How to extend GP training and improve urgent and emergency primary care

INTRODUCTION

Extension to GP training is needed but progress is slow given current financial constraints. A 6-month mandatory period of training in urgent and emergency primary care in the fourth year of an extended training scheme would offer the prospect of making financial savings while addressing training needs that are now inadequately met in the current training programme.

THE CASE FOR EXTENDING THE LENGTH OF GP TRAINING

Good primary medical care is central to the provision of high-quality, equitable, and cost-effective health services.[1] The strong tradition of general medical practice in the UK is a major component of the high performance of the UK healthcare system, which ranked second out of seven in a recent systematic comparison by the Commonwealth Institute.[2]

The UK has one of the shortest periods of postgraduate training for general medical practitioners among the advanced economies. The Royal College of General Practitioners (RCGP) has published a detailed case for the extension of training to 4 or 5 years, and detailed proposals for the form that such an extension might take.[3] Extension of training is perceived by many as vital if UK general practice is to retain its internationally acknowledged strengths.

The proportion of medical graduates training in general practice is too low for projected NHS workforce requirements. Plans are in place to increase the number of training places in general practice training schemes, but current negative perceptions of the future for primary care have led to recent under-recruitment to existing training schemes.

The NHS now faces several years of standstill funding, a situation unprecedented in its 65-year history. Every sector of the service is tasked by government with finding ways to do more with less. The prospects for the necessary funding for an extension of GP training seem remote under these circumstances.

GOVERNMENT POLICY ON URGENT AND EMERGENCY CARE

Increased pressure on hospital emergency services is a major concern for policymakers, and likely to become more so as the number of accident and emergency departments and of acute hospital beds falls over time. The *Five Year Forward View*[4] includes an intention to redesign urgent and emergency services, pointing out that compared with 5 years ago hospital emergency departments in England are seeing 3500 additional attendances every day. It speaks of providing *'... evening and weekend access to GPs or nurses working from community bases'*. NHS England's Urgent and Emergency Care Review Team, led by Professor Keith Willett, in its initial report and 2014 update,[5] talks of *'... providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E'* and of progress in developing urgent and emergency care networks. It sees a growing role for ambulance paramedics *'... developing our 999 ambulances into mobile urgent treatment services'*. All of these policy documents recognise the need for more to be done in primary care, but say little about the resourcing of and the training needs for out-of-hours primary care. The valuable recent report for Health Education England by the Primary Care Workforce Commission devoted only one of its 60 pages to urgent care, and its sole recommendation in respect of urgent care training is that *'Community staff making urgent assessments of acutely ill patients should receive basic training in the skills of other members of their team in order to increase the efficiency of their assessments.'*[6]

It is difficult to escape the conclusion that these policy documents fail to accord sufficient importance to a vital element in emergency care provision. Strengthening out-of-hours primary care — and maintaining the expertise of GPs in providing this — must be given higher priority if the objectives of the *Five Year Forward View* are to be achieved.

THE NEED FOR BETTER TRAINING IN ACUTE AND URGENT PRIMARY MEDICAL CARE

Urgent and emergency care is a key competency for GPs both in and out of normal working hours.

In 2004 a change in the GP contract actively promoted by government and widely welcomed by GPs ended the formal responsibility of GPs for out-of-hours care. The wisdom of this change is now questioned. It is clear that a return to the extremely long hours worked by many GPs prior to this change is out of the question. There is a growing recognition that access to primary care outside routine working hours needs to be improved, but there is a lack of clarity about whether this availability should be for routine or emergency work. Pilot schemes are being funded for practices to open 12 hours a day, 7 days a week, but this would pose major challenges for all except very large practices or confederations. Its widespread feasibility is doubtful, and the additional funding offered by government to achieve extension of routine care (currently known as the Prime Minister's GP Access Fund) arguably diverts attention and funding from the more pressing challenge of improving out-of-hours care.

Alongside the 2004 contract change, other factors have further reduced the exposure of GP trainees to acute and urgent clinical problems, and to independent clinical decision making. Many acute clinical presentations have become less common due to better management of chronic disease and reduced incidence of acute severe infectious illness. The European Working Time Directive has substantially reduced the hours worked in hospital and general practice training posts. Foundation programme and post-foundation hospital training posts tend to be of only 4 months' duration and many take place in non-acute services and settings. Shorter hours and shorter posts mean that many trainees enter general practice with relatively little experience of decision making and management in acute and emergency settings. Experience of out-of-hours primary care is confined to 12 or 18 shifts with out-of-hour services during the 12–18 months of practice-based training. Much of this experience is closely supervised. This constitutes a much reduced exposure to out-of-hours practice and independent clinical decision making than was the case prior to 2004.

Also, partly as a result of the 2004 contract changes and the subsequent understaffing of out-of-hours services, a culture has developed of sending patients who may have acute illness directly to hospital without initial assessment in primary care. This has extended to in-hours practice. Acutely-ill people are less often seen in daytime primary care and trainees working in well-

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staffed practices may have little daytime experience of assessing and treating acute illness.

Current general practice training arrangements will progressively fail to ensure the acquisition of expertise and confidence in the management of acute illness. Such experience is vital if the workforce skills necessary for a well-functioning out-of-hours primary care service are to be maintained. Such skills are also clearly very important for in-hours practice.

INTRODUCING A STANDARD 6-MONTH TRAINING PLACEMENT IN ACUTE AND EMERGENCY PRIMARY CARE INTO GP TRAINING

I wish to put forward the radical proposal that a mandatory 6 months of the fourth year of postgraduate GP training should be spent working exclusively in urgent care settings. This has the potential to save at least as much as it costs by strengthening the provision of out-of-hours and emergency primary care, and reducing hospital admissions and emergency department attendances.

Where would the posts be based?

These 6-month posts would need to be organised, taking into account local circumstances, across the range of acute and emergency primary care provision in GP out-of-hours services and urgent care centres. Further posts could be based in hospital accident and emergency departments; ideally in those centres in which GPs are already working alongside emergency department consultants and their trainees. Normal hospital emergency department posts would be less suitable but could be considered acceptable for those doctors who had not already done such a post earlier in their training. Accident and emergency departments should be encouraged to develop posts particularly suited to GPs in training. The possibility of basing some or part of these posts with emergency ambulance services could be considered. As in all training posts a proper balance should be found between service commitment (a legitimate expectation in return for the salary) and educational value.

What are the advantages of this proposal?

Enhanced training in emergency and out-of-hours primary care would ensure that every GP acquires significant expertise, beyond basic competence, in clinical decision making and management in acute and urgent primary care settings. This would, over time, drive up standards of assessment and management of acute and severe illness in in-hours primary care. It would provide a valuable addition to the workforce for the provision of acute and urgent primary care services. It could offer opportunities for valuable skill sharing between GPs in training and ambulance paramedics. Supervision, and curriculum design and development, for trainees in urgent primary care settings would offer a valuable avenue for career development for doctors continuing to work in these settings. By strengthening provision of acute and urgent primary care it would achieve substantial reductions in the burden on hospital emergency departments and in the number of acute hospital admissions: many of which have been judged preventable by better primary care management.

This proposal would involve initial investment to save. But additional investment in out-of-hours care is needed in any case, and investment in this form would carry the major advantage, over time, of upskilling the entire GP workforce in acute illness recognition and care. Some argue (without supporting evidence) that out-of-hours primary care can be done at lower cost by nurses, paramedics, and other healthcare professionals. But maintaining a high level of expertise in the assessment and management of acute illness among primary care doctors should remain a key priority.

CONCLUSION

Extension of GP training is necessary but there are major financial and organisational obstacles to its implementation. Urgent and emergency care is a key competency for GPs for which current training experience may progressively become inadequate. This proposal offers a way of addressing both of these problems, and of contributing in a positive way to the transformation of urgent and emergency care envisaged by policymakers.

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