin Thompson, Cardiff University
Alice Wu, Cardiff University
Dr Kevin Thompson welcomed everyone, thanking the Chief Medical Officer, Ruth Hussey, Karen Gully the Primary Care Advisor to Welsh Government, Geraldine Buckley, Policy Manager within the NHS Education and Training Workforce Team, Jonathan Richards from Cwm Taf Health Board and John Bligh, Dean of the School of Medicine for sparing the time to attend. Also thanked were Meirion Evans, consultant in Public Health, Helen Houston whose vision and determination along with Chris Butler ensured the Scheme’s inception and successful launch, Adrian Edwards, the Institute Director, GPs who had come to present and the Academic Fellows.

Professor Adrian Edwards also gave a warm welcome to all, saying how much he appreciated so many people with such an interest in the Scheme making the time to attend. He gave particular thanks to Kevin Thompson for keeping the Scheme running smoothly year on year.
Welcome Address, Professor Adrian Edwards, Institute Director, Primary Care and Public Health

There is a context where general practice gets its fair share of knocks and the Academic Fellows Scheme is part of the planning for a good response to that.

There is a very strong collaboration of the relevant stakeholders to make things happen in the right way within Wales for the coming year. These include the University Health Boards, Welsh Government, RCGP Wales and, in the University setting, the Deanery / Postgraduate and the School of Medicine / Undergraduate. A positive part of this collaboration and development is The Primary Care Plan that has now been put out for consultation. In order to thank some members here for their contribution, NISCHR, the research arm of Welsh Government, has now approved the Wales Centre for Primary and Emergency Care Research, so that we, leading from Cardiff University, are one of the five centres placed in with the top priorities for health and research alongside Medical Health, Cancer, Dementia and Population Health.

Today we will celebrate the good things that have been going on and hear about some of the practice developments and the good academic outputs and qualifications of the Fellows.

One point to note is Dr Harry Ahmed’s achievements. Harry was one of our Fellows until the autumn and he has been successful in being one of three GPs in the UK to gain an NIHR PhD student Fellowship, so it is a great output from this Scheme. We have also just recently secured publication for a journal article in Education for Primary Care which summarises the Scheme over the last 10 or 12 years. As soon as we get the PDF version, we will be able to start disseminating that and distributing it widely and specifically.

One or two summary points: The Scheme was started in 2001 by Helen Houston and Chris Butler. Since then we have amassed a cohort of really good quality GPs working at the coal face, being involved in teaching, research and leadership. Although many former Fellows are in leadership roles (GP appraisers, LHB management, senior academics), the particular important feature is the retention of the workforce here locally in Wales. At our last count, 70% of Fellows graduating are now working in South East Wales, the majority of those in deprived areas, so this is a jewel in the crown for development in the field generally to solve some of the recruitment and retention issues. Perhaps partly because of this, we are getting a strong sense of support from Welsh Government that we should expand the Scheme to reach out to colleagues in north and west Wales to develop similar schemes in those areas as well. Our GP academic colleagues in Wrexham have a track record with the Scheme in Flintshire LHB in previous years and they have an academic base which should make it reasonably easy to build upon to expand the Scheme there. We are also very keen to work with colleagues in Swansea to work out how we can start and establish the Scheme in that area.

The other point to highlight is the policy relevant dimension. We are actively involved in discussions with leaders of the Inverse Care Law initiative for Cwm Taf and Aneurin Bevan UHBs about how we can support this initiative with Academic Fellows working with those
practices to maybe enable some of those GPs to be more involved in the interventions themselves.

The Scheme has policy relevance with the Inverse Care Law work and addresses priorities like the recruitment and retention challenges. These are key outputs.

What you are going to hear about today is some of the practice development and quality improvement work that is going on. Yes, practices have got good ideas and want to improve quality, but they often don’t get the appropriate support to do it. The support doesn’t have to be money, it can be time backfilled into the practices and I think this is a really useful model. We could perhaps think about how to apply this model more widely to support the practices in the work that they want to do.

**Introduction, Dr Kevin Thompson, Director, Academic Fellows Scheme**

The initial *Service Level Agreement* with Welsh Government was set up by Prof. Chris Butler and Prof. Helen Houston to provide the following:

- Support by trained general practitioners, to general practices in areas of high need in Wales, to enable them to improve health care delivery
- Higher professional training for the Academic Fellows
- Establishing and maintaining academic links with general practices in economically and socially disadvantaged areas

**Outputs**

*Attached Practices: achievements*
Practices are chosen because they are in the 20% most deprived areas according to the Welsh Index of Multiple Deprivation. Practices also complete a questionnaire and produce a development plan.

**Previous Academic Fellows**

30 AFs completed 79 GP attachments between 2001 and 2014.

29 out of the 30 published during the Scheme

**Postgraduate Qualifications**

- 18 in Medical Education
- 8 in Public Health
- 2 in Epidemiology, 1 in Preventive Cardiology and 1 in Psychological Medicine
- 12 Masters, 5 Diplomas, 13 Certificates

2 former AFs have been awarded PhDs, 1 is working on a PhD Fellowship

**Unexpected Outcomes**

30 graduates of the Scheme 2001-2014

- 70% of graduates of the program are now working clinically in South East Wales.
- 57% are working in areas of high deprivation, mostly in the South Wales Valleys.
- 2 ex AFs are working within Public Health in Spain, 1 in community medicine in the Netherlands and 1 is a full-time clinical academic in Cardiff.
Before the Scheme started, very few Valleys practices hosted undergraduate medical students. This number has grown considerably in recent years.

8 participating surgeries have now become teaching practices.

26 previous AFs committed to further academic roles on completion of the Scheme.

Of these, 13 graduates of the Scheme are currently in academic posts and 10 commit to regular session teaching work. Previous Academic Fellows involved in teaching undertake medical education research.

6 ex Fellows are currently in research posts. 2 have gained a PhD and 1 is currently working on a PhD Fellowship.

This attracts people not necessarily wanting to become academic GPs or to become teachers but people who want a more rounded professional life afterwards and it gives them the opportunity to move in those directions.

Ashgrove Surgery, Dr Steve Harris

Dr Freya Davies joined the Surgery for six months and the plan was to develop two key areas, to improve the clinical services (this can be challenging with a rise in age and chronic clinical conditions) and systems.
It is very important to have accurate information and know the prevalence for planning of services. This also has QoF relevance.

Over the last 10 years there has been success in dealing with unplanned pregnancies in teenagers, but there are other needs so throughout the 6 months we audited our current service. New guidelines for implants were developed and we continue to provide one of the only coil fitting services in this part of RCT. We also wanted to develop our understanding and practice of using the LARCs as emergency contraception. Re-audits are in progress to keep an eye on our services progressing. We have had a vasectomy service for many years now. A team of primary care surgeons is organised through Ashgrove Surgery. We supply some of the services ourselves and organise a team of GP surgeons from Cardiff & Vale and RCT. This particular development was to improve the communication that people would have around the service and the treatment that they were looking for.
The practice has quite a name in terms of minor surgeries so we have continued to develop that. At present 5 of the 6 partners are actively involved in providing minor surgery, again to try to move care into primary care from secondary care.

Another very important part of primary care since I’ve become a GP is the increase in how much we rely on our IT systems. We use Vision+ and that is constantly developing. Dr Tom Hodges-Hoyland (the lead GP for the Academic Fellow attachment) has got a particular talent for this and is on a committee working with the developers of Vision. He has made our lives a lot easier when it comes to printing off referral forms, inputting data like flu jabs and this can save hours a week if the time is counted across a primary care team. He has also looked at recent guidance released, again trying to help us jam as much into that very complicated 10 minute consultation that we are allowed with patients. Obviously it goes over, but we try our best to provide useful information for people to go home with, so they are not overburdened with complicated facts.
We have got what is the envy of some other practices, referral forms that come off with the click of a button, but that has taken time to develop because of the complicated IT system that we have now in the practice. We have also as part of our strategy developed an interest in research and we are just on the edge of becoming more involved with one cohort of patients – children with eczema, enrolling them to the study and developing that service within Ashgrove. There are several reasons for becoming more involved in research. One of them is that colleagues want to develop this interest to have more variety in the everyday work that we do and also hopefully improve the care for certain patients.

_Cwm Gwydd Medical Centre, Dr Naomi Stanton_

I work in the Rhondda. I am a GP partner in the practice that I was attached to as an Academic Fellow a number of years ago. I have gone on to be a GP Appraiser and I still work in the University as a Clinical Lecturer. I have also taken on the role of the Clinical Director for Rhondda.

I am very interested in looking at remodelling primary care and the way we deliver our traditional management of patients in primary care because I don’t think the way we deliver it at the moment is going to be sustainable for much longer. I am particularly interested in
traditional chronic disease management and how we can look at maybe remodelling that within the practice and then also leading on from that to tackling the risk factors for chronic disease.

Over half our patients live in the most deprived fifth in Wales and risk factors and disease prevalence are higher than the Welsh and Cwm Taf averages. In terms of obesity, the figure is 18.9%. In fact a final year medical student recently looked at the BMI of any patient coming through the surgery doors to see the healthcare assistant, the nurse or the GP and actually that figure was getting up to around about 40% of patients. We are also seeing that it is the young people who are coming through the door.

As I said earlier one of the things we have done during Harry’s attachment - thank you very much Harry - was to look at our disease prevalence as well and make sure our disease prevalence data was tidy.
I think the inverse care law is still very evident. Obesity, smoking, alcohol and drugs are prevalent and a house in Tonypandy was in the national press as being the cheapest in the whole of the UK.

**Chronic Disease**

The risk factors, intermediate conditions and disease endpoints are really all tied up. Whenever we have got these conditions we have got to think about lifestyle. A more than medicines approach needs to be adopted.
This is a chronic care model that has been developed to give advice, thinking about the healthcare system as a community, how to improve self-management and support for patients and hopefully end up with improved outcomes. I am quite interested in looking at motivating patients so have spent a lot of time looking at the King’s Fund reports and how to support people to manage their health.
The overall aim is to place the patient at the centre of their care and empower patients to take some responsibility but also to improve their knowledge, understanding as well as their skills and their desire to take on some of their self care. We are looking at identifying the priorities that are patient centred, so when patients come in and they have a lot of different problems, to find out what their goals are for that point in time and focus things down. We would think about a patient in the context of their home, their work, money problems (which are huge). These issues impact on the patient and how they feel they can cope. The idea then is to look at the patient’s goals and to also link them into support outside medicine within the community. To also give them the skills to be able to do that.

**Steps along the way**

- Map out current support systems and engage with third sector and Communities First
- Background research
  - What’s been done elsewhere and works and how
- Risk-stratify patients who have data within the practice
- Identify patients with missing data and determine “screening” approach
- Training for HCAs, Practice Nurses, GPs and admin staff
  - Brief intervention training, motivational interviewing, coaching skills
- Change the chronic disease consultation model

We have mapped out the current support systems. We have a named worker within Communities First and can either refer to them informally or formally. We tidied up the prevalence data but are also looking to risk stratify patients as they very often have multiple
diseases.

Progress

- Patients on existing registers have been risk stratified
- HCAs and PNs have had brief intervention training
- Discussing with patients the patient-held record to ensure fit-for-purpose
- Discussions with IT about pulling off the data to populate patient-held record

We have the prototype and are starting to discuss with patients the idea of what they would like to have to take home and make sure it’s fit for their purpose. The problem is the IT, pulling the data off the records, so I have got an idea for what we want to do but trying to get serial readings into a record for patients is actually proving to be problematic. I have had contact with a couple of companies but at the moment this is going to have to be hand-filled.

Discussion / Comments:

I need to also know what the impact is on the practice because it is not just the consultation, it would be the whole admin system so we need to have a look at one admin person to be responsible for different risks and be able to pull in patients as well. The idea is eventually to give a whole holistic one stop chronic disease management appointment and I would think there are going to be several steps on the way.
We are looking at the same problem at our practice in Merthyr. We now have a redesigned clinical system with one stop shop and it is in its 3rd month. We have fewer appointments, better patient information and have worked to set it up. So far we are delighted with the progress and so we are waiting to see how we can take on board your lessons and hopefully we can then separate our lessons.

With regard to the material, I am learning to be very pictorial which is why I wanted the data trends, I wanted to actually be able to plot a graph to illustrate what was happening. This is the feedback I am getting. Also patients have fed back they want 2 sides of A4. I am also looking at the wheel of life: so getting patients to put down what is happening in their life, their work, their stresses, the impact, what is stopping them making those changes that need to be made. Are there issues with medication, etc., so it is looking at the broader picture. That pictorial representation.

Foundry Town Clinic and Aberaman Surgery, Dr Harry Ahmed

The practice boundary extends all the way from Hirwaun down to Mountain Ash and includes Penywaun which was the 4th most deprived area in Wales in the recent WIMD. Our practice has been through a huge transition over the last 3 years. I started at the practice in 2010 as a GP registrar and stayed on as a salaried GP and then became a partner there this year.
Over that time the practice took over an independently run single handed practice in Aberaman which had been managed by the Health Board for some time.

This year our senior partner became semi-retired so that has also meant some transition.

We had already started making changes and some improvements to the way that we deliver services, for example a complete overhaul of our prescribing system and the way we monitor drugs that we prescribe. We have also changed some of our clinical system in the way we review patients with disease and have tried to combine a diabetic clinic with our CHD clinic to review both conditions in a single appointment.

We are really grateful for the opportunity to have Madeleine who started with us as an Academic Fellow about a week ago, and we plan to do the following for the time Madeleine is with us (1 day/week over the next four months)

As a practice we put together what we thought were our priorities.

We currently run a minor surgery service which unfortunately is inefficient at the present, partly due to staff sickness and partly because we inherited a waiting list from the practice
that we took over a year or so ago. So the minor surgery service is going to be completely
overhauled and redesigned. A second partner will also be trained up in minor surgery so
that there will be two partners offering the service and we can try to deliver that in a more
effective and efficient manner.

We intend to start developing protocols for the two practices. Our priority areas are
hypertension COPD and diabetes. Our prevalence of COPD and diabetes is well above the
Welsh average and we are going to try and standardise that prescribing and bring it in line
with the prescribing recommendations from the Health Board. This is going to be done in
line with the HB pharmacist.

There is currently only one practice in the whole of the Cynon that offers the implanon
service so we intend to train one partner to enable us to offer this service.

Most importantly, we offer a substance misuse service for Cynon and this has been almost
singlehandedly run by the senior partner who is now coming up to retirement. We need
some time for one of the other partners to be trained, sit in and develop that service and
hopefully the transition will be seamless and we can continue to deliver a good service in
that area.

Routes into Academic General Practice, Dr Madeleine Attridge, Dr
Harry Ahmed, Dr Alison Cooper
Madeleine Attridge

I am one of the current Academic Fellows. Some of you have heard us speak over the last couple of years so we thought we would show you how people have come from different backgrounds to the Scheme and how it benefitted them.

2.5 years ago having just qualified as a GP colleagues were chasing partnerships and salaried posts. My leadership mentor had told me to bear in mind I’d have the next 35 years (and that figure is increasing) to fill my career and there was plenty of time to decide. I was keen to explore options and although interested, I didn’t have a lot of experience in teaching or research.

I had only previous done my GP training in Pencoed and Cowbridge and some neighbourhoods were very, very affluent. I really wanted to work in a deprived practice and I hadn’t had that opportunity before.
One development worked on in the last year is the Paired Practices Programme as a good way of sharing ideas and experiences. Some practices may encounter difficulties working on their development project and instead of re-inventing the wheel, they could look at what other practices have done already and use their ideas. Practices have done some brilliant projects.

On the three non-clinical days, the time is split between teaching, research and working towards a qualification. I am working towards a Masters in Medical Education, but I have also been training in other things. I have a Certificate in Menopause Care, an introductory certificate in alcohol misuse, substance misuse and hepatitis AB management and have completed implanon coil training.
We have gained a tremendous amount of teaching experience. If intending to apply for a further teaching role, there is much to include. You would have hardly any teaching experience if coming from a GP practice role.

Research wise I have been involved in a few publications and have been a lead author on a Cochrane Review. Even if I don’t want to be involved in research in the future, it’s just been a great experience to know what is involved in a systematic review and how to do a proper literature search and in a teaching role I am able to advise people how to do their research project. I have been a co-author on an article for BJGP on the Leonardo exchange scheme and I have also written an article on GP revalidation of GPs who have worked abroad.

Before the Scheme my career options were very limited and it was very difficult for me to get into teaching and research but this Scheme has really given me a lot of experience from which I can apply to a whole range of roles and hopefully I am going to work as a portfolio GP.
I started as an Academic Fellow four weeks ago. I haven’t taken a traditional route into academic medicine. I went to Oakfield Surgery in 2003 as a trainee and I qualified in 2006. I stayed on then as a salaried doctor and became a partner in 2008. It is a busy practice with 13000 patients in the Welsh valleys with 7 partners. As a partner I ran some joint injection clinics. This was an area of interest as I previously completed an MSc in sport and exercise medicine. I also did the minor ops and trained a partner when I left. Later on I set up sexual health clinics fitting implants and coils. Now one of the salaried doctors is going to take on that role as well.

About a year ago I started working as a GP appraiser which I really enjoyed and found very stimulating. It gave me the opportunity to meet lots of very interesting GPS and discover what other roles GPs can have. I was especially interested in medical education and research and was trying to work out how to get into those areas. Then I saw the Academic Fellows Scheme advertised and thought that is a good way to do it, it has a very supportive framework.

During the last four weeks I have already had the opportunity to be involved Clinical Skills and Communication Skills teaching in the amazing Cochrane building with all their facilities. I have already started studying for the Post Graduate Diploma in Medical Education, so I am actually looking at the theory behind problem based / case based learning which is obviously what the C21 is based on. When I was in medical school, the teaching was very different.
Research wise, I have just joined the PISA team. This is a big team looking at the incident reports in primary care. They have 12,000 reports to analyse. The aim is to gain an understanding about events and contributory factors that led to such patient safety incidents. Statistical methods will be used to identify priority areas that warrant intervention to minimise risk to future patients. As an experienced GP, I feel that I can maybe offer advice on what systems are currently in place and contribute to suggestions that might improve patient care.

I am still keeping up my clinical skills. I am still working in deprived areas and I anticipate that I will continue to work in those areas. I get to share my skills in the Valleys with the practices that I am working in and also I am continuing my role as a GP appraiser which I really enjoy as well, so I am doing that as an extra.

I don’t know where I will be in 2 years time. I’ve just started and plan to make the most of every opportunity. I feel sure that my time in the scheme will be a positive experience whichever avenue I choose to follow. When I first started I was thinking medical education was the way I was going to go but I am really enjoying the research. Whatever route I do go down I can only think the Academic Fellows Scheme will be of benefit to my career.

Dr Harry Ahmed

Harry Ahmed
Former Academic Fellow (August 2012 – August 2014)
Current roles:
NIHR Doctoral Research Fellow (WAG/NISCHR Funded)
Cochrane Institute of Primary Care & Public Health
GP Partner, The Foundry Town Clinic, Aberdare

I absolute thoroughly enjoyed every minute of being an Academic Fellow. I am currently working on an NIHR Fellowship looking at outcomes in people who present to Primary Care with UTIs.

I thought at the start of this presentation I would just give a very quick overview of what the training options are for GPs in Wales who want to do academic training. I came out of medical school in 2003 and went on to do some surgical training for about 5 or 6 years. I then decided I wanted to come into general practice and went on the Cwm Taf VTS. I was in the Cwm Taf VTS for about a year and thought it would be really good to get a flavour of academic general practice. At that point, from what I could find out, there were only 2
schemes in Wales, the Welsh Clinical Academic Track (WCAT) and the General Practice Speciality Academic Training (GPSAT)

The WCAT scheme recruits at specially trained year 1 level and then time in ST2 is split 20/80 research / clinical. Time is then taken out of clinical training to do a PhD, then back into clinical training after which you are awarded the certificate of completion of training (CCT).

In GPSAT scheme recruitment is in specially trained year 2 and the ST3 year, which would normally be the last year of training, gets split 50/50 to research and clinical, so you essentially do an ST3 and ST4 year before completion.

This was the scheme that I applied for and I was lucky enough to get a place. I think what was fantastic about this scheme is that it is very flexible. The 50% research side of the scheme was orientated around the trainee and you get to develop yourself in whichever way your interests take you, whether that be research, teaching or quality improvement.
I used my ST3 and ST4 years in the GPSAT to do some teaching courses, some research training and to complete a diploma in epidemiology from the London School of Hygiene and Medicine. I was lucky enough to get some publications while working on existing data. I did some presentations around existing data as well and most importantly, I developed some strong links with senior academics in the Institute of Primary Care and Public Health.

I then applied for the Academic Fellows Scheme and the reason I applied to the Scheme was its split of 40% clinical and 60% orientation academic, which meant I was able to keep up my clinical skills and also allowed me to build upon the experience and the exposure to research and teaching during training.

Though the 60% is split between teaching, research and other activities, it is again very flexible and it is orientated around you. I was lucky I was supported to develop very clear goals for the next 2 years and I was supported to achieve those goals. My main goal was to secure external funding in order to undertake a PhD.
I was fortunate with the right support and the right application, and I was awarded a Fellowship in 2014: NIHR Doctoral Training Fellowship (funded by WAG/NISCHR “Improving Outcomes for Older People with Urinary Tract Infection in Primary Care.”
By 2035 one in four of us will be over 65 and this is a population that is under researched because they are difficult to recruit and retain into trials and observational studies. I thought that using data from these databases would overcome some of those difficulties and try to answer some important questions within this population.

The other reason why it was important to look at this population is because they are a huge source of admission to hospital.

The graph shows that UTIs were responsible for about 95,000 hospital admissions over a period of a year in the over 65s.
So using this data, what kind of questions can we answer? We can look at effectiveness studies, for example all the people prescribed trimethoprim who are over 65 and look at all those prescribed amoxicillin over 65 for a UTI. We can match them and see if they are more or less likely to lead to a hospital admission, re-prescription, a kidney injury, re-consultation or recurrent infection. And we can use this to try and investigate a series of questions and hopefully this will translate into improved clinical outcomes.

I owe a lot to the Academic Fellows Scheme to getting me to this place now.

*The academic fellows scheme attracts and produces people who are going to make a difference outside the boundaries of the practices that they are attached to.*

**Keir Hardie Health Park, Dr Huw Davies**

Keir Hardie Health Park is based in Merthyr and has 5 partners and 9.5 thousand patients. We had an academic fellow mainly because I am very interested in teaching medical students and hopefully registrars in the future. Most of the members of my practice didn’t have any experience of teaching at all and were very nervous of having students and the impact this would have on the amount of work that they would have to do. I thought it was very important. I have a passion for teaching because I was born in the Valleys and left to study in London. I always wanted to go back and think the Valleys sometimes get a very bad press because people don’t understand it and they don’t see it. The more students, registrars the more people come up to see the Valleys then hopefully the better retention and recruitment in future years. I don’t want to work anywhere else and if I can transfer some of my passion to some of the people I am teaching, then hopefully they will see it as I
see it – as one of the best places you can work where the patients are so good and you can still make a difference.

Our academic fellows allowed us to prepare the practice to become a teaching practice. This included (among other things) staff training and tutorial preparation.

We also took a relatively large number of students which involved quite a lot of preparation.

The tutorial preparation and marking involved a surprisingly large amount of work and time, so much so that some colleagues found this problematic and the marking work was taken back to the University.

Student feedback was good and they seemed to enjoy their experience with us. The patients however really enjoyed having students and still talk about them. It could be quite intimidating to have people from all over the country in your home but patients got a lot out of it and I think some actually learned more about their condition because of the students. Members of staff also enjoyed having students, perhaps not so much at the start but those who were initially nervous became encouraged by it. We would need to take it slowly but perhaps we could also take 5th year students in the future.

As seen in the photograph, my carpark is ruined by this wonderful new university building which hopefully will involve teaching and research and will again bring more people into the valleys. Hopefully, students will be able to use the facilities and I will be able to get involved a little.

The 1st year medical students will come again next year. 2nd year medical students started this year.

I don’t think we could have become a teaching practice without the Academic Fellows Scheme, it helped us to do the work involved and convince my partners, or Prof. Helen Houston who has been a constant support, even sitting in on my teaching sessions where
she was very, very helpful and thanks also to Simon Braybrook the Academic Fellow who was absolutely superb.

*Our Agenda would be to encourage practices to have medical students and there is evidence that people who have a good experience in areas where they are medical students and training, the more likely they are to work there afterwards.*

*White Rose Medical Centre, Dr Glyn Davies*

The picture represents a typical Valleys scene. It is a lovely place to work, partly because of the people but also the environment; nowadays it is a very nice place to look at and work in. The area includes a small community within New Tredegar which is the most deprived place by far that I have worked and I’m amazed that it didn’t come out as being in the top ten in
the recent Wales deprivation data. There are 18.5 thousand patients and we also run a practice in Llanhilleth and Blaenau Gwent. We have trainees and medical students similar to Keir Hardie Health Centre. We also have 5th year students and foundation doctors, so there are a lot of people around.

However pleasant it looks, the Valleys can be difficult places to work with their own challenges. Deprivation is in the top 20% in the country. Many Valleys have a problem of geographical isolation, which can create difficulties in getting to work and recruitment. It is also a problem for patients and it’s a real difficulty for them to get out partly for work if there are no jobs locally but also for things like shopping. We have got 4 chip shops or Chinese takeaways in New Tredegar, I think it is 4 pubs and there is one shop that just about sells some veg, but this is a little shelf. To try to encourage good lifestyles and activities in the Valleys can be challenging.

We have also got the problem of an ageing workforce, not so much in White Rose, we are actually quite a young practice, but there are a lot of people who are coming up to retirement age and there are big recruitment difficulties locally. There are also increasing political and social pressures on general practice.
The darkest shading, represents the 10% most deprived areas in Wales, and the map demonstrates that all the practices here that are participating in the Scheme are situated in the pretty dark areas representing deprivation in Wales.

We were very lucky to have Alison who started with us 3 weeks ago and it’s a great
opportunity for us. She is a very experienced GP so has fitted straight into the team and it is
great to have her there on a day to day basis. This has freed up time for us to concentrate
properly on the merger with a practice further up the Valley. We know that the easiest way
to meet the earlier challenges is to work together in bigger teams. We started the merger
process with meetings and organisational work. There is a huge amount to do and it is quite
a headache. The majority of the time will free us up to do that, but we also plan to do a few
other smaller things. We will review the prescribing formulary just to make it more user
friendly, safer and more cost effective in prescribing. We want to have a couple of meetings
with all the doctors to address our mail handling system to make it a bit safer and more
efficient and better at coding data. And also we need to do an atrial fibrillation audit of
patients on aspirin who should probably be on something else. So a smaller body of work
but still very important and the Scheme will allow us to do that.

Ynysybwl Surgery, Dr Swarna Bhat

Academic fellow scheme

Ynysybwl surgery

Dr Swarna Bhat

We were very pleased to have Simon Braybrook with us for nearly six months.

Background

- Small rural practice
- High Deprivation – over 30%
- Senior partner retired in November 2012
- Practice nurse.
- Practice manager

We are a 2,300 patient practice, a small one and we have high deprivation. A second
partner and practice nurse/manager retired in November 2012. At that time, I had a part-time practice manager, no practice nurse and I was the sole GP with one day cover by a locum GP. So I had to recruit a practice nurse and update all the practice policies and also upskill myself. Those were the objectives when we first applied to the Scheme. But then, due to administrative reasons, the application was not sent. By then I had recruited a new practice manager and practice nurse. As the practice nurse came from medical wards, we employed a PCSU nurse to train her. There were then new issues which came up. Our Tramadol and Pregabalin prescriptions were higher than average and our medication reviews were not up to mark so our revised objectives were to audit, review and then update our prescription policy for medication reviews. We were going to train two receptionists because we couldn’t afford to have a new healthcare assistant. We have shorter hours and it is not very financially viable for them.

**Objectives**

- Medication review
- Tramadol prescription
- Pregabalin prescription
- GP skills
- Support for Practice nurse
- Policy updates

We were given about 52 half day sessions. 2 sessions were used for a COPD project half day teaching sessions.

We conducted an audit and updated our prescription policy. The challenge is to get the patients in for a medication review. With the tramadol prescriptions, we did a face to face consultation, followed the LHB guidelines and we did have about 40% reduction in total tramadol prescribing. We did the same for pregabalin but there were not many pregabalin prescriptions that came from us. Because we have high mental health patients, the prescriptions were initiated by secondary care. I attended quite a few minor op and minor surgery clinics. I also did some gynae. training.
Tramadol

- Excluded patients where Tramadol was started by secondary care
- Applied AWMSG guidelines
- Recall for Face to face consultation
- Tramadol stopped
- All Followed up
- 40% reduction

Pregabalin

- Excluded patients where Pregabalin was started by secondary care
- Applied LHB Pain pathway guidelines
- Notes review & face to face consultation
- Pregabalin stopped or reduced
- All Followed up

GP skills

- GPwSI led minor surgery clinics
- Orthopaedics
- Gynaecology coils and pipelle biopsy
- Hysteroscopy clinic
- Respiratory clinic
- ENT
Experiences of Research and Teaching, Dr Freya Davies, Dr Simon Braybrook

Dr Freya Davies: Research

I am both a former academic fellow and a future academic fellow at the same time. I started on the Scheme in August 2012 and came to the end in August this year. I was lucky to become involved in a research project, which I have been working on since August. Fortunately I have now been given the opportunity to re-join this Scheme which I am really looking forward to in order to capitalise on the experiences I have had so far.

I wanted to spend a couple of minutes giving an overview of how I have gone from somebody with no research experience at all to hopefully someone who has got an ongoing interest in research.
I came into the Academic Fellows Scheme having qualified as a GP and worked as a locum for about a year. I had decided locuming wasn’t for me and was looking for something a bit different.

The advantage of working in a large Primary Care department is that there are many ongoing projects that can enable you to start in research by working with pre-existing data.

There was this very interesting data set from 3 focus groups in South Wales which was part of a wider multi-national study. It was suggested that I look at the Welsh focus group data to start handling qualitative data and to start some basic analysis.

Having done some analysis and produced some findings, I put together a poster to present at the South West Society of Academic Primary Care meeting. This was my first experience of seeing research on a larger scale, with many academic GPs from different institutions with research relevant to practice and this opened my eyes to what general practice research was all about:
It was then suggested that I do some secondary analysis on the data from the other six participating countries: Norway, Russia, Poland, Hong Kong, Netherlands and Germany. I had a lot of data to go through and I noticed from the focus groups that there was a lot of talk around self-management of COPD, how people had used these action plans and how clinicians gave people a prescription to take home for COPD exacerbations. That hadn’t been the focus of the main research project, but we decided this was ripe for a bit of further analysis and that is what I got involved in. I was lucky enough to successfully get a paper published which described our findings.

Around the time I was finishing this project, an opportunity to become involved in a new project around secondary progressive multiple sclerosis funded by the MS Trust arose. A bid had been put in by Adrian Edwards and other colleagues in the department to look at secondary progressive MS because it is a long term, chronic condition with probable parallels with many other chronic conditions, which of course we are very used to managing in general practice. The MS Trust were very keen that we try to look at patient experiences
around early secondary progressive MS, when their MS deteriorates and perhaps patients
are getting gradually increasing disability. Of course this time I was involved much earlier on
and I really got a good overview of stages of research. I was there from the beginning doing
study set up, which involved a huge amount of paperwork which I wasn’t aware of – getting
all the approvals from the ethics committees, from the local research and development and
then the process of how are we going to go about this and start recruiting people, how are
we going to find people, how are we going to prepare them and what information to send
out to them? Then there was the physical data collection, etc. I went on training on
conducting semi-structured interviews and focus groups and then went out and met with
patients and carers and clinicians to talk about their experiences. That was really valuable as
a clinician as well. It is very different doing a research interview when you sit in someone’s
house and you spend an hour with them while they tell you their story about their condition
to the ten minute appointment that we have in general practice. You are not getting the
full insight in that ten minute appointment.

Stages of research

- Study set up – ethics, recruitment
- Data collection – conducted semi-structured interviews and focus group
- Data analysis – inductive thematic analysis
- Results dissemination – presentations and papers

I generated pages and pages of transcripts and then conducted a thematic analysis.
Fortunately this was where some of my experience from the COPD project could be applied.
I have now become involved in the dissemination of the results and trying to ensure the
information is actually spread.

Last month we presented at the annual MS Trust Conference where we ran a workshop
largely for an audience of MS specialist nurses, thinking about the challenges and seeing if
our findings were reflected in their work. This was very useful because as well as validating
our findings, it helped us develop more around how we can take this forward.
I hope my next 2 years in the Academic Fellows Scheme will allow me to get a bit more of this top section to go from the research planning to actually developing a new research idea and getting right through the method of that research process.

We have learned it is very difficult for academic fellows to get straight in and do a full research project so we have learned two lessons: first, they stick to one of the research themes in the Institute and second is that they use existing data and get support. This pays dividends and means the AFs have a slide into research which allows them, as with Freya, to then, if they can, generate a full scale research project.

Simon Braybrook, in contrast to Freya who moved towards research, has moved heavily towards teaching and has done a great and, as you will see, inspiring job.

*Dr Simon Braybrook - Teaching*
I am now a partner in Butetown Health Centre. I entered the Scheme thinking I was going to be very interested in research, but I really really enjoyed the teaching. I am not going to talk about the teaching projects. I really enjoyed Communication Skills and lecturing on health behaviour change. I really enjoyed History of Medicine but one of the things I was passionate about was the opportunity to innovate and the Drama and Public Health project was one where I felt there was an opportunity to do that.

The Drama and Public Health project was started by Dr Guru Naik a former Academic Fellow who had trained in India. One of the things they did in Medical School in India was go out into rural communities and use drama as a way of communicating public health messages. They would take local stories and presentations and use them to communicate a message that people might not want to listen to.
WHY USE DRAMA?

- Drama already embedded in the medical curriculum (e.g., communication skills training, OSCEs)
- 'All the world's a stage' – we all use 'performance, acts, plots and counterplots' to interpret our lives and the lives of our patients (Garro et al., 2000)
- Theatre demands group participation – the audience are bonded by a common experience, facilitated by open communication and self-disclosure (Shapiro and Hunt, 2002)
- Theatre presents fictional characters and stories using real people – facilitates emotional engagement without intellectualisation or avoidance (Shapiro and Hunt, 2002)

I.E. EMPATHY

THE DEVELOPMENT OF THE PROJECT

Learning Aims:

- Knowledge
  - Understand health in the context of the community
  - Understand the principles of public health (surveillance, promotion, prevention)
  - Consider strategies currently used to propagate public health messages

- Skills
  - Improve communication skills, with each other and with children
  - Improve team working
  - Improve ability to write, experiment and role play

- Attitudes
  - Develop a holistic approach to medicine and health
  - Develop empathy for those from a different culture/social background
  - Learn 'by reflection'
THE DEVELOPMENT OF THE PROJECT

Objectives:
- Introductory talks on the principles of public health and existing drama-based public health campaigns (video, radio drama, plays etc)
- Drama workshop with actors from Going Public Theatre Company:
  - Excerpts of health related plays
  - Drama workshop to break down inhibitions, develop characterisation and plot
  - Advice on developing ‘Theatre in Education’ and ‘Drama in Education’ pieces
- Explore health themes relevant to primary school pupils and develop key messages and potential plot
- Visit school to meet pupils and staff, and contextualise health themes.
- Script, rehearse and perform a 20 minute ‘TIE’ play suitable for yr. R-6 assembly
- Plan and deliver a 40 minute ‘DIE’ workshop which develops theme with 30 KS2 pupils
- Reflect upon experiences and learning.

MAIN CHANGES TO THE PROGRAMME: 2012-14

- Inclusion of Going Public Theatre Company:
  - Charity providing high quality TIE and DIE programmes into primary and secondary schools (e.g. mental health, sex and relationships, binge drinking)
  - Opportunity for students to learn from high quality performances
  - Opportunity for coaching from actors on drama skills and script writing
  - Relationship between GP and CU, providing them with health information
- Inclusion of the Workshop element:
  - Allows students to have closer interaction with primary school children
  - Develops new skill set – teaching and communication, facilitation of role play
  - Encourages time keeping and working together as a team.
- Involvement of Rhondda schools:
  - Exposes students to an unfamiliar community with own culture and health needs
YEAR TWO SSC PLAYS TO DATE (2012-14)

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<thead>
<tr>
<th>Title</th>
<th>Theme</th>
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<tr>
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<td>Infection control / hand washing</td>
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<tr>
<td>style</td>
<td></td>
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<tr>
<td>The Tooth Fairies</td>
<td>Dental care</td>
<td>Gabalfa Primary, Gabalfa</td>
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<tr>
<td>The Fit Factor</td>
<td>Healthy diet and activity</td>
<td>Tref-yr-Rhyg Primary, Tonyrefail</td>
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<tr>
<td>Klean Kidz</td>
<td>Infection control / personal hygiene</td>
<td>Hawthorn primary, Llandaff North</td>
</tr>
<tr>
<td>A Lousy Play</td>
<td>Head-lice</td>
<td>Hendreforgan Primary, Gilfach Goch</td>
</tr>
</tbody>
</table>
FEEDBACK FOR SCHOOL / LOCAL GP

From most recent play:

*Many thanks to you and the girls for an informative and entertaining assembly and workshops last Friday. Feedback from both staff and pupils was positive. The big “test” for us will be to see a reduction in the outbreaks of nits over the coming months.

-Acting Head Teacher, Hendieforgan Primary School

*Don’t know if your students have chosen their topic yet, but if not, have just spoken to the practice manager here who had spoken to their school nurse - apparently nits are a huge problem there at the moment, so it might be quite timely if they did a play on that!!!

-Dr Naomi Stanton, GP and member RCT LH8

YEAR 3 SSC

- Extension of the project to a 9 week full time module
- "Commissioned" by a local 6th form to develop TIE/DIE materials on relevant health issues identified as important by students
- Aim: To develop an evidence base as well as an educational package including both TIE materials and workshop
- Focus on physical, social, psychological and emotional health

Some of the issues identified by 6th form students:
- Going to Uni
- Failing exams
- Accessing sexual health services
- Pregnancy scares
- Sexting
- Porn use
- Contraception
- Binge drinking
- Travel health
YEAR 3 SSC

Objectives:
- Attend seminars and discussion groups on public health principles.
- Cover some educational theory to help construct a health message.
- Undertake drama workshops to help develop drama and script writing skills.
- Research in depth an area relevant to the topic and write a 1500 word literature review informing the development of class materials on the topic.
- Design a 20-30 minute theatre piece, and a drama in education lesson plan for delivery in schools.
- Consider how best to evaluate their lesson and assess a change in their students’ knowledge and/or behaviour.
- Deliver the theatre piece and lesson in schools.
- Assessment on their participation in the programme and by their essay.

Output:
- Beyond our expectations!
- Students scripted, performed and filmed a 3 scene video piece centering on 6 students finishing A-levels and moving on.
- Issues included: failing exams, work vs. uni, maintaining a distance relationship, binge drinking/one night stands, sexting, chlamydia, losing virginity, coming out as gay, travel health scares and more.
- In addition, a package for class room discussion and literature reviews describing published evidence were created.
- Poster presentations delivered to local primary school teachers at a showcase event organized by Going Public.
- One presentation went on to win the Academic Prize at the Year 3 Celebrating Excellence conference.
THE FUTURE

- The workshop package and videos impressed Going Public theatre company and are now being used in schools.
- The characters and plot are being developed into a live theatre piece, due to be completed this summer.
- Discussions are being had regarding researching the change in knowledge and attitudes in students exposed to the workshop.
- Mutually beneficial relationships continue between Going Public Theatre Company and the Academic Fellowship Scheme.
- The Academic Fellowship Scheme hopes to continue to run Drama and Public Health modules within the medical curriculum.
Discussion / Comments

Just thinking of in terms what Naomi Stanton was talking about earlier, whether you see potential for this for the more chronic condition management where the problem is to get the messages across in a way that can be used to really engage - whether that might be a potential resource for practitioners who want someone to sit and think and they might find it
interesting to watch?

I think there is from doing this project I have gone from a project that was focused originally on healthy eating and hand hygiene to dealing with aspects about mental health about psychosis about suicide, binge drinking, sexting, porn use. I don’t think there is a topic that couldn’t be covered by this medium especially in schools. You have got the contemporary media. I have a bit of a love hate relationship with how health conditions are presented in the media but I think there is a lot of potential for that to be communicated. I think the ideas are vast.

It is interesting that there was a conscious decision to start with primary school children to keep it simple so that the students wouldn’t have to present complex message and then get lost in it all or come to grief in some way. But it has come on very rapidly hasn’t it?

Yes, I think partly that is us underestimating what the students are capable of. Almost all of them had done drama GCSE, 3 of them had done drama A level. A lot of these students have already got many skills that we don’t know or tap into in medical school and actually they leapt to it.

There are so many initiatives in Merthyr to try and do things with or for people, I just wondered about the evidence that these kind of things do really make a difference in the real world to the children in terms of their longer term behaviour? It is encouraging while people are actually there doing something with an initiative but actually Merthyr in terms of behaviours is much the same as it was 30 years ago?

Yes and no in terms of evidence. It is important to come back to what this is about. This is about the medical students who do the modules learning. The change that happens in the school if there is any would be wonderful. Unfortunately when it comes to the evidence however qualified the health educators, however qualified the actor, when they drop into a school, do a presentation and fly out again, there is no lasting change. What young people need are people who are going to still be with them and really enforce the messages. In terms of using this as a tool in education, I think there is a lot of evidence. In terms of it being an effective health promotion programme in schools, it needs to be linked in with what is existing which is why I encourage the students to find out what is already happening in the schools and build on that.
Closing

Dr Kevin Thompson started by saying:

‘It is a great privilege for me to be associated with a scheme that makes an obvious real difference to patients and makes a difference to bright people’s future professional lives.’

He went onto reiterate Prof. Edwards announcement that at the suggestion of the Welsh Government, the possibility of a Scheme in North Wales is being explored in discussion with Prof. Clare Wilkinson and her Research Group.

In South Wales, there are plans for involvement with the Inverse care Law projects in Blaenau Gwent and Cwm Taf, in the hope that the AF Scheme can contribute to making a difference to Public Health in these areas.

He concluded by thanking the contributors, attendees and Mrs Sue Evans for her usual excellent organisational and administrative support.
13:00-14:00  Registration and Lunch

14:00-14:15  Introduction
Dr Kevin Thompson, Chair, Director Academic Fellows Scheme
Welcome Address
Prof. Adrian Edwards, Institute Director, Primary Care and Public Health

14:15-14:40  Presentations from General Practice Representatives
Ashgrove Surgery; Dr Steve Harris
Cwm Gwyrrdd Medical Centre; Dr Naomi Stanton
Foundry Town Clinic; Dr Harry Ahmed

14:40-15:00  Routes into Academic General Practice
Dr Madeleine Attridge, Dr Alison Cooper, Dr Harry Ahmed

15:00-15:30  Coffee
Posters and displays

15:30-16:00  Presentations from General Practice Representatives
Keir Hardie Health Centre; Dr Huw Davies
White Rose Medical Centre; Dr Glyn Davies
Ynysybwll Surgery; Dr Swarna Bhat

16:00-16:15  Experiences of Research and Teaching
Dr Freya Davies, Dr Simon Braybrook

16:15  Comments, discussion and feedback
The Academic Fellows Programme: improving clinical care in deprived areas

Attridge M, Ahmed H, Braybrook S, Davies F and Thompson K
Cochrane Institute of Primary Care and Public Health, Neuadd Meirionnydd, Cardiff University

Background:
"The availability of good medical care tends to vary inversely with the need for it in the population served" (Tudor Hart)¹

Aim:
To improve clinical care in areas of socio-economic deprivation

Methods:
In 2001, with Welsh Government funding, our university established the "Academic Fellows Programme". The scheme provides for Academic Fellows who are trained general practitioners to practices in deprived high-need areas. The Academic Fellows cover up to four clinical sessions per week for three to six months. Practices formulate development plans and use the time covered by their Academic Fellow to undertake development projects within their practice. This allows the Academic Fellows to gain experience of clinical practice in deprived areas while the practice can spend time dedicated to development.

In 2013 the scheme developed an online forum “the Paired Practices Programme” with the aim of encouraging participating practices to share ideas for development. The scheme has also established academic links with the practices involved as well as providing higher professional training for the Academic Fellows themselves.

Results:
Since 2001, there have been 30 Academic Fellows on two year rotations who have completed 80 attachments in 46 practices in economically and socially disadvantaged areas. Achievements of the scheme include:
- An extensive number of development projects (practices often carry out several of these during the attachment period), examples are given in the table shown.
- The Paired Practices online forum has started collating a ‘bank’ of completed projects by participating practices which is offered as a resource of ideas for other practices.
- 59% of previous Academic Fellows now work in deprived areas.

<table>
<thead>
<tr>
<th>Development area</th>
<th>Example practice development projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing projects</td>
<td>Opioid and hypnotic reduction, polypharmacy, project for collection of dispensed prescriptions for patients on mental health register</td>
</tr>
<tr>
<td>Practice development</td>
<td>Upgrading IT system, new practice building</td>
</tr>
<tr>
<td>Establishing a new service</td>
<td>Minor illness clinics, nurse-led peripheral vascular disease clinic, dermatology</td>
</tr>
<tr>
<td>Education</td>
<td>Becoming a training practice</td>
</tr>
<tr>
<td>Practice protocols</td>
<td>Joint nurse diabetic clinic, COPD management, review process for patients with multiple co-morbidities</td>
</tr>
</tbody>
</table>

Conclusion:
This initiative has led to improvements in service delivery and academic capacity by general practices and also enhanced recruitment in areas of high socio-economic deprivation. Now, with development of the Paired Practices Programme, it is hoped this will grow exponentially.

References

Acknowledgements
a. With thanks to Alasdair Rae at Sheffield University

Contact:
attridgeMa@cardiff.ac.uk
www.pairedpractices.co.uk
To infinity and beyond!
Developing academic GPs of the future

Attridge M, Ahmed H, Braybrook S, Davies F and Thompson K
Cochrane Institute of Primary Care and Public Health, Neuadd Meirionnydd, Cardiff University

Background
This two year Academic Fellows Scheme offers early career GPs the chance to experience both teaching and research with the hope of fostering a future academic career.

Method
Academic Fellows (AFs) who are usually within two years of qualification, spend 3 days a week at the institute focussing on teaching and research and two days at a practice in a deprived area. Participants are encouraged to get involved in a research project, are given a wide variety of teaching responsibilities including developing their own ideas and also develop themselves by undertaking further qualifications.

Career outcomes
Research
- 6 in research posts

Public Health
- 2 working in Public Health in Spain
- 1 in Community Medicine in the Netherlands

Education
- 12 in university teaching role
- 8 teaching medical students in practice
- 4 GP appraisers

Results
Of the 30 who have completed the programme, 29 have had publications including Cochrane reviews, journal articles and conference presentations.
All achieved further qualifications in areas such as medical education, public health, preventative cardiology and psychological medicine.

Number of qualifications awarded

Discussion
This poster shows what participants of the scheme have achieved in just two years and how their enthusiasm for academic general practice has influenced their future career choices. It provides encouragement for other GPs to see the endless opportunities an academic fellowship can offer.

Contact
Author: attridgema@cf.ac.uk
If you are interested in applying to the scheme or finding out more information please send enquiries to Susan Evans: evansS31@cardiff.ac.uk
Teaching the Humanities in Medicine

A overview of current teaching programmes with the Academic Fellowship Scheme

Dr Harry Ahmed, Dr Madeleine Attridge, Dr Simon Braybrook, Dr Freya Davies, Dr Katie Savage
Academic Fellowship Scheme, Cochrane Institute for Primary Care and Public Health, Cardiff University

Introduction:
A large proportion of the Academic Fellows time constitutes teaching within Cardiff University’s Undergraduate Medical Curriculum. Although the core of this teaching consists of communication skills and clinical skills, some academic fellows have elected to create or become involved in other teaching programs. A number of these have been within the medical humanities which are outlined here. The medical humanities is described as “is an interdisciplinary field of medicine which includes the humanities... social science... and the arts... and their application to medical education and practice”. Some medical humanities such as psychology, philosophical ethics and sociology are already established within the medical curriculum, whereas others such as cinema, history and literature remain on the fringes. In recent years, the academic fellowship scheme has increased the emphasis on offering opportunities to study the humanities as applied to medicine. This has included:
- Optional ethics seminars
- “Top 10 Film’s for medical students” film club
- Literature and medicine special study module
- Drama and public health special study module
- History of medicine special study module
- “Heroes and villains” case studies on professionalism

Methods:
Mixed methods were used for the development of each course component. Some (year one ethics and professionalism sessions) have been taught as part of the core curriculum and are compulsory for all students. Others (Drama and public health, History of Medicine) have been offered as student-selected components and so are undertaken by interested students selecting the module from a menu. In each module we have had the opportunity to explore our own interests and expertise. For example, in the history of medicine module, each fellow led a week following a different specialty. Talks were delivered by fellows themselves or by selected external speakers including experts in their field. In the “optional ethics seminars” fellows created different ethical discussions for the students to discuss coping from management of a disease outbreak, evidence-based drug policy or the ethics of screening. A mixture of talks, film clips, student exercises and discussion, field trips were used to maintain interest and connect with the deeper themes of the module.

Field visits:
During the history of medicine module, students learned about the history of surgical techniques at St Fagans open air museum, learned about the asylum era at Whitchurch Hospital, and the history of Public health in Llandaff and Grangetown high streets. Support from RCT LHB has permitted the drama programme to reach deprived areas of the valleys.

Guest Experts:
Guest experts included:
- Academics from Cardiff University and Kings College London
- Historians from Museums Wales, Wales History of Medicine Society, and the Whitchurch Hospital Historical Society
- Professional actors from Going Public Theatre Company schools-based Personal, Social and Health Education charity (PHSE)

Use of artistic media:
The use of film, art and literature is a key feature of teaching the humanities. The programs used such materials as the poetry of Siegfried Sassoon to explore the impact of shell shock and PTSD, and paintings such as “The Rake’s Progress” by Hogarth to explore perceptions of the mentally ill throughout the enlightenment. A variety of films were used to explore not only the medical scene depicted but the attitudes and biases of the film-maker in the context of their time. These included:
- One Flew Over the Cuckoo’s Nest (film of Ken Kesey’s book)
- The Madness of King George (Alan Bennett play and film)
- The Seduction (film adaptation of a poem by Eileen McCauley)

Results and Feedback:
Assessment methods varied for the different modules. The majority required satisfactory participation only whereas the 9 week SSCs required submission of a 1500 word essay and verbal presentation of their findings. Feedback forms were returned by all students which consistently show positive regard for the modules and provide suggestion for improvement. Involvement of external speakers, field visits and opportunities to develop presentation skills are always highly valued. In addition to the work done in the modules, the students participating have the opportunity to present their work outside the University. Within the Drama and Public Health modules presentation of their work to local primary schools is a key outcome, whereas for History of Medicine the best presentations are selected for delivery and the annual Wales History of Medicine Society meeting.

References:

History of Medicine
Year: 3
Module: Student Selected Component
Duration: 9 weeks (full time)
- Each week devoted to the study of a different medical specialty
- Classroom learning includes lectures by world experts and student presentations
- Field visits include St Fagans open air museum, Whitchurch hospital and Llandaff and Grangetown high streets
- Art (film, literature, visual art) used to illustrate history of specialty and attitudes / bias of artists

Drama and Public Health
Year: 2
Module: Student Selected Component
Duration: 5 days
- Introductory talks introduce the influences on children’s health and the role of public health.
- Workshops with professional actors from Going Public Theatre Company show health messages through drama and assist students in developing ideas
- Visit to the school enables students to contextualize their theme within the curriculum, setting and community
- Students develop a whole school assembly and drama workshops for year 3, 4 and 5 students

Ethics Seminars
Year: 1
Module: Professionalism
Duration: Single seminar
- Individual tutors lead a session taking students through an ethical dilemma
- The dilemma is discussed in small groups and further information sought
- Key ethical principles such as Autonomy, Justice, Beneficence and Non-maleficence are highlighted
- Group discussion and debate help explore the pros and cons of different courses of action

Heroes and Villains
Year: 1
Module: Professionalism
Duration: Single seminar
- Students research examples of good and bad professional behaviour
- Heroes: from BMJ obituaries
- Villains: from GMC fitness to practice reports
- Students consider what professional values (or mistakes) led to the outcome

Guest Experts:
- From BMA Health Education charity (PHSE)
- From WHS History of Medicine Society, and the Whitchurch Hospital Historical Society
- Professional actors from Going Public Theatre Company schools-based Personal, Social and Health Education charity (PHSE)

Use of artistic media:
- Poetry of Siegfried Sassoon
- “The Rake’s Progress” by Hogarth
- “One Flew Over the Cuckoo’s Nest” (film of Ken Kesey’s book)
- “The Madness of King George” (Alan Bennett play and film)
- “The Seduction” (film adaptation of a poem by Eileen McCauley)

Results and Feedback:
- Assessment methods varied for the different modules
- Majority required satisfactory participation
- 9 week SSC’s required submission of a 1500 word essay
- Verbal presentation of their findings
- Feedback forms were returned by all students

References:

Dr Andrew Wakefield
Dr Helen Lester
History of Medicine
Students on Visit to Whitchurch Hospital

Drama and Public Health
Students perform to local primary school children
A year 3 (9 week full-time) SSC was piloted last year and will be offered this summer.
# Previous Academic Fellows
## 2001-2014

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<td>Diane Owen</td>
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Previous Academic Fellows

Cochrane Institute of Primary Care & Public Health

*On the basis of scientific evidence... Anica Cochran*