RCGP Response to GMC consultation on Recognising and Approving Trainers

1. I write with regard to the GMC consultation on Recognising and Approving Trainers.

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 you will see below, rather than respond to all the questions we have addressed a few of them from a specifically general practice perspective.

4. Beyond the scope of the questions themselves, we would like to query why the consultation document does not contain any mention of the proposed new structures in medical education and training in England. We appreciate that these structures are still subject to change, but we should have thought it was at least relevant to consider the potential role of Local Education and Training Boards (LETBs) and where they will fit within the planned GMC regulation of training ‘providers’ and ‘organisers’. It seems odd to ignore this aspect altogether, and we would hope that the GMC’s response to this consultation will include discussion of this.
1. Have we identified appropriate objectives for recognising and approving trainers?
Yes.

2. Does adopting the seven areas in the Framework for the professional development of postgraduate medical supervisors provide a suitable structure for quality assurance?
Yes, the seven areas appear appropriate, and should be applicable to current training models with relatively little adaptation.

3a For postgraduate training, is it appropriate to restrict the proposed arrangements to named educational supervisors and named clinical supervisors?
Yes. We welcome these proposals in postgraduate training, as we hope that they will place the clinical supervision of GP registrars in hospital on a sounder educational basis and bring equality with the training already provided in general practice.

3b Will people understand the terms ‘named clinical supervisors’ and ‘named educational supervisors’?
Yes.

4a For undergraduate training, is it appropriate to cover the lead coordinators of undergraduate training at each local education provider as well as those responsible for overseeing students’ educational progress at each medical school?
Please see 4b below – if ‘local education provider’ is intended to include individual GP practices this will pose considerable difficulties.

4b Will people understand the terms ‘lead coordinators of undergraduate training at each local education provider’ and ‘those responsible for overseeing students’ educational progress at each medical school’?
In our view, the arrangements proposed and the language used are not appropriate for undergraduate general practice teaching. The GMC need to specify more carefully who the ‘providers’ are in this setting, to avoid placing general practice at a great disadvantage as against hospital settings. If it is intended that the provider is to be understood as the individual GP practice, this has the potential to place a huge burden both on GPs and on medical schools.

The magnitude of the problem may be illustrated by data held by the Heads of Teaching group of the Society for Academic Primary Care on the numbers of
teaching practices affiliated with 17 of the 33 UK medical schools. These schools engage with a total of 2108 practices, an average of 124 practices for each school. A simple extrapolation to the 33 schools in the UK would suggest a total of around 4092 undergraduate teaching practices nationwide. One school alone has 304 affiliated practices.

If this was applied, and all undergraduate teaching practices were required to have an approved undergraduate educator, the risk would be either that some medical schools withdraw from undergraduate teaching in general practice or that many general practices withdraw from undergraduate teaching.

The GMC needs to define ‘provider’ in this context at a level larger than the individual practice (perhaps the CCG?), or provide medical schools with the leeway to make this definition themselves. Alternatively, they should make clear that the proposals apply only to GPs with significant supervisory education roles in medical schools/Trusts and not to GP tutors taking students on placements.

Equally, it is unlikely that undergraduates in general practice will be able to name (as detailed in para. 65) both the lead coordinator and ‘those responsible for overseeing the educational progress of students’ – more likely that they will be able to name their lead for each module and their personal tutor. Also, where the same paragraph mentions ‘NHS consultants’, it should for clarity include GP leads.

It is stressed throughout the document that the intention is not to make the system overly bureaucratic and to make use of already existing information – as applied to primary care undergraduate teaching the proposals as they stand will fail these tests and, at a time of increasing work and resource pressure threaten the goodwill to teach in primary care.

5 Does the scope of the recognition and approval of trainers properly reflect arrangements in all settings including primary and secondary care as well as clinical and non-clinical practice?

Please see 4b above.

6. Does the definition in Appendix C properly reflect the training roles of GPs, consultants, SAS doctors and senior trainees?

Please see 4b above. As argued, the definition of ‘Lead coordinator of undergraduate training’ is problematic if each local education provider is intended to include GP practices.

7 Have we correctly identified the responsibilities of local education providers?
Yes, the responsibilities identified are correct, though see previous comments about the definition of local education providers. Ideally all local education providers should also be accredited/reaccredited as training organisations as they are in GP practices for postgraduate GP training.

9 Should the GMC set a date by which the local requirements for grandparenting must be met by all the trainers who should be covered by these arrangements?

Yes.

10 Have we correctly identified the responsibilities of education organisers?

Again, this depends on the definition of local education provider. If medical schools are expected to approve undergraduate trainers in every training practice this will be a huge stretch for both the schools and the practices.

11 Should we develop guidance for education organisers?

Yes - to ensure a standardised approach to the implementation of the GMC’s Quality Education and Training standards.

12 Should we do an annual survey of trainers?

Improving the accuracy of the database(s) of trainers may have some impact on the response rate to this annual survey, but even with this it is likely that trainers will not regard this as a priority – impinging on the reliability of any survey results. One suggestion is that completion of an annual survey could be linked as a condition to the reaccreditation of trainers.

13 How can we best gather information from trainers?

In GP training the process for the accreditation/reaccreditation of trainers has traditionally required the submission of a completed standardised questionnaire which is held on record. This covers the trainer as a clinician; the trainer as a teacher and the practice as organisation and LEP.

14 What are the most important topics to ask trainers about?

See answer to Q. 13.

15 Are the existing standards for trainers appropriate?

The standards for GP trainers are appropriate having been established for well over thirty years and these have been subject to review and development over time e.g. to adapt to the PMETBs nine domains of quality standards. The problem for GP training has been the lack of such standards for hospital-based trainers.
16 Are the proposed quality assurance arrangements appropriate?
Yes, but should be kept under review.

17. Are the categories of information we are proposing to collect about approved trainers appropriate?
Yes, but should be kept under review.

18 Should the recognition and approval of trainers be aligned with revalidation?
Yes.

19 Will the proposed arrangements promote and enhance the value of training for individual doctors and organisations that employ doctors in training?
Please see response to 4b above. We do oppose the regulation of undergraduate trainers per se, but the arrangements need to reflect the vast differences between a hospital or larger teaching practice which provide large quantities of undergraduate supervision, as against a small inner city practice which provides only a few days a year. These arrangements as currently stated may be a huge deterrent to participation in education for these practices, which however offer an important aspect of GP undergraduate training.

20 Will the proposed arrangements promote and enhance the value of training in individual job plans?
Hopefully yes.

21a What are the main benefits and costs that will arise from our proposals?
Benefits include promoting the service / education and training balance in LEPs (this is sadly lacking in many hospital Trusts). Costs include the establishment of an accreditation system for all trainers, IT support, maintaining databases, review visits etc.

21b Do the benefits exceed the costs?
Hopefully yes, in terms of enhanced patient and trainee safety and better trained doctors. The cost of education and training is expensive, but so too is the cost of medical mistakes when measured in terms of patient morbidity and mortality.

22 What will be the impact from the perspective of equality and diversity?
Any new proposals should be implemented in such a way to avoid an impact on equality and diversity.

23 What will be the impact from the perspective of patient safety?
24 Should we publish guidance on any aspects of the recognition and approval of trainers. If so, on which aspects?

Yes – see above.

25a Is it appropriate to expect implementation of our proposals from the academic year 2013–14?

Again, this depends on the applicability of ‘local education provider’ to individual GP practices. If this approach is taken, it will be very difficult to make the necessary adaptations within this timeframe, especially with the anticipated repercussions for smaller practices.

25b If not, on what grounds should implementation be deferred?

6. We gratefully acknowledge the contributions of the College’s education leads in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council