

Deep End Report 7

**General practitioner
training in very deprived
areas**

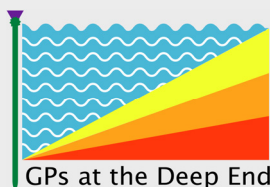
*The seventh meeting of "General
Practitioners at the Deep End"*

04 June 2010

Eleven GP trainers met on Friday 04 June 2010 at the Section of General Practice & Primary Care at the University of Glasgow for a workshop on GP training in very deprived areas, drawing on the experience and views of GP trainers and trainees.

SUMMARY

- While 39% of practices in the most affluent 20% of Scotland are involved in GP training, this drops to 24% of practices in the most deprived 20%.
- A major explanation has been the small size of most practices in deprived areas, making it difficult to accommodate training requirements.
- The practical requirements of a training practice, in terms of organisation, record keeping and IT, are considered less of a barrier, now that all practices have addressed such issues, as part of the Quality and Outcome Framework (QOF).
- It was felt that training practices have to be particularly well organized to include training activities within the generally intense nature of general practice in very deprived areas.
- Training status is highly valued by trainers, allowing expression of professional values, and providing a constant stimulus for improvement, regular contact with colleagues and protection against burn out.
- Special features of the clinical environment in deprived areas include problems of alcohol and drugs misuse, multiple morbidity, psychological distress as a major co-morbidity, polypharmacy with risk of side effects and drug interactions, child protection issues and a high prevalence of social problems.
- An increasing aspect of practice is the large number of immigrants to Scotland, speaking foreign languages, with distinct customs and beliefs and who are often concentrated on arrival in very deprived areas.
- Patients are often less articulate than patients in affluent areas and have different views and priorities, for example, concerning anticipatory care and self management. As experienced clinicians, trainers can help trainees acquire the consultation skills to work with such patients.
- Understanding the benefits system is often a steep learning curve for trainees, which is made more challenging by the expert knowledge of patients on this subject and the importance of benefits for economic survival.
- Nothing compares with home visits for trainees to acquire an understanding of the realities of patients' lives in deprived areas.
- Although it is desirable that all GP trainees acquire some experience of general practice in deprived areas, it is not clear how this could be accommodated.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.



“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.

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ATTENDING

Name	Location	CHCP	Deprivation ranking	List size
Roger Black	Whitevale St	GLA (E)	65	5563
Alison Bowman	Govan HC	GLA (SW)	80	8338
Julie Dalgleish	Crewe MC	ED	75	8270
Bill Doak	Admiral St	GLA (SW)	79	10592
Maria Duffy	Pollok HC	GLA (SW)	53	3966
Lesley Macdonald	Crewe MC	ED	75	8270
Jim McKinlay	Barony MC	GLA (N)	71	6913
Lindsey Pope	Port Glasgow	GLA (IC)	89	4195
Petra Sambale	Keppoch MC	GLA (N)	1	3162
David Willox	Croftfoot	GLA (SE)	69	6869
Marie Wilson	Easterhouse HC	GLA (E)	5	2430

Mark Russell	NES GP Inequality Fellow
Graham Watt	Professor of General Practice, University of Glasgow

The meeting involved 11 GP trainers with a combined experience of 110 years as trainers, ranging from those just starting to two with 21 years of experience.

Eight trainers work in Glasgow, two in Edinburgh and one in Port Glasgow

INTRODUCTION

Discussion at the meeting addressed the following issues:

- The decision to become a training practice
- The decision to work in a very deprived area
- Why is GP training less common in very deprived areas?
- What does GP training in deprived areas comprise?
- What is the GP trainee experience of training in very deprived areas?
- Should all trainees have experience of working in deprived practices?
- What is “special” about training practices?
- Post-training experience

THE DECISION TO BECOME A TRAINING PRACTICE

Trainers reported several reasons for becoming a training practice.

Originally, in the early days of GP training, the clinical work that a GP trainee could carry out, albeit as an inexperienced GP, was welcome in reducing the clinical burden on the practice.

More recently, the general increase in workload in general practice, the more prescribed nature of the GP trainee experience (including three non-clinical sessions per week) and the additional demands on GP trainer time, has meant that the clinical advantage to training practices is less clear.

The view was expressed that many trainees have difficulty in filling the three non-clinical sessions usefully, and that part of the training experience in deprived practices should be to share in the intensity and volume of clinical work that is characteristic of very deprived areas.

In a health centre where most other practices were involved in training, a non-training practice thought it prudent also to become a training practice.

Training status is thought to make a practice more attractive to higher calibre applicants for clinical vacancies.

The nature of GP training is valued as reflecting the holistic nature of general practice more than many other aspects of current practice, such as those driven by the Quality and Outcomes Framework.

Involvement in training is recognized as a stimulus to GP trainers' personal learning, as trainees provide a continual stimulus to keep up to date and to maintain enquiring and reflective attitudes.

Involvement in GP training is a way of avoiding the isolation and lack of contact that practices often have with GP colleagues. Training involves a range of direct and indirect practice support.

Training is considered a way of helping to avoid burnout.

A deterrent to acquiring training status used to be the perceived workload involved in meeting training practice requirements (e.g. in relation to the quality of patient records), but this was thought to be less of a factor now that the new GMS contract has resulted in an almost universal improvement in the organization of practices.

It was said the training practices have an ethos which GPs value and would be loathe to lose.

THE DECISION TO WORK IN VERY DEPRIVED AREAS

Severe deprivation is so widespread in the Clydeside conurbation that it is part of the normal experience of most GPs in the area. The decision to work in such areas is often the default option for GPs wishing to work in the Glasgow area.

Where severe deprivation is less common it is likely that other factors determine practice choices.

One trainer, who had had the simultaneous choice of GP partnerships in a very affluent practice and a very deprived practice in the Glasgow area had chosen the latter because of the preference to avoid having many “worried well” patients. Other trainers confirmed that for them the decision to work in a deprived area had been a positive choice.

Whereas previously trainees could choose to train in a deprived area, the current process of allocating posts is random, which can result in “square pegs in round holes”. On the one hand, random allocation exposes a wider range of trainees to deprived practices and encourages training practices to consider what are essential aspects of training in their environment; on the other, trainees who opt positively for placements in deprived areas may be better prepared and attuned to the nature of practice in deprived areas.

WHY IS GP TRAINING LESS COMMON IN VERY DEPRIVED AREAS?

It was noted that while 39% of practices in the most affluent 20% of Scotland are involved in GP training, this drops to 24% of practices in the most deprived 20%.

A major explanation is the small size and intensity of work of most practices in deprived areas, making it more difficult to meet the training requirements. that GP trainees should have their own consulting room.

The same explanation was given for the historical low uptake of ancillary staff in deprived areas, resulting in funding differences between large and small practices which had been consolidated as part of the new GMS contract, in order to minimize practice disruption.

The organizational requirements of training practices are now considered less of a deterrent, for the reasons described above in relation to the Quality and Outcomes Framework. Prior to the QOF, practice accreditation had also helped to reduce the challenge of meeting training practice criteria.

WHAT DOES GP TRAINING IN DEPRIVED AREAS COMPRISE?

GP training in deprived areas conforms to the national GP training curriculum but does so in a clinical environment characterized by problems of alcohol and drugs misuse, multiple morbidity, psychological distress as a major co-morbidity, associated polypharmacy with risk of side effects and drug interactions, child protection issues, a high prevalence of social problems, negative attitudes towards health behavioural change and a high degree of knowledge and dependence on the welfare and benefits system.

Patients are often less articulate than patients in affluent areas and have different views and priorities, resulting in a different starting point for many NHS initiatives, such as those concerning anticipatory care and self management. It was noted that patients often do not fit the stereotype which seems to drive much NHS policy, namely employed, health literate patients, with small numbers of health problems, few social problems and a preference for access outside daytime working hours.

An increasing aspect of practice is the large number of immigrants to Scotland, speaking foreign languages, having distinct customs and beliefs and who are often concentrated on arrival in very deprived areas.

Trainees sometimes have difficulty in relating their experience of day to day encounters with patients in deprived areas, involving multiple morbidity and social complexity, with the way their clinical skills are formally assessed e.g. via Clinical Skills Assessment (CAS), within single issue ten minute consultations.

Some patients in deprived areas find it a surprise and a challenge to be asked what they think or expect. Research on consultations in deprived areas has shown that patients are less likely to wish or expect to share decision-making with their doctor.

While the multiple morbidity of elderly patients is common to virtually all practices, the multiple morbidity associated with deprivation typically has a larger social component.

While patient-centred care involving anticipatory care, self help and self management is possible in deprived areas, the starting point may be different and progress is slower. In addition to the management of medical complexity, trainees also have to learn how to “tune in” to their patients’ discomfort. Trainees have to adapt to the pace of what is possible, with no substitute for sustained professional experience, reflection and learning.

Several trainers felt that there is still much to be gained from the apprenticeship model, whereby trainees are grounded in the realities of practice. Distractions, such as impending assessments, tend to prevent this until late in the trainee experience. The last two months of the trainee year, after the assessments have taken place, is thought to be the best time for trainees to acquire apprenticeship-type experience.

In order to get most value from their practice attachment, trainees must be involved in the work of the practice, experiencing the work ethic and understanding the peaks and troughs of needs and demands which do not finish neatly according to the clock.

Nothing compares with the home visit for trainees to acquire an understanding of the realities of patient's lives in deprived areas, including an idea of "what is normal". No amount of intellectual understanding of deprivation and health inequalities provides equivalent learning. Trainers commented that such experience and exposure can transform trainees' attitudes.

It was noted that while personal safety issues for the doctor doing home visits are generally greater in the perception than in the reality, trainers nevertheless have to give careful consideration to this issue.

Practices vary in the extent to which they are knowledgeable about the communities in which they practice and the local environments in which patients live their lives.

Understanding the benefits system is often a steep learning curve for trainees, which is made often more challenging by the more expert knowledge of patients on this subject and the importance of benefits for economic survival. There is much for trainees to learn, including the roles of other professionals and agencies and the limits of the role of the GP.

Trainers described the dilemma of deciding how active a role to take in patient management. On the one hand, experience shows that continuity of care takes extra effort, to ensure that patients remember referral and follow-up appointments; on the other, if practice staff take it upon themselves to do this consistently, patients may come to rely on such help, becoming more dependent in the process. Trainers described whether to involve a "safety net" all of the time or some of the time. Knowing when and how to make such judgments is best learned in conjunction with an experienced practitioner and trainer. In this respect, it was said that 20 minutes at the end of a consulting session could be more useful than longer, formal tutorials.

WHAT IS THE GP TRAINEE EXPERIENCE OF TRAINING IN VERY DEPRIVED AREAS?

The group discussed the preliminary results of a survey of current GP trainees working in Deep End practices (See Annex).

In general, there was a large measure of agreement between the views of trainers and trainees.

Trainees had expected to encounter patients with drug problems and challenging behaviour. Their experience was less than expected, but alcohol problems were more common.

Trainees valued their exposure to patients with large numbers of serious medical problems and the satisfaction of “making a difference” not only clinically but also via patient education.

Trainees were aware that they may be missing out on the challenges of working with “worried well” patients. They commented that “patient-centred medicine”, as required for clinical skills assessment (CSA), is more difficult when patients are not expecting it.

Trainees felt that it would have been helpful, prior to starting their work in very deprived areas, to have been better prepared concerning addiction issues, the benefits system and recognizing vulnerable patients.

SHOULD ALL TRAINEES HAVE EXPERIENCE OF WORKING IN DEPRIVED PRACTICES?

It was reported that trainees with no experience of working in deprived areas often have unrealistic perceptions and anxieties about the nature of such work. The best antidote to such views is personal experience.

In general it was felt that short term visits to practices were too short for trainees to acquire significant learning (as it can take several weeks to become familiar with new practice arrangements), but could be useful for trainees who express an interest.

Trainers were unanimous in rejecting a conscript approach whereby trainees are expected to visit deprived practices by rote.

At present, it is not clear when such short term attachments could be timetabled – the most obvious period being the last two months of the trainee year, after formal assessments, but this is a time which many trainers use to take annual leave. The ST1 attachment to practice may be better suited.

It was said that some trainees include exposure to deprived areas as a positive feature of their curriculum vitae when applying for jobs.

Risk management issues may vary between affluent and deprived areas. Affluent patients were thought to be less forgiving and more likely to sue their doctor. They are also thought to be more “up front” in raising their health concerns, whereas patients in deprived areas may provide minimal clues for the practitioner to pick up.

Trainees in deprived areas reported that their training experience lacked exposure to “printout patients”.

It was said that out of hours work is the best environment in which to teach risk management and that the issues in risk management of patients in deprived areas can be very different from those in affluent areas.

In general, the experience of GP trainers in deprived areas is an extension of that of all GPs in such areas, addressing high levels of clinical need with insufficient time, not only for consulting but also for reflection and re-charging between consultations. Finding time for the increased requirements of training has become more difficult in recent years as the general workload and practice pressures have also increased.

WHAT IS “SPECIAL” ABOUT TRAINING PRACTICES?

It was felt that training practices have to be particularly well organized to include training activities within the generally intense nature of general practice in very deprived areas.

Following the general investment in organization, information, IT and teamwork in all practices as a result of the QOF it is not clear whether there are any “quality” differences between training and non-training practices. It was acknowledged that many practices concentrate on the service they deliver, and deliver a high quality service without involvement in training.

Trainers who are also GP appraisers commented that training practices tend to make better use of appraisal and may be better placed to develop team-based learning.

One trainer described the essential attributes of a training practice as comprising purpose, passion, belief, leadership and wisdom.

It was suggested that part of the expression of such attributes should include a systematic commitment to raise quality, based on coverage, audit and evidence.

The existing informal network of Deep End practices which are also training practices is considered a potentially valuable resource, for sharing experience and activities in education and practice development.

Research has shown that Deep End practitioners work under greater stress to achieve similar results as practices elsewhere.

Trainers differed in their views as to whether the stresses of practice were increased or decreased by days out of the practice. One GP found it helpful to be present in the practice on every day for at least part of the day. Others disagreed.

POST- TRAINING EXPERIENCE

It was noted that NES had established a GP Inequality Fellowship Scheme, analogous to the longer established remote and rural scheme, in which two fellows are appointed annually to work in deprived practices while having protected time to define and pursue personal interests and pursue personal development. The appointments are currently split equally between the east and west of the country. In general the group had insufficient knowledge or experience of the scheme’s objectives to be able to comment on its usefulness.

Another possible approach was discussed in which fellows could be attached to practices in severely deprived areas with similar objectives, in terms of the clinical and career development of the fellow, but using the clinical attachment to provide protected time for the GP trainer.

It was felt that the main value of such fellows to the practice would be in clinical work and in sharing the training role, under supervision. The main effect on practice development, however, would be via the released time of the trainer.

One trainer described how he would use such time to develop leadership and co-ordination activities within his practice, developing the practice as a hub for attached workers in a range of disciplines.

ANNEX TRAINING AT THE DEEP END – TRAINEE OPTIONS

GP trainees were asked the following questions:

- What did you expect working in a GP practice in a deprived area to be like prior to beginning your post?
- How did the reality of practice compare with what you expected?
- Do you think there are benefits to training in a deprived area? If so, what are they?
- Are there any downsides to training in a deprived area?
- What are your future career intentions, and have these changed as a result of
- Did you specifically choose to train in a deprived area or were you allocated to train there?
- Do you think that issues specific to General Practice in deprived areas are covered adequately in GPST training? If not, what areas or difficulties do you feel are important to specifically cover?

The questionnaire was sent at short notice to all 44 GP STs currently based in Deep End general practices. Replies were received from 14 doctors (32%).

A number of common themes emerged. Those mentioned by a significant number of respondents are in bold.

Expectations

- **Drug problems**
- **Challenging patients**
- Prior knowledge of area
- Busy
- Significant morbidity
- Unemployment
- Safety Issues

Reality

- **Less drug misuse problems (but more alcohol)**
- Less challenging behaviour
- Social problems associated with deprivation (the ripple of crime)
- Busier than expected
- Patients – more difficulty articulating problems than expected
- Home visits – eye opener

Benefits

- **Pathology**
- **Satisfaction - making a difference**
 - *clinically*
 - *patient education*
- Dealing with most vulnerable
- Variety
- Trainers as role models – hard working, committed, not focussed on profit
- Learning to work under pressure
- Experience of dealing with challenging consultations

Downsides

- **No experience of dealing with affluence – the “printout patient”**
- **Difficult to learn a patient centred approach – CSA**
- Dealing with low patient motivation
- Vernacular could be difficult
- Busy, stressful
- Steep learning curve – no “easy” patients
- Pressure of time – tutorials squeezed
- Personal safety

Career

- Half explicit about wishing to continue practice in a deprived area
- Half of them said this was a change
- No one said the experience put them off!

Uncovered Areas

Most interpreted this question to mean specific areas that it would have been useful to have had teaching on **prior** to starting in general practice.

- **Addiction issues**
- **Recognising vulnerable patients**
- **Benefits system**
- Making best use of SW services
- Motivational interviewing
- Dealing with the social aspects of general practice