Abstracts Book

Summary

2nd International Congress of Health Workforce Education and Research

We are very pleased to announce that the 2nd International Congress of Health Workforce Education and Research will take place at the European University Cyprus in Nicosia, Cyprus from Thursday 9th May 2019 to Friday 10th May 2019. Hosted in collaboration with the School of Medicine at the European University Cyprus, the International Network for Health Workforce Education holds its Congress once a year and it is the prime meeting place for international health workforce educators, researchers and policy makers.

Congress Theme: Future Education for Healthcare

During a time of great change for global healthcare systems the future education of healthcare professionals is key to ensuring long term sustainability for populations. International institutions have called for policies that allow for the education of flexible health professionals capable of dealing with the ever-changing healthcare environment. A multi-stakeholder and inter-professional approach to tackling this issue is paramount to ensuring this takes place. Educators must ensure that they employ the most effective teaching methods, researchers must identify the right skill combinations for future professionals, and policy makers must make effective changes to national and international planning and legislation.

The health workforce faces a number of complex challenges at local, national and global levels. At the global level, a key challenge is the increasing number of mobile healthcare workers who are challenging country-based health workforce education and planning. At a national scale, research projects have identified that education and training must adapt to the skill requirements needed to keep the health workforce compatible with policy plans. Therefore, at a local level, educators must assess their curricula, the approaches they take to teaching and the assessment methods that they implement. The health workforce education community is already attempting to address some of these challenges, for example by moving towards inter-professional teaching, competency based training programmes, and clinical reasoning education techniques, but there is still much work to be done.

The International Congress of Health Workforce Education and Research allows participants to discuss the diverse possibilities and challenges of “Future Education” with international colleagues.

2018171: Strategic Healthcare Simulation: Interprofessional ICU Bedside Rounding

Dr. Valeriy Kozmenko, Director, USD SSOM, United States

Dr. Mark Beard, Dean of Medical Student Education, USD SSOM, United States

Miss Jessica Simpkins, Medical Student, USD SSOM, United States

Shane Schellpfeffer, MEd, United States

Objectives

Background: The intensive care unit (ICU) is one of the most dynamic interprofessional environments in healthcare. An average patient in the ICU has an unstable course, may have multiple organ system failures, and often has a need for function support or replacement and extensive use of monitoring and life supporting equipment. Providing care for such patients requires a truly multi-professional team. To effectively provide patient care, providers need to know the roles of each member of the team, including their scope of practice and responsibilities. Bedside rounding is one of the most important daily events in the ICU because this is when patients are assessed, and decisions are made regarding further treatments. Learning the skills associated with bedside rounding is less than ideal at the site of patient care when one considers the instability of patients, the busy daily ICU routines, and the associated cost of staying in an ICU. Teaching ICU bedside rounding in a high fidelity simulated environment can be accomplished without risking the quality of care delivered to patients. Bedside rounding involves analysis of the patient's ICU course over the last hours and days and therefore heavily relies on the use of the electronic health record (EHR). There are several EHR systems employed by healthcare institutions in the United States including Epic, Cerner, Meditech, and NextGen to name some of the most widely used. Many of these systems are expensive, lack inter-compatibility, and are not well-suited for simulated environments. Additionally, the commercially available simulated EHRs (S-EHR) that do exist are often targeted for a specific healthcare specialty and have limited use for interprofessional education (IPE) and simulation.

Hypothesis/goal: An interprofessional group of healthcare educators from the University of South Dakota (USD) has developed an interactive ICU bedside rounding IPE course that uses a custom-designed S-EHR. The S-EHR is a web-based application that contains the healthcare records of simulated patients. It does not aim to replicate a real EHR but rather to provide an enhanced educational experience to healthcare learners in a simulated IPE environment.

Method

The course consists of a series of simulation scenarios that take place in an ICU.

Each scenario has a set of specialty-specific and interprofessional learning objectives. The content of each scenario realistically portrays the complex overlap of a patient's chronic conditions with new problems, deconditioning, medication side-effects, and iatrogenic complications. Encounters are documented with the use of a custom-designed S-EHR.

Prior to the activity, students learn about their simulated patients by reviewing their charts in the S-EHR. On the day of the event, an interprofessional group of learners assesses a simulated patient, discusses the patient's condition, identifies problems, develops an assessment and treatment plan, and delegates responsibilities based on each participant's scope of practice. Students from each specialty are evaluated by the IPE-trained faculty from their respective specialties. Assessment instruments are designed from specialty-specific and interprofessional criteria. Immediately after completing a scenario, all learners participate in a debriefing. The discussion is guided by the facilitator in such a way that all teaching points of the scenario are discussed. After debriefing, learners round on the next patient(s) and have an opportunity to apply knowledge and skills they acquired during the debriefing. At the end of the session, participants complete a learner's satisfaction survey. This course is delivered at the end of Pillar 3 of the USD Sanford School of Medicine curriculum. We plan to survey participating medical students when they are six months into their residency training. We will obtain their

feedback on the applicability of the skills they learned during this course and ask for suggestions on how to improve the course.

Results

This course is currently in development. Preliminary results will be available at the time of presentation. We expect knowledge and skills acquired during this course to be applicable not just to the ICU bedside rounding but to many other aspects of interaction among various healthcare providers and patients.

Conclusions

We expect participants from various health professions to learn how to evaluate a patient's course in the ICU, develop patient management strategies, and learn about the roles of each specialty in patient care. We are also using this course as an assessment of usability of the USD proprietary simulated electronic health record (S-EHR) system.

2018174: Taking Action to Enhance Nursing Research Capacity

Prof. Bibi Holge-Hazelton, Professor in Clinical Nursing, University of Southern Denmark, Denmark

Prof. Val Wilson, Professor of Nursing Research, University of Wollongong, Australia

Mrs. Denise Edgar, Research Manager, Illawarra Shoalhaven Local Health District, Australia

Short Paper

All nurses are expected to practice from an evidence base. The advanced clinical nurse is also expected to lead evidence based practice and contribute to the body of nursing knowledge through research activity. The Clinical Nurse Consultant, an Australian example, has research in their role description and works at the clinical interface, therefore is ideally positioned to conduct clinically relevant nursing research to improve patient care or understand the patients care experience. However, there are known barriers to nursing research including time due to competing demands and research skills. While effort could be invested to up skill the nursing workforce in research knowledge, without managerial support and strong leadership, these clinical nurses' efforts are likely to be futile. A strategic approach is required to build nursing research capacity and a research culture where research use and generation are seen as part of normal everyday nursing practice.

As part of establishing an evidence base for 'nursing research capacity building' an international collaborative between two clinical nursing professors and their research units (Denmark and Australia) has been established. An initial project is the introduction of Action Learning Sets (ALS) with head-nurses, midwifes and physiotherapists (Denmark) and mid-level nursing and midwifery managers (Australia) within their respective health organisations. ALS use a "process of learning and reflection that happens with the support of a group or set of colleagues who work with a real problem with the intent of getting things done " (McGill and Beaty, 1995 p.1). Since these health-care managers have direct responsibility for clinical nursing, the aim of the ALS is to assist them to lead, support and enhance practice development and research activity, including the use of evidence in their speciality area. The ALS was initiated by the Danish, with the Australian participants following a similar path, both groups have agreed that the overall themes relate to managers roles in capacity building, and are facilitated as reflective teams. Participation is voluntary, and all participants are encouraged to prepare cases related to the overall themes from their practice, and share them with the group. They are also encouraged to make explicit their own learning objectives.

A short questionnaire has been developed to evaluate the ALS in order to identify if the participants expectations and learning needs are met, what was gained from participation in the ALS and any further reflection and learning. Preliminary results from Denmark have found that the participants highly value and prioritize the sessions because they are confidential and non-competitive. This has created spaces where the managers can receive feed-back and gain new ideas of how to proceed with the difficult task of securing room for research and development in a busy and demanding daily practice. The common themes, key learnings and solutions from both countries will be shared in this presentation. This will provide participants with insights into ways in which health care leaders can support the future development of research and the use of evidence to inform healthcare practice.

McGill I & Beaty L 2001, Action Learning for professional, management and educational development, 2nd edn, Kogan Page Ltd, London.

2018175: A person-centred co-design approach to advancing facilitation: Outcomes of an advanced facilitation program

Prof. Val Wilson, Professor of Nursing, University of Wollongong, Australia

Dr. Rebekkah Middleton, Snr Lecturer, University of Wollongong, Australia

Objectives

Background: Skilled facilitation is a core element of education, learning and development, leadership and change management and is key to the success of the evolving health care landscape. The International Practice Development Collaborative (IPDC) has been training facilitators for 20 years through a five day foundational school which aims to provide participants with basic skills and knowledge about facilitation, evaluation and change strategies. The course which originated in the UK has been taught across Europe, Canada, South Africa, Australia and New Zealand and has been delivered to take into account the local context and language (e.g. taught in German). There is wide ranging evidence to suggest that using a facilitative approach, and working alongside people improves outcomes in learning and development, staff engagement, critical questioning, reflective practice, change processes and most importantly in the delivery of care to patients.

It is clear however that the skills and knowledge gained in the foundational skills are just a starting point in developing as a skilled facilitator. There has been a call over more recent years to provide advanced facilitation skills, knowledge and theory to enable and support those facilitators in healthcare who wish to take their facilitation to the next level. With this in mind members of the IPDC from six countries worked together to develop a principle based advanced facilitation curriculum for health care professionals that focussed on person centred practice. The curriculum has flexibility to ensure that at least 50% of the content and delivery is co-designed by the participants themselves. The curriculum is delivered across 4 months with full day workshops for 2 days in the first month then a full day after two months and a final day after another 2 months. Pre reading and activities was given prior to the course, there was also activities to be undertaken between the face to face days. This was to allow for consolidation of learning and for trialling new ideas in the practice setting. In this presentation we will cover the development, implementation and evaluation of the curriculum for the first two cohorts of participants which took place in Australia.

The objective of this work was to evaluate the implementation of the advanced curriculum in order to:

- establish the learning outcomes for the participants both during and after the course
- uncover the experiences of the participants in the co-design elements of the curriculum
- review the delivery mode and methods of the course
- outline the experience of those involved in delivering the program

Method

A mixed-methods design was used to evaluate the course. Participants individual learning goals formed part of the overarching evaluation questions (these were themed to provide group learning goals). At the end of each full-day participants were invited to score each learning goal from 1 (not achieving this) to 5 (absolutely achieving this). Other data included pre and post reflective words, high challenge/high support grids, poems, learning portfolios and a 3 month follow up survey distributed via survey monkey. Simple descriptive statistics was used to analyse all numerical data and this was presented as mean scores across the learning time span (4 months). All other data was themed. The facilitators delivering the program used debrief notes and reflective journaling to assist with the evaluation of the program.

Participants: In the first cohort there were 12 participants from a variety of nursing, midwifery and allied health backgrounds. The majority worked in healthcare settings, a couple of participants worked in higher education. The second cohort had 16 participants again from a range of disciplines and whilst the majority were in health

care settings there were a higher number that were from higher education settling. The groups were deliberately kept small to ensure an active learning style could be used.

Results

The results indicate that overall the participants individual learning needs were met. However everyday they attended saw an increase in their scores in meeting their objectives, outlining the importance of a continual learning process. It was also clear from their learning portfolios that having the space between the workshop days enabled them to consolidate their learning, incorporate new knowledge and skills into their facilitation and to test out their emerging theoretical knowledge in a practice setting. Their portfolios were enriched by seeking valuable feedback from a range of people. Key themes emerging from those participating included enhanced reflection and increasing self-awareness; sharing my learning with others; the need for critical companions, working with other and how they were exploring new frontiers in facilitation and making an active contribution to the evolving art and science of facilitation. From those facilitating the course the program was successful and the format worked well. It was good to keep groups sizes small (1 facilitator for every 6-8 participants), co-design enhanced engagement and learning, there was flourishing for all involved.

Conclusions

It is key from this evaluation that those who participated that there was a need for an advanced facilitation curriculum. The participants to date have highlighted their learning about theory and how this connects to them improving their facilitation of transformational change in the workplace, using person centred approaches. The curriculum will continue to evolve and the next phase of this work is to implement the program in Europe in 2020. It is important to note that all facilitators who complete the advanced facilitation program are then invited to join an International group of critical companions who are there to offer support and mentorship to facilitators working across the health care landscape.

2018177: Exploring current research about the role of values for undergraduate nurses

Mrs. Carolyn Antoniou, Lecturer, University of Wollongong, Australia

Objectives

Within healthcare, professional nursing values are a guiding principle, which articulate the beliefs and standards of the profession, unifying and identifying the individual to the group with the intention of providing high quality and safe care. Professional values are evident in the professional standards that guide role and registration standards, and in the healthcare policies of each country. Health professionals themselves are individuals with their own personal values, influenced by multitudinous factors and are widely varied. Evidence suggests that people are drawn to the profession of nursing when there is a sense of alignment between their personal values with their perception of the role of nurses. However the way in which a person assimilates their own values and that of the profession they have entered are not well understood. Within nursing curricula, educational components transition the individual through the process of adopting and internalising professional nursing values. Then, through practice, students actualise all they believe and have learnt, in an environment that is complex and does not always live up to the values it espouses. This literature review unearths what is known internationally about the development of student nurses professional values. This enables us to consider ways in which we can incorporate the development of professional values into nursing undergraduate education in ways which support the mobility of healthcare as they transition from the academic setting into clinical practice.

Method

The literature review sought to identify international research of student nurse values between 2005-2018. Using the keywords “student nurse” “values” “education” and “curriculum”. Thirty seven papers were identified from eleven different countries which met the inclusion criteria of being within the relevant time period, primarily related to student nurses and related to values. From this list papers were excluded if they were concerned with the development of a single value, for example compassion. The papers were analysed for similarities and patterns as described by Braun and Clarke (2006), producing a themed analysis of the research to date (Braun & Clarke, 2006).

Results

The literature review sought to identify international research of student nurse values between 2005-2018. Using the keywords “student nurse” “values” “education” and “curriculum”. Thirty seven papers were identified from eleven different countries which met the inclusion criteria of being within the relevant time period, primarily related to student nurses and related to values. From this list papers were excluded if they were concerned with the development of a single value, for example compassion. The papers were analysed for similarities and patterns as described by Braun and Clarke (2006), producing a themed analysis of the research to date (Braun & Clarke, 2006).

Conclusions

Research into identifying values, exploring values and value development has been wide ranging however; we do not yet have a clear understanding of how professional values evolve during nursing education or the impact of this evolution on an individual’s ability to be active participants in the healthcare workforce. In situations where professional values are not always enacted, there can be an uneasy intersect with students own values and this has been identified as a significant reason why people leave the profession. It is imperative we consider the development of student nurses values during these formative years to ensure they are equipped to provide the highest quality care.

The research unearthed by this literature review demonstrated a clear international interest in this area especially as the nursing profession continues to struggle under the strain of poor retention and an ever increasingly complex healthcare environment.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101. doi: 10.1191/1478088706qp063oa

2018178: Leading a Research and Development Capacity Building Program at a new University Hospital

Prof. Bibi Holge-Hazelton, Professor in Clinical Nursing, University of Southern Denmark, Denmark

Short Paper

In 2015, a hospital in Denmark changed its status from Regional Hospital to University Hospital. The new status meant that, the hospital had to strengthen its focus and involvement in research and development across departments and professions. The hospital had little prior tradition of research among nurses and allied health professionals. On that background, a special focus was directed towards research and development capacity building among these groups, including establishing designated positions for research such as postdocs and a professorship with special responsibilities within capacity building in nursing.

In 2017 the 5-year research program CAPAN (CAPAcity building in clinical Nursing) was established at the hospital. CAPAN is concerned with developing clinical nursing towards

person-centred practice and to co-create and implement a meaningful, accessible and flexible infrastructure for translating and integrating nursing evidence across and the departments and specialties at the hospital. The underlying approach in CAPAN is that all initiatives must be clinically relevant and participatory. CAPAN is inspired by the Promoting Action on Research Implementation in Health Services (PARIHS) framework(1) and uses an evaluation framework developed by Cooke (2) to document the process and measure the impact . The evaluation framework is embedded in a policy context and consists of two dimensions. The first dimension consists of four structural levels of development activity: individual, team, organisational, and network. The second dimension consists of six principles of capacity building: Develop skills and confidence; support linkages and partnerships; ensure the research is 'close to practice'; develop appropriate dissemination; build elements of sustainability and continuity; invest in infrastructure. Each principle must operate at all structural levels.

From the perspective of the program leader, the presentation will describe concrete initiatives and share the key learnings including necessary actions to adjust the program during its first two years.

References

1. Kitson AL, Harvey G, McCormack B. Enabling the implementation of evidence-based practice: a conceptual framework. Qual Health Care. 1998;7.

2. Cooke J. A framework to evaluate research capacity building in health care. BMC Fam Pract. 27. oktober 2005;6:44.

2018179: Medical students' self-assessed level of intercultural competence: first results of a Hungarian survey

Dr. Erika Marek, Senior Lecturer, Dept. of Operational Medicine, Medical School, University of Pécs, Hungary

Ms. Dora Schmel, Medical Student, Dept. of Operational Medicine, Medical School, University of Pécs, Hungary

Dr. Zoltan Katz, Assistant Professor, Dept. of Operational Medicine, Medical School, University of Pécs, Hungary

Dr. Zsofia Feiszt, Clinical Consultant, Dept. of Internal Medicine, Medical School, University of Pécs, Hungary

Short Paper

Since 2013 the rapidly growing international migration in Europe has posed new challenges to the EU healthcare systems. Due to the crisis situation in 2015 a „High-level meeting on Refugee and Migrant Health" was organised by World Health Organization (WHO) and its Outcome Document emphasizes the importance of 'providing migrant-sensitive health care and the periodic assessment of the sufficiency and preparedness of the health system capacity which can adapt and respond to the needs of a changing population and take account of cultural, religious, linguistic and gender diversity. Training of health professionals and relevant non-health actors is a key element to achieve this purpose'. Along these WHO recommendations a comprehensive questionnaire survey was conducted between Sept, 2016 and May, 2018 at Medical School (MS), University of Pécs (UP), Hungary aiming to assess the medical students' actual level of intercultural competence (ICC): their awareness, skills, and attitudes regarding the health and healthcare for migrant populations, as well as to identify the areas for improvement. We collected data of participants' previous ICC trainings as well as the students' opinion, expectations and recommendations about incorporating intercultural contents into the medical curricula. The survey was conducted in three languages: Hungarian, English and German, the 3 languages of the international medical training programs at MS-UP. The target groups for the research were both freshmen and senior students, and as this latter group already obtains clinical experiences, this may allow comparisons and data regarding the effects of the current curriculum on students' ICC level. The questionnaire used was the 'Clinical Cultural Competence Questionnaire (CCCQ)', which was translated and modified with the permission of its author, Professor Robert C. Like (New Brunswick University, US). Altogether more than 1200 medical students completed our anonymous questionnaire survey, and the final analysis of the total results is currently ongoing. Based on the preliminary results - which are covered in the current study - (involving 244 persons, grade 4 students), no significant difference was found between sex, and age regarding the 4 main examined domains: 'Knowledge', 'Skills', 'Attitudes' and 'Comfort-level in Intercultural Situations'. Compared by study programs, the students of the German Program demonstrated significantly higher scores for 'Knowledge' domain, while students of the Hungarian Program had higher scores for the 'Skills' domain. The longer time interval one has spent or lived abroad showed higher 'Comfort-level' scores, but –unexpectedly- showed no relation with better intercultural knowledge, skills and attitudes. Significantly higher scores were clearly demonstrated in terms of 'better language competencies' for all of the 4 examined domains, while 'previously completed intercultural training programs' were only related to a higher level of 'Knowledge' and had no effect on the participants' 'Skills', 'Attitudes' and 'Comfort-level in intercultural situations'.

Based on our preliminary results (ie. previous ICC trainings resulted in students' better 'Knowledge' but had no effect on their 'Skills', 'Attitudes' and 'Comfort level in cross-cultural situations'), we concluded that future training programs at medical schools, in addition to improving students' awareness, shall focus more on developing skills and enhancing attitudes using various interactive teaching methods. Our study highlighted some specific areas to consider during future curriculum developments, such as 'providing culturally-sensitive end-life care' as our study participants demonstrated the lowest 'Skill'-scores regarding this issue. Another important area to focus on is to improving students' coping strategies when dealing with derogatory remarks from colleagues and patients on ethnicity (both on their own and others' ethnicity, including the patients). It is encouraging, that study participants considered it really important to offer ICC training for healthcare workers, and a great majority (80%<) of them expressed interest and willingness to participate on future trainings which aim to improve their intercultural competencies. Considering our study participants' concerns and

recommendations regarding the development and launch of a new optional ICC course at the University will surely contribute to its success in the close future.

This research was supported by the János Bolyai Research Scholarship of the Hungarian Academy of Sciences. The support period of this stipend is 2017/09/01-2020/08/31. „Supported BY the ÚNKP-18-4 New National Excellence Program of the Ministry of Human Capacities”.

2018180: Healthcare Practitioner Educational Interventions: Skills and Strategies for a Culturally Sensitive Care

Dr. Pepi Burgos, Senior Lecturer/Researcher, Wageningen University & Research, Netherlands

Short Paper

Objective: Ethnicity and culture are commonly seen as barriers to achieve an effective healthcare practitioner-patient communication. Raising awareness about these barriers among healthcare practitioners may contribute to ameliorate intercultural medical communication, what is likely to impact patient satisfaction. The aim of this paper is to present an intercultural communication skill training program aimed at achieving a culturally sensitive care.

Background: The landscape of healthcare has dramatically changed in the last decades. Migration plays a key role in this change. Thousands of migrants from different ethnic and cultural groups have arrived – and keep arriving – to Europe seeking a better life. The expectation is that the number of migrants will increase over the coming years. In fact, the majority of population growth in some European countries, such as the Netherlands and Spain, is currently determined by foreign immigration (e.g., in 2017 22,6% of the population in the Netherlands had a migrant background). This increase in patients with a migrant background raises a fundamental question, namely to what extent does belonging to a different ethnic and cultural group influence the communication process between health care practitioners and migrant patients. This fundamental question needs to be addressed in today's multicultural society in which healthcare practitioners are increasingly confronted with patients from different ethnic and cultural backgrounds. The expectation is that the communication process between individuals from different ethnic and/or cultural backgrounds will develop differently than that of individuals who share the same background, as individuals from different cultures hold different norms, values, and beliefs about communication, health and illness.

This divergence on cultural values and beliefs is often exacerbated by linguistic barriers. When the migrant patient does not speak the practitioner's language in a proficient manner, the exchange of information is hampered. As a result, practitioners may fail to understand what the patient intended to say and to arrive at the right diagnosis. Also, the treatment advice may not be properly understood by the migrant patient due to this miscommunication. Healthcare practitioners are often confronted with the arduous task of providing good quality care, ideally a patient-centred care, to a diverse group of patients, each of them with his/her own unique cultural background and mother tongue. As to linguistic barriers, not only verbal but also non-verbal communication during these medical encounters may be susceptible to misinterpretations. In some cultures, like the Western culture, eye contact when speaking with other person can be considered a gesture of respect, whereas in some Eastern cultures the same act can be interpreted as unpleasant and disrespectful.

Additional barriers that can be found in healthcare practitioner-patient communication, particularly when it comes to pursuing a patient-centred care, are 1) holding different communication styles, 2) not sharing similar values about health and illness, 3) having different role expectations, and 4) having/experiencing bias and prejudices, which may influence the exchange of information during medical encounters.

However, intercultural medical encounters – and their possible miscommunications ¬– are not solely found between health practitioners and migrant patients, but also between health practitioners themselves. Notice that in European countries such as the Netherlands, United Kingdom and Finland, there is a significant increase of qualified healthcare practitioners, for example nurses, which results in cultural diversity in the health workforce. This situation presents new challenges as practitioners, who share similar knowledge, can experience difficulties in communicating with peers from a different cultural background. It is thus essential for both national and expat healthcare practitioners to adjust their professional practice and to involve in reciprocal integration by acquiring appropriate intercultural communication skills.

In sum, educational interventions to enhance healthcare practitioners' intercultural communication skills are necessary, particularly in multicultural medical environments. Staff development training programs can assist health practitioners to better communicate and engage with others (practitioners and patients) from culturally different backgrounds.

Theoretical framework: In this training program two models and a theory will be addressed, namely the Hofstede model of national culture [1], the theory of high/low context cultures of Hall [2] and the 5As (Ask, Assess, Advise, Agree and Assist) behavior change model [3]. The Hofstede model of national culture and the theory of high/low context cultures of Hall will contribute to raising awareness of the impact of culture on communication, whereas the 5As behavior change model will serve as a manageable evidence-based behavioural intervention strategy that has the potential to improve patient-centred communication in healthcare practitioner-patient consultations.

Suggested training program: The aim of the suggested intercultural communication competence training program is twofold. First, to raise awareness about the impact of communication in an intercultural context, and second, to build cultural competence to navigate possible miscommunications and perceptions of unsatisfactory care. During this training healthcare practitioners will 1) raise self-awareness of the way they communicate due to their own cultural background, 2) raise awareness of the way migrant patients communicate because of their own ethnic and cultural background, 3) gain insight into the degree in which healthcare practitioners' and migrant patients' own culture affects their behaviour, reactions, assumptions and expectations during medical encounters, 4) put into practice the knowledge acquired to build cultural competence, and, eventually, 5) integrate the 5 As model to improve patient-centred communication in healthcare practitioner-patient consultations.

Conclusion: Cultural competence training programs show promise as a strategy for improving healthcare practitioners' knowledge, attitudes, and skills and patients' ratings of care. Interventions that focus on raising cultural awareness, the avoidance of bias, and patient-centeredness are promising strategies that should be prioritized in multicultural medical environments.

Practice implications: Increased knowledge of nations' cultural norms and values on medical communication, different communication styles across cultures, as well as the 5As behaviour change model may contribute to a culturally-appropriate and effective communication between healthcare practitioners and patients from different ethnic and cultural backgrounds.

References

[1] Hofstede, G. (1991). Cultures and Organizations: Software of the Mind. London, UK: McGraw-Hill.

[2] Hall, E. T. (1976). Beyond Culture. New York, NY: Doubleday.

[3] Vallis, M., Piccinini–Vallis, H., Sharma, A. M., & Freedhoff, Y. (2013). Modified 5 As: Minimal intervention for obesity counseling in primary care. Canadian Family Physician, 59(1), 27–31.

2018181: Embracing technology to assess skills and competencies of the community pharmacy workforce to deliver national enhanced services

Miss Debra Roberts, Associate Pharmacy Dean & Head of Programme Development, Health Education and Improvement Wales, United Kingdom

Prof. Margaret Allan, Honorary Professor and Pharmacy Dean, Health Education and Improvement Wales, United Kingdom

Short Paper

The Welsh Government has a vision for the National Health Service within Wales to provide the majority of care closer to people's homes,1 which will involve an increasing number of clinically focussed enhanced services being offered through community pharmacies2. The community pharmacy contractual framework, which sets out the services that should be delivered from pharmacies, was revamped in Wales during 2017 to accommodate Welsh Governments' aspirations for community pharmacy to become more focussed on the quality of service provision rather than the supply function.

Traditionally community pharmacists have had to attend specific face to face training events and pass knowledge / skills assessments for each enhanced service that they offer, which often involved duplication of knowledge and time delays for service provision, whilst waiting to attend a training event. With the new focus on quality and clinical services local health boards, who commission the enhanced services from the pharmacies, decided to modernise the way pharmacy services were delivered and how accreditation was done.

The aim of the project was to create a new streamlined accreditation approach, embracing technology, to give pharmacists and pharmacy technicians more flexibility when accrediting for services, which is less reliant on face to face training, whilst still being robust enough to ensure the competence of the pharmacy professionals delivering enhanced services across a range of generic skills. The new assessment will provide a baseline assessment of the skill set of the pharmacy team, which can then be built on, as more clinically complicated enhanced services are commissioned from community pharmacies, over subsequent years.

All pharmacists and pharmacy technicians who already deliver any enhanced services in Wales are required to complete the new National Enhanced Service Accreditation (NESA) process during 2018-19. New pharmacy professionals who wish to initially accredit must complete the process prior to commencement of delivery of any of the enhanced services.

The assessment comprises of two specific elements - generic skills and competency assessment that needs to be completed once to demonstrate competency and a clinical knowledge assessment that needs to be completed for each enhanced service if deemed necessary.

The generic skills and competency assessment comprises of:

· Seven generic competencies (information governance, Equality Act, mental capacity, patient group directions, protection of vulnerable adults, quality improvement techniques and

Safeguarding children and young people) which are assessed via scenario based multiple choice questions

· Two generic skills– patients centred consultations and brief intervention skills which are assessed using video critique and avatars

The simulated avatar consultation was chosen as it provides a fair, objective and standardized assessment, with tailored feedback being provided. Due to the avatars inability to assess body language, empathy, tone, etc., the avatar assessment was combined with video critique, in order to assess the full range of skills required. Assessing consultation skills through the more traditional OSCE style exam was not feasible due to the number of community pharmacy professionals in Wales (too costly, time consuming and inconvenient). Using technology

for simulation allowed for increased access in a timely manner and standardisation, as actors / patients often behave differently when large numbers of assessments are run.

Each assessment was designed by educationists and practising pharmacists and reviewed by a team of practising pharmacy reviewers, from a range of backgrounds to ensure consistency, robustness and relevance to practice.

The entire assessment process was piloted with 227 pharmacy professionals, with a range of demographics representative of the profession in Wales. A questionnaire was completed by all participants that completed the entire process (n = 89) within the two month pilot period.

Whilst the majority of respondents (83%) felt the new generic skills and competency assessment would benefit their practice, there was mixed feedback in response to the use of avatars and video critique, within the assessment.

'I think the principle of this way of learning is excellent. Despite the avatars completely doing my head in, I think the idea is good' (P7)

'…much easier than attending courses' (P13)

'Avatar ….is not reflective of how we operate in practice as every patient is different. I feel it undermines our professional abilities' (P1)

The most negative responses were focussed on the use of the avatar with 65% of respondents stating that they didn't find communicating with the avatar easy. The feedback on the video critique was mixed with 44% of respondents finding them a useful way of reflecting on their own practice and 40% stating the opposite.

Following the pilot several changes were made to the avatar and the video critique, before the new process for obtaining national services accreditation was launched across Wales on 3rd April 2018. The avatar consultation process was altered to improve the natural flow and a practice avatar was made available in the learning resources. New video critiques were created to remove any ambiguousness. Monthly review of the assessment was conducted.

There are 716 community pharmacies in Wales, with approximately 2500 pharmacy professionals needing to complete the assessment by March 2019. Results to end of November 2018 was 912 pharmacy professionals had passed all elements. Over 1700 people had started the assessment with the majority completing the generic competency assessment first, with a 98% pass rate, before starting the generic skills assessment, with a 92% pass rate, after the adaptations post pilot.

The assessment has proved successful in ensuring a baseline set of generic competencies and skills within the pharmacy workforce, with over 1/3rd of the pharmacy professionals passed to date. The use of technology has ensured a cost-effective, robust, standardised assessment has been put in place which has increased the workforces' generic skills, whilst still ensuring ease of access and convenience for the pharmacy professionals.

References

1. Welsh Government. (2015). A Planned Primary care Workforce for Wales

2. Welsh Government. (2018). A Healthier Wales: our Plan for Health and Social Care.

2018183: Simulation games are part of the future of public health education

Mrs. Irina Wagner, Senior Health Advisor, The Royal Tropical Institute (KIT), Netherlands

Short Paper

Introduction: Games are fun and can bring in parallel learning processes on work environment beside the main learning objectives. Participants can learn and practice on the competencies needed in their professional career. Limited literature suggests that learning outcomes might be similar, but long-term impact might be higher. More courses are now integrating games as part of their curriculums. At The Royal Tropical Institute (KIT) in Amsterdam, we have three games that are used in educational programs.

The Health Resource Allocation Game (HRAG) is one of the games developed and played in different master courses at KIT. It is a simulation exercise, in which students (players) in small groups are required to develop a health system in a fictitious country. This fictitious country is represented on a map, with roads, cities, villages, rivers, mountains depicted on a board. A description of number of inhabitants, socio-economic distribution and expected burden of diseases of this particular population is provided. Using a limited budget, hospitals, health centres, health posts can be bought and placed throughout the country. Students can also introduce different financial mechanism from social health insurance to privatization and apply different health preventive programs. In the second phase of the game, the health system built is tested using a sample of patients (cards) presenting with different health problems. Patients belong to given socio-economic level, come from a specific location and require a specific level of care. Depending on the system built, the outcome might be successful (the disease has been prevented or the patient could reach the right level of care on time) or unsuccessful (patient failed to reach the right level of care on time due to lack of physical or financial access). The investments, approach and outcomes are compared between groups and discussed.

This game allows to practice decision making on resources allocation In a low resource setting, which is a vital skill that health professionals and policy makers need to have. The strength of the game is that participants not only can visualize a health system but also experience the consequences of their planning decisions on the outcomes of 150 individual patients that are testing the system. As such the game is a powerful tool for advocacy of rational and cost effective planning. In the past 20 years the game became very popular and a number of public health schools throughout Europe use it in different programs.

Objectives of the session:

- Demonstrate Health Resources Allocation game
- Discuss the role of gamification based on example of HRAG in future public health education

Method:

- Game demonstration
- Interactive discussion

Duration: 3 hours

Facilitators:

- Irina Wagner, PhD, Senior advisor, KIT
- Mahdi Abdelwahab, MSc., Junior advisor, KIT

Subthemes:

- Leadership and Health Management
- Skill Mix and Competency-Based Policy Making
- Education in Public Health

2018184: How to learn health systems the fun way? Short and mid-term learning outcomes of the HRAG

Ms. Charlotte van der Eng, Intern, The Royal Tropical Institute (KIT) / VU, Netherlands

Mr. Mohamed Abdelwahab, Junior Health Advisor, The Royal Tropical Institute (KIT), Netherlands

Mrs. Prisca Zwanikken, Senior Health Advisor, The Royal Tropical Institute (KIT), Netherlands

Mrs. Irina Wagner, Senior Health Advisor, The Royal Tropical Institute (KIT), Netherlands

Short Paper

Intro: Games and playing are forms of human interaction that have proven benefits in child development and sometimes used as interventions for assessment(1). In the past decades, serious games have been introduced for health adult education. Although there is not enough research done on formally assessing the effects of using games in health education, the available research shows that gaming was as effective as traditional didactic methods in delivering the knowledge to the students. However, using games provided better enjoyment and may enhance long-term memorization of the information. (2) They increase students' engagement and allow participants to have a real situation experience, in addition to learning about life skills as teamwork and decision making. All of that without having to do a trial and error on real patients or lose real resources in the process. (3)

At the Royal Tropical Institute in Amsterdam (KIT), the Human Resources Allocation Game (HRAG) has been used in the global health courses for around 40 years. HRAG is a board game that simulates a real-life situation where the participants have to decide on how to use the limited resources they have to plan and implement a fully functioning health system in an imaginary country. The gameplay takes one and a half full study days and is divided into 3 phases; Planning, Implementation, and Evaluation. (4)

At KIT, the game is played as part of two courses: the Global Health and Tropical Medicine Course (NTC), with participants mostly with more clinical background from the Netherlands, and Health Policy and project management module of the masters of international health, participants are usually mid-career public health professionals from LMICs. We have observed that the end results and the approach of decision making of both groups are different. although the students' feedback is always positive, we lack former assessment of the game outcomes and educational impact.

Objectives:

- To assess learning outcomes and mid-term impact of the health resource allocation game
- To understand how different group backgrounds can affect the game flow and impact the short- and mid-term outcomes
- To identify what factors make the game more effective in achieving short- and mid-term outcomes.

Method:

To investigate the effectiveness of the game a mixed-methods design will be used, in which both interviews as well as a survey using an experimental design are used. Research tools to be used:

- Questionnaire with current students who played the game recently and alumni of last year
- Interviews with facilitators of the game at different institutions
- Post-session feedback sheets
- Data on individual group composition and final outcomes of the game

Results:

Will be available by end of April 2019

References

1. Salcuni S, Mazzeschi C, Capella C. Editorial: The Role of Play in Child Assessment and Intervention. Front Psychol [Internet]. 2017 [cited 2019 Jan 11];8:1098.

Available from: http://www.ncbi.nlm.nih.gov/pubmed/28706502

2. Blakely G, Skirton H, Cooper S, Allum P, Nelmes P. Educational gaming in the health sciences: Systematic review [Internet]. Vol. 65, Journal of Advanced Nursing. John Wiley & Sons, Ltd (10.1111); 2009 [cited 2019 Jan 9]. p. 259–69. Available from: http://doi.wiley.com/10.1111/j.1365-2648.2008.04843.x

3. McCoy L, Lewis JH, Dalton D. Gamification and Multimedia for Medical Education: A Landscape Review. J Am Osteopath Assoc [Internet]. 2016 Jan 1 [cited 2019 Jan 11];116(1):22.

Available from: http://www.ncbi.nlm.nih.gov/pubmed/26745561

4. H.R. F. Allocation of resources using a simulation game. Med Teach [Internet]. 1980;2(1):10–7. Available from: http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L10036166%0Ahttp://rug.on.worldcat.org/atoztitles/link/?sid=EMBASE&issn=0142159X&id=doi:&atitle=Allocation+of+resources+using+a+simulation+game&stitle=MED.+TEACH.&title=Medical+Teach.

2018185: Exploring context in continuing medical education: development of a theoretical framework

Dr. Thomas Roux, SPHeRE PhD Scholar, School of Public Health, Physiotherapy and Sports Science, University College Dublin, Ireland

Dr. Conor Buggy, Assistant Professor in Occupational and Environmental Studies, School of Public Health, Physiotherapy and Sports Science, University College Dublin, Ireland

Dr. Susan Murphy, Coordinator, MSc in Development Practice (MDP) & Director, Trinity International Development Initiative (TIDI), School of Natural Sciences (Geography), Trinity College Dublin, Ireland

Dr. Mirjam Heinen, Lecturer in Epidemiology and Biomedical Statistics, School of Public Health, Physiotherapy and Sports Science, University College Dublin, Ireland

Objectives

Continuing medical education (CME) has been put forward as a means of maintaining clinical competence amongst healthcare practitioners. However, evidence indicates that CME continues to be poorly developed and inappropriately utilised. As a result, there has been increasing interest in the literature in evaluating what role wider contexts play in CME development and delivery. As part of an ongoing study, the authors developed a theoretical framework grounded in learning theories to further explore context in CME.

Method

A non-systematic narrative review of learning theories within medical and social science literature was conducted. In order to address the research questions of the overarching study, theories which fulfilled the following three criteria were evaluated: 1. Cognisant of contexts beyond the individual learner; 2. A systems understanding of interactions between contexts and learner; 3. An appreciation of learning as more than mere acquisition of knowledge.

Results

Discourse within the literature indicates the need to consider sociocultural theories of learning within medical education. Two theories were considered adequate in addressing the overarching study's research question. A theoretical research matrix incorporating Bronfenbrenner's four levels of educational environment (micro, meso, exo, macro) and Biggs' presage-process-product model of constructive alignment was developed.

Conclusions

The lack of explicit application of theoretical frameworks in medical education research has been pointed out in the literature. The development of this framework not only addresses that concern in the current study, but also allows the exploration of the applicability of wider learning theories in CME research.

2018186: Health care students' attitude towards health care teams at the Lithuanian University of Health Sciences

Mrs. Ausrine Kontrimiene, MD, PhD Student, Lithuanian University of Health Sciences, Lithuania

Mrs. Lina Jaruseviciene, Professor, Lithuanian University of Health Sciences, Lithuania

Mrs. Renata Paukstaitiene, Assoc. Professor, Lithuanian University of Health Sciences, Lithuania

Mrs. Aurelija Blazeviciene, Professor, Lithuanian University of Health Sciences, Lithuania

Objectives

Interprofessional education (IPE) is strongly linked with interprofessional collaboration and teamwork in healthcare. Incorporation of IPE early in the undergraduate program is expected to be the most effective. Lithuanian University of Health Sciences (LUHS) initiated the first IPE course in 2017 for students of different health care programs to be held together. The aim of our study was to identify student's attitude towards health care teams before and after the course.

Method

The "Attitudes toward Health Care Team Scale" (Heinemann, G. D., Schmitt, M. H.) was used to measure the change of students attitude towards health care teams before and after the IPE course at the LUHS, Kaunas. Questionnaire was distributed in person for all the students during the first and the last day of the course. Students from nursing, medicine, kinesitherapy, obstetrics and psychology study programs participated in the course. Statistical data analysis was performed using data acquisition and analysis package program SPSS (SPSS version 23.0).

Results

A total of 756 questionnaires were gathered (395 before and 361 after the course). Majority of students were women (79,2%) and a larger part of the students was from medicine program (65,8%). Statistically significant favourable changes were identified in domains related to: patient care (more students after the course agreed on better response to emotional and financial needs of patients while working in teams (57,2% vs after 71,9%, $p<0,001$)); physician centrality (after the course students less agreed that only physicians are natural team leaders (before 70,1% vs after 56,5%; $p<0,001$)). However, team efficiency domain demonstrated that students after the course more agreed on teamwork taking too much time (before 43,5% vs. after 58,7%; $p<0,001$), complicating things (before 63,3% vs. after 71,5; $p<0,05$) and answered positively that there are better ways to spend time rather than in team meetings (39,7% vs 52,1%; $p<0,001$).

Conclusions

IPE course did have a statistically significant favourable impact on the change of students' attitude towards health care teams, particularly on patient care and physician centrality domains, however, the attitude towards time constraints was affected unfavourably.

2018187: Intended and actual outcomes of Erasmus+ mobility: an exploration of nursing students' experiences

Dr. Josef Trapani, Lecturer & International Coordinator, Department of Nursing, University of Malta, Malta

Dr. Maria Cassar, Senior Lecturer & Head, Department of Nursing, University of Malta, Malta

Objectives

Several nursing students participate in Erasmus+ mobility programmes every year; yet, few published studies have explored their experiences. In view of the increasing emphasis on evaluating the quality of higher education internationalisation, the objectives of this study were: (1) to explore the motivations for and experiences of Maltese nursing students' Erasmus exchanges; and (2) to compare these experiences with the intended outcomes of the Erasmus+ programme as stipulated by the European Commission.

Method

Sixty-five current and former nursing students who had participated in Erasmus mobility in the last ten years completed an online questionnaire (response rate: 44.8%). Sixteen of these students then took part in a focus groups lasting two hours, which explored their experience in more depth.

Results

Questionnaire data revealed that the participants generally agreed that the intended outcomes of the Erasmus+ programme were achieved through their exchange. The outcomes which were perceived to be achieved to a very large extent by the greatest majority of participants were related to "improvement in self-empowerment and esteem" and "motivation from participating in future education or training". Thematic analysis of the focus group data revealed five themes: jobs and employability; exposure to culturally diverse healthcare systems; personal growth; context-sensitivity of nursing care delivery; language and citizenship.

Conclusions

The positive experiences reported in this study suggest that healthcare educators should continue encouraging and facilitating study-abroad experiences, and that such opportunities should be provided to even more students. As such, these findings should be of interest to policy makers, programme developers and international co-ordinators. However, more research is required to explore any negative outcomes of Erasmus exchanges and whether student perceptions of their mobility experience change over time.

2018188: Predicting Nurses' Burnout: An Incremental Validity Study

Dr. Michael Galea, Senior Lecturer, University of Malta, Malta

Objectives

This population study examined the incremental validity of spirituality in predicting burnout among Maltese professional nurses.

Method

Cross-sectional and mixed-method design was conducted. Measures in this self-report questionnaire included the Maslach Burnout Inventory, Faith Maturity Scale, Satisfaction with Life Scale, Big Five Inventory and a demographic section, together with a brief qualitative section.

Results

Response rate was 78%. All hypotheses were supported. Maltese nurses (N = 121) suffer from high levels of burnout, in particular from low professional accomplishment, high levels of depersonalization, and moderate to high emotional exhaustion. Qualitative data supported these findings and suggested that the physical and moral environment of nurses was conducive to an increase of burnout. Furthermore, multiple regression analysis indicated that spirituality predicted burnout after controlling for personality and well-being.

Conclusions

This study highlights the need to attend to health professionals' well-being, such as nursing staff, especially in view of burnout and work-related stress, to ascertain better care of patients. Furthermore, results suggests that spirituality may be an important potential source of resilience for nurses who risk burnout in their employment.

2018189: Applying for EU funding for research on education of therapy radiographers: Our experience of a successful application

Mr. Jose Guilherme Couto, Assistant Lecturer, University of Malta, Malta

Dr. Sonyia McFadden, Lecturer, Ulster University, United Kingdom

Dr. Paul Bezzina, Lecturer, University of Malta, Malta

Dr. Patricia McClure, Associate Head of School, Ulster University, United Kingdom

Dr. Ciara Hughes, Senior Lecturer, Ulster University, United Kingdom

Short Paper

Background: Research in radiography is continuing to evolve however it can be difficult to secure grant funding to promote research activity. The European Union (EU) has funding available in many areas e.g. regional development, employment or research. These funds are assigned with the objective of supporting the European strategy for growth. Some of these funds can be used to develop projects in Medical Imaging and Radiotherapy, as well as the radiography profession.

Aim: This presentation aims to describe our experience of applying to the EU Sector Skills Alliance grant funding to develop research on education and curriculum development for therapy radiographers.

Results: The proposed research initially aligned with the requisites of the EU funding call i.e. cooperation for innovation and the exchange of good practices. The research proposal identified areas where good working practice could be achieved and maintained. Seven international partners across Europe were invited to join the consortium to perform specific required tasks for the application with one partner identified as the Principal Investigator. Twelve 'work packages' were identified and described within the protocol. An online application was then submitted with input from all partners.

The application was initially submitted in 2017, but was unsuccessful. Feedback was provided by the evaluation panel, enabling the completion of an improved resubmission in 2018 which secured 499,736Euros of research funding. The project started in January 2019.

Conclusion: EU research funding is available for radiographers (and other health care professionals). The application to European funding is complex, but achievable, allowing to develop the profession and improve the practice of these professionals and, as a result, improve care to our patients.

2018190: Global experience supports healthcare workforce skills development

Mr. David Keen, Head of Global Workforce Education, Health Education England, United Kingdom

Ms. Elin Sandberg, Head of Programmes, Global Engagement, Health Education England, United Kingdom

Prof. Ged Byrne, Director of Global Engagement, Health Education England, United Kingdom

Anna Lee, Global Health Consultant, Global Engagement, Health Education England, United Kingdom

Rebecca Stevenson, Global Project Officer, Global Engagement, Health Education England, United Kingdom

Short Paper

Context: Almost all countries face challenges in education, deployment and retention of their health workforce (1). Globally, demand will continue to outstrip supply due to varying levels of investment in training combined with growing needs (2), including changing health and disease patterns, rapid population growth in some countries and ageing populations in others. The World Health Organization (WHO) estimates that by 2030 the workforce gap will reach 18 million and states that this represents the single largest barrier to the delivery of universal health coverage and the achievement of the UN Sustainable Development Goals (3).

We know that more than ever healthcare staff from the UK and overseas are globally mobile. 12.5% of the current NHS workforce are from outside of the UK (4). Less data is available on numbers of UK nationals working overseas, although anecdotally we know this is high. A 2016 study in the North West of England found that 42% of NHS staff had some form of overseas experience, mostly as students, while more than 7% reported placements of more than one year overseas (5).

The healthcare landscape is changing, and all staff will need increasingly adaptable skills to provide 'whole person' care in multi-disciplinary teams. There is growing evidence of the transformational benefits well-supported global learning placements have on individual clinicians and patients. Individuals contribute to capacity-building (6) in health systems and develop strong leadership and meta-skills. The NHS can provide a highly attractive place for clinicians to work and develop their skills. As we seek to support NHS staff to work and learn overseas, we should also attempt to support the efforts of overseas staff to work and learn in the NHS in a manner that minimises the risks of skills drain in their home country.

Health Education England (HEE)

HEE's Global Engagement directorate has been established to explore how best to support the English NHS by workforce and education transformation through global learning. The directorate is developing more advanced thinking and evidence on issues such as:

- How can we make our current educational programmes more globally oriented to enable a more comprehensively trained workforce?
- How can we retain our clinicians by making jobs more attractive by building on our plans for volunteering and especially international volunteering?
- What sort of new educational providers and systems should we support that are agile, responsive and affordable?
- How can we undertake 'ethical' international recruitments and not take away trained clinicians from low- and middle-income countries without giving something back?

Learning through global experience

HEE has developed the Global Learners Programme which offers a three year work-based educational experience in the UK for nurses and other healthcare professionals. This will enhance and add to their existing skills and provide an opportunity to work in the NHS whilst gaining new knowledge and experience. Each Global Learner will return with developed skills to their home countries and ultimately apply this enhanced level of

practice into their own hospitals or clinical environments. It is also important to recognise that the qualified healthcare professionals entering the programme will already possess a wealth of knowledge and skills acquired and refined in their home country and it will be to the benefit of the UK healthcare system for them to share their experience of practice from different healthcare backgrounds and systems. We can learn from their skills, knowledge and experience through creating a network of Global Learners and the educational programme will endeavour to utilise all shared learning, to improve our own systems and processes when delivering world class patient focused healthcare.

There are five elements to the education programme offered:

- Preparation and support for the Global Learner prior to coming to England
- Orientation, preparation and support to become a registered practitioner with the UK statutory regulators after arrival in England
- Post-registration consolidation of practice (preceptorship), support and development
- A formal programme of study that is academically accredited
- Professional and pastoral support mechanism

HEE is also supporting overseas placements for NHS staff, including a programme of paid-for training placements in rural South Africa, as well as a multi-professional quality improvement, and leadership development volunteer opportunities in Cambodia, Myanmar, South Africa and Zambia.

These individuals can bring back innovative ways of working from overseas, increasing productivity and realising benefits for their organisations as well as themselves. Creating links with overseas institutions can give NHS organisations a competitive advantage in recruitment and retention, while generating new opportunities for partnerships, research and revenue generation abroad.

Summary

An increasingly global healthcare workforce presents both challenges and benefits to healthcare systems all over the world. HEE is working to support staff to work and learn globally. For those coming to the NHS to work HEE is enabling a structured learning experience which supports workers to access the very best education programmes the UK has to offer, for those working in the UK, HEE is looking to embed global learning into their training and career pathways. For both inward and outward movement of healthcare workers HEE is aims to add greater understanding and clarity to the global learning experience.

Footnotes

1) WHO (2016) Global Strategy on Human Resources for Health: Workforce 2030. Available at http://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf [Accessed 7 September 2018]

2) Center for Global Development (2017) Investing UK Aid in a Global Skills Partnership: Better Health at Home and Abroad. Available at: https://www.cgdev.org/sites/default/files/investing-uk-aid-global-skillspartnership-better-health-home-and-abroad.pdf [Accessed 7 September 2018]

3) UN Sustainable Development Goals website.

Available at: https://sustainabledevelopment.un.org/?menu=1300 [Accessed 7 September 2018]

4) House of Commons Library (2018) NHS staff from overseas: statistics. Available at: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7783 [Accessed 7 September 2018]

5) Chatwin & Ackers (2016) Volunteering and overseas placements in the NHS: a survey of current activity. Available at: https://bmjopen.bmj.com/content/bmjopen/6/10/e012160.full.pdf [Accessed 7 September 2018]

6) The United Nations has defined capacity as ‘the ability of individuals, institutions, and societies to perform functions, solve problems and set and achieve objectives in a sustainable manner..

2018194: Let's work together - 28 UK Universities connect to strategically work towards the complexities of practice learning in 2020 and beyond

Mrs. Abbie Fordham Barnes, Associate Professor, Birmingham City University, United Kingdom

Mrs. Jenny Pinfield, Principle Lecturer, University of Worcester, United Kingdom

Mr. Gary Parlett, Associate Director of Education, University of East Anglia, United Kingdom

Rachel Bacon, MEPLG Project Co-ordinator, Deputy Lead for Practice - Nursing, University of Nottingham, United Kingdom

Tracy Baker, Academic Practice Learning Manager, Staffordshire University, United Kingdom

Paul Jackson, Head of Practice Learning, University of Wolverhampton, United Kingdom

Short Paper

In the UK there has been an unprecedented move for Universities to work closely together. This has been achieved across the Midlands, Yorkshire and East of England Universities who have formed a Practice Learning Group (MYEPLG), with representatives from 28 Universities. This innovative group have formed a strategic leadership role in response to a significant period of change in healthcare education following the publication of the Standards Framework for Nursing and Midwifery Education Standards (2018). The MYEPLG recognise a proactive approach and a stronger alliance between Universities and practice partners can help to manage the challenges ahead and unravel the intricacies of the local, regional and national drivers. At the same time acknowledging the growing importance for Universities to consider the impact of the Sustainability and Transformation Partnerships and Local Workforce Advisory Boards.

In recent years there has been several high-profile failures of care reported often resulting in the University faced with assuring the professional regulator and Health Education England of the suitability of learners remaining in the practice learning environment, especially following an external inspection by the Care Quality Commission (Francis, 2013; Bubb, 2014; Gordon 2016). In parallel there is increasing expectations of fee paying students to have a good quality practice learning experience (Bunce et al, 2016). There is a continuous balance of assessing the suitability of students remaining in the practice setting against staff shortages impacting on patient care (RCN, 2017). There is also a growing emphasis for the University to recruit and retain students, therefore re-emphasising the importance of adopting new models of practice learning (RCN, 2015; MacSharry and Lathlean, 2017), increasing placement capacity, and working closer with practice partners (Fisher at al, 2017). Universities are also being encouraged to work in partnership to develop a national practice assessment document, which is designed to facilitate a consistent approach practice assessment (Hunt at al, 2012).

The MYEPLG members have explored the value of strong leadership to drive the practice learning requirements of the pre-registration health programmes across the sector to embrace these challenges. The connection between the MYEPLG Universities has a primary focus of practice learning, resulting in sharing good practice, problem solving and proactive decision making. This model of partnership working across a large number of Universities and practice partners has formed a substantial alliance and a collective regional voice to raise the profile of practice learning and assessment. The MYEPLG key outcomes discuss initiatives and strategies to enhance the student experience and partnership working with practice partners, sharing resources, expertise and knowledge when faced with adversity. The MYEPLG aim to work together to implementation of a regional pre-registration nursing practice assessment document.

References

Bubb, S. (2014). Winterbourne View – The time for change, A report by the Transforming Care and Commissioning Steering Group.

Bunce, L., Baird, A., Jones. S. (2016). The student-as-consumer approach in higher education and its effects on academic performance. Studies in Higher Education, Vol 42, issue 11

http://www.tandfonline.com/doi/abs/10.1080/03075079.2015.1127908 (Date accessed 20/01/2018)

Dyson, S. (2017). Nursing, Nurse Education and the National Health Service; A Tripartite Relationship. Critical Pedagogy in Nursing. Pp 21-51 https://link.springer.com/chapter/10.1057/978-1-137-56891-5_2 (Date accessed 20/01/2018)

Fisher, M., Bower, H., Chenery-Morris, S., Jackson, J. (2017). A scoping exercise to explore the application and impact in pre-registration midwifery programmes across the United Kingdom. Nurse Education in Practice, Vol 24, pp 99-105.

http://www.sciencedirect.com/science/article/pii/S1471595316000214 (Date accessed 20/01/2018)

Francis, R. (2013). The Mid-Staffordshire NHS Foundation Trust Public Inquiry.

http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/ (Date accessed 20/01/2017)

Gordon, D. (2016). Secret film exposes care home failures, BBC Panorama http://www.bbc.co.uk/news/health-38019806 (Date accessed 20/01/2017)

McSharry, E., Lathlean, J. (2017) Clinical teaching and learning within a preceptorship model in an acute hospital in Ireland: a qualitative study. Nurse Education Today, vol 51, pp 73-80

Taylor, C., Angel, L., Nyanga, L. (2017). The process and challenges of obtaining and sustaining clinical placements for nursing and allied health students. Journal of Clinical Nursing

http://onlinelibrary.wiley.com/doi/10.1111/jocn.13502/full (Date accessed 20/01/2018)

Royal College of Nursing (2017) Safe and Effective Staffing

http://www.rcn.org.uk/-/media/royal-college-of-nursing/.../2017/.../pdf-006415.pdf (Accessed 20/01/2018)

Royal College of Nursing (2015) Mentorship Matters, Royal College of Nursing, London.

2018195: Exploring student-led use of social networking tools to support learning in undergraduate clinical education

Mrs. Alison Hartley, Associate Dean (Learning and Teaching), Faculty of Health Studies, University of Bradford, United Kingdom

Short Paper

An emerging body of research is supportive of the use of social networking sites to promote a socio-constructivist approach to learning, with most research exploring teacher-led innovations. (Sharma, Joshie and Sharma, 2016; Greenhow and Lewin, 2016).

Yet we know, or we think we know, that undergraduate healthcare students, and healthcare practitioners are driving the creation and ongoing use of social networking tools such as Facebook, or through instant messaging tools such as WhatsApp to discuss their educational experience with peers in the educational and clinical settings (Hartley and Kassam, 2015).

What is happening in these spaces?

How might this activity provide support to learners, it at all?

Are these spaces supporting learning at all, and if so how?

As a community of clinical educators, is this an area we should learning more about ourselves? What are the research questions we should be exploring to understand this phenomenon? What theoretical frameworks can help us to critically explore this learner-led pedagogy and its impact on their learning?

Summary of work:

This paper presents work-in progress on designing a PhD study to explore the impact of peer-led, peer-supported informal learning through social networking tools.

I will present how the gap in the literature exploring learner-led activity supports the need for further study in this area of clinical education and aim to challenge us all, as clinical educators, to consider how social networking might support the student journey towards more nuanced, more personalised collaborative learning and a move towards more self-directed learning.

Implications:

Students are driving contemporary innovations in the way they approach their learning, develop their support networks and in their selection of tools to do so. The fact that this is learner-led suggests that we must work with learners in understanding these shifting pedagogies. This has implications for us as clinical educators whether that be in the educational or the clinical setting.

References:

Greenhow, C and Lewin, C. 2016. Social media and education: reconceptualizing the boundaries of formal and informal learning. Learning, Media and Technology. 41(1), pp. 6-30.

Hartley, A.S, Kassam A.A. 2015. Social Networking for Learning in Higher Education: Capitalising on Social Capital. Paper presented to 2015 Social Media for learning in Higher Education. Sheffield Hallam. December 2015

Sharma, S., Joshie, A. and Sharma, H. 2016. A multi-analytical approach to predict the Facebook usage in higher education. Computers and Education 55, pp. 340-363.

2018196: Equipping the pharmacy technician workforce to take on emerging roles within the pharmacy team

Miss Debra Roberts, Associate Pharmacy Dean & Head of Programme Development, Health Education and Improvement Wales, United Kingdom

Mrs. Wendy Penny, Head of Work Based Technician Training (Pharmacy), Health Education and Improvement Wales, United Kingdom

Short Paper

Background:

The Modernising Pharmacy Careers (MPC) review looking at developing the existing workforce acknowledged that as a relatively new profession, pharmacy technicians would require support to enable transition from an occupation to a profession (1). Alongside this is Welsh Government's vision to move healthcare services from managed sector to primary care (2) and the need for all healthcare professionals to work at the top of their license, resulted in pharmacy professionals being required to deliver new services to patients.

Whilst pharmacy technician training has changed dramatically over the last few years, it still has a strong focus on knowledge elements rather than patient and interpersonal skills, so the development of a range of accredited level 4 work-based skills programmes were commissioned.

Public Health

Public Health is a key area for practice development for the pharmacy profession to improve patient outcomes. This programme is designed to ensure participants gain an understanding of how to deliver evidence-based public health services, develop skills and tools to make effective brief interventions and gain the confidence to seek out opportunities to become an advocate for health.

Professionalism

Professional regulation is key to safeguarding patients and the public, by ensuring registered professionals demonstrate the necessary knowledge and skills to practice safely and are accountable for their practice. This programme is designed to ensure participants increase their understanding of professional regulation, enhance application of self-assessment and peer assessment techniques, develop critical appraisal, emotional intelligence and reflection skills.

Consultation skills

Pharmacy roles are becoming more varied, with increasing levels of patient contact requiring effective consultation skills. This programme is designed to ensure participants recognise the value of agreeing a shared agenda with patients, undertake effective pharmacy practice consultations, reflect on the elements that create high quality pharmacy practice consultations and manage challenging situations effectively.

These programmes have been designed to be studied in isolation or in the future, as part of a higher level qualification. Each programme involves blending learning, with eLearning, taught skills based workshops, directed reading, assignments and patient interventions. All the programmes require participants to demonstrate competence in the workforce by compilation of a portfolio of evidence.

Aim:

This aim of this study was to evaluate the impact of the three level 4 learning programmes (consultation skills, professionalism and public health), on the participant's knowledge and confidence to implement the learning in practice.

Methods:

Blended learning programmes and evaluation questionnaires were developed and piloted. The questionnaire was created, using the four point Likert scale with comments boxes for further expansion, to determine the effectiveness of the programmes in upskilling the participants. All participants who completed any of the three level 4 programmes, were invited to complete a questionnaire, to ascertain their perceived changes in knowledge, confidence in their abilities to implement what they had learnt into practice and intention to change practice after completion of the training. Data was collated and analysed.

Results:

1. Consultation skills - 100 % response rate (n = 10)

All the participants (100%) reported a change in knowledge and the majority of participants (84%) stated they felt confident or fully confident in their ability to use the skills / techniques after completion of the training programme. Top three things learnt were to consider the patients agenda (63%); negotiation skills (63%) and structure for consultations (60%).

All the participants (100%) stated that they had gained something new from participating in the programme and that they had changed their practice. Top three changes to practice were using the medication related consultation framework (MRCF) tool to reflect on consultation skills (50%); introducing themselves and their role differently (40%) and planning their message using social influencing techniques (40%).

2. Professionalism - 100 % response rate (n = 13)

All the participants (100%) reported a change in knowledge and the majority of participants (86%) stated they felt confident or fully confident in their ability to use the skills / techniques after completion of the training programme. Top three things learnt were reflecting writing models (77%); peer review techniques (56%) and how to give constructive feedback (31%).

All the participants (100%) stated that they had gained something new from participating in the programme and that they had changed their practice. Top three changes to practice were saying 'no' to dumping and use of delegation skills (83%); setting up medicine review clinics (55%) and using influencing skills in patient consultations (55%).

3. Public Health - 100 % response rate (n = 7)

All the participants (100%) reported a change in knowledge and the majority of participants (81%) stated they felt confident or fully confident in their ability to use the skills / techniques after completion of the training programme. Top three things learnt were how to run an effective public health campaign (71%); techniques to engage patient in lifestyle discussions (57%) and making every contact count 'healthy conversations' (57%).

All the participants (100%) stated that they had gained something new from participating in the programme and the majority (86%) stated that they had changed their practice. Top three changes to practice were running an effective public health campaign (57%); involving patients in decisions about lifestyle much more (57%) and proactively approaching patients about lifestyle issues (43%).

Conclusion: The level 4 programmes were effective in increasing the participant's knowledge and confidence to implement the skills and knowledge learnt into practice. Two additional programmes have subsequently been developed – education and training skills and leadership skills, which are currently being piloted.

References:

1. Modernising Pharmacy Careers. Review of post-registration career development: Next steps. Report to Medical Education England Board. September 2012.

2. Welsh Government. A Planned Primary Care Workforce for Wales. 2015.

2018197: Active Blended Learning and Changemaker at the University of Northampton

Mrs. Alison Power, Faculty Lead for Interprofessional Education / Senior Lecturer (Midwifery), University of Northampton, United Kingdom

Dr. Rachel Maxwell, Head of Learning and Teaching Development: Policy and Practice, Institute of Learning and Teaching in Higher Education, United Kingdom

Short Paper

The opportunities of advances in technology allow educators to be more creative and innovative in their learning and teaching design, The University of Northampton's (UoN) approach to learning and teaching is 'Active Blended Learning' (ABL), which is a student-centred approach to support the development of subject knowledge and understanding, independent learning and digital fluency. By ensuring face to face teaching is practical and collaborative with clear links to related interactive e-learning; learning is multidimensional, encouraging students to develop autonomy, confidence and adaptability – key attributes for health and social care students in contemporary practice. By adopting innovative learning, teaching and assessment strategies to incorporate the judicious use of technology to complement more traditional approaches, the University of Northampton ensures its health and social care students are prepared to meet the demands of their chosen careers (Power and Cole, 2018).

As the first university in the UK to be awarded the Changemaker Campus designation by Ashoka U in 2013, Northampton is internationally recognised for its commitment to developing student employability through engagement with social innovation which distinguishes the University within the higher education sector (Alden Rivers and Maxwell, 2015). Social innovation is a contested concept emerging from many disciplines (Ayob et al., 2016); however the European Union adopts the definition that draws together a number of perspectives and defines social innovation as:

'…new approaches to addressing social needs. They are social in their means and in their ends. They engage and mobilise the beneficiaries and help to transform social relations by improving beneficiaries' access to power and resources' (TEPSIE, 2015)

For students at Northampton, Changemaker is about spotting a social problem and doing something about it. In 2014, the University committed to social innovation as a core competence that would enhance the student experience and contribute to improved student outcomes, thereby aiming to fulfil our aim be the UK's number one university for Social Enterprise (UoN, 2010). Alden Rivers et al. (2015) identified a Changemaker employability framework which mapped social innovation competencies to 21st century skills development and how employability and curriculum could be aligned to Changemaking (Irwin and Maxwell, 2015). The adoption of this framework created an approach that embedded Changemaker into the curriculum and allowed for subject specificity to be articulated (Maxwell and Armellini, 2018).

Central to the approach was the priority to provide students with the opportunity to explore social problems within the context of their chosen subject. This enabled student to apply social innovation techniques to real world situations giving them the opportunity to develop their ideas and potentially, entrepreneurial mindsets, within their chosen career or places of work. Involvement with Changemaker would allow students to be socially innovative, explore social issues they are passionate about and make a real difference to society.

In relation to Interprofessional Education, the Faculty of Health and Society at The University of Northampton are introducing an interprofessional 'collaborative curriculum' in September 2019 for its midwifery, nursing, paramedic science, occupational therapy, podiatry, policing, social work and dental nursing undergraduate programmes. It will adopt an ABL approach and will have Changemaker embedded in its face to face and online elements.

Historically, students learned about the theory and practice of interprofessional collaboration and working as a uni-professional activity – the antithesis of IPE, since such an approach does not support professional

socialisation within an educational context. Logistically IPE is challenging to organise in terms of co-ordinating multiple timetables and finding appropriate teaching spaces. Add to this the mindset that IPE is somehow perceived as an additional 'learning burden' and it is clear that an innovative, engaging and authentic strategy (i.e. students learning with, from and about students they will actually work with in the practice setting) to help students from across the Faculty understand the relevance and importance of IPE and motivate them to engage with it is key to its successful implementation (Power, 2019). ABL affords educators the flexibility to design and deliver interprofessional learning opportunities that transcend physical, geographical and logistical barriers.

The University of Northampton is committed to providing its students with an innovative, engaging, high-quality learning experience as they prepare for employment and beyond. Our commitment to pre-registration education for health and social care students within the interprofessional 'collaborative curriculum' is to ensure that on qualification our students are confident and competent practitioners, equipped to deal with the ever more complex demands of their chosen profession within the multi-professional/multi-agency team. The fact that students are unique individuals, with individual preferences is acknowledged and celebrated. Active Blended Learning offers a range of learning and teaching approaches both face to face and online to meet the diverse needs of students, thereby supporting them to develop their autonomy, confidence and adaptability. By embedding Changemaker in the curriculum our students will be knowledgeable graduates, who are socially responsible and digitally proficient with the potential to make a positive impact on the communities they serve as qualified practitioners.

2018198: Influence of Global Health Governance on Health Workforce Education

Ms. Soosmita Sinha, President, Health Law Institute, Switzerland

Short Paper

The World Health Assembly adopted the Global Strategy on Human Resources for Health: workforce 2030 in resolution WHA69.19 (2016) that subsequently led to the United Nations' High-Level Commission on Health Employment and Economic Growth convened between the World Health Organization (WHO), International Labour Organization (ILO) and Organisation for Economic Co-operation and Development (OCED). Currently, this informs much of the dialogue in the health workforce space and has also led to the joint WHO/ILO/OECD five-year action plan for health employment and inclusive economic growth ("Working for Health"). However, it has also highlighted the use of varying definitions and discrepancies in global estimates. In fact, many a times global estimates can be confusing and cannot be extrapolated to national realities due to lack of sufficient or standardized data. With an expected estimated shortage of 18 million health workers by 2030 to bridge the gap in health workforce requirements as required by the Sustainable Development Goals and Universal Health Coverage (UHC) targets, it is crucial to understand the interplay of supply, need and demand and how this informs or is informed by health workforce education. In this paper, I intend to look at how the term health workforce is understood by relevant international organizations and with a few country examples explain this dynamic and also delve into the relationship between investing in the health system on non-health occupation jobs in the larger health sector.

In an effort to achieve UHC, there is a renewed focus on Alma Ata, reaching vulnerable populations through health associates and community health workers, and health personnel migration. I will reflect upon the implications of these initiatives on health workforce education and the need to tailor curriculums to the realities of the job including building awareness of abuse and violence, understanding of rights and responsibilities, regulations, legislations and accountability mechanisms. Also, possible barriers to education, issues with health workforce retention and need for more data are of concern.

Figure 1 provides a simplistic schematic view of the above concepts in highlighting the key role of education in supply, need and demand for health workers as well as barriers to education and avoidable loss of the health workforce once educated.

Keeping with INHWE's mission of improving education and training of health workforce globally, bridging gaps between educators, researchers and policy makers and promoting bottom up policy change, I will suggest some recommendations on the role of health workforce educators in order to achieve "workforce 2030".

Supporting Documents

2018185

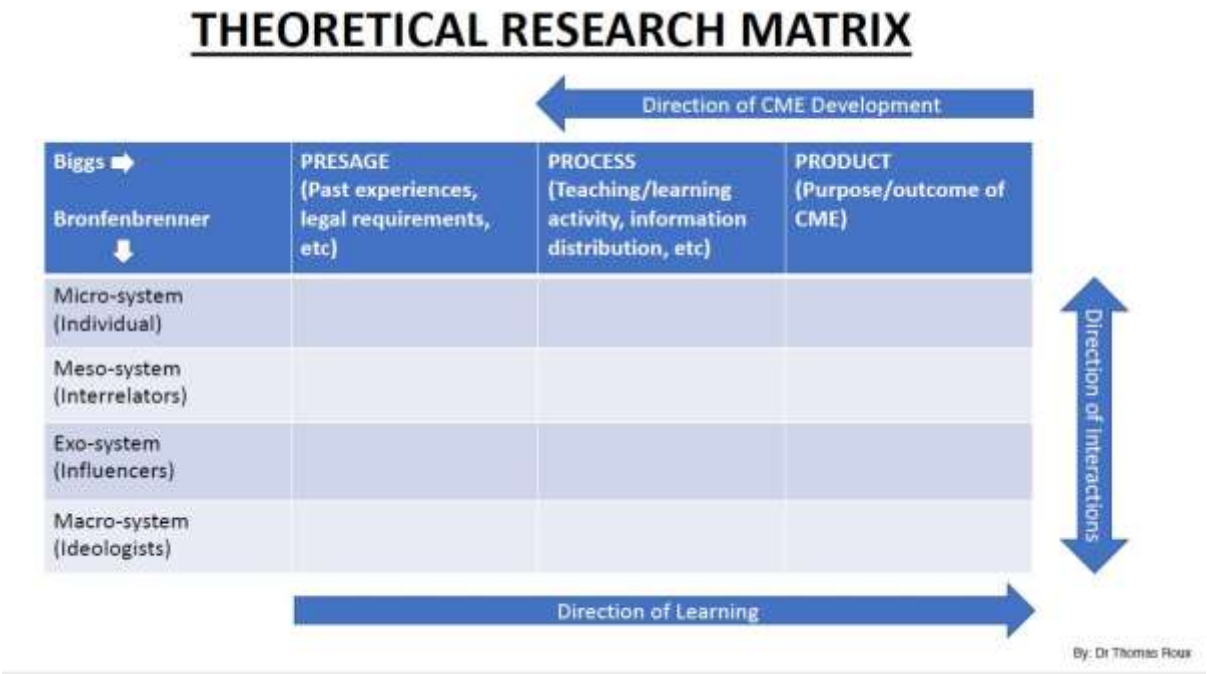

Table A
Correlation matrix for key variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12
MBI												
1.PE	-	42**	.53**	.00	-.11	.09	-.05	.12	-.14*	-.11	-.03	-.08
2.EX		-	.61***	-.03	-.02	.23***	-.02	.05	-.32**	-.08	.00	-.04
3.DE			-	-.12	-.09	.15*	-.02	.08	-.26***	-.05	.02	-.02
BFI												
4.EXT				-	.02	-.08	.32***	.14	.15*	.08	.15*	.12
5.CON					-	-.18**	.22***	-.22**	.02	.29***	.25**	.29*
6.EmS						-	-.06	.08	-.22***	-.20**	-.23*	-.23*
7.OP							-	-.02	.04	.12	.13	.13
8.AGR								-	.09	-.29***	-.13*	-.23*
SWLS												
9.T-Sc									-	.23*	.17*	.22*
FMS												
10.FMV										-	.74**	.94**
11.FMH											-	.92**
12.FMT												-

N=121. *p<.05; **p<.01; ***p<.001. All two-tailed tests. Note: MBI= Maslach Burnout Inventory; PE = Professional Efficacy; EX= Exhaustion; DE= Depersonalization; BFI= Big Five Inventory; EXT= Extraversion; CON= Conscientiousness; EmS= Emotional Stability; OP= Openness; AGR= Agreeableness; SWLS= Subjective Well-Being Scale; T-Sc= Well-Being Total Score; FMS= Faith Maturity Scale; FMV= Faith Maturity Vertical; FMH= Faith Maturity Horizontal; FMT= Faith Maturity / spirituality total score

Table B
Burnout levels

	N	%	α	M	SD
PA			.74	17.28	4.18
Low	114	094			
Mod	007	006			
High	000	000			
EX			.71	13.95	4.27
Low	24	20			
Mod	61	50			
High	36	30			
DE			.70	14.02	3.04
Low	001	01			
Mod	013	11			
High	107	88			

PA= personal accomplishment, EX= emotional exhaustion, DE= depersonalization

Table C
Predicting Burnout

Step	Variable	R	R^2	ΔR^2	*F* Change	Sig. ΔF
1	BFI	.194	.093	.054	2.365	.044
2	SWLS	.321	.126	.095	2.741	.016
3	FMT	.344	.137	.102	2.216	.031

Note: BFI = Big Five Inventory (Personality), SWLS= Subjective Well-Being, FMT= Faith maturity total score.

2018198

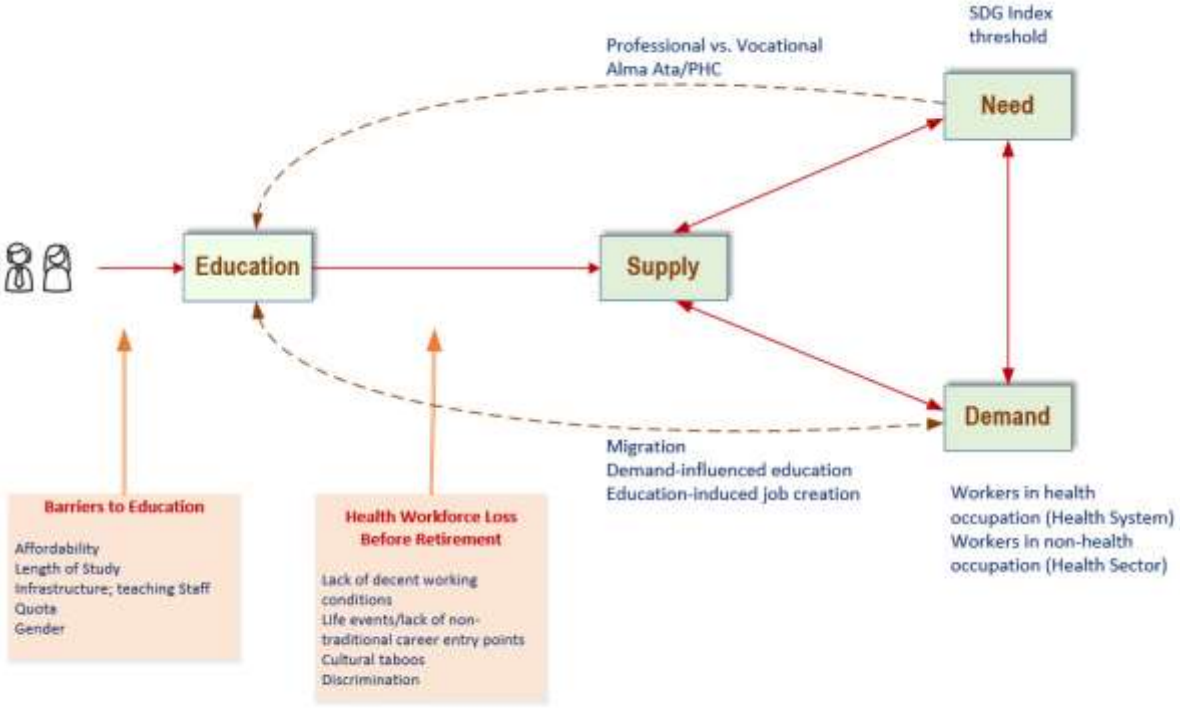

Figure 1: Role of Health Workforce Education in Supply, Need & Demand for Health Workers.