TITLE OF PROPOSAL:

Maximising GP trainee Throughput

BUSINESS CASE DOCUMENT

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Purpose of Document

The Business Case is used to document the justification for undertaking the project, based on estimated costs against the anticipated benefits to be gained and offset by any associated risks. It should outline how and when the anticipated benefits can be measured.

1 Executive Summary

Purpose

1.1 The number of General Practitioner (GP) trainees recruited in Wales has increased from 136 prior to August 2019 to a minimum of 160 per year thereafter, with permission to recruit up to 200 per year if candidates are appointable. Clear evidence linking assessment scores from the national recruitment process to the likelihood of completing GP training within the prescribed three years was published in April 2022[1]. This evidence shows that the additional trainees recruited since the expansion in numbers in 2019 are working to a standard where they are highly likely to achieve their license for independent practice but may require between one and three extensions to training of six months each to do so. These extensions need to be undertaken in GP posts.

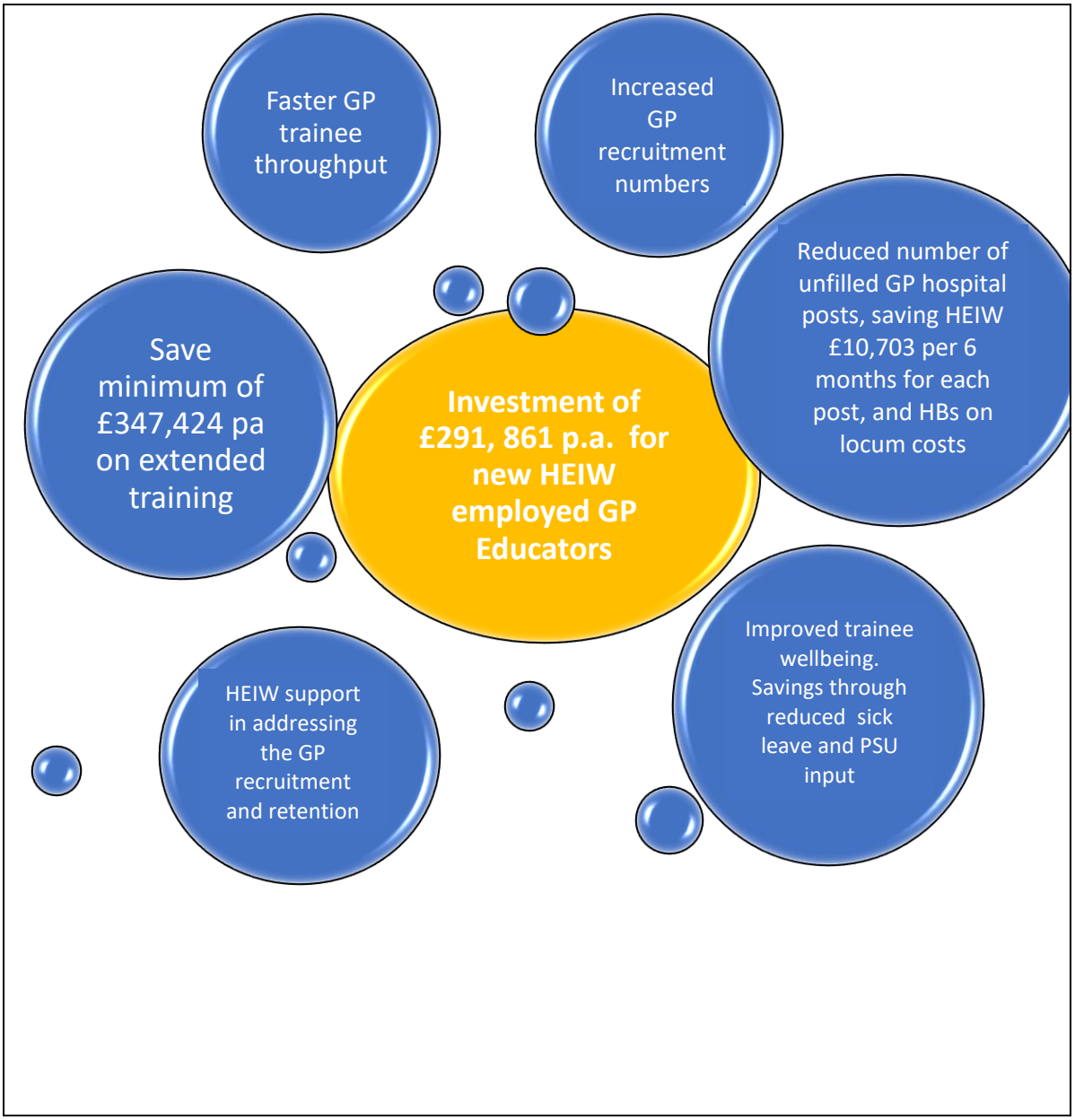
1.2 The large increase in the numbers of extensions to training already being observed are filling GP training placements, hence limiting the number of GP trainees we can continue to recruit. A further consequence of this is that recruiting less GP trainees leaves GP-aligned hospital placements unfilled, so Health Boards (HBs) need to rely on costly locum doctors, and HEIW effectively lose their 50% contribution to the post cost.

1.3 This proposal is to recruit more GP Educators with a specific remit to undertake additional and bespoke training with the group identified by the evidence as being most at risk of having a complicated training journey whereby failing examinations and periods of extended training are almost inevitable. This bespoke training would be in addition to the normal offering. It can be demonstrated that this supplementary intervention work will reduce the number of trainees requiring extended training, hence increasing GP trainee throughput and maximising recruitment numbers. The amount invested in the new staff will result in an overall cost saving of at least £347,424. The new educators will use evidence-based educational interventions which will reduce the numbers of extensions to training required by a third.

1.4 Reviewing evidence from similar intervention programmes around the UK, which were supported by Health Education England to the tune of around £4.5 million, the intervention would need to save seven extensions to training of six-month each to represent an overall cost saving. Training extensions are awarded as per the Gold Guide to Postgraduate Training[2]. They are given in blocks of six months, and each trainee can have up to three in total. The evidence suggests that the intervention proposed should reduce extensions to training by 33%. We expect a minimum of 45 extensions to training per year, so to reduce that to 30 would save £639,285 annually. The cost of the intervention would be £291,861, representing an overall saving to the GP training budget of £347,424. The faster throughput will also enable more trainees to be recruited annually, up to the maximum of 200 per year, which will also ensure our GP-aligned hospital posts are largely occupied. Most importantly, there will be an increase in the number of newly qualified GPs available to work in Wales.

1.5 It is recognised that this is a significant investment for HEIW and that this intervention is not a defined deliverable within the current IMPT. The evidence which shows the 30% of our 2022 intake of trainees will not progress smoothly through training was published in April 2022. This proportion is a massive increase on the numbers not progressing smoothly previously, so we are compelled to review our current level of support and intervene with a new initiative on an urgent basis. This intervention is an opportunity to 'spend to save'; investing in new HEIW staff to reduce the projected overspend on the GP training salary budget. The evidence contained within this business case clearly demonstrates that in addition to saving money overall, this intervention will increase the number of GP trainees recruited annually, maintain GP trainee presence in our GP-aligned hospital posts (saving on HB locum budgets and reducing unutilised trainee grade salary budget), and improve trainee morale and wellbeing.

1.6 General Practice is the first specialty to produce clear and robust evidence which identifies the group requiring early, targeted support. Inevitably, similar evidence will emerge for other postgraduate specialty training programmes and those programmes will be able to review the evidence of benefit from the GP interventions and create similar targeted support opportunities for those trainees. The Medical Deanery at HEIW would therefore consider this intervention for GP trainees as a pilot which will inform the strategy to support Foundation and Secondary Care trainees as evidence emerges to define their respective target groups.



Link to the strategic priorities?

Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'.
1.7: Lead, develop and embed a range of actions to support workforce and workplace wellbeing and colleague experience.

In Wales around 30% our newly recruited GP trainees are expected to have a complicated training journey, to include failed mandatory examinations and extensions to training. This has a significant and detrimental impact on the wellbeing and motivation of these highly trained, intelligent, and dedicated doctors. Postgraduate trainees have commonly never experienced failure in the past and can have an exaggerated negative response to a perceived failure, which can further adversely impact progression through training. Introducing early enhanced training will prevent detrimental events on the training journey and hence improve wellbeing. The close supportive relationship of the Programme Director with a group of just eight trainees for a monthly group session, plus separate monthly individual mentoring sessions will also improve wellbeing and motivation and

reduce the need for a proportion of the trainees to require individual support from the Professional Support Unit. The most effective teams have the best patient outcomes. Individuals needs to be able to work at their best to contribute to an effective team.

Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.
2.6: Lead and promote a reduction in differential attainment in education and training in line with the Strategic Equality Plan**.**

Around 85-90% the doctors in the group identified for additional training graduated overseas. Independent of the score at recruitment overseas graduates have a negative attainment gap compared to their UK graduate colleagues in postgraduate medical training. The reasons for this attainment deficit are multifactorial and complex, but the evidence suggests that to reduce the attainment gap this group will need additional support and resource, to ensure equity with their UK colleagues. A key part of the resource required is a close supportive relationship with an educator who understands the root causes of differential attainment and has open and honest individual and group sessions where the reasons for the attainment gap are shared and addressed. It is important to understand that the target group is those trainees scoring less than 480 at the MSRA so will also include the UK graduates who are likely to have a complicated journey. This proposal will help reduce the attainment gap for those overseas graduates who would otherwise have a complicated training journey by addressing the root causes of differential attainment and implementing evidence-based strategies for improving training outcomes.

Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
3.1: Lead, embed and evaluate the value chain and impact of the Health and Care Leadership Strategy across NHS Wales.

The Programme Directors and Associate Dean(s) who lead this intervention will become leaders within the Medical Deanery to support postgraduate trainees to have less complicated training journeys. They will have as part of their remit a requirement to share resources with our training community. They will disseminate training to our community on compassionate leadership and supporting individuals within the workplace to flourish and achieve their potential. In turn this will create an ongoing chain of positive role modelling within the NHS. As similar data emerges from other postgraduate specialty training programmes our team delivering this pilot for the Medical Deanery will support colleagues in delivering similar programmes of support.

Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.
4.1: Support the development and implementation of multi-professional workforce models for primary and community care, in line with the Strategic Programme for Primary Care.

A key project for HEIW is the introduction of primary care academies which support training of healthcare workers in primary care. GPs are an essential part of this project and will be supporting its implementation. There is a GP recruitment crisis at the present time, with workforce planners reporting that each retiring GPs needs to be replaced by two newly qualified GPs due to portfolio careers and part-time working[3]. HEIW need to ensure that trainees acquire their license to practice at the fastest possible pace. Avoidance of extended training through examination failure and stress-related periods of ill health is the key driver for this proposal. The increased trainer workload associated with dealing with trainees on a complicated training journey, in addition to the other key stressors in current General Practice are causing trainer attrition. Improving trainee

performance and well-being will reduce trainer stress and burnout, allowing them the mental space to embrace supporting the implementation of multi-professional workforce models for primary and community care.

Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
6.1: Initiate measures to further improve customer experience and organisational profile including refresh and relaunch the HEIW Communications and Engagement Strategy.

Trainees are an important customer of HEIW and their training experience is critical. They are our future doctors and future compassionate leaders. Supporting them in achieving true equality through giving enhanced support to such a vulnerable group from the start of their training is a key intervention that will serve to support other customers in seeing HEIW as an excellent partner, influencer and leader.

Summary of financial costs and funding to support the Business Case

a) Annual additional investment: £291,861

b) Estimated annual direct saving through reduced extensions to training: £639,285

Overall annual saving: b) – a) = £347,424

a) 18 weekly sessions of GP Educator time (GP01)[4], plus 2 weekly sessions of GP Associate Dean time (GP04) plus one full-time Band 4 administrator – salaries plus add-ons.

b) Reducing extensions to training by 33% will save 15 extensions to training per year, each costing a minimum of £42,619.

1.7 This is a conservative estimation since the evidence of interventions from around the UK uses interventions after trainees have already failed examinations. This intervention will start from the outset of training so should have a much greater impact and prevent a larger proportion of extensions. The cost of extensions is also likely to be higher than stated as those trainees who have the most medical experience prior to commencing GP training are most likely to have a complicated training journey, and they attract higher salaries due to increments and incremental credit.

1.8 There are a finite number of GP training placements. Recruitment to GP training is being reduced by the number of trainees needing extensions. Reducing the number of recruits results in unfilled GP-aligned hospital posts. These posts are usually funded at 50% by HEIW and 50% by the HB. Unfilled hospital posts are 'handed back' to the HB. The HB pay for a locum to fill the post, but HEIW still pays the 50% regardless of there being no GP trainee in post. Each six-month posts costs HEIW £10,703. The expansion of GP trainee numbers started in five schemes in 2019, so trainees on a complicated journey are now blocking input from 2022. The modelling for how many hospital posts will need to be handed back is less straight-forward than modelling for saving extensions. In the 2020 – 2021 training year 20 posts were handed back unfilled. In 2021- 2022 that number increased to 40. This is HEIW resource effectively wasted. However, relinquishing these posts prevents us easily being able to expand numbers of recruits in the future once the intervention is successful.

1.9 A second less easily measurable outcome would be reduced episodes of sickness for trainees. Trainees who are stressed and struggling may take more sickness leave. It is hoped that regular monthly mentoring sessions, along with more intimate half-day educational sessions will represent a significant increase in the current level of support and should have a natural consequence of less sickness absence. This in turn would increase trainee throughput and support General Practices in Wales during this recruitment and retention crisis. It could also save on support from the Professional Support Unit (PSU).

1.10 Finally, trainees who are failing examinations often reduce the working hours to free up time for private study, but also to create more time between examination attempts in their time-limited programme. This in turn reduces even more training placements. GP practices will not take trainees on a slot-share basis so if a trainee reduces to 50% from 100% nobody fills the other 50%.

Timescale

1.11 Recruitment of GP Educators and administrative support to be as soon as possible. If funding is agreed by September 2022 the administrator and GP Programme Directors can be recruited ready to start delivering the programme by December 2022. However, recruitment is not fixed to a single point in the training year and can be introduced at any time. Given the rapidly evolving issue we would seek to commence as soon as funding is agreed to. We have scoped interest in the role from within our existing Training Programme Director pool and around five have expressed a clear interest in the role, in addition to their current role. Since they are already employed by HEIW the onboarding process will be smooth if their applications are successful.

2 Outline of the Business Case

Current service provision

2.1 Wales is currently in a GP recruitment and retention crisis[3]. The shortage is worsening with existing GPs reducing sessional commitment, resigning and retiring sooner than planned. We need to recruit more GP trainees in Wales. That has been achieved to a certain extent in that the number of recruits has increased, but the number that can be recruited on an ongoing basis is being limited by trainees blocking training placements through needing extended training, a worsening pattern from 2022.

2.2 GP training is a three-year programme. Trainees will undertake one year of training whilst working in hospital specialties, and two years of training in GP training posts. Trainees face a tripos of assessments before they are certified to practice independently. They undertake workplace-based assessment (WPBA) throughout the whole three years. They need to be graded as 'Competent for Licensing' in all 13 areas of capability by the point at which they are due to complete training to be deemed to have successfully passed WPBA. In addition, they need to pass a machine-marked examination called the Applied Knowledge Test (AKT) and a recorded consultation assessment called the Recorded Consultation Assessment (RCA). Both these assessments are delivered by the Royal College of General Practitioners (RCGP).

2.3 GP trainees are recruited via a UK-wide, national recruitment process. Prior to the start of the

coronavirus pandemic in 2020 trainees undertook machine marked tests called Multi-Specialty Recruitment Assessment (MSRA) and attended a selection centre in person for further assessment. Once the pandemic started the face-to-face element was removed and trainees were recruited solely on their MSRA scores. There was some evidence before 2020 that MSRA scores alone were sufficient to rank trainees and that the face-to-face element added little more than face-validity. The pandemic forced a change that was probably inevitable.

2.4 The expansion in GP trainee numbers has, by the nature of any competitive entry programme, resulted in recruiting a greater proportion of trainees from the lower end of the selection process performance scale. The GP section has seen an exponential increase in the number of trainees requiring extended training. This has been a phenomenon observed to a similar extent in England and Scotland. A nationally determined and applied 'cut score' identifies which trainees are trainable. There is evidence across the nations that recruited trainees close to the cut score will be more likely to require the additional 18 months of training available to GP trainees, i.e. the cut score reflects those trainees who won't be able to complete training at all, as opposed to those who won't be able to complete training within the usual three years.

2.5 In Wales trainee numbers were increased from August 2019 – increasing from a target of 136 to 160, but with the permission to recruit up to 200 if appointable and of sufficient quality. Training years run from August to July. In the 2019-20 year 187 trainees were recruited. 2020-2021 saw recruitment of 200 trainees and the intake for 2021-2022 was lower at 184.

2.6 In the training year 2020 - 2021 we saw our usual number of extensions to training more than double, from a stable average of 13 to 16 per year, to 34. A significant proportion of these extensions were for trainees in their first and second training years, before taking their examinations i.e., those recruits who started in 2019 and 2020. Many of these trainees awarded an early extension will be likely to require a second extension at the end of training owing to them subsequently not passing the exit examinations.

	Number of Each Outcome per Academic Year (August to July)						
ARCP Outcome	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021 – 2022
Extensions to training (3)	7	16	10	13	16	34	40
Released from training (4)				3	2	3	4

2.7 We are receiving frequent feedback via our Associate Deans, Programme Directors, the British Medical Association's (BMA) General Practice Committee and our hospital colleagues that they perceive the average level of performance of GP trainees seems to have deteriorated in the past few years. The expanded intake includes a larger proportion of lower performers needing additional support whilst still having approximately the same number of high-performing GP trainees. On average it is the trainee ranked 110th in Wales that scores 479. Therefore trainees ranked lower will be likely to have a complicated training journey. If 200 are recruited we will have 90 needing extra support, but when we were recruiting 136 trainees only 26 needed extra support, around 2 per scheme which was manageable within existing resource and training placements.

2.8 We have expanded our numbers of GP trainers hugely to prepare for the increased trainee numbers and the Primary Care Training Academies. We currently have 200 training practices and

546 GP trainers. Also, the number of foundation trainees working in General Practice placements has increased. The feedback we are receiving is giving us great concern over the likelihood of GP trainer attrition. Having expanded rapidly in the last few years, we are now experiencing fewer new practices coming forward, and think we are reaching saturation in terms of new practices wishing to become approved for training.

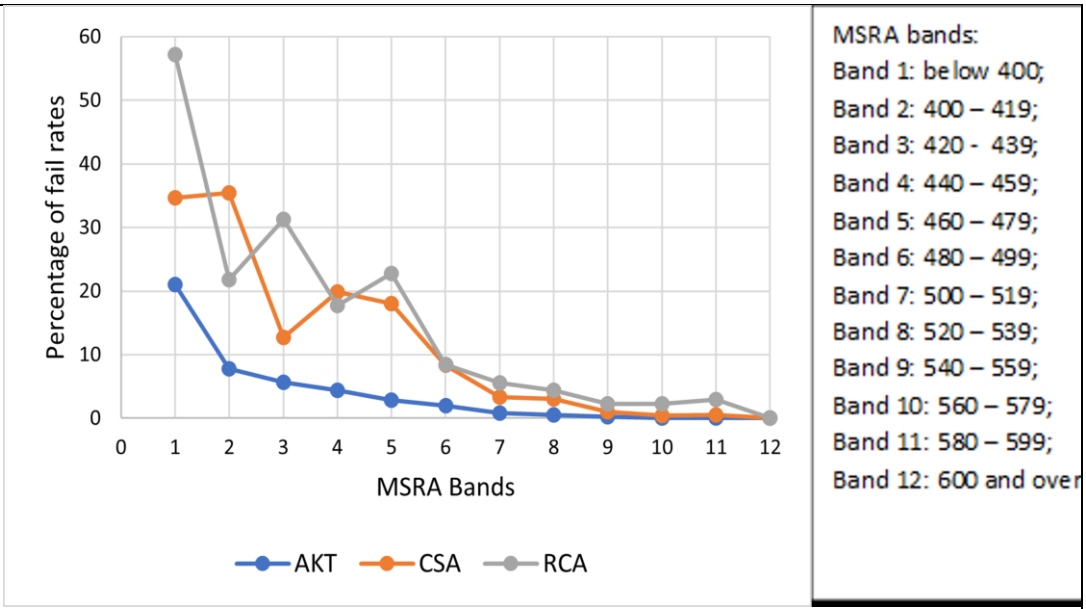
2.9 It is worth stating that trainers feel an enormous sense of personal responsibility when trainees failed examinations or are released from training. The GP trainer-trainee relationship is very close, and the trainer will usually deliver the majority of the structured educational sessions and do most of the workplace-based assessments. In addition, trainers review cases for the RCGP's recorded consultation assessment. This adds a further onerous responsibility, which risks increasing trainer attrition.

2.10 Finally, GPs in general are leaving General Practice at a high rate, an issue caused by soaring pensions tax charges, ill-informed adverse press reports, and escalating patient demand[3]. Lack of sufficient practice staffing is adding to trainer attrition. Additionally, for the first time the GP training section was notified by a practice on 6.5.22 that they were refusing to accept a placement for a trainee who had no prior NHS experience as they felt the task of providing a full induction to both General Practice and the NHS as a whole in addition to the usual workload of GP trainers, was simply too much. GP practices have independent contractor status so cannot be compelled to take trainees, and it is expected that there may be further instances such as this in the future.

2.11 Health Education England recognised the impact of the consequences of the expansion of intake in numbers and in 2020 agreed to invest an additional £4.5 million to be distributed around the regional Deaneries. This money was used to support trainees due to the inevitable disproportionate increase in numbers of trainees experiencing a complicated training journey.

2.12 The UK National Recruitment Office (NRO) coordinate recruitment for England, Scotland, Wales and Northern Ireland. The NRO, along with the RCGP have supported Lincoln University to write a research paper entitled '*How is performance at selection to general practice related to performance at the endpoint of GP training*?'[4] This ground-breaking research paper reinforcing the already known fact that GP Selection Centre scores correlated closely with scores at the RCGP exit exams. Moreover, in addition to reinforcing this important fact, the paper pin-pointed a level of selection score at which it was highly likely that trainees would initially fail the RCGP exit assessments. The paper concluded that the optimal Multi-Specialty Recruitment Assessment (MSRA) threshold score for predicting an uncomplicated training pathway to licensing was around 500 (497 and over). An uncomplicated training pathway was defined as both RCGP assessments being passed on the first attempt, in addition to positive workplace-based assessment outcomes.

2.13 The paper shows that a steep increase of failed exit assessments occurs for those recruits scoring less than 480. So, although those under 497 will have a complicated training journey, those scoring between 480 and 497 are likely to just fail a single examination which can be addressed within normal training time. For the August 2022 intake, 62 of the 155 (40%) recruited scored below the 497 threshold for a complicated training journey and 47 scored under 480 (30%). The graph below demonstrates the take-off at 480:



2.14 Whilst one failed examination can usually be managed within ordinary training time, failing on two or more occasions would most commonly cause a need to extend training time beyond three years. The Gold Guide[2] allows up to two six-month extensions to be awarded as standard, plus one further six-month extension can be awarded at the Dean's discretion. The RCGP exams can both be taken on up to four occasions. An exceptional fifth attempt of one of the exams is available if the trainee has passed the other exam plus workplace-based assessment. The RCA pass rate is approximately 76% and the AKT is 73%.

2.15 It is likely that a large proportion of those who scored less than 480 at selection will go on to need their training extended by up to eighteen months. Each six-month extension costs around £42,619 inclusive of salary, add-ons and trainers' grant. However, this is based on a trainee starting training at the bottom of the pay-scale. Trainees have pay-protection when moving to GP training from another specialty, and if moving from England or abroad are eligible for incremental credit based on their previous experience. Our experience shows that the more experienced a doctor is in a single specialty, the more likely they are to have a complicated training journey. This means those trainees having extended training are very often trainees with salary protection, so the average cost of an extension is likely to be closer to £50,000.

2.16 The reason for focusing on extensions to training is not just about cost. Trainees requiring extended training limit the number of new trainees which can be recruited. Additionally, recruitment numbers need to be submitted to the National Recruitment Office before we know how many trainees will require extended training, so Programme Directors need to be conservative at giving recruitment numbers, taking into account which trainees may require extended training.

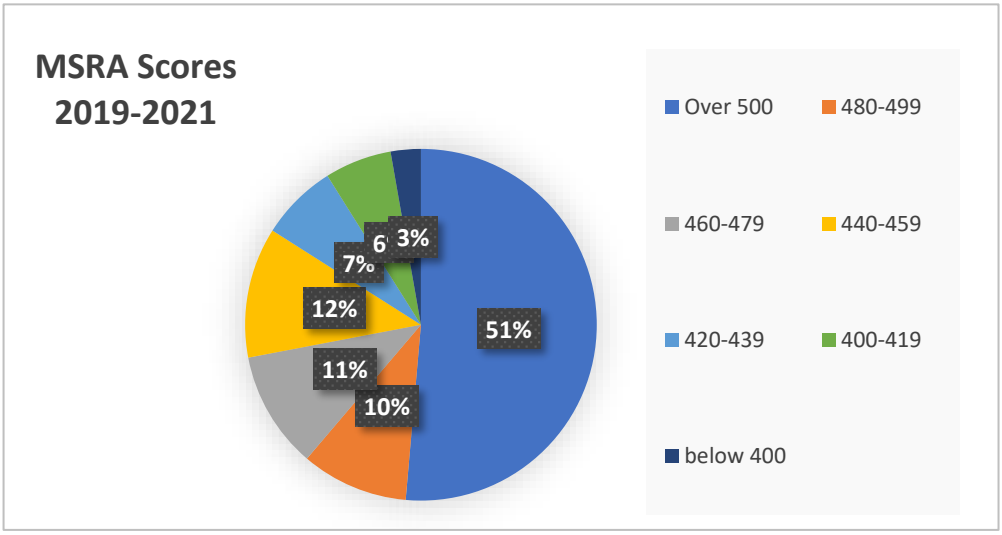
2.17 Since GP trainee numbers have expanded, training placements are in much shorter supply. All extensions to training need to be undertaken in GP placements as they allow the trainee to sufficiently demonstrate capability progression, and the regulations require trainees to end training with a full year in a GP post. When we had an average of 13 - 16 yearly extensions this equated to a maximum of two per scheme, which were fairly easily accommodated. Now those extension numbers have increased, and each scheme is already much larger due to the expansion, schemes need to actively reserve placements for trainees likely to need extensions. This further

reduces the numbers recruitable. Funding of extensions all comes from the GP trainee salary budget.

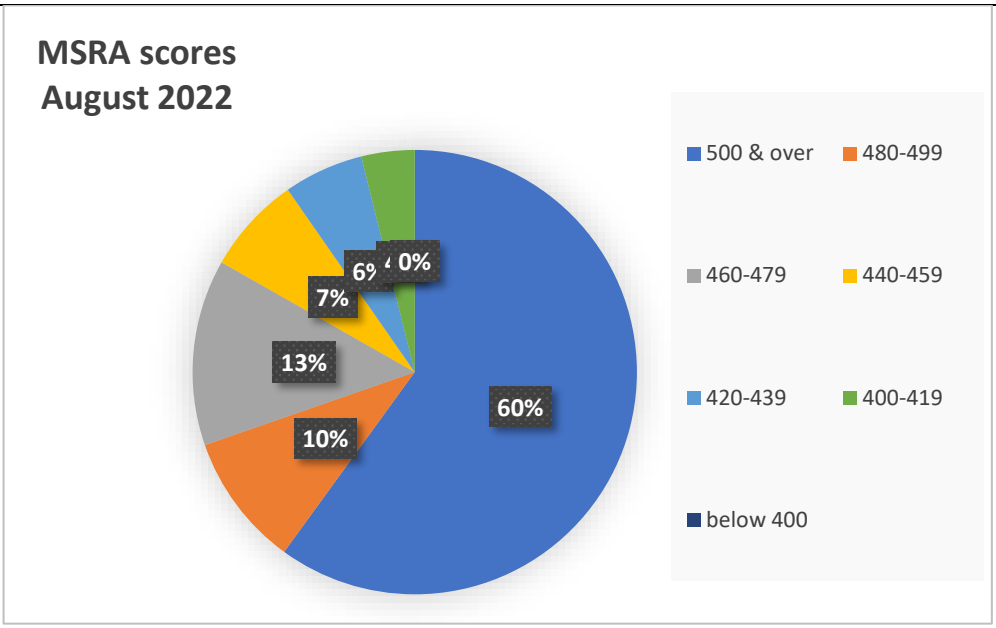
2.18 For the August 2022 intake, 47 out of 155 (30%) trainees scored below 480 at selection. The charts below demonstrate an improvement in recruitment scores from the combined data of the 2019 to 2021 intakes compared with the 2022 data. This improvement in 2022 is caused by the reduction in number of recruits as explained previously that the trainee ranked 110th and below will all have scored under 480 at selection:

Recruitment Year	Number recruited
2019	187
2020	200
2021	184
2022	155 (so far, Round 2 not complete)

2019-2021 Recruitment Scores



August 2022 Recruitment Scores



The Current Wales Offer of Support

a) Support for Induction

2.19 We recognised a large increase in trainees who required additional support in the 2019 and 2020 cohorts of recruits. In line with ours Deanery areas around the UK we introduced a support programme for all our doctors who qualified from overseas, regardless of how much NHS experience they had. It is called the Wales Enhanced Support for Trainees (WEST programme), and it started in August 2021. The resource for this was redirected from the previous resource used to deliver the face-to-face element of GP recruitment. The focus of the WEST programme is to support trainees who are less familiar with UK general practice to have a greater understanding of the standards and expectations in UK General Practice and address cultural issues as they arise. General Practice abroad bears little resemblance to UK GP so even trainees who have worked in the UK for many years often have little knowledge of what to expect when starting a GP placement.

Support for RCA and WPBA

2.20 For the past decade the GP section has examined the recruitment data and offered a session with an RCGP examiner and their trainer during the second year of training to trainees scoring the bottom 10% in the MSRA, to provide support in developing consulting skills. There hasn't been a formal evaluation of this approach, but it was well-received and the trainers and RCGP examiners felt it was a worthwhile intervention. Additionally, all trainees who fail an attempt at the RCA, or are expected to, are also offered a session with an RCGP examiner.

2.21 The RCGP with Fourteen Fish (the company who host the RCGP portfolio) have created an 'RCA plus' package. The GP section are promoting the use of this package from August 2022, having recently delivered training for the trainers in using the tool at all eleven trainers' workshops around Wales.

Support for AKT

2.22 All trainees who fail the AKT are given access to the 'AKT plus' package.

Proposals for Future Model of Support

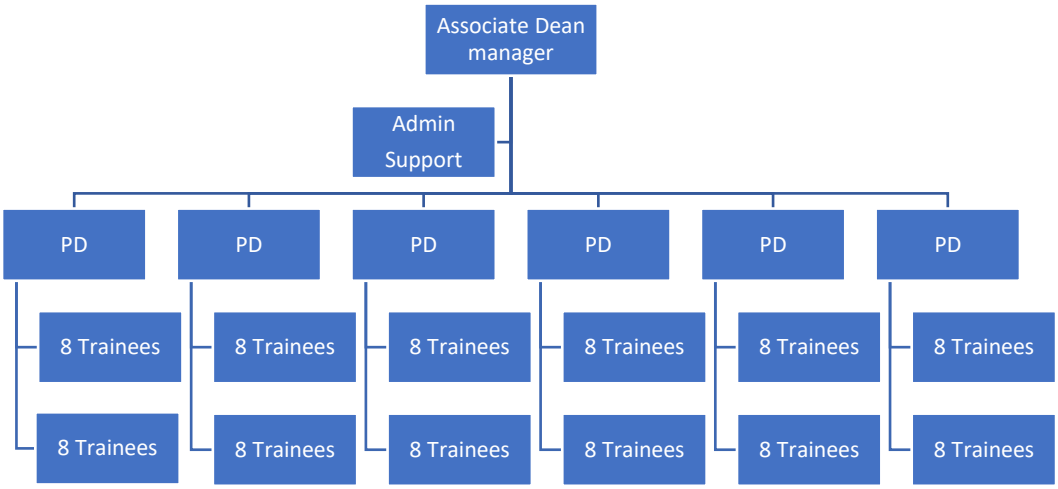
2.23 The Deputy Director for GP training and GP Associate Deans have met to consider how best

to support this group who are likely to have a complicated training journey. We all agree that early intervention is preferable to the models where trainees only receive extra support after failing an examination. It is agreed that early intervention will increase the speed of capability development and maximise chance of examination success in the first or second attempts. Trainees commonly become very despondent with examination fails and, coupled with limited time for any remedial intervention to take effect between examination diets it would better to intervene earlier.

2.24 We would therefore like to introduce a programme of additional support for those who score under 480 in the MSRA, which starts from the beginning of the training programme. This will need to be resourced in addition to the current budgets.

2.25 Our previous average of 13 extensions to training per year cost £554,047. The year 2021-2022 saw 40 extensions. This cost £1,704,760. Modelling for the same period 2022-2023 suggests we will be awarding a minimum of 45 extensions, costing £1,917,855. When GP trainee numbers were expanded the modelling was based on the same proportion of extensions to training, but the proportion is much greater. We will therefore spend an extra £1,363,808 on extensions over and above our previous average spend. Early intervention with targeted support and training will prevent a proportion of those extensions, so the cost of the additional training will represent a cost saving overall.

2.26 The proposal is to recruit 18 sessions of GP Educator time (GP Programme Director, GP01 on the GP Educator Pay-scale[2]). There would be six Programme Directors (PDs) working at three sessions per week. Additionally, two weekly sessions of Associate Dean time would be required to lead the initiative and the PDs. The GP Educator pay-scale is the only recognised pay-scale for GP educators. The group needing additional support would be those scoring below 480 in the 2022 and 2021 intakes. This would amount to a group of 96 trainees around Wales. They would be split into twelve groups of eight trainees each. The PDs would have two groups each. This group would be enrolled on an enhanced educational programme, targeted to the specific areas where trainees who score under 480 in the MSRA need most support. This will be separate to, and addition to the standard educational delivery for all GP trainees, in recognition of the groups' enhanced needs.



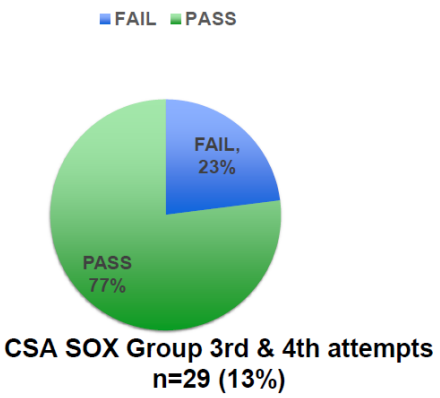
2.27 Over every four-week period each group of eight trainees would attend one half-day group teaching session, so the PD would deliver two separate sessions every four weeks as they have

two groups each. The PD would also deliver monthly mentoring to all individuals and liaison with their trainer, plus planning, preparation and administration. Additionally, they would attend trainers' workshops, support ARCP panels, support ARCP appeal hearings and meet regularly as a group with Associate Dean oversight.

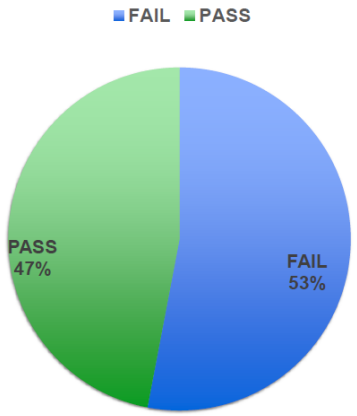
2.28 The at-risk trainees would stay with the supporting group until the start of ST3, unless the early intervention has been sufficiently successful that they no longer need the additional support. Also, as other trainees fail exams or workplace-based assessment they would be included in the remediation group.

2.29 The cost of PD and AD salary with add-ons amounts to £249,026 per year. A full-time Band 4 Administrator would cost £30,835. A scheme budget of £1000 each would be needed for the twelve groups of trainees. This intervention would cost £291,861 and would need to save seven of the expected minimum of 45 extensions in order to be cost neutral. After this point financial savings would be made.

2.30 Evidence from around the UK shows some very effective programmes are being delivered to trainees who have failed the RCGP examinations in some Deaneries. The CSA-Sox (Clinical Skills Assessment – Support On Extension)[5] programme was introduced in 2016 in North-West England and supported trainees after a CSA fail. The CSA was the RCGP examination which was replaced by the RCA at the start of the pandemic. They worked closely with trainees on their consulting skills and found that their International Medical Graduate (IMG) 3rd attempt pass-rate was 71% compared with a non-intervention rate of 35%. For IMGs on a 4th attempt the intervention group pass-rate was 83% compared with 57% in the non-intervention group. Various iterations of this type of intervention around the UK have produced similar results and reduced extensions to training. Further statistics are shown below:

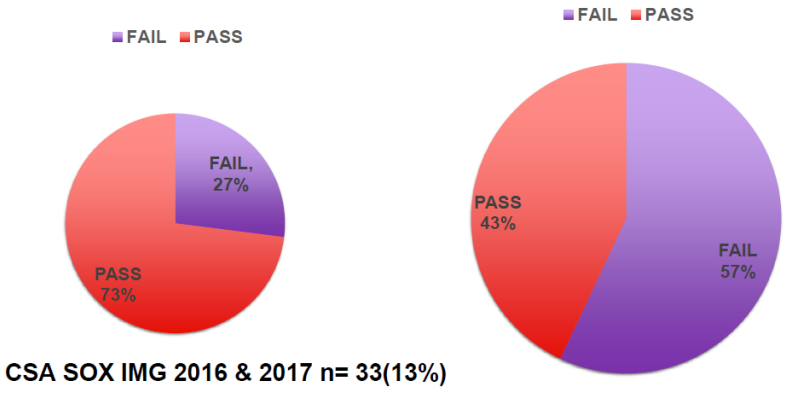


CSA SOX Group 3rd & 4th attempts n=29 (13%)



***National CSA Group 3rd & 4th attempts n=231**

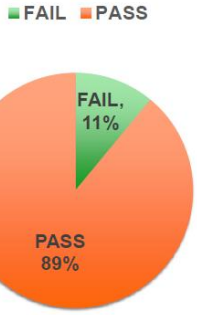
*National CSA MRCGP 2016/17 Annual report



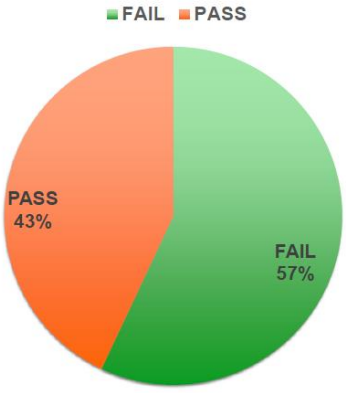
CSA SOX IMG 2016 & 2017 n= 33(13%)

***National CSA 2016/17 n=351**

*National CSA MRCGP 2016/17 Annual report



CSA SOX UKG 2016 & 2017 n= 18(16%)



***National CSA 2016/17 n=351**

2.31 This North-West CSA-SOX programme started in 2016. Health Education England gave £4.5million to deanery areas in 2021 to support struggling trainees in addition to the usual budget, in recognition that the expansion in GP trainee numbers had created an urgent need to greatly increase educational support to ensure these trainees progressed through training. The North-West used their new allocation to employ an addition 41 sessions of GP Programme Directors and started working on improved induction and dyslexia screening. They also started an additional programme of support for new recruits who ranked the lowest, but without the benefit of the evidence-based cut-off that the Lincoln Paper has identified.

2.32 Since their interventions are new they are as yet unevaluated. Their plans are similar to the proposals we make this case for. Of note we have been asking all trainees to screen for dyslexia at the start of their training programme for several years. If our proposed interventions were funded and were at least as successful as CSA-SOX then we would see at least a 33% reduction in extensions to training. This would equate to reducing extensions from 45 per year to 30 per year, saving £639,285 per year. The cost of the staff and scheme budgets required to deliver the intervention would be £291,861, representing a year on year saving from the GP budget of

£347,424 annually. In addition to simple cost savings, reducing extensions allows more trainees to be recruited annually, and with the current and worsening GP workforce crisis this is a highly desirable outcome. Increasing recruitment reduces our number of unfilled GP-aligned hospital-based training posts. Despite the posts being left unfilled by a GP trainee HEIW's 50% of the cost of the post is still sent to the HB - £10,703.50 for six months. Around 10 are unfilled every six-months due to drop-outs and less than full-time training. As the trainees in difficulty from 2019-2022 reduce available rotations to recruit to we would expect the number of unfilled hospital posts to further increase. This represents a significant wastage of HEIW money from the Trainee Grade Salary budget, although that money remains in the NHS with the HBs.

Feasibility

2.33 We have shared our outline proposals with our group of training Programme Directors. They gave an extremely positive response and found no suggestions for amendments. We explained that ideally this group of new Programme Directors should be experienced educators. Subsequent to the meeting five current Programme Directors contacted us independently to state they would be interested in the role and could undertake in addition to their current Programme Director role.

WEST Programme

2.34 The WEST programme is for all GP trainees who qualified overseas as an induction. WEST remains vital for all our overseas graduates due to the need to understand UK General Practice. Currently it delivers cultural orientation and training but also some additional basic training, in recognition that overseas doctors are most at risk of a complicated training journey. This is not ideal as many doctors attending do not require the basic training, just the cultural aspect of UK practice.

2.35 If this proposal was accepted the WEST programme would be changed to exclude the basic training element, which would be delivered solely to the group who we know through evidence are most likely to have a complicated training journey – a mix of UK and overseas graduates. WEST would be delivered for just the overseas doctors in their first year of training, as opposed to both their first and second year. The WEST programme has been delivered without any additional resource. This was possible because the removal of the face-to-face component of GP recruitment was removed.

2.36 We were concerned that trainees may feel unhappy with being asked to attend additional training just because they graduated overseas. We have been delighted to find that the programme was uniformly welcomed. This leads us to believe that equally trainees being invited to a package of supplementary support based on their recruitment scores will be equally welcome. Below are some quotes from trainee feedback on the WEST programme:

> You guys are the absolute best, thank you so much for having me and my fellow colleagues.

> Been an IMG has its perks- I feel very welcomed to Wales. I really want to make the deanery proud as this program has impacted on my clinical and social skills.

> To be honest I can't thank them enough for all the time effort in supporting us. I feel it's important to have this program for IMGs and all the modules are very relevant. Also gives a chance for everyone to share their questions and experiences so improve each other and also set for the future trainees

Feel more comfortable in myself and accepting that I have qualified abroad. Also don't hesitate anymore in asking for whatever is new to me.

WEST modules have definitely given me confidence and encouragement. I am now better able to understand the expectations of my patients and how to deal with them in a professional way and practice in an ethical manner. I know in the back of my mind that support is available if I face any struggles.

Risks

2.37 The risks of this intervention are small. Potentially failure to recruit sufficient educators could occur, but this seems highly unlikely based on the five Programme Directors making contact regarding their interest in the potential role.

2.38 There is a risk that the proportion of trainees scoring under 480 reduces to an extent that we have an excess of educators – this seems unlikely, as increased output from UK medicals schools to date has not translated into increased UK applicants into GP Specialty training. This risk could be mitigated by starting these Programme Directors on a three-year fixed term contract. It would need to be a minimum of three years as they would need to be employed to review the outcomes of the interventions. If the trainee pool becomes smaller then the cut off score for inclusion in the target group could be increased to 497, meaning more trainees just above the 480 score are included. This is likely to have a positive outcome because the very lowest scorers will have a complicated journey regardless, but those closest to the cut-off are those most likely to benefit in terms of not requiring extended training. Also, the RCGP is likely to move towards a capability rather than time-based programme, so future iterations of additional support input could focus on both weaker and stronger candidates, with a view to supporting very high performing trainees in achieving their GP qualification in less than three years.

2.39 The GP section has collected all data from 2021-22 and 2022-23 intakes available in readiness to use in the evaluation of this intervention. Evaluation will be led by the Associate Dean with the support of the Programme Directors and will be a mix of both qualitative and quantitative data.

Summary

2.40 We hope this business case has clearly set out the need for urgent intervention, and shows that the proposals and suggested benefits have a sound evidence based and will deliver as expected, if accepted by the HEIW Executive Team.

References and Links

1. GPNROMRCGPstudyfinalreport.pdf (lincoln.ac.uk)
2. Gold Guide - 8th Edition - Conference Of Postgraduate Medical Deans (copmed.org.uk)
3. Pressures in general practice data analysis (bma.org.uk)
4. GP educator pay scale 2021 to 2022 - GOV.UK (www.gov.uk)
5. A description and evaluation of an educational programme for North West England GP trainees who have multiple fails in the Clinical Skills Assessment (CSA): Education for Primary Care: Vol 30, No 3 (tandfonline.com)

Case for change. Service Need?

2.41 As outlined above – Primary Care is at its most vulnerable state in recent times and is in desperate need for new GPs. We have expanded the number of recruits but those extra numbers

are required extended training , costing HEIW from the GP training budget and limiting GP trainee recruitment, at the worst possible point in time.

Impact on other services / departments?
2.42 Additional early support for trainees will increased GP trainee throughput and prevent GP aligned hospital posts being left unfilled. This will support hospital departments through savings on recruiting locum doctors and support continuity of care. Increasing output of GP trainees will support the Primary Care Training Academies as GPs will play an essential part in delivering support for these. Improved trainee performance will reduce trainer attrition and support the GP workforce at a time of a recruitment and retention crisis.

Evidence Base
2.43 Included within the case above.

3 Business Case Objectives

To ask the HEIW Executive for the funding to recruit GP Educators and provide a small training budget for their supplementary training programme.

4 Desired Outcomes and Benefits

1. Maximising the throughput of trainees in the 3-year GP training programme, minimising the costs of extensions to training and the increasing the chance of recruiting a consistently high number of new trainees annually.
2. Reducing trainer burnout and attrition
3. Improve trainee morale with a positive impact on sickness levels and more effective teamworking. Human factors training has proven that the most effective teams have the most positive outcomes for patients, and conversely dysfunctional teams have patient safety implications.

5 Options Appraisal

Option 1

Do Nothing (baseline):
Benefits/Value: No increased initial costs to GP training staff budget
Pay & Non Pay Costs: The GP budget is overspent, largely due to extended training through ill-health, parental leave and failure to progress through training.
Risks including consequence, likelihood and mitigating action/s: There is a sustained increase in number of trainees needing periods of extended training from a previous steady state of 13-16 per year costing £554,057, to a new steady state of at least 45 per year, costing £1,917,855. The high number of GP trainees with a complicated training journey will block available GP training placements and reduce the number of trainees that can be recruited. Trainee salary budgets are needing to be expanded significantly to fund the extensions to training. A third of these extensions

can be avoided by injected resource into GP Educators to work with an evidence-based target group, representing a cost saving which would be missed by doing nothing.

Option 2
Title/Outline description: Recruit 18 sessions of GP Programme Director and two sessions of Associate Dean, plus one full-time Band 4 administrator.
Benefits/Value: Overall cost saving of £347,424 per year
Pay and Non Pay Costs: £291,861 per year
Risks including consequence, likelihood and mitigating action/s: The main risk is that the number of trainees recruited who are likely to have a complicated training journey reduces to an extent we are left with a relative over-supply of educators. The likelihood is low as the increased output from UK medical schools has not yet led to those graduates applying for GP training – no more UK graduates appear to be entering GP specialty training. To mitigate, in this scenario we would move the threshold for inclusion in the target group to 497, which would then include trainees who are only just likely to have complications whereby the interventions should have a very positive outcome.

Option 3:
Title/Outline description: Recruit the same but on a 3.5 year fixed-term contract rather than into substantive posts
Benefits/Value: If the pool of trainees likely to experience complicated training journeys reduces then the staff could be made redundant
Pay and Non Pay Costs: £291,861 per year for 3.5 years with option to convert to a substantive post
Risks including consequence, likelihood and mitigating action/s: It may be more difficult to recruit the skills educators required if the post is fixed term. I have been advised that under fixed term contract regulations employees can request conversion to a substantive post after a continuous period 4 years. Offering 3.5 years is long enough to demonstrate the intervention is effective and produce the evaluation data but shy of the 4 years.

6 Financial Analysis

Annual addition investment: £291,861 (1)
Estimated annual direct saving through reduced extensions to training: £639,285 (2)

Overall annual saving: 2-1 = £347,424

This is a conservative estimate as outlined in 1.7 – 1.10 of the Executive Summary

7 Investment Appraisal and Value

Increased numbers of qualified GPs in Wales through early action by HEIW when evidence emerged that there was an opportunity to support progressing trainees through training more rapidly. Supports the IMPT Objectives 1.7, 2.6, 3.1, 4.1 and 6.1 as described in the Executive Summary.

8 Timescale and Implementation Plan

As soon as funding is approved recruitment can begin. The plan can be implemented at any time of year, but the sooner it is started the more positive outcomes will be observed.

9 Conclusion and Recommendation

The GP section is looking to recruit additional educators with administrative support to introduce supplementary training to a specific group identified via their recruitment scores for whom there is sound evidence to show they will have a complicated training journey including failed examinations and extended training. This resource will lead to an overall cost saving through reduced extensions, and lead to an increased number of GP recruits due to a faster throughput. As other postgraduate training specialties acquire similar evidence to define their target groups our educators will support the rest of the medical deanery in implementing suitable targeted support using the evidence from the evaluation. It is recognised that additional support in hospital specialties will need to be quite different to our proposals due to the differing nature of the training programmes.
The GP section recommends the HEIW Executive Team agreed to fund this proposal.

10. Glossary

AKT	Applied Knowledge Test (one of the tripos of assessments for GP trainees)
BMA	British Medical Associate – Union for doctors
CSA	Clinical Skills Assessment (Previously one of the tripos of assessments for GP trainees – now replaced by RCA)
GP	General Practice or General Practitioner
HB	Health Board
IMG	International Medical Graduate
MSRA	Multi-Specialty Recruitment Assessment (the machine marked assessments prospective GP trainees take at recruitment)
NRO	National Recruitment Office (coordinates recruitment of GP trainees nationally)
PD	Programme Director (A GP Educator on the GP Educator Pay-Scale)
PSU	Professional Support Unit at HEIW
RCA	Recorded Consultation Assessment (one of the tripos of assessments for GP trainees)
RCGP	Royal College of General Practitioners
WEST	Wales Enhanced Support for Training (a programme currently delivered to all overseas graduates in GP training in Wales)
WPBA	Workplace Based Assessment (one of the tripos of assessments for GP trainees)