

# Project Brief

## **A Review of GP Specialty Training in the UK**

**A Project to conduct an Option Appraisal on the issues surrounding the recommendation by the Tooke Report for 5 Years Specific Specialty Training for General Practice**

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# INTRODUCTION

## Purpose of Document

The purpose of this document is to give initial definition to the project. It also provides an outline statement of how and when the project's objectives are to be achieved and a further expansion of the Business Case.

Approval of this document will provide the gateway to the full initiation of the project.

## Background

Sir John Tooke's report on Modernising Medical Careers (Aspiring to Excellence; Jan 2008) recommended that training for general practice should be extended to five years.

### Recommendation 45

The length of training in General Practice should be extended to five years, (three years in Core plus two years as a GP Specialist Registrar supervised by a Director of Postgraduate GP Education). Extension to five years would bring GP training in line with the other developed European countries.

Opportunities should exist to accommodate late entrants to GP training with other specialist skills.

As Tooke does not closely define what is meant by "five years training" it will be necessary to do so for the project work to maintain focus. The initial scope of this project will therefore be assumed to be the case for extending duration of the specific specialty training for general practice leading to a CCT. It will not include "foundation" training undertaken before entry to the CCT programme, nor will it include Higher Professional Education undertaken after the award of a CCT. The content of both Foundation training and HPE are of course highly relevant to the content of the specific specialty training, and changes in either could influence the case for extending specialty training. An option appraisal will therefore be necessary to demonstrate whether the expected benefits of extending specialty training to (eg) a five year programme could be realised on a cost-effective basis through, for example, changes to the Foundation years; other durations of specific specialty training; or an HPE programme.

It is worth noting that there are European minimum requirements for general practice training (contained in the Doctors Directive) which have been implemented in the UK, most recently in the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. At present the minimum European requirement (exceeded by many Member States) is for three years training, but there have been discussions at European levels about the possibility of increasing the minimum length. Should this happen the UK would be obliged to follow suit.

Current UK regulatory requirements therefore specify the minimum required to meet European standards of three years specific specialty training for the award of a CCT. Most doctors in the UK will have previously successfully completed a general Foundation programme. We do not currently “count” Foundation years towards the overall duration of training in any specialty (to do so could be interpreted to mean that the UK already had five years postgraduate training for general practice). Foundation training is not currently designed as specialty medical training and taking it into account (as currently designed) as part of specialty training (rather than a pre-requisite for entry to specialist training) might well breach the relevant European requirements.

Introducing a five year programme as recommended by Tooke would mean that doctors training for general practice in England would in future therefore have to successfully complete two years foundation training; five years of specific specialty GP training; and demonstrate that they had at least reached the required standard before being eligible for entry to the GP register and therefore independent practice.

The response of the Department of Health to the Tooke Report was published in February 2008. On recommendation 45, DH said:

I [DN: SofS] think that this recommendation warrants serious consideration.

The Inquiry also intimated that the design of general practice training should be resolved by the relevant Royal Colleges. General practice has a notable record of developing and implementing training, including curricula development and the general practice selection process. I therefore also agree that, in principle, further work should be profession-led, under the auspices of the Programme Board arrangements, and with the relevant general practice and general practice education partner organisations such as COGPED and the BMA's General Practitioners Committee and wider stakeholders.

I am also conscious of the need for the extended general practice training programme to be developed alongside other changes. The work taking place on how the roles of clinicians needs to develop (see recommendation 5) is important in deciding exactly how this recommendation is taken forward, particularly given the significance of and value to primary care of the wider team.

I am also clear that there are good reasons for ensuring that general practice training is developed to a timescale and in a way that allows the right links to be made to the further development of specialty training. There are shared issues of workforce planning, transition, cost and wider service impact to be considered for the service as a whole.

For that reason, I envisage that the work should take place in a way that allows common issues to be considered alongside the work to take forward the development of recommendations 31 and 33 to 35. This will also allow training as a whole to be developed in the light of evidence and testing and built on a consensus-based approach. I also envisage implementation beginning – on whatever basis is appropriate – from 2011.

DH subsequently commissioned the Royal College of General Practitioners to carry out work as a feasibility study intended to establish the business case for extending training. The interdependencies identified by DH need to be resolved or mitigated, and the program of work directed to implementation in 2011.

As a first step, DH has asked for a report from the College by May 2009.

# PROJECT DEFINITION

## Project Objectives

To establish the business case for extending GP training.

## Project Scope

The project scope should include all factors bearing on GP training. This will as a minimum take into account:

- Quantification of the benefits expected from the proposed extension to training
- Quantification of the opportunity costs of not extending training
- Costs associated with extending training, particularly an additional two years' training and savings (current or projected) accruing elsewhere as a result
- The shifts in revenue budgets necessary to fund additional years from training budgets
- The views of patients, the profession, and NHS employers
- The effect both on doctors' choice of general practice as a career and on other specialties
- The overall impact on general practice – eg doctors entering independent practice at an older age
- The ability of doctors in training to “switch” between training paths at points in their career
- The attitudes and intentions of the devolved administrations in the rest of the UK
- The capacity required for the GP training system to handle additional workload set against current capacity, review of the trainer/trainee funding relationship, the implications for flexible training and an evaluation of capital and revenue needs
- Impacts on supply and demand, including consideration of the service impact on both general practice and hospital training posts
- A revised set of standards for GP training
- An extended curriculum, particularly a five year curriculum – eg the content not only of an additional two years of training but also the effect on the initial three year period (see below)
- Means of assessment, both formative and summative
- The regulatory, financial and legislative changes required to bring the scheme into being
- The means for managing EEA doctors and doctors from the rest of the world, both for entry to training and entry to practice (ie the test of “equivalence” will alter)

## Outline Project Deliverables

The initial phase of the work will be directed toward the production of a report to DH in May 2009. However, if the report recommends the introduction of an extended (eg five year) programme, and if DH adopts the recommendation, a further project plan will need to be worked up covering implementation. As the College's commission currently ends with the production of the report, planning for implementation is not directly considered in this project plan.

## Exclusions

None.

## Constraints

It is certain that DH will judge that a Public Sector Impact test may be required. While this is a matter for the Department, the report needs to anticipate and address the issues. We therefore propose to structure the final report to clearly identify:

- The Issue
- Policy Objectives
- Options
  - Option Evaluation
- Benefits
- Costs
- Favoured Option(s)
- Further policy development requirements
- Wider Issues
- Additional Requirements
  - Eg Race, gender and disability impacts; Human Rights; Rural proofing; Small Firms Impact etc.

## Interfaces

DH/Medical Education England (main customer)

Patients

NHS Employers: SHAs; PCTs; NHS Trusts; Independent sector service providers

HM Armed Forces

GPs: Trainers; Registrars; independent practitioners

BMA/GPC

COPMED/COGPED

Other Royal Colleges

Universities/medical schools

HM Treasury

European Commission

Devolved Administrations

## **Customer's quality expectations**

Quality expectations are of the highest. The risk of severe financial or service pressures arising from miscalculations, loopholes in the arrangements, or perverse incentives mean that a five year system must be cost-effective, reliable, robust, and flexible.

## **Acceptance criteria**

- Cost-effective system
- Improvements in GP capability through improved training
- Supporting other government priorities
- Interoperability and interchangeability of doctors in training
- Minimal impact on workforce supply and demand
- Minimised bureaucracy
- Ease of use

## OUTLINE BUSINESS CASE

### Reasons

The Tooke Report highlights the contrast between the Government's intended plans for moving more activity away from hospitals into general practice, and the short period of training currently required for becoming a general practitioner. GPs may currently have spent as little as 12 months in general practice before certification.

Extending training would therefore recognise the drive towards an increased and expanded role for the general practitioner in the modern NHS, and the key task would be to ensure that the training delivered produces a GP able to respond effectively to the changing demands of patients and the NHS. This means that the additional years cannot be "more of the same" – the full five year programme needs to be realigned to ensure that these objectives are met.

While extending training will clearly require a commensurate transfer of resources into the training budget, we will need to establish whether, and if so, the extent, to which the salaries and training elements would be an additional cost pressure on overall budgets. For instance, trainees at the conclusion of their third year currently move on to substantially higher salary scales as salaried GPs and as independent practitioners; assuming a five year period as recommended by Tooke, pay scales for GP training years four and five would be required, similar to those already in existence for hospital doctors. The net overall saving on salary budgets for certificated GPs would need to be compared alongside the increased costs for training budgets, to enable (if required) a transfer of appropriate funding into MADEL from overall salary allocations. Alongside this will need to be considered the additional costs arising in the training system itself and the greater time commitment needed from the trainer and training management cadres. It is unlikely that the project will be able to determine a precise costing here as new pay scales for GP registrars and related issues would be subject to negotiation with the BMA.

The project will determine whether changes would be at risk of a loss of service provision. Trainees provide a substantial amount of service in the form of direct patient contact; this contribution has often been overlooked because of the "supernumerary" factor – ie PCTs do not take GPs in training into account when establishing service profiles. It will be necessary for the project to establish the service contribution made by trainees in general practice compared with a year one or two independent practitioner/salaried GP and set this against the reduced salary cost of a trainee compared to a salaried GP or independent practitioner.

We understand that DH does not require the project to deal directly with the full workforce implications. However, given that implementation ("on whatever basis") is envisaged in 2011, the project will need to consider several related issues including:

- a. Training requirements for General Practice for next 5-10 years (taking cognisance of trends in patterns of care and in related issues e.g. gender shift, recruitment patterns) including the required training capacity in terms of trainers, premises and deanery support;
- b. Impact of proposed changes in general practice training on recruitment, retention and supply in other specialties;
- c. The number of GP training programmes required across England;
- d. The distribution of GP training programmes between deaneries taking into account likely needs at SHA level;
- e. The views of stakeholders: we envisage doing this by a “select committee” method - including Chair PTB, Project Lead, Director Professional Standards and Development, COGPED nominee, GPC nominee;
- f. The regulatory and budgetary changes necessary to deliver objectives under the various options;
- g. The means of identifying and quantifying transferable competencies (in collaboration with the Academy’s working group) for doctors transferring in and out of GP training;
- h. The content and outcomes expected from extended training programmes for general practice;
- i. Review current assessment methodologies and propose a scheme of assessment for new programme(s) - for example, to consider split core/specialty elements of the programme, taking into account the criteria for award of a CCT in general practice in future
- j. Identify tasks for transition modelling so that transition can be achieved with minimal disruptions to the service and doctors in training

## Options

There are several options mainly relating to implementation, with fewer affecting the project itself. Options for implementation (eg staged entry or “big bang”) are not central at this stage.

The main task for the project is to determine the most cost-effective means of realising the benefits expected from extending training to five years. There are several options here, for example:

- to issue certificates at the conclusion of year three (as now) and regard extended years (eg years four and five) as compulsory “post-certification” HPE training; or
- to consider one or both Foundation years as part of specific specialty training; or
- to issue certification only at the conclusion of an extended period of specific specialty training including consideration of periods both longer and shorter than five years.

The focus will in all cases be on the programme of specific specialty training intended to lead to the issuing of a certificate entitling the holder to be entered on the GP Register. The broad options identified above need to be expanded, costed, and appraised.

## Benefits expected

We expect an extension of GP training to produce better-trained GPs more capable of responding to the changing needs of patients and of the NHS. Given that the standards set by PMETB for certification will reflect the basic requirements for independent practice in the NHS, we should expect to see a reduced failure rate for the required examinations. Better training should also deliver GPs with (for example):

- more cost-effective and patient-centred referral and prescribing patterns;
- a broader and deeper range of clinical knowledge and expertise from general practice
- better skills at leading multi-disciplinary teams;
- direct experience of delivering primary care in a much wider range of settings, for example, deprived areas in inner-city or rural practices, or the armed forces; and
- practical experience of management of commissioning, for example in practice-based commissioning clusters
- greater ability to deal with complexity and multiple morbidity
- greater exposure to particular needs of children in primary care.

The project will quantify these as far as possible.

We would expect to see around 3300 “5 year” GPs entering independent practice each year from 2016 onwards, assuming introduction in 2011 and assuming that the target of 800 extra GPRs per annum is fully met. Clearly the impact of improving training will not be felt for some time and full benefits will take time before realisation. This is true of almost all change in medical education and training – for example, there are still many GPs in the NHS who entered practice before specific training was mandatory for all GPs.

## Cost

The project would as currently defined cost [under 250,000 GBP / c.305,000 GBP]. The breakdown cost of the project is contained in the business case supporting the bid submitted by RCGP to DH. As described above, a central task of the project is to establish the likely costs, benefits and savings of extending training, with particular reference to the Tooke recommendation for five years specialty training.

## Timescales

We have been asked to submit a final report to DH/Medical Education England in May 2009. We intend to provide an interim report substantially earlier than this in late November with emerging issues and findings, particularly focusing on option appraisal and a cost/benefit analysis; and to provide a near-final draft for comment at least six weeks before final submission. This will have been subject to consultation with interested parties.

## Project Risks

ID	Brief Description	Probability	Impact	Impact Date
1	Financial pressure	M	H	At implementation
2	Adverse impact on NHS	L	H	At implementation, and c. 7 years following
3	Adverse impact on other specialties	M	H	At implementation, and c. 7 years following
4	Impact on recruitment to General Practice	L	H	At implementation

## **ORGANISATION**

### **Senior Responsible Owner**

Professor Steve Field FRCGP

Chair of Council RCGP

### **Project Manager**

Kenneth Allen

### **The Customer(s)**

DH

### **The User(s)**

Patients; Doctors in training; GPs, particularly GP trainers; HM Armed Forces; PCTs; NHS Trusts; COPMED/COGPED; Universities/medical schools; general practices; independent sector providers

### **Other Interested Parties**

Devolved administrations; BMA; GMC; PMETB; other government departments; European Commission; EEA member states; media; political parties; general public

## Document Information

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## AUTHORISATION

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