Academy of Medical Royal Colleges Wales’ response to Enhanced GP Training

April 2014

AMRCW POSITION

1. Recommends that WG facilitates the introduction of enhanced GP training over 4 years in order to improve the quality of GP provision.
   a. WG takes the initiative and appoints a working party to help implementation.

2. The enhanced training should include more experience of unscheduled care and emergency care plus management of multiple morbidity and mental health.

3. That consideration should be given towards the concept and training requirements for Community physicians. Such individuals might be developed from general physicians or general practitioners.

4. That length of training in General practice be the same throughout UK

BACKGROUND

1. 4 year training proposed by RCGP
   a. To support skill and knowledge acquisition of GPs in training to meet the needs of an ageing population with complex multiple morbidity.
   b. Additional training to improve efficient use of diagnostics and the quality of workup of referred patients and increase consultants confidence in returning patients to primary care allowing specialists to spend more time in assessing complex problems and planning management.

2. The proposal is supported by all Colleges through AMRC-UK, COPMED, CMO, HEE and their equivalents in Scotland and NI

3. The Secretary of state Health-England anticipates
   a. training 50/50 GP/Hospital consultants - currently 40/60

4. RCGP have stated
   a. They do not envisage additional hospital posts with extra year.
   b. No clear curriculum from RCGP but greater integration with social care and preparedness to pilot initiatives.
   c. Areas of current deficiency in training or need additional experience
      i. Emergency care
ii. Paediatrics
iii. Complexity/old age
iv. Mental health

OPPORTUNITIES for Wales

1. Develop a training programme that anticipates future working relationships with secondary care
   a. Closer alignment of ED/A+E/OOHs GP
   b. Consider these areas “acute general practise”
2. Identify current overlapping responsibilities
   a. Emergency Departments
      i. Part of 4th year in ED depts.
   b. Hospital at Home—virtual ward
      i. Part of 4th year with outreach physicians
3. Well organised 4 year training may improve applications for and retention of trainees in Wales.

DIFFICULTIES

1. FUNDING
   a. Assume cost neutral- training or service money moves from hospital to GP
      i. Reduce speciality trainee numbers-Which ones? How many?
         1. Not supported by any College (except RCGP!)
      ii. Reduce secondary care services-transfer to GP eg
         1. Post op care-clarify pathways.
         2. Earlier discharge-already creating problems in GP
         3. Manage more complexity in community
      iii. GP budget funds the extra year
         1. Acknowledge that the 4th year trainee will provide service
         2. Streamline supervision work
2. CAPACITY Insufficient GP training facilities--capacity/estate
3. SHORTAGE Loss of a cohort year of qualified GPs

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### Appendices

**Supporting information**

<table>
<thead>
<tr>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Collated views from Wales Academy members on enhanced GP training in Wales</td>
<td>4</td>
</tr>
<tr>
<td>RC Paediatrics and Child Health</td>
<td>4</td>
</tr>
<tr>
<td>RC Physicians</td>
<td>4</td>
</tr>
<tr>
<td>RC Psychiatrists</td>
<td>4</td>
</tr>
<tr>
<td>RC Surgeons</td>
<td>5</td>
</tr>
<tr>
<td>RC Anaesthetics</td>
<td>5</td>
</tr>
<tr>
<td>RC Obstetricians and Gynaecologists</td>
<td>5</td>
</tr>
<tr>
<td>B) RCGP overview of the Four-Year Integrated Training Programme</td>
<td>6</td>
</tr>
<tr>
<td>C) Wales Deanery. Enhanced GP Training : discussion paper for AMRCW</td>
<td>8</td>
</tr>
<tr>
<td>D) Wales Deanery. GP Recruitment, retention, clinical roles, sustainability.</td>
<td>13</td>
</tr>
</tbody>
</table>
A) Collated views from Wales Academy members on enhanced GP training in Wales.

December 2013 – April 2014

RC Paediatrics and Child Health

- Most, but not all GP trainees spend some time in paediatrics. If extending the time would mean more or the same number of trainees, then it would be seen as very acceptable.

- If (suspect unlikely) this would reduce the numbers of GP trainees in paeds, then we would not be supportive.

- Gp trainees are a valuable source of junior doctors for us, and they both contribute to paediatric services and training as well as benefit for their own future careers, it would be a shame if this was lost

RC Physicians

- The RCP believes that a four year training programme for GPs could be a positive development, provided that there is no reduction in hospital posts, in particular at the core medical training level, to fund it.

- We know that the fourth year of training provides a greater service response, especially for out-of-hours acute care in the community, and currently, there is some evidence that GP trainees have limited out-of-hours, and less experience in NHS service delivery while training. For example, we would support a focus on training for GPs in chronic disease management, especially in diabetes, rheumatology, care of the elderly and acutely ill patients. Finally, the programme should not effectively become five years by using Broad Based Training (BBT) as an entry point.

- The RCP would therefore welcome a Wales-wide assessment of the time spent in service delivery versus training in both hospitals and GP placements. We know that Wales has had specific problems recruiting to the core medical training programme in the past. With that in mind, we would welcome an assessment of the need for both hospital and GP trainee numbers, as anything that makes GP training ‘more attractive’ in Wales could be to the detriment of hospital training, and this should be taken into account when making the decision.

- The RCP feels that trainee GPs should spend more time in hospital, particularly in the specialties of acute medicine and care of the elderly. In order to reduce hospital admissions, we will need more doctors, including GPs, to work directly with patients in the community, and we believe that GP trainees would therefore benefit from this
extra experience. It is also crucial that we see no further reduction in CMT posts. There are currently too few CMTs to fill the current ST3 and LAT medicine posts, and we cannot afford any further loss of training posts in medicine.

RC Psychiatrists

- Assuming some flexibility, increasing GP training from 3 years to 4 years may benefit psychiatry as long as more GPs will have an opportunity to do psychiatry placement.
- There should be an assurance that current Psychiatry training posts are not going to be fore-fitted for the new GP post or that funding will be moved from established posts in psychiatry to use for the proposed GP posts. Money to fund these posts should be sourced from other parts of the Deanery and possibly 50% funded by LHBs.
- Noted that as long as there are considerations to the above, there is general enthusiasm from psychiatry to this proposal.

RC Surgeons

- Relatively few of our trainees except for the very junior…..F1 doctors and a few of the F2 go into general practice.
- The surgical view point is that few GPs have had much exposure to the acute abdomen and other surgical emergencies.
- If GP training was going to increase we would welcome a little more exposure particularly to surgical emergencies.

RC Anaesthetics

- With regard to anaesthetics the devil will be in the detail in what knock-on effect recruitment of any additional GP posts has on the number of training posts remaining in anaesthetics / critical care. If there were to be no reduction in anaesthetic trainee numbers then there is unlikely to be a major effect on our speciality.
- If however the additional GP trainee numbers come from anaesthetic trainee numbers then clearly there would be an effect which is fairly obvious.
- If trainee numbers were reduced then we may struggle to train adequate numbers of staff to recruit to consultant posts.
- In addition anaesthetic trainees do provide a significant service element to rotas in most hospitals covering areas such as critical care and obstetric anaesthesia as well as emergency surgery.
- Several hospitals already struggle to find sufficient staff numbers to fill all these rotas and already rely on agency staff and overseas doctors. This situation would only get worse and would be compounded with Deanery drives to move to 1 in 11 rotas.
RC Obstetricians and Gynaecologists

- Do not anticipate any problems or threats to the current training.
- The general issue would be if the funding for secondary care was reduced as a result.

B) RCGP overview of the Four-Year Integrated Training Programme.
Paul Myres. Chair of RCGP Wales. March 2014

With the support won for its educational arguments for enhancing GP training, the RCGP has worked with a range of partner organisations with representation from all four UK nations, including COGPED, Deaneries, COPMeD, BMA (GPC), GMC, and other stakeholder groups, as well as trainee, lay and patient representatives, to develop a detailed proposal for an enhanced four-year programme (FTE) of GP specialty training that will:

- Deliver a workforce of highly skilled general practitioners with a greater fitness for purpose, equipped with the capabilities, skills and adaptability to meet the changing needs of the NHS
- Add significant value for trainees, patients and the service in all four nations, through enhanced training, improved health outcomes and increased quality and safety of care; and
- Enable doctors to make an effective transition to independent and multi-professional practice, self-directed continuing professional development and revalidation-readiness.

Specifically, the proposal sets out that future GPs will complete an integrated four-year enhanced curriculum, assessment and quality improvement programme, where they will:

- **All** receive specialist-led training opportunities in child health and mental health problems (Less than 50% of GP trainees currently undertake placements in these specialties)
- Spend at least 24 months (FTE) of their training programme in general practice-based settings – to learn how to manage an aging population of complex patients, with multiple morbidities, in their communities and homes (Fig. 1)
- Undertake more integrated training placements, consisting of combined general practice-based and specialist service-based experience, based in a range of relevant settings according to local circumstances
- Gain experience of general practice early in training, to improve the educational effectiveness of subsequent specialty-based training placements
- Successfully complete the summative Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA) components of the MRCGP before progression to the fourth training year
• Complete a structured Quality Improvement Programme in the fourth training year, involving supervised project work that will directly improve NHS services in their local communities
• Undertake workplace-based assessments with a formative focus throughout the programme, including in the fourth year, by developing the supervised learning event (SLE) model
• Have greater flexibility to incorporate research training and to change career pathways in response to workforce needs, with more options to tailor their training for their own learning needs and local circumstances; and
• Become effectively prepared to transition into a career of independent practice, self-directed professional development and revalidation.

Figure 1: The RCGP’s educational case for enhanced GP training

For full details on the educational objectives, training methods and assessment strategies proposed for the extended GP specialty training period, please see the RCGP’s full Educational Case.

www.rcgp.org.uk/gp_training/reviewing_specialty_training.aspx
C) Wales Deanery. Enhanced GP Training: discussion paper for Academy of Medical Royal Colleges Wales.

Professor Malcolm Lewis, Wales Deanery. March 2014

This paper outlines some key issues in relation to the implementation of a 4-year training programme for General Practice in Wales. We cannot consider extension of GP training in isolation and must also be mindful of Welsh and UK issues relating to the future GP workforce.

Background.

Over the past 6 years the RCGP has been working with COGPED (UK Postgraduate GP Education Directors) and others to develop a new curriculum for GP training that recognises future patient needs, demographic changes and the requirement for an enhanced GP training programme fit for future purpose. The proposals have been accepted by the UK Scrutiny Group as having demonstrated the educational case. Furthermore, a final recommendation paper to the Scrutiny Group was accepted by the UK Scrutiny Group in November 2013. It included the following recommendations:

I. The Medical Education UK Scrutiny Group support the Steering Group’s commitment to modifying GP training to ensure future patient and service needs are met.

II. In moving forward, collaborative working across the UK is essential to ensure consistency of standards, whilst recognising that diverging models of care delivery should reflect variety of application to reflect national, regional and local drivers.

III. Publication of the Shape of Training report and wider reviews of Primary Care services require a broad perspective is taken, and changes to GP training should not be decided in isolation.

IV. Momentum should not be lost and the opportunities to modify GP training should not be delayed. Consequently the four UK Health Departments response to Shape
should include a commitment to consider proposals for GP training as an early deliverable within any plans consequent upon the Shape recommendations.

V. Opportunities to support these changes should be sought within the overall changes that Shape might drive across all specialties, funded by redistribution within the overall training financial envelope.

The Academy will be aware of the Shape of Training Review of Professor David Greenaway (published in October 2013)\textsuperscript{ii}. The review suggests significant changes to specialty training including a resurgence of generalism, not exclusively in GP but in all specialties. This provides opportunities for different models of care and raises the question ‘do we have the right type of doctor/nurse in the right place for patient care?’ There is a potential to work collaboratively to develop curricula for training programmes and for credentialing that better reflect patient and service needs.

The report of the Bevan Commission on Primary Care was submitted to the Minister in December 2013 (this is referenced in the attached ‘paper to Welsh Academic Board’).

We must also be mindful of the situation in England. The attached final edit of the NHS England GP Taskforce report is to be received in confidence and not for wider distribution. The report will go to Health Education England for consideration. For the purposes of the Academy meeting, the pages 5-11 are of most interest. We do not have this level of workforce intelligence in Wales, but the other attached paper on GP workforce gives a comparison with England and a reflection on the scale of our difficulties here. Expansion of English training numbers will not help our recruitment situation. This paper was written for one of the LHB chairs and suggests some ‘left field’ alternative pathways to community medical training and the potential for a new ‘community physician’.

The Academy has additionally posed the following questions:

- The impact of the 4 year programme from a Deanery perspective on GPs and all other training programmes.
We believe that we have the capacity in terms of numbers of trainers and training practices in Wales to deliver the enhanced programme. However, the current one-to-one trainer/trainee relationship would have to be sacrificed to some extent in order to deliver the whole package.

If the change has to be cost neutral, there are various ways of addressing this:

1. Reduce the number of GP trainees in post to around 105/year
2. Reduce the number of trainees in other specialties
3. A combination of the above
4. Find the money from other Welsh Government budgets

It is clear at a glance that none of the above are wholly, if at all acceptable. The UK Steering Group paper suggests some alternatives. In Wales we anticipate the annual gross cost without considering any offsets to be of the order of £10-12 million.

There is a possibility that some training programmes will be shorter subject to removing sub-specialty elements under Shape of Training.

- **Are there any recruitment issues and what will the impact of these issues be?**

There are recruitment issues in GP on a UK wide basis (see attached papers). One key issue in Wales is that we only have GP attachments in 22% of foundation programmes, compared with an average of over 50% in England. There is good evidence that high rates of foundation exposure increases recruitment to GP training.

It is unlikely that extension to a 4-year programme would have a negative effect on GP recruitment. The RCGP’s trainee representative and the First Five Group (those within five years of obtaining a CCT) are supportive, as is the BMA’s Junior Doctor Committee and their GP representatives.

- **Is the Deanery planning specifically for the 4th year?**

We do not yet have a written format for the programme but the underlying principle should be that the additional time should be spent in addressing the new spiral
curriculum. The added value will come from a programme that is sensitive to the needs of the trainee but at the same time can reflect service needs. We have suggested in the past that using a hub-and-spoke arrangement could enhance the experience of trainees in areas where there are fewer training practices and where the inverse care law predominates. Some time spent in such non-training practices, particularly if tied to the final year project could be of value to trainees, to the ‘spoke’ practice and potentially to future recruitment.

Trainees might identify areas of specialty practice where they have had little exposure. Arranging time in either out-patient or acute attachments could address this deficit. In essence, the final year should have a bespoke feel with a potentially varied experience in the structure of the week, month and year.

- **For the 4th year, what proportion of that time will be spent in the hospital based setting? Community based setting?**

  See above. It is worth adding that there will be an expectation that acute paediatrics will be a component part of each programme, although probably in advance of the final year. Elderly care (medicine) and mental health also featured heavily in the presentation of the educational case.

  At the outset we must recognise and agree that filling on-call rotas is not the primary purpose of GP specialty training, regardless of the duration of the programme. There is a tendency for all specialties to make the case for time spent in their domain. If we add time for all specialties and ***ologies we will very quickly be looking at a 10-year programme. The time most valued by trainees during the current three year training programme is that spent in GP; we must rely on a large chunk of the GP curriculum being delivered in GP, by GP trainers.

- **Do you have any information on workforce modelling? Do you require a minimum number of trainees to run the programme?**

  The model will be similar to the current set up but will obviously require an extended training faculty. The final year should not present any structural difficulties to either large or smaller local schemes. Of more impact might be the wider reconfiguration of
NHS services in secondary care. Through Dr Phil Matthews, Deputy Director and Head of GPST School, we are closely monitoring the potential impact of reconfiguration on hospital based elements of GP training in relation to the current and any future extended models.

- **How will the gap between the 3 and 4 year programmes be managed? Do you perceive this transition to be a problem?**

I should first describe transition. Entry to the programme will be ‘big-bang’ which means that from (for example) August 2015 entry, there will only be an option for the 4 year programme and the new curriculum and assessments. At that time, those entering ST2 will be the last cohort on the old programme. Most of those will qualify with CCT in August 2017. Those entering ST1 in August 2015 will achieve the 4-year CCT in August 2019.

There appears to be a significant transition gap in August 2018. This is less of a problem that it might first seem. Although the impression is of having a year when no GPs qualify in a particular August, there are factors that significantly negate this.

The failure rate of the final year assessments leads to extensions in training for around 15% of trainees. At any time approximately a further 15% will be on maternity leave. There is also a small percentage of out-of-programme activity. These all contribute to a reasonable amount of flux, such that there will be GPs qualifying during the transition phase, albeit fewer than usual. Advanced warning and awareness of the actual figures

- **The general consensus amongst all Royal Colleges in Wales is that they are in favour of the 4 year programme, but they wish to know the impact on their respective training programmes. Does the Deanery anticipate any training slots being removed from some specialities?**

See above. With reference to the attached documents, it is important that enhanced GP training takes place in a planned and coordinated way that reflects policy
direction of NHS Wales. The context of the service in general, the Greenaway Review and the recommendations of the Bevan Commission report need to be factored into any implementation plans. None of this should happen in isolation.

Professor Malcolm Lewis, Wales Deanery. March 2014

D) Wales Deanery. GP Recruitment, retention, clinical roles, sustainability.

Professor Malcolm Lewis. Wales Deanery. February 2014

GP Workforce England.

The English LETBs are planning to increase the number of GP trainees going through programmes from 2800 to 3200, starting in 2012-13. In 2004 the target number was around 2300-2400. The increase is substantial and is likely to threaten recruitment to Wales.

GP workforce in Wales.

1. If mapped on Barnett formula or populations to England, the number of trainees entering GP training in Wales should amount to 190-200. The funding available relates to 136/year, but a large element is spent on less than full time training, maternity leave and extensions due to failing end-point assessments. In reality GP trainee recruitment to Wales’s training programmes has fallen short by over 100 in the past 5 years.

2. In the current recruitment environment, it is difficult to identify specialties that can manage a significant reduction in training numbers in order to increase the numbers training for general practice.

3. Reduction, for example in core training for paediatrics, medicine, psychiatry would lead to difficulty in LHBs when covering rotas in these specialties.
4. The popularity of GP as a specialty of choice is plummeting with a reduction across the UK of 15% (12.8% in Wales) in numbers of applicants to this year’s recruitment round. So in the current climate we could not possibly attract many more quality candidates to GP even if these were funded by WG.

5. Following from the above, there are several questions that relate to creating a sustainable model of primary care.

Some ideas.

1. ML presented a paper to the Wales Academic Board on GP training, encompassing a blend of the Bevan Commission Review of Primary Care, the Greenaway review of Medical Training, and the proposals for extending/enhancing GP training. After questions from the Board, Baroness Finlay concluded that a working group be set up to take these issues forward. We have not heard on how this is moving forward.

2. Consideration might be given to
   a. Increasing the number of salaried GPs in Wales under direct employment of LHBs. A unified contract could be developed based upon the consultant contract. The job description and terms and conditions would be negotiable, but the incumbents might work to a different model to the current GMS contract, e.g. more like the current consultant model.

   b. Developing a curriculum and assessment programme for a CCT in a new specialty. Experience locally (ABMU and elsewhere) has shown a significant reduction in admissions to hospital beds by employing senior and experienced GPs to work part of their week at the front door of hospital (GP Assessment units). This could be further developed to create a new specialty of doctors, if this suits service needs and appeals to professional aspirations).
The new ‘community physician’ could be a hybrid between a GP and part of a current hospital specialty (in the general rather than sub-specialty sense) e.g. GP/paeds, GP/A+E, GP/psych etc. They would work under a consultant contract, maybe called consultant community physicians.

In the GP setting they would do much the same work as GPs currently, but probably less of the mundane walk-in work, perhaps having ‘second sight’ after appropriately trained nurse practitioners. They would split the week between this environment and front door hospital work in any of the specialties listed (or indeed others). This could be a very fulfilling role for clinicians but also could do a lot for the integration agenda. It could bridge the dangerous and expensive gap between community and hospital practice – a gap that is growing rapidly despite the intended integration.

The function of writing a curriculum and assessment process for a training programme is traditionally the role of the various Royal Medical Royal Colleges or Faculties, but this role is not confined in law as the exclusive domain of these organisations. For example, NHS Wales, perhaps in conjunction with our universities could describe a curriculum and training programme of a specialty that we feels suits the needs of our patients and NHS.

c. Engage with others to better coordinate the development and career structure of practice nurses and nurse practitioners. Some joint RCGP and RCN work is progressing on this at present but currently informal. RCGP Wales is particularly keen to be involved as are the UK Directors of GP Postgraduate Education (COGPED). Development of practice-based nurse practitioners would be an essential component of a primary care efficiency plan. Although some research has demonstrated that NPs can be more expensive than GPs (higher referral/investigation and prescribing costs),
these data relate to relatively inexperienced nurses in short studies. Any or all of these can be improved with experience and supervision/CPD.

Prescribing.

d. In addressing the need for consistency of quality prescribing, consideration should be given to the development of a single formulary for GPs in ABMU (or preferably in Wales). There is no logical or sustainable argument for the wide variations seen in prescribing patterns between practices of similar size and demography. To succeed, such a formulary should not be undermined by loss-leader prescribing in the secondary sector. Same, efficient and conservative prescribing would be the underlying principles.

http://www.shapeoftraining.co.uk/reviewssofar/1788.asp