Summary Report of the GP Training Task Force

Final Report

28 March 2019

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1 Introduction

1.1 Preamble

This is the Summary Report of the Irish College of General Practitioners (ICGP) *GP Training Task Force*. It is intended to capture the key themes, findings and conclusions of the Task Force.

For a detailed and comprehensive report of the work of the Task Force setting out the full terms of reference, background, findings and the complete proposed training model, see the full Report: *A Model for the Future Delivery of GP Training in Ireland*.

1.2 Background and Context

In late 2018, the ICGP established a Task Force to produce a framework for moving towards a national model of GP training, delivered by the ICGP.

This Task Force was designed to include perspectives from across the GP training landscape and consider issues and options for a future training model. The model adopted will improve the educational quality of training, provide value for public money, enhance the trainee's experience, and contribute to the delivery of high-quality healthcare services to patients and communities.

1.3 The Work of the Task Force

Primarily the work of the Task Force included a series of intensive workshops, organised around specific themes and topics for consideration. Conversations were informed by broad consultation as well as desk research.

The Task Force set out a strategic vision, mission, and values for the future of GP training in Ireland and a **proposed training delivery model,** which is summarised in the following pages, highlighting the key points and issues.

The work of the Task Force was facilitated by Crowe (an advisory firm), who provided administrative, research, consultation, and drafting support.

2 The Transition to a New GP Training Model

2.1 The Current Model

There are currently 14 ICGP-accredited schemes across the country, overseen by Steering Committees comprising representatives of the programme directing team, GP trainers, hospital consultant teachers, GP trainees, the Health Service Executive (HSE), and the ICGP. Trainees completing the schemes are assessed and certified by the ICGP.

The current schemes vary in terms of governance and staffing, structures and delivery. The Task Force is keen to preserve the strengths of the current model into the future, including:

- A focus on small group learning and postgraduate workplace learning which gives a positive trainee experience;
- An approach which emphasises patient-centred care;
- A varied teaching, learning, and assessment environment with adequate development opportunities; and
- A strong connection to the local community.

2.2 The Rationale for Change

The Task Force considered the many complex and interconnected influences prompting change in GP training, as outlined in more detail in the full report. The new model addresses this broad context as fully as possible.

From a regulatory perspective, following the enactment of the Medical Practitioners Act (MPA 2007), the legislation dictates that the onus is now on the ICGP to take responsibility for its own training programme, in line with other medical education bodies. In addition, the HSE has, since 2010, indicated its intention to withdraw from the delivery of GP training. The ICGP will be the single recognised provider for GP training in Ireland and fully take over this responsibility from the HSE.

From a practical point of view, the requirement to take on programme delivery presents a positive opportunity (and big challenges for the ICGP). There is scope for improving:

- Consistency of training delivery and administration;
- The quality of the GP trainee experience; and
- Efficiency and value for public money in delivering GP training.

The proposed model presents a chance to bring a single, modern strategic focus to GP training in Ireland, while preserving the value of the existing schemes.

3 The Future of GP Training in Ireland

3.1 Vision, Mission, and Values for the Future of GP Training

Drawing on the strategic context and rationale for change, the Task Force defined the following vision, mission, and values for the future of GP training.

Vision Statement

- Every patient and their community has access to a professional, committed, and holistic GP who has the ability to respond to the physical, psychological, and social health needs of their patients and the communities in which they practise.

Mission Statement

- The mission of the training programme is to train doctors to be professional, competent, community-adaptive, and fulfilled GPs in an effective and equitable way that meets the current and future needs of patients, trainees, and the profession.

  This will be done by providing an appropriate combination of workplace learning, taught elements, self-reflection, mentoring, and peer learning, in a variety of settings, to foster individual progression from novice to independent practitioner and instil habits of life-long learning.

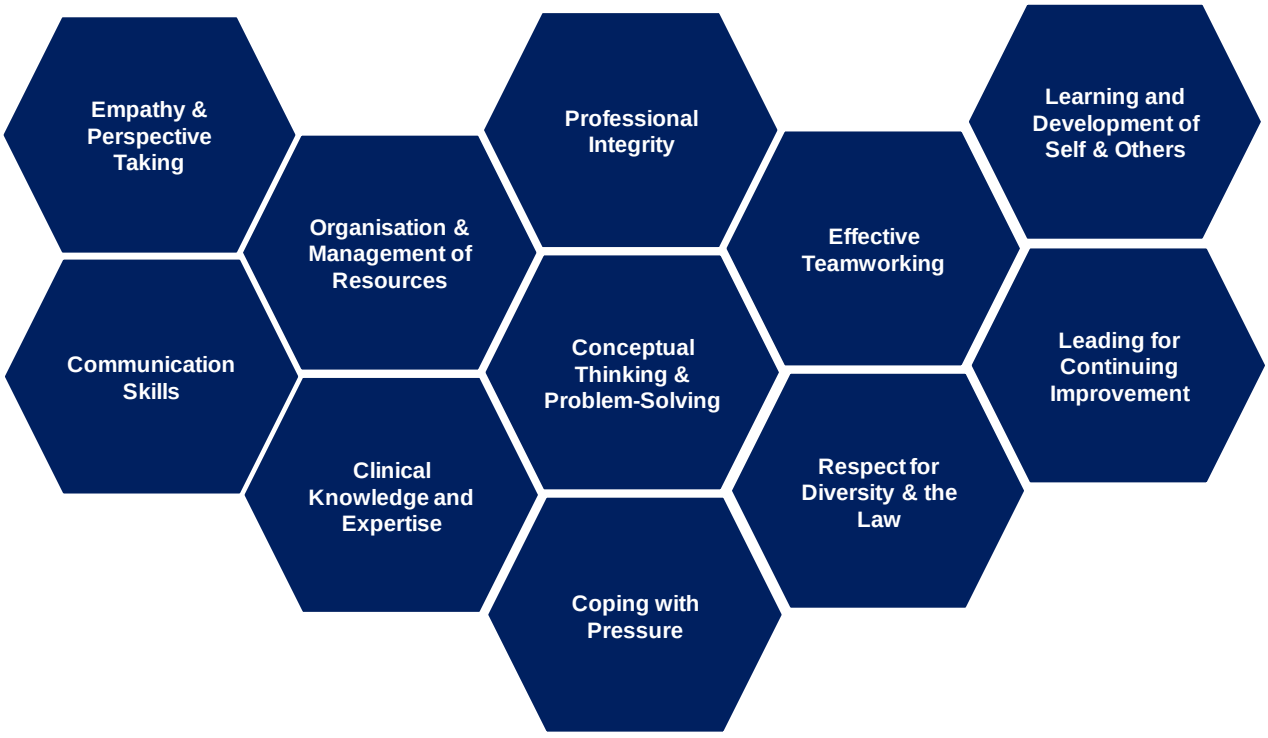
Values Statement

- The national training programme should be based on the values of community responsiveness, patient-centredness, high quality, evidence-based practice, and holistic care.

The Task Force recognises that well-trained, committed, professional, and highly competent general practitioners provide value to patients, communities, and the health system. As well as providing positive health outcomes for patients and the associated benefits to their families and communities, GPs who are well-trained and competent ensure that patient care is delivered in the most appropriate and cost-effective way.

3.2 Looking Forward

These statements set the scene for training the kind of GP we will need in the future. GPs ten years from now will have needs and face challenges that are difficult to predict. Those doctors must have a flexible toolkit of competences, such as those described by Patterson *et al*[1], as illustrated below:



Core Domains of Competency for General Practice

The proposed model is built to create a learning environment which facilitates trainees acquiring these skills and insights.

[1] Patterson, F., Tavabie, A., Denney, M., Kerrin, M., Ashworth, V., Koczwara, A. and MacLeod, S., 2013. A new competency model for general practice: implications for selection, training, and careers. *Br J Gen Pract*, *63*(610), pp.e331-e338.

4 The Proposed Model

4.1 Introductory Comments

This chapter sets out the key features of the proposed model.

4.2 A Revised Regional Training Structure

A **single national training programme** is envisaged to be delivered in four regions through 11 training areas. These regions and areas are aligned with acute hospitals. The proposed geographic distribution meets existing and anticipated capacity needs, while providing space for future expansion. Following the adoption of this report, there will be a transitional period of implementation of the new structures on a phased basis.

	Training Area (indicating amalgamation of existing schemes where relevant)	Proposed location of educational site	2018 Intake	Est. Total Trainees†	Potential intake
Region 1	Cork	Cork	14	56	*21*
	South West	Tralee	10	40	*12*
	Limerick	Limerick	14	56	*18*
Region 2	Midlands* • Ballinasloe (8) • Tullamore (12)	Athlone	20	80	*24*
	Donegal	Letterkenny	9	36	*12*
	Sligo	Sligo	9	36	*12*
	Western	Galway	18	72	*24*
Region 3	Dublin North/North Leinster* • Dublin North (16) • RCSI (12)	North Dublin	28	112	*33*
	North East	Navan/Drogheda	20	80	*27*
Region 4	Dublin South/South Leinster* • TCD (16) • UCD (12) • Naas (8)	South Dublin	36	144	*39*
	South East	Waterford	15	60	*18*
	Total: 11 training areas		**193**	**772**	***240***

** these amalgamated schemes would merge over time with one identity*

† (based on x4 of current intake)

The proposed model ensures adequate regional cover and minimises trainee and trainer travel distances between training areas and clinical environments.

In considering the optimum structures for the new model of training, a “blank sheet” approach was taken, based on the principle that training would continue to be delivered at educational sites throughout the country to preserve the value of regionally-based training for GPs. The Task Force considered that a smaller number of training areas than the current number of schemes would enable the training programme to be more efficient and sustainable, and would be capable of leveraging the capacity for larger training areas to operate with better-equipped and more appropriate accommodation, along with improved IT support and other resources. The areas proposed are based on establishing training areas with adequate numbers of trainees to generate such efficiencies, with the exception of some smaller areas based in geographically outlying parts of the country, where the distances involved in combining existing schemes would be impractical for trainees.

The process of moving to this revised regional model will require improvements in educational, accommodation, technological and administrative facilities and infrastructure for the GP training programme.

4.3 Improved Curriculum and Assessment Frameworks

The Task Force proposes an improved curriculum framework, with flexibility for local areas to design their own curriculum, which builds on international best practice for:

- Medical education;
- Work-based learning;
- Postgraduate education;
- Teaching, adult learning, and assessment.

The new model will improve the training experience for trainees, educators, and trainers, and will also provide benefits for administrators, and ultimately patients.

The new teaching, learning and assessment approach is based on a firm commitment to a revised ICGP curriculum framework, which is founded on competency-based GP education. The new model will:

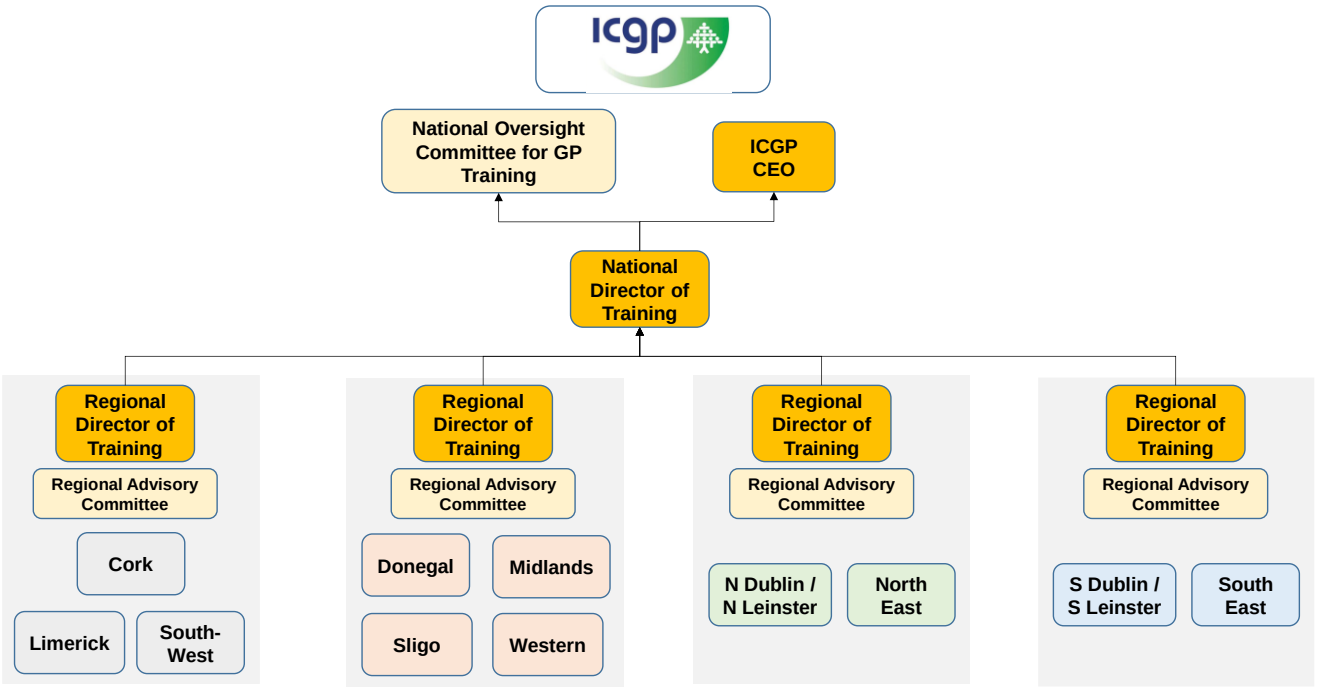
- Improve fairness, validity and consistency in the delivery of the programme nationally, whilst allowing for flexibility to design a curriculum at local level;
- Use appropriate technologies to enhance teaching, learning and assessment (such as online portfolios);
- Increase opportunities for reflection and sharing of educational experiences between trainees;
- Sustain the focus on small-group teaching, mentoring and a close relationship between trainee and trainer;

- Ensure that progression in training is determined by robust evidence of attainment of the required standards, as assessed by progression-review panels – a move away from purely time-based accreditation;
- Redistribute the trainee assessment burden from small numbers of high-stakes assessments to more frequent lower-stakes assessments that involve a focus on:
    - Assessment of learning
    - Increasing the scope for demonstration of achievement of learning outcomes
    - Providing timely and useful feedback
    - Ensuring there is greater awareness of difficulties trainees may experience and identifying trainees who are not progressing as expected
- Support trainers and hospital consultants in providing formal feedback and assessing competence in trainees across multiple low-stakes assessments, contributing to an evidence base for progression rather than a binary yes/no decision;
- Empower trainees to take ownership of their education and training process, by shifting the onus to the trainee to ensure they are gathering appropriate evidence of their competence as they progress through the training programme.

Critically, GP training will be based on best practice and will be consistent across the country.

4.4 Quality Assurance and Governance

The most significant structural change, as described earlier, is that rather than 14 separate schemes for training, there will be a single ICGP-led model, which is illustrated below:



The training areas will be supported by a regional structure, led by new Regional Directors of Training (supported by Regional Advisory Committees), who will be responsible for the delivery of the training programme within their own region and to work together with the other Regional Directors in the delivery of the programme nationally. The ICGP will provide oversight and support through a National Oversight Committee and the National Director of Training. This structure will oversee all decisions relating to the programme, including establishing policies and procedures for:

- Developing the programme, monitoring the delivery of training and assessing trainees;
- Allocating resources to the programme;
- Making decisions regarding admission, progression, certification, and management of trainees;
- Deciding appointments of trainers and other staff;
- Continuing professional development;
- Managing relationships with partner hospitals and their associated academic institutions; and

- Managing regulatory and compliance affairs for the programme (such as accreditation and qualifications).

The governance system will be the key central organising feature of the new model, ensuring that the programme enables trainees to meet the standards required for qualification as GPs.

4.5 Resources and Costs

4.5.1 Training Model Resource Requirements

Indicative resourcing requirements for the delivery of training are set out below. These estimates are based on a training area taking in 12 trainees per year, operating with four active cohorts (48 trainees). The model proposes a standardised academic year of day release across all areas, with the remaining weeks used to support planning, preparation, site visits, and other activities. Taking into account the range of activities involved (see Appendix 6 in main report) and the need to have appropriate resources to provide teaching, it has been estimated that an Area Lead would require approximately 19 hours per week and a GP Educator team would require approximately 50 hours per week altogether.

Elements of the work of Area Leads, for example participation in committees and other activities, may be outside the scope of this resource estimate.

The figures stated above are intended to represent an indicative amount of hours, and are not meant to be definitive or prescriptive: this is merely a starting point for calculating the resources required within the model, and the assumptions and estimates will need to be tested and examined in detail. Further work during the implementation process will be required to determine more accurately the time requirement for an Area Lead and GP Educators.

Appropriate administrative support will be provided at educational sites; this support may need to shift in focus from the administrative tasks performed in the current training schemes as more support is provided centrally from ICGP and as the requirement may emerge for more local technical support for the increased use of technology (e.g. e-portfolios).

This training area resourcing model will be supported by a Regional Director of Training, operating 2-3 days per week and supporting multiple training areas.

In order to support the delivery of the national training programme, and the work of the Area Leads and GP Educators within the educational sites, the ICGP will require appropriate resources to provide the necessary inputs to the programme, including centralised administration support and responsibility for accreditation, compliance, recruitment, certification, and educational development and advancement.

4.5.2 Cost

The Task Force has designed a programme which requires appropriate resourcing and the associated funding for this. The model we recommend will not be capable of implementation without the required resources being put in place. However, the capacity of the Task Force to develop a detailed, reliable cost model to estimate the costs of the proposed national GP training programme was significantly limited.

The HSE was not in a position to provide relevant cost data in relation to the existing schemes. In the absence of this information, it is not possible to accurately cost the changes proposed in this report.

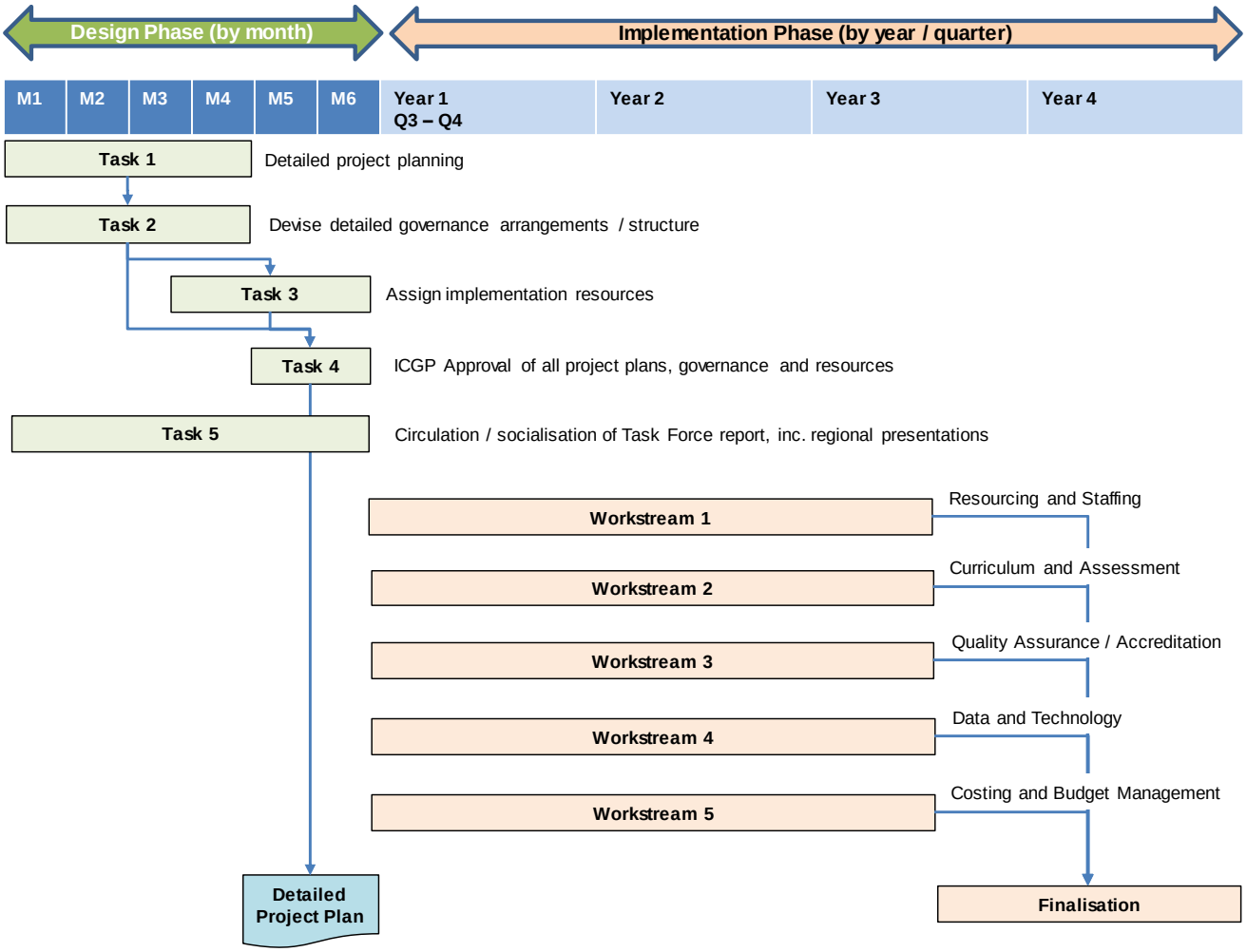
4.6 Implementation

The proposed model will be implemented in a phased way through a large programme of work, lasting up to four years. The ICGP will provide leadership and direction to the sector during implementation, with contributions from a large group of stakeholders within the GP training, healthcare and education sectors.

The next steps are:

- Development of a detailed implementation plan;
- Identification of timelines, milestones, deliverables and resources;
- Appointment of key project staff;
- Creating a budget, resourcing model and oversight system, and;
- Agreement of progress reporting arrangements and timescales.

A high-level implementation plan is set out in the figure overleaf.


Design Phase (by month)
Implementation Phase (by year / quarter)
M1
M2
M3
M4
M5
M6
Year 1
Q3 – Q4
Year 2
Year 3
Year 4
Task 1
Detailed project planning
Task 2
Devise detailed governance arrangements / structure
Task 3
Assign implementation resources
Task 4
ICGP Approval of all project plans, governance and resources
Task 5
Circulation / socialisation of Task Force report, inc. regional presentations
Workstream 1
Resourcing and Staffing
Workstream 2
Curriculum and Assessment
Workstream 3
Quality Assurance / Accreditation
Workstream 4
Data and Technology
Workstream 5
Costing and Budget Management
Detailed Project Plan
Finalisation

5 Concluding Comments

The work of the Task Force consisted of a very deep and detailed examination of the existing model for GP training, as well as a far reaching examination of issues and options for the future.

The Task Force proposes this model with a high degree of confidence that it can and will be able to implement it with hard work and the goodwill of all the stakeholders concerned.