End of Fellowship Report
Carmel Wills
March 2022

Introduction
I have thoroughly enjoyed this year in the role of the GP Fellow in Outreach. I have utilised the time, opportunities and study funding available to pursue my passion of medical education. I have developed many new skills and have used every opportunity to learn and have grown so much as a GP, as an educationalist and as a person.

Project
During my interview for this position, I was asked about my ideas for a potential project. My previous experience had been informally creating multi-professional Balint-style reflective groups and a joint GP-Paramedic training event. In my clinical time, my area of interest is Elderly Medicine and Palliative care. I wanted to create a project that bridged both of my passions and fulfilled a need for education in care homes and realising the dream of the NHS Long Term Plan for a diverse Primary Care Workforce. During the pandemic, the care homes have been disproportionally affected by Covid-19 and support to the band 1-4 carers to date has been lacking.

The clinical need for this project was clear. Locally we have a rising elderly population in care homes and, with the Care Homes DES, this work takes a lot of GP time. In my own Practice, we look after eleven separate care homes and are trying to utilise the skills and experiences of the new diverse Primary Care Team to help support the carers in the homes looking after our most complex patients.

My vision was to create a culture of multi-professional education to support carers looking after our complex elderly residents. The aims of the project were two-fold; 1) to empower carers with skills and confidence through education and 2) to nurture professional relationships between carers, GP, multi-professional facilitators.

My mentor advised me to spend time simplifying the aims of the project, researching what resources were already available and to present monthly highlight reports of progress or challenges to the Primary Care Training Hub team. I liaised with the local Telemedicine service to try to identify the particular learning needs. We identified the top five clinical themes of calls from care home staff to the Telemedicine service and decided to create a bespoke learning package to address those clinical needs. The themes were:

1. Sepsis and the Deteriorating patient
2. Nutrition and Hydration
3. Falls
4. End of Life Care Issues
5. Dementia

I then invested some time meeting with my multi-professional team members who were specialists in these fiver areas and who might not otherwise have had direct educational experience in care homes. I found that spending the time communicating my vision meant that the other stakeholders understood the vision and aims of the project and were all very

enthusiastic to become involved as co-facilitators on the project. I recognised that all co-facilitators were extremely busy in their clinical roles and wanted to compensate them for their time with the project. Together with my mentor, I submitted a financial bid to the Hampshire Care Association for finances to offer the facilitators a small financial payment for their time and expertise. However, the majority of facilitators declined the payment offered to them as they shared my passion for the project and were willing to be involved in their own time.

I also ran my ideas through the experienced educators at the Primary Care Training Hub who gave me very helpful support and advice and other interested contacts to make. I also found the Local Academic Health Sciences Network (AHSN) to be a great support for support and educational resources which were a local priority for the ICS, in particular the Restore2 Mini resources, NEWS2 scales, SBARD handover resources, the e-lfh Nutrition and Hydration modules and the Respect training videos. The AHSN admitted they had created these resources but did not have the contacts to bring them directly into the care homes and were delighted for me to utilise them as some of the basis of my educational events.

I then spent time meeting the care home managers of two pilot care homes. Both were delighted by the vision and aims of the project, agreed that the learning needs identified matched those of the carers in their homes, agreed to prioritise time for the carers to be allowed off the rota to attend the events on a Wednesday afternoon for two hours on alternate months for a series of five educational sessions. I planned to include up to 12 carers at each care home per session, ideally the same 12 carers each time (rota permitting) and I would evaluate feedback pre and post the sessions to evaluate the sessions.

At the first meeting, I invested time to meet the carers, explain the idea of the project and the need for their honest feedback to help create a valuable learning environment for them. We created ground rules unique to each of the pilot care homes, they included communication, respecting each other's opinions and they agreed that if there were any clinical or educational issues arising, I would feed these back directly to the care home manager or GP in charge of the care home.

Session 1:Sepsis and the Deteriorating patient

This session was co-facilitated by a Elderly Medicine Nurse Consultant from the local hospital. He often provided clinical input to care home residents in clinic or in A&E but had not previously been involved in providing education directly to care homes. We co-facilitated a very successful event to both pilot care homes including a range of video learning resources, topic discussions, practical session on how to take observations, case discussions and role play. I coordinated with the other Outreach Fellow to use the sphygnomanometers, thermometers and oxygen saturation probes to teach the carers how to take observations, how to interpret them, how to plot them on a NEWS2 chart and calculate a NEWS2 score, what this meant and how to communicate concerns to another healthcare professional. We also learned about the value of good handover and using the SBARD style as a guide to frame professional conversations and highlight concerns.

The carers found this session helpful and enjoyable. We collected pre and post session quantitative date which showed that after the session, all carers were more confident to

recognise sepsis, take observations, calculate a NEWS2 score and communicate with other healthcare professionals afterwards. Crucially we collected qualitative data which mirrored this in main themes of feeling more confident in communicating with others.

An unintended consequence of this was that the carers could now do observations which aided the temporary transition to virtual care home ward rounds during Covid-19 outbreaks at each of the two pilot care homes and Covid-19 saturation home monitoring programme when residents were positive for Covid-19 but could be monitored remotely.

The GP for one of the pilot care homes mentioned in the week after the session: "*A carer called to discuss a resident. Without prompting, the carer had already done the observations and presented a good SBARD handover*"

Session 2: Nutrition and Hydration

This session was co-facilitated with two Community Dieticians from the local CCG Medicines Optimisation in Care Homes (MOCH) team. They were a new team who were looking to forge links with GPs and local care homes to highlight the CCG "Food First" programme, review prescriptions for oral nutritional supplement (ONS) and ensure cost-effective prescriptions were issued to reduce costs to Primary Care and appropriateness to the patients.

The session was informative and enjoyable and included how to recognise malnutrition and dehydration, how to fortify a diet and improve hydration in a diet, how to calculate BMI and a MUST score, how to estimate height from forearm length and estimate BMI from upper arm circumference in residents who cannot stand or be weighed. We also performed a taste test of a range of ONS and compared this to a recipe for a milkshake that could be made by the catering staff. All carers were shocked at the price of ONS and all agreed the home made milkshake was more palatable.

We have both qualitative and quantitative feedback showing how the carers found the session very informative and enjoyable. After the session all carers were more confident in recognising and managing malnutrition and dehydration, aware of the "Food First" programme and if needed, a prescription for a low cost formulary approved ONS could be discussed with the GP.

An audit of the ONS prescriptions at the local GP practice prior to the educational sessions showed no requests for the local formulary-approved lower cost ONS. After the sessions, there were 11 new residents commenced on the local formulary-approved lower cost ONS. This demonstrates that this session is pivotal in changing prescribing behaviour for ONS with a significant cost saving to the local Practice.

Session 3: Falls

Falls is a huge burden to the NHS and I planned an innovative session on falls prevention to be co-faciliated by clinical pharmacists to discuss falls prevention, what physical and environmental factors can contribute to falls, how medication can predispose to falls and how being on anti-coagulant medication can contribute to bleeding after falls. This links back into the first session of communicating such concerns to the GP to crucially review medications to prevent falls and especially the need to review medications after a resident has fallen.

This was the most popular and interactive session in the programme to date and the carers found a lot of value from the session. The clinical pharmacists were impressed by the skills and knowledge of these band 1-4 carers. Qualitative Feedback from carers included themes such as improving confidence and preventing falls;

> "I am more mindful about preventing falls and more knowledgeable about how medication can impact on a fall"
>
> "I didn't know elderly residents were more sensitive to side effects from medication"
>
> "how medication can affect the health and contribute to falls and bleeding after falls"

Creating this session has now forged close working relationships with the pilot care homes, GP practice and the BSW Medicines optimisation in care homes team. The pharmacists involved in the education project have now agrees to review all prescriptions from the local care homes attached to the GP Practice. As a result of this clinical collaboration, an unintended outcome of this session is improve appropriateness of prescriptions to care homes and to reduce costs to General Practice.

Session 4: End of Life Care

This session was co-facilitated by two community palliative care nurses attached to the local hospice. There prior care home experience had been to occasionally provide clinical input to complex palliative care residents but they had never been asked to provide educational sessions to care home staff. We planned this session towards the end of the programme as it allowed the group of carers to gel and feel confident to share their experiences on this emotive topic. In planning the session, we were mindful that the carers will have experienced a lot of end of life care issues professionally during the pandemic and many will have also experienced personal loss. We therefore provided the opportunity during the session for carers to speak in private to the facilitators if any of the topics discussed proved too emotive or upsetting.

The session covered topics such as how to identify those residents who may be approaching the end of their life, what a "Respect form" is and what the clinical teams do to complete one, how to cater for a residents physical, emotional and spiritual needs, physical strategies to manage palliative symptoms and to be aware of the medical options for symptom management. We also discussed what to do after a resident has died. At the request of the carers, they also wished to discuss strategies to use when having difficult palliative conversations with residents or their families. The carers felt confident to share their professional experiences of palliative care. Some also shared their personal experiences of family loss, including during the pandemic, and how this affected them when caring for residents who were dying. We discussed strategies for self-care and support.

As in previous sessions, the community palliative care nurses were extremely impressed at the devotion, care, experience and wealth of knowledge of the carers. We recognised that the carers grieved for the residents and occasionally carried the grief from personal losses into their daily work. They discussed how they felt proud to be carers and what a privilege it is for them to care for residents at the end of their life. We were shocked that in one care

home, that the official guidance from the management staff for self-care and support was to signpost the carers to an App. We fed our surprise back to the care home manager and suggested a more personal approach to provide support to carers managing end of life carer issues.

Session 5: Communication in Dementia

Due to the challenges navigating lockdowns in the care homes, this session has been postponed until April 2022. This session evolved out of my plan to provide an interactive session on Communication in Dementia using Forum Theatre. This has never been done before in a care home setting and has generated much interest from various stakeholders. I met with my co-facilitators to explain my vision and they all kindly agreed to be involved. I wrote a challenging case of a carer and resident interaction, loosely based on real experiences, with an actor carer, actor resident and expert facilitator for the session. The plan is to explore how good communication in dementia can meet a residents physical and emotional unmet needs and create better outcomes. The plan is for the initial interaction to run and the group to identify where the unmet needs are and draw on their own skills and experience to re-run the interaction with their suggestions using a forum theatre method. This session will be co-facilitated by the Simulation team at Portsmouth University, Southern Health and Chichester University.

Challenges

There have been several challenges in this project. I have drawn on many skills including communication and coordination between various teams and planning dates and sessions with each of the stakeholders. The Covid-19 pandemic has obviously impacted on how the sessions could run. Each care home had their own policies which we needed to attend to, including Covid-19 testing prior to attending the care homes in person, social distancing, wearing masks, ventilation of rooms and limits on numbers of attendees permitted in the room. I had planned for this as a potential risk in my highlight report. Despite this, some sessions had to be postponed when each of the care homes had a local Covid-19 outbreak and were on lockdown to visitors and at other times there were significant staff illnesses causing pressure on the care home staffing rota. I had to make a decision whether to run the End of Life session virtually or to postpone the session until it could be run in person. Due to the nature of the topic, I decided to postpone the session and run it in person to permit a more open discussion and also to provide in person on the day support to any carers who were upset by the discussion. I feel this was the correct decision as it made for a very open and honest discussion in the session and a lot of learning and support was provided. I believe that, although we have run four out of the planned five educational sessions in the two care homes, this has been a success and plan to run the final planned session with only a month delay in April. The enthusiasm and support for the project from the cofacilitators, care home managers and the carers has been excellent and we all look forward to the final planned session.

At one of the care homes, there has been a lot of management staffing issues, where the initial care home manager was absent from the position and the carers had to step up into senior positions and cover gaps in the rota for many months. Some carers felt unsupported and left employment at this care home. This led to some remaining carers not able to attend the educational sessions due to clinical commitments. When the new interim manager was

appointed at this care home, I met with him to explain the project and he agreed it was needed more than ever and reiterated his support and commitment to allowing carer to attend the pre-planned sessions. I feel that this strategy was helpful to facilitate ongoing commitment from this care home to the project, and more importantly ongoing education and support for the remaining carer who were in a very challenging environment.

Educational Opportunities

I have availed of all educational opportunities presented to me during the Fellowship year. This has broadened my experience and understanding of education, assessment and facilitation.

1. I have been an OCSE examiner for the third year medical students at Southampton University
2. I was asked to give a presentation at a Careers morning to the Mid-Wessex GP trainees talking about being a Salaried and Portfolio GP
3. I co-facilitated a session for Wessex GP trainees at the Wessex Patient Safety Training Day
4. I attended a very helpful Facilitation Course for the GP Fellows
5. I attended the monthly Primary Care Training Hub meetings where I was able to meet the rest of the team, learn about other educational work happening at the Primary Care Training Hub, share learning and ideas and provide updates and receive feedback on my project monthly highlight reports
6. I agreed to be part of the Leadership team for the 4th cohort of the Wessex Next Generation GP. This is part of a national leadership programme for GP trainees and new GPs in Wessex to connect and learn from leaders in the NHS and other organisations to inspire and empower with new skills and engage with other GPs to create a peer support network. Previous attendees have found the programme very helpful and helped to progressed into leadership roles. In our own time in the evenings, we the leadership team have organised and are facilitating the 4th cohort of the Wessex Next Generation GP Programme online to 50 Wessex GPs. This involves marketing, budgeting, coordination of dates, booking local and national leaders, interviewing the speakers, arranging smaller group networking time and evaluating the sessions. I have gained skills and confidence being part of this leadership team. We are currently arranging some face to face session in the near future.

PGCE

I am completing my PGCertMedEd at Winchester University. I find that reflecting on my experiences of educational theory, research and assessment has complemented the work I am doing in my project and other Fellowship educational opportunities. In addition, I have reflected on the Fellowship for some of my assignments in the PGCertMedEd.

Conferences

I have attended the RCGP Conference in Liverpool in October 2021 where I enjoyed listening to inspiring speakers, in particular listening to Prof Sir Chris Whitty talking about being the CMO during the pandemic and wider issues affecting Primary Care such as health inequalities and climate change. I enjoyed learning about clinical topics and learning about other projects throughout the country. This was the first time I had met some of my Fellows in person and we enjoyed networking.

I attended the DEMEC conference in December 2021 and enjoyed hearing about educational projects and challenges during the pandemic.

I presented at the Wessex GP Fellows Mini-Conference in March 2022 and enjoyed presenting the findings of my project to date and hearing about the projects and experiences from the other GP Fellows. It was wonderful to finally all meet face to face and we enjoyed networking at this mini-conference.

Abstracts and Posters

I submitted an abstract which was accepted for a poster presentation at the RCGP Conference.

I have submitted an abstract to the SAPC conference and await to hear if it has been accepted (see appendices).

Peer Support and Networking

I have enjoyed networking virtually with the other Fellows at the monthly Action learning sets. As part of my PGCertMedEd I conducted a case study of the learning from the Fellows (see appendices). We also had a WhatsApp group where we regularly shared ideas, resources, skills and links to conferences and courses. Although for most of the Fellowship we could not meet in person, I found this virtual support to be very helpful.

Other skills

I have developed other skills as part of the Fellowship, not least being proficient in using Teams and Zoom for meetings and conferences.

Having experience of writing the financial bid for the Fellowship, I used these skills to write another successful financial bid for the Wessex Next Generation GP which will ensure the future of the programme.

Personal Development

I found it very helpful at the start of the Fellowship to reflect on my personality. I completed the Myers-Briggs indicator test and found that I was ESFJ which helped me to understand how to use my strengths but also highlighted some areas for development. I also read a lot about Belbin and the language of effective teams and also found this helpful to understand my natural role in teams.

Alongside the Fellowship, I arranged Coaching through the Southwest Leadership Acadamy. This experience helped me to understand my values, boundaries and plans for the future and this was instrumental to me gaining confidence and availing of all opportunities throughout the Fellowship.

The Future

I plan to use the Fellowship extension to complete the project by running the final Communication in Dementia Simulation. I also plan to further evaluate the project and present locally and more widely the outcomes and hopefully publish my work.

Further to the success of being an OCSE examiner, I have been invited to be a small group Seminar Leader for the third year medical students at Southampton University, including doing topic based learning, case discussions and completing their assessments.

I am delighted to have accepted a job as a Training Programme Director at the Primary Care Training Hub and look forward to drawing upon the experiences that I have had during the Fellowship. I am in no doubt that completing the Fellowship has given me the confidence and skills to apply for my dream role as a Training Programme Director at the Primary Care Training Hub.

Acknowledgements
I would like to thank Sue Clarke who has been my mentor during this Fellowship for her fantastic support and guidance. I would like to extent this gratitude to all members of the Primary Care Training Hub who have been very generous with their time and support for my project. The Hampshire Care Association their generous funding to permit the payment of cofacilitators for their time. To the Wessex Academic Health Sciences Network for the sharing of resources. Dr Alex Corcoran for the use of the medical equipment for the first session of the care home project. Sam Scallan for her support and advice on evaluation of the project and submission of educational abstracts. To all of my co-facilitators who helped me realise my vision of a multi-professional education network. To the care home managers who showed such leadership and support for the project despite being under enormous pressure during the pandemic. Finally to the carers, their enthusiasm, skills and knowledge and devotion to the residents is admirable. My co-facilitators and I have learned as much from them as they may have learned from the project and without whom the project would not have been such a success.

Appendices
RCGP Abstract

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Multi-professional care home education on the deteriorating patient.

Dr Carmel Wills, James Lee, Susan Clarke, Dr Samantha Scallan.

Aims

The coronavirus pandemic has disproportionately affected the elderly care home resident population. Carers have felt under pressure caring for complex elderly patients while care homes were in lockdown during the pandemic. Education provided to this pivotal sector has been inconsistent to date. (1) We aim to empower carers with skills and confidence to recognise the deteriorating patient and escalate concerns effectively to other healthcare professionals. Through multi-professional facilitators, we aim to nurture professional relationships to improve care for our elderly care home residents.

Content of presentation

We created an educational event with facilitators from multi-professional backgrounds on recognising soft signs of deterioration, how to take observations and record them to calculate a National Early Warning Score (NEWS2) and to communicate concerns effectively with other healthcare professionals. We used case-based discussions and role plays to allow the group to discuss and reflect on challenging cases and to work through possible ways of managing them. This poster presents an overview of these sessions, their development, and an evaluation of their reception.

Relevance/Impact

We will evaluate pre and post-session confidence ratings and qualitative feedback.
The data collection to evaluate the sessions commences June 2021.

Outcome

We will present the feedback provided by the carers and how this learning has influenced their daily practice. It is hoped the findings will inform understanding about the educational needs of these healthcare professionals. We discuss how projects such as this create better professional relationships and improved care for residents.

References

Fitzpatrick JM, Roberts JD. Challenges for care homes: education and training of healthcare assistants. Br J Nurs. 2004 Nov 25-Dec 8;13(21):1258-61. doi: 10.12968/bjon.2004.13.21.17124. PMID: 15580072.

Multi-professional care home education on the deteriorating patient

Dr Carmel Wills[1], James Lee[2], Susan Clarke[1], Dr Samantha Scallan[3]

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Introduction

- The coronavirus pandemic has disproportionately affected the elderly care home resident population.
- Carers have felt under pressure caring for complex elderly patients while care homes were in lockdown during the pandemic.
- Education provided to this pivotal sector has been inconsistent to date. (1)

Aims

1. We aim to empower carers with skills and confidence to recognise the deteriorating patient and escalate concerns effectively to other healthcare professionals.

2. Through multi-professional facilitators, we aim to nurture professional relationships to improve care for our elderly care home residents.

Methods

We created an educational event with facilitators from multi-professional backgrounds on recognising soft signs of deterioration, how to take observations and record them to calculate a National Early Warning Score (NEWS2) and to communicate concerns effectively with other healthcare professionals.

We used case-based discussions and role plays to allow the group to discuss and reflect on challenging cases

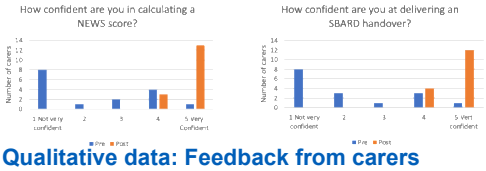
We ran this across two care homes in Salisbury

Results

Quantitative data

Using pre and post data questionnaires, after the educational session, all carers showed increased confidence in:

- Measuring and recording observations
- Measuring and recording a NEWS2 score and interpreting what that means
- Delivering an SBARD handover
- Communicating concerns to other healthcare professionals



Qualitative data: Feedback from carers

"You have empowered us to do our work with confidence"

"Very nice as you feel listened to. Find useful coming from somebody who has dealt with the situation. It gives us confidence to carry out our job specifically if nervous"

"How to communicate with other health professionals from other disciplines using SBARD handover and NEWS2 score. This will help me raise my concerns about residents"

"I will use SBARD format to do handover from now on"

Feedback from GP responsible for care home

"*A carer called to discuss a resident. Without prompting, the carer had already done the observations and presented a good SBARD handover*"

Conclusions

- Carers found this learning helpful and all felt more confident in recognising the deteriorating patient and communicating their concerns
- We anticipate this will create better multi-professional relationships
- Both learning and better relationships will improve care for residents
- We have identified other future learning needs from the carers and plan to deliver an ongoing educational programme to meet these needs.

Reference Fitzpatrick JM, Roberts JD. Challenges for care homes: education and training of healthcare assistants. Br J Nurs. 2004 Nov 25-Dec 8;13(21):1258-61. doi: 10.12968/bjon.2004.13.21.17124. PMID: 15580072.

Wessex Academic Health Science Network

NHS Health Education England

Hampshire and Isle of Wight Primary Care Training Hubs

Supporting the Development of our Primary and Community Care Workforce

SAPC Abstract: Multi-professional Care Home Education on Nutrition and Hydration

Carmel Wills, Clare Padfield, Rachael Warren, Susan Clarke

With the aging population in the UK, locally a rising number of our patients now live in care homes. A significant proportion of our care home residents have issues achieving adequate nutrition and hydration. This is reflected in rising costs of oral nutritional supplements (ONS) and request for dietician referrals. Education to band 1-4 care home staff on this area has been inconsistent to date and they have reported feeling unsupported through the pandemic.

Our aims were two-fold. Firstly to empower the band 1-4 care home staff to confidently identify and manage residents with issues around poor nutrition and hydration to improve the appropriateness of prescriptions of ONS and reduce costs to Primary Care. Secondly, we sought to nurture multi-professional relationships in Primary Care through having multi-professional facilitators.

We created a learning event across two pilot care homes in Salisbury facilitated jointly by two prescribing support dieticians from the CCG and a local GP. This was an interactive session with the following objectives:

- how to recognise malnutrition and dehydration
- how to calculate a MUST (Malnutrition Universal Screening Tool) score, including estimating weight and height in bedbound residents
- how to treat malnutrition with a “Food-first” programme and fortifying a diet and improve hydration in a diet
- sharing a recipe for a high calorie milkshake and taste testing this against prescribed ONS
- understanding which are the local formulary-approved lower cost ONS alternatives to traditionally prescribed high-cost brands
- when to involve specialist dietician services

We undertook pre and post session evaluations of the carers including confidence intervals and space for qualitative feeding and a pre and post session audit of the local formulary-approved lower cost ONS in the GP practice attached to the care homes.

Qualitative and quantitative feedback shows how the carers found the session both informative and enjoyable and increased their confidence managing residents with issues around poor nutrition and hydration and how this will change their practice. (Data demonstrating this will be included in the final presentation). An audit of the ONS prescriptions at the local GP practice prior to the educational sessions showed no requests for the local formulary-approved lower cost ONS. After the sessions, there were 11 new residents commenced on the local formulary-approved lower cost ONS.

This demonstrates that this session is pivotal in changing prescribing behaviour for ONS with a significant cost saving to the local Practice. Creating this session has now forged close working relationships with the pilot care homes, GP practice and the BSW Medicines optimisation in care homes team to review all prescriptions from the local care homes. This will improve appropriateness of prescriptions and reduce costs to General Practice.

Professional Education and Development: Assignment 2
Carmel Wills

I am undertaking a year of professional development through my appointment to a GP Educational Fellowship. I have been fortunate to have a group of Fellowship peers and we meet virtually every month to network, provide support, share our learning and participate in Action Learning Sets (ALS). ALS were developed in the 1940s by Reg Revans (Revans, 1980) and a definition is:

> "A method for individual and organisational development based upon small groups of colleagues meeting over time to tackle real problems or issues in order to get things done; reflecting and learning with and from their experience and each other as they attempt to change things." (Edmonstone, 2003, p3)

The format includes a facilitator to guide the process, one member brings a problem to discuss and the solutions and action points arise from the other group members.

My previous experience of ALS had been from a mentorship programme for new GPs where an experienced GP had facilitated one session. It felt very structured, sometimes a little "artificial" in how each section progressed, not like a natural conversation. I did not feel that my previous experience was valuable as to my mind the group did not achieve its aim of solving the presenter's problem. Therefore when I learned that we were to have monthly ALS as part of the Fellowship, I was disheartened.

We participated in a series of ALS facilitated by our Fellowship Programme Director. It dredged up my feelings of frustration at this regimented structure of sharing problems with the group and asking for help. In addition, I did not know how vulnerable I could be sharing my challenges with the group.

I was interested to know how my peers felt about ALS. Did they share my frustrations at the process or did they find it a helpful educational tool to solve a problem? Therefore I planned to conduct a case study of GP Fellows experiences of ALS. Golby and Parrott discuss case study as a study of individuals or groups that the researcher is interested in and a variety of research methods may be used to record the data (Golby and Parrott, 1999). I felt that interviewing would be a powerful research method to use for my case study to explore the experience and meaning of ALS by GP Fellows. Seidman explains the purpose of interviewing as:

> "an interest in understanding the experience of other people and the meaning they make of that experience" (Seidman, 1991).

Therefore I decided to interview two of the Fellows who had been at the most recent ALS.

I planned for the interviews, heavily influenced by my reading of La Croix (La Croix, 2018). I knew that developing rapport was important, allowing the interviewee to feel more comfortable and share more honest information. I was also conscious that I was interviewing my peers and would the answers they provide be skewed by their desire to please me? I decided to prepare for this by using a semi-structured interview style as discussed by La Croix. I reflected that this semi-structure would allow me to start with an open question on their about experiences generally of ALS, allowing me to treat each interviewee equally,

before allowing a natural conversation-style flow to the interview. To permit the conversation, I had the written pre-planned questions for reference on paper and recorded the audio of the session with permission. The aim of this was two-fold; to permit natural conversation without interruption by writing answers and avoiding eye contact, and to avoid recall bias of any written interview questions.

After the interviews I re-immersed myself in the data by listening to the recordings. The answers naturally grouped themselves into themes derived from the data itself, *a posteriori*, and interestingly there were some oddities that I noted. I described the main themes and divided the data into manageable "units" as described by Wellington (Wellington, 2000). These units tended to cluster around main "themes", some were overlapping, and both interviews hit similar themes which helped with the validity of the data I had captured. Similar exact phrases were used.

With regards to the structure of the ALS, most of the data was positive. The participants liked the "boundaries" of the structure, understood when to talk, found it a safe space to air difficulties as a presenter and a safe space to give feedback with the phrase "I wonder if.." without having to be concerned about hurting the feelings of the presenter. A large portion of data was related to the group. Many different words were used throughout by both participants regarding how important trust in the group was. Interestingly several times the word "safe" and phrase "safe space" was recorded by both participants. An offshoot of this was a large portion of data regarding a shared experience, the word "relevant" was used four times. Only one negative comment on the structure of the ALS was recorded, the word "false".

There was a lot of emotional data recorded. "Anxiety" and similar negative emotive words were used multiple times by both participants with regards to presenting a case. Silence was mentioned in both negative and positive connotations. The phrase "awkward silence" was used by both participants, but participant two furthered this by stating the "silence brought more ideas" and sometimes brought "a natural pause" was mentioned three times. These inconsistencies demonstrate how each individual has a different perception and interpretation of the same experience. This highlights how qualitative data captures the phenomenology of the learner (Pring, 2015).

With regards to the question, do you find ALS useful, overwhelmingly the data was positive. When asked why this might be, both participants stated due to "new ideas", they both enjoyed the reflective element, valued the opinions of their peers who has a shared experience and found the process helpful in both group roles of presenter and participant. When the participants discussed if they would use ALS techniques in future, both said yes. Interestingly, the language of the ALS was mirrored in the interview. The stock phrase "I wonder if.." was used by both participants a total of six times in the interviews. Being an "inside practitioner" made me party to the language and culture of my peers (Le Gallais, 2003) so I could recognise and understand the significance of the use of the phrase "I wonder if.." in the interview demonstrating real life continual learning from the ALS process.

I am aware that the findings of this case study are particular to the interviewees and their experiences, but I agree with Golby and Parrott that the themes in the data I have found could be connected to other case studies and in doing so, we are building the body of more generalisable evidence (Golby and Parrott, 1999). I was curious to see if other studies were reporting similar findings?

With regard to the high levels of anxiety mentioned in my data, this has been echoed in other research. Robertson mentioned an interesting paradox about anxiety in ALS (Robertson, 2017). She demonstrated that anxiety was experienced with any new educational "radical relearning", some of which arose from fear of exposure in front of peers. However Robertson furthered this to say that a certain degree of anxiety is needed to facilitate the learning process which echoes my findings.

With regards to the power of the group, Robertson also describes how there is a strong sense of belonging in the group and that, over time, participants realised the talent in the group and felt a sense of connection to the group as a whole. This echoes the safe space mentioned frequently in my data. The beauty of ALS is that each individual member of the group provides a diversity of opinion that help to further the group's objective of solving a problem. Robertson states this collaboration creates an environment of personal growth. This is the true ethos of ALS and the value of this cannot be fully understood at the first session and may not even be fully understood until after the ALS has finished.

Reflecting on my findings fit with the literature review, I realised that ALS is not just the scenario discussed but that it is the development of an adult learning ethos, a new way to learn, and the process continues beyond the end of the ALS group. The high degree of anxiety experienced at the start of the group may be due to an individual feeling exposed, to the judgements of their peers, and partly not understanding the process. Over time, trust in the group members develops and understanding of the structure and ground rules of the group develops leading to perception of a "safe space" to share difficulties and offer advice as a participant. This process involves a lot of reflection and personal development, promoting a deeper level of understanding of the problem but also of oneself, and this reflection persists beyond the group. This learned ethos and framework for solving difficult problems or giving advice is transferable both to future professional educational practice and to clinical practice.

I feel that the process of conducting these interviews as a small-scale case study has helped me to understand more about educational research generally. Interviewing as a research method is time and labour-intensive. I now understand the richness of the data derived from qualitative research, including emotional data, helps develop a deeper level of understanding of professional educational enquiry. Moreover, this data would not be readily collected by a tick-box rating scale. I was delighted that my study has raised data themes which are shared in the literature. There are some interesting inconsistencies and this has piqued my curiosity. Future research would include triangulating the data using other methods including observational work and questionnaires and conducting a series of interviews over time.

Writing this assignment has helped me better understand case study. Using Golby and Parrott as an example, my case fulfilled their criteria of case study as a purposeful enquiry into a real-life context that has engaged the researcher (Golby and Parrott, 1999). In this assignment I have demonstrated how my findings are connected through the literature to other case studies. In building up my understanding of multiple case studies, this is a significant body of evidence that is generalisable and together increase the strength and validity of evidence as a series of case studies.

Writing this case study has also taken me on a journey of reflection. Having had one single negative experience of ALS, I naively thought that this encapsulated all of what I needed to know about ALS and that my peers would share my views. Through my experience of

participating in an ongoing ALS, and researching it for this case study, my own opinion has evolved. I realise that the true power and learning in ALS does not come from attending a single event, but that it is a process. Through the process of completing my previous assignment on my experiences attending Balint groups (Appendix 1) and this assignment, I realised this is actually a series of case studies of my own educational arrogance of an positivist "scientific" approach to medical education getting in the way of me embracing other educational methods. This period of critical self-reflection has deepened by understanding of educational enquiry and changed my perspective on what I deem educational. I have found that the process of building trust in a group, allowing myself to be vulnerable to my peers, valuing their opinions and advice has affected me beyond the specific issue discussed. It has allowed me to redevelop my educational approach to my own self-development and for future professional educational practice.

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