Shape of Training Review

1. I write with regard to the Shape of Training Review.

2. The Royal College of General Practitioners is the leading professional organisation in the United Kingdom representing general practice. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this review.
Q1. Over the next 30 years, how do you think the way patients are cared for will change?

The RCGP has recently completed a major consultation on the future changes in healthcare as part of the development of its 2022 Vision for General Practice\(^1\). The broad findings were as follows:

- **The health needs of our population are changing**: we belong to an ageing population in which an increasing number of people have multiple long-term conditions – people who require more complex medical care delivered in their community or at home. Quite rightly, expectations for individual and family wellbeing are rising and there is growing intolerance of long-standing inequalities in health. Technology is revolutionising how we communicate and access health information or services.

- **The constituents of effective, high quality healthcare are changing**: we are in a time of transition, moving away from a twentieth century model of care with unhelpful divisions of hospital-based and community-based practice and of health and social care. We are moving instead towards a twenty-first century model of integrated care where patients, carers and healthcare professionals work closely together in flexible teams across organisational boundaries, formed around the needs of the patient and not driven by professional convenience or historic location.

- **The financial environment in which healthcare is provided is changing**: health and social care systems are under increasing financial pressure while the needs of patients and populations continue to grow, in both complexity and volume. These constraints mean that a move towards more cost-effective, integrated, resilient systems of care is essential, with new structures that enable communities to take an increasing role and responsibility for the design and delivery of localised services and to develop as self-sufficient health resources in their own right.

These long-term trends mean that healthcare will need to change over the next 30 years times in the following ways:

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• **Large-scale development of integrated and personalised healthcare services:** to enable a comprehensive, continuity-based, person-centred approach, in order to diagnose, manage and treat the growing number of patients with complex long-term conditions and multi-morbidity; to provide cost-effective, high quality care in both community-based and hospital-based care settings, in the context of the growing social and other holistic care needs of an ageing, increasingly diverse and mobile population.

• **A higher proportion of healthcare professionals with generalist expertise:** to enable the incorporation of increasingly sophisticated biomedical knowledge into a comprehensive and whole-person understanding of the patient and their family; to manage multiple risks safely and cost-effectively; and to share complex decisions with patients and carers while adopting an integrated, system-based approach to the coordination of care.

• **Routine involvement of patients and communities as partners in care:** to enable patients and carers to be more informed about their conditions and their evidence-based management; to increase the numbers of patients participating in community-based research in order to increase the evidence base on multi-morbidity; to improve shared decision-making to inform clinical decisions and to enable patients and carers to participate in service re-design; to support the development of communities as health resources and to improve the self-sufficiency and resilience of communities and the individuals and families within them.

The way care is structured and delivered, particularly in primary care, will change in a number of ways, in response to a range of societal drivers:

- Increasing diversity of the population with increased migration, not only internationally but also nationally and locally. Due to the changing nature of work and the pattern of work, more individuals will move location more often, thereby changing practice profiles. This will increase pressures on general practitioners to remain vigilant to the presentation of conditions not commonly seen in the UK.

- Changes in the physical environment (e.g. climate change) resulting in an increased threat to health from infection and non-infectious disease.
More personalised medicine, which not only provides holistic care tailored to the needs of the individual, but also more personalised preventative medicine including genetic screening and genome therapy.

The challenge of promoting healthy lifestyles and behaviours and of engaging patients in their own care.

A change in patient expectations about the NHS and the service that it can provide, as patients increasingly become consumers that are used to more immediate service and results.

Ongoing changes to the structure of health and social care, particularly in England in the wake of the Health and Social Care Act.

The potential for service fragmentation as a result of competition and the use of multiple providers; and continuing barriers to better integration between health and social care.

Q2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

The requirement for more generalist, integrated and personalised approaches to care apply to both community- and hospital-based settings. A key challenge for the health service will therefore be to break down the barriers that have arisen historically between primary and secondary care, and between health and social care, and to adopt more outcome-orientated and person-centred approaches to care delivery, which will in turn need to be reflected in workforce organisation and training.

The need for more generalist expertise in both community- and hospital-based healthcare services is supported by a growing evidence base. However, it is important to define what is meant by ‘generalist expertise’, so that this understanding can be applied to future developments in training across the breadth of healthcare. The RCGP has drawn on the work of many stakeholders who contributed to the Independent Commission on Generalism and the Enhanced GP Training development work to identify a number of key themes of generalist expertise that can be applied broadly to all disciplines and healthcare settings (Figure 1).
What is generalist medical expertise?

Medical generalism is an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient’s problems. Its principles will be needed wherever and whenever people receive care and advice about their health and wellbeing, and all healthcare professionals need to value and be able to draw on this approach when appropriate. The ability to practise as a generalist depends on the doctor’s training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs.

It involves:

a) **Whole person care** - Seeing the person as a whole and in the context of his or her family and wider social environment, and using this perspective as part of one’s clinical method and therapeutic approach to all clinical encounters

b) **Expert medical care** - Being able to deal with undifferentiated illness and the widest range of patients and conditions

c) **Complex care** - In the context of general practice, taking continuity of responsibility for people’s care across many disease episodes and over time

d) **Systems of care** - Also in general practice, coordinating his or her care as needed across organisations within and between health and social care.

As discussed in question 3, GPs will play a key role in, coordinating the activities of a range of professionals around their patients, so that patients and carers experience seamless care centred on their needs. This will require GPs to extend their area of work beyond the traditional primary care setting.

Similarly, a larger number of secondary care specialists will, in future, need to extend their work into communities, working more closely with GPs and others. This will lead to both GPs and specialists being based together in some health settings; examples might include running joint community-based services in some practices and working together in intermediate care and urgent care units.
These approaches were discussed in the joint paper ‘Teams Without Walls’, and more recently we have provided in-depth discussion in the RCGP’s policy report on integration of care. We define integrated care as:

‘Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes.’

The report (p19) also identifies a number of features that characterise the design and delivery of services that provide integrated care:

- Shared electronic patient record systems providing the ability for both community- and hospital-based teams to access and use information about patient problems, medication, actions, previous failed strategies and what the patient has been told, along with information on the goals of the patient;

- The development of new community based and intermediate services, such as outpatient clinics, hospital at home and re-enablement schemes;

- Employment of generic care workers who can undertake basic health and social care tasks;

- Initiatives to promote more timely hospital discharge, for example proactive discharge planning by hospital discharge co-ordinators;

- The use of best practice clinical guidelines and the development of clinical protocols to spell out who has responsibility for different elements of the care pathway;

- Establishment of common intervention thresholds and needs assessment frameworks;

- The introduction of new structures for clinical governance and leadership;

- Systems to allow easier access to specialist advice, including through the use of online technology;

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The development of disease registers and the employment of risk stratification techniques to identify those most likely to benefit from proactive intervention.

Q3. What do you think will be the specific role of general practitioners (GPs) in all of this?

The future of general practice in the NHS will be built around the general practitioner’s central role as a community-based, family-orientated, expert generalist clinician and as a coordinator and navigator of personalised, integrated healthcare. This role will be essential to improve health outcomes, reduce inequalities and to ensure the long-term sustainability of the service.

GPs are well placed to take on an enhanced coordinating role within the teams delivering integrated healthcare services to local patients and families; they are used to working in community-based practices as part of a multidisciplinary team, which commonly includes nurses, healthcare assistants, receptionists, managers, and other staff. In the future, the community healthcare team will be expanded to include closer working with a range of other healthcare professionals, such as consultants and other specialists, health visitors, pharmacists, midwives, and social care workers. There is also scope for GPs to work across traditional organisational boundaries and to become more involved in work in hospital settings and in the pre-hospital care of acute medical cases.

Currently, only one out of every 20 consultations with a GP results in a secondary care referral4. The vast majority of problems are dealt with in primary care. In the future, GPs will provide a wider range of investigations and treatments in the community. If a more specialised intervention is required, however, they will continue to refer the patient to a specialist team.

GPs also provide a wide range of educational, leadership, management and academic roles in the NHS. They are increasingly responsible for local service redesign across the UK and, in England, for the commissioning of healthcare services. As more care shifts into the community, the wider NHS workforce will have to realign accordingly, and this workforce will include a greater number and diversity of trainees in community settings, including GP specialty trainees but also more undergraduate and postgraduate trainees from a range of disciplines and also more nurses and allied health professionals. This will require an expansion in the educational capacity

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of general practice and new approaches to how training and supervision is funded, planned and delivered.

In practical terms, the way care is delivered in general practice, will change in a number of ways:

- With the growth of multi-morbidities, there will need to be greater flexibility in the length of patient-clinician consultations
- There will be flexibility in how consultation and communication with patients is conducted – with face-to-face, remote, home visit, individual and group consultations and an increased use of technology to facilitate communication
- The multi-disciplinary team will use risk stratification to identify patients who would benefit from a move from reactive unstructured care to planned proactive care
- The team will use technology more effectively, for example for ‘virtual’ consultations and to help identify high-risk patients and support their care in community settings. We can also expect an increase in the use of social media-type technologies in response to patient demand.
- Patients will be supported to self-care using electronic information systems as well as shared decision-making with their GP

GPs will continue to provide holistic, comprehensive care for their patients and act as ‘navigators’ of care for patients in the health service, coordinating integrated teams of primary and secondary care clinicians (along with other professionals such as social workers), as discussed in our report on integrated care:

‘Beyond the direct provision of care, GPs’ role as the gateway to more specialised treatment means that they play a crucial role in facilitating the smooth transition for patients across organisational boundaries. The ability of GPs to make appropriate referrals and assist patients and carers in navigating their way around the system, is vital. Increasingly, GPs are also being looked to for the provision of advice to patients on the options open to them under the Government’s policy in England of choice of healthcare provider.’
GPs in England will also be commissioners of care, leading in the decisions on which services are developed within local communities. GPs in the devolved nations will be involved in leading the planning and delivery of healthcare services which are centred within the community rather than being based in hospitals.

Q4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors’ training (including GP training) change to meet these needs?

General principles of relevance to all disciplines

To meet changing population and service needs, a greater number and range of community-based and hospital-based professionals will need training as generalists. We recommend that all health care professional training promotes generalist approaches to patients regardless of specialisation later in training, as generalists do not just belong in primary care or community settings. More generalists are needed in hospitals, particularly in the management and treatment of the undifferentiated acutely ill and those with co-morbidities.

Communities and primary care settings are, by their nature, however, predominantly generalist environments and therefore well suited to the development of generalist competences and, to accompany the shift in patient care, an increased amount of multi-disciplinary training will need to occur in these settings. This was discussed in the report of the Independent Commission on Generalism5:-

‘Medical training needs to become much more generalist in content, with more of it taking place in primary care settings.’

It is also important that placements in general practice and the community are provided more widely in undergraduate and Foundation (i.e. early postgraduate) training so that all doctors have experience of primary care from an early stage in their careers, and enough time to build their confidence and interest in general practice and community healthcare.

Generalist training has historically been associated with a broad training experience early in training. Acquiring a breadth of clinical experience is an important component of generalist training, but is only a part of what is required to develop generalist competence and, beyond this, proficiency. A longitudinal development of generalist skills throughout a doctors' career is of particular importance and this must be reflected in the design of future training and assessment programmes: to be effective, generalist clinical training must focus on themes of generalist expertise that are most relevant to the development of clinical competence and career-long flexibility. These themes must run throughout undergraduate and postgraduate training and be revisited and assessed over time, on each occasion being applied in broader and more sophisticated contexts of direct relevance to the doctor's developing role. This approach needs to start early, in medical school, and continue throughout the duration of the doctor's career.

The proposed model for enhanced four year GP training is based on this 'spiral' approach, where expertise in community-based generalism is built up incrementally over time. The trajectory of the spiral is intended to take the learner both higher in becoming progressively more expert and wider in being progressively more able to apply skills to wider contexts – the individual patient encounter, the team-based approach and ultimately the organisations and systems of care in which they work.

For the purposes of enhancing GP specialty training, the RCGP has identified five ‘developmental themes’ of key relevance to the development and assessment of generalist expertise. These themes will be represented within the curriculum and assessments and run as developmental ‘threads’ throughout each individual training programme, articulating conceptually with pre-programme competences (e.g. undergraduate, broad-based training, foundation) and post-licensing CPD and revalidation.

The five developmental themes are: expert medical care (e.g. first contact care, urgent care and common long-term conditions), whole person care (e.g. a holistic and person-centred approaches), complex care (e.g. multi-morbidity and comprehensive care), systems of care (e.g. quality improvement and patient safety) and relating to self and others (e.g. team-working and leadership). It would be possible to define other expert themes of relevance to generalist care and apply these to other programmes seeking to develop generalist skill – these five have been selected because of their importance in contemporary educational development and assessment of generalist competence.
Although separated for conceptual reasons, such themes would not be learnt or assessed as isolated entities but integrated as part of a developmental progression. The educational purpose of the themes is to clarify, illustrate and promote areas of professional generalist expertise that require particular focus in training as these will be critical to ensuring that tomorrow's doctors are prepared for the future NHS.

We would therefore propose that the developmental spiral approach we have developed for community-based generalist training, such as the theme-based model described here, might also serve as useful models for future undergraduate and postgraduate training more broadly. With this approach, there is potential for generalist training to be expanded to meet the training needs of not only community-based generalist practitioners but the greater numbers of doctors that will perform generalist roles within a wide range of hospital-based disciplines.

It is important to recognise that specialists working in the community will need a different skill set from that most commonly used in hospital, and that training will be required to provide this.

**Changes to enhance and extend general practice training**

To fulfil the role required of them in 2022, GPs will need enhanced and extended training in order to develop the knowledge, skills and expertise to be fit-for-purpose in the NHS and to meet the health needs and expectations of patients and the wider population. The RCGP is therefore proposing an enhanced four-year specialty-training programme to:

1. Develop GPs with the clinical expertise and experience to manage an ageing population with complex multi-morbidity, who will receive an increasing proportion of their care in community-based or homely settings. In particular, this requires the development of expertise in community-based medical care, complex comprehensive care, whole person/holistic care, and co-ordinating systems of care.
2. Address the weaknesses identified in current GP training in relation to the care of children and young people, those with mental health problems, those requiring urgent care and those needing rehabilitation. Also to deal with identified patient safety issues, such as improving child safeguarding and reducing community prescribing errors; and
3. Provide sufficient time and multi-disciplinary training opportunities for GP trainees to acquire (and be assessed on) the quality improvement and
leadership skills necessary to contribute effectively to the development of new services and quality improvement initiatives, to reduce health inequalities and to work collaboratively with specialist colleagues and other health professionals; all of which are key elements for effective commissioning, service planning and integrated care.

**Figure 2: The Educational Case for enhanced four-year GP training**

### Educational Case for Enhanced GP Training

<table>
<thead>
<tr>
<th>Enhanced Clinical Skills</th>
<th>Enhanced Generalist Skills</th>
<th>Enhanced Leadership Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>More effective clinical care for patients with the full range of conditions commonly encountered in primary care, with focus on:</td>
<td>More effective, comprehensive care for patients, carers and families, with focus on:</td>
<td>More effective leadership at practice, local and national level, with focus on:</td>
</tr>
<tr>
<td>1.1 Improved care for children and younger people</td>
<td>2.1 Increased understanding of the relationship between work and health, and of the health needs of the local community</td>
<td>3.1 Improved delivery of primary care services, both in- and out-of-hours</td>
</tr>
<tr>
<td>1.2 Improved care for people with mental health problems</td>
<td>2.2 Improved health promotion and disease prevention</td>
<td>3.2 Increased coordination and leadership of multidisciplinary teams</td>
</tr>
<tr>
<td>1.3 Improved care for people with alcohol and substance misuse problems</td>
<td>2.3 Increased co-ordination of care for patients with multiple co-morbidities and long-term conditions</td>
<td>3.3 More effective engagement in the development of local services, working collaboratively with specialists and patients</td>
</tr>
<tr>
<td>1.4 Improved urgent care and rehabilitation for people with illness or trauma</td>
<td>2.4 More cost-effective and timely use of resources, including investigations, referrals and treatments</td>
<td>3.4 Improved academic skills for evidence-based practice, innovation, quality improvement, education and research</td>
</tr>
<tr>
<td>1.5 Improved care for older adults and their carers</td>
<td>2.5 Improved end-of-life care, especially for those who choose to die at home</td>
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**New generalist training programmes for nurses and other professionals**

In the future NHS, care will be provided by multi-professional teams utilising the skills and expertise of nurses, physician assistants, pharmacists, physiotherapists and other professionals who require some degree of generalist training for their role, which will complement that of the generalist physician or surgeon. These key health professionals will bring a range of unique skills and competences including, with additional training, prescribing and advanced nursing skills.

This nursing team will help deliver care for patients within the practice and wider federated organisations of practices and health providers. This might include, where appropriate, routine visits to nursing homes and working more closely with house-bound patients, those with long term conditions, those requiring case management and those receiving end-of-life care at home.
Q5. How can the need for clinical academics and researchers best be accommodated within such changes?

Primary care departments in universities need strengthening and expansion, as well as closer integration with deaneries, and the bodies that will replace them, to overcome the currently disruptive undergraduate/postgraduate division. It may be that Local Education and Training Boards (LETBs) will have a role in resolving this in the future.

To ensure that the work of clinical academics is understood and to attract clinicians with high levels of ability to pursue careers which facilitate the development of best practice in delivering high-quality patient care, specific attention should be given to supporting trainees in gaining experience in academia and research.

Research should be encouraged at all levels and opportunities to learn research methodology should be open to all. Those wishing to add a fellowship in research should be permitted to take a year out during their training without losing their training post. All specialty training should include the requirement to undertake a significant research or quality improvement project under supervision. The enhanced and extended training programme proposed by the RCGP will include a quality improvement initiative for all trainees.

However, academic general practice training posts are under threat, particular National Institute for Health Research-funded Academic Clinical Fellow posts. There are already far fewer of these posts than exist for other specialties. The main key performance indicator of these posts is conversion to PhD. However, general practice is unique in that when academic training is finished the trainee receives their CCT and is able to practise as an independent clinician. At this point they usually (and understandably) opt to consolidate their clinical skills rather than continue research, although they may ultimately like to continue research in the future. Further problems arise in that many funders are not interested in general practice work. Other specialties can finish their academic training, complete a PhD and return to clinical training before receiving their CCT. Therefore, when funding decisions are being made about which specialties to give Academic Clinical Fellow posts to, both locally and nationally, general practice fares less well. This situation might be remedied by:
**Support**

- Support, as in other disciplines, for more routinely available (and funded) options for GPs in training to take additional time to complete an academic component pre-CCT, which will overall improve the capacity of the GP workforce to undertake clinical leadership, as well as expanding the national pool of academically oriented GPs.

- A change in the key performance indicators of these posts, not focusing on purely conversion to PhD;

- Promoting the need for academic GPs;

- More support for GP trainee academic posts.

**Flexibility**

Q6. How would a more flexible approach to postgraduate training look in relation to:

a. Doctors in training as employees?

Partly, though not exclusively, as a result of the increasing numbers of women in the medical workforce, there has been and will continue to be an increase in part-time working. Training (and subsequent employment) needs to become more flexible to accommodate this, and also needs to increase in capacity. In the recent past we needed to train around 150 GP trainees to fill the equivalent of 100 full time posts – this ratio is increasing, and it will be important for the Centre for Workforce Intelligence to keep training programmes updated on this. This applies equally to other members of the primary healthcare team.

Current surgical training in particular is often incompatible with the modern workforce, with no flexibility to allow for part time working. There is also scope to change how training contracts are held and managed, to make it easier for trainees to move between placements. In some areas, training providers are already moving to a ‘lead employer’ system, where a single provider coordinates the placements for all trainees. This approach will help ensure that trainees get a more appropriate range and quality of training placements, including research placements.

b. The service and workforce planning?

It may become even harder to divert trainees to the specialties that the NHS needs UK-wide. Already we have thousands of people who hope for a surgical career after
obtaining a CCT, but who have no hope of progression. Flexibility needs to be balanced with reality and needs-based planning.

Allowing greater flexibility for the movement of doctors working in different areas, including from overseas, would increase capacity to manage complex conditions.

c. The outcome of training – the kinds and functions of doctors?

Core postgraduate medical training needs to be much better at producing generalists as well as specialists, an approach that should extend throughout all areas and curricula – so that, for example, surgical training would be sufficiently flexible that trainees could be equipped to pursue careers in areas such as emergency medicine. At the moment most training is far too specialised too soon, and the trainees entering the workforce are unable to be re-deployed to other specialties without extensive further training. They may be described as fit for practice, but often not fit for purpose in a changing NHS.

The outcomes required for generalist training broadly and GP training in particular are described in detail in the response to Q4.

d. The current postgraduate medical education and training structure itself (including clinical academic structures)?

The College recognises the benefits of trainees entering general practice with other speciality skill sets, including extended clinical, research, leadership and quality improvement skills. The Review should look at ways to facilitate credentialising of postgraduate training – the establishment of recognised transferable competencies that would enable trainees to transfer between specialties with a reduced additional training burden. There are plenty of specialties with overlapping competencies – community paediatricians, for example, may have many competencies applicable to general practice – but the degree of compatibility needs to be formally and very thoroughly assessed.

We are open to the possibility of other specialty trainees entering general practice training. However the ‘way in’ points in the different curricula involved are difficult to match, because we cannot always assume that posts that may sound relevant to general practice (e.g. neonatal paediatrics) are in fact relevant to the competencies needed in primary care – the context of training is as important as the time spent.
It is currently difficult to accommodate trainees from other specialties within the current three-year training programme, but it will be more feasible to do this within a four-year programme.

All accredited educational providers (i.e. trusts and GP training practices) need to implement fully the GMC’s standards for flexible training (domain 3 of the quality standards), and structures and systems of training need to adapt accordingly.

The College understands the benefits of Broad Based Training and is keen to support the increase in generalist medical skills across all specialties. However the primary purpose of the Broad Based Training programme is not to enhance GP training but to offer a more flexible early training pathway for trainees. For further information on future models for improving generalist training, see Q4.

**Patient needs**

Q7. How should the way doctors train and work change in order to meet their patients’ needs over the next 30 years?

Complex healthcare challenges due to changing patient needs are placing a range of new demands on GPs. These include:

- a move of traditional secondary care activity into the community in order to bring care ‘closer to home’;
- progress in medical care leading to people living longer but with more complex health and social care needs;
- an ageing and diverse population suffering from multiple concurrent health problems;
- increased rates of survival from cancer and other previously fatal conditions;
- a greater population health and disease prevention role;
- increasing financial constraints;
- changes in NHS structures in England, with clinically-led commissioning expected to address local patient needs; and
- increased training in globalisation and health.

The NHS is changing: we are no longer looking at the twentieth century model with its division of hospital and general practice. We are moving to a twenty-first century
model of integrated care where patients are always put first and professionals work closely together irrespective of specialty or location. The RCGP believes that more integrated care, delivered in primary care settings along agreed patient pathways, within networks of care that maintain team-based care close to home will enable more people with long-term conditions to be managed entirely within the community, will improve health outcomes and minimize healthcare costs.

What will being a patient be like in the future NHS?

- Easy access to health information and advice for you and your family when you need it
- Flexibility to access registration, consultations, health records and treatments remotely
- Assessment by an expert generalist clinician who has access to your full record and can draw on a wide range of skills, diagnostics and resources as needed
- Being shown respect and dignity regardless of who you are
- Provision of more support to improve health literacy and to enable shared decision-making
- Longer consultation times to adequately address your problems in the context of your family, work and home
- Excellent communication between your GP and your specialist, with shorter waits to access specialist advice and more coordinated care
- Routinely being involved (with your carer if you wish) in all decisions about your care
- Choice of being treated in a local environment by familiar staff and clear signposting of where to go with what problem
- Improved resilience and self-sufficiency to manage your own health and illness, with appropriate support from a range of community resources; and
- Assurance of the best possible care at the end of life in the place of your choice.

In relation to general practice specifically; the role of the GP has continually evolved since the introduction of the NHS and must continue to do so to meet the challenges and expectations of a modern health service. In addition to providing accessible and effective clinical care, the role of the GP needs to evolve from healthcare ‘gatekeeper’ to ‘navigator’, providing information, support and expert clinical judgement to guide patients in shared decisions about the management of their health problems. The effective performance of this role is crucial for the success and sustainability of the modern health service. The GP’s role at the centre of a hub of care is being further extended to encompass a range of responsibilities in budget-holding, commissioning, service redesign, safety and quality improvement.
With the move of secondary care services into primary care settings, GPs are now dealing with a more complex case load. Since the existing three-year duration for GP training was introduced 30 years ago, there has been a steady increase in the volume and complexity of work performed in primary care, as care has shifted into the community, and this shift has accelerated over the past decade.

The RCGP believes that enhancing and extending GP postgraduate training from three years to four is necessary to have the clinical, generalist and leadership skills needed by GPs to deliver high quality patient care in the future⁶.

Q8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

In general, patients value a continuing relationship with a doctor they know and trust. Official roles, titles and responsibilities are often secondary concerns to many patients, although this can be a source of confusion and there may be scope to further clarify this aspect. In general patients assume their doctor is competent for the procedures that he or she is undertaking, or if not competent that they are supervised by someone who is. Doctors can only practise to their level of competence and not beyond, and patients should be made aware of this for trainee and patient benefit, and for medico- legal purposes. In many cases patients may prefer to be treated by a junior doctor, who may have more time to devote to them – so long as that doctor has sufficient training or supervision to deliver care effectively and safely. Since the SHO grade was abolished, ST1 and ST7 doctors are both informally called Registrars. This creates the risk of doctors being asked to work beyond their competence which endangers patients.

Q9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

GPs work within multidisciplinary teams to manage the vast majority of health problems in the NHS and therefore must be trained as ‘expert generalists’. In the future NHS this role will dovetail with that of specialists with expert technical and

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discipline-specific skills, as well as supporting the development of more secondary care specialists with generalist skills.

Services cannot be designed or delivered effectively without the full participation of all the healthcare professionals involved. This requires GPs to engage with the full range of professionals – in local GP practices, community teams, specialist teams and hospitals – to identify opportunities for improvement and to design responsive, cohesive systems of care and evaluate data on patient experience and outcomes.

The rise of multi-professional teams will lead to much more opportunity for shared learning. The RCGP agrees with the Commission on Generalism\(^7\) ‘that GPs and hospital consultants should learn together and from each other…Such integration and continuity across the primary/secondary care divide is essential if the benefits of generalism are to be realised for the good of patients and their families.’ Work-based learning is a well established concept for multiprofessional teams\(^8\).

Working in partnership with the community, specialist teams, local authorities and other bodies, GP trainees will have opportunities to understand how these organisations are shaped and organised, the levers to activate change, and how they utilise health informatics to shape services to meet the needs of local patients, ensuring that they take account of the needs of marginalised members of society.

Examples of such enhanced multi-disciplinary training opportunities might include defining and developing a healthcare service within the locality in which a trainee is training, as part of a Quality Improvement Initiative in ST4. Such a service might be in areas related to deprivation or special need. This would provide experience of working alongside other professionals, such as healthcare managers, public health consultants and practitioners, interface working with local government and social care and being involved in public and patient consultation processes. Whilst some elements of leadership can be delivered in the early years of training, the higher level

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\(^8\) See e.g. Burton J, Jackson N ed., Work-based learning in primary care (Radcliffe Medical Press 2003)
performance must be based upon the foundation of the core clinical, humanistic and scientific competencies of general practice.

**Breadth and scope of training**

Q10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

It is not within our remit to comment in detail on the competence of specialist colleagues coming out of training. However, our consultations with our specialist colleagues, our experience of patient care, and our discussions with patient groups suggests that doctors coming out of training now need further professional development opportunities in order to take on senior roles in the short-term; lacking leadership, management and advanced clinical skills. Just as is the case with new GPs, new consultants may be fit for practice in specific settings now, but they are probably not fit for purpose for an adaptable career in the changing NHS.

Within hospital settings, older patients with long-term conditions and multi-morbidity make up the majority of admissions and costs; yet patients are predominantly treated in both inpatient and outpatient settings within disease- or specialty-based silos, with relatively little planning for how care will be personalised, applied with continuity or adapted in the context of their own homes. It is now widely recognised across healthcare that wider, more holistic approach is required, with a focus on goal-centred rather than specialty-centred care planning. This requires a greater number of healthcare professionals with highly developed generalist skills working within hospital settings.

There is also a need for more senior doctors working in acute care settings to have both specialist and generalist expertise, in order to manage acutely ill co-morbid patients. Every on-call shift at a hospital should contain healthcare professionals capable of taking responsibility for managing all the illnesses of the patients in their care – this does not require one doctor to be a specialist in everything, but rather to have the expert generalist skills required to perform comprehensive and accurate risk-based assessments and to access, interpret and coordinate advice from multiple specialists, then apply this understanding to shared care decisions within the unique context of the patient’s health, social and home situation.

Hospital-based consultants often have little experience of primary care and subsequently may not appreciate the challenges. To provide a fully integrated
healthcare system in the future, this requires more training in primary care, which currently may only be available in general practice.

Q11. Is the current length and end point of training right?

In the case of general practice, there is now a wealth of evidence that training is not long enough and ends at a point where many new GPs so not have the skills or experience to take on the role that twenty-first century general practice requires.

After extensive research and consultation the RCGP has come to the conclusion that three years is not long enough to train a GP to meet the needs of patients and the NHS in the future.

The College has produced an Educational Case in support of enhancing and extending General Practitioner (GP) training across the UK. This provides an evidenced summary of how this new generation of GPs will improve outcomes for patients and the National Health Service (NHS). It clearly demonstrates the need for change in the present GP training and assessment framework in order to optimise the educational effectiveness of GP specialty training and extend the total training period for all GP trainees to a minimum of four years, with a minimum of 24 months in general practice placements.

The new four-year enhanced programmes proposed will differ from the current three-year schemes in the following key respects:

The new four year GP specialty training programme will be based on a spiral model of incremental skill acquisition and application. To be effective, this must include early experience of working in a primary care environment (e.g. in ST1). This will build a firm foundation of skills as the GP progresses from novice to expert generalist, applying a broader and more complex set of skills, honed to the primary care environment. This approach will increasingly incorporate leadership skills to enable service integration and improvement.

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The GP curriculum will be adapted to incorporate enhanced training outcomes. Meeting these outcomes will require relevant and appropriately supervised training opportunities throughout all four years of the programme. All trainees will gain specialist-led exposure to patients with child health and mental health problems.

The mechanisms of assessment currently in use will be adapted for enhanced GP training, with the summative elements of the examination (the Applied Knowledge Test and Clinical Skills Assessment) extended to accommodate the expanded curriculum. There will be an enhancement of Workplace-based Assessment with the addition of an externally-assessed Quality Improvement Project in ST4. Both the MRCGP and CCT will be awarded at the end of ST4, following successful completion of the required assessments and training placements.

Q12. If training is made more general, how should the meaning of the CCT change and what are the implications for doctors’ subsequent CPD?

A CCT should indicate an end point in training when sufficient competence has been gained and demonstrated by the trainee performing safe independent practice in the appropriate clinical context (be it hospital, community focused or both).

Expertise is needed in generalists as well as ‘partialists’; although they are different in the scope of practice, the expertise is equally complex to develop and to retain. It is therefore right that the achievement of a CCT where training has been more generalist in nature will be an indicator of the practitioner having acquired a set of high level generalist competencies. This is just as valid in terms of demonstrating the level of expertise developed by the doctor as a CCT showing that a trainee has achieved specialist or technical expertise in a narrower field of practice.

CPD is not intended to bring inexperienced or under-trained doctors up to the standard of competence and confidence required to deliver care safely in their chosen specialty – but to maintain those standards over time, through changing circumstances in society and the healthcare system, and to ensure that the existing population of qualified doctors is able to operate at the same standard as new entrants.

Attention should be paid to the transition from training into independent practice during the first few years post-CCT as there is evidence that increased support is needed during this important period. The RCGP has sought to provide this for newly qualified GPs by developing a ‘First5’, an initiative to support newly-qualified GPs
from receipt of their CCT or CEGPR through until their first revalidation. First5 provides networking, events, e-learning and mentoring, and has proven to be popular with newly-qualified GPs who regard it as a valuable resource. It will be important for the Shape of Training review to pay some attention to the ‘new consultant’ group across all disciplines.

Q13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?

For general practice, it is absolutely critical that the GPs of the future have the opportunity to undertake a minimum of four years of enhanced specialty training (WTE).

The enhanced GP training programme put forward by the RCGP incorporates a central role for reflective learning but, essentially, triangulates reflective practice and self-assessment approaches against a range of other evidence-based learning and assessment methodologies, including subjective and objective competency-based approaches and global performance-based judgements, quality improvement data, patient satisfaction data and multi-source feedback.

Additionally, it is essential that trainees have hospital placements that are selected for the quality of the learning experience, rather than, as is sometimes the case at present, posts that are inadequately supervised and deliver a poor quality learning experience.

As part of the enhancement and extension of GP Training we have proposed a new integrated training model where the GP trainee is based in a ‘home’ practice but spends much of their time working across boundaries in a range of relevant specialty-led placements - especially in community-based (e.g. addiction services) or front-line specialist-led services (e.g. children’s A&E).

Trainees need protected time for teaching to instil and develop reflection and a culture of lifelong learning. General practice has led the way in this respect. It is essential that education and training not be 'drowned out' by service, to allow time for delivery of the curriculum, assessment of progress through the training programme etc. However, it is also important to ensure that the training period is not assessment driven at the expense of the development of the enthusiasm to learn to improve and personal interest. Flexibility for interests and time to embed experience without overly detailed repetitive assessment encourages professionalism and independenet
practise. Attention to implementing the GMC quality standards for education and training is also essential.

Q14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

At the moment, the lack of continuity across the transitions in training means recognised gaps in training are not being met – for example, where a trainee at undergraduate or foundation stage may have identified needs or shortcomings, and this information is not carried across to the subsequent stage, the needs may never be addressed – to the extent that the trainee might struggle to attain CCT or even retain into their subsequent career a problem which should have been resolved in training. Better information transfer and continuity of development throughout programmes, therefore, will be a key development. Addressing this issue will be of critical importance to the success of future broad-based training and generalist training programmes (see Q4).

As regards the transition into independent practice, GP trainees need an ST4 that will give them the skills and confidence to act as fully functioning GPs from the start, able to undertake the range of roles expected of GPs under the current and forthcoming healthcare system.

A key aim of the final year of the proposed enhanced four-year GP training programme, therefore, will be to support the transition of senior trainees from workplace-based assessment-driven learning and summative assessment to self-directed, portfolio-based approaches which support both the subjective and objective measurement of quality and performance.

**Tension between service and training**

Q15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

It is our view, and that of many trainees, that training in general practice currently provides an excellent balance between delivering service and learning through experience. Unfortunately, there is not a sufficient duration of training in this setting, and training delivered in hospital settings is often less suitable for the generalist trainee – there is the opportunity for hospital training placements to give the trainee a rounded understanding of the treatment of the kinds of conditions that are
encountered first in primary care, but training posts need to be driven by learning needs rather than service provision, and must allow supervision for clinical situations beyond their level of confidence. The RCGP notes the concerns of GP trainees that there have been reported instances in the past where inappropriate posts have been included in GP training programmes due to service demands and pressures in funding. Robust mechanisms should be deployed to ensure that any repetition of this practice is avoided; the educational value of training placements is of paramount importance.

Training in general practice would also benefit from more experience in unscheduled care and, in particular, out-of-hours care.

Q16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

‘Learning by doing’ remains a valid and useful way of delivering training – but only if, as well as delivering service, trainees are receiving regular supervision and feedback on their progress. It is our view that this feedback is often absent or deficient at present, so that training has much less educational value than it ought to have.

The implementation of enhanced GP training provides an enormous opportunity to significantly expand the training capacity of primary care. This will provide benefits not only to GP training, but to the training of the wider NHS workforce. This expansion is needed not only to deliver and sustain the increased numbers of GP trainees required for the future NHS workforce, but also to meet the requirement to develop new training pathways for the wider primary care workforce, including practice nurses and allied healthcare professionals.

A range of other options to increase capacity in primary care have been proposed for further consideration; for example, an innovative ‘hub and spoke’ model of training, whereby a trainee is based in a training practice (the ‘hub’) but gains experience for periods of time within multidisciplinary teams in other suitable practice-based or community-based services (the ‘spokes’), as their growing experience and independence allows. This would provide great opportunities for multidisciplinary learning and would help to address capacity issues. However, such a model of GP training would require a change in current training practices and robust arrangements would need to be put in place to ensure that the trainee has access to adequate clinical supervision and that the working environment is well-resourced and appropriate for GP training.
Integrated training posts (ITPs) are increasingly widespread in current three-year GP training programmes. Based on evidence from the GMC annual national trainee survey\textsuperscript{10}, they are extremely popular with GP trainees as a way of providing contextualised learning opportunities across a range of specialty areas. GP Directors and Deans are likely to use this model to deliver a large proportion of approved GP training posts should enhanced GP training proceed.

The trainee’s work plan varies between posts. A typical post might consist of:

- **Base practice** – four clinical sessions and two educational sessions (e.g. tutorials and day release courses)
- **Specialist service** – three clinical sessions (activity depends on nature of service) + one educational session (e.g. unit-based teaching)
- If the post involves out-of-hours shifts (e.g. A&E), the timetable is adjusted according to EWTR principles
- Some integrated posts include study towards an additional qualification (e.g. PGCE, DFFP) but in general the focus is on integrated care and cross working between general practice and the specialist service.

There is a wide range of such innovative integrated posts in place at the moment and much scope to increase this to meet both new service and training needs – examples of specialties and services currently offering integrated placements include:

- Child health/paediatrics
- Community and Adolescent Mental Health Service (CAMHS)
- Community mental health
- Dermatology
- Diabetology and metabolic medicine
- Gynaecology
- Homeless medical services
- Learning disability services
- Medical education
- Substance misuse services
- Sexual and reproductive health
- University/student health; and
- Urgent care and assessment.

Workplace based assessments are undertaken in both settings (proportionately). The clinical supervisor in the specialist service is required to meet GMC defined standards for a clinical supervisor and the training environment must meet the deanery’s learning environment standards.

The posts are registered within the GP specialty programme with the GMC.

GPs on training placements are currently treated as supernumerary – the GPC is better placed to outline the advantages or disadvantages of this. Whatever the technical status, all training needs to have sufficient supervision for safety, and sufficient challenge to hone the skills and stamina of practitioners in training as independent practice approaches.

**General questions about the shape of training**

Q17. What is good in the current system and should not be lost in any changes?

As already suggested, much of the training delivered in general practice settings is of a very high standard, and where this is coupled with high quality hospital placements, this offers a well-constructed programme with good exposure to relevant medical conditions and healthcare challenges and well-regarded assessments – but there is simply not long enough of it in the current three year programme. GP training needs to be enhanced and extended from the present three years, with a minimum of 24 months spent in general practice settings.

In addition, the medical generalists of the future need greater exposure to primary care.

The educational supervisor (GP trainer) – trainee relationship lies at the heart of GP training and future generalist training should preserve and build on this relationship. The capacity of primary care tutors, trainers and educators, as a community, to provide high quality educational supervision to a greater number of trainees at various stages of training will need to be increased. This would include increasing the numbers of educators within existing training practices and also supporting the development of new teaching and training practices.

Q18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?
As already suggested, one key to delivering medical training that is fit for the future is to have more training placements based in community and integrated settings and more capacity to deliver enhanced generalist training to GPs and other disciplines. To achieve this, we will need to expand the training capacity of these settings and greatly increase the options for trainees to undertake a variety of community placements – we need more GP practices offering training placements, along with options for innovative placements in settings such as urgent care, dementia units and intermediate care. We should also be looking to unlock the capacity of third sector providers as a training resource.

Most training in the community is still on a one-to-one basis, which enables the trainer and trainee to see and identify issues and personalise input. The GMC’s annual trainee survey always highlights this as an example of good practice, and the educational benefit that this approach brings would be valuable for all trainees.

It is important that any significant structural change is accompanied by the investment to support it. The RCGP is confident that general practice can change and further improve the quality of the education and care it provides in order to meet the future needs of patients and the service, but will need commitment and investment to achieve this.

4. To summarise, the RCGP foresees that the role of GPs now is central to the NHS and is becoming much more complex. We therefore need ‘more GPs spending longer with their patients doing more patient-centred complex medical care’. The Shape of Training review needs to put GPs on a similar footing to other disciplines (longer training, more academic opportunities, more flexible models), and to embed generalist training in all disciplines up to the point where specific career subgroups divide. Since 50% of the medical workforce become GPs this should be the core of training design.

5. We gratefully acknowledge the contributions of members of Council and the College’s medical education leads (especially Ben Riley) in formulating this response. Please do come back to us for any clarifications or formal responses.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council