12th April 2012

GMC call for evidence on induction for doctors new to practising in the UK

1. I write with regard to the GMC call for evidence on induction for doctors new to practising in the UK.

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 call for evidence. We have consulted widely among educationalists and those who work with international entrants to UK practice. Our response therefore represents a variety of views – there is a unanimous view, however, that this is an issue, particularly for entrants to general practice coming from other countries, and that a well-considered and funded solution would be very welcome. In particular, the induction and refresher scheme
previously supported by the Department of Health (prior to 2006), is well regarded and, in our view, should provide a model for a mandatory and appropriately funded future scheme, which could help prevent the loss to the NHS of many valuable GPs who may otherwise find themselves in difficulties.

4. We have provided answers to the individual questions of the call for evidence below, with a focus on the requirements for entrants to UK general practice:

1. What induction does a doctor new to practice in the UK require?

As already suggested, there are clearly issues, at both national and local level, that make some form of induction for doctors new to UK practice, particularly those coming from overseas contexts that may be very different, desirable. Anecdotally, it is observed by some of our deanery contributors that doctors in difficulty are more likely to have qualified outside the UK, and that these doctors are more likely to be drawn to the deanery’s attention because of conduct or ethical issues which may in part be due to lack of understanding. Broadly, matters requiring induction can be divided into organisational/structural issues, education and training and cultural/environmental issues, but a list might look something like this:

Organisations/Structures

- The NHS structure - the history of it and what it means to the public. The new NHS plan and introduction of the new structures.
- Information on national/regional and local structures/networks so that new doctors can understand the organisations involved in delivering healthcare. Interaction with key national bodies i.e. DH, HEE, LETBs
- Prescribing and the British National Formulary
- Funding, leave and how local resource is allocated and how this is monitored.
- Public expectation of the NHS and the doctors within it. NHS mission statement and values.
- Patient pathway/experience - how they access services/processes a patient may go through to access care.
- Primary / Secondary care interface.
o Working with others including working in multi professional teams and respecting others’ roles in safe patient management.

o Equality of opportunities and diversity.

o The structure of provision of training i.e. the Deanery structure.

o Duties of a Good doctor- including appraisal, certification and revalidation.

o Performers List (if working in primary care).

o Other bodies – BMA and MDU/MPS(and others).

o Role of the coroner.

**Education and Training**

o Professional registration – why we have this, when this happens, how information about this is shared with the public.

o Structure of postgraduate training and development- Deanery structures and role.

o Overview of the different career pathways for doctors and the structure of training and development for each (i.e. training and non-training grades).

o Involvement of Royal Colleges in specialty training, curriculum development and specialty examinations.

o Different professional standards expected. To cover:
  
  - Competencies required for training posts (RC curriculum etc)
  - ARCPs
  - Educator Development/Standards

o Processes for doctors in difficulty and how this is supported.

o Risk management and prescribing skills.

**Cultural/ Environmental**

o UK culture

o Language / regional colloquial sayings
Overview of regional differences in terms of structure and requirements for service - for example, the practical and linguistic skills required of a doctor working in the remote Scottish islands are very different to those in central London.

2. Which aspects of the requirements that you listed in Q1 should be supported by the GMC as part of its induction programme?

All the issues listed above are important, and all should form part of an induction programme. That said, the areas that should be specifically covered by the GMC would include:

- Appraisal and revalidation
- NHS structures
- Professional values
- Adult learning
- What to do if in difficulty

With regard to the other aspects, we would expect the GMC to specify:

- Those that must be covered prior to commencing appointment;
- Areas that are useful to have knowledge of and which can be covered locally over a short period of time after starting appointment;
- Ongoing learning and development to be delivered over a longer period

3. What examples of best practice that you are aware of might the GMC use to support the induction of doctors new into UK practice?

For general practice, the ‘GP Returner Scheme’ that had Department of Health funding until 2006 and was extended to include induction for new EU entrants to UK practice is, anecdotally, successful and well-supported. Since 2006 funding for this has been at the discretion of PCOs and is likely to be under further pressure under the new NHS arrangements. The GMC should press for this scheme to be extended, funded and made mandatory, following a period of evaluation to establish which elements of the scheme were most successful.
4. What formats of delivery might be used to support the induction of doctors new into UK practice?

It is suggested that some pre-arrival induction might be a useful start – web-based e-learning tools, even use of virtual role-playing tools such as ‘Second-Life' could help new entrants to UK practice get prepared even before arrival.

However these would supplement rather than replace a period of face-to-face learning, as this will be essential to ensure new entrants mix with UK NHS colleagues and develop understanding of the language and specifics of the culture. This could incorporate role-playing scenarios – covering aspects such as breaking bad news, phoning a consultant at night or asking a colleague for help – since these may help bring out large differences in attitudes towards the team in different cultures.

Beyond this and in the medium term, it would require workplace-based training and assessment.

Further to our earlier comment about the relationship between doctors in difficulties and their qualifying background, we would also like to note that there is some evidence of a continuing problem with career advancement for some members of this group of doctors; they may find themselves failing exams and unable to secure career progression, yet remain working in the NHS, often in under-doctored areas. Beyond induction, perhaps more should be done to offer these doctors some ongoing training and feedback, so that their careers can progress in line with their contributions.

5. How might the effectiveness of any induction programme be measured?

Lack of evidence is an issue currently in preferring any form of induction programme – but our contributors have suggested a number of forms of evidence that might be used to assess this going forward:-

- Online questionnaire and/or face-to-face interviews with those who have recently completed the programme – to assess immediate retention of appropriate learning.

- Pre- and post- questionnaire to assess development through the programme.

- Line manager feedback on those who have undertaken the induction, 3-6 months into first NHS post.
Evidence of retention of full GMC registration over time/number of fitness-to-practice enquiries

Annual survey of those who have been in the programme, such that data can be analysed by cohort to assess development over time.

5. We gratefully acknowledge the contributions of members of COGPED, the College’s Professional Development Board, Postgraduate Training Board and International Committee in formulating this response.

Yours sincerely

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Honorary Secretary of Council