

expose a student or patient to an unacceptable level of risk. We have therefore developed an immersive simulation course that aims to enhance undergraduate psychiatry training.

**Method.** Our course was developed by medical education faculty and psychiatry staff. The course handbook includes storyboards, patient scripts and debrief guidelines. Clinical scenarios are mapped to university intended learning outcomes and include; conducting a risk assessment for a patient with emotionally unstable personality disorder and comorbid depression, managing a manic patient in the Emergency Department and assessing a patient with obsessive-compulsive disorder who has developed skin damage due to hand washing.

The one-day course is delivered to groups of 4-8 students from the Universities of Glasgow and Edinburgh during their placements in NHS Lanarkshire. The course takes place in a simulation suite and is facilitated by psychiatrists and medical education faculty. Students each take the lead role during a clinical scenario in which they will encounter a simulated patient. Live video from the simulation is broadcast to other candidates. Scenarios last 10-15 minutes with a 20-30 minute group debrief immediately afterwards. The debrief utilises the PEARLS framework (Promoting Excellence and Reflective Learning in Simulation) and provides the opportunity for peer and facilitator feedback, as well as discussions regarding mental state examination, diagnosis and management.

**Result.** Qualitative and quantitative feedback has been collected via an anonymous electronic post-course questionnaire. To date, the course has received universally positive feedback. 93% of candidates rated the overall quality of the course as a learning experience as 'excellent'. Students reported that the course helped them develop communication skills which they could apply to future clinical situations. In addition, candidates felt participation had increased their confidence in taking a psychiatric history and performing a risk assessment.

**Conclusion.** Immersive simulation is an underutilised tool in psychiatry education. Our course complements the existing educational programme of lectures and ward-based teaching and has been positively received. It provides the opportunity for students to develop interview techniques and communication skills in a safe, controlled environment.

### Bedside teaching: an invaluable tool in undergraduate medical education

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**Aims.** Bedside teaching is one of the most important modalities in medical education. Sir William Osler stated, "Medicine is learned by the bedside and not in the classroom". Despite this, the use of bedside teaching in the undergraduate curriculum has been declining, potentially due to changes in course design, increasing clinical workloads and reducing inpatient numbers. In my role as a Clinical Teaching Fellow (CTF), I have aimed to maximise bedside teaching and promote it as the primary approach for student learning.

**Method.** As a CTF, I deliver teaching to students from the Universities of Glasgow and Edinburgh during their placements in NHS Lanarkshire. Weekly teaching is provided to groups of 2-4 students, with around 50% of sessions delivered 'at the bedside'.

Within psychiatry, there is a vast range of potential bedside teaching topics. Given the length of time required to conduct a

full psychiatric history and mental state examination (MSE), teaching sessions instead focus on one specific component of the patient interview, for example, assessing perceptual abnormalities or delusions, conducting a substance use history or exploring social circumstances and the functional impact of illness. This approach allows for more focussed feedback and teaching. Session structure is based upon Cox's model of bedside teaching, which I have modified slightly for the psychiatry setting.

Student feedback has been collected via an anonymous electronic end-of-block questionnaire.

**Result.** Qualitative feedback reveals that students in NHS Lanarkshire value bedside teaching, with one student describing it as "informative, comprehensive and relevant for upcoming exams and clinical practice".

There are a number of potential barriers to consider when delivering bedside teaching in psychiatry. These include issues identifying suitable patients who can provide informed consent to participate and the ethical concerns regarding exploring difficult subjects such as suicide risk assessment with patients for purely educational purposes.

These issues can be overcome; in inpatient units, there is usually a small cohort of patients who are able to consent and engage in student teaching, and difficult subjects can alternatively be addressed during role-play or simulation sessions.

**Conclusion.** Despite its challenges, bedside teaching can be an enjoyable and rewarding approach in undergraduate medical education, with feedback revealing it is positively received in NHS Lanarkshire. By utilising Cox's model and focussing on specific aspects of MSE and history-taking, bedside teaching is more accessible and an invaluable tool for psychiatric teaching. Clinicians and educators are encouraged to keep the patient at the centre of student learning.

### Balint in the time of COVID-19: participant and facilitator experience of virtual Balint groups compared with in-person

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**Aims.** Our Trust increased Balint group provision, relocating virtually for psychiatry doctors to explore the emotional impact of clinical practice and doctor-patient relationships, during unfamiliar challenges of the pandemic. This unique context allowed comparison of multiple virtual and face-to-face (F2F) Balint-type group experiences for participants and facilitators.

**Method.** In March 2020, existing core trainee (CT) year 1 and 2, higher trainee (ST) and consultant Balint groups became virtual, with new CT3 and Speciality Doctor and Associate Specialist (SAS) virtual Balint groups established.

All 57 participants and 5 facilitators were sent an anonymous electronic survey to retrospectively rate virtual Balint (March-August 2020) and their preceding F2F Balint group (suggesting September 2019-February 2020) experience.

**Result.** The response rate was 89% for participants (51 respondents) and 100% for facilitators (5 respondents).

For group participants, 90% (virtual) and 78% (F2F) agreed or strongly agreed that Balint group provided an opportunity to explore challenging aspects of clinical work. 76% (virtual) and 71% (F2F) agreed or strongly agreed that it made them feel more supported. Almost 50% agreed or strongly agreed that virtual and F2F Balint group helped work feel less stressful. Both

ratings and free-text feedback emphasised virtual Balint attendance being easier.

Facilitators rated virtual and F2F formats similarly highly with regards to exploring difficult doctor-patient interactions, richness of discussions and their enjoyment. Facilitators felt virtual attendance was easier but more draining, with more difficult adherence to Balint group etiquette and boundaries.

82% of participants and 75% of facilitators agreed or strongly agreed that virtual format made them more likely to attend future Balint groups. The rich pool of free-text comments received were predominantly positive, whilst noting challenges during virtual Balint in remaining present, with more distractions (for participants) and additional difficulty accessing group dynamics (for facilitators).

**Conclusion.** Participant and facilitator responses indicate Balint-type groups being professionally and clinically beneficial across different psychiatrist grades, and promoting clinician wellbeing when both F2F and virtual during pandemic-related restrictions. Facilitator ratings (unlike participants) suggested specific virtual process challenges such as feeling more drained, perhaps in part due to technical application issues around this emerging format.

Both participants and facilitators reported attendance being easier when virtual. Although some suggested returning to F2F post-COVID, more preferred to continue virtually or utilise a blended format. This was particularly for non-CT groups where geographical challenges (e.g. region-wide ST Balint) or competing clinical demands (e.g. consultant/SAS Balint) made regular commitment and attendance more difficult.

## GMC training survey and missing trainees in psychiatry

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**Aims.** To investigate the extent of misattributed responses in the General Medical Council (GMC) National Training Surveys (NTS).

**Background.** As part of its role in quality assurance of medical training, the GMC conducts an annual survey of trainers and trainees. Benchmarking of trusts' performance is indicated by red flags denoting outlying poor performance. The validity of this depends on the correct attribution of responses to trusts. We have previously found that responses for Foundation Year One (FY1) trainees undertaking psychiatry placements were misattributed to trainees' affiliated acute trusts (AT), even though the mental health trusts (MHT) were providing the training placements.

**Method.** Data from the online reporting tool were used to calculate the numbers of FY1, Foundation Year Two (FY2), and General Practice Speciality trainees (GPST) on psychiatry placements attributed to ATs and MHTs in 2019. A range is provided for the data, as results for trusts with one or two trainees are not reported. The data were analysed by training level and the 13 Health Education England (HEE) regions to give a proportion of trainees missing from the MHT data (% missing), an indication of response misattribution.

**Result.** 296-302 FY1s were attributed to MHTs and 114-148 to ATs, giving a % missing of 27.4-33.3%. 261-275 FY2s were attributed to MHTs and 89-125 to ATs, giving a % missing of

24.4-30.0%. 507-511 GPSTs were attributed to MHTs and 49-73 to ATs, giving a % missing of 8.8-12.6%.

Across the three training levels, all HEE regions were affected by data misattribution. The regions most affected were South London, Kent Surrey Sussex, and North West London, with missing % of 51.6-54.3%, 33.9-40.7% and 29.9-32.5% respectively. The HEE regions least affected were East Midlands, North Central and East London, and East of England, with missing % of 4.3-6.0%, 5.6-8.1% and 5.5-10.4% respectively.

**Conclusion.** Response misattribution for psychiatry placements in the NTS is rife, with the greatest impact on FY1s. While this issue affects all HEE regions, wide variation exists. Response misattribution means that the calculation of outliers is based on incomplete data, threatening the validity of the results. By liaising with our local HEE office to ensure correct attribution of our trainees, Surrey and Borders Partnership NHS Foundation Trust reduced our % missing from 50.0-56.8% in 2018 to 5.4-10.1% in 2019, thus proving that it is possible to remedy the situation on a local level.

## A model for improving postgraduate medical education using the GMC survey

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**Aims.** To investigate whether the General Medical Council (GMC) National Training Surveys (NTS) can be analysed to develop a plan of action that improves postgraduate training.

**Background.** As part of its role in quality assurance of medical training, the GMC conducts an annual survey of trainers and trainees. The Doctors in training survey, part of the NTS, consists of 70 questions which are grouped into 18 indicators of quality. At Surrey and Borders Partnership NHS Foundation Trust, we were keen to use the comprehensive data in the NTS to improve training. We analysed each question to create a plan of action to improve the quality of training.

**Method.** We used data from the online reporting tool to calculate the scores for each question in the 2018 NTS. Taking into account the impact of year-on-year changes in the content of the survey, we examined the score, change from 2017 to 2018, and difference between the score and indicator mean to identify poorly-performing questions. Other questions with clear potential for further improvement were also highlighted. A plan of action was produced by the Leadership and Education Fellow and Director of Medical Education.

**Result.** 29 actions were identified. The most common were to ensure that information (e.g. job descriptions, professional opportunities) was accessible to trainees (8 actions); liaise with other teams (e.g. Human Resources, Safety team) (6); discuss issues with or provide information to trainers (5); discuss with trainees to contextualise survey results within their experiences (4); and ensure that information was delivered at induction (3).

To implement these actions, we conducted a workshop for trainers and held feedback meetings with trainees. 76.5% of trainers (13/17) and 88.5% of trainees (23/26) surveyed following these respective events agreed or strongly agreed that the NTS can be used to improve the training experience. A presentation on making the most of the placement was added to trainee induction and was rated excellent or good by all respondents (28/28).