

Education and Training in the Deep End

Thursday October 10th 13:00 - 17:00

Cardiff City Stadium



This event was the 5th Deep End Cymru Round Table, where we took a deep dive into a common challenge to come up with some solutions. We have already identified that education and training is a critical issue for recruitment and retention in Deep End practices, which in turn is crucial for practice leadership and sustainability. We know that Deep End practices are more fragile, with double the rate of closures or mergers than other practices. This has an unfair impact on those more deprived communities that they are serving.

Aim: to explore how training and education for primary care staff can better meet the needs of practices serving people living in more deprived areas.

Objectives:

1. Understand how education and training for GPs, clinical staff and administrative staff currently meets the needs of Deep End practices
2. Explore some practical ways to better meet these needs

Speaker: We heard from our keynote speaker, Dr Austin O Carroll, GP in Dublin and founder of the North Dublin City GP Training scheme, which is innovative in that it specifically trains GPs to work in areas of deprivation and with marginalised groups. It also has several innovative elements including a social medicine module; a self-care module that is integral to the curriculum; a Change Management Module; Special Interest Posts for Marginalised Populations; and a Vision and Mission Committee. The scheme was founded in North Dublin in 2009. This is an area with vast tracts of blanket deprivation. We did not record this but you can hear Deep End Cymru GP Dr Jonnie Currie interviewing Austin on his recent [podcast here](#) or more info at [Education NDCGP | healthequity](#)

There were **30** participants, including GPs, Practice Managers, Training Program Directors, representatives from Primary and Community Care Academies, Public Health, medical students, RCGP staff and GP trainees.

We then gathered our views on the challenges and solutions for three groups of primary care team staff: doctors, other clinical staff, and administrative staff.

Key messages

Attracting people to train in deprivation health

The issues:

Deep End staff love working where they do, they feel that they are making a real difference for their patients and communities. However, we felt that this is not recognised and highlighted to anyone seeking to train in Wales. We know that it can be scary at first to work in a Deep End community, and there are negative stereotypes putting trainees off. We believe that many young people are keen to train and work in our communities, but there is little specific encouragement or information, for example in the Train Work Live website.

The ideas:

We suggest that there should be greater emphasis and clear messages about the benefits of working in more deprived communities and with health inclusion groups, that students should be actively recruited from more deprived communities and should be taught about health equity and exposed to primary care and Deep End practices, and that financial incentives be considered in Deep End training sites.

General Practice training

The issues:

We know that trainees are more likely to stay where they train, but there is no systematic approach to allocate trainees to practices where they are most needed or to match trainees with Deep End practices when they have already developed an interest. We are not aware of any specific GP training content in deprivation medicine or inclusion health, as there is elsewhere¹, even though Wales has a significant proportion of its residents living in deprived areas, and significant number of people in health inclusion groups². We are not aware of many opportunities for relevant learning for example in substance misuse, minority ethnic health issues, with homeless services or those for asylum seekers and refugees. If a potential trainee is interested, there is little information, especially for International Medical Graduates who we felt may be highly motivated to work in Deep End. Many have to rely on word of mouth for advice re training scheme locations and content. Deep End practices tend to be smaller, and workload is higher, so taking on trainees is more challenging. Deep End practices in the Valleys may be harder to commute to.

The ideas:

we would like all training schemes to offer content on deprivation medicine and health equity, and ideally have at least one training scheme aimed at those with this interest, as have been set up elsewhere³. We felt that trainees should be asked if they have a preference for deprivation medicine, and that this should be facilitated. We would like to see greater curriculum delivery on self-care in a stressful environment, social medicine, and trauma-informed care. We felt that Deep End practices should be given greater priority when placing trainees, especially if places are reducing from 200 to 160 soon. We would like to support for trainees to be placed in Deep End sites (e.g. help with accommodation and additional transport costs), and support for smaller Deep End practices to become training sites, perhaps sharing and also using Third Sector and other placements. We felt that support for trainees and First5s could be improved, such as mentoring by Deep End GPs, Balint Groups and specific schemes such as the Scottish Deep End [Pioneer scheme](#) and [Trailblazer scheme](#) across England that it inspired.

Clinician Training

The issues:

We felt that many nurses and AHPs knew little about primary care and in particular about deprivation medicine and did not have much exposure in undergraduate training, so are not used to complex Deep End patients, and can feel out of depth. For example, pharmacy foundation placements are purely exam-based, and Deep End areas are not chosen. Deep End practices are not all aware of what's available, such as the Primary and Community Care Academies in each Health Board. Wages can be a challenge, when alternative careers/jobs can pay more. We felt that the Primary Care Model for Wales promoting a more diverse staff team has not worked well for Deep End practices: the complexity of patients means that the team needs relatively more GPs and fewer other staff (when the opposite has happened). We felt that it's hard to be innovative when fire-fighting, that Clusters have the same funding which is equal and therefore inequitable, that roles across Clusters are less attractive to recruits, such as physios and pharmacists, with reduced satisfaction.

The ideas:

We felt that Deep End practices should be formally engaged with the multi-professional training academies, that there should be defined roles for everyone in the primary care team and all should understand each other's roles. The Academies should teach more Deep End relevant content, there should be mentoring and

¹ For example, the Health Equity Focussed Training in each Region in England, e.g. [Health Equity Focussed Training - Severn Primary Care](#)

² Inclusion health can include any population group at the sharp edge of health inequalities. These groups experience stigmatisation, social exclusion, discrimination and experience "severe, overlapping and multiple disadvantages" across their lives, significantly increasing their risk of poor health.

³ The Deprivation Training Program, Manchester. [GM Deprivation GPST Programme | Become a GP in Greater Manchester](#) and [North Dublin City GP Training Scheme](#)

clear career progression. Students should have placements in Deep End and inclusion health services. We wondered if apprenticeships would be helpful.

We felt that there should be a core team of GPs to ensure team management/ supervision and manage complex cases. And that there should be disproportionately greater funding to Deep End practices for training and supervision, and fair salaries/ wages for staff once qualified.

Administrative Staff

The issues:

We felt that pay and conditions were not great, and this led to a high loss of trained staff and low morale at times. Workload is high and can be very stressful and scary, with complex and troubled patients, needing additional staff to manage safely. Many staff are very local, so need to manage expectations from their neighbours, although most are very committed to their communities. There is additional paperwork in Deep End, such as sick notes and welfare benefits forms. Roles are changing and carrying more responsibility, for example care navigators. There is a lack of structured training and education to suit these roles.

The ideas:

More technology to support the role, with suitable training, such as AI, patient booking and managing communications from secondary care. Fair wages and defined job roles, continue to recruit locally and celebrate progression. We felt that administrative staff should be included in messages to the public and media from General Practice, that they are on the patient's side. We felt that there should be additional education from the Primary and Community Academies, with clear structure to support, and debrief/ give sanctuary.

The discussion was rich and voluble, so its not possible to capture everything in this summary.

Resources

- [Home | Train Work Live | Wales](#)
- [HEIW GP Training](#) : Training schemes in Wales
- [Wales Inclusion Health Program for Primary Care: Professional development & training](#)
- [Fairhealth](#) Online health equity training and learning
- [Multi-professional Training and Development Unit for Primary and Community Care](#)
- Primary and Community Care Academies in Health Boards:

Health Board	Primary Care Academy email address/ website
Aneurin Bevan UHB	abb.pccacademy@wales.nhs.uk
Betsi Cadwaladr UHB	BCUHB Academy
Cardiff And Vale UHB	primaryandcommunitycareacademy.cav@wales.nhs.uk
Cwm Taf Morgannwg UHB	ctm.academy@wales.nhs.uk
Swansea Bay UHB	SBU.PCCAcademy@wales.nhs.uk