GMC consultation on Routes to the General Practitioner and Specialist Registers

1. I write with regard to the GMC consultation on Routes to the General Practitioner and Specialist Registers.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 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 consultation as it is a very important issue for us. The emphasis on patient safety and high professional standards accords with College principles. Our responses to the questions posed in the consultation document are as follows:
1. Do you agree that the current model for evaluating equivalence by assessing documents should be replaced by a model based on the four elements set out below?

   1. a period of acclimatisation to UK health services through recent UK medical practice (for those doctors not already working in the UK)
   2. demonstration of specialist knowledge
   3. workplace evaluation of performance in practice in the UK
   4. documentary evidence of experience

The College welcomes the new model and the requirement for all applicants to have a period of acclimatisation to NHS general practice in a supervised placement. We would value the increased engagement between GMC and College Assessors as stated in the report.

2. Do you agree that the period of acclimatisation should be at least six months in the previous three years? If not, what would be an appropriate period?

The College would support the following process:

**Placements**

We would support a period of in-practice assessment and achieving an appropriate balance between documentary evidence and performance assessment in the UK general practice context.

For a CEGPR, the supervised placement would need to be in general practice (and not any other setting), under the supervision of an appointed trainer, in order to deliver the required competences.
The placement must be fully supervised by an appointed trainer who has been trained for the task, particularly as some candidates may have special needs.

A six month supervised placement will be sufficient for some applicants for a CEGPR but will not be suitable for all; there will be applicants who require more than six months. A placement may have to be extended in order to achieve the competences.

As you have identified, there is a need for legislative change in relation to the Performers List regulations to allow doctors who are not on the GP Register or do not have a National Training Number (NTN) to see patients in general practice.

Other problems which would need to be overcome in general practice are training capacity within deaneries and funding for the placements.

Entry into a supervised placement

A decision has to be made about the evidence requirements at the point of entry and whether an assessment is needed as part of the selection process for entry to the placement.

Primary Care Organisations and Deaneries would need to be assured of the basic level of knowledge and skills of doctors entering the programme. This assurance could be provided in a number of ways:

- Provision of more streamlined documentation on previous training, qualifications and experience including structured references that would allow the College / GMC to agree that the applicant is able to enter such a programme;
- Initial assessments, as with the Induction and Refresher programmes to ensure that applicants do have the basic knowledge and consulting skills to enter a supervised GP placement; and
The GMC PLAB assessment proposed for all equivalence route applicants.

Doctors entering the scheme must demonstrate that they are at least Foundation competent. The College believes that since they are entering as an ST3 equivalent, the demonstrated competence should be at this level.

**Assessment**

The period in an approved practice would allow:

- Assessment of performance using currently validated tools – CbDs, COTs, MSF
- The opportunity for the applicant to gather further evidence in the UK context – reflective logs, significant events, audit etc, rather than submitting this evidence from their own health system
- Increased awareness of medico-legal, clinical governance and other regulatory issues

At the end of the placement the supervisor would provide a report on progress against the current Certificate of Completion of Training (CCT) competencies.

3. **Do you agree that applicants should be required to demonstrate their specialist knowledge by taking a formal test of knowledge in their specialty set by the relevant medical royal college or faculty?**

The RCGP strongly recommends the Applied Knowledge Test (AKT) element of the MRCGP examination as providing a valid and reliable test of knowledge in context, which should be completed and passed before the end of the placement. Whilst there is an argument for use of the Clinical Skills Assessment of the MRCGP as a test of consultation skills, evidence from the placement supervisor based on observation and
workplace based assessments is more practical given the short length of the placement.

At the end of the placement the applicant would submit:

- Initial application documentation
- Additional documentary evidence created during the post
- Placement supervisor’s report
- AKT results

On the basis of this evidence a recommendation would be made as to whether the applicant has submitted sufficient evidence that permits the GMC to place the applicant on the GP register. Please see Flow Chart at Annex A.

4. Not all colleges and faculties have existing tests of knowledge in every specialty set at the appropriate level. With this in mind, would it be reasonable to use tests for those specialties they exist for, but to evaluate applicants’ knowledge in other ways where no appropriate test exists?

The College believes tests should be set up, if necessary, so there is equivalence.

5. Do you think that formal tests of knowledge should NOT be part of the CESR/CEGPR application requirements? If so what other valid and reliable means of assessing applicants’ knowledge should we use?

We have no comments.

6. Do you agree that successful application for a CESR/CEGPR should require evaluation of performance in practice in the relevant specialty in the UK against prescribed competences at the level of the final year CCT?
Yes. The College believes that the public have a right to expect a minimum level of competency for all new entrants. Most educators and assessors should be able to take account of the candidate’s experience when assessing competency.

7. Do you agree that the performance in UK practice of CESR/CEGPR applicants should be evaluated by approved specialty (including GP) educational supervisors?

Yes.

8. How do you think we should ensure assessments are objective and independent?

The College believes there should be standard training of educational assessors to include fairness, equity and diversity training.

9. For those specialties for which there wasn’t a formal test of specialist knowledge (see questions 3–5 above), could evidence of performance in UK practice at the same level as the final year of a training programme leading to a CCT provide enough assurance that applicants have the necessary breadth and depth of knowledge?

We have no comments.

10. Do you agree that applications from figures of genuine international renown should continue to be evaluated on the basis of documentary evidence rather than through evaluating their performance in practice?

The College does not support the proposal for a different application route for distinguished general practitioners. However, if legislation were
changed to allow temporary admission to the GP register, this could offer a way forward for visiting distinguished GPs to work in general practice for a given period with a named supervisor.

11. Do you agree with the criteria at Appendix G for evaluating applications from doctors of international renown?

We have no comments.

12. Do you think that the proposed new model provides a robust, fair, proportionate and accessible means of evaluating whether doctors possess the knowledge, skills and attributes equivalent to those required for a CCT? If not, why not and what alternative would you propose?

The College sees its role as providing recommendations to the GMC on:

- Whether the initial documentation indicates that applicants training, qualifications and experience are at a level which would permit them to enter a programme;
- Whether the final documentation, supervisors report and candidate’s performance in the AKT, provide evidence of equivalence to the current CCT;

and would wish to be involved in quality management of all stages of the process.

13. Are there particular groups of doctors who could be adversely affected by the proposed model and, if so, how could we reduce or prevent the adverse effects?

We have no comments.
14. Our report contains 13 specific recommendations for changes to the current CESR/CEGPR process set out here and listed in full at the end of our report. Do you have any other comments on the conclusions of the review and the report recommendations?

Additional periods of supervised practice under this programme should not be open to doctors previously released from their CCT training programme.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council
Annex A

Potential Flow Chart

1. Basic documentation
2. Initial assessment
3. Additional documentation
4. Practice placement
5. Applied Knowledge Test
6. RCGP Recommendation for placement
7. RCGP Review and recommendation to GMC
8. GMC decision on GP Registration