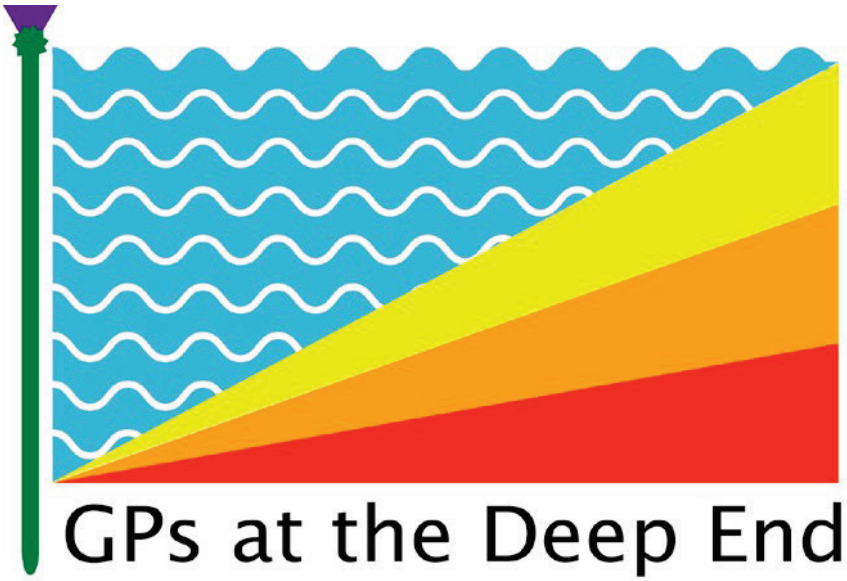


Deep End Report 24

What are the Continuing Professional Development needs of GPs working in Deep End practices?

Eleven general practitioners met in a round table meeting on 14 March 2014 to discuss the CPD needs of GPs working in Deep End practices. The participants considered these questions: How could GPs working in deprived settings better serve their population? What learning needs do they have to meet to achieve this? What is the gap between current practice and better practice that education could address? This report was prepared by Ronald McVicar and Andrea Williamson and has been reviewed by participants.

June 2014

Eleven general practitioners met in a round table meeting on 14 March 2014 to discuss the Continuing Professional Development (CPD) needs of GPs working in very deprived areas. The participants considered these questions: How could GPs working in deprived settings better serve their population? What learning needs do they have to meet to achieve this? What is the gap between current practice and better practice that education could address?

SUMMARY

Following a discussion of the issues Deep End GPs encounter in their daily work, eleven learning needs were identified as being of high importance to Deep End GPs:

1. Engaging with patients (autonomy/health literacy/screening)
2. Promoting GP tenacity/realistic optimism
3. Drugs and alcohol
4. Safeguarding children
5. Asylum seekers/migrant health
6. Multimorbidity
7. Poverty
8. Vulnerable adults
9. Evidence-Based Medicine (EBM) and unhealthy populations
10. Previous sexual abuse
11. Homelessness

The topics that the group wished to take forward were prioritised by focusing on identified learning resource gaps:

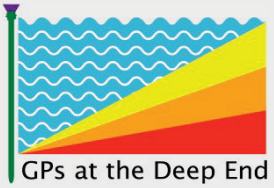
1. How to address low patient engagement in health care and increase health literacy.
2. How to promote and maintain therapeutic optimism when working in areas of high deprivation.
3. How to use EBM effectively when working with patients with high levels of multimorbidity and social complexity.
4. How to meet the health needs of migrants including people seeking asylum and refugees.

The first three are being taken forward as PBSGL modules.

This report will be of use to those who are interested and involved in supporting primary care learning in the UK especially those working in deprived communities.

CONTENTS

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 Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*



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PARTICIPANTS

General practitioners attending

Name	Location	List size	Deprivation ranking
Lisa McIntyre	Gorbals	6059	60
Paula Rogers	Shettleston	8701	56
Marie Wilson	Easterhouse	2462	5
Cathy Norton*	Paisley	3179	336
Stephen Macpherson	Bridgeton	3953	50
Susan Langridge	Possilpark	2165	20
Petra Sambale	Possilpark	3085	1

*formerly Gorbals Health Centre

Also attending

Ronald MacVicar	GP and Director Postgraduate General Practice Education, North of Scotland Region of NHS Education for Scotland
David Cunningham	GP and Assistant Director of GP Education West of Scotland Region of NHS Education for Scotland
Adam Hay	GP and Health Inequalities Fellow, Homeless Health Services, Glasgow and NHS Education for Scotland
Andrea Williamson	GP Homeless Health Services Glasgow and Director of Community Based Education (Strategy and Innovation), GPPC, School of Medicine, University of Glasgow

FORMAT

13.45 **Introductions**

14.00 **Discussion of the issues**

15.15 **Break**

15.30 **Turning issues into learning needs**

16.45 **Close**

GENERAL DISCUSSION

The following issues emerged through discussion, not in order of importance:

Multimorbidity

Multimorbidity is the new norm and while by no means exclusive to areas of high deprivation, there are important aspects to appreciate including

- The high numbers of patients in deprived areas.
- The fact that multimorbidity occurs at a younger age in these settings.
- The prevalence of mental health problems as the commonest comorbidity in very deprived areas.
- The experience that that working with patients with multimorbidity is often complicated by lower patient engagement in care.

Patient engagement

Health and engagement in health care activities is only one of a number of competing priorities for many patients living in very deprived areas. Non-attendance at specialist clinics and consequent discharge as 'DNA' means that secondary care support is withdrawn and 'it is left to us to sort it out the best we can'. This is irrespective of complexity and leaves the primary care team with difficulties in optimising care for these patients. Non-engagement was aggravated by transport difficulties to secondary care centres, and participants suggested that those patients with multi-morbidities had a considerable burden of attending a number of clinics spread across various hospitals in the city with resultant costs relating to public transport. This was a particular issue for patients with significant mobility problems.

Engagement with screening and immunisation programmes is a significant challenge. Practitioners considered that they were disadvantaged with regards to practice income with QOF payments centred on high levels of patient engagement. Although high coverage levels are often achieved, the effort required to achieve these levels is considerably greater than in practices serving more affluent areas.

Drugs and alcohol

Problem substance use is a 'massive issue', interlinked with trauma, family and relationship issues, employability and physical health consequences. Deep End GPs accept the evidence about the role of brief interventions and motivational interviewing but the interventions will not necessarily be brief, may have little short term impact and there is a requirement to stay engaged with the patient over the long term. This is not always easy. Ensuring effective and safe assessments of patients concerns when under the influence of drugs or alcohol was also raised. Participants raised their concerns about high levels of prescription drug misuse and long term prescribing of anti-depressants. Many saw this, in combination with drugs and alcohol, as many patients' way of coping with life in very deprived areas.

Applying Evidence-Based Medicine (EBM)

Applying EBM to individual patients was generally agreed to be a major challenge when taking into account multimorbidity and lower patient engagement in health care. Existing clinical guidelines usually offer little in the way of practical support to help clinicians work through these issues. Participants considered that trials focusing on single diseases were often irrelevant for patients from deprived areas who had multimorbidity.

Patient autonomy

Autonomy is recognised as being of fundamental importance but was felt to be problematic when levels of health literacy are low. Some participants described tensions between the ethical principles of autonomy and beneficence when working in very deprived areas. Some adults in deprived areas lack motivation to remain autonomous and interact with health services with a sense of 'learned helplessness' and a 'fatalist' approach to themselves and their lives. Participants considered that these patients tend to plan and survive from day to day rather than considering the future.

Material poverty

Poverty is an ever-present issue and ill-appreciated in the context of many well-meaning patient-centred interventions, for example where technological interventions assume internet access or smart phone ownership. Participants felt that those who organised such interventions had little knowledge or experience of engaging with patients in very deprived areas.

Identifying and supporting vulnerable children and adults

These issues cause significant concern. There are uncertainties about legislative frameworks regarding vulnerable adults (including elderly patients and the concept of elder abuse) and available sources of support for working through them.

Providing services for migrants, refugees and asylum seekers

Providing services for these groups involves several challenging issues:

- Understanding the cultural health beliefs of diverse populations and migrants' knowledge of the NHS and social care. Health-seeking behaviours differed markedly in other countries and cultures, which can cause conflict for practitioners.
- Health needs that are culturally or risk specific from migrants' country of origin (eg tropical infectious diseases, understanding prevalence, risks and management of female genital mutilation).

- Migrants come from diverse parts of the world and are no longer from one specific area. They also settle in scattered areas rather than in one concentrated area. Practitioners have to learn and cope with various different cultures rather than one other 'new' culture.
- Coping with 'refugee' patients with complex physical and psychological trauma from past lives abroad, and managing this with language problems in short consultations. Participants recognised issues relating to their own mental health and need for psychological supervision.

Fitness to work

Legislation to support long-term welfare claimants back into work has been particularly challenging for patients in Deep End practices because of the impact of threats to welfare support, both material and psychological. These types of requests are especially concentrated in Deep End practices, with no extra resource to deal with them.

Tenacity and resilience is required by Deep End practices

'Tenacity and resilience' is required by the GP, others in the practice team and indeed the team itself *'in order not to give up'.* A position of *'realistic optimism'* is required for the practitioner and the patient with a strong suggestion that despite some assumptions to the contrary *'our patients do want choices and options'*.

> '*Maybe we are overdoing our [biomedical] role. Maybe the critical thing is that Dr X retains an optimism for them. The therapeutic relationship is perhaps the big thing'*

Maintaining realistic optimism is emotional, demanding and exhausting work. In contrast it was accepted that this patient group is more accepting with lower expectations of themselves, the system or their healthcare professional. Suggested reasons for this included learned helplessness or it being a survival strategy to cope with numerous difficult life experiences.

Therapeutic relationships

Participants described in strong terms the importance of the therapeutic relationship and their perception of the key role that the GP or the healthcare professional has for patients. The feeling was that some of that was to do with the breakdown of traditional family and community supports for many people:

> *'We are the first and the only person for them, their critical friend, the person that goes the extra mile'*
>
> *'You are the major influence, someone that won't let them down'*
>
> *'The GP may be the only trusted individual that a patient may have'*
>
> *'We are left with the communication'* [in the context of a consultant's letter copied to the patient that had confused and frightened them]

Working effectively with patients who disclose a sexual abuse history

This is not specific to areas of high deprivation but the related consequences of relationship, social and addiction problems meant it was of particular importance in Deep End practices.

Homelessness

Homelessness was recognised as a manifestation of health inequalities in an extreme form rather than as a separate set of issues.

Contractual issues

The current GP contractual arrangements do little to address the inverse care law and in some respects may exaggerate it.

Managing prescription drug requests

Prescription drug misuse, especially psychoactive drugs, and managing 'drug seeking behaviour' is particularly challenging in the context of complex multimorbidity.

Managing obesity

Childhood obesity and obesity in young women, with their consequent management challenges, were recognised as major issues.

LEARNING NEEDS

The group was challenged to address the issues described above. How could they be understood and addressed and prioritised as learning needs?

The topic headings described above were written on a white board. The group decided that low engagement, autonomy, health literacy and screening should be considered together and that contractual issues could not be tackled in a CPD context so this was discarded. This left the group with 11 headings. Using a modified nominal group ranking technique, each participant had three votes to indicate which topics should be prioritised. The purpose of the exercise was to decide which topics should provide the focus for a Practice-Based Small Group Learning module (see below), and also what Deep End GPs might wish to focus on for their more general CPD needs.

- Engaging with patients (autonomy/health literacy/screening): 8 votes
- Promoting GP tenacity/realistic optimism: 4 votes
- Drugs and alcohol: 3 votes
- Safeguarding children: 3 votes

- Asylum seekers/ migrant health: 3 votes
- Multimorbidity: 2 votes
- Poverty: 2 votes
- Vulnerable adults: 1 vote
- EBM in unhealthy populations, previous sexual abuse and homelessness received no votes.

The group considered how these might be prioritised, taking into account topic areas where there are currently significant learning resources available (such as safeguarding children and drugs and alcohol) and where the biggest impact could be felt for Deep End practices.

Prioritised learning needs

How to address low patient engagement in health care and increase health literacy

Engagement with choices about health-threatening or health-promoting behaviours requires a degree of health literacy, but this is perceived by practitioners as being low in Deep End settings. There is a need to understand what resources are available, what approaches are effective and how health professionals and teams can best empower and engage patients, families and communities. Practitioners wanted to know how they could structure their services to be more effective e.g. using on-the-day appointments and walk-in options.

How to promote and maintain therapeutic optimism when working in areas of high deprivation

Working with patients in areas of severe health deprivation requires a high degree of emotional work and a tenacious and resilient approach, that can be characterised as the maintenance of therapeutic optimism. Never was the observation more apt that the doctor (or other health professional) is the drug, than when working in this setting. The therapeutic relationship is paramount to engagement and there is a need to understand and implement a range of techniques and resources to support health professionals in this role. Participants also raised concerns of how they can keep their primary health care team healthy and motivated to continue to work in deprived areas.

How to use EBM effectively when working with patients with high levels of multimorbidity and social complexity

Evidence-Based Medicine is largely founded on studies of interventions in patients with a single condition. This is not the reality in areas of high deprivation where multimorbidity is the norm and the onset of chronic conditions occurs at a younger age than in more affluent areas. There is a need to provide tools that will help practitioners working with these populations to interpret and apply meaningful evidence in the context of the individual they are sitting alongside; who may struggle with engagement in health care; who may have low health literacy; and who will often have multiple chronic conditions.

How to effectively meet the health needs of migrants including people seeking asylum and refugees

This learning need is a growing one reflecting the recent fragmentation of primary health care services for the asylum seeking community in Glasgow.

THE ROLE OF PBSGL

Practice-Based Small Group Learning (PBSGL) is a form of Continuing Professional Development (CPD) that originated in Canada, was introduced to Scotland in 2003/2004 and has been 'rolled out' by NHS Education for Scotland (NES) from 2006. From small beginnings, with five groups involving less than 40 members, PBSGL now has over 2000 members including over a third of Scotland's GPs, many from areas of health deprivation, as well as an increasing number of other primary care professionals.

PBSGL has three key components

1. Peer-facilitated small group learning
2. Topic-specific evidence-based educational modules
3. A cohort of trained peer-facilitators

The PBSGL team aims to produce approximately 14 modules per year and has received financial support from NHS Health Scotland to produce module(s) to address the national priority of health inequalities. They approached GPs at the Deep End to help guide this task.

Based on the outcome of the meeting reported in this paper, there is an opportunity in 2014/2015 for the PBSGL team to work collaboratively with others to produce modules on:

1. Addressing low engagement and increasing health literacy
2. Maintaining therapeutic optimism working in areas of high deprivation
3. Multimorbidity

CONCLUSION

This report describes the identified learning needs of GPs working in settings of high deprivation based on a meeting of nine Deep End GPs. The starting point was the issues and concerns they wished to address that would improve general practice care and the health of their patients. Eleven learning needs were identified:

1. Engaging with patients (autonomy/health literacy/screening)
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