The Review

The training capacity of general practice revisited: advanced training practices

In 2005 I wrote an article on the training capacity of general practice.¹ The article described the experiences of multiple training at the White House Surgery in Sheffield. This article explores developments in multiple training and what has happened at the White House since then as the Surgery has developed its role as a Multi Professional Learning Organisation (MPLO).

The need for more healthcare workers trained in the community continues to grow. The population is increasing and becoming older² and care is being shifted out into the community. More health professionals will be needed in the future to work in this setting. They are best trained within the community where they learn skills of managing risk and dealing with uncertainty.

This has led the deaneries to set up pilot studies to examine how this increased training can take place. The existing training practice network has been utilised and practices identified to look at this are called Advanced Training Practices (ATPs) or MPLOs.

In the Yorkshire Deanery various pilot sites have been identified and funded to explore these possibilities. We are one them. Some are a consortia of practices. The advantage they have is of size, with the capacity to train large numbers of students. The White House is a small practice with a list size of just below 6000. Its main drawback is capacity, but it has been an established training practice with a tradition of multiprofessional learning for many years so enhancing the quality of the educational experience with a multiprofessional dimension has always been high on the agenda. Its small size also gives it the advantage of rapid decision making and the ability to implement those decisions quickly.

When the project began in July 2009 we were given to tasks by the deanery. The first was to explore the potential for increasing the numbers of health professionals, particularly nurses that could be trained in the community. The second task was to develop multidisciplinary training. The benefits of interprofessional education have been described by Barr *et al*³ and the GMC advocate that health and allied professionals should learn together.⁴ The value of interprofessional education has been evaluated recently by Layzell and Chahal.⁵ The project was to run for 5 years and we were to be funded up to £75k per year. There is an ongoing qualitative evaluation by the Hull/York medical school

and a value for money study by the deanery. The feedback so far from students, trainers, and patients has been very positive.

We are now halfway through the third year and will examine what we have achieved so far in two sections. First we will look at the processes that have been set up and then we will look at the outcomes.

We have employed a salaried doctor to give the medical lead a half day to devote to MPLO work and to give partners time. We paid for our senior district nurse lead to be seconded from the health authority for one day a week initially and more recently for a half day a week for MPLO activity. We have extended our use of healthcare assistants to free up practice nursing time for teaching. Most of our nurses are trained mentors. We have employed an educational administrator.

These changes have meant that the educational activity within the practice has become more coordinated. Everyone has been given the time to teach and not just expected to fit it in as another activity.

We now have four registrars and one foundation doctor, with medical students most of the time. We have increased the number of nursing students we train from one to four at a time. These are mainly conventional undergraduate nurse placements but we also take graduate nurses training to be district nurses and nursing students aiming to go straight into the community. We offer placements to nurse prescribers.

We have a social work student who is jointly placed with the surgery and the local mental health team as well as a pharmacy student whose main placement is with the PCT pharmacy advisor but works with us 1 day a week. We offer observer placements to physiotherapy, midwifery, and emergency practitioner students. They take an active part in the multidisciplinary educational sessions.

We have tried to influence the placement of students in the community by sitting on a university committee. We have joined a local group of research practices so that the learners can develop an insight into the

research potential of primary care.

As well as training clinicians in conjunction with a local college we offer two apprenticeships to local young people taking NVQ qualifications in customer service and office-based skills. They spend 2 to 3 years working in our reception and attend college on a day release basis.

As well as increasing numbers we have developed the multiprofessional aspect of the training. Universities try to do this with formal sessions often based around mock scenarios. These can be difficult to organise and are not always well received. Our method is to embed the learner in a working multiprofessional team. The learner takes on as much real work as their experience allows and they are supervised by their mentors. They experience the modelling of multiprofessional work demonstrated by a fully integrated team. They are expected to attend the weekly multiprofessional team meeting and encouraged to present their work. Here, as well as becoming active team members themselves, they see modelled patterns of respect and cooperative working from more senior team members.

After the team meeting the undergraduate learners then have a formal session of multidisciplinary teaching. This is based around reflections on work done at the practice or discussions that have taken place in the team meeting. This is usually facilitated by an experienced nurse. Sometimes a senior registrar will do this to enable them to develop their own teaching skills. The session is divided in two. The first half looks at work the students have prepared following the previous weeks session while the second half looks at issues that arose in that weeks team meeting. Tasks are identified to research and bring to the following weeks meeting. Thus a rolling programme of work is set up.

Feedback on the sessions is positive. The discussions are focused on real work that is taking place in the practice so students can see its relevance. Participation is expected so the learning is active and hence should be at a deeper level.

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As well as formal teaching, it must be appreciated how much informal learning takes place. The role of the teachers is to facilitate this. Every opportunity is taken to teach across disciplines and to involve learners from different disciplines and encourage interaction. The physical environment and timetables are aimed at encouraging this. We are helped by now having a new purpose-built surgery with teaching facilities included and enough clinical rooms for all the learners. A seminar room where teaching can take place and a library, staff and meeting room where both formal and informal meetings and interaction can occur are also in place.

What is the future for us? We think that the multidisciplinary dimension we have now added enhances the quality of the training we offer. However, we recognise that increasing quality alone will not be enough to justify extra funding. We need to build up the numbers of students that we are influencing.

We hope to develop a role as a central hub practice recruiting other practices to extend their nurse training capacity. We would encourage practice nurses to train as mentors whenever possible. We have already recruited two practices and plan to recruit more. As well as recruiting the practices, we will offer advice and continuing support if needed. These practices will be regarded as spoke practices to our hub. They will be funded by the Strategic Health Authority with money they have saved by reducing funding to the hubs. In this way we would hope to encourage local practices to develop their own training capacity, particularly the capacity to train nurses. We have also developed links with a local school. We work in a very deprived area where there are low levels of expectation of achievement and pupils may not feel that they could become healthcare professionals. We want to do joint work with the schools to raise expectations and show that a career in health care is a real possibility.

There are difficulties ahead. These difficulties are not just for us but apply to professional education in general. The financial situation means cuts are inevitable. We were meant to receive £75k per year for 5 years but in March 2011 our budget was cut by 15%. In January 2012 we were told our budget will be cut further from March 2012 by another 20%. This cut may be extended to 50% in March 2013. Cuts of this magnitude will threaten our continuation in the project. To meet the objectives we were given we have already made changes to the practice structure that are difficult to quickly reverse. We are committed to training but we are an ordinary general practice and educational

activity has to be paid for. If we receive less money from the project then we will have to do less work. What do we not do? Develop the school links we wanted so much to make? Ignore the wider practice community we were trying to influence? Or do less within the practice and let the quality of the multiprofessional training suffer? These dilemmas will be faced throughout the training community.

The £75k we were given seemed generous but the time taken to negotiate and deliver these placements should not be underestimated. The practice also receives trainer's grants for the doctors and medical students but no funds for the other learners. If this idea is to be rolled out to other general practices then it will have to be funded. A tariff and levy system would seem to be the obvious answer but will the funding be available to match that which comes with registrars and medical students? It's not easy to see where adequate funding will come from but without a significant student tariff it is difficult to see how general practices will be able to give that most expensive commodity, doctor, and nurse time that is needed to make this work. If the nursing student is mentored by a practice nurse then it is easy and fair for the tariff to be paid to the practice. If the district nursing team are involved in mentoring the extra nurses trained in the spoke practices then who receives the tariff payment? Concerns are raised that extra payments may be made when allowances are already made in nursing budgets for training purposes; double payment. These are very real issues that are still being discussed.

Changes proposed in the Health and Social Care Bill are being implemented before there is even a guarantee that it will be passed. Chaos threatens. PCTs and strategic health authorities will go. Who will employ deanery staff? Who will take the long-term view of training needs? Purchasers and providers will be identified. Contracts will be drawn up and quality will be stated to be an important factor. Experience with clinical services does not provide a great deal to be optimistic about. With limited funds and a purchaser provider attitude, how many clinical services have we seen been given to organisations who claim that although their bid is more expensive they should be given the contract because the quality of what they offer is better?! The contract goes to the lowest bidder who then has to struggle to maintain quality with an insufficient budget. We have educational facilities built into our new practice building because of generous deanery grants. Will they continue? The Department of Health intends to reduce its role in overseeing education and training.⁶

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The risks as well as the opportunities of these reforms for education have been described by Professor Howe.⁷

We are exploring the potential of multidisciplinary training because of farsighted policies concerning the training needs of community health professions for the future. Who will take these decisions and provide this funding in a system driven by cost alone?

Opportunities and challenges lie ahead. The financial position will be challenging but the potential for training workers in general practice for the health service of the future is there. It does require however, effort, money, and planning to be developed for the benefit of the NHS and its patients.

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