THE EDUCATIONAL CASE

Royal College of General Practitioners

PREPARING THE FUTURE GP:
THE CASE FOR ENHANCED GP TRAINING

ENHANCED GP TRAINING: THE EDUCATIONAL CASE

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FOREWORD

What will the health service look like in five years' time? In a fast-changing world, predicting the future has never been harder. If those of us working in the health service are going to maintain and improve standards of care for our patients, it's a question we've got to start answering now.

The NHS is changing: we are no longer looking at the twentieth century model with its division of hospital and general practice. We are looking at a twenty first century model of integrated care where patients are always put first and professionals work closely together irrespective of specialty or location.

We have now reached a crunch point. We must ensure that our training programme prepares every GP trainee for his or her full role as a generalist, both as it is now and as it will be in the future. To achieve this goal we need an enhanced training programme, focusing on the particular needs and challenges of primary care.

I'm extremely excited about the future of generalism in the UK. But the changing world requires us to make changes to GP training and practice – this report shows why these changes are needed, how we will deliver them and the benefits they will bring.

Dr Clare Gerada MBE FRCGP
Chair of Council
Royal College of General Practitioners

'The move to shift more clinical care into the community means GPs will need to take on more complex care for their populations. To do this they need high quality training and experience and, while we heard that the length of training for consultants was widely felt to be about right, there was an almost unanimous view that the length of postgraduate GP training should be extended.'

***Education and Training – Next Stage*:**
A report from the NHS Future Forum, January 2012[1]

1 *Education and Training – Next stage. A report from the NHS Future Forum* (2012). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132025.pdf.

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EXECUTIVE SUMMARY

KEY POINTS

- A high-quality primary care service is essential to maintain and improve population health and thus save healthcare costs, control access to secondary care services, tailor services to local population needs and help patients navigate an increasingly complex healthcare system. Every year, over 300 million consultations take place with GPs in England alone and 95% of problems presented to GPs are managed entirely within primary care.

- The NHS faces new challenges that require changes to general practice training: services traditionally provided in a secondary care setting are moving closer to home into the community; we have an ageing population with multiple, often concurrent, health problems; increasing financial constraints mean that cost-effective, integrated care is essential; and a new structure to the health service with GPs increasingly responsible throughout the UK for design and delivery of services.

- The present system of GP training only meets the minimum European Union requirements and, even when educational opportunities are optimised, the existing three-year programme is no longer able to accommodate the increased training needs of future GPs. For example, one in six of all GP consultations are with children, yet currently fewer than half of GPs in training currently have had an opportunity to gain experience of acute childhood illness in a specialist-based training placement.

- Enhanced GP training is essential for both the primary and secondary care sectors in order to maintain the level of service currently offered. To meet these future challenges, we propose an evidence-based four-year programme of training with at least 12 months employed in posts in specialties relevant to general practice and at least 24 months spent in general practice placements.

- Enhanced GP training will concentrate on increasing clinical skills, generalist skills and leadership skills with a focus on increasing skill acquisition over time. The doctor will learn basic skills across a wide range of topics in these three priority areas of training; how to apply those skills in a primary care setting; and then how to integrate that knowledge to achieve improved service delivery. The GP curriculum and examination system will be enhanced and modified to accommodate the new system of training, resulting in GPs that are fit for the future NHS.

All patients, families and carers, regardless of background and age, deserve access to high-quality, safe, co-ordinated and comprehensive NHS care. To deliver this, the UK needs a workforce of highly trained general practitioners (GPs) with the expertise, skills and time to care for patients in their homes and communities to ensure that healthcare is effective and holistic across all aspects of the health service.

This report explains why an enhancement and extension of GP training from three to four years is needed to meet this goal. It sets out the role of the GP and primary care service in the modern NHS; the key challenges and drivers for change; how enhanced GP training will address current healthcare challenges faced by patients and services; and how enhanced GP training can be cost-effectively delivered to achieve high-quality, safe and efficient care.

GENERAL PRACTICE FOR TODAY AND TOMORROW

More than 90% of the UK population is registered with a GP. General practice is the main point of access to healthcare services for patients, carers and families[1] and patients attend an average of 5.5 consultations with their GP each year[2]. The vast majority of problems that patients present with are managed entirely within primary care, with only one in 20 consultations resulting in a secondary care referral[3].

The primary care service in the UK and the GPs who work within it are rated amongst the best in the world. A recent *British Medical Journal* review of published data from international comparisons of healthcare systems in high income countries found that healthcare in the UK is more accessible than in any other country studied, better organised, safer and more patient-centred[4]. Moreover, this is achieved at a 20% lower than average per capita cost to our national economy[5].

Working within their communities, GPs assess, plan and deliver services to accommodate local population needs, providing both acute and ongoing patient care for an increasing array of problems. This involves supporting appropriate access to specialist services in the most cost-effective way possible. This is not simply a matter of signposting; it is a highly complex task that involves co-ordinating care and enabling patients to best navigate the healthcare system. All care must be tailored to the individual with consideration given to co-morbidities and social context. To achieve high-quality care, therefore, GPs require a wide array of expert attributes and skills.

Despite the high regard for UK general practice within the NHS, there is now a need for a change in the current system of GP training. This is because the role of the GP within the NHS has changed considerably over the past decade and will continue to evolve further. These changes include:

- Selected care previously provided in hospital is moving 'closer to home' in the community, increasingly supported by GPs and primary healthcare teams
- Our ageing population and advances in medical management have resulted in increased complexity of care within primary care and an increased emphasis on integrated care

1 Starfield B. *Primary Care: Concept, evaluation and policy.* Oxford University Press, 1992. ISBN: 019507517X.
2 Hippisley-Cox J, Fenty J, Heaps M. Trends in Consultation Rates in General Practice 1995 to 2006: Analysis of the QRESEARCH database (2007). Accessed via: www.ic.nhs.uk/webfiles/publications/gp/QRESEARCH%20Consultation%20Rates%20Report%20FINAL.pdf.
3 King's Fund. *Improving the Quality of Care in General Practice*. Independent inquiry, 2011. p.17. Accessed via: www.kingsfund.org.uk/document.rm?id=9040.
4 Ingleby D, McKee M, Mladovsky P, Rechel B. How the NHS measures up to other health systems. *British Medical Journal* 2012; 344:e1079.
5 *Ibid.*

- The focus within primary care has broadened to include whole population health with prevention at its core
- Increased provision of care in the community requires a new focus on primary care-based research
- GPs have taken an increasing role in education of both doctors and other health and social care professionals at all levels; and
- Financial constraints and the changing structure of the NHS are bringing new leadership challenges for GPs to innovate and redesign care delivery for their practice populations.

For the past 30 years, GPs have undertaken just three years of mandatory GP training, currently involving 18 months' supervised working in hospital specialties and 18 months in general practice. GP training in the UK only meets the **minimum** European Union requirement; 14 other European countries now have longer GP training schemes[6].

The evidence in this report demonstrates how the current system of GP training is now inadequate in both scope and duration for the needs of the changing UK population and constantly evolving NHS. Today's GP trainees will provide an excellent service but an enhancement and extension of GP training is essential to enable future GPs to fulfil their roles safely and effectively. Enhanced GP training will produce a GP workforce that is more experienced, flexible and better equipped to address the needs of an ageing population with multiple co-morbidities, social inequalities and other public health issues and to enable service innovations. It will also enable future GPs to be able to adapt to advances in medical management, new technology and future changes to the NHS.

This report identifies and reviews the evidence-based priorities for enhanced GP training. It describes the key challenges that the NHS faces and explains how enhanced GP training will address them. Together with its **Supporting Evidence** appendices, this document clearly demonstrates that there is a need for change in the present GP training framework in order to:

1. **Optimise the educational effectiveness of GP specialty training** – this involves updating and modifying the curriculum and assessments and ensuring all training placements are as relevant to a modern GP's role as they can be.

2. **Extend the total period of GP specialty training, initially to a minimum of four years** – even if optimal educational effectiveness is achieved in all GP specialty training placements, a three-year programme will not be sufficient to deliver the training outcomes required for future GPs; as a result we are proposing that GP training be extended from a period of three to four years initially, with a **minimum of 24 months** spent in general practice placements. The remaining training time will be spent in appropriately supervised specialty, integrated and practice-based placements that have been approved for GP training, which meet the educational needs of GP trainees. This change will be followed by an impact assessment and it is anticipated that a further extension to five years will be required in the future.

6 EURACT. Accessed via: http://www.euract.eu/resources/specialist-training.

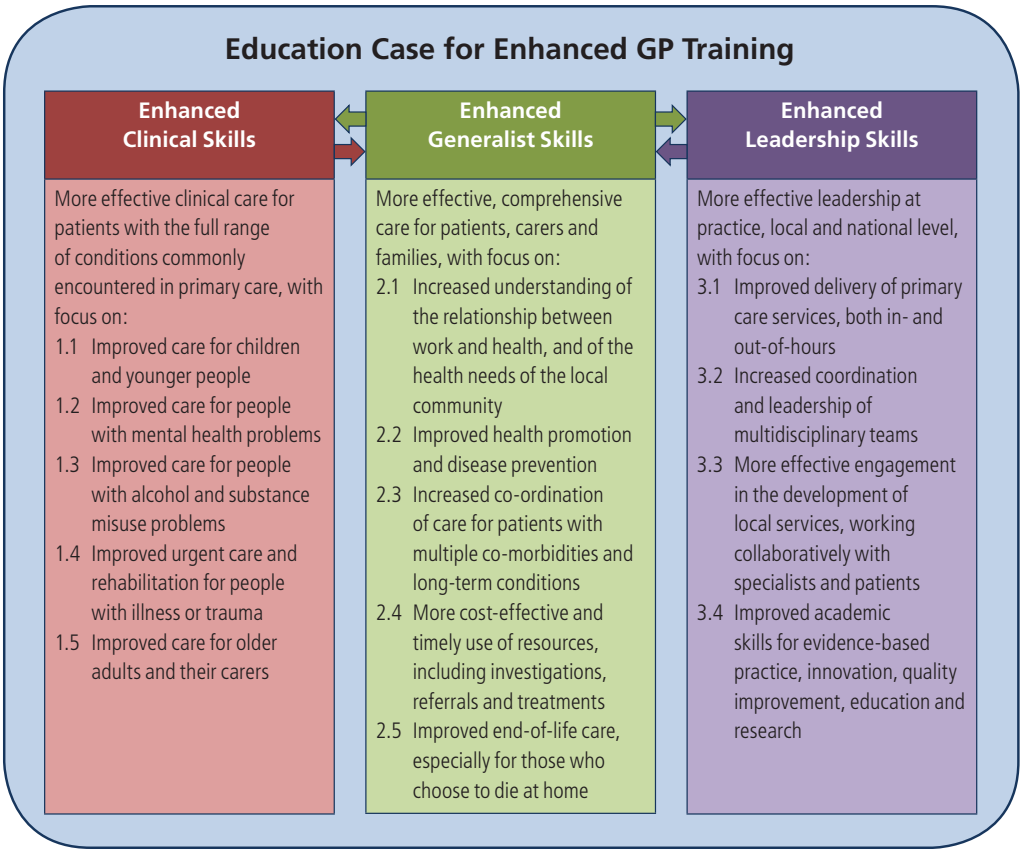
ENHANCING GP TRAINING

To achieve the required outcomes for the NHS, enhanced training programmes must focus on the central role of GPs as:

- **Clinicians** – providing high-quality care to the British population for the 95% of medical problems managed entirely within primary care
- **Generalists** – co-ordinating care for patients, carers and families from cradle to grave in the context of their own homes and communities and helping patients to navigate through the health system while also ensuring cost-effective use of resources
- **Leaders** – with a role in service planning, quality improvement and development through local change management, research, education, innovation, service redesign, and commissioning.

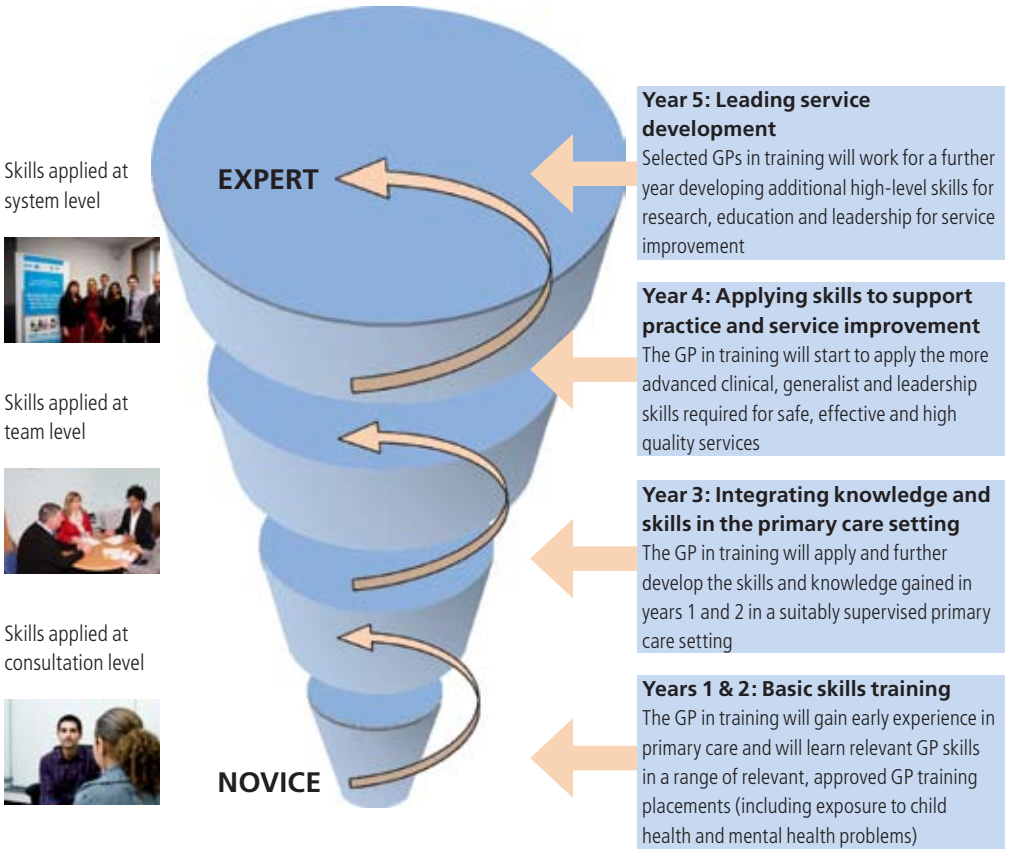
Using an evidence-based approach within each of these three broad priority areas, we have highlighted a series of outcomes for which there is currently a demonstrable additional GP training need (Figure 1) and detailed for each outcome the educational and service challenges that enhanced GP training will address. For further information see *Chapter 3 'Enhanced GP Training: Challenges and outcomes.'*

Figure 1: Framework detailing the three priority areas and fourteen outcomes identified for enhanced GP training over a four-year period



The new four-year GP specialty training programme will use a spiral model of incremental skill acquisition and application (Figure 2). This will be based on a firm foundation of skills that will build in complexity as GPs progress from novice to expert generalist and hone their skills to the primary care environment. This approach will incorporate team-based leadership competences to enable service appraisal and improvement both within the practice and more broadly in the community.

Figure 2: The spiral model of incremental skills development for enhanced GP training



The GP curriculum will be adapted and updated to incorporate the enhanced training outcomes for a four-year programme. Meeting these outcomes will require enhanced training opportunities designed throughout all four years of the programme. Within *Chapter 2 'Enhanced GP Training: Our vision'* there are examples of an enhanced four-year training programme.

Tried and tested mechanisms of assessment currently in use will be adapted for assessment of enhanced GP training. The Membership of the Royal College of General Practitioners (MRCGP) tripos (the Applied Knowledge Test, Clinical Skills Assessment and Workplace-based Assessment) will be extended and modified to accommodate the enhanced curriculum. The addition of an externally-assessed Quality Improvement Project in ST4 will enable trainees to demonstrate acquisition of more complex, system-level clinical, generalist and leadership skills (e.g. analytical, resource utilisation, team leadership and change management skills) and the application of these to improve services within the practice and the local community contexts. Both the MRCGP and Certificate of Completion of Training (CCT) will be awarded at the end of ST4 following successful completion of all the required assessments and training placements.

The economic evaluation of the benefits of enhanced GP training is contained within the accompanying *Supporting Evidence document 4: Feasibility and Implementation of Enhanced GP Training*. Clear processes for mitigating the additional costs of implementing a fourth year of GP specialty training have been identified and will form part of a more detailed implementation plan developed in conjunction with the British Medical Association and Postgraduate Deans. These will ensure contractual compliance of an extended period of training and preserve equity with other specialty training funding mechanisms.

ENHANCED GP TRAINING: THE NEED FOR CHANGE

KEY POINTS

- Patients, families and carers, of all backgrounds and ages, deserve access to high-quality, safe and comprehensive care from their local NHS general practice. To deliver this, we need a workforce of highly trained general practitioners (GPs), with the expertise, skill and time to care for patients in their homes and communities.
- This document describes the educational case in support of enhancing and extending GP training and how this new generation of GPs will improve outcomes for patients and the National Health Service (NHS).
- Future GPs need enhanced training because of the way care in the NHS is changing. The traditional boundaries between primary and secondary care are dissolving; care previously provided in hospital is moving 'closer to home' in the community; the ageing population and advances in medical management are resulting in increased complexity of care; financial constraints and the changing structure of the NHS bring new challenges for GPs, such as commissioning (in England) and greater population health responsibilities in all UK nations.
- For the past 30 years GPs have undertaken just three years of mandatory GP training; currently this involves 18 months' supervised work in hospital specialties and 18 months in general practice. This approach is now inadequate in both scope and duration for the needs of the modern NHS and an enhancement and extension of GP training is needed to enable future GPs to fulfil their new role safely and effectively.
- To achieve the required outcomes for the NHS, enhanced training programmes must focus on the central role of GPs as generalists; co-ordinating care for patients, carers and families from cradle to grave, in the context of their own homes and communities; and helping patients to navigate through the health system while also ensuring cost-effective use of resources.
- Changes must also encompass the leadership role of GPs in service planning, quality improvement and development through local change management, research, education, innovation, service redesign and, in England, commissioning.
- A longer period of GP training will prepare newly qualified GPs to respond positively to the needs of patients in the community and make them less likely to leave the profession at an early stage of their career. Future GP trainees will develop a greater ability to respond flexibly, appropriately and insightfully to new skills and knowledge requirements, and the capacity to adapt to new technology and organisational changes as they inevitably happen.

WHY GP TRAINING NEEDS TO BE ENHANCED

'The Royal College of General Practitioners (RCGP) proposes an extension to the length of training for general practitioners (GPs) and the NHS Future Forum has been persuaded by their arguments. It is in all our interests to ensure that the next generation of GPs receives the comprehensive and high quality training that they need and the current training schedule is tight.'

***Liberating the NHS: Developing the Healthcare Workforce – from Design to Delivery*, 2012**[7]

Patients, carers and their families deserve high-quality, safe and comprehensive care from general practice. To deliver this, we need a workforce of highly trained and skilled general practitioners (GPs), with the time, skill and expertise to care effectively for patients in their homes and communities.

Although UK general practice is currently rated highly on care and efficiency by most international comparisons[8, 9, 10], complex healthcare challenges are placing a range of new demands on GPs. These include:

- a move of traditional secondary care activity in order to bring care 'closer to home'
- progress in medical care leading to people living longer with more complex health and social care needs
- an ageing 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; and
- changes in NHS structures and clinically-led commissioning for local patient need.

The role of the GP has become increasingly complex and diverse, encompassing a wide range of clinical, academic, leadership and managerial functions.

Recognition of this expansion of the GP's role and responsibilities has been highlighted in the 2012 Department of Health report *Liberating the NHS: Developing the Healthcare Workforce – from Design to Delivery*[11], the 2011 King's Fund report *Improving the Quality of Care in General Practice*[12], and both Darzi's *Next Stage Review of the NHS*[13] and Tooke's *Independent Inquiry into Modernising Medical Careers*[14], all of which recommend an extension of GP training to meet the challenges of the future.

This document identifies and reviews the evidence-based priorities for enhanced GP training. It describes the key challenges that the NHS faces and explains how enhanced GP training will address them, with the supporting evidence presented in the attached

7 Department of Health. *Liberating the NHS: Developing the Healthcare Workforce – from Design to Delivery* (2012). Accessed via: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076.
8 The Commonwealth Fund Report (2010). Accessed via: http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx.
9 Ingleby D, McKee M, Mladovsky P, Rechel B. How the NHS measures up to other health systems. *British Medical Journal* (2012) 344:e1079.
10 The Commonwealth Fund Report (2011). Accessed via: http://www.commonwealthfund.org/Surveys/2011/Nov/2011-International-Survey.aspx.
11 Department of Health. *Liberating the NHS: Developing the Healthcare Workforce – from Design to Delivery* (2012). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132076.
12 The King's Fund. *Improving the Quality of Care in General Practice* (2010). Accessed via: www.kingsfund.org.uk/document.rm?id=9040
13 Department of Health. *High Quality Care for All: NHS next stage review final report* (2008). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf.
14 Tooke J. *Aspiring to Excellence: Findings and recommendations of the independent inquiry into modernising medical careers* (2008). Accessed via: http://www.consultationfinder.com/econsult/uploaddocs/Consult1/MMC_InquiryReport.pdf.

documents. This evidence clearly demonstrates that there is a need for change in the present GP training framework in order to:

1. **Optimise the educational effectiveness of GP specialty training** – this involves updating and modifying the curriculum and assessments and ensuring that all training placements are as relevant to a modern GP's role as they can be. For example, GP training posts need an appropriate amount of time spent in outpatients and community-based clinics, and must encompass ongoing medical management issues rather than focus on emergency interventional care. Services involving multidisciplinary teams and integrated care are also settings where GP trainees may receive effective training and supervision.

2. **Extend the total period of GP specialty training, initially to a minimum of four years** – even if optimal educational effectiveness is achieved in all GP specialty training placements, a three-year programme will never be sufficient to deliver the training outcomes required for future GPs; we are therefore proposing that GP training be extended from a period of three to four years initially, with a minimum of 24 months spent in general practice placements. There is much evidence to support the need for an extension in training time and this has been collated within this report.

A logical and cost-effective approach to extension

A longer period of GP training, incorporating elements of both task-specific training and professional education, will prepare newly qualified GPs to respond more effectively to the needs of patients both in their consulting rooms and in the wider community and will improve clinical outcomes. Longer training will mean that GP trainees will develop a greater ability to respond flexibly and appropriately to new skills and knowledge requirements for their role, and the capacity to adapt to new technology and organisational changes as they inevitably happen.

To deliver enhanced training in a cost-effective manner, we propose an initial extension of all GP training programmes from three to four years, together with a restructuring of the existing training framework to make the most effective use of the available time. The impact of these changes on training outcomes, patient care and future service needs will then be evaluated; given the likely ongoing expansion of the GP's central NHS role over the coming years, in both scope and complexity, it is anticipated that an additional extension to a five-year training programme is likely to be required at a point in the not-too-distant future.

The international perspective

Currently in the UK, doctors who choose to become GPs enter specialist training following their two-year Foundation programme. In the future, some trainees may choose to enter GP specialty training after completion of a Broad-based Curriculum[15]. The minimal duration of GP specialty training is currently three years in total. Although there are slight differences between training schemes in different areas of the UK, most trainees are employed for 18 months (full time equivalent) in hospital training posts approved for GP training and 18 months in general practice under the supervision of an approved GP trainer.

The breadth and depth of knowledge, skills and understanding that GPs must acquire has increased enormously since the three-year GP vocational training scheme model was rolled out over thirty years ago in the early 1980s. Although the system of primary care in the UK

15 Medical Education England. Medical Programme Board minutes, 13th April 2011. Accessed via: http://www.mee.nhs.uk/pdf/MPB_Minutes_130411.pdf.

is one of the most developed in Europe, GP training in 14 other European countries with primary healthcare systems is now longer in duration than it is in the UK (Table 1.1).

Table 1.1: Duration of general practice specialty training in Europe

European Country	Total duration of GP training (years)	Duration of training in a General Practice setting (years)	Duration of training in a hospital or other setting (years)
Finland	6	4-6	0-2
Norway	5	4	1
Sweden	5	2.5–3.5	1.5–2.5
Denmark	5	2.5	2.5
Iceland	5	2	3
Slovakia	5	1–2	3–4
Switzerland	5	0–3	4.5–5
Ireland	4	2	2
Poland	4	2	2
Portugal	4	2	2
Slovenia	4	2	2
Spain	4	2	2
Greece	4	1	3
United Kingdom	3	1.5	1.5

Source: EURACT (2011)[16].

The national perspective

Although general practice requires application of a broad range of complex competences, in order to manage patients with multiple co-morbidities in a community-based context, doctors training for general practice in the UK currently have a substantially shorter period of time to develop, apply and undergo assessment of their core skills than doctors training for other clinical specialties (Table 1.2). This issue has been highlighted in a recent report from the NHS Future Forum:

'The move to shift more clinical care into the community means GPs will need to take on more complex care for their populations. To do this they need high quality training and experience and, while we heard that the length of training for consultants was widely felt to be about right, there was an almost unanimous view that the length of postgraduate GP training should be extended'.

***Education and Training – Next stage: A report from the NHS Future Forum*, January 2012**[17]

16 EURACT (European Academy of Teachers in General Practice). Accessed via: http://www.euract.eu/resources/specialist-training.

17 *Education and Training – Next Stage. A report from the NHS Future Forum* (2011). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132025.pdf.

Table 1.2: Periods of specialty training in medical and surgical specialties in the UK

Specialty	Minimum duration of specialty training
All surgical specialties	9 years
All medical specialties	7 years (84 months)
Emergency Medicine	6 years
Psychiatry	6 years
Pathology	5 years
Radiology	5 years
General practice	3 years

A similar view has also been expressed by patient groups and lay representatives:

'With the ever increasing complexity of modern medicine, patients and the public would, I believe, if asked, expect GPs to have at least the same length of training as some of the other specialties. This is especially so as they treat everybody and need to diagnose or know who can diagnose every condition; with the shortest training of any specialty this is a huge challenge for any individual to attain.'

Anthony Chuter, Chair, RCGP Patient Partnership Group

The trainees' perspective

GP trainees themselves recognise the need for longer training. A survey presented to the 2011 Annual RCGP Conference in Liverpool found that 41% of trainees believed that their three-year GP training period would **not** prepare them adequately for a career in general practice[18]. A 2012 survey performed for the RCGP to seek the views of trainee GPs and those within the first five years of independent practice post-training found that 84% were in favour of an extension of GP training to four or five years in order to better equip them for practice as an independent GP[19].

In 2011, an independent, three-year evaluation by the University of Birmingham showed that trainee GPs in the UK were already struggling to cover the existing GP curriculum within the current three-year training period. The authors recommended an extension to the training period[20].

18 Presentation at RCGP Annual Conference (2011). Accessed via: http://www.rcgp.org.uk/courses__events/rcgp_annual_conference/past_conferences/liverpool__2011/presentations_2011.aspx.
19 Lawrence M. Personal communication, February 2012. Survey due for publication in *InnovAiT* in 2012.
20 Bedward J, Davison I, Burke S, Thomas H. Evaluation of the RCGP GP Training Curriculum (2011). Accessed via: www.birmingham.ac.uk/Documents/college-social-sciences/education/crmde/rcgp-report-june2011.pdf.

Weaknesses in current UK GP training have been identified in a number of specific clinical areas such as care for children[21], care for those with mental health problems[22, 23], care for those with dementia[24] and care for people living in residential care homes[25]. Addressing these training needs will be critical to ensuring that future GP trainees develop the skills required to fulfil their roles in a complex and changing NHS environment.

It has previously been suggested that enhanced GP training might be delivered by retaining the duration of GP training at three years but further increasing the weekly working hours of GP trainees. This option has been evaluated in detail by the RCGP but would be ineffective and impracticable for a number of reasons. Legally, the number of actual training hours that could be realised through this approach is low due to European Union (EU) working time regulations. Furthermore, due to logistical considerations, such as nationally contracted practice opening times, additional weekly hours would be of limited value to GP training, would incur considerable additional clinical supervision and administrative staffing costs, and would risk potentially increasing work-related stress and sickness absence. As such, this option would not meet the educational needs of future GPs nor the needs of patients and the NHS (see *Supporting document 4: Feasibility and Implementation of Enhanced GP Training* for the full options for appraisal with supporting evidence).

Enhancement of GP training to meet the challenges of the future cannot be achieved without an extension of the duration of GP training programmes. Extending GP training programmes by one year will add around 1800 hours of valuable training experience at times when trainees are most receptive to learning and when their educational and/or clinical supervisors are available. It will also provide the time and opportunity for every trainee to acquire and apply their more advanced clinical, generalist and leadership skills to the improvement of local NHS services.

The perspective from pilot schemes

As part of the preparation for this submission, the RCGP has evaluated a range of pilot schemes involving additional training for GP trainees and newly qualified GPs, including four-year extension pilots and Higher Professional Education (HPE) programmes. Relevant examples include:

- Four-year academic GP training programmes in London
- Four-year extended GP training schemes in Scotland
- Five-year extended GP training pilot schemes in the North West Deanery;
- First5 peer group learning schemes for newly qualified GPs; and
- Higher Professional Educational scheme pilot schemes across the UK.

21 Kennedy I. *Getting it Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs* (2010). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119446.pdf.

22 Gofal. *The Voice of Lived Experience* (2011). Accessed via: http://www.gofal.org.uk/wp-content/uploads/2011/10/The-Voice-of-Lived-Experience.pdf.

23 Lester H. Shared care for people with mental illness: a GP's perspective. *Advances in Psychiatric Treatment* (2005);11:133-139. Accessed via: http://apt.rcpsych.org/content/11/2/133.full.pdf.

24 House of Commons all Party Parliamentary Group on Dementia. The £20 billion question: an inquiry into improving lives through cost effective dementia services (2011). Accessed via: http://www.insidehousing.co.uk/Journals/1/Files/2011/7/12/Dementia.pdf.

25 Joseph Rowntree Foundation. Improving care in residential care homes: a literature review (2008). Accessed via: http://www.jrf.org.uk/sites/files/jrf/2326.pdf.

Academic evaluations of these pilot schemes have demonstrated a number of benefits including increased confidence[26 27] and improved multidisciplinary team work[28] . Evaluations of the recent extension of GP training to four years in the Republic of Ireland have reported that the increased length of training enhanced professional and personal development, improved confidence and readiness to practice and created a more varied and diverse learning environment[29 30].

Although these findings have greatly informed the development of this case, many of the UK pilots are not directly comparable with the extended training framework set out here; for example, some were based on an 'add on' year that occurred before or after the formal GP specialty training programme. In contrast, the enhanced GP training programme set out in this bid will provide an integrated four-year programme in which training experiences and assessments are optimised to support the acquisition and application of GP curriculum competences.

An HPE programme, in contrast to a training programme, is largely voluntary so the most educational benefit is gained by the more motivated participants. Poorly-performing and less skilled doctors may not engage with these programmes. Unlike training, an HPE programme cannot be robustly assessed to the licensing standard required for independent practice; as it occurs after training, the doctor is already licensed for independent practice, a status protected by national and European-wide regulation.

For these reasons, a post-CCT programme of CPD for newly qualified GPs, although of educational value for many, would not provide the same consistent, quality managed, targeted and nationally assessed training that is required to ensure that future GPs are able to meet the challenges they will face in a changing NHS. It would also not provide the supervised training opportunities required to enable doctors to safely develop the educational outcomes identified for enhanced GP training, particularly as the majority of newly-qualified doctors increasingly find themselves working in locum or sessional posts. The absence of close educational supervision and mentoring will have a particularly detrimental effect on the acquisition of the higher-level generalist and leadership competences that will be required for delivering service improvements, the QIPP agenda, and for cost-effective local commissioning in England.

In contrast to an HPE scheme, an enhanced GP training programme will enable key out-of-hours, leadership, and team-working competences (such as delegation) to be developed, demonstrated and assessed over time, in a safe and appropriately supervised learning environment.

26 Barron R, Pitts J, Vincent S. A higher professional education course in Wessex the first year. *Education for General Practice* (1995); 6: 157-162.
27 Smith A, Wright A. Expectations and benefits of the Somerset New Principles Course: 'Ten years experience in one year.' *Education in Primary General Practice* (2001);12:169-177.
28 Howard J. An evaluation of the Higher Professional Education Scheme for General Practice in Mersey Deanery (2003).
29 Dowling S, Rouse M, Thompson W, Sibbett C, Farrell J. Extension of general practice training from three to four years: experiences of a vocational training programme in Southern Ireland. *Education for General Practice* (2009); 20(3):167-72.
30 O'Shea E B. What's another year? A qualitative evaluation of extension of general practice training in the West of Ireland. *Education for General Practice* (2009); 20(3):159-66.

IDENTIFYING THE EDUCATIONAL PRIORITIES

General practice is the main point of access to healthcare services for patients, carers and families[31]. There is increased recognition internationally of the value of a general practice-based system in delivering accessible, equitable and cost-effective care for patients[32, 33]. The key advantages of the UK GP-based system, which must be maintained and strengthened, include:

- trust
- co-ordination of care
- continuity
- flexibility
- population coverage and
- leadership[34].

To produce the case for enhanced GP training described in this document, the Royal College of General Practitioners (RCGP) has reviewed the literature and sought evidence and submissions from a wide range of professionals, patients and organisations (see Acknowledgements). This evidence was collated and reviewed by an expert group in order to identify the priority areas of challenge for future general practice, resulting in the identification of a number of key outcomes where GP training must be enhanced. These outcomes are based on the core roles of the GP in the modern NHS.

The modern GP's generalist role in caring for patients, carers and families
GPs work within multidisciplinary teams to manage the vast majority of health problems in the NHS[35]. Quite simply, they must be trained as **'expert generalists'**. In the future NHS, this role will dovetail with that of specialists with expert technical and discipline-specific skills, as well as supporting the development of more secondary care specialists with generalist skills.

According to the most recent available NHS data analysis, a patient in England in 2009 had an average of 5.5 consultations with their GP each year (rising from an average of 3.9 in 1995)[36]. Only one out of every 20 consultations (5%) with a GP results in a secondary care referral, however[37]. The vast majority (95%) of problems are dealt with in primary care.

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[38], and this shift has accelerated over the past decade. For example:

- GPs now provide routine care for patients with a range of complex conditions, such as insulin-dependent diabetes, entirely within the community, whereas a decade ago they would have been managed in secondary care. Many GPs now perform insulin-conversion entirely in the community

31 Starfield B. *Primary care: Concept, evaluation and policy.* Oxford University Press (1992). ISBN: 019507517X
32 The Commonwealth Fund Report (2010). Accessed via: http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx.
33 The Commonwealth Fund Report (2011). Accessed via: http://www.commonwealthfund.org/Surveys/2011/Nov/2011-International-Survey.aspx.
34 Gillies J, Mercer S, Lyon A, Scott M, Watt G. Distilling the essence of general practice. *BJGP* (2009);59:e167-76.
35 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011). Accessed via: http://www.rcgp.org.uk/pdf/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20_rev_7%20OCTOBER%202011.pdf.
36 NHS Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database. Accessed via: http://www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_1995_2008.pdf.
37 King's Fund. *Improving the Quality of Care in General Practice*. Independent inquiry, 2001; p.17. Accessed via: www.kingsfund.org.uk/document.rm?id=9040.
38 Department of Health. *Keeping the NHS Local: A new direction of travel.* London: Department of Health, 2003.

- Procedures such as insertion/removal of hormone and long-acting reversible contraceptive implants, joint injections and minor skin surgery procedures are now performed routinely in the majority of GP surgeries
- Shared care guidelines are commonly used for the monitoring of drug treatments that were previously managed in secondary care (e.g. disease-modifying anti-rheumatic drugs) and planned reviews after serious illnesses (e.g. monitoring of patients with melanoma)
- Early discharge schemes mean that many patients who have had surgery are discharged within hours of their procedures and more patients who have suffered a stroke receive specialist care at home with the support of GPs than in hospital
- General Practitioners with a Special Interest (GPwSI) work with secondary care colleagues to provide community-based clinics for a wide range of clinical problems.

GPs care for patients, their carers and families from before birth to after death. They diagnose most illnesses, manage the majority of health problems, promote better health and prevent disease, provide screening programmes, certify sickness and disability, support rehabilitation, monitor and manage a wide range of chronic health conditions, support carers, and optimise access to specialist services. In order to provide a safe and effective service, GPs must be highly skilled in providing general, comprehensive and holistic care for patients and their carers and families, delivered in the community setting over time[39].

The principle of *population health* is a critical tenet of the new NHS, transforming it from a national illness service to become a national health service. The financial viability of the NHS is dependent on this paradigm shift and GPs are key to its implementation.

Clinical management in general practice requires more than checking the clinical symptoms and signs, prescribing medications, and referring for further medical care. It also requires a complex understanding of managing multiple conditions and therapeutic interventions, including how aspects of patients' experiences and individual contexts influence the effects of disease, the way that patients react to these, and their concordance with and response to treatment. For example, an elderly lady who cares for her sick husband and has a fall may not injure herself physically, but may lose her confidence and become unable to retain her mobility, resulting in subsequent deterioration and long-term health impacts to herself and her husband. A narrow assessment of physical injuries alone would fail to identify the wider implications of her fall to both her and her husband's wellbeing.

However GPs cannot work alone but must form part of an integrated system of care that facilitates and enables specialist teams to perform their expert roles:

'Specialists and GPs, though sometimes perceived as opposites, are inextricably dependent on each others' skills and, crucially, most are keenly aware of the extent of this interdependency.'

Iona Heath, President of the RCGP (2011)[40]

39 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011). Accessed via: http://www.rcgp.org.uk/pdf/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20_rev_7%20OCTOBER%202011.pdf.

40 Heath I. Harveian Oration 2011: Divided We Fail. Accessed via: www.rcplondon.ac.uk/sites/default/files/harveian-oration-2011-web-navigable.pdf.

The intellectual and contextual framework within which expert generalists operate is as demanding as that of expert specialists; however, it is different within a number of parameters, as described by Marinker[41]. Some of these key differences are set out in Table 1.3.

Table 1.3: The differences between the generalist and specialist clinical contexts

A generalist must develop the skills to:	A specialist must develop the skills to:
Tolerate uncertainty – generalists must manage a large proportion of patients with undifferentiated symptoms; including those who present early in the course of illness, those with evolving conditions, or those whose symptoms do not form a characteristic pattern of disease.	**Reduce uncertainty** – specialists are expected to discover a diagnosis and to investigate until this is achieved. If they are unable to identify a diagnosis within their own specialty, they are usually expected to discharge the patient or suggest referral on to another specialist, rather than manage the diagnostic uncertainty.
Explore probability – generalists see patients from an unscreened population with a relatively low incidence of serious disease. They require highly developed diagnostic skills, including recognition of common conditions and awareness of the limits of their knowledge. Their decisions are based on the epidemiology of the community and the consequent probability that the patient's symptoms are medically significant.	**Explore possibility** – specialists see a pre-selected population of patients with a relatively high incidence of serious disease. They require expert knowledge of the rare and esoteric conditions that are relatively more likely to be the cause of the problem in this population.
Marginalise danger – a key skill of a general practitioner is to recognise and act on potential dangers to patients even when there is diagnostic uncertainty; this often requires referring the patient or initiating treatment before a diagnosis has been established (e.g. in a case of suspected meningitis or cancer).	**Marginalise error** – a specialist must ensure that they reach an accurate diagnosis to guide treatment for the patient, in order to enable a successful outcome.

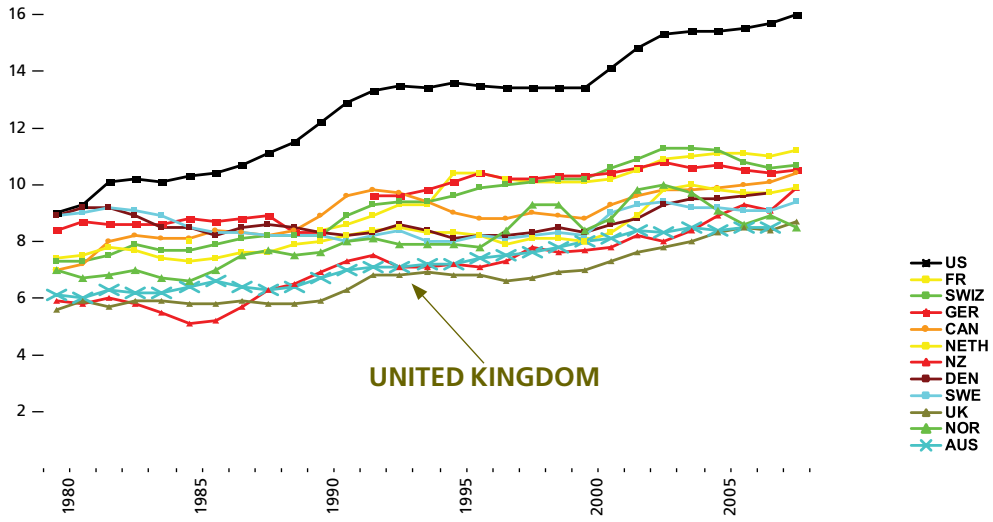
It is these complementary but crucial differences in working context between generalist and specialist services that doctors entering general practice for the first time find most challenging[42]. They are the foremost reasons why the high-level skills required of modern general practitioners can only be acquired through relevant high-quality learning experiences and opportunities to apply skills in the general practice environment.

41 Marinker M. Bayliss Lecture. London: Royal College of Physicians, 1994.
42 Clark J. Insecurity and risk in the consultation. Br J Gen Pract. (2009); 59(564): 548-549. doi: 10.3399/bjgp09X453666.

The modern GP's gatekeeper and navigator role

Since the beginnings of the NHS in 1948, GPs have acted as the 'gatekeepers' to hospital services. The active management of access to specialist care within the health service has been an important factor in enabling the UK to achieve a creditable position in international comparisons of health status indicators (such as longevity and perinatal mortality) while absorbing a smaller proportion of gross domestic product (GDP) than most other western countries (Figure 1.1)[43 44]. The role of the GP in moderating demand for specialist care is recognised by both NHS and private healthcare providers[45]. The gatekeeping role of general practice is therefore crucial for the long-term financial sustainability of the NHS.

Figure 1.1: Total expenditure on health as percentage of gross domestic product



Source: OECD Health Data 2010.[46] Reproduced with kind permission from The Commonwealth Fund.

'GPs can only work safely to the limits of their knowledge and skill if they can refer easily and promptly to their specialist colleagues when those limits are reached. Specialists can only use their skills maximally if they are enabled to work with a highly selected population for whom their particular skills are appropriate. There is an almost perfect complementarity between the two parts of the profession and the interface between GP and specialist care needs to be seen primarily as a means of extending the effectiveness of both.'

Iona Heath, Harveian Oration 2011: 'Divided We Fail', Royal College of Physicians (London), 2011[47]

In addition to gatekeeping, the modern GP plays an increasingly important role in the care of the growing number of patients with complex needs, long-term conditions and multiple morbidities. For these patients and their families, the effective co-ordination of care is especially important and requires an increased focus on the quality of the pathway that patients and carers take through primary care and the health service as a whole, as well as the care they receive from a variety of agencies. This model, with general practice sitting at the hub of a network of services, has been described as the GP's '**navigator**' role, whereby

43 Organization for Economic Co-operation and Development (OECD) (2011). Health Data. Accessed via: www.oecd.org/document/16/0,3746,en_2649_34631_2085200_1_1_1_1,00.html.
44 The Commonwealth Fund Report (2010). Accessed via: http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx.
45 Vallance Owen A. Evidence to the Independent Commission on Generalism (2011).
46 Reproduced from The Commonwealth Fund Report (2010). Accessed via: http://www.commonwealthfund.org/Surveys/2010/Nov/2010-International-Survey.aspx.
47 Heath I. Harveian Oration 2011: Divided We Fail. Accessed via: www.rcplondon.ac.uk/sites/default/files/harveian-oration-2011-web-navigable.pdf.

the GP is responsible for working in partnership with patients and carers to guide them effectively and safely through the healthcare system[48].

The central co-ordinating role of the GP is especially important when a patient is crossing between primary, secondary and social care boundaries. It is central to achieving optimal access to specialist care, for the avoidance of unnecessary duplication of investigations, and in maximising genuine patient choice within the bounds of limited resources[49].

This role is far more complex than simply signposting patients to specialist services – a modern GP must actively manage their patients at all times throughout the process, interpreting information from specialist services and integrating disease-specific components of patient care into the context of the whole person (i.e. allowing for the effects of other morbidities and social factors that impact on an individual patient's health). A GP must dovetail new specialist management plans with those already in place for each patient, while also enabling the patient to self-care in the interval between consultations and addressing the barriers, attitudes and beliefs that may hinder progress. Given the increasing quantity and complexity of information and choices facing NHS patients, expert clinical judgement, a patient-centred focus and good consultation skills to promote shared decision making are paramount.

The growing importance of the GP's role as patient navigator was highlighted by the Royal College of Physicians in 2010[50], which reinforced the view that GPs 'must be engaged fully in deploying their key skills of interpreting complex choices for patients'.

Deciding which resources are most appropriate and cost-effective for each individual patient, and guiding the patient to the most effective services and specialists is a highly complex task. In addition to well-developed diagnostic and consultation skills and the ability to work effectively within their multidisciplinary team, it requires the GP to recognise and pro-actively manage service bottlenecks and to contribute to the ongoing development of innovative and more cost-effective patient pathways. Enhanced GP training must equip future doctors with the skills to act simultaneously as both effective gatekeepers and navigators of the NHS for their patients.

'It is not enough for clinicians to act as practitioners in their own disciplines. They must act as partners to their colleagues, accepting shared accountability for the service provided to their patients. They are also expected to offer leadership and to work with others to change systems when it is necessary for the benefit of patients.'

General Medical Council, *Tomorrow's Doctors* (2009)[51]

The GP's role in service redesign and improvement

Over the past 20 years there has been a substantive shift in all the nations of the UK towards GPs playing a greater role in influencing services beyond the boundaries of their own practices. Federated models, integrated service configurations and new community agency innovations require and encourage cross-boundary working, although the clinical leadership and other competences needed to underpin these service development models

48 Department of Health (2010). *Getting it Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs*. A review by Professor Sir Ian Kennedy. Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119445.

49 Royal College of General Practitioners. *The Future Direction of General Practice*: A roadmap. London: RCGP, 2007. Accessed via: www.rcgp.org.uk/PDF/Roadmap_embargoed%2011am%2013%20Sept.pdf.

50 Royal College of Physicians. *Future Physician: Changing doctors in changing times.* London: RCP, 2010. Accessed via: http://bookshoprcplondon.ac.uk/details.aspx?e=314.

51 General Medical Council. *Tomorrow's Doctors* (2009). Accessed via: http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors_2009_foreword.asp.

are not currently achievable in the existing three-year GP training period.

The UK government has stated its intention that, from 2013, groups of GPs and other clinical professionals will start to take on formal responsibility for commissioning the majority of NHS services in England, working in partnership with other health professionals, local communities and local authorities. As members of Clinical Commissioning Groups, GPs in England will need to take a lead role in assessing the needs of a population, planning, procuring and monitoring services for that population, and then monitoring and evaluating the impact of those services.

Although the commissioning process in the devolved nations will be different from that in England, GPs in those nations will be actively involved in influencing healthcare provision for their local populations, improving population health, reducing inequalities and assisting with service development and redesign. To successfully perform this role, and to work collaboratively with neighbouring practices and other health and social care providers, all future GPs in the UK will require the skills to effectively analyse and understand the healthcare needs of their population and critically evaluate evidence from multiple sources. This will allow them to negotiate effectively with others at an individual and corporate level.

GP training needs to build on core clinical and generalist skills to develop a range of new public health, commissioning and leadership skills that can be specifically applied to service redesign, quality improvement and other commissioning-related tasks.

The GP's role in research

'Despite the perceived success of vocational training, general practice remains academically disadvantaged compared with hospital medicine. Most general practitioners have no contact with research or academic general practice, few achieve higher degrees compared with hospital consultants, and there are few academic posts in general practice.'

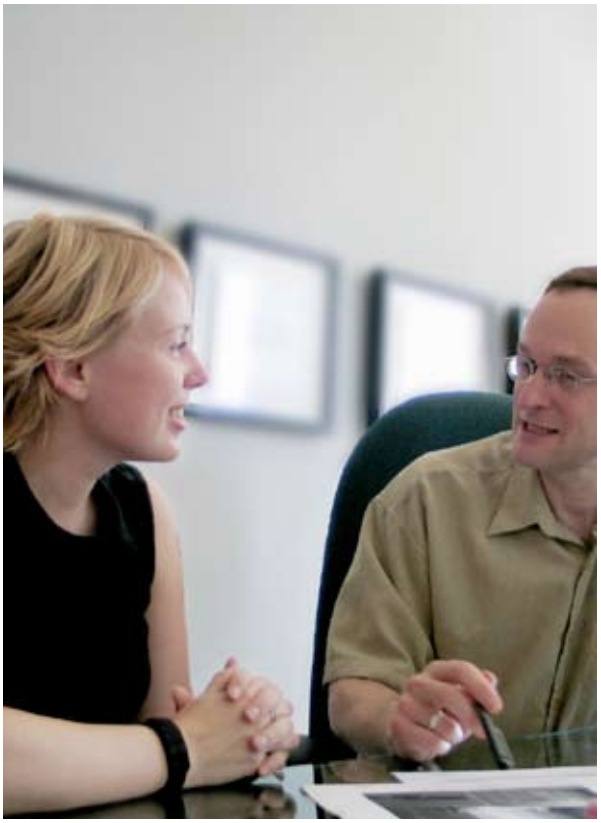
Dr Toby Lipman in *The Future General practitioner: Out of date and running out of time*, (2000)[52]

General practice has a long history, but its academic and professional development was only formalised comparatively recently. The RCGP itself was only founded in 1952, and the world's first GP professor was appointed in Edinburgh in 1963. Despite recent progress, general practice is still perceived by many medical students and doctors as being a 'non-academic' career, with few opportunities to engage in research training or academic projects.

Much of the available body of clinical evidence has been derived from selected patient populations studied within secondary care. There are many reasons for this situation, including ease of recruitment and access; availability of research funds orientated to secondary care specialties; and availability of suitably trained researchers. Furthermore, many of the undifferentiated symptoms that are commonplace in general practice are hard to study with traditional single method research models. Thus much of the available evidence cannot be directly applied to patients in the community setting and GPs must interpret it with care. Enhanced GP training can help to address this situation by enabling future GPs to be more research responsive and by equipping them with the skills needed to enable them to collaborate effectively in primary care-based research.

To help address these challenges GPs need, as a minimum, well developed critical appraisal skills to assess and apply evidence appropriately. Undergraduate training in these areas is barely built upon during the current three-year training programme, where clinical evidence

52 Lipman T. The future general practitioner: out of date and running out of time. *Br J Gen Pract.* (2000);50(458):743-746.



is widely used but the practice of research skills is limited by time and opportunity.

Tomorrow's GPs will need to understand and apply relevant evidence to inform clinical decision making and to be competent in collecting and analysing data for service improvement and advancing clinical knowledge. Promotion of research capacity and activity relevant to primary care must be key priorities in general practice training of the future.

Academic training posts are relatively few in number and by definition require a year's extension to allow these additional competences to be acquired. Although only a minority of GPs will take an active part in leading research, all should be scholarly in their approach to their work[53], making connections across disciplines to throw light on complex issues, applying research findings in every day practice and, where appropriate, in their teaching of trainees.

The GP's role in education

The role of the GP in education has grown rapidly since the 1960s, when undergraduate attachments started developing beyond a fortnight's GP attachment in the final year and vocational training in practice became mandatory. It is expected by the General Medical Council that all clinicians are able and willing to act as teachers.

GP teachers undertake roles in the teaching of basic clinical skills and problem-based learning in many medical schools. In London, a recent report found that 15% of the entire undergraduate medical curriculum is delivered in general practice, with each London medical school working with up to 600 GP teachers and 400 training practices[54]. Student evaluations indicate high levels of satisfaction with undergraduate teaching in primary care[55].

GP teachers are also widely involved with the training of postgraduate doctors. General practice placements are now a routine part of the Foundation years, accounting for 42% of Foundation year placements[56], and there are currently around 9,000 trainee GPs in specialist

53 Boyer E. *Scholarship Reconsidered: Priorities for the professoriate*.Princeton New Jersey the Carnegie foundation for the advancement of teaching (1990).
54 Peters M, Jones R. General practice the future teaching environment. Undergraduate primary care education in London: a report from the Heads of Departments of General Practice and Primary Care (2008). Accessed via: http://www.kcl.ac.uk/content/1/c6/04/49/17/HoDsreport.pdf.
55 Peters M, Jones R. *ibid.*
56 The UK Foundation Programme Office. *Foundation Programme Annual Report 2011*: UK Summary. Accessed via: http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs#fpar.

postgraduate training at any time in the UK. In addition, GPs are often called upon to provide clinical teaching for other groups, such as practice nurses or patient groups.

Furthermore, once qualified for independent practice, all GPs are required to maintain their clinical and professional skills on an ongoing basis and need to demonstrate this for annual appraisal and revalidation purposes. Thus GPs have an increasing responsibility for the education of themselves as well as others. The extent of this educational role is only limited by the availability of resources and the expertise needed to deploy them most effectively. It is important that enhanced GP training delivers skills to enable GPs to act as effective educators both within their own practices and the wider healthcare community.

The GP's role in management and leadership
Traditionally GPs have worked as partners in small businesses. New service models mean that GPs are increasingly working as:

- sessional doctors
- local medical directors, senior medical advisors and local governance leads
- leaders of out of hours services, and
- innovators and commissioners of care.

On a national level too, many GPs have management and leadership roles; for instance in Deaneries, Medical Schools, NHS bodies, the RCGP, Department of Health, British Medical Association, National Institute for Health and Clinical Excellence, or national charities and voluntary organisations.

All of these roles require leadership and management skills that cannot be applied or assessed during the current three-year training programme due to lack of time. Addressing this need is essential if new GPs are to take leading roles in the future development of NHS services.

The GP's central role in NHS leadership is explored further in Priority Area 3, in the '*Challenges and outcomes*' chapter of this document.

SUMMARY OF THE NEED FOR CHANGE

This chapter has demonstrated how 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 is evolving 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 and quality improvement.

GPs also contribute to education, research, management and leadership at all levels of the health service. As the GP role becomes more complex and developed, so too must GP training. For this reason, enhanced and extended GP training is essential to equip new GPs with the opportunity to develop and demonstrate competence in the skills to provide patients with first class, effective primary care services in the future.

ENHANCED GP TRAINING: OUR VISION

'There should be an immediate extension of the length of specialty training for GPs... This must include specific provision for training in disciplines particularly relevant in general practice, including paediatric care, learning disability, mental health, care of people with life-limiting conditions, and end-of-life care for patients and their families.'

Independent Commission on Medical Generalism (Chair: Baroness Finlay), 2011[57]

KEY POINTS

- Based on an evidence-based analysis of health service challenges and the changing roles and responsibilities of modern NHS GPs, three priority areas have been identified for enhanced training: enhanced clinical training, enhanced generalist training and enhanced leadership training.
- Within each of these three priority areas, evidence-based outcomes are identified in which there are demonstrable additional training needs; for each outcome, the educational and service challenges that enhanced GP training will address have been identified.
- The delivery of the outcomes for enhanced GP training is based on two principles – optimising the effectiveness of training delivery and extending the total training period, initially to four years.
- The new four-year GP specialty training programme will be based on a spiral model of incremental skill acquisition and application. This will build a firm foundation of skills as the GP progresses from novice to expert generalist and is able to apply a broader and more complex set of skills, honed to the primary care environment. This approach will increasingly incorporate leadership skills to enable service appraisal and improvement.
- The GP curriculum will be adapted to incorporate the enhanced training outcomes. Meeting these outcomes will require relevant and appropriately supervised training opportunities throughout all four years of the programme.
- The mechanisms of assessment currently in use will be adapted for assessment of 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 all the required assessments and training placements.

57 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011). Accessed via: http://www.rcgp.org.uk/pdf/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20_rev_7%20OCTOBER%202011.pdf.

THE ENHANCED GP TRAINING FRAMEWORK

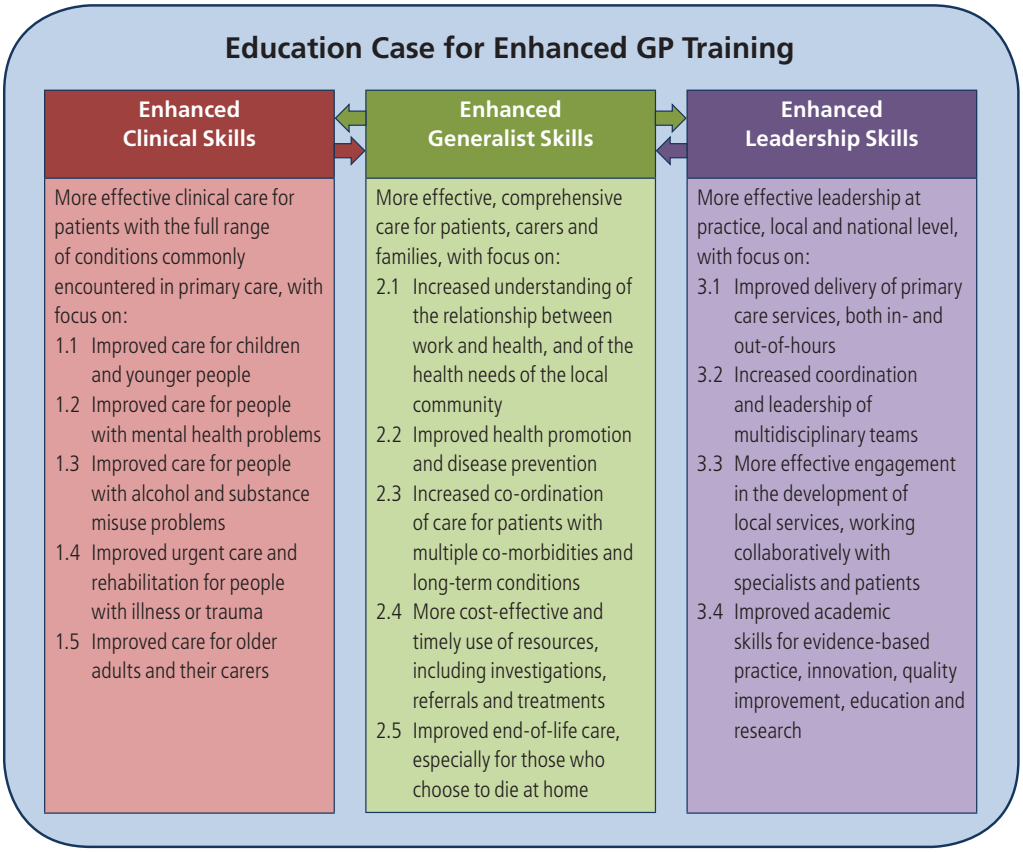
Based on the patient care and service needs identified earlier in this document, the enhanced aims for GP training for the future can be organised into three broad priority areas:

- Enhanced Clinical Skills.
- Enhanced Generalist Skills.
- Enhanced Leadership Skills.

Within each of the three broad priority areas, a number of specific, evidence-based outcomes for enhanced training have been identified. Each of these outcomes represents an area of unmet training need within the current system of GP training.

Figure 2.1 shows how the priority areas and outcomes of enhanced training fit together and emphasises the central importance of generalist skills to high-quality general practice.

Figure 2.1: Framework detailing the three priority areas and fourteen outcomes identified for enhanced GP training over a four-year period



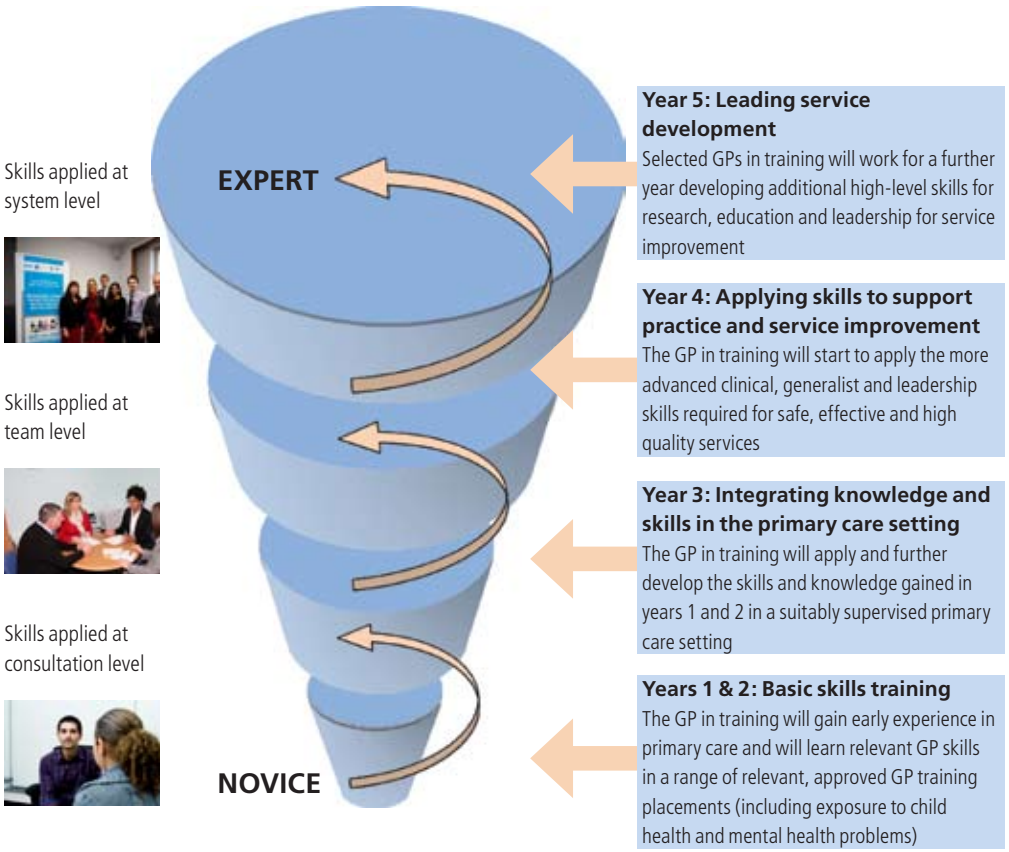
How the enhanced GP training outcomes will be delivered

Our vision for the delivery of the outcomes for Enhanced GP training is based on a spiral model of incremental skills development, founded on two fundamental educational parameters:

- **Effectiveness of training** – training experience must be optimally effective at supporting skill development; this requires the experiences provided during GP specialty training placements to be relevant to the GP's role and to be adequately supervised
- **Adequate duration of training** – the minimum duration of training required to ensure development, application and demonstration of the required skills at the expected level of expertise.

Figure 2.2 illustrates the spiral model of incremental skills development that will be adapted for enhanced GP training. This model is based on a synthesis of the Harden and Stamper[58] spiral curriculum model and the Dreyfus and Dreyfus[59] model of skill acquisition from Novice to Expert.

Figure 2.2: Spiral model of incremental skills development



58 Harden R, Stamper N: What is a spiral curriculum? *Medical Teacher* (1999);21(2):141-143.
59 Dreyfus H , Dreyfus S. *Mind over Machine: The Power of Human Intuition and Expertise in the Era of the Computer.* Oxford: Basil Blackwell, 1986.

THE SHAPE OF ENHANCED GP TRAINING: AN OVERVIEW

The RCGP believes that an enhanced GP training programme is the essential way to equip new GPs for their future NHS roles.

Within this document we set out the case for an immediate extension of all GP training programmes, initially from three to four years, together with a restructuring of the existing training framework to make the most effective use of the available time.

To deliver the fourteen outcomes identified in this case, it is envisaged that a **minimum of 24 months** training will be required in the general practice setting, with the remaining time being spent in relevant placements depending on local arrangements including:

- appropriate and relevant secondary care placements
- integrated community-based placements, and
- general practice placements.

Although the placements within individual training programmes could be configured flexibly, depending on local circumstances, it is expected that years three and four would be spent predominantly in primary care. For example, many training programmes currently include a period of time in general practice towards the start of training, which enables trainees to place their subsequent training experiences into context, and we envisage that such arrangements would continue.

Years one and two

GP training requires a sound clinical knowledge and skills base as its foundation. In addition to training gained in medical school and the foundation years, the first and second years of GP specialty training will focus on developing the basic skills required for a generalist primary care role, acquired in appropriately supervised, approved placements of relevance to the doctor's future role as a generalist clinician.

However, it is important that the first two years are not spent exclusively outside of general practice. General practice requires a cognitive and attitudinal approach essential for holistic, comprehensive care that needs to be introduced and understood early in training (i.e. during ST1). Only after experiencing this can trainees then apply this insight to the experiences they gain from subsequent attachments and thereby gain the relevant generalist competences that the curriculum requires. This insight is critical to ensuring the optimal educational effectiveness of training placements.

We envisage that individual training programmes will consist of a series of different placements, including a range of practice-based, secondary care and integrated posts that provide GP trainees with a baseline of relevant clinical skills on which to build. While recognising the service need, it is crucial to the successful delivery of enhanced GP training to ensure that all training placements, including those based in secondary care, are relevant to the acquisition of GP curriculum competences.

More specifically, in order to deliver the outcomes identified for enhanced clinical training in child and mental health, we envisage that the first two years will include placements that provide all GP trainees with adequately-supervised exposure to:

- paediatric problems, including the assessment and management of acutely sick children; and
- psychiatric problems, including common mental health conditions, psychosis and suicide risk assessment.

The rationale behind these specific recommendations is explained in the '*Enhanced GP Training: Challenges and Outcomes*' chapter of this document.

Year three

During the third specialty training year, GP trainees will work predominantly in primary care, within a designated training practice under the supervision and mentoring of a GP trainer. During this year, trainees will focus on applying the skills gained in the first two years of training to the primary care environment, both in- and out-of-hours.

In addition to embedding their previously acquired skills, a key aim of practice-based training is to enable the development of decision-making based on an understanding of the local population demography and predicted epidemiology.

We envisage that all GP trainees will be given additional community-based training with focus on improving their skills in:

- caring for children and young people with long-term conditions
- safeguarding children and vulnerable adults
- management of alcohol and drugs misuse, including screening and brief interventions
- end-of-life care in the community; and
- prescribing safely and cost-effectively in primary care, including for patients with co-morbidities.

As at present, all GP trainees will undertake regular and appropriately supervised out-of-hours and in-hours sessions on-call in order to develop skills in management of acute and urgent care problems.

The application of clinical and generalist knowledge and skills within the consultation context will be assessed through nationally organised Applied Knowledge Test (AKT) and Clinical Skills Assessment (CSA) examinations, which assess knowledge and skills primarily within the consultation context and which must be successfully completed to enable progress to the more advanced training in year four.

Year four

Once the basic skills required for working in a primary care consultation context have been acquired, the fourth year of GP training will concentrate on the development and application of the more complex clinical, generalist and leadership competences, building on the skills acquired earlier in training to deliver advanced and enhanced GP training outcomes.

Within the primary care setting, we envisage that year four will include aspects of advanced consultation and generalist skills training, facilitated and assessed through an enhanced Workplace-based Assessment, with focus on high-level competences, including:

- co-ordinating and managing care for patients with multiple morbidities
- involving carers in care planning and supporting carers in their roles
- improving population health and addressing healthcare inequalities
- holding difficult conversations and advance planning in end-of-life care
- supporting self-care, the return to work and reducing long-term worklessness
- effecting behaviour change for health promotion and disease prevention; and
- ensuring effective use of resources and shared decision-making.

More on-call and out-of-hours sessions, undertaken with increasing independence as the doctor's expertise grows, will further embed and improve skills in management of acute and urgent care problems presenting in the community.

As well as continuing their clinical work in primary care, the fourth year will also provide trainees with additional skills in population health, team and organisational leadership, critical appraisal of research evidence, epidemiology as applied to practice and local populations, multidisciplinary team-working and quality improvement both within their training practice and their wider community.

To enable the acquisition and demonstration of these complex skills, trainees will be expected to complete an externally appraised **Quality Improvement Project (QIP)**. Although the trainee will have the choice to tailor the project to the practice, primary care organisation or local community within which they work, the project will be based on local needs and framed within parameters designed to foster the acquisition of key generalist and leadership skills. These will include: identifying population needs, examining current service provision (e.g. through audit and data analysis), engaging with professional colleagues and the public in service improvements, and leading a multidisciplinary team to effect positive change. Demonstration of local needs analysis, impact on patient care and/or improvement in quality of services will be key outcome measures for the project.

Successful completion of the enhanced Workplace-based Assessment and QIP in year four (in addition to the AKT and CSA in year three) will be required for the award of the Certificate of Completion of Training and MRCGP qualification, after which the doctor will be entitled to enter independent practice.

Year five

At present, a small number of GP trainees already undergo an additional year of training in order to allow them to develop specific skills. They include academic trainees, who currently undertake their GP training whilst simultaneously learning academic skills in research and education attached to a university department of primary care. In addition, leadership fellows work at a managerial level in primary care organisations in order to learn high level management and political skills. We envisage that these schemes will stay in place, providing a fifth year of training for a small number of the most able trainees.

EXAMPLES OF ENHANCED GP TRAINING PROGRAMMES

The following examples demonstrate how the proposed four-year training structure might be arranged to incorporate the enhanced GP training outcomes. These examples are just intended as illustrations – we envisage that placements within individual specialty training programmes will be relevant to GP curriculum outcomes and tailored to local circumstances.

1. Enhanced Clinical Training

Table 2.1: Examples of how the enhanced clinical training outcomes might be delivered within the four-year programme

<table>
<tr><th colspan="2">Outcome</th><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Year 4</th></tr>
<tr><td></td><td>CLINICAL SKILLS
GENERALIST SKILLS
LEADERSHIP SKILLS</td><td colspan="4">  </td></tr>
<tr><td>1.1</td><td>Improved care for children and young people</td><td rowspan="6">EARLY GENERAL PRACTICE EXPERIENCE</td><td colspan="2">Training in supervised hospital or integrated placements in paediatrics*</td><td colspan="2">Supervised GP placement allowing the application of skills in the primary care environment</td></tr>
<tr><td>1.2</td><td>Improved care for people with mental health problems</td><td colspan="2">Training in supervised hospital or integrated placements in mental health</td><td colspan="2">Supervised GP placement allowing the application of skills in the primary care environment</td></tr>
<tr><td>1.3</td><td>Improved care for people with alcohol and substance misuse problems</td><td colspan="2">Medical, mental health or A&E placement providing exposure to patients with substance misuse problems</td><td>Integrated placement in a specialist alcohol or substance misuse clinic</td><td>Application of skills in the supervised general practice environment</td></tr>
<tr><td>1.4</td><td>Improved care for people presenting with acute illness or trauma</td><td colspan="2">Acute medicine or accident and emergency placement providing an opportunity for training to a level enabling entry into the sub-specialty of pre-hospital emergency medicine on completion of training.</td><td colspan="2">Supervised GP placement with regular supervised experience of in- and out-of-hours emergency care</td></tr>
<tr><td rowspan="2">1.5</td><td rowspan="2">Improved care for older adults and their carers</td><td colspan="2" rowspan="2">Specialist or integrated community placement in general medicine, elderly care medicine or palliative care</td><td colspan="2">Audit of an aspect of primary care (e.g. provision to care homes)</td></tr>
<tr><td colspan="2">Supervised GP placement allowing the application of skills in the primary care environment</td></tr>
</table>

*including exposure to acute paediatrics

ST1–ST2

Table 2.1 demonstrates that hospital-based or integrated community and secondary care placements, following a period of early general practice experience, are critical aspects of GP training to gain essential clinical skills.

As there is a relatively low prevalence of serious illness in the community, some specific aspects of healthcare training are best delivered in a specialist environment. For example, a specialist paediatric placement can provide trainees with exposure to large numbers of sick children in a safely, supervised environment within a relatively short period of time. However, early experience of general practice is required to enable GP trainees to place their specialist-based learning experiences into context.

Finally, specialist-based placements also afford unparalleled opportunities for GP trainees to learn about the role of secondary care in the management of both acute and serious long-term conditions and the issues faced by people with rarer disorders. However, early experience of general practice is required to enable GP trainees to place their specialist-based learning experiences into context.

ST3

Although specialist placements result in exposure to a range of acute problems in a controlled environment, this alone is not sufficient to train GPs adequately in the wide range of common and long-term health issues encountered in the community context. This is partly because of the difference between primary and secondary care working environments (see the '*Enhanced GP Training: The need for change*' chapter) but also because pressure on training posts from career specialists and increasing specialisation in hospitals makes a broad, generalist experience more difficult to achieve in the secondary care environment. Furthermore, with the ongoing shift in care closer to home, patients with long-term conditions will spend less time in secondary care – in other words, the trainee will need to follow the patient.

The ST3 year will therefore provide an essential opportunity to apply the skills learned in the specialist setting to the primary care environment. It will also give GP trainees the chance to learn about conditions largely managed in primary care, such as minor self-limiting illness and common long-term conditions, plus interventions to promote health and prevent serious disease. Finally it will enable GPs to address individual areas of weakness in their clinical training where their previous experience may be limited, such as end-of-life care, prescribing in the community and the identification and management of substance misuse.

To increase continuity of care, GP trainees will gain more opportunity to be involved with providing care alongside others in the multi-disciplinary team in order to acquire the knowledge, skills and subtleties of the generalist approach. They will also be able to develop their role as health system 'navigators' for parents and families.

ST4

Extending GP training to four years will enable the trainee to successfully integrate their primary and specialist clinical training across different conditions, simultaneously managing multiple morbidities, and polypharmacy in different clinical settings. They will be able to demonstrate that they can make best use of their consultation time, incorporating opportunistic health promotion and disease prevention, and taking account of the patient's social context in decision-making. These generalist skills are complex and take time and guidance from experienced colleagues to develop.

An extension to GP training will naturally also provide opportunities for doctors to improve their skills in many other areas of clinical need relevant to generalist medical care, e.g. women's health, pregnancy care, eye problems, ENT problems, etc.

Finally trainees will use their clinical and generalist skills to examine service provision, multidisciplinary working patterns and participate in service redesign with the aim of delivering more integrated care closer to home. This will provide an opportunity for trainees to start to develop the leadership skills required to address the organisational aspects of care in their practice and community and to engage effectively with colleagues. Work done through the Quality, Innovation, Productivity and Prevention (QIPP) programme[60] shows that integrating GP knowledge and teamwork can save referrals, and increase patient engagement.

Additional benefits of extending GP training to ST5

To improve clinical care for people of all ages there is a strong educational case to be made for extending GP specialty training to a five-year programme. This would provide trainees with the educational opportunities and time to develop and demonstrate competence in the more complex, higher-level skills required to provide more high-quality, cost-effective and efficient primary care services. To do this successfully, GPs need to be fully conversant with patient care in all its dimensions. In addition to improving their generalist clinical skills and ensuring comprehensive curriculum coverage, trainees would also have additional opportunities to develop areas of special expertise, leading to potential career development as a practitioner with special interest.

A five-year training programme would also provide trainees with the opportunity to undertake projects in their community that focus on whole system change in relation to providing more integrated clinical services, linked to the evaluation of their local data. Additionally, it would provide opportunities to focus on developing care pathways based on the needs of specific patient groups, which take into account their social, emotional and mental health as well as their physical well-being.

60 Department of Health. *Innovation, Productivity and Prevention* (2010). Accessed via: http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm.

2. Enhanced Generalist Training

Table 2.2: Examples of how the enhanced generalist training outcomes might be delivered within the four-year programme

Outcome		Year 1	Year 2	Year 3	Year 4
	CLINICAL SKILLS GENERALIST SKILLS LEADERSHIP SKILLS	→	→	→	→
2.1	Increased understanding of local population and public health needs and the relationship between work and health	EARLY GENERAL PRACTICE EXPERIENCE	Training within specialist and community-based integrated placement, focusing on helping people of working age to remain working or return to work	Training within general practice including specific training about epidemiology of local population needs, sickness certification in primary care and helping people to return to work	
2.2	Increased prevention of acute and chronic illness through health promotion and risk factor management		Health promotion and risk factor management within specialist or community-based placements	Training in public health and population health within the primary care setting	Health promotion and disease prevention work in primary care
2.3	Increased co-ordination of care for people with multiple co-morbidities and long-term conditions		Training in and experience of managing long-term conditions both in primary and in secondary care		Training in management of multiple co-morbidity
2.4	More cost-effective and timely use of investigations, referrals and treatment		Experience of investigation and ongoing management of a range of conditions, both within primary and secondary care, with reflection on best practice		Audit of referrals and suggestion of actions to reduce unnecessary referrals. Quality Improvement Project (QIP) in local service re-design
2.5	Improved end-of-life care, especially for those who choose to die at home		Specialist or integrated community placement in end-of-life care		Experience of managing end-of-life care in general practice

ST1–ST2

Table 2.2 demonstrates that some generalist skills, such as provision of end-of-life care, coordination of care and cost-effective use of resources, can be acquired throughout GP training. Following a period of early general practice experience, these skills can be applied within the hospital environment, building on this foundation during community-based placements. For example, co-ordination of care across boundaries is an essential skill both in hospital and generalist settings. Understanding the perspective of others is important and so

even when working in primary care an understanding of the way that hospital-based staff might approach an issue will help to ensure well-co-ordinated care.

ST3

The ST3 year will provide an opportunity to learn and apply the specific generalist skills that GPs must develop in order to practise independently within primary care. For example, an essential primary care skill is the art of effective referral: when and how rapidly to refer; alternatives to referral; and choice of appropriate referral pathways. Health promotion and disease prevention is also an activity largely carried out in primary care. Integrating health promotion and disease prevention activity into routine primary care consultations is a new and complex area; specialised skills such as motivational interviewing are essential to effect behaviourial change.

Furthermore, the ST3 year is an opportunity to extend skills learned in the secondary care setting to the primary care environment. For example, end-of-life care skills learned in a hospital setting must be adapted for application in the home. Specific training with a team working in the community is required in order to achieve this.

ST4

Extending GP training to four years will enable trainees to develop their generalist skills. Successful management of multiple co-morbidity is particularly challenging and trainees should expect to become competent in the following generalist competences:

- assessing patients with multiple co-morbidities
- producing comprehensive problem-oriented and patient-centred plans of care
- working with integrated multidisciplinary teams to optimise care
- helping patients and carers to navigate the healthcare system
- signposting patients and carers to other appropriate resources including self-help options
- following up appropriately; and
- safety netting.

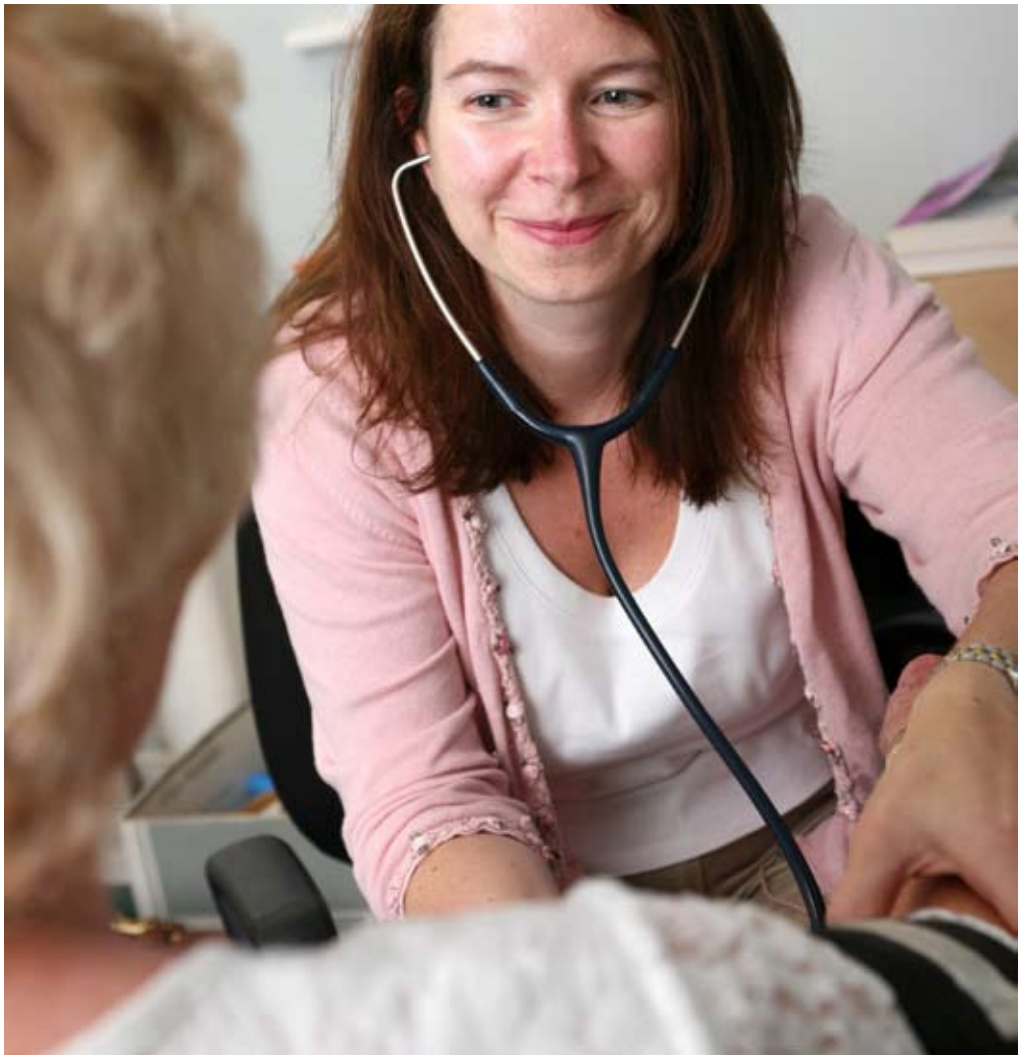
In the ST4 year, trainee GPs will be expected to use skills learned in their ST3 year in their everyday practice, for example providing brief interventions for problem drinkers, or taking the lead in management of a terminally ill patient in the community.

Trainees will also be expected to appraise team performance through both significant event audit[61] and criteria-based audits of aspects of generalist care. This will enable them, working within their multi-disciplinary teams, to examine service provision, identify improvements and share findings with the aim of delivering better generalist care to patients.

61 National Patient Safety Agency. *Significant Event Audit, Guidance for Primary Care Teams*. Accessed via: http://www.nrls.npsa.nhs.uk/resources/?entryid45=61500.

Additional benefits of extending GP training to ST5

Extending GP specialty training to a five-year programme would provide trainees with the educational opportunities and time to develop the more complex and higher-level epidemiological and critical appraisal skills required to assess the health needs of a population and appraise the relevance of the available research evidence to the general practice setting. As much of the available evidence for effectiveness of interventions is derived from secondary care populations or is setting-specific, these skills are essential for effective future service planning and development for the more generalist aspects of primary care.



3. Enhanced Leadership Training

Table 2.3: Examples of how the enhanced leadership training outcomes might be delivered within the four-year programme

Outcome		Year 1	Year 2	Year 3	Year 4
	CLINICAL SKILLS GENERALIST SKILLS LEADERSHIP SKILLS				
3.1	Improved delivery of primary care services both within and out-of-hours	EARLY GENERAL PRACTICE EXPERIENCE		Experience of working in daytime primary care	Experience of primary care provision for socially deprived populations.
				Audit of an aspect of primary care provision to care homes	
				Experience of supervised working within a supervised out-of-hours care environment	
3.2	Increased co-ordination and leadership of multidisciplinary teams		Increasing experience of working within multidisciplinary teams within the secondary care and primary care sectors and across sectors, with increasing responsibility and leadership over time		
3.3	More effective engagement in the development of local services, working collaboratively with specialists and patients		Increasing experience and understanding of the role of colleagues and healthcare services within all healthcare sectors and across sectors	Experience of working in practices involved with delivering the QIPP agenda	Detailed quality improvement project (QIP) examining an aspect of service provision and recommending improvements to meet local health needs and improve quality
3.4	Improved academic skills for evidence-based practice, innovation, quality improvement, education and research		Training in critical appraisal and evaluation of research evidence and application to care. Teaching and supervision of colleagues and multidisciplinary team members	Involvement with routine audit and research activity in general practice	Audit and improvement of an aspect of practice such as referrals quality or improving a local service

ST1–ST2

Although the more advanced leadership skills will primarily be demonstrated in ST3–4, these skills will be developed throughout training and informed by a sound grounding of both clinical and generalist skills. Key leadership skills for general practice can be learned even in non-GP placements; for example through modelling of effective consultant and clinical supervisor behaviours, or by observing how experienced team members manage the multidisciplinary team.

ST3

The ST3 year will be crucial to learn how to work in the out-of-hours environment in the community context in a supervised capacity. This is a situation completely unfamiliar to trainees before the ST3 year. When working in a multidisciplinary team, the dynamics often change when moving from secondary to primary care. Junior doctors in secondary care are team members but rarely team leaders, but in primary care GPs are often team leaders and trainees may find themselves in this role fairly early in their ST3 year. They need to learn ways to co-ordinate the team, respect other people's views and delegate effectively. Participation in routine audit and quality improvement activity within practices will help to provide basic hands-on training in these important skills.

ST4

The Academy of Medical Royal Colleges' Medical Leadership Competency Framework (MLCF)[62] defines the domains, the generic competences and the levels of performance required at three stages of NHS leadership. The Stage 2 competences described in the MCLF have been written into the current three-year GP curriculum. However, they are only currently assessed as learning outcomes at the level of Stage 1 (describing) rather than Stage 2 (demonstrating). To deliver the competences to the level of demonstration required of Stage 2 performance, which is necessary for practice in the modern NHS, GP trainees will need an extended period of time in environments where their leadership competences can be developed then adequately demonstrated and assessed.

Extending GP training to four years will therefore enable trainees to develop their leadership skills further. A large proportion of leadership skills training will take place in the ST4 year.

Trainees will then be able to address areas insufficiently covered in their individual training experience, for example by spending some time working with socially disadvantaged populations. Such placements will allow them to appreciate the range of problems that such groups might face and the problems that there may be adapting and designing services for their special needs. Trainees will also undertake work designed specifically to improve their understanding of the challenges of providing a primary care service and managing patients in care homes. They will do specific training to equip them with a level of critical appraisal skills that enables them to judge research evidence for its impact and relevance to improving the care of their practice population.

These additional skills will allow GPs of the future to understand the range of problems that their practice populations might face, and to integrate their clinical and generalist skills, plus audit and information appraisal skills, to look critically at service provision and design new or improved services to address unmet patient needs and to improve quality of care.

Additional benefits of extending GP training to ST5

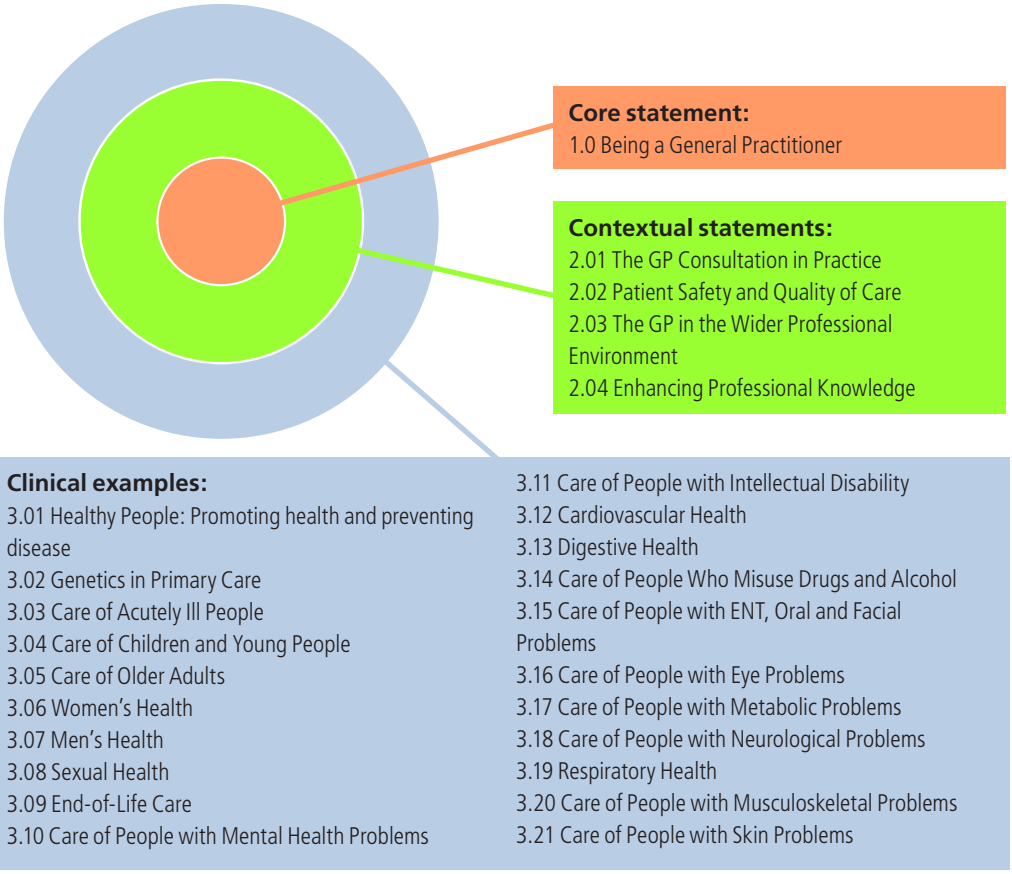
Extending GP specialty training to a five-year programme would provide trainees with the educational opportunities and time to develop more complex and higher-level leadership skills. For example, trainees might do a small research project, run a course for fellow trainees on a topic that interests them, or implement service redesign and evaluate its effectiveness either at practice or at commissioning group level, thus effecting whole system change.

62 Academy of Medical Royal Colleges. *Medical Leadership Competency Framework.* 3rd edition. Coventry: NHS Institute for Innovation and Improvement, 2010.

THE RCGP CURRICULUM FOR GP TRAINING

The RCGP training curriculum[63] was implemented in 2007. For the first time, it attempted to define the competences required by doctors entering independent general practice at the end of the GP specialty training programme. A revision of the original GP curriculum has been submitted to the GMC and will come into operation in August 2012 (Figure 2.3).

Figure 2.3: Summary of the RCGP curriculum (2012 revision)



63 GP curriculum statements. London: RCGP (2007).

Evolving the Curriculum for Enhanced GP Training

To ensure it remains valid and relevant, the RCGP curriculum, like any medical curriculum, has been designed in a way that can be changed in response to:

- Changes in the healthcare needs of the population
- Changing expectations of patients and the public
- Changing needs of the service
- Ever-changing knowledge of best practice; and
- Experience of trainees, trainers and other educational supervisors.

Since its development, the RCGP curriculum has been subject to a continuing review process, based on the collated responses of a wide range of stakeholders, the results of formal assessments, and a formal evaluation conducted by the University of Birmingham[64]. As part of this process the curriculum has already undergone changes, in accordance with the approved GMC revision processes (for example incorporating learning outcomes of the Medical Leadership Framework in 2010).

Similarly, the RCGP curriculum will evolve to describe, support and reinforce the educational objectives of the enhanced GP training programme.

The RCGP curriculum is an educational framework for career-long learning in general practice and will also inform the development of future CPD programmes for post-CCT GPs preparing for revalidation. As such, it will empower those in current practice to acquire, apply and build on the important GP skills identified in this document.

64 Bedward J, Davison I, Burke S, Thomas H. *Evaluation of the RCGP GP Training Curriculum* (2011). Accessed via: www.birmingham.ac.uk/Documents/college-social-sciences/education/crmde/rcgp-report-june2011.pdf.

ASSESSMENT FOR ENHANCED GP TRAINING

GPs in training must successfully complete all three current elements of the Membership examination of the Royal College of General Practitioners (MRCGP) in order to obtain their Certificate of Completion of Training (CCT) and become fully qualified, independent GPs.

The three elements of the MRCGP examination, known as the 'tripos', are:

- a multiple choice style Applied Knowledge Test (AKT) examination
- an examiner-observed simulated surgery or Clinical Skills Assessment (CSA) examination; and
- ongoing Workplace-based Assessment (WPBA) and assessment of the trainee's ePortfolio of evidence, demonstrating training activity, reflection and performance, plus regular clinical supervisors' reports.

Enhanced GP training would build on these current tested and evidence-based systems of assessment, adapting them to accommodate the competences required of the enhanced training curriculum.

Adapting the assessment system for a four-year training programme
For a four-year enhanced GP training programme, the current system of assessment for GPs would be adapted as illustrated in table 2.4.

The **Applied Knowledge Test (AKT)** and **Clinical Skills Assessment (CSA)** external examinations will be developed to test the core clinical and generalist competences that GPs need in order to practise safely and to ensure that the outcomes expected of enhanced GP training are sufficiently tested. The AKT and CSA are designed to robustly assess the essential competences a GP must demonstrate *within the context of the primary care consultation*. Success in these assessments will be required in order to progress into the fourth year of training.

However, the role of the future GP requires trainees to demonstrate the application of a range of advanced competences within much broader and more complex working contexts than an isolated doctor-patient consultation. This includes work within busy workplace environments, within patients' homes, within multidisciplinary teams, within practice and out-of-hours organisations, and within local community services and bodies. To enable assessment in these broader contexts, all GPs in training will continue to be required to maintain an ePortfolio of achievement and reflection, and will undergo enhanced **Workplace-based Assessment (WBPA)**, supervised by their clinical and educational supervisors throughout their four-year specialty training. As under the current system, progress will be appraised annually and successful completion of WPBA over the whole four-year training programme will be required for the award of the Certificate of Completion of Training (CCT) and the MRCGP qualification at the end of ST4, thus enabling licensing for independent practice.

WPBA will be adapted to ensure that all areas of the enhanced curriculum have been covered in sufficient breadth and depth so that every trainee is competent for the full range of independent practice. Minimum portfolio standards for quality and sufficiency of evidence will be defined using the same principles as other specialties; this evidence will inform the summative licensing decision at the final Annual Review of Competence Progression (ARCP) panel review.

Finally, in addition to completing the enhanced WBPA within the practice context, candidates will be required to demonstrate acquisition of more complex, system-level clinical, generalist and leadership skills (e.g. analytical, resource utilisation, team leadership and change management skills) and the application of these to improve services within the practice and local community. This will require each trainee to choose an element of healthcare to look at in depth as part of a **Quality Improvement Project (QIP)** which will be externally assessed.

Although the specific content of the QIP will be flexible in order to support local healthcare needs, it will incorporate an externally evaluated summative assessment that will require demonstration of the successful application of the required skills in the primary care context, evaluated according to nationally agreed quality standards.

Timing and delivery of assessment
The introduction of a four-year programme will require a number of practical adaptations to the timing and delivery of the assessments. Proposals for these adaptations, which have been developed in consultation with the RCGP Assessment Committee and Committee of GP Education Directors (COGPED), are described below.

Although the AKT and CSA examinations could be taken any time during ST3, trainees will be encouraged not to take these assessments until both the trainee and their educational supervisor agree that sufficient experience has been obtained to enable a high chance of success. Success in the CSA and AKT examination, which assess competences within the context of the GP consultation, will be required for progression into the ST4 year.

For those who fail to complete the AKT and CSA components by the end of ST3, there will be recourse to the usual Gold Guide Regulations on extension to training operated by Deaneries across the UK. This system works well and can easily be adapted for an extended programme of training.

In the ST4 year, the WPBA will include case-based discussions that will explore contextual competence and application of the skills learned in the previous three years. ST4 will also include the Quality Improvement Project (QIP).

Table 2.4: Proposed assessment schedule for a four-year enhanced GP training programme

	MRCGP component	Main focus of assessment
ST1 and ST2	Workplace-based Assessment (ePortfolio & ARCP panel)	Clinical and professional development
ST3	Applied Knowledge Test	Applied clinical and professional knowledge
	Clinical Skills Assessment	Key communication and clinical skills in the GP consultation context
	Workplace-based Assessment (ePortfolio & ARCP panel)	Clinical and professional development (passing ARCP review at end of ST3 is required before starting ST4)
ST4	Quality Improvement Project (QIP)	An externally evaluated summative assessment, performed in the primary care context, to facilitate the application and assessment of generalist and leadership skills
	Workplace-based Assessment (ePortfolio & ARCP panel)	Clinical and professional development (passing a final ARCP review towards the end of ST4 is required for CCT)

Completion of **all** of the above components will be required for the award of the Certificate of Completion of Training (CCT) and the MRCGP qualification at the end of ST4, enabling licensing for independent practice.

Successful completion of **all** the elements of the enhanced MRCGP examination (i.e. the AKT and CSA in ST3 and the WPBA in ST 1–4, incorporating the QIP assessment in ST4) plus the passing of a final ARCP panel review towards the end of ST4 will be required for the Certificate of Completion of Training (required for independent practice) and for the award of the MRCGP qualification. The assessment approach adopted will be complementary to wider changes in postgraduate training, such as a potential shift towards the use of specified learning events within specialty training curricula and the introduction of the broad-based curriculum.

This approach re-balances the existing focus away from the high stakes 'gateway' assessment that currently occurs in ST3, just before the entry-point into independent practice, while preserving the integrity of the MRCGP tripos and maintaining the summative component in the final licensing decision. It will therefore enable the public to remain confident that the family doctors of the future will be safe, competent and highly-skilled independent practitioners and will help to foster a career-long culture of excellence.

ENHANCED GP TRAINING CHALLENGES AND OUTCOMES

KEY POINTS

- Each of the fourteen outcomes identified for enhanced GP training have been divided into a small number of evidence-based, educational challenges that enhanced GP training must address. These educational challenges are described and an explanation given as to how enhanced GP training will address them.
- For conciseness and ease of reading, the detailed evidence base for each outcome is not cited here but is presented separately in **Supporting Evidence** documents 1–3.

PRIORITY AREA 1: ENHANCED CLINICAL CARE

This priority area will deliver more effective clinical care for patients with the full range of conditions commonly encountered in primary care, with particular focus on:

- Improved care for children and younger people
- Improved care for people with mental health problems
- Improved care for people with alcohol and substance misuse problems
- Improved urgent care and rehabilitation for people with illness or trauma
- Improved care for older adults and their carers.

The full evidence base (including references) for this priority area and its outcomes is presented in Supporting Evidence document 1.

Outcome 1.1: Improved care for children and young adults

'The UK gets a lot of criticism from Europe for not having primary care paediatricians. But I think that is creating a parallel workforce. I think that we should be looking more to the Swedish model - that is, enhancing the training of every GP.'

Dr Patricia Hamilton, Director of Medical Education, Department of Health, 2011[65]

The educational challenge			How enhanced GP training will address this challenge
1	**Spotting the sick child**	Children and young people deserve reliable and high-quality access to urgent care, delivered by clinicians trained in the appropriate skills for assessment, diagnosis, treatment and continuing care. Currently, however, only 40-50% of GP trainees undertake a paediatric placement during their GP training. The report *Why Children Die* found failure to recognise severity of illness was one of the key avoidable factors in the national audit of child deaths. Specifically, failures were identified in understanding the importance of history, clinical examination, interpretation of physical signs, recognition of complications, clinical supervision and prompt referral and treatment.	Enhanced GP training will ensure that all doctors entering general practice have the time and opportunity to assess and manage acutely ill children in a suitably supervised care setting, in order to develop the skills and experience required to adequately recognise sick children. The RCPCH's *Facing the Future* document sets out the mutually beneficial role that placements for GP trainees in acute paediatric services can provide[66]. Additional training in primary care will ensure that all future GPs are better able to assess, diagnose and manage sick children safely and effectively in the primary care setting, using appropriate safety netting, review and referral.
2	**Improving safeguarding**	The role of the GP in safeguarding is wide-ranging: recognition of patterns of neglect, referring in a timely and appropriate manner to secondary healthcare colleagues or social care, responding to inter-agency requests, supporting families and giving context at case conferences. GPs must also engage more effectively with vulnerable groups such as Looked after Children, trafficked children and children of asylum seekers or migrants who have particularly poor outcomes in health.	The GP holds responsibility for safeguarding children registered with their practice. GPs require enhanced training to enable them to fulfil their wide-ranging safeguarding role effectively with specific training about recognition of patterns of neglect and abuse, sharing information and referring in a timely and appropriate manner to secondary healthcare colleagues or social care, responding effectively to inter-agency requests, supporting families and giving relevant contextual information at case conferences.

65 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011). Accessed via: http://www.rcgp.org.uk/pdf/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20_rev_7%20OCTOBER%202011.pdf.

66 Royal College of Paediatrics and Child Health (2011). Accessed via: http://www.rcpch.ac.uk/facingthefuture.

3	**Improving care for children with complex and long-term conditions, including those with intellectual disability**	General practice sits at the hub of a wide system of care and must take increased responsibility for clinical care, co-ordination of care and signposting to services both within and beyond healthcare. More integrated care for those with complex medical needs should be delivered in primary care along agreed patient pathways, within networks of care that maintain team-based care close to home with access to specialist care when needed.	Enhanced GP training will enable GPs to develop stronger professional relationships with social care workers and school nurses, as well as other healthcare providers, in order to effectively co-ordinate care for young people with long-term conditions. In addition, enhanced training will enable GPs to actively co-ordinate the transition period when a young person with long-term illness or disability is transferred into adult services.
4	**Improving end-of-life care for children and young people**	There is a continuing trend to shift healthcare 'as close to home as possible`. This will require GPs to play a greater role in providing end-of-life care for children, alongside paediatric and nursing specialists. As well as providing clinical care, this will involve development of advance care plans for children with life-limiting conditions and caring for bereaved parents and families.	GPs currently receive little or no training about managing children with life-limiting disease in the community. Enhanced GP training will equip GPs with the strategies and knowledge to enable multi-agency working to support such children at home and signpost parents and children to further sources of support.
5	**Supporting healthy childhood development**	We know that a child's experience in early life has a crucial impact on their life chances. There is evidence that providing early years care in the primary care setting delivers improved child health outcomes. Access to community-based antenatal care and healthy life-style advice to support parents is key to improving longer-term health outcomes. GPs must work with secondary care colleagues to develop more effective pathways for making effective family interventions for the prevention and management of potentially avoidable or reversible conditions, such as obesity, that can adversely impact on long-term health.	Enhanced GP training will provide additional skills to GPs so that they are able to deliver higher quality early-life care for at-risk infants and children. This will include caring for premature babies following early neonatal discharge, children with intellectual disability, supporting parents, and developing more effective multi-agency pathways for effective family interventions in the prevention and management of lifestyle-associated health conditions, such as obesity, smoking and alcohol misuse.
6	**Developing youth-friendly services**	GPs must be able to design health services that children and young people can access discreetly and easily for issues regarding their mental, emotional, physical and sexual health. This includes encouraging young people to participate in their own healthcare plans and in developing services that impact on their health and wellbeing so that they are treated in an appropriate environment.	Enhanced GP training will enable trainees to learn and apply the practical measures that can improve accessibility to children and young people. For example, ensuring that appointment booking systems within practices meet the needs of school age children and take into account the particular needs of disabled children and young people.

7	**Improving organisational aspects of healthcare for children**	GPs will need to develop a greater understanding of the role and expertise of other child health and public health professionals across local authority and third sector agencies, as well as acute care, and the skills to work effectively with them in shared team leadership roles. They will need the skills to develop systems to monitor and reduce safety errors across pathways of care and to identify those at high risk, thus ensuring that communication and information flows are effective in improving quality and reducing error.	Enhanced GP training will enable GPs to develop a greater understanding of the role and expertise of paediatric and other child health and public health professionals across local authorities and third sector agencies as well as acute provision and the skills to work effectively and plan high-quality services with them in shared team leadership roles. The commissioning or planning of children's services needs to start with pre-conceptual care to make an impact. Integration with adult mental health, drug and alcohol abuse services, youth offending teams and adult medicine services will be essential.

Potential future impacts on children and young people if GP training is not enhanced:

- Limited reductions in death rates from conditions that typically present first to GPs in an undifferentiated manner, such as meningococcal disease, pneumonia, and asthma
- Missed opportunities to improve the care of children with long-term conditions, resulting in preventable suffering for children and families, poor quality care or services far from home and lost life chances
- Failure to recognise and intervene early to address safeguarding needs of children and young people
- Failure to improve quality of healthcare services for children and young people and reduced clinical engagement with service improvement and redesign
- Missed opportunities to better integrate children's care, resulting in reduced co-ordination, reduced continuity, reduced satisfaction and increased healthcare costs.

How GP training will change to meet this outcome:

- All GP trainees will receive enhanced training in child health, including placements that provide exposure to acute paediatric problems, where training will include spotting the sick child, caring for the child with serious illness and understanding the role of the specialist paediatric team in caring for children with long-term conditions
- In primary care placements, GP trainees will receive training on common and self-limiting illness, managing long-term conditions in the community, and the role of primary care team
- In ST3–4, training will focus on the integration of clinical skills, health promotion and disease prevention, family support, co-ordination of care closer to home, organisational aspects of care, quality improvement and design of child/youth-friendly services
- All GP trainees will undertake training in safeguarding children and young people to level 3 of 2010 Intercollegiate Guidelines[67]
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could include improving integration of services and care for children and young people
- All GP trainees will have the opportunity to work on a Quality Improvement Project in ST4, which could focus on improving the quality of local services for children and young people
- The RCGP curriculum statement *Care of Children and Young People* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the enhanced child health skills expected of doctors entering general practice.

67 *Safeguarding Children and Young People: Roles and competences for healthcare staff* (2010). Intercollegiate Guidelines. Accessed via: http://www.rcn.org.uk/__data/assets/pdf_file/0004/359482/REVISED_Safeguarding_03_12_10.pdf.

Outcome 1.2: Improved care for people with mental health problems

'GP surgeries need to be welcoming places for people with mental health problems. All primary care staff have a key role in looking after the physical as well as mental health of people with a mental illness.'

Centre for Mental Health, 2010[68]

The educational challenge			How enhanced GP training will address this challenge
1	**Promotion of mental wellbeing and improved resilience**	Good mental health results in decreased incidence and prevalence of mental illness, and improved physical health, education and employment prospects. Mental health promotion is an area that is poorly covered in GP training at present but in which good primary care could yield immense benefits in cost savings and improved population health.	Enhanced GP training will deliver additional training in the promotion of mental well-being in order that GPs can provide opportunistic and targeted mental health promotion to their practice populations, and also to enable them to influence local health policy and inter-agency mental health promotion strategies.
2	**Earlier recognition of psychotic illness**	Recognition of psychosis and intervention early in the course of the illness can reduce emotional distress for sufferers and carers, halve associated suicide risk and improve the likelihood of return to work. GPs need the skills to recognise and assess people with early signs of psychosis and refer appropriately to mental health services.	Early intervention for psychosis produces significant benefits compared to standard care for both patients and the health service. Enhanced training will provide GPs with the knowledge and skills for timely detection and referral to specialist early intervention services.
3	**Improved detection and management of common mental disorders**	Common mental disorders (CMDs) include different types of depression and anxiety disorder. These are often treatable yet account for one in five days lost from work in the UK. Most CMDs are managed in primary care. GP training must equip GPs with awareness of patterns of behaviour that might indicate a CMD, knowledge about high risk groups that might benefit from screening, evidence-based treatments and strategies for the development of effective management pathways in the community.	Enhanced GP training will ensure that GPs have the consultation skills to detect common mental disorders, the knowledge to target those at high risk of common mental disorders with screening questionnaires, and the professional experience to treat and refer such patients successfully and cost-effectively. This will improve both short and longer term health and social outcomes for patients.

68 Centre for Mental Health. *No Health without Mental Health: A guide for general practice* (2010). Accessed via: http://www.centreformentalhealth.org.uk/pdfs/Web_Mental%20Health%20Strategic%20Partnership%20GPs.pdf.

4	**Improved physical healthcare for people with mental illness**	People with chronic physical health problems have poorer prognosis if they have co-existent depression. Those with schizophrenia or bipolar disorder die on average 16–25 years prematurely and have higher rates of respiratory and cardiovascular disorders, infectious disease, diabetes, and obesity; medication side effects are common. Emphasis in GP training and beyond on the links between physical and mental health is vitally important to reduce health inequalities that patients with mental ill health experience.	GPs receive very little formal training about the interactions between physical and mental health. Enhanced GP training will develop the GP's ability to manage multiple co-morbidities in the same individual, including combinations of physical and mental health problems. This will improve quality of care and lead to improved medicines management and use of resources, thus optimising health outcomes.
5	**Mitigation of self-harm and suicide**	The UK has the highest rate of recorded self-harm in Europe. In most cases self-harm is a coping mechanism for emotional distress, but it is also a risk factor for suicide. Suicide results in 4,400 deaths every year in the UK. Sensitive assessment by GPs of people who have self-harmed or are at risk of suicide and the provision of strategies to mitigate risk saves lives.	Enhanced training will provide GPs with skills to enable more accurate suicide risk assessment. It will also promote closer liaison between primary and secondary care services to implement the 12-points to a safer service identified by the National Suicide Prevention Unit and assist in the meeting of National Suicide Prevention targets.
6	**Improved detection and management of dementia**	Prevalence of dementia is rising as our population ages. Early signs of dementia are most likely to be detected in primary care; early detection allows better planning for the future and interventions that may slow progression. Later on in the disease, good GP care to manage non-cognitive symptoms, deal with issues of mental capacity, and co-ordinate health and social services effectively maintains quality of life and dignity.	Enhanced GP training will equip GPs with the necessary skills to recognise dementia at an early stage. It will also provide GPs with strategies (both non-pharmacological and pharmacological) with which to manage non-cognitive symptoms of dementia. Improved knowledge and understanding of dementia will enable better liaison between primary and secondary care, so new care pathways can be developed to keep costs to a minimum whilst maximising quality of life and dignity for those with dementia and their carers.
7	**More integrated support for people with mental health issues and their carers**	People with mental health problems experience stigma as a result of their condition. They are more likely to have low income, be unemployed and live in more deprived areas. Their carers also suffer emotional, physical, social and financial consequences as a result of their caring roles. Primary care is often the initial point of access to obtain further support. Knowing how to attend to support needs is an essential role of the modern NHS GP.	Enhanced GP training will develop the skills GPs need to provide personalised support for patients and carers to maintain the well-being of people with mental health problems in the community. The introduction of clinically-led commissioning in England provides an opportunity for integrating health and social care, but to do this GPs need an enhanced understanding of their role and the expertise of other professionals, plus the skills to work effectively in shared team leadership roles.

Potential future impacts on people with mental health problems if GP training is not enhanced:

- Missed chances to promote mental well-being in general practice, with subsequent long-term adverse effects on the individual and society at large
- Failure to recognise mental illness at an early stage and intervene, resulting in poorer mental, physical and social outcomes and increased health costs
- Lack of recognition of physical health problems associated with mental ill-health and its treatment, resulting in excess physical morbidity and mortality in those affected
- Missed opportunities to engage GPs in reducing the suicide rate in the UK
- Inadequate detection and treatment of dementia causing reduction in quality of life, loss of dignity and excess social and healthcare burden
- Poor support for people with mental health problems and their carers resulting (depending on circumstances) in social isolation, deprivation, unemployment and breakdown in the care giving situation
- Poor quality commissioning of services to support people with mental health problems.

How GP training will change to meet this outcome:

- All GP trainees will undertake training in mental health during their four-year training programme, including placements that provide exposure to people with common mental health problems and to people with psychotic illness
- All GP trainees will receive targeted training in the early detection of psychosis and the assessment of suicide risk in the community context
- All GP trainees will receive training in the care of people with dementia
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on the needs of people with mental health problems and their carers
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local services for people with mental health problems
- The RCGP curriculum statement *Care of People with Mental Health Problems* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the enhanced mental health skills expected of doctors entering general practice.

Outcome 1.3: Improved care for people with alcohol and substance misuse problems

'Primary healthcare is ideally placed to offer screening for substance misuse and early intervention.. ... Achieving change requires social action to reduce the acceptability of substance misuse; professional action to improve early training, attitude consciousness and lifelong support; and resource allocation action to match the demand for care.'

Alcohol and Drugs Misuse Subgroup of the Changing Minds Campaign, 2003[69]

The educational challenge			How enhanced GP training will address this challenge
1	**Identifying harmful drug and alcohol misuse**	Whilst alcohol and drug dependence can affect anyone, those with a background of abuse, neglect, trauma or unemployment are disproportionately likely to be affected. Currently, only a small proportion of those who are misusing drugs or alcohol receive appropriate treatment. Identification is a key step in providing support and harm minimisation.	Enhanced GP training will equip GPs of the future with the skills to recognise and perform an initial assessment including brief intervention for those who misuse alcohol or drugs. Even if such patients are not ready or willing to change their behaviour, additional training in harm minimisation strategies will improve the health and wellbeing of these patients and result in significant cost savings for health and criminal justice systems.
2	**Improving access to evidence-based treatment and harm reduction**	There is a need for greater access to local, evidence-based interventions for patients who misuse alcohol and drugs. Effective treatment brings benefits not only to patients but to their families, children and society. Evidence-based treatment of drug misuse is also effective in preventing wider damage to the community – such as high volume acquisitive crime. Primary care based interventions can reduce the harms caused by the spread of blood-borne viruses like hepatitis B and HIV.	At present, most GPs in training do not spend any time working with specialist or community services for alcohol or substance misuse. Enhanced GP training will ensure that more GPs in training have direct experience of working with specialist services that provide treatment for drug or alcohol misuse and specific education about treating such patients in the community to ensure integrated care closer to home. In particular GP trainees will benefit from specific education about screening, brief interventions for alcohol misuse, community detoxification and safe opiate substitute prescribing.

69 Alcohol and Drugs Misuse Subgroup of the Changing Minds Campaign. *Drugs and Alcohol – Whose problem is it anyway? Who cares?* (2003). Accessed via: http://www.rcpsych.ac.uk/pdf/whocares.pdf.

3	**Managing the health impacts of alcohol and drug misuse**	Over 60 alcohol-related diseases have been identified and chronic excess alcohol consumption increases the risk of mental health disorders and suicide. Drug taking is also associated with physical and mental health problems. Illicit drugs may interact with prescribed medication, and injecting drugs can result in blood-borne disease, sepsis or thromboembolism. Both drug and alcohol misuse lead to social problems including domestic violence, marital breakdown, child abuse and neglect, absenteeism and job loss.	GPs must be aware of the health impacts of alcohol and drug misuse and take steps to minimise them. Enhanced GP training will ensure that GPs are not only aware of these harms but have effective harm minimisation strategies and consultation skills required to improve both short and longer term outcomes for these patients.
4	**Tackling alcohol and drug misuse in young people**	Young people's problem drinking results in 13,000 hospital admissions for alcohol-related problems each year. A third of the adult treatment population (drug or alcohol) have parental responsibility for a child. The risks to children are significant when living in an environment of alcohol/drug misuse and helping these families can change the lives of affected children by reducing potential neglect or abuse and improving life chances.	Enhanced GP training will enable GPs to gain experience of managing substance misuse within the family context. It will enable trainees to recognise those children and young people at increased risk of substance misuse and provide strategies to tackle this. This will include organising appointments and services at times and in locations that young people can access discretely and easily, and enabling young people to talk openly about issues regarding drugs and alcohol.
5	**Developing and improving integrated drug and alcohol services**	Alcohol and drug problems cut across the whole spectrum of society and are associated with (but often not recognised in) many common physical and mental illnesses. GPs are in a unique and significant position to provide cost-effective interventions in primary care and to lead the re-design of integrated services.	Enhanced GP training will equip GPs with the complex skills required to gain a detailed understanding of the health data and diverse needs of their local community when evaluating and re-designing integrated services. They will also engage with specialists and with a group of patients that, by its nature, can be hard to engage.

Potential future impacts on patients and the public if GP training is not enhanced:

- Missed chances to recognise many of those at greatest risk of alcohol misuse and so failure to intervene early in primary care, thus preventing future harms to the patient, their family and children
- Lack of effective interventions in primary care to tackle harmful drinking or drug use and to support people with severe dependency
- Lost opportunities to reduce harmful drinking behaviours which lead to local hospital admissions and Emergency Department attendances by patients
- Failure to work effectively with public health, specialist colleagues and commissioners to develop and improve an effective and evidence based specialist treatment service
- Lack of primary care support for local criminal justice interventions (which turn people away from alcohol-related crime and into treatment).

How GP training will change to meet this outcome:

- All GP trainees will undertake training in the detection and management of alcohol and drug misuse during their four-year training programme, including opportunities to learn in specialist or community clinics
- All GP trainees will receive training to enable them to deliver targeted alcohol screening, brief interventions and harm reduction strategies in primary care
- Throughout the four-year training programme, trainees will gain opportunities to learn in drug and alcohol services or clinics. There will be greater opportunities for interdisciplinary learning with alcohol and drug workers, safeguarding teams, substance misuse specialist midwives and health visitors, blood-borne virus (BBV) nursing teams and psychosocial therapists
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on the needs of people with alcohol or drugs misuse problems
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local services for people with alcohol or drug misuse problems
- The RCGP curriculum statement *Care of People who Misuse Drugs and Alcohol* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the enhanced alcohol and drug misuse skills expected of doctors entering general practice.

Outcome 1.4: Improved urgent care and rehabilitation for people with illness or trauma

'Urgent care in general practice matters. It matters to patients, who may be harmed or distressed if diagnosis and treatment is delayed. It matters to the NHS as a whole, because urgent care arrangements which have not kept pace with other operational changes within the NHS place pressure on the rest of the system, driving people towards A&E and avoidable hospital admissions. It matters to practices, where workloads can become unmanageable if urgent care is not handled well. It also affects the reputation of the service – unhappy patients tell their family, friends and colleagues about their experience.'

Primary Care Foundation, 2009[70]

The educational challenge			How enhanced GP training will address this challenge
1	**Provision of improved urgent care**	In general, patients report that they would prefer to seek advice from their GP than access another service if they have an urgent problem. As well as improving health outcomes and the experience of care for patients, improvements in urgent care provision by GPs in the community could substantially reduce Accident and Emergency Department attendance and emergency hospital admissions. This will result in considerable savings in healthcare costs.	Enhanced GP training will provide increased emergency care training both within normal working hours and out-of-hours. New GPs will thus be competent and safe to manage patients presenting with urgent care needs across a variety of different general practice settings and can participate in the design, commissioning and delivery of new urgent care services.
2	**Opportunities for training for GPs to meet standards for entry into the sub-specialty of pre-hospital emergency medicine**	Increasing expectation of more sophistication of out-of-hospital emergency care skills has led to the approval of a new subspecialty: pre-hospital emergency medicine. The RCGP was one of the lead Colleges involved in the creation of this sub-specialty. However, despite clear advantages for a subset of GPs to be trained in this subspecialty, GP training does not currently equip GPs with sufficient emergency care skills to be eligible for entry into postgraduate training for it.	Enhanced GP training will provide opportunities for more GPs in training who would like to pursue a career in pre-hospital emergency medicine to undertake elements of training of relevance to this sub-specialty.

70 Primary Care Foundation. *Urgent care: A practical guide to transforming same day care in general practice* (2009). Accessed via: http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf.

3	**Rehabilitation following major trauma**	Major trauma is a serious public health problem; it is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity. Veterans with long-term injury also need effective rehabilitation in the community. GPs need to provide effective care for major trauma patients transferring back into the community, provide support for their families/carers, and assist in commissioning services to meet their needs,. They hence need knowledge of the problems that patients may suffer following major trauma, the principles of rehabilitation and services available to support such patients and their families. Using this knowledge they must then work effectively as part of the multidisciplinary team.	Currently rehabilitation following trauma is not covered within the GP curriculum. Enhanced GP training will extend the GP curriculum, and the experience of trainees, to encompass rehabilitation following major trauma, including injured veterans. This will promote better care for patients who have suffered major trauma when they return to the community and also enable GPs to design, commission and implement new and improved community rehabilitation services.
4	**Rehabilitation following illness**	GPs are often the lead health professional co-ordinating care for patients who have long-term illness or are recovering from serious illness. Traditionally, care in general practice has been reactive: providing solutions for problems as they arise. However, the principles of rehabilitation using a multidisciplinary team and a holistic, pro-active, problem-based approach with goal setting and regular reviews can be very effective in improving patient functioning and quality of life. This reduces hospital admissions and assists adults of working age to return to work.	Enhanced GP training will ensure that all GPs in training have received adequate training in the principles and practice of rehabilitation in the community. They can thus work together with patients and their families/carers within the multidisciplinary team to optimise their functioning in society, quality of life and enable those of working age to return to work earlier.
5	**Improved care for Veterans and their families**	Veterans are a large and often neglected group of patients with specific healthcare needs. They are at increased risk of ongoing ill-health, including long-term mental health, substance misuse, and physical health problems. In addition, they must cope with socio-economic and cultural issues relating to the transition to civilian life. In many cases, family members and children may also suffer or face their own problems as a result of someone near to them who has ongoing mental health problems or physical injuries.	Enhanced GP training will enable future GPs to develop many of the key skills required to improve the care available to veterans. In addition to the improved rehabilitation skills for illness and injury set out in this outcome, GPs will be better placed to deal with mental health and substance misuse problems (see Outcomes 1.2, 1.3) as well as provide increased support to family members who are acting as carers for those with long-term health conditions (see Outcome 1.5).

Potential future impacts to patients requiring urgent care or rehabilitation if GP training is not enhanced:

- Inconsistent provision of high-quality urgent care resulting in missed diagnoses and patient harm
- Exclusion of GPs from becoming pre-hospital emergency care specialists to the detriment of service provision in communities where such expertise would be extremely valuable to patients (e.g. rural or remote locations)
- Poor ongoing rehabilitation and community support for people who return home following major trauma resulting in failure of patients to reach their maximum potential
- Failure to improve the rehabilitation available to people suffering from long-term illness or recovering from serious illness, resulting in poorer functioning in the community, poorer quality of life, delayed return to work and increased hospital admissions
- Failure to improve the care and support offered to Veterans and their families.

How GP training will change to meet this outcome:

- All GP trainees will receive training in rehabilitation during their four-year GP training programme, with greater opportunities to learn in specialist and/or community-based rehabilitation services
- All GP trainees will receive targeted training in urgent care
- During the enhanced GP training programme, most trainees will gain 33-50% more out-of-hours GP training experience than under current arrangements; the expected out-of-hours training competences will be updated accordingly
- There will be opportunities for GPs wishing to pursue an interest in pre-hospital emergency medicine to undertake training needed for entry into this sub-specialty
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on acute care or rehabilitation
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local services for people requiring rehabilitation following major trauma or illness
- The RCGP curriculum statement *Care of Acutely Ill People* will be updated to support the learning of the required competences (and other relevant statements)
- The MRCGP assessments will be updated to assess the urgent care and rehabilitation skills now expected of doctors entering general practice.

Outcome 1.5: Improved care for older adults and their carers

'The British Geriatric Society believes that the traditional model of general practice in the UK is advantageous to older patients, and that a GP's commitment to a locality and knowledge of services for older people within that locality is important. Building up trust and strong relationship over time helps the patient to believe that the doctor will make the right decisions for them in the future and understand their health needs and preferences….'

British Geriatric Society, 2010[71]

The educational challenge			How enhanced GP training will address this challenge
1	**Maintaining health and preventing disease in the elderly**	Primary, secondary and tertiary prevention of disease and interventions to assist older people to regain their independence after illness, both benefit older people and result in more efficient use of resources. However health promotion is often a neglected area for older people and requires a greater focus within GP training.	Currently health promotion for older people is not a training priority for general practice. Enhanced GP training will deliver additional training in promotion of health in older people in order that GPs can provide opportunistic and targeted health promotion to older people within their practice populations. This will enable them to influence local health policy and inter-agency health promotion strategies for the elderly.
2	**Recognising serious illness in the elderly**	Recognising serious illness in elderly people can be difficult as non-specific symptoms may be wrongly attributed to existing conditions, communication may be difficult and elderly people may present atypically. All GPs must develop and maintain skills required to adequately recognise, assess, diagnose and manage serious illness safely and effectively in the elderly.	Enhanced GP training will provide additional training in the assessment and management of complex elderly patients to enable serious illness to be detected sooner and thus managed more effectively.
3	**Managing multiple morbidities**	The elderly are more likely to suffer from multiple health problems. In the UK hospital-based medicine has become increasingly specialised. This trend towards more secondary care specialisation tends to disadvantage people with multiple morbidities. The effective management of such patients requires a holistic, patient-centred and problem-oriented approach, which is most cost-effectively provided through general practice.	Although GP training currently provides a framework for GPs to provide good care for people with a single condition, it does not provide sufficient training to manage the growing numbers of complex patients who have multiple morbidities. Enhanced GP training will equip GPs with improved clinical skills and knowledge to manage patients with multiple morbidities successfully and act as a hub for co-ordination of care between primary care, secondary care, social care, and third sector agencies.

71 British Geriatric Society. 'Striking a balance' Consultation (2010). Accessed via: www.bgs.org.uk/index.php?option=com_content&view=article&id=1150:gppartnershipconsultation&catid=14:consultations&Itemid=110.

4	**Avoiding drug-related problems in the elderly**	Drug side effects are more common in the elderly due to altered pharmaco-dynamics and pharmaco-kinetics. When an older person is taking a number of drugs each drug may result in side effects, reducing quality of life, and on some occasions causing serious illness and even death. The more drugs a person is taking, the more likely it is that there will be a serious interaction between drugs resulting in harm. Improved GP training to manage medicines safely in the elderly is essential.	GPs receive very little formal training about prescribing in the community context. They do pick up the practicalities of doing this in their GP placements, but enhanced GP training will deliver focused and more comprehensive training in medicines management, so that the significant wastage and harm from inappropriate prescribing and prescribing errors that currently occur can be reduced.
5	**Developing services appropriate for the elderly**	Consultation rates increase with age. Consultations are also more complex, often involving multiple co-morbidities with chronic ongoing conditions, and may be particularly challenging because of difficulties in access, communication, or as a result of cognitive deficit. Traditional models of care comprising 10-minute appointments with the GP may need to be rethought.	GPs will develop a greater understanding of the role and expertise of other elderly care and public health professionals during their training and the skills to work effectively with them in shared team leadership roles in order to develop new ways of delivering care to this increasingly complex group.
6	**Including carers in care planning**	Carers know the people that they care for better than anyone else. This knowledge can be useful to health and social care professionals in planning patient care, and also in identification of problems that may require intervention. If care is planned without the input of the carer, an opportunity has been lost. Engagement and co-operation with carers is an essential part of good patient care and thus enhanced GP training.	Although carers are regularly mentioned within the GP curriculum, there is currently no emphasis on including them as partners in care or on the benefits that this can bring. Enhanced GP training will stress the importance of carers to the success of care in the community and demonstrate to GPs in training how involving carers in care planning can benefit both patients and health services alike, as well as practical techniques for doing this.
7	**Supporting carers in their caring roles**	Carers experience physical, psychological, social and financial consequences as a result of their role. Failure to attend to carers' health and social needs and to signpost to appropriate financial support may lead to collapse of the care giving situation. Primary care is often the initial point of access for carers to obtain further support. Therefore identifying carers and attending to their support needs is an essential and increasingly important role of the GP.	In order to support carers within primary care, extended education for GPs will provide opportunities to teach trainees about the problems that carers face and ways in which they can be supported both within primary care and through signposting to other resources and services.

Potential future impacts on older people and their carers if GP training is not enhanced:

- Missed chances to prevent avoidable disease, resulting in decreased quality of life and premature death for older people, increased care needs and increased health and social care costs
- Risk of failing to recognise serious illness in the elderly, causing late presentation, and resulting in increased healthcare costs and poorer short- and long-term outcomes
- Increased fragmentation of care for individual health problems resulting in treatment of the disease and not the patient and failure to appreciate the effect that multiple conditions in the same person have upon each other
- Poor drug management resulting in increased prescribing costs, increased morbidity and healthcare costs as a result of drug side effects and interactions, and poor concordance
- Poor quality commissioning of services to support older people and their carers
- Failure to include and support unpaid carers in care planning, resulting in poor concordance with care plans for older people, ill health of carers and breakdown of the care giving situation and thus increased health and social care costs.

How GP training will change to meet this outcome:

- All GPs will receive targeted training in safe prescribing for the elderly during their four-year GP training programme, including opportunities to learn in specialist and/or community clinics that provide healthcare for older people with co-morbidities
- All GP trainees will receive training on the inclusion of carers in care planning and supporting carers in their roles. Such training could be built on the successful training model developed by the RCGP and Carers UK
- During the ST3–4 stages of their GP training programme, all GP trainees will receive community-based training in health promotion and co-ordination of care for older people
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on care for older people
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local services for older people and/or their carers
- The RCGP curriculum statement *Care of Older Adults* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the skills in caring for older adults and supporting carers that are now expected of doctors entering general practice.

PRIORITY AREA 2: ENHANCED GENERALIST CARE

This priority area will deliver more effective and comprehensive care for patients, carers and families, with particular focus on:

- Increased understanding of the relationship between work and health, and of the health needs of the local community
- Improved health promotion and disease prevention
- Improved co-ordination of care for patients with multiple co-morbidities and long-term conditions
- More cost-effective and timely use of resources, including investigations, referrals and treatments
- Improved end-of-life care, especially for those who choose to die at home.

The full evidence base (including references) for this priority area and its outcomes is presented in Supporting Evidence document 2.

Outcome 2.1: Increased understanding of the relationship between work and health, and of the health needs of the local community

'Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury is essential if we are to reduce absence and prevent people becoming dependent upon benefit. ... Patients view their GPs as their first point of contact when health problems arise and trust their advice and guidance. They are well placed to offer simple fitness for work advice to their patients and to provide the focused support necessary to assist their recovery and retention in work.'

The Faculty of Occupational Medicine, 2005[72]

The educational challenge			How enhanced GP training will address this challenge
1	**Gaining an enhanced understanding of the health needs and priorities of the local community**	High-quality, localised primary care services improve health outcomes for people, families and communities. Improved self and community care can greatly reduce costs of healthcare. However, to be effective and high quality, these localised services require GPs to gain a robust and evidence-based understanding of the health needs of the local population. Once local health needs and priorities have been understood, this understanding must be translated into locally tailored, cost-effective action, both in the individual consultation and in the wider health service.	Enhanced training will provide GPs with opportunities to engage with their local populations and to develop a greater understanding of local health needs, through contact with local community-based health organisations. Trainees will also have the opportunity to apply this greater understanding to their everyday gatekeeper and navigator roles and, in later training, to their broader service improvement and leadership roles. These enhanced skills will ultimately deliver substantial health, cost and efficiency benefits to the health service.
2	**Evaluating and interpreting local health data and service performance**	To be effective, local health services must be designed around an understanding of local health needs, service utilisation and performance, and patient outcomes. This will require GPs to learn new skills in using epidemiological data, trends analysis, indicators of variation, and analysis of safety, quality and the patient experience.	Through enhanced training, GPs will have an opportunity to undertake a Quality Improvement Project, incorporating an assessment of the needs of their population, including those with the greatest need, and to understand how health data on people, and the services they use, are collected. Trainees will also have an opportunity to acquire data interpretation skills to evaluate unmet needs, predict trends and to identify opportunities to improve, so informing the setting of commissioning priorities in partnership with specialist colleagues, the public and other agencies.

72 Faculty of Occupational Medicine. *The Health and Work Handbook* (2005). Accessed via: http://www.facoccmed.ac.uk/library/docs/h&w.pdf.

3	**Understanding and supporting the positive relationship between work and health**	Evidence supports the beneficial effects of work on health outcomes, and the importance of reversing the harmful effects of long-term unemployment and prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including issuing 'statements of fitness to work', reflects an incorrect assumption among many doctors and patients that illness is incompatible with being in work. This can be a frequent source of conflict in the consultation.	Enhanced GP training will educate GP trainees about the relationship between work and health. It will support the development of a culture in which GPs maximise efforts to keep people in work, in the belief that it will improve the health and wellbeing of the individual patient and population as a whole.
4	**Intervening effectively to support patients in returning to work and in reducing long-term worklessness**	Enabling adults to return to work after a period of illness is beneficial for their long-term health. Long-term worklessness causes poor health and health inequality. However, there is evidence that GPs find this area particularly challenging and, although high-quality, evaluated training on this topic is now available, few GPs currently receive this.	Enhanced GP training will enable all GP training programmes to incorporate consultation skills-based training designed to enable doctors to effectively support their patients to return to work. This training could be based on the successful training programme recently developed by the RCGP, Department of Work and Pensions (DWP), Faculty of Occupational Medicine, and Society of Occupational Medicine.

Potential future impacts on patients and the public if GP training in health and work is not enhanced:

- Failure to harness the potential of the GP to help tackle the social determinants of health
- Risk of GPs failing to design and commission healthcare services based on an accurate and robust understanding of the health needs of the local population
- Risk of GPs failing to consider and address the needs of vulnerable and disadvantaged groups
- Inadequate skills among the GP workforce to enable long-term, structured and accurate decisions to be made about local service outcomes and design in England
- Failure to use the unique role of the GP to address the incorrect assumption that work and ill-health are incompatible
- Missed opportunities to effectively support patients in returning to work, so harming their further health and reducing life chances
- Failure to reduce long-term worklessness, so placing a potentially avoidable burden on the UK economy.

How GP training will change to meet this outcome:

- All GP trainees will receive enhanced training in population health and interpreting local health data, predominantly during the ST3–4 stages of their GP training programme
- All GP trainees will receive tailored consultation skills training relating to supporting return to work, reducing long-term unemployment and fitness for work certification issues. Such training could be based on the successful training model for GPs recently developed by the RCGP, Department of Work and Pensions (DWP), Faculty of Occupational Medicine, and Society of Occupational Medicine
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on support for people returning to work
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local services or re-designing services around local health needs. This will include opportunities to learn in local public health services and/or commissioning organisations
- The RCGP curriculum statement *Healthy People: Promoting health and preventing disease* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the skills in population health and supporting return to work that are now expected of doctors entering general practice.

Outcome 2.2: Improved health promotion and disease prevention

'The NHS in the twenty-first century increasingly faces a disease burden determined by the choices that people make: to smoke, drink excessively, eat poorly, and not take enough exercise. Today, countless years of healthy life are lost as the result of these known behavioural or lifestyle factors.'

Department of Health, 2008[73]

The educational challenge			How enhanced GP training will address this challenge
1	**Engagement with strategies to promote better population health**	GPs can promote health through activities both within the consultation, within their own practice teams and more broadly through co-operation with other agencies. The ultimate aim of all public health initiatives is to improve population health; tackling health inequality is closely linked to population health improvement.	The increased role of GPs in health commissioning in England will enable future GPs to engage with other agencies to develop new services to improve population health and well-being and address health inequalities. To do this GPs will require new skills to understand the health needs of their local population and enable them to work in shared leadership roles with other health social and third sector organisations.
2	**Communication skills to effect behaviour change**	In primary care many disease prevention activities require patients to change their lifestyles. Although GPs are confident at identifying those at high risk of disease, they often feel ill-equipped to intervene in order to effect behaviour change. Other barriers that stop GPs from helping their patients to alter their lifestyle behaviours include time factors and the perception that intervention might adversely affect the doctor–patient relationship.	Enhanced training will equip GPs with the skills to maximise the potential of disease prevention opportunities in the consultation (and in the practice more broadly) so that GPs are confident to broach the topic of lifestyle change with their patients and can motivate their patients to effect behaviour change.
3	**Improvement in established disease prevention programmes**	There are a number of established disease prevention programmes already in operation in the UK. Some of these take place in primary care and others are run by other agencies. Information from GPs is often a crucial factor in influencing patients' decisions about whether to engage in any health promotion or disease prevention activity.	Enhanced GP training will provide GPs with the expertise to run efficient and patient-centred chronic disease management clinics in primary care and the communication skills to educate patients about risk and the benefits of disease prevention activities. This can occur both within and outside the practice.

73 Department of Health. *High Quality Care for All: NHS next stage review* (2008). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf.

4	**Development of new ways of providing care to promote health and prevent disease**	The increased involvement of GPs in planning services will provide new opportunities to find cost-effective ways to integrate health and social care and prevent disease.	Enhanced GP training will provide GPs with a better understanding of public health and the health needs of their local population. It will also equip GPs with the skills to appraise the efficacy and cost-efficiency of health promotion and disease prevention interventions to enable them to provide new illness prevention care pathways that are both targeted and value-for-money.

Potential future impacts on health promotion and disease prevention if GP training is not enhanced:

- Missed opportunities to prevent avoidable disease, resulting in decreased quality of life, premature death, increased care needs and increased health and social care costs
- Increase in health inequalities that result in different sectors of our population having very different life expectancies and levels of health and well-being
- Risk of poor quality commissioning of services for disease prevention
- Limited GP understanding and support for future public health initiatives.

How GP training will change to meet this outcome:

- All GP trainees will receive additional training in health promotion and disease prevention during the ST3–4 stages of their GP training programme, with focus on the need for cooperative working across boundaries with other professionals and agencies
- All GP trainees will receive advanced consultation skills training relating to effecting behaviour change, particularly in relation to smoking, alcohol, obesity and nutrition
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could include health promotion and disease prevention initiatives
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local health promotion and disease prevention strategies. There will be opportunities for trainees to learn in public health and other relevant organisations
- The RCGP curriculum statement *Healthy People: Promoting health and preventing disease* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the skills in health promotion and disease prevention that are now expected of doctors entering general practice.

Outcome 2.3: Improved co-ordination of care for patients with multiple co-morbidities and long-term conditions

'The biggest single change facing the profession [medicine] is the shift from a routine dominated by making interventions to treat patients' episodic illness to one dominated by working in partnership with the growing numbers of patients living with long-term conditions.'

Royal College of Physicians, 2010[74]

The educational challenge			How enhanced GP training will address this challenge
1	**Developing new skills to support increasing numbers of people with long-term conditions**	The number of people with a long-term condition is set to rise by 23% over the next 25 years. People with long-term conditions are intensive users of services accounting for 52% of GP appointments, 65% of outpatient appointments and 77% of hospital bed days. New models of integrated care that will enable more people with long-term conditions to be managed entirely within the community are needed to improve health outcomes and minimize healthcare costs.	Enhanced GP training will equip GPs with improved clinical skills to manage a broader range of long-term conditions in the community. GPs could also develop more innovative working practices to adapt their own practices to the demands of providing high-quality care to people with complex long-term conditions. GPs with better knowledge of the role of other care providers will facilitate better integration of care across boundaries. Enhanced technical skills will allow GPs to embrace new technology to improve care and develop the population health skills to design and create innovative and integrated services.
2	**Enabling people with long-term conditions to self-care**	GPs have a central role to play in promoting self-care and challenging dependency. Supporting people to self-care is a key component of successful long-term disease management. It is also important for improving patient confidence and reducing anxiety in managing their minor ailments. However many healthcare professionals currently lack the skills required to facilitate their patients to self-care.	Enhanced GP training will equip GPs with the strategies and communication skills to promote self-care and support their patients to do this by outlining options and negotiating self-care plans with patients and their carers. A more effective approach will ensure that patients are more motivated to follow self-care plans that are realistic and sustainable, and that can be reinforced and modified at each review. This will require good clinical knowledge about best practice over a wide range of long-term conditions, improved knowledge of the roles and responsibilities of other care providers and excellent communication skills.

74 Royal College of Physicians. *Future physician: Changing doctors in changing times* (2010). Accessed via: http://bookshop.rcplondon.ac.uk/contents/pub314-8a7acca7-30a1-4972-867f-d4207bbcc2c6.pdf.

3	**Managing multiple co-morbidities in the same individual**	One in five adults has more than one long-term health condition. The effective management of such patients requires a patient-centred and evidence-based, problem-oriented approach that depends heavily on multidisciplinary team working. GPs are both care providers and navigators, steering their patients through the complexity of the health and social care system.	Enhanced GP training will provide GPs with improved clinical and generalist skills so that they can optimise the management of patients with multimorbidity and act as a hub for co-ordination of care between primary care and other health, social and third sector agencies. It will also provide improved academic skills to assess research evidence and clinical guidelines for relevance to patients with multiple morbidities.
4	**Cost-effective and safe prescribing**	GPs write 98% of prescriptions issued in primary care; 70–80% of medications issued in primary care are prescribed on repeat prescription for chronic and ongoing health problems. Better medicines management results in improved health outcomes, reduced harm, and cost-efficiencies.	Enhanced GP training will deliver focused and more comprehensive training in medicines management so that the significant wastage and harm from inappropriate prescribing that currently occurs can be avoided.
5	**Managing medically unexplained symptoms**	Medically unexplained symptoms (MUS) are the presenting features in up to a quarter of primary care consultations. They can cause disability as severe as those which originate from organic pathology. The diversity of the presenting symptoms and the associated diagnostic uncertainty make them difficult to manage.	Enhanced GP training will provide improved communication skills for GPs together with better knowledge about the underlying mechanisms of MUS and effective treatment strategies. This will facilitate improved services for patients with MUS with the aim of reducing distress and improving functioning within the community, and reduce excess usage of health and social care resources and thus healthcare costs.
6	**Caring for people with intellectual disability**	Around 2% of patients on a GP's registered patient list have an intellectual disability. With closure of large institutions for people with intellectual disability, the shift to community-based care, increasing longevity, and increasing complexity of modern interventions, the responsibility for healthcare has shifted increasingly to GPs. A full-time GP will be caring for about eight patients with clinically significant intellectual disabilities, who often have complex co-morbidities. For example, 50% of patients with profound learning disabilities also have epilepsy. However, in England in 2010–11, only 49% of eligible adults with intellectual disabilities received the advised annual structured GP health check.	Enhanced GP training will equip GPs with advanced consultation skills to deal with the communication and sensory difficulties that can lead to diagnostic overshadowing and failure to address important healthcare issues (e.g. sexual health). GP trainees will learn to perform a structured annual health check and receive feedback from their trainer, patients and carers. During primary care placements, trainees will have an opportunity to improve the organisational aspects of care for patients with intellectual disability in their own practice. A Quality Improvement Project (QIP) undertaken in ST4 will provide an opportunity for trainees to identify health needs for this vulnerable group and to work with colleagues on service redesign and improvement.

7	**Including and supporting carers**	Carers suffer health, social and financial consequences as a result of their role. Primary care is often the initial point of access for carers. Therefore it is important that GPs and primary care teams are aware of the problems that carers face, and GP practices are organised to identify carers, involve them in patient care where appropriate, and support them to maintain the care-giving situation.	Enhanced GP training will stress the importance of carers to the successful management of people with long-term conditions and demonstrate to GPs in training how identifying carers, supporting them and involving them in care planning can benefit both patients and health services alike.

Potential future impacts on patients with long-term conditions if GP training is not enhanced:

- Failure to effectively integrate care resulting in poorer health outcomes for those with chronic disease and increased care costs through unscheduled admissions and unnecessary hospital stays
- Reduced ability of people with long-term conditions to self-care, resulting in poorer health outcomes and increased strain on health and social care resources
- Increased fragmentation of care for individual health problems, resulting in treatment of the disease and not the patient and failure to appreciate the effect that multiple conditions in the same person have upon each other
- Over-investigation and inappropriate treatment for people with medically unexplained symptoms that wastes resources, may harm the patient and further fuel health anxieties
- Risk of poor drug management resulting in increased prescribing costs, increased morbidity and healthcare costs as a result of drug side effects and interactions and poor concordance
- Failure to include and support unpaid carers in planning, resulting in poor concordance with care plans for older people, ill health of carers and breakdown of the care giving situation and thus increased health and social care costs.

How GP training will change to meet this outcome:

- All GP trainees will receive more training in co-ordinating care for people with co-morbidities and long-term conditions, with increased focus in the latter stages of training on the synthesis and application of the clinical skills gained predominantly in ST1–2 and the generalist and leadership skills gained predominantly in ST3–4
- All GP trainees will receive training on the inclusion of carers in care planning and supporting carers in their roles. Such training could be built on the successful training programme model developed by the RCGP and Carers UK
- During ST3–4, all GP trainees will receive tailored consultation skills training to support patients to self-care and for the assessment and support of patients with co-morbidities, medically unexplained symptoms and patients with intellectual disability
- All GP trainees will receive training in safe prescribing and medicines management in primary care for patients on multiple drug treatments
- All GP trainees will have the opportunity to perform a structured health check for patients with intellectual disability, and to receive feedback on their performance
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on improving co-ordinated care for patients with co-morbidities, long-term conditions and/or learning disability
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the integration of local services for patients with long-term conditions or on improving services for people with intellectual disability
- The relevant RCGP curriculum statements will be updated to support the learning of the required competences (affects multiple statements)
- The MRCGP assessments will be updated to assess the skills in the co-ordination and management of co-morbidities and long-term conditions that are now expected of doctors entering general practice.

Outcome 2.4: More cost-effective and timely use of resources, including investigations, referrals and treatments

'Our health service faces a huge challenge: how to respond to reduced funding without reducing the quality of the services we provide, or the quality of the care our patients deserve. ... GPs and their primary healthcare teams are a key part of the solution.'

Professor Steve Field, 2010[75]

The educational challenge			How enhanced GP training will address this challenge
1	**Improving the cost-effective use of primary care investigations and treatments**	To increase quality and cost-effectiveness of patient care, GPs must be knowledgeable and make effective, evidence-based and patient-centred decisions about investigations and treatments used in primary care. They must balance the needs of the individual patient with the available resources for the wider community.	An extended period of training in primary care will enable GPs to develop the complex skills required to make high-quality, appropriate management decisions in a primary care context. It will also provide an opportunity for these decisions to be subjected to peer review and quality improvement processes in a supportive environment. Trainees will also have time to learn the more advanced consultation skills to use tools which provide information to support decisions made during the consultation, while maintaining good rapport with the patient and acting in a patient-centred manner.
2	**Reducing inappropriate referral decisions**	For common illnesses there is good evidence that chronic disease management is most effective and leads to better outcomes if provided in general practice rather than by multiple teams of secondary care specialists. Making unnecessary referrals carries an extra cost and inconvenience and occasionally results in over-investigation and harm to the patient. Delayed referral can result in late or missed diagnoses.	To make appropriate referral decisions, GPs must learn how to reach a shared decision with the patient (and/or their carer) on whether a referral is needed, why it is needed, to whom, and on what timescale. They must also be able to understand and communicate when an alternative to referral would be more appropriate for the patient. These are complex and challenging skills that take time and supervised input to develop; enhanced GP training will provide opportunities for these skills to be acquired and practised safely.

75 **Field S.** *Total Politics Magazine* **2010; 23rd March.**

3	**Improving the quality of the referrals process**	Once a GP makes a decision to refer, a suitable mechanism must make that referral happen in a timely and effective manner, avoiding delays and reducing bottlenecks. Practices must develop efficient advice-seeking and referral systems using new technology, which requires changes in traditional referral behaviour.	A deeper understanding of the referrals process will allow GPs and their teams to improve the referral experience for patients and carers. GPs will gain experience of using and developing referral systems and integrated pathways to streamline patient care and to improve the interface between primary and secondary care.
4	**Evaluating and acting on individual and practice activity data**	GPs must learn to analyse and interpret individual and practice data on prescriptions and referrals and establish a system for reviewing borderline or challenging cases in a timely way. However, simple data on individual clinician referral rates does not correspond to the appropriateness or quality of that clinician's referrals. For example; in addition to identifying potentially avoidable referrals, GPs must identify patients who should be referred but are not. Further in-depth analysis is therefore needed in order to make accurate and robust decisions and to sustain a change in behaviour.	Enhanced training will provide GP trainees with opportunities to collate, analyse and interpret qualitative and quantitative data on referrals, while understanding the aspects of care important to patients that cannot be readily measured. It will help GP trainees to develop the ability to engage in, reflect on and respond to peer review, and to understand the steps required for system-wide change within practice teams and organisational structures. Targeted training on prescribing in primary care will improve cost-effectiveness and safety.

Potential future impacts on patients and the health service if GP training is not enhanced:

- Risk of ineffective and wasteful use of health system resources
- Failure to reach shared understanding with patients and carers, with inability to encourage appropriate, well-informed choices
- Risk of poor quality referral decisions being made about patients and carers without their involvement, and risk of harm to patients from inappropriate referrals
- Missed chances to reduce delays and bottlenecks in the referrals process and patient pathway
- Poor referral management skills and failure to prioritise demand
- Risk of inaccurate interpretation of individual and practice-level prescribing and referral data
- Failure to sustain a change in clinical behaviour when it would be appropriate to do so
- Ineffective relationships between primary and secondary care teams.

How GP training will change to meet this outcome:

- All GP trainees will receive enhanced training in child health, mental health, drug and alcohol misuse, urgent care, rehabilitation and care of older people (as described in outcomes 1.1–1.5), resulting in more effective use of health service resources
- During the four-year programme, all GP trainees will receive training in academic skills (as described in outcome 3.4) to enable evidence-based decision-making and changes in practice
- All GP trainees will receive targeted training on safe and cost-effective prescribing in the primary care context
- During ST3–4, all GP trainees will receive advanced consultation skills training on shared decision-making and communicating appropriate alternatives to referral
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on improving referrals processes in the practice
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of referral pathways to secondary care
- The relevant RCGP curriculum statements will be updated to support the learning of the required competences (affects multiple statements)
- The MRCGP assessments will be updated to assess the skills in the effective use of resources that are now expected of doctors entering general practice.

Outcome 2.5: Improved end-of-life care, especially for those who choose to die at home

'Patients who are approaching the end of their life need high-quality treatment and care that support them to live as well as possible until they die, and to die with dignity.'

General Medical Council, 2010[76]

The educational challenge			How enhanced GP training will address this challenge
1	**Identification of people approaching the end of life**	Better identification of people approaching the end of life results in improved symptom control, reduced unplanned hospital admissions, better family and carer support, and a greater likelihood that the person's choice of place of death is respected.	Enhanced GP training will deliver additional training in end-of-life care for all trainees, which includes identification of those approaching the end of life as a priority.
2	**Developing skills to communicate effectively with people approaching the end of their lives and their families**	Understanding patient and carer preferences and delivering patient choice requires good communication. However, the majority of GPs do not feel confident or prepared by their training to initiate conversations with patients about end-of-life care. Communication skills training for end-of-life care can increase that confidence.	Enhanced GP training will provide all GPs with advanced consulting skills training which will improve communication between GPs, patients and families/carers about end-of-life issues. This will result in a higher proportion of patients approaching the end of life having their individual choices and preferences respected, plus improved carer and family outcomes.
3	**Assessment and care planning for people approaching the end of life**	Although two thirds of people would prefer to die at home, currently 53% die in hospital. A substantial proportion of deaths in hospital could take place at home with better care planning and support in the community. This would result in a better experience for patients and carers, and also significant cost savings for the NHS.	Enhanced GP training will provide all trainees with training in advanced care planning and symptom control, enabling GPs to support people on their palliative care registers and their carers/families better, to avoid unnecessary hospital admissions, and to use NHS resources more cost-effectively.
4	**Delivery of high-quality, co-ordinated services in all locations**	Delivery of co-ordinated, high-quality services that are available to every person approaching the end of life, and are tailored to the individual, is a highly complex task involving co-operation across health, social services and the third sector. GPs have a pivotal role in developing and commissioning services to meet end-of-life care needs.	GP trainees will develop a greater understanding of the role and expertise of other organisations and individuals providing end-of-life care and the skills to work effectively with them in shared team leadership roles. This will enable them to develop new care pathways and commission new services in their future roles.

76 General Medical Council. *Treatment and Care towards the End of Life: Good practice in decision-making* (2010). Accessed via: http://www.gmc-uk.org/static/documents/content/End_of_life.pdf.

5	**Support for family and carers, both during a person's illness and after death**	Primary care is often the initial point of access for carers to obtain further support. Identifying carers and other family members, and attending to their support needs both whilst caring and after bereavement is an essential role of the GP in end-of-life care.	In order to support carers and other family members within primary care, enhanced education for GPs will teach trainees about the problems they face whilst caring and after bereavement, and ways in which they can be supported both within primary care and through signposting to other resources and services.

Potential future impacts on end-of-life care if GP training is not enhanced:

- Failure to identify people approaching the end of life and thus initiate end of life care pathways
- Failure to communicate with people approaching the end of life and their families, resulting in preferences for care and place of death being ignored
- Inadequate care planning and support of carers resulting in unnecessary hospital admissions at substantial cost both to the individuals involved and the NHS.

How GP training will change to meet this outcome:

- All GP trainees will receive additional training in end-of-life care, including more training opportunities in specialist and/or community end-of-life services
- During ST3–4, all GP trainees will receive tailored consultation skills training relating to end-of-life care, including: raising difficult issues, providing support and advanced care planning
- All GP trainees will receive training on safe and cost-effective prescribing in relation to end-of-life care
- In ST3–4, all GP trainees will be expected to lead improvements in the organisational aspects of care in their practice, which could include improving care for those at the end-of-life
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality and integration of local end-of-life services
- The relevant RCGP curriculum statement *End-of-life Care* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the skills in end-of-life care that are now expected of doctors entering general practice.

PRIORITY AREA 3: ENHANCED LEADERSHIP

This priority area will deliver more effective leadership at practice, local and national level, with particular focus on:

- Improved delivery of primary care services, both in- and out-of-hours
- Increased co-ordination and leadership of multidisciplinary teams
- More effective engagement in the development of local services, working collaboratively with specialists and patients
- Improved academic skills for evidence-based practice, innovation, quality improvement, education and research

The full evidence base (including references) for this priority area and its outcomes is presented in Supporting Evidence document 3.

Outcome 3.1: Improved delivery of primary care services, both in- and out-of-hours

'General practice is primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.'

WONCA, 2002[77]

The educational challenge			How enhanced GP training will address this challenge
1	**Managing increasing demand for, and complexity of, GP consultations**	Over the past 15 years there has been a progressive increase in demand for general practice appointments. This has been accompanied by a change in the severity and complexity of the problems that GPs see in their surgeries, and an increase in the number of managerial and leadership functions that GPs have been expected to fulfil. These trends are set to continue into the future. The GPs of tomorrow will need to embrace new ways of working in order to manage increasing primary care workload and other demands on their professional time, whilst ensuring continued high-quality patient care.	Enhanced GP training will equip GPs with improved skills to manage a range of conditions traditionally managed in secondary care. This will be facilitated by better knowledge of the roles of other providers and excellent inter-professional communication skills so that it is possible to co-ordinate care effectively across boundaries; technical skills to embrace new technology in order to use resources in the most efficient way possible; and innovative working practices to redesign, commission and implement new care pathways.
2	**Improving the provision of primary care services for people in residential care homes**	Those in residential care are some of the most vulnerable in our community. Yet GPs receive no specific training in care of people who live in residential care. Residents of care homes are less likely to have their long-term conditions managed to national standards; medication errors are more common; they often receive substandard end-of-life care and may be admitted to hospital inappropriately. Finding innovative new ways to deliver high-quality medical care to care home residents is a priority.	Enhanced GP training will provide GPs with increased understanding of the difficulties associated with providing primary healthcare to care home residents; better clinical knowledge to manage their healthcare problems; improved communication skills to promote team working with nursing home staff and reduce medication errors; better organisational skills to ensure regular review; and flexibility to explore and assist with commissioning new working practices that could improve medical services to care homes.

77 WONCA (World Organisation of National Colleges, Academies) Europe. *The European Definition of General Practice/ Family Medicine* (2005). Accessed via: www.woncaeurope.org/Web%20documents/European%20Definition%20of%20family%20medicine/Definition%202nd%20ed%202005.pdf.

3	**Improving care for socially excluded populations**	There are a number of distinct socially excluded populations, including people with learning disability, those who are homeless, and refugees and asylum seekers. Often health services do not meet their needs and this can result in increased prevalence of preventable disease, premature mortality and excess use of unscheduled care and hospital services.	Improved GP training will provide GPs with the skills to manage the barriers to healthcare that socially excluded groups face, to interpret health data about vulnerable groups, and to develop and provide integrated services with sufficient flexibility to meet their needs.
4	**Improving the provision of out of hours care**	Primary medical care is provided by out-of-hours services from 18.30 to 08.00 on weekdays and for weekends and public holidays; a total of at least 70% of every week. Although there is considerable overlap between the work of within hours GPs and out-of-hours GPs, some specialised and very different skills are needed when working out of hours.	GPs in training currently receive limited exposure to provision of out-of-hours care. Enhanced GP training will provide increased emergency care training and out-of-hours experience so that new GPs are competent and safe to work in out-of-hours primary care settings on completion of training.

Potential future impacts on patients and the health service if GP training is not enhanced:

- Undertrained GPs who will be unable to deliver high-quality or cost-effective primary care services in- and out-of-hours in the complex healthcare environment of the future
- Risk of inadequate care for care home residents resulting in poorer health outcomes, medicines wastage, and inappropriate use of hospital beds and secondary care services
- Increased health inequalities for those from socially disadvantaged populations, with associated increased morbidity, mortality and healthcare costs
- Failure to tackle high level of complaints regarding inconsistent or poor standards of some out-of-hours care services
- Wastage of resources and unnecessary pressure on unscheduled care services such as Accident and Emergency Departments and the Ambulance Service.

How GP training will change to meet this outcome:

- All GP trainees will receive enhanced clinical training in child health, mental health, drug and alcohol misuse, urgent care, rehabilitation and care of older people (as described in outcomes 1.1–1.5), resulting in improved primary care services both in- and out-of-hours
- All GP trainees will receive emergency care training and, during their primary care placements, will gain a 33–50% increase in out-of-hours experience by working regular sessions with out-of-hours providers
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which could be focused on improving the practice's processes and systems to enhance patient care (e.g. improving prescribing in local nursing homes)
- In ST4, all GP trainees will complete a Quality Improvement Project, which could be focused on improving the quality of local in- or out-of-hours services
- The relevant RCGP curriculum statements will be updated to support the learning of the required competences (affects multiple statements)
- The MRCGP assessments will be updated to assess the skills in the effective use of resources that are now expected of doctors entering general practice.

Outcome 3.2: Increased co-ordination and leadership of multidisciplinary teams

'We want GPs and hospital consultants to learn together and from each other, and from patients; to communicate directly person-to-person with each other for the benefit of patients and their families... 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.'

Baroness Finlay, Chair of Independent Commission on Generalism, 2011[78]

The educational challenge			How enhanced GP training will address this challenge
1	**Engage GPs in the leadership of quality improvement**	Research evidence shows a link between the engagement of doctors in leadership and the quality of services. The education and development of doctors as leaders therefore needs to be linked to appropriate incentives and career structures. While this has happened in many secondary care specialties, the opportunities for leadership training in the current three- year GP training is very limited and patchy. It is therefore essential to incorporate further leadership training opportunities into an extended GP training programme, in order to ensure the effective engagement of this large section of the medical workforce.	There are around 10,000 trainees in general practice training programmes in the UK. Enhanced GP training will require each trainee to lead and manage a quality improvement project as a key component of their overall training programme. Darzi Fellowships in Clinical Leadership have demonstrated the value of the junior medical workforce in this regard. This is an untapped resource and, given the large numbers of trainees involved, will make a major contribution to the quality, innovation, productivity and prevention (QIPP) agenda.
2	**Take responsibility for continuity across many disease episodes over time and co-ordinate care across health organisations**	GPs need the skills and experience to operate effectively across the many boundaries that exist within the health and social care system. This gives them a unique responsibility for promoting continuity and integration of care and support for people in need, and for achieving optimal cost-effective use of services.	Enhanced GP training will provide trainees with the opportunity to take responsibility for their patients' care over an extended period of time. This will enable increased focus on the development of the skills required to co-ordinate care; such as communicating freely and clearly with patients and professionals across health and social care boundaries.

78 Report of an Independent Commission for the Royal College of General Practitioners and The Health Foundation. *Guiding Patients through Complexity: Modern medical generalism* (2011). Accessed via: http://www.rcgp.org.uk/pdf/COMMISSION%20REPORT%20ON%20MEDICAL%20GENERALISM%20_rev_7%20OCTOBER%202011.pdf.

3	**Develop the skills required for leading and managing complex health organisations**	NHS care is increasingly delivered in ways that span systems and require teams to work across organisations, sites and interdisciplinary boundaries. In addition, patients expect more care to be delivered 'closer to home'. GPs must learn to work in these complex new systems of care, while managing the influences of increased competition, patient choice and consumer-led healthcare provision. Currently, however, GP training does not assess any competences at the organisational or service level of care.	Enhanced training will provide increased opportunities for team working, systems awareness and organisational literacy that will lead to increased quality and safety of healthcare. To facilitate this, trainees will engage in quality improvement initiatives both within and without the practice – this will require them to generate new ideas, set appropriate objectives, test and refine the proposed solutions, measure changes and ensure improvements are enacted at an organisational level.
4	**Contribute to the development of population-based interventions to prevent ill health and enhance wellbeing**	There is growing focus on improving the health of populations rather than just individuals. GPs have a duty to protect the needs of the vulnerable, the overlooked and the ignored, and to promote health and wellbeing. This will require GPs to think more broadly than focussing on individual patients and to develop a new range of skills to ensure that data about population needs and service utilisation covers all relevant population groups. They will also need to maintain effective working relationships with colleagues in a wide range of organisations.	Through enhanced training, GP trainees will gain opportunities to develop a perspective of health which is broader than their immediate practice. 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.

Potential future impacts on patients and the health service if GP training is not enhanced:

- Failure to engage the next generation of GPs in medical leadership, with profoundly damaging consequences for the NHS
- Missed chances to improve team working and communication, systems awareness and organisational literacy, leading to reduced quality and safety of healthcare
- Failure to develop GP leadership capacity in population health and service improvement will lower overall health outcomes.

How GP training will change to meet this outcome:

- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4, which will require a shared leadership approach within the multidisciplinary team
- In ST4, all GP trainees will complete an externally evaluated Quality Improvement Project (QIP) as part of the MRCGP, which will incorporate the development and assessment of leadership, quality improvement and change management competences. This will provide opportunities for trainees to work in partnership with community organisations, specialist teams, local authorities and others
- Examples of QIP activities that demonstrate leadership include contributing to the development or improvement of a service within the locality in which a trainee is training. This would require working effectively alongside hospital-based colleagues, healthcare managers, public health consultants and practitioners, interface-working with local government and social care and participating in public and patient consultation processes
- The RCGP curriculum statements *Patient Safety and Quality of Care*, *The GP in the Wider Professional Environment* and *Enhancing Professional Knowledge* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the leadership attitudes and skills now expected of doctors entering general practice.

Outcome 3.3: More effective engagement in the development of local services, working collaboratively with specialists and patients

'It is not enough to have excellent general practice. To a large extent, we already have that. No, we must go further and empower general practice to organise, to co-ordinate and to innovate beyond the confines of the practice.'

Andrew Lansley, Secretary of State for Health, 2010[79]

The educational challenge			How enhanced GP training will address this challenge
1	**Engaging with professional colleagues**	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.	Through the Quality Improvement Project, enhanced training will provide GP trainees with opportunities to learn the importance of engaging all relevant healthcare professionals in the evaluation and design of local systems of care, to understand the factors which promote professional engagement, to manage potential conflicts of interest and to employ appropriate strategies and behaviours to engage professionals locally.
2	**Engaging with patients and the public**	Patient-centred care and shared decision-making are now widely accepted as essential features of high-quality general practice. Similarly, patient and public engagement is regarded as an essential feature of high-quality commissioning. 'Public engagement' requires the ongoing, active participation of patients, carers, community representatives, community groups and the public in how healthcare services are planned, delivered and evaluated.	GP trainees will gain additional training on the sharing of information and decision-making with patients and carers. For example, this could be achieved through working with patient participation groups in practices and with local third sector and community-based patient organisations, such as Healthwatch. Enhanced training programmes will also help GPs to develop skills in translating data into meaningful intelligence about local needs and services.

79 Lansley A. Secretary of State for Health's speech to the Royal College of General Practitioners, 9th October 2010. Accessed via: http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_120666.

3	**Participating actively in needs assessment and service re-design**	GPs have a key role in assessing local health needs and in re-designing services to meet local priorities, ensuring that robust processes are used to do this. These processes should be informed by high-quality evidence and experience of innovative approaches to service delivery. GPs require a deep understanding of local health data, patient safety, quality improvement, efficiency and patient experience to design safe and cost-effective services.	The fourth year of enhanced training will provide GP trainees with the opportunity to learn about the impact of well designed systems on patient outcomes. For example, trainees could contribute to local efforts to redesign systems or processes of care, including the collection and auditing of feedback and other health data. They could also contribute to the local interpretation and application of evidence-based policies, guidelines, protocols and procedures in order to deliver high-quality community-based services. They could work to identify, analyse and communicate threats, risks and opportunities relating to the improvement of service quality in their local area and help to co-ordinate the collection of patients' data and views.
4	**Working collaboratively with a range of non-clinical colleagues and organisations**	To develop integrated services and to address the social determinants of ill health, GPs will increasingly need to work effectively with colleagues from a range of non-clinical backgrounds and organisations, such as public health bodies, local authorities and third sector organisations. They will need the ability to work flexibly with wider, looser teams and collaborative organisations and appreciate the contributions of these colleagues to local healthcare services.	To deliver these key skills, enhanced GP training will include opportunities to gain experience in relevant organisations – this could include commissioning groups (in England) and other commissioning organisations, public health organisations and other relevant community projects that are engaged in tackling local health needs. Trainees could undertake health needs assessment and health promotion projects within their practice populations. Working with local authorities (perhaps via the Health and Wellbeing Boards) and the voluntary sector would also be possible.

Potential future impacts on patients and the public if GP training is not enhanced:

- Failure to adapt the NHS to changes in population needs and expectations in the context of major incremental changes in demographics requiring a different focus of care in the community as well as increased health and social complexity
- Failure to take wider responsibility for the health of the local community within the available resources as part of leading clinical commissioning
- Inability of future GPs to work proactively with colleagues within wider community teams, including team members from local authorities
- Failure to extend the GP role beyond the one-to-one relationship with patients in the consulting room that is required for greater community involvement, empowerment and co-production
- Missed opportunities for GPs to engage with a more informed public
- Failure to work collaboratively within wider groups of practices to deliver improved access to the population and to make required changes to the business model of primary care
- Limited appreciation of the need for greater public health involvement in service redesign in order to reach a true understanding of concepts such as joint strategic needs assessment (JSNA).

How GP training will change to meet this outcome:

- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4. This will include a requirement to engage with professional colleagues and patients as appropriate
- In ST4, all GP trainees will complete a Quality Improvement Project (QIP) as part of the MRCGP, which will involve a need to work with professional colleagues across boundaries and engaging with patients and the public as appropriate. There will also be opportunities for trainees to engage in service re-design and improvement and to work with local commissioning organisations
- Examples of QIP activities based on service design and improvement include contributing to the development or improvement of a service within the locality in which a trainee is training. Such a service might be related to deprivation or an identified healthcare need. This would require the trainee to gain an understanding of the processes of service re-design and the importance of working effectively with local commissioning, provider and local government organisations and of engaging with public and patient consultation processes
- The RCGP curriculum statements *Patient Safety and Quality of Care*, *The GP in the Wider Professional Environment* and *Enhancing Professional Knowledge* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the population health and leadership attitudes and skills now expected of doctors entering general practice.

Outcome 3.4: Improved academic skills for evidence-based practice, innovation, quality improvement, education and research

'Research has not traditionally been a core component of general practice. Indeed, it has been viewed by many within the profession as having little relevance to practice at the coalface. Yet, paradoxically, it lies at the very heart of what we do.'

Professor Paul Wallace, University College London, 2010[80]

The educational challenge			How enhanced GP training will address this challenge
1	**Developing a robust academic skill set for general practice**	Over the past decade there have been numerous high-profile, evidenced reports calling for greater development of relevant academic skills in general practice in order to bring about improvements in healthcare service redesign, innovation, quality and research (see Supporting Evidence document 3). However, with the necessary focus on core clinical and generalist skills, GP trainees have insufficient time within current three-year training programmes to acquire and apply the essential academic, leadership and change management skills the health service now requires.	Introducing an academic skill set for all GP trainees will underpin the specific improvements in care identified across all the enhanced GP training outcomes. Improved skills in critical appraisal, audit and quality improvement will improve surveillance and the routine collection of data as well as the appropriateness and quality of the data collected. This in turn will enable the general practitioners of the future to provide their patients with a reasoned account of the basis for their advice, thus promoting better-informed decision-making, cost-effective practice and reduced patient harm.
2	**Developing academic skills in the critical appraisal and implementation of evidence-based practice improvements**	General practice requires effective use of the relevant evidence base in order to guide prevention, screening diagnosis and management. There is a need for GPs to acquire the necessary skills to understand how evidence is generated and to be able to interpret research findings appropriately. Following this understanding, GPs need to develop the academic and leadership skills and attitudes to initiate and maintain sustained changes in individual, team and organisational behaviour, thus achieving evidence-based practice.	Enhanced training in these areas will mean that future generations of practitioners will regard evidence-based service change as a natural part of continuing professional practice. This will fundamentally alter relationships with healthcare managers, resulting in collaborative healthcare delivery based on an alignment of values. Alignment of this sort has great potential for improving the efficiency with which doctors and managers work.

80 Wallace P. Research in general practice and primary care. *InnovAiT* (2010);3(5):298.

3	**Developing academic skills to facilitate innovation and quality improvement**	Patients rightly expect a high-quality healthcare service with access to the latest innovations. This is set against a background of growing complexity, with increasing multi-morbidity as the population ages and survival improves, and greater polypharmacy as more drugs are developed and incorporated into guidelines.	Raised awareness of innovation and a better base of skills will mean that patients will be increasingly served by proactive rather than reactive practitioners, who generate change at local level which is thereby tailored to local need. Enhanced training will enable trainees to engage in the concept and mechanism of change and to acquire the specific competences needed to generate it. They will have an opportunity to utilise these new skills in practice, to model and transmit this practice to others, and to contribute to the reporting of data on quality processes and outcomes.
4	**Increasing the impact of research in and on primary care**	The importance of research to practice is not perceived within primary care to the degree that it is within secondary care. The causes are multi-factorial but include the secondary care-based nature of much clinical research, the attitudes and skills of individual doctors, and the academic status of qualitative research. As a result, general practice is not perceived as an 'academic' discipline by the public – many patients with co-morbidities request to see a 'specialist' in one condition when an expert generalist would be more appropriate (and more cost-effective) for their needs.	By equipping all GP trainees with core academic skills, enhanced GP training will help to foster an academic culture in primary care, which will help attract high-quality trainees and promote critical reflection and innovation throughout the profession. Every general practice team has a duty to facilitate research and enhanced training will provide opportunities to stretch the most academically talented doctors and provide them with a launch pad for an academic career. A more robust academic approach will greatly help to reinforce a culture of excellence.

Key risks to patients and the public if GP training is not enhanced:

- Failure to bring about the required improvements in healthcare service redesign, innovation, quality and research
- Failure to apply evidence effectively in the community context, resulting in poor health outcomes and increased costs
- Failure to develop the skills needed to provide an increasingly knowledgeable and inquisitive patient population with the reasoned explanations and advice that they deserve
- Failure to understand and apply the skills required to initiate and sustain change
- Failure to attract sufficient numbers of the most able trainees into an academic career in general practice
- Failure to establish an academic culture in general practice, so reducing engagement in research, evidence-based healthcare and service improvement.

How GP training will change to meet this outcome:

- During the four-year programme, all GP trainees will receive additional training in academic skills, including critical appraisal, audit, change management and quality improvement
- All GP trainees will be expected to lead improvements in the organisational aspects of care in their practice in ST3–4. The scale of change need not be large, but should be tailored to local need based on an evaluation undertaken by the trainee. The whole process will also involve evaluation of the outcomes, thereby completing both an audit cycle and a change cycle
- In ST4, all GP trainees will complete a Quality Improvement Project (QIP), which will involve the application of academic skills to benefit patients and improve quality. This will provide opportunities for trainees to engage in academic activity and research. For example, work-based projects co-tutored with academic departments would allow trainees to develop some core Masters-level skills while undertaking critical work of direct relevance to improving the quality of the local health service
- All the academic activity undertaken by the trainee should be promulgated as widely as appropriate, thereby developing the trainee's skills in presentation, publication and dissemination and fostering a culture of continuous quality improvement. This could be as simple as local cascade by email/poster, personal presentations to groups, or formal publication
- The RCGP curriculum statements *Patient Safety and Quality of Care*, *The GP in the Wider Professional Environment* and *Enhancing Professional Knowledge* will be updated to support the learning of the required competences
- The MRCGP assessments will be updated to assess the academic skills now expected of doctors entering general practice.

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