

Deep End Report 6

Patient encounters in very deprived areas: what can be achieved and how?

The sixth meeting of "General Practitioners at the Deep End"

14 May 2010

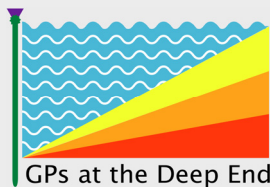
Fifteen Glasgow GPs met on Friday 14 May 2010 at the Section of General Practice & Primary Care at the University of Glasgow for a workshop on patient encounters in very deprived areas, drawing on experience, evidence and policy, and focusing on what can be achieved and how.

SUMMARY

- Consultations with patients are the largest and most important part of the work of general practitioners.
- In severely deprived areas, consultations are typically characterised by higher levels of need, multiple morbidity (including psychological and social co-morbidity) time constraints and practitioner stress.
- Consultations always address the problems presented by patients on the day (reactive care), but can also address potential future problems (anticipatory care).
- A key aspect of the consultation is the relationship between the patient and the doctor, who often know each other from previous consultations. Maintaining this relationship and ending the consultation on a positive note are important outcomes of the consultation.
- Research has shown that patients in deprived areas are less likely than patients in affluent areas to wish to have an active role in decisions concerning their care. Patients may also be less interested and ready to address changes in health behaviour.
- Addressing such issues within consultations is time consuming and is often not immediately effective. Explanations may take longer due to problems in health literacy. Practitioners describe “chipping away” at these issues, rather than achieving large and sudden changes in behaviour.
- Whether a consultation includes more than reactive care depends on many factors, including appropriateness, having time available, patient and practitioner expectations, and practitioner stress.
- NHS policies tend to underestimate the constraints and difficulties in moving beyond reactive patterns of patient and practitioner behaviour.
- The incentives of the Quality and Outcomes Framework do not reward practitioners for extending consultations beyond a narrow range of targets and the QOF agenda, highlighted via computer alerts, can be felt as an intrusion in the consultation.
- Current NHS initiatives concerning patient self help and self management appear to have poor penetration in deprived areas and were not recognized by practitioners at the meeting
- Practitioner stress can affect both practitioner and patient behaviour within a consultation, influencing what the patient presents and how the practitioner responds
- Prior knowledge and experience are important factors in the professional intuition required to know how and when to extend the aims of a consultation.
- Consultations are more likely to be successful if carried out in a systematic way, establishing the patient’s agenda at the outset, picking up clues (“psycho-social red flags”) and ending with clear agreement as to what has been decided (plan of action).

Continued overleaf

- Surgeries (serial consultations) can be made more efficient by good practice organisation, involving clear communication and the involvement of other members of the team including receptionists and practice nurses
- A frequent and important aspect of many consultations is referral to other professionals and services, requiring clear explanation. Referral is most likely to be effective when it is quick and to a familiar local setting.
- Practices provide a hub for referral to a huge range of other professions and services. Many of these pathways are dysfunctional, with poor communication and feedback
- Multiprofessional working across organizational boundaries works best via established relationships with named individuals, with regular, reliable contact and opportunities for professional exchange.
- Practitioners are keen to make use of the full range of possible services and sources of help for patients (e.g. via ALISS), but frequently lack accurate and up to date information about what is available locally.
- Patients also need ready access to health information and resources available within the local community.
- When a referral is made, some patients would benefit from additional help, support and reminders, to increase the probability of the referral being taken up.
- Evaluated experiments are needed in ways of providing access to consultations, of teamwork in addressing the needs of patients with complex problems, and in ways of providing and using additional time.
- There are few opportunities for practitioners working in severely deprived areas to share experience and views concerning the conduct of consultations and the organisation of practice.
- Additional education and training is required not only for young practitioners preparing to work in deprived areas, but also for established practitioners, to build on their substantial knowledge, experience and ideas.



GPs at the Deep End

“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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MEETING CONTENT

Presentations

- ***Anticipatory care***
Graham Watt, Professor of General Practice, University of Glasgow
- ***What do we know about consultations in deprived areas from recent research?***
Stewart Mercer, Professor of Primary Care Research, University of Glasgow
- ***Self management update***
Christine Hoy, Practice Nurse, and Programme Manager, Long Term Conditions Unit, Scottish Government

Discussion and comment

Each presentation was followed by short discussion. The rest of the meeting comprised two sessions involving two discussion groups, each followed by plenary discussion. The meeting ended with a general discussion. To avoid duplication, the points made during these discussions have been organized under a series of headings.

ATTENDING

Name	Location	CHCP*	Deprivation ranking	List size
Wilma Best	Gorbals HC	SE	54	6184
Ronnie Burns	Parkhead HC	E	13	3203
Christine Grieve	Drumchapel HC	W	14	2342
Iain Kennedy	Hyndland St	W	97	1122
Gillian Kidd	Midlock MC	SW	72	8543
Susan Langridge	Possilpark HC	N	15	2206
Pauline McAlavey	Glenmill, Royston	N	24	6061
Alison Macbeth	Gilbertfield	E	33	4988
Susan McKean	Allander St	N	9	4186
Stephen MacPherson	Bridgeton HC	E	31	3944
Bob Mandeville	Keppoch MC	N	1	3162
Alan Millar	Admiral St	SW	79	10592
Nick Treadgold	Pollok HC	SW	53	3966
Pierre Tsang	Bridgeton HC	E	52	1255
Alan Winter	Edinburgh Rd	E	62	5146

Christine Hoy	Practice nurse and programme manager Long Term Conditions Unit, Scottish Government
Stewart Mercer	Presenter and convenor of meeting
Graham Watt	Presenter and organiser of meeting
Michael Norbury	GP research fellow and rapporteur
Andrea Williamson	GP and rapporteur
Rosaleen O'Brien	Primary care researcher and rapporteur

*all practices come from the five Community Health and Care Partnerships within Glasgow City.

INTRODUCTION

Patient encounters in very deprived areas are typically short of time relative to need, with practitioners reporting high stress levels. Increasing consultation time for patients with complex problems is associated with increased patient enablement and reduced GP stress. NHS policies encourage anticipatory care, self help and self management, but are these objectives realistic, when habits are entrenched, time is short and “health literacy” is low?

This meeting aimed to draw on GP views, research evidence and experience of NHS initiatives, in considering the nature of patient encounters in very deprived areas. What can realistically be achieved, and how?

SUMMARIES OF THREE PRESENTATIONS

Anticipatory care

Graham Watt *Professor of General Practice, University of Glasgow*

KEY POINTS

- Anticipatory care has come to mean different things to different groups.
- Within Government health policy, expressed via Keep Well, anticipatory care tends to mean primary prevention, with a screening approach, delivered via general practice and linking with a range of health improvement services.
- Within general practice, as pioneered by Julian Tudor Hart, anticipatory care means finding time within routine encounters not only to deal with today’s problems as presented by patients but also to address future problems.
- The general practice definition spans primary, secondary and tertiary prevention, and is driven by patient’s needs rather than specific prevention programmes.
- The strengths of the general practice approach are: reactive care provides a large measure of population coverage; continuity and flexibility come naturally; and there is the possibility of developing long term relationships, based on mutuality and trust.
- Tudor Hart used epidemiology to measure what he hadn’t done and what he had achieved.
- In addition to people with significant disease risks (as addressed by Keep Well), other starting points for anticipatory care include mothers and young children, people with long term conditions (especially those with multiple morbidity), and people approaching old age.
- Not all patients need their care to be delivered in this way.
- The huge challenge facing health systems is to avoid the fragmentation of care which results from having multiple providers in different settings.

- General Practitioners at the Deep End work under pressure because of time constraints in addressing heavy burdens of need. Maintaining the status quo can be exhausting.
- Anticipatory care challenges primary care to move from the back foot to the front foot, not only reacting to patients problems but also looking ahead to prevent future problems.
- To what extent is this a realistic challenge in very deprived areas?

What do we know about consultations in deprived areas from recent research?

Stewart Mercer *Professor of Primary Care Research, University of Glasgow*

KEY POINTS

- The consultation is the front line of patient care.
- The evidence shows that primary care makes a difference and can improve population health, mostly by doing simple things for large numbers of people.
- The inverse care law states that the availability of good medical care (which can make a difference) tends to vary inversely with the need for it in the population served.
- In Scotland this results from the mismatch of resources whereby there is a steep social gradient of health need associated with a flat distribution of manpower in primary care.
- Recent research in the West of Scotland has provided a human dimension to the inverse care law by showing how it operates within consultations.
- Long term conditions, multiple morbidity, and psychological co-morbidity, are more common in deprived than in affluent areas.
- This results in increased demands on primary care, in terms of consultation rates, the numbers of problems patients wish to discuss in consultations, and the greater frequency of complex consultations, with physical, psychological and social elements.
- Patient enablement (ability to cope better with an illness, and with life generally) is less in patients with complex needs in deprived areas than in affluent areas.
- Paradoxically, whereas 22% of GP consultations in affluent areas last 15 minutes or more, the figure in deprived areas is 13%.
- GPs in deprived areas report higher levels of personal stress following patient encounters, especially after long consultations when stress levels are 50% higher in GPs working in very deprived areas.
- Patients in deprived areas had lower expectations of taking an active role in decisions within consultations, and were much more likely to expect the doctor to determine the significance of symptoms, to assess risk and benefits and to choose treatment.
- Overall, patient satisfaction and reported outcomes were poorer in deprived areas.

- Patient perception of GPs' empathy (as measured by the CARE measure) was the main consultation factor that predicted symptom improvement following encounters on both deprived and affluent areas.
- Empathic care is associated with both direct effects on symptoms and indirect effects on well being.
- Professor Mercer is leading a Chief Scientist Office NHS Applied Research Programme which aims to develop and evaluate a whole-system intervention to support patients with multiple morbidities living in deprived areas, including extra time for consultations and support for both patients and practitioners.
- Pilot work suggest that extra time for consultations can reduce practitioner stress and improve patient enablement not only for patients with complex problems, but also patients with less severe problems.
- As part of the Governments new Quality Strategy, the CARE Approach is being development, using the CARE measure and involving the 4 stages of **C**onnecting, **A**ssessing, **R**esponding and **E**mpowering.

RESPONSES TO THIS PRESENTATION INCLUDED

- Patients in deprived areas seem to be less tolerant of being kept waiting.
- An added dimension to deprivation in Glasgow is immigration.
- Consultations with immigrant patients can be stressful due to time constraints, language problems, working through interpreters and taking account of cultural expectations.
- The example of the methadone programme was used to illustrate the beneficial effect of removing the care of a problematic group of patients from mainstream care for all patients.
- It was noted that GPs varied a great deal in their susceptibility to stress and their reactions to it.

Self management update

Christine Hoy *Practice Nurse, and Programme Manager, Long Term Conditions Unit, Scottish Government*

KEYPOINTS

- Self care and self management are important parts of the Government's new Healthcare Quality Strategy for NHS Scotland. There is a national strategy for self management for long term conditions called *Gaun Yersel* which was launched in 2008.
- The Long Term Conditions Alliance Scotland (LTCAS), comprising a large number of voluntary organizations, were main authors of *Gaun Yersel*.
- Self management is a major part of the health care improvement programme, the Long Term Conditions Collaborative.
- Self care is what each person does on an everyday basis. It is often compromised for a person living with a long term condition.
- Self management is the process each person develops to manage their conditions.

- Fifteen minutes of care amounts to only three hours per year: people are already self managing, but often not very well.
- Additional help is needed for elderly people and those with lower educational and socio-economic status.
- The Healthcare Quality Strategy includes references to the CARE measure and a commitment to equity (in tandem with *Equally Well*, the Government's policy to address health inequalities), and focuses on health literacy, communication/ encounter skills and partnership working (e.g. between health and social care).
- Ongoing work includes a self management fund (to support voluntary sector initiatives), "Co-creating health" (a project hosted by Ayrshire and Arran Health Board and funded by the Health Foundation), a communication and human relationship skills fund, the development of a Patient Portal (for patient access to personal health information), ALISS (a project to improve access to Local Support to Self Management) and work to improve access to emotional and psychological support.
- Examples of funded projects include: consultation skills (practice nurses using the CARE measure in Lothian), consultation skills for pharmacists, training for nurses and allied health professionals in building therapeutic relationships, use of the CARE measure by physiotherapists, and enabling difficult conversations in end of life situations.
- ALISS is an imaginative project, which aims to make it easier to find local support for health and well being and encourage people to create content for local resources.
- 23% of adults in Scotland may have low literacy skills, which are associated with poorer health status and less knowledge of self management and of health promoting behaviours.
- If self management can be successfully promoted in this group, the policy will be "right for all".
- The ALISS health literacy report calls for health care practitioners to be educated in relationship skills, literacy, personalizing care and brokering health information.
- There should be wider use of existing techniques such as "Ask me 3", "Teach Back" and leaflets such as "It's OK to Ask".
- Perhaps literacy tutors should deliver anticipatory care.
- Should literacy levels be coded in health records and if so, how?
- Barriers to supporting patients with literacy and numeracy issues include time constraints, workload, perceptions of the role of primary care and gaps in skill and knowledge.
- The tendency for medical authors to write in ways which are incomprehensible to patients has a very long history.
- Ideas for the future include:
 - Primary care education system.
 - Templates specially designed for deprived areas could collect valuable (currently hidden) data which could be used to guide change.
 - Flexibility in appointment times.
 - Primary care teams developing according to the needs of practice populations.
 - Sharing innovative practice.

- Alterations to the Quality and Outcomes Framework (QOF).
- Imaginative use of Enhanced Services.
- Applying the *Patient Safety* approach in primary care.
- Applying *Better Together* in primary care.
- Health conversations as a quality marker.

RESPONSES TO THIS PRESENTATION INCLUDED

- None of the Deep End GPs present had heard of *Gaun Yersel*, despite it being a flagship policy, or of the Long Terms Conditions Alliance Scotland.
- There was felt to be an overload of initiatives and a problem in responding to them within general practice consultations, most of which are about dealing with the problems presented by patients.
- There is always a time cost in introducing new information, or in getting the patient to where they need to be.
- It was felt that policy documents tend to be written in a language that is not helpful for GPs looking for quick reference points.
- The ALISS project could help in meeting the needs of patients with lots of questions ('I want to talk about 5 things'), making it easier to refer patients on, making life easier for both patients and GPs.
- GP experience is that when they flag up the issue of literacy, patients may start backing away.

GENERAL DISCUSSION

NB Notes were taken of group discussions during the day by Michael Norbury, Rosaleen O'Brien and Andrea Williamson. As there was a considerable degree of overlap between sessions, these notes have been combined in an edited version prepared by Graham Watt.

The reports of discussions at the meeting have been collated under the following headings:

- A. General considerations on the nature and role of encounters
- B. Knowledge, experience and intuition
- C. Patient access to consultations
- D. Preparing for the consultation
- E. Structuring the consultation
- F. Ending the consultation
- G. After the consultation
- H. Teamwork
- I. Information for practitioners
- J. Referral
- K. Practitioner stress
- L. Sharing practitioner experience
- M. Outcomes

A. General considerations on the nature and role of consultations

- The main purpose of consultations is to respond to the problems presented by patients.
- The role of the practitioner is to listen, to interpret the patient's story, to try to reach a shared understanding of the nature of the problems presented and how they can be addressed and to agree a course of action.
- 'Patients tell us their stories, which we translate into problems' (often complex stories relating to murder, cancer, bullying, drugs etc).
- When time and opportunity allow, it is possible to address other issues, concerned with possible future problems and how they can be avoided.
- Even if little is achieved on a particular occasion, showing respect and ending on a positive note are important aspects of establishing and maintaining a relationship, based on familiarity and trust, as a platform for the next consultation with the patient.
- Changing from an outlook of pessimism to one of optimism may take a long time.
- GPs can also be pessimistic about what can be achieved.
- Patients in deprived areas often present a complex variety of problems, many of which are beyond the practitioner's ability to help.
- How can we make an impact when working against the tide of negative influences on health? (e.g. the availability of poor quality food).
- Medical diagnoses and treatments may be peripheral to patients' main needs.
- Practitioners need to be sensitive to the social norms of their patients, and how these may be different from professional expectations.
- Patients may be a long way, emotionally and practically, from taking an anticipatory approach.
- It is counterproductive to develop new services based on unrealistic expectations of patient behaviour.
- Most change is incremental with practitioners nudging patients along the health promoting path.
- Although consultations with GPs provide a central point of contact, GPs can only do so much. There was discussion about the nature, and limitations, of this pivotal role.
- Are there other ways of providing what patients need? Is there a place for patient advocates?
- How can GPs incorporate strategies into what we do already?

B. Knowledge, experience and intuition

- Several comments highlighted the importance of previous knowledge and experience of patients, and the time required for these to be acquired.

- There is huge variation between patients living in derived areas in how they are affected by health and social problems and can be helped to deal with them.
- GPs filter, prioritise and rely on their experience and intuition.
- Participants felt that Government and policy makers do not appreciate this filtering and prioritising role, undervalue the intrinsic skills, knowledge and experience required in managing complex patients and overestimate the extent to which this function could be 'replaced overnight'.
- It was felt that 'red-flags', indicating when action might be required, vary from family to family, but practitioners can only judge this when they have come to know a family well.
- There may be large gaps in a practice's knowledge of a family, when family members are registered with different practices.
- Family tree information in the case notes can be helpful.
- Other members of the practice team, including receptionists, practice nurses and health visitors, often have valuable knowledge that the GP lacks.
- For example, other staff members' knowledge of patient's family and social connections can help in knowing how to find a patient urgently (especially receptionists and admin staff who often live locally).
- Participants felt that familiarity, friendliness and continuity can help to deliver effective care.
- Participants qualified that time efficiencies are only likely with experienced practitioners who have an awareness of 'the bigger picture' and who have high energy/reserve levels.
- Intuition and "hunches" require substantial past experience of patients, conditions and consultations.
- "It takes years to learn how to prioritise and intuitively work out what might be needed, based on knowledge of the patient.
- Working in this way "depends on how you're feeling" i.e. practitioners' own emotional reserves during a series of consultations.

C. Patient access to consultations

- GPs described several different ways of providing patients with access to appointments, including open access, same day appointments, advanced booking and combinations of these approaches within practices.
- GPs discussed the pros and cons of asking patients to assess how long they expected a consultation to be and creating a booking system to accommodate such preferences.
- Some felt that in open-access surgeries patients seem to 'cut to the chase' more quickly, which can be less stressful for GPs due to lack of fixed time appointments.
- Attempts to control demand by limiting patients to one problem per consultation, were mentioned as something that other practices did, but was not considered good practice in areas where multiple problems are the norm.

- “One appointment for one problem – if more, you need a double appointment.”
- Same day appointments worked in one practice, perhaps because there was less demand for appointments made several days in advance.
- Making changes to appointment schedules is not without risk in terms of practice efficiency, if time ends up being wasted, through patients not attending or no longer requiring the longer consultation they had requested.
- In general, it was not clear which approach, or combination of approaches provided the best approach, but better information about each approach could help practices choose the best approach for them.

D. Preparing for the consultation

- The smooth running of surgeries could be disrupted by many factors, but it was agreed that smooth running is more likely if the practice is well organised and practitioners are well prepared for each surgery.
- Some participants reflected that additional time checking patient records before starting the encounter could bring time savings later (in terms of knowledge of the patient and previous referrals etc.) but this is not always possible due to running late and the stress this may cause.
- An important part of each consultation is to re-connect with the patient, based on previous encounters.

E. Structuring the consultation

- Taking time to establish the patient’s agenda early on can free up time later in the consultation.
- Asking early ‘what would you like me to do?’ was considered important in identifying issues and therefore in saving time within the consultation
- GPs felt that the apparently unnecessary ‘pre-amble’ is sometimes used by patients to test the water before raising particular concerns within the consultation.
- Patients could also test the GP with trivia (e.g. a sore throat), in which case does the GP open up the conversation or close it down?
- GPs compared the strategies they use to transform the consultation e.g. discussing football before using that topic to open up patients who find it difficult to engage.
- When a relationship is established and an extra 2 or 3 minutes are available, the time can be used to nudge patients towards preventive activities.
- Several GPs spoke of the need to have a period of time without the patient where they can think directly. One GP spoke of his use of “thinking time” (e.g. when taking blood pressure).

F. Ending the consultation

- At the end of the consultation, it is important to establish clear and achievable plans (to keep things moving between consultations).
- Providing a written plan of action at the end of the encounter can help to keep things outside the consultation.

G. After the consultation

- Following the consultation, there is often the problem of not knowing what progress is being made and sometimes finding out after several weeks that no progress has been made.
- Poor communication from secondary care is often the cause of inefficiency and fragmentation.
- GPs can spend much of their time 'stalling' or keeping the patient 'ticking over' whilst awaiting review by secondary care during the usual 3 month wait for the appointment, the 3 week delay in hearing the outcome of the review or receiving the clinic letter, plus any associated time wasted with DNAs and re-referrals.
- Mobile phone follow-up and text reminders for appointments could help to reduce such discontinuity.

H. Teamwork

- Without "underselling" the GP's role, there are many ways in which other members of the practice team can help to increase the efficiency of consulting time.
- When the practice is busy, everyone should be busy e.g. avoiding the stressful situation where the GP is very busy but the practice nurse has spare appointments.
- One GP saw complex patients with her practice nurse. The nurse takes the history and identifies problems, before the GP joins the consultation in a 'decision-making' capacity as per the consultant surgeon model now commonly used in secondary care. This model was thought to provide the GP with more opportunity for clear thinking, thereby facilitating quicker diagnosis and management plans, without distraction or 'crowding-out' by extraneous issues.
- Joint consultations with the nurse only work, however, if the GP has identified complex patients in advance.
- In general it was recognized that having good staff and keeping them is essential to the smooth running of practices.
- It is important to GPs to be able to refer patients to colleagues with particular skills e.g. for health promotion, especially when these are available "in house" and can be taken up quickly.
- Other team members can be effective in getting patients to engage in health promoting activities, and with other services, especially when they

have the necessary training and can combine this with additional time and less formal relationships with patients.

I. Information for practitioners

- GPs need to know what referral options are available locally and to have such information at their fingertips within consultations.
- The social model of care is important for GPs. They want to use the available services to support their patients (“social prescribing”) but need accurate and up to date information on what services are available locally.
- Having easier access to and knowledge of voluntary agencies is also likely to be useful.
- If the information were more available, GPs could spend less time trying to find such information and could use consultation time encouraging patients.
- There is uncertainty, however, as the best use of limited time to encourage patients to access relevant information and other services.
- What positive support structures can be triggered for patients?
- IT issues were also discussed in terms of systems supporting rather than slowing practitioners down. To be particularly useful, the available information has to be bespoke to the practice and locality.
- Some GPs described having a separate ‘non-NHS’ PC in their room with fast internet connections that they use to provide information more swiftly to patients.

J. Information for patients

- IT support was also discussed in terms of waiting room resources for patients to utilise whilst waiting, improving their knowledge and understanding.
- Local libraries might have a role in promoting sources of information and other services.
- Librarians could be considered as part of the local team, providing a signposting function for patients looking for health information.

K. Referral

- Referral to other disciplines and services is highly valued but frequently dysfunctional.
- GPs need a bespoke information base (who to refer to and where – for local services).
- Patients geographical ‘territorialism’ is often not taken into account when services are planned.
- Service planning often presents practical difficulties (time and cost) for patients; the example was given of four hour’s travel time by public

transport for patients to get to another city hospital as part of a waiting times initiative.

- It is a practical matter of fact that referral to other colleagues and services is much more likely to be effective if available in house, capitalizing on existing relationships and minimizing discontinuities of time and place.
- Health promoting policy initiatives are often seen as distant from general practice.
- The Keep Well model of the outreach worker was viewed positively by one GP as a way of enabling patients, but was noted to have worked better for some services (e.g. stress and exercise centres) than for others (counseling for alcohol problems or support for illiteracy).
- Referral to outside agencies and personnel can install additional barriers to coordinated care.
- When referral is to outside staff or services, it is desirable for both the practice and the service receiving the referrals to consider issues of patient acceptability and uptake.
- Where referral processes are dysfunctional, it is necessary to look at the problem from all perspectives, including what external agencies think of GPs.
- Familiarity helps to avoid fragmentation.
- Referral must be timely. e.g. when psychological support is needed, the impetus is lost when waiting times for appointments may take several weeks.
- Fragmentation of care can arise when patients “disappear” into other care systems and several types of person (e.g. care managers in addiction services, key workers in accommodation projects, DNA support workers) may have responsibility for the coordination of care.

L. Practitioner stress

- Given the data on GP stress in Professor Mercer’s presentation, participants felt it was important for GPs to be aware of this issue and to prevent it as much as possible.
- It was noted that patients are often good monitors of GP stress (“are you having a bad day doctor?”) and may edit what they intended to ask, accordingly.
- The most stressful type of appointment observed in the research study had been long consultations for multiple morbidity, including psychological co-morbidity, in deprived areas.
- It was felt that the stress of such consultations could be reduced by earlier identification of patient cues and “red flags”.
- A lack of evidence on how to deal with complex patients, however, adds to the stress.
- The potential for missing cues/red-flags is considerable.
- Some patients wanting quick turn-around within consultations, while others do not.

- Having a bad or stressful day or running late also increases the likelihood of missing cues and red flags.
- The imperatives of the Quality and Outcome Framework (QOF) can take up valuable time within the consultation, 'crowding' out time for other components.
- Working serially, and under pressure, with both the financially poor and those with little expectation or motivation, can be exhausting for the GP.
- On bad days there is a fear of missing things. One GP managed by switching off QOF pop up boxes – which could present problems within his practice.
- To avoid demoralization, GPs need praise and reinforcement of their efforts. Criticism can be taken badly.
- One surgery has a PHC team members weekly meeting with no agenda simply to discuss issues or concern or problems encountered.
- Another GP discussed working for a few sessions in a neighbouring practice so as to then offer ideas/constructive feedback or share ideas relating to practice improvements.
- It was acknowledged that all practitioners are different and that practices need some 'box-tickers', as realistically, that's how practices receive their income.
- Minimising GP stress and providing peer support was seen as being important for maintaining safety and effectiveness.
- It is important for the "Deep End" not to become a whirlpool with GPs becoming overwhelmed by the volume of insoluble problems.
- There is a need for personal "housekeeping" – putting your own house in order - addressing GP's need for support first – then patients.

M. Making good use of time

- More time is the factor most likely to enhance the consultation process and outcomes.
- It was felt that additional time would deliver gains for both patients (improved outcomes) and practitioners (reduced stress).
- Participants discussed how time might be more effectively used.
- Additional time could be used for blank appointments in surgeries that could be used at the GP's discretion.
- However, participants in partnerships highlighted that negotiating longer consultations with their partners could be problematic (in a zero sum situation, other partners might have to see more patients).
- Additional time could be used for screening or health improvement work
- It was recognised that in the absence of evidence, new ways of allocating and using time within consultations and practices could have unforeseen consequences
- For example, re-organising the use of time in-house might impact on continuity and the ability of patients to see the GP of their choice

- Solutions may create problems. Patients could return to a GP repeatedly, knowing they will engage in a great chat. There is potential for abuse.
- Can increased length of consultation be linked with reduced frequency of consultation?
- One suggestion was that after a lengthy consultation to address issues in depth, the pattern and volume of consultations should return to normal.
- Patients need to value the time being offered, and to share responsibility for making good use of the extra time.
- The practice team also need to be sensitive to what time is being used for. One GP spoke about receptionists interrupting him when he was still trying to write up notes.
- How do we identify those who need more time? Give patients choice – what would you like? 5, 10, 20 minutes? How long do you think it will take?
- Some practices have used nurse triage to identify which patients need more or less time with the GP.
- A GP commented that GPs need to be part of the prioritizing process.
- How do you know when a patient's problems are complex? Indicators include the number of illnesses, and repeat medications, and whatever causes stress for the GP.
- Complicated measures of complexity, requiring lengthy assessment of patient needs, have no place in busy general practice.
- It was noted that in Professor Mercer's research, "complexity" could only be operationalised in terms of GP perceptions of whether a patient was "complex". Knowledge of the patient is as important as counting the problems.
- Although the idea of a longer consultation was discussed, most discussion was focused on what could be done with a few extra minutes.
- A major problem is the gap between the patient and GP agenda and the time it takes to bridge this.
- One GP felt that it was worth working hard with particular patients with complex needs in order to enable him to reduce his workload later on.
- Difficulty in predicting the amount of time needed also adds to stress(e.g. squeezing a 15 min appointment in a 10 min slot is stressful).
- One GP discussed the use of motivational interviewing to explore why patients aren't moving on with a particular problem (chipping away at the problem rather than telling patients what they should be doing).
- Some practices already make time, as best they can.
- For some GPs this is at the end of the day.
- Some practices having double appointment slots in the afternoons to do fast screening, and identify health needs.
- A single-handed GP described having 15 minute appointments.

N. Redesigning primary care

- More time is definitely needed – but it is not clear how this additional resource would best be used.

- It is possible that ‘minor’ illnesses could be managed in another way, but most felt that contacts with patients for ‘minor’ things was important, not only for getting to know patients and establishing a relationship, but also to provide welcome relief from the burden of dealing with complex patients.
- By keeping contact with all patients, practitioners acquire knowledge about patients that will be useful in the future.
- It was felt that the 15% of patients who account for about half of all consultations might need different arrangements from the 85% who consult rarely, and in some cases hardly at all.
- In the case of “heartsink” patients and others with entrenched patterns of behaviours, there was a feeling that something is needed to break the pattern.
- Can the next round of contract negotiations be used to make our position clear and provide a statement of what we wish to achieve in our GP consultations?

O. Sharing practitioner experience

- Many practices are doing things differently but, working in isolation, do not know what each other are doing.
- There are insufficient opportunities for the sharing of professional and practice experience between colleagues with the common experience of working in areas of concentrated severe socio-deprivation.
- Postgraduate training in consultation skills, including motivational interviewing, time management within encounters, and GP shadowing, would be useful to support those new to working in deprived areas.
- Continuing professional development activities are needed, from the starting point of practitioners with substantial experience and knowledge of working in deprived areas.
- Reviewing consultation skills and models was briefly discussed in terms of the value of focused feedback, providing reassurance and alleviating self doubt.
- Activities that prompt and support reflection and feedback include medical student attachments and the organized sharing of tutor experience.

P. Outcomes

- The desired outcomes of patient encounters in deprived areas include : enablement; increased understanding; reduction of GP stress; reduction of barriers to outreach services (invite them into practice); and reflection on successes (however tiny).
- There is a sense that ‘successful’ patients are the ones that tend to move out of the area.

SUGGESTIONS BOX

At the end of the meeting, participants were asked to state three things that could be done differently – within consultations, in practice organization and in working with other professions and services.

What could be done differently within consultations?

- Something active to break entrenched patterns (e.g. motivational interviewing).
- Proactively identify sources of stress.
- A little more time, uninterrupted, with each patient, to manage fully – efficiencies elsewhere.
- Perhaps have simple written plan, to a preset format, to be completed by GP and given home with the patient detailing main points covered in the consultation.
- Longer consultations to do more holistic care – selected people/finite number of patients – not all – better outcomes, but I would need to buy in more doctor time.
- Joint appointments with practice nurse for complex patients.
- Take a comfort break; never work with a full bladder.
- Before patient comes in, check details of previous encounter.
- After explaining and illustrating a discussion on paper, surrender that piece of paper to the patient rather than throwing it in the bin.
- One click list of local resources on computer.
- Mobile number confirmation with timed call back agreed.
- To hand patient any explanatory diagrams drawn during the consultation.
- Written management plans.
- Patient information leaflets on conditions and services available.
- Return to basics – assure the patient's voice is heard (30 seconds longer).
- Which consultation models work best in deprived areas?
- I previously worked in Canada where I had 2 consultation rooms. The patients were put in each room and had their weight and BP checked by the receptionist while they entered and undressed if necessary which saved so much time and saved waiting for patients to arrive.
- Motivational interviewing.
- Stop and think about patient's hidden agenda.
- Break points.
- Holism – reduce computer use during consultations and explore psychosocial factors in more detail.
- Reflect more on my consultation style – do I smile and give eye contact?
- Try and clarify early and soon in consultation the main reason for consultation/patient concern.

- Using patient experiences –knowing who your patients are and finding out how they feel about consultations. Research, case studies, story telling, creative writing, to better understand the patient experience. Non-judgmental.
- Ask patients for their ideas.
- Thinking about health literacy and health beliefs.
- Longer consultations allowing time for motivational interviewing, encourage enablement, compliance etc.
- Use of resource which lists local services (? Webpage).
- Education in communication skills for deprived practices at registrar and GP level.

How could practices organize themselves more effectively?

- Flexibility in appointment system (free slots/on the day vacancies).
- Availability of in-house psychology/counsellor/social animator.
- Communication between members of staff to be fuller, standardized – saves time in the long run.
- Encourage as few interruptions as possible – to be allowed to complete one task before being asked to start another.
- Open surgery, vetting of all requests for consultation.
- Have annual assessment (? 1 hour) where nurse and GP are involved in formal plan.
- In-house (or nearby) support services e.g. a counsellor could be available half a day per week; also identified social worker for your patients i.e. the old fashioned primary care team model is a good one.
- Delegate follow-up of patients to other services to other members of the practice team.
- Wednesday's seem to be the quietest day of the week. Why not start the surgery with a sign saying "staff training this afternoon" – and then use the time to catch up with paperwork, hospital referrals, insurance reports etc (banks do it).
- The use of health care assistants particularly trained about local resources with background reception knowledge.
- Waiting room health care assistants picking up routine screening and pre-consultation problem listing.
- Tick box patient questionnaires re family/job/smoking/alcohol/ family history/problems.
- Things I'd like to try – open-access surgeries, nurse-led phone triage, longer appointments.
- Possibly more telephone/nurse triage and phone consultations.
- Family trees.
- Vacant slots throughout the surgery.
- Open practice meetings.
- Mentoring and buddying.

- Peer support – discuss “complex” patients.
- Increases in support, but objectively.
- Consider joint consultations for complex patients – nurse interview followed by GP.
- In real world – create longer consultation.
- In reality – try and find ways to “create” extra time during the day.
- Mobile numbers – contact patients directly and support them to attend follow-ups e.g. practice contact workers or case workers (pharmacy project has had great success supporting patients with complex needs to engage with self-management and diabetes mainstream services).
- Share filmed consultations.
- Shadowing within teams and localities.
- Team learning and easy local access to known AHPs/social workers.
- How do CPNs and alcohol liaison nurses work?
- Better computer system – nothing worse than computer crashing mid-surger.
- Triage/signposting to other health care professionals/GPs.
- Having in house professionals to refer to e.g. CPN/counsellor/dietitian.

What additional outside help would be helpful?

- Training on which strategies to use in consultations.
- CHCP-based information systems that identify current voluntary organizations and possibly a NAMED social work contact for each practice
- Secondary services particularly stress counselling, alcohol/drug counselling and mental health services to have short waiting times – to avoid return visits to GP where less can be achieved.
- Details of all agencies we might refer to, to be available centrally and kept fully up to date and easily accessible.
- Advisers/counsellors locally available, preferably within the practice.
- Mental health worker, drug worker, social worker (attached to practice).
- Internet sites that both patients and health care staff can access.
- A web based (and hard copy booklet) listing local (i.e. nearby) support services, voluntary and NHS.
- Clinical psychologist, parenting psychologist, with CBT training.
- Time for feedback via video consultations.
- Support to access ALISS.
- CBT training for GPs.
- More CBT services (in my area).
- Physio and chiropody appointments (when needed) are needed now, and not 4-6 weeks later.
- ? a matchmaking service for single-handers to merge.

- Local health resource mentors shepherding patients to agreed referral destinations, perhaps in co-operation/contact with library services.
- Named social worker/CPN attached as first point of contact.
- Well man clinics locally (not just Sandyford).
- Data from neighbouring practices that do any of the experimental things mentioned in B above (what works and how).
- List of outside agencies with names and addresses of social services/mental health and talk etc and times when people are available to discuss cases i.e. on call social worker, on call psychologist – who to contact and when?
- Increased social work, counselling within the practice.
- Second ring-fenced computer giving doctor internet access.
- Plans of action/information.
- Information about ALISS.
- Community worker attached to practice to link non-resident professionals with practice population.
- Named social work contact.
- Aliss or portal which is kept up to date for links to local services.
- Outreach worker to “hand hold” helping people keep appointments.
- Improved, up to date and accurate information concerning locally available patient support services.
- Easy and rapid access for patients to these services.
- Referral services that GPs can trust.
- Feedback on referrals back to the GP so they know if it helped.
- Working in a disempowered community – how does this affect the GP’s patients? People have a poor experience of services in general e.g. housing, education, police. Can GPs support a community empowerment model? For example, working with community workers, literacy tutors, lay health workers, peer support etc.
- Sharing local knowledge.
- Quick access to handy info.
- Could GPs/practice nurses with this experience and knowledge share it in teams?
- Work four days and leave one day for educating teams.
- Named social worker for practice.
- In house CPN/counsellor.
- Appointment officer – someone you can refer a patient to who is at high risk of DNA for further appointments including hospital appointments i.e. someone to refer patient to at point of referral to encourage to attend, phone reminders, ensure transport etc.