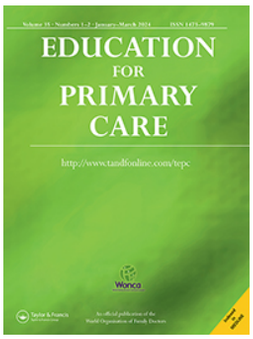

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RESEARCH ARTICLE

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An overview and evaluation of the differential attainment champion role in the North West of England GP school

Catherine Morgan[a], Rebecca Baron[a], Liam Jenkins[b] and Jeremy Brown[b]

[a]NHS England North West, Manchester, England; [b]Health Research Institute, Edge Hill University, Ormskirk, England

ABSTRACT

Background and aims: In the Northwest of England, a national allocation of funding to minimise the effects of differential attainment has been used to support experienced GP educators to act as Differential Attainment Champions (DAC) since October 2021. An evaluation of the role's impact was undertaken.

Methods: The evaluation was designed to gather the views and experiences of DACs and their trainees via online semi-structured interviews during the first 12 months following establishment of the intervention programme.

Results: Thematic framework analysis identified three main themes: DACs' adaptive approach to support trainees; barriers to fulfilling the DAC role; and the positive impact of the DAC role on training. The following aspects of the DAC role worked well: the freedom to tailor support to the individual needs of the trainees; the targeted and proactive support early on in GP core training; the support of trainees in a wide range of areas including e-portfolio advice, examination preparation, and personal help. Trainees valued one-to-one support when needed. Reported improvements included: improved examination outcomes; portfolio engagement recognised in some cases by Annual Review of Competence Progression (ARCP) panels.

Conclusions: The individualised and adaptive approach works well but it does mean it is difficult to quantify how many trainees can be supported by one DAC and their workload needs to be monitored.

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International medical graduates (IMGs); Differential attainment (DA); GP training; trainer-trainee relationship; support

Introduction

International Medical Graduates (IMGs) experience disproportionally worse outcomes from General Practitioner (GP) Specialty Training in the United Kingdom (UK) when compared to their peers [1–3]. This variation in outcomes is not explained by any single identifiable factor such as aptitude or motivation and is called differential attainment (DA) [4–6]. Woolf et al. [7,8] reported on both the barriers to progression as well as the enablers that allow others to be empowered and progress. This has informed organisations on how to begin to support trainees better through more targeted interventions. Failure in the membership examination of the Royal College of General Practitioners (MRCGP) delays trainee progression and has a significant impact on the trainee themselves. Examination failure in this context refers to components of the MRCGP examination: the Applied Knowledge Test (AKT), as well as the Simulated Consultation Assessment (SCA), replacing the Recorded Consultation Assessment (RCA), and the Clinical Skills Assessment (CSA) before that. It adds to financial pressures on training organisations to provide extra supervisory resources to support additional training time and impacts on workforce capacity.

Early targeted support interventions have been demonstrated to have a positive impact on GP training. Hawkridge and Molyneux reported that targeted support developed by the Northwest deanery for candidates and their trainers significantly improved examination pass rates amongst those retaking the CSA in the Northwest of England [9].

A national allocation of funding to minimise the effects of DA in GP training was established for Health Education England in 2021 [10]. In the Northwest, it has been used to support experienced GP educators to act as DA champions (DACs). DACs (GP trainers/educators) were appointed to support all non-UK graduates, doctors in training with adverse Annual Review of Competence Progression (ARCP) panel outcomes and those identified by educators as benefitting from additional support. DACs received three hours of online

CONTACT Jeremy Brown brownjm@edgehill.ac.uk Medical School, Faculty of Health, Social Care & Medicine, Edge Hill University, St Helens Road, Ormskirk, Lancashire L39 4QP, England

induction training. This training focused on providing DACs with an understanding of the role, through making them aware of the issues trainees face, as well as what support processes and resources they can be directed to. It provided them with a plan for the first three months of their role. This included how to identify a trainee in difficulty, how to conduct the initial meeting with trainees using a template guide, and external signposting. This was followed up by monthly or bimonthly DAC support meetings focussing on specific topics such as examination support. Many of the DACs were AKT and CSA Support On eXtension (CSA SOX) educators [9]. Training was provided: focussing on coaching and mentoring, bystander training, conscious competence, cultural competence and allyship. There was neurodiversity training with appropriate signposting to dyslexia screening and general training in a holistic approach to settling in the UK for the IMGs. This included how to provide signposting to practicalities such as setting up a bank account, household utilities, organising childcare and how to access lead employer support. Ongoing DAC support was provided by a one-day annual DAC conference, regular meetings and DACs had access to a group messenger mobile telephone application where they could share ideas with each other. This training and support aimed to prepare DACs to deal with the breadth of issues trainees may discuss with them.

DACs had some autonomy to decide the best use of time for a trainee's needs. They were guided on areas to focus on such as they received training on: how to support trainees preparing for examinations; how to guide trainees on portfolio use; where to direct trainees for issues relating to communication skills or health issues. DACs were highly trained with a wide range of tools to use and the autonomy to put these to the best use for the needs of an individual trainee. The frequency, format and content of the support provided may have differed for each individual trainee. Most DACs conducted meetings with trainees online via Microsoft Teams™.

Often trainers request DAC input to support what they are already doing as the DAC has more paid time for this and is highly trained. Also, there is good evidence (9) from the SOX project that a triadic tutorial with the trainee and trainer together is beneficial and the DAC could arrange this where appropriate, with the full agreement of the trainer and trainee.

Evaluation methods

The evaluation gathered the views and experiences of DACs and their trainees on the impact of this targeted support. The aim was to interview each DAC three times over the first 12 months of their new role. The first interview explored expectations of the role. The second interview, carried out six months later, explored experiences so far and what had been implemented. A final interview, approximately 12 months into the DAC role, focused on whether expectations had been met and explored the enablers barriers to fulfilling their role. GP trainees were interviewed once to explore their views and experiences of being supported by DACs to gauge whether this had helped them during their postgraduate training. Semi-structured interviews lasted up to 20 minutes and were audio-recorded.

Recruitment

Those taking up the role as DAC were notified of the study in their induction, and subsequently received an email with a participant information sheet from the GP School to explain that the evaluation was taking place. Volunteers emailed to arrange an initial interview via Microsoft Teams™. At the start of each interview the wording of the consent form was talked through by the interviewer and the participant gave their verbal consent to proceed. Follow-up interviews were arranged via email. DAC interviewees forwarded email invitations to trainees they were supporting. Trainee interviews were arranged and conducted in the same way.

Analysis

The interview transcripts were analysed using a Thematic Framework Analysis method [11]. We adhered to established techniques of analysis to ensure credibility and transferability with two authors (LJ and JB) independently interrogating the anonymous transcripts. In areas of disagreement the two authors discussed the discrepancies until agreement was reached. Transcripts were first read to familiarise the interview's content. Next, codes were identified across each interview, which were subsequently selected into themes across all transcripts. Key quotations were identified within each selected theme.

Findings

Fifteen DACs were initially interviewed. Eight took part in a follow-up interview. Six then participated in a second follow-up interview. Ten trainees were interviewed. Thematic framework analysis identified three main themes: DACs' adaptive approach to support trainees; barriers to fulfilling the DAC role; and the positive impact of the DAC role on training.

DACs' adaptive approach to support trainees

DACs explained in their initial interviews that they saw this as an opportunity to provide support to trainees in a more structured and organised way. Having a defined role provided them with time to provide individualised support to trainees. Some participants described previously supporting failing trainees, or even having the same experience themselves as IMGs. The DAC role was seen as a facilitator for participants to provide support on a more regular and individual basis:

> It depends on individual needs of the trainees, so that's why it's more one-to-one focus as a DAC. So I'm kind of focusing on their needs, really. (DAC participant 4)

DACs welcomed the opportunity to offer support at an earlier stage in GP training. They recognised the importance of early targeted support:

> Just trying to bring the ideas in very early to try and help these doctors get up and running early on in their three years. (DAC participant 2)

There was acknowledgement amongst DACs that support may focus as much on the personal aspects of living in the UK, often away from family members, than professional support:

> Lots of these trainees are away from family, away from their home, lots of them haven't been home for two years because of covid and various reasons. I hope to provide some sort of support. (DAC participant 8)

DACs and their trainees explained how the role was beginning to work in practice. DACs reported taking an adaptive approach to meet each trainee's needs:

> I got several coming forward but the support they each wanted was all quite different. So it's very much dependent on where they were and what they were experiencing. (DAC participant 3)

Trainees acknowledged the personalised nature of the support they received:

> It was very much tailored to me. He was fully aware of the specifics of the situation. (Trainee participant 2)

> He was focusing on me, my worries, my difficulties. (Trainee participant 5)

This adaptive approach included encouraging trainees to contact them when needed:

> I kept the door open, so look, here's my contact. You know where to find me? Send me an e-mail if you need anything and I'll be here listening and hoping to help. (DAC participant 1)

Trainees reported being particularly appreciative of this flexible approach:

> He said when we next meet it can be as soon or as long as you want. The amount of time you had available to talk was great. I think the first time we spoke for two hours so it didn't feel rushed at all. It didn't feel rushed at all. Sometimes, maybe I felt with my supervisor because they were busy, running a GP surgery at the same time that maybe didn't have as much time as the DAC could provide, it was really good. (Trainee participant 2)

DACs appreciated the freedom to structure their role in a way that suited them. They explained how they had managed the role to fit in with other commitments. DACs reported supporting between 15 and 30 trainees at any one time. Most were IMGs but not all. There was an inevitable variation in how much time was spent supporting each individual trainee:

> Some just needed one meeting just to see how they're doing and I just say, I think you're doing well. And there are people who actually I have met three or four times, because they really struggled and they contacted me frequently and two of them had to go through adverse ARCP panels. (DAC participant 1)

DAC participants explained that trainees appreciated having them there to listen to when needed:

> A lot of the trainees are in distress and just need someone to be able to have a chat with and not feel that I'm not there to judge them. I'm there to help them. (DAC participant 5)

Most trainees referred to e-portfolio advice as a key aspect:

> He is the best person and he has a lot of experience and on the GP portfolio. (Trainee participant 1)

> We looked at my portfolio together. He looked at the clinical cases and he advised me on how I could improve them because I was really struggling with my portfolio. It was just one big confusing thing. Although my supervisor had explained it to me multiple times. But, sometimes you tend to understand when it comes from a different perspective. So that really helped. (Trainee participant 8)

Another key aspect of DAC support was around examination guidance:

> We did do quite a bit of work with them to get them on board with AKT preparation. (DAC participant 4)

Trainees confirmed how useful they found examination advice:

> The DAC had a good knowledge of that examination because they were a GP trainer, so he would talk me through some of the things and so provided some reassurance. (Trainee participant 2)

Communication skills were also focused on:

> The DAC helped us to arrange some kind of communication sessions which were massively helpful. (Trainee participant 7)

Barriers to fulfilling the DAC role

DACs reported that a barrier to implementing their role was a reluctance amongst some trainees to sign up to the support:

> Well, there might be some people who don't make contact because they don't want it, they don't want to flag themselves up. So that would be my worry. (DAC participant 3)

Another reason behind this lack of engagement may be that some of the trainees lacked awareness on what the DAC role could offer. This is evidenced by one DAC, who mentioned that a trainee only realised the true benefits of using the support on offer, after meeting with them:

> He first thought that my role was just to tell him how I did it . . . and when he started to realise actually my role is more a lot more than that, he was amazed and he said OK, actually, some of my colleagues might benefit from you as well. How can I put them through to you? (DAC participant 1)

DACs would appreciate help with the administrative aspect of trying to initially engage with trainees:

> It felt a bit overwhelming at times, I had this huge long list of trainees and you'd email, some of them will get back to you straight away, others just wouldn't. You would never hear from them again. And perhaps some administrative support would be useful. (DAC participant 7)

Positive impact of the DAC role on training

Participants reported the impact tailored support was beginning to have on training. Both trainees and DACs had positive perceptions on the impact of the role, both professionally and personally:

> There was one particular trainee who had failed her AKT on one occasion, which was completely unexpected . . . she had never failed anything in her life and what she needed really was a bit of additional support. She was going through a difficult time at home. There were some issues there with her family. And so I probably met with her four or five times over the space of about two or three months. I think just having that additional support, having someone take an interest in her and having someone . . . . just kind of a listening ear, probably did make an impact. (DAC participant 7)

This professional and personal impact was confirmed by trainees:

> He also basically did tailor it according to what my needs were and what he thought my needs would be. And then I made a lot of changes which did impact my performance at work as well as at home. (Trainee participant 8)

DACs reported improvements in work-based assessments and examination performance:

> I've seen positive outcomes in terms of progression through workplace-based assessments and exam passes. (DAC participant 14)

Trainees reported the impact this DAC support had on examination performance:

> Well, we talked about examination and rankings and he was of the opinion that I should try and put in more effort in my examinations because he felt maybe a few things were just borderline. And I had reasons for some of those outcome anyway, but I think I utilised it for my subsequent exams and I think it paid off, yeah. (Trainee participant 6)

Advice on writing skills in portfolio entries had a noticeable impact:

> In fact on Friday I received an e-mail from the chair of an ARCP panel to say that they were really happy with the input I provided for a trainee who had been sent, who's portfolio was being reviewed at panel and they were happy with my ongoing support of that particular trainee. (DAC participant 14)

Discussion

Summary of research findings

This evaluation focused on the expectations of the DAC role, how it developed in practice before identifying how the role had impacted on trainees' GP training. DACs expected their support to be individualised to each trainee. They expected to advise not only on professional practice but also personal matters, if needed. This professional and personal support was reported in practice. There was enthusiasm for offering early support in a trainee's GP training that had the potential to help them avoid the stress and anxiety related to examination failure. Overall, the DAC role in practice met initial expectations and was reported to be having a positive impact. There was freedom to tailor support to the individual needs of the trainees early on. This support covered a wide range of areas including e-portfolio, examination and ARCP advice; communication skills; and personal advice. A key enabler for the DACs was having the freedom and flexibility to structure their

ways of working with their trainees. Trainees appreciated the one-to-one support; and having a GP contact who was perceived to be unbiased.

These factors contributed to the following reported positive impacts on GP training: reported improvement in examination outcomes; improved portfolio engagement recognised in some cases by ARCP panels. DACs expressed some concern that trainees were not always aware of the type of support the DAC could offer them. This lack of awareness of the DAC role meant some trainees were not making contact to access support and this led to allocated time being spent on administration duties inviting trainees to make contact with them. DACs would welcome help in advertising their role more extensively with trainees. DACs felt their role was rewarding and valued but workloads need to be carefully monitored. DACs had varied employment contracts in terms of sessional time, and the amount of DAC time for each programme was apportioned in accordance to differential attainment risk in that area. Some trainees only needed one short meeting for reassurance that they were on track, while others needed much more regular online and face-to-face input. It is difficult to gauge workloads for each DAC.

Comparisons with existing literature

De Silva et al. reported on how a multifaceted approach enhanced the possibility of a successful outcome for trainees on the Targeted (TGPT) GP Training Scheme [4]. The DAC role ensures specialists in this area proactively deliver a bespoke and individualised approach, reaching all trainees in the Northwest identified as needing extra support. This does include TGPTs, along with all non-UK graduates, trainees receiving adverse ARCP panel outcomes, as well as trainees identified by training programme directors and supervisors. The bespoke nature of this role was aided by the DAC role differing from that of an Educational Supervisor (ES) role; DACs had protected time to individually support trainees beyond the capacity of an ES, and were more highly trained for the role, with particular attention placed in their training to areas such as allyship, IMG support, cultural competence, active bystander, and neurodivergence. This may have facilitated the impact of the DAC role.

Recommendations for further research and impact on practice

To sustain the DAC role the freedom and flexibility of working in a way that suits the DAC should be maintained. The individualised and adaptive approach works well and the reported improvements in examination outcome and portfolio engagement suggests this strategy has value. This may raise expectations amongst trainees of the support that can be offered to them and should be monitored over time to ensure DACs can sustain this level of input. Future research and evaluation should monitor progression in training in the GP School in parallel to further qualitative exploration of the perceptions of DACs, GP trainers and trainees.

To gain a deeper insight into the impact of the DAC role requires assessment of other measures beyond the views of those who engaged in this evaluation. For example, gathering the views of other key stakeholders and exploring regional examination data to investigate the performance of groups of trainees offered this extra support.

Limitations

Findings reported only represent the DACs and trainees who volunteered to take part in the evaluation. Not all DACs who took part in the initial interviews volunteered to participate in subsequent interviews. All trainees who took part were those who were supported by DACs who had participated in this evaluation. As there was an opt in process for the trainees it is possible that those with a more positive initial outlook on the programme were more likely to volunteer to participate in this study. We do not know the reasons why trainees participated.

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Disclosure statement

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Ethical approval

Ethical approval was granted by Edge Hill University's Health Related Research Ethics Committee.

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