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Extended training to prepare GPs for future workforce needs:

a qualitative investigation of a 1-year fellowship in urgent care

Abstract

Background
It has been argued that UK general practice specialist training should be extended to better prepare GPs for the challenges facing 21st-century health care. Evidence is needed to inform how this should occur.

Aim
To investigate the experience of recently trained GPs undertaking a 1-year full-time fellowship programme designed to provide advanced skills training in urgent care, integrated care, leadership, and academic practice; and its impact on subsequent career development.

Design and setting
Semi-structured interviews conducted longitudinally over 2 years augmented by observational data in the West Midlands, England.

Method
Participants were interviewed on at least three occasions: twice while undertaking the fellowship, and at least once post-completion. Participants' clinical and academic activities were observed. Data were analysed using a framework approach.

Results
Seven GPs participated in the pilot scheme. The fellowship was highly rated and felt to be balanced in terms of the opportunities for skill development, academic advancement, and confidence building. GPs experienced enhanced employability on completing the scheme, and at follow-up were working in a variety of primary care/urgent care interface clinical and leadership roles. Participants believed it was making general practice a more attractive career option for newly qualified doctors.

Conclusion
The 1-year fellowship provides a defined framework for training GPs to work in an enhanced manner across organisational interfaces with the skills to support service improvement and integration. It appears to be well suited to preparing GPs for portfolio roles, but its wider applicability and impact on NHS service delivery needs further investigation.

Keywords
general practice; portfolio career; qualitative research; service integration; urgent care; vocational training.

INTRODUCTION

The health service in the UK is facing unprecedented difficulties, reflecting the needs of an ageing population, with increasing levels of complex multimorbidity, budgetary constraints, and changing organisational arrangements. A workforce crisis is affecting general practice and emergency care, with ever-increasing difficulty in recruiting and retaining staff.[1] Growing numbers of GPs are considering early retirement, career breaks, relocation, or reducing their hours of working.[2,3]

It is argued that new models of care are needed, together with a workforce that is better equipped for working in a more integrated health system.[4] The NHS *Five Year Forward View* anticipates integrated networks of GP practices, nurses, community services, and hospital specialists working collaboratively to provide 'joined up' care, supported by interface clinicians who have been trained in one specialism but work across health economies.[5–7]

The emergence of new models of care and closer inter-agency service delivery are creating opportunities for professional development and a need to rethink current arrangements for medical education and training. The *General Practice Forward View*[8] and Primary Care Workforce Commission[9] provided a policy framework for developing a primary care workforce that has access to enhanced and extended training. GPs are needed with the skills to lead, change, and coordinate services across organisational boundaries and professional groups.[10,11] The Shape of Training report[12] recommended greater workforce flexibility through the development of *'formal accreditation of competences* [which include knowledge, skills and performance] *in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area …'* Such credentialing opens the doors for the development of enhanced competencies through educational programmes (such as fellowships) based on service need.

In response to these challenges, a 1-year fellowship programme was launched in the West Midlands in England, with the aim of providing advanced skills training in urgent care, integrated care, leadership, and academic practice to GPs who are within 2 years of having gained their certificate of completion of vocational training (CCT). Seven GPs completed the pilot for the scheme in 2014/2015; this article reports a longitudinal, qualitative evaluation of their experience and its impact on their subsequent employment.

METHOD

Fellowship design

The aims and intended outcomes of the programme are summarised in Box 1. The programme was delivered through three complementary elements:

- 2 days a week clinical attachments, each of 4 months' duration in an emergency department, a medical admissions unit,

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How this fits in

New approaches to training are needed to better equip GPs for the challenges of 21st-century health care, but there is little evidence to inform how these should be designed. This study investigated the experience of recently qualified GPs participating in a 1-year fellowship that involved structured placement-based learning together with a university-accredited educational component. It was designed to prepare GPs to work at the interface between primary care and urgent care services. The participants described numerous benefits in terms of academic, clinical, and leadership skill development, and subsequent employment opportunities. This model has the potential to deliver significant benefits to the NHS and those entering the GP workforce, and could be adapted for extended GP training.

and an ambulance service;

- 2 days a week within a GP training practice; and
- 1 day a week undertaking academic study, which included a bespoke postgraduate certificate in Urgent and Acute Care, and participation in an action learning set.

Recruitment

GPs were recruited to the fellowship via national advertisement in two phases, with the first three enrolling in January 2014 and a further four in August 2014. They were subsequently invited to take part in the evaluation and received introductory information about the proposed methodology and their consent to participate was sought.

Data collection

Each fellow was interviewed on at least three occasions: twice while undertaking the programme (during the first 6 months and again towards the end of the year), and additionally at 6 and 20 months' post-completion for the January 2014 cohort, and at 12 months' post-completion for the August 2014 cohort.

Interviews were carried out by two researchers (both of whom were independent of the fellowship scheme) and arranged at convenient times, either face to face or by phone. They were semi-structured and varied in length from 15 to 50 minutes. The first interview explored individual aims, expectations, and early experience of the fellowship, while the second covered the fellow's overall experience, with particular attention given to working across organisational interfaces, service improvement projects, academic development, leadership, and future career plans. The interviews conducted after completion of the fellowship explored how the training had influenced employment opportunities and career intentions.

In addition, observational data were collected at each of the clinical settings of fellows' activities and interactions in order to contextualise the interview data. Using an observation checklist, evidence was recorded of teamwork, integrated care working, communication across settings, teaching, and academic activity.

Data analysis

All interviews were recorded verbatim, transcribed, and anonymised. To maintain anonymity, the fellows were randomly assigned a unique identifier 1–7; qualitative quotes in this article are attributed to these identifiers. A framework approach was applied to analyse data.[13] Two researchers

Box 1. Aims and learning outcomes of the fellowship programme for GPs

Aims

- To explore ways in which the skills and experience of the GP can be enhanced within urgent/emergency care teams
- To develop ways in which the GP can apply enhanced urgent and acute skills to support the development of alternative community-based care pathways
- To raise GP interest in hybrid emergency/urgent and primary care roles
- To support the national policy drive for integration of primary, secondary, and social care

Intended learning outcomes

- To better understand the needs of patients, why they are attending emergency departments, and how the GP's role could be adapted to improve avoidance of hospital attendance and admission
- To develop innovative ideas/share best practice of meeting the urgent care/emergency medicine agenda in primary care
- To successfully complete the Worcester University Postgraduate Certificate in Urgent and Acute Clinical Care, demonstrating increased understanding and clinical skills in managing urgent care presentations, competence in critical appraisal of evidence, and ability to formulate and implement care according to best practice

listened and re-read audio transcripts, familiarising themselves with the data. Data were then coded using both a deductive and inductive method to allow for exploration of unexpected findings coupled with predetermined themes, ensuring important aspects were not missed. Variation in experience and views at one interview and subsequent interviews were noted. Any differences in interpretation were discussed, reviewed, and resolved, involving other members of the research team when required. NVivo software (version 10) was used to interrogate the data and facilitate a framework matrix. Qualitative quotes were identified to illustrate each theme.

RESULTS

All seven fellows participated in the evaluation, giving 24 interviews in total. The overarching themes related to fellows' expectations; experience of professional development, academic training, and service improvement and integration; and subsequent career activity. With few exceptions, fellows' views about the scheme were very positive and remained unchanged across the two interview points during the fellowship year.

Expectations of the scheme

All participants described having been attracted to the fellowship scheme as an early career opportunity to gain experience and skills that went beyond those obtained in vocational training, particularly in relation to understanding the roles and expertise of primary care professionals working across the urgent and emergency care system. Generally, this reflected personal ambitions to develop a portfolio career within which urgent care would be a key aspect. The elements of the programme were viewed as being varied and well balanced in terms of developing a breadth of competence and self-confidence:

'... potentially open up another scope of practice to me, to try and improve the chances of working in an acute and urgent care environment.' (1)

'I have never worked with a paramedic before ... I wanted to find out what they do and what barriers they have, what is their role, and see what I can do to make things better.' (5)

Experience of the professional development and service improvement activities

Service improvement and integration. The fellows felt that they were benefiting patient care and contributing to service improvement and integration in several ways: through the impact of their clinical work, the varied interaction with colleagues in urgent/emergency care and primary care settings, and by undertaking service improvement projects. They felt that the fellowship was changing the way that they worked, their understanding of the healthcare system, and in particular their capacity to help patients receive care in the community and avoid hospital admission:

'It has had a huge impact on my practice. You see the total care. If you are just working in isolation you don't see it. [As a result of the fellowship] *you get a better perspective on the services and the care, and what you can do.'* (4)

'The impact was more on my own learning ... and it has made a difference to my practice in the community. An example of this is the way I see elderly patients in nursing homes and look after the step-down patients just out of hospital — so the experience is helping to manage those patients.' (7)

'I don't have the data but my admission rate is lowest. It is quite a lot less than the other GPs who work in the system who have not done the fellowship ... I think this is because we have more of a 360 degree perspective of working in medicine, A&E, and the community.' (6)

This fellow went on to explain that:

'... it is completely different working as a GP in A&E to working as a trainee in A&E, it is completely different, and I think getting that experience on the ground is invaluable really ... understanding the way that services are set up really helped me moving forward with the things I am doing because now I have that understanding.' (6)

They also had greater awareness of the barriers to delivering integrated care. For example, with the requirement to treat patients within designated time frames, some fellows experienced organisational barriers in emergency departments when trying to implement alternatives to patient admission:

'In terms of the 4-hour target ... they are more focused on that and they don't see anything outside that. So there were barriers ... me saying, "You know if you don't do this, if you don't admit this patient, then the NHS

has saved, what, £1000 per night per patient, so why don't you send them home?"' (5)

There were numerous examples of how the programme was felt to be helping patients to access community-based and specialist services more efficiently, and avoid attendance at emergency departments or unplanned admissions, particularly when they were working with the ambulance service or out of hours:

'Last night as an out-of-hours GP I had a confused old lady, lives on her own, no family around, and a GP's mind is, "Oh, we've got no choice, we've got to admit the patient." But having gone through the fellowship, it made me think laterally and, with access to all this knowledge, I was able to get an emergency social worker, speak to the community emergency response team, we were able to keep the patient at home.' (3)

The opportunity to facilitate more integrated care by applying their knowledge about community resources, and encouraging communication and working relationships across organisational and professional boundaries, was viewed as a significant benefit. It was observed on several occasions that medical staff in urgent care environments approached fellows for advice about community and primary care:

'I just say "pick up the phone". They say "the named GP is almost never there" and I was saying "don't worry about their named GP, [the other GPs at the practice] *will have access to the same information".'* (6)

Professional development and academic training. The weekly academic days were felt to complement the clinical skills development and were valued as providing practical, evidence-based learning opportunities and peer support. They provided an opportunity to consolidate on experiences and build confidence. For some, the prospect of Masters-level academic training was a distinct attraction of the fellowship:

'You cannot pinpoint it to one thing, especially when comparing the academic with the clinical days. It is a combination of both for success, as you learn on the academic day what you try to apply in your clinical and vice versa.' (6)

'[The taught days] *afforded us a lot more knowledge of how to manage subacute and acute cases in the community. So we had teaching about diabetes, heart failure, acute MIs, orthopaedics, musculoskeletal, which could sometimes present as an acute condition.'* (3)

For some participants, there were gaps where it was felt more professional development would have been of value, as reflected in the following comment:

'What I think it lacks a little bit is the paediatric side of things when you are talking about urgent care and I think that could be incorporated possibly a bit more.' (4)

Working towards a Masters-level award, writing assignments, and making presentations about their service improvement projects were among the most demanding aspects of the programme. The projects enabled the fellows to explore how to meet patients' needs more effectively and efficiently, and potentially contribute to longer-term service improvement. They covered issues such as triaging patients, patients' attendance at emergency departments during surgery hours, and the impact of advanced care plans for nursing home residents on reducing emergency ambulance calls. One project involved writing new guidelines for reviewing pregnant women who attend emergency departments; this has now been implemented in the hospital. Another involved the fellow creating a community resource pathway booklet for the hospital; this has been made available on its intranet.

Although most participants appeared to thrive on this, some found it difficult to balance within the context of the clinical activities:

'Doing a sort of degree and doing the work, it's just balancing that out, because it can take over your life.' (5)

'I'd not done academic writing before. It was quite a steep learning curve for me ... It was another challenge and opportunity. I don't think I would have been able to do that doing a regular job.' (2)

The Postgraduate Certificate in Urgent and Acute Care was valued as an important element of the scheme that demonstrated the application of reflective clinical, strategic, and operational thinking:

'The critical appraisal of things, which is one of the skills we learn as well ... this is what

this evidence says but is this really relevant in our setting? Having that perception shift — that has been really useful in the academic days.' (5)

Challenging negative attitudes. Challenging the negative attitudes about general practice that are held in secondary care was viewed as an unanticipated benefit of the scheme. The leadership training was felt to prepare them for this, and their presence in acute care settings had led to secondary care colleagues becoming more appreciative of the skillset of general practice:

'Everybody is working in silos and we are actually just trying to bridge that gap … you need people to act as the ambassadors of each side to go to them and say, "Well, this is what we do, do you want to know more? We don't bite, you can come and ask us questions, you know."' (5)

'I think changing attitudes was probably the biggest achievement for me of the fellowship, and I think that was the case in every placement that we had.' (4)

'It was up to me to assert myself. Learning leadership helped. Being clear in your head what your role is and conveying that clearly.' (3)

However, there were examples of acute clinical teams who were less receptive to the aims of the fellowship scheme, sometimes seeing the GP as just 'another pair of clinical hands', and on reflection all fellows felt this needed further attention:

'She took me round and introduced me and said "this is our new GP", but that was it because she didn't really understand … "What are they going to do?" and "Why are they here?" was missing … I think they really struggled with the concept of who we are.' (4)

As the fellowship became more established, measures were introduced to address this issue, including a programme manual for all individuals who have responsibility for implementing the fellowship within each clinical setting.

In addition, the regional leads of the programme meet regularly with all sites to facilitate the smooth running of the placements.

Impact on career opportunities and the GP workforce

Career opportunities. The fellows described how their employment since completing the fellowship had been supported by the knowledge, skills, and experience gained from the training.

They believed their skillset was highly valued by potential employers. Three were now working part-time as GPs in emergency department roles in addition to working sessions in general practice, one was appointed urgent and acute clinical lead for a clinical commissioning group (CCG) and clinical lead for an ambulance service physician response unit, and three were working in urgent care and walk-in services:

'The fellowship has opened up different horizons and opportunities … the guy who hired me knew about the fellowship, so he approached me because I was on the fellowship, it was definitely an advantage.' (2)

'I am still in touch with many of the people that I worked with at the hospital. So even a few weeks ago somebody e-mailed me about a vacancy that they had and that they were considering a GP for and whether I knew somebody from the fellowship who would be interested in it.' (4)

'I was approached by various headhunters and locum agencies for salaried posts. I had quite a few interviews as a result and my current post was offered to me based on the experience gained during the fellowship.' (5)

There were examples of how the fellows had already taken on leadership roles in relation to clinical practice, commissioning, and service development:

'In my current role, [I am] *lead clinician with a team of ANPs* [advanced nurse practitioners], *trainee ANPs, shop floor nurses, HCAs* [healthcare assistants] *in a minor injury unit/A&E.'* (7)

'I have taken the lead on the urgent care side in the practice, working with [CCG] *looking at developing things in different areas. I use a lot of what I have learnt and picked up whilst on the fellowship. I have been working with the CCG on their urgent care schemes … it's amazing how natural it feels now.'* (4)

Another fellow had taken on a lead role at CCG level:

'I provide clinical oversight for the urgent care work that is done within [CCG] *… The*

fellowship helped, very much so. It gave me a good insight into the organisational structures within acute care and the ambulance service. I certainly wouldn't be doing this job had I not done the fellowship.' (1)

Two of the cohort had decided to continue their academic development, with one working towards a Masters degree with the aim of becoming an educational lead and the other doing a postgraduate diploma in diabetes in order to strengthen the delivery of diabetes care in the community:

'I am doing a negotiated learning for 40 credits towards a Masters looking at care of marginalised groups. That's building on the whole service enhancement theme that there was within the fellowship.' (4)

'You see a lot of diabetes cases in A&E and in the community, and they do contribute to a lot of admissions. This is something that can be managed in the community very well, so that is what led to my interest in it.' (6)

Impact on the GP workforce. The fellows described numerous ways in which they had found that the programme was attracting interest from those undertaking vocational training:

'We went there [Vocational Training Services (VTS) training days] *and did a talk about clinical teachings and all that and there were so many ST1s* and *ST2s who said they were interested in it and they said "This is new, this is so interesting, I would like to do that, it is exciting!"'* (6)

'I have found it very positive and everyone who I have spoken to — whether that is potential future employers, whether that is colleagues, even friends who I have been telling what I have been doing — have all found it really interesting and I have lots of interest. My inbox has been inundated with, "When is the new one going to start?"' (4)

It was felt that the opportunity of undertaking extended training may influence medical students and recently qualified doctors to consider GP vocational training by highlighting new career opportunities associated with working at care interfaces:

'[Those who] *like acute care ... might then choose to do GP training whilst they keep their feet in acute care. It will be more attractive because it is giving an extra option to people.'* (2)

'So when you think general practice, you think of a Monday to Friday job sitting in a surgery, but the urgent care fellowship is a whole way of thinking, not just as a GP, but as a doctor that's an interface position, working both primary and secondary care ... It breaks all boundaries, it breaks all limitations, the world is your oyster.' (3)

The experience of being an independent GP before embarking on the fellowship was felt to be important, particularly in terms of the value and impact of having a GP working within acute clinical settings.

Hence, some felt that the fellowship objectives would be compromised if it was embedded into vocational training:

'I would not have preferred it as another 1 year in GP training. I think it would make a big difference being in the roles that we were, as a fully qualified GP compared to GP in additional training.' (7)

DISCUSSION

Summary

Overall, the study found a high level of satisfaction with the fellowship scheme and the broad range of opportunities and challenges that it offered participants. The fellows described numerous ways by which the fellowship was felt to be enabling improved patient care, integration of care, admission avoidance, and service improvement in the clinical settings within which they were placed. They felt that the scheme facilitated improved working relationship across the urgent care/primary care interface, and challenged negative attitudes about general practice that are still present in secondary care. Participation in the fellowship was experienced as addressing key professional development needs relevant to the challenges of 21st-century health care, which involve more advanced learning than gained during vocational training. The fellows felt the programme was preparing them for clinical and leadership interface roles, and at 1-year follow-up it was evident that this had been achieved. The opportunity to undertake the fellowship was thought likely to make general practice a more attractive option for medical students and recently qualified doctors.

Strengths and limitations

A strength of the evaluation is that all the participating GPs agreed to fully participate

in interviews, so allowing the collection of longitudinal data. This enabled description of fellows' experience of the scheme at different points in the year, as well as its impact on subsequent career opportunities.

However, the findings need to be interpreted in the context of a relatively small cohort of GPs undertaking what was a pilot year of the scheme. The scheme was only open to a small number of individuals, and it is possible that the seven who were appointed may have been atypical in terms of interest, aptitude, and commitment.

Shortcomings, such as staff in some settings not fully understanding the purpose of the fellowship, were identified as early difficulties. Setting up the programme had been dependent on a high level of enthusiasm and shared commitment from those providing clinical, organisational, and academic leadership. Such shared commitment may not be present in all areas.

It was beyond the scope of the study to undertake an economic evaluation of the scheme. Although the costs of running the fellowship scheme, including the leadership, administration, and fellows' employment costs, can be readily identified, the benefits of the scheme are more complex to quantify and cost. These include the impact of the service-related clinical and quality improvement activities that the fellows undertook, together with the immediate and longer-term impact of the scheme on facilitating improved understanding, resource utilisation, and communication at the urgent care/primary care interface. In addition, an economic analysis would need to consider opportunity costs, such as those relating to GPs taking on interface roles rather than working in mainstream general practice.

Comparison with existing literature

The fellowship scheme provides a template for advanced training and professional development combined with enriching the GPs' clinical experience that could be applied to other key interface clinical areas, such as mental health. The findings also provide evidence to inform discussion about extending general practice training to 4 years. The need for general practice to evolve is viewed as essential to meeting the aspirations of the NHS *Five Year Forward View*,[5] which include blurring the boundaries between primary and secondary care, health and social care, and physical and mental health. The Shape of Training report[12] supported by the Royal College of General Practitioners[14] recommended that all specialist training should be a minimum of 4 years, and newly qualified GPs are reported to feel underprepared for independent practice.[15] An extra year of training is felt necessary to ensure the increasingly complex demands of the NHS are met by a workforce with the skills and attributes to meet them.[16]

A fourth year of training already exists in a few training schemes across the UK, with a variety of academic and clinical contents. First5 GPs have described opportunities that extended training could provide as including strengthening of multidisciplinary relationships, widening managerial and leadership skills, focusing on commissioning work, and increasing the variety of training settings to develop generalist, transferable competencies that reflect those needed to work across the boundary between primary and secondary care.[17] This fits closely with the opportunities that the fellowship scheme offers participants. However, those participating in the scheme described here felt that it was important to consider the fellowship as separate to vocational training, and something to be undertaken post-CCT. The fellows were of the view that the learning was at a more advanced level than can be accommodated within vocational training, and, in order to effect quality improvement and change in secondary care settings, the fellows needed to have completed their certificate of training.

A key challenge will be the ability to deliver this type of training post within the constraints of the current hard-pressed NHS financial system. The recent emergence of Sustainability and Transformation Plans (STPs) in England offer a significant opportunity to influence the development of workforce programmes through the Local Workforce Action Boards. The Royal College of General Practitioners has already announced regional ambassadors who will work with STPs to promote the voice of primary care.[18]

Implications for practice

The fellowship model provides a defined framework for training GPs to work in an enhanced manner across primary, urgent, and emergency care settings, with the clinical, academic, and leadership skills to influence service improvement and integration. It extends understanding of the care pathways and resources available within the community beyond that gained during vocational training, and facilitates awareness of community-based care within hospital and urgent care settings.

Whether such training should be

provided as an optional additional year of vocational training or to individuals who have already gained clinical experience following completion of vocational training needs further evaluation, as does the transferability of the fellowship model to other clinical areas. The scope to integrate elements of the fellowship scheme into the current GP training curriculum also needs to be considered.

There is also a need to consider the impact of such schemes on the future GP workforce. Although undertaking the fellowship may support integration of care and open up career opportunities for GPs, so making vocational training in general practice a more attractive option for newly qualified doctors, there is a risk that in the short term such portfolio and interface roles will exacerbate the workforce crisis facing general practice. Inevitably, undertaking a further year of training post-CCT has an immediate impact on the frontline workforce and, additionally, there may be a longer-term impact if such individuals take on future roles outside mainstream general practice. The NHS is currently committed to creating an additional 8000 GP posts in order to address the requirements of mainstream general practice,[8] but the emergence of interface career opportunities may mean that this figure needs to be increased. The sustainability of this fellowship model will depend on addressing these wide-ranging workforce issues, as well as developing systems of funding that invest in the academic, clinical, and broader professional development of fellows in order to achieve service improvement at the interface with urgent care.

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Ethical approval

University of Warwick's Biomedical Sciences Research Ethics Approval and NHS R&D approval were obtained (REGO-2014-1126).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

Matthew Aiello is employed by Health Education England West Midlands as Programme Lead for Urgent, Acute and EM Workforce Transformation. Veronica Wilkie is responsible for the design of the Postgraduate Certificate in Urgent and Acute Care.

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