GP TRAINING PLACEMENT EXPANSION FELLOWSHIP THAMES VALLEY : DR SARAH AVERY

AIM

Increase practice training placements for GP registrars in Thames Valley to meet anticipated increase in training placement requirements

OBJECTIVES

1. Increase training placements within existing training model
2. Explore new training models
    a. Use urgent care and out of hours GP services
    b. Create hub-and-spoke model within PCNs
3. Focus training placement expansions in areas of greater deprivation to reduce health inequalities

NARRATIVE

1. INCREASE TRAINING PLACEMENTS WITHIN EXISTING TRAINING MODEL

Worked with all GP training programmes across Thames Valley and used PHE data to create spreadsheet detailing every practice, list size, deprivation score, PCN, ICB, training programme, number of trainers and FTE trainee capacity.

This spreadsheet can now be used to more easily identify which training practices have room for additional trainee capacity now, and which practices have appropriate support and capacity to offer significant benefit if supported to become a training practice.

2. EXPLORE NEW TRAINING MODELS

a. USE URGENT CARE AND OUT OF HOURS GP SERVICES

My main role is as Clinical Lead for an Urgent Care and Out of Hours GP Provider. We host GP trainees for their out of hours component of training, but with recent changes in Primary Care provision we now offer significantly more in hours urgent primary care. I believe this could provide an excellent training environment for GP trainees and create additional capacity.

I liaised with my counterparts across Thames Valley and there was high level of support across the region to support GP training through hosting GP trainees within urgent care services.

CHALLENGES

Whilst there is clear guidance from GMC on GP training requirements, the interpretation of this guidance was not always as clear. Furthermore, there were limited opportunities to get clarity with sometimes only quarterly meetings within HEE/NHSE TV where this could be discussed and several iterations and meetings required to get this over the line. Despite some frustration with this, I continued to persist with these discussions and meetings after the completion of my fellowship time to get the approval required and am delighted to now have a pilot programme planned in Bucks, which should it be

successful should be scalable within the county and across Thames Valley and could support a significant increase in GP training placements. My fellowship mentor will continue to support and review the pilot programme. See attached proposal.

b. CREATE HUB-AND-SPOKE WITHIN PCNS

Working with a small group of HEE/NHSE team, brainstormed and explored different training models. With proposals to move away from training practices and create PCN level learning environments, we agreed to pursue a hub-and-spoke model within PCNs. In this model, an experienced Educational Supervisor would be based in a training Hub practice and support trainees in practices across the PCN, completing their clinical placement in non-training practices. See attached latest proposal for this model.

CHALLENGES

Similar challenges as already discussed regards clarity on GMC guidance and opportunities to discuss/challenge/approve these.

Further challenges included very significant changes with HEE changing to NHSE during this fellowship programme as well as the release of the NHS long term workforce plan. The impact of both of these was a loss of focus from the working group and wider team. This is of course very understandable but nevertheless frustrated the process during a short one year fellowship programme.

We were unable to get any data or forecasts to understand the size of the problem currently or the predicted shortfall in the future. Not fully understanding the problem made it much more challenging to try to find the right solutions. The release of the long term workforce plan did help to quantify the needs, though added further greater challenge as its clear that there will need to be very significant changes to the current training model for GP training, requiring change in GMC requirements, to facilitate training the proposed numbers of GPs in the future. Any models proposed now can only be a bridge to these more significant future changes.

3. FOCUS TRANIING PLACEMENT EXPANSIONS IN AREAS OF GREATER DEPRIVATION TO REDUCE HEALTH INEQUALITIES

Practices in areas of greater deprivation experience more challenges with staff recruitment and retention. Increased list sizes per doctor and higher staff turnover with reduced continuity impact health inequalities. Training practices experience a boost in staff recruitment and retention.

The practice spreadsheet included deprivation scores specifically so this could be used to focus efforts in increasing training placements in areas where improved recruitment and retention could help reduce health inequalities.

Whilst this has not yet been actioned, the data is now available to support this.

REFLECTIONS

At the end of the 12 month fellowship, we had not created one additional training placement. This was very disappointing and frustrating given the work that had gone into trying to make positive change.

Through persistence after the end of the fellowship, I do have a pilot programme agreed with a local practice and supported by the School, which has certainly lessened the disappointment and I look forward to starting this soon (hopefully from February 2024).

However, this disappointment has been excellent ground for reflection!

I think I, and perhaps my mentor too, were overly ambitious in our objectives for a 3 days a month one year fellowship. Whilst I might advise future fellows to hone a small, discrete project to avoid such frustrations, perhaps big changes need big ideas and having the opportunity to make the first dent in a project that others can carry on after you is of greater benefit long term and outweighs the individual satisfaction of a neatly completed project with limited reach?

Working in a team also brought some challenges, as well as the obvious benefits. I greatly appreciated the time, support and advice of my team members and I know they contributed significantly to the learning I gained from this experience. There were certainly significant benefits from shared experience and collaboration for brainstorming and problem solving, but as the project went on, with all team members having other roles for most of their working week, it could be difficult to arrange meetings and so on. The logistics around reaching consensus delayed decision making and with similar barriers to progress reaching HEE approval, 12 months disappeared quickly. Had there not been significant upheaval in HEE during this year perhaps we would have found it easier to move things forwards as a team. I realise now too that 12 months is probably a very short time in health education policy making timescales and perhaps this is a key lesson learned.

The monthly CPD sessions were always a joy. My peers were all interested, interesting, motivated, optimistic and creative and spending time together, even virtually, was always a boost. My small group offered each other fantastic support, coaching and advice throughout – not just for our fellowship projects but with life and career, benefiting from my group's many decades of collective experience as GPs. I am very grateful to you all.

CONCLUSION

Whilst I failed to achieve my primary aim of increasing GP training placements within the 12 month programme, I found the experience of the fellowship, not least the challenges and disappointments, were hugely beneficial to my own personal development. It gave space in the working week to think creatively and an opportunity to network with and learn from a hugely talented and supportive group of peers. My fellowship turned out to be much more about the journey than the destination, and as a frankly rather goal orientated individual, that was a great lesson to learn.

I would like to thank everyone involved in this fellowship for their time, effort, support and this opportunity.