

General  
Medical  
Council

# Recognising and approving trainers: a consultation

General  
Medical  
Council

Regulating doctors  
Ensuring good medical practice



# Contents

<b>About this consultation</b>	<b>02</b>
Why the consultation should matter to you	03
Consultation period	03
How to respond	03
<b>Background</b>	<b>04</b>
Why we are consulting	05
<b>Executive summary</b>	<b>06</b>
<b>Context</b>	<b>08</b>
The importance of training	08
Reviews and developments	09
Regulatory policy	10
Developing the proposals	11
The current legal position	12
<b>Objectives for recognising and approving trainers</b>	<b>14</b>
<b>Overview of the proposals</b>	<b>16</b>
Who will be covered by proposals to recognise and approve trainers?	17
<b>Scope of the recognition and approval of trainers</b>	<b>20</b>
<b>Management of trainers by local education providers</b>	<b>26</b>
<b>Identification of trainers by education organisers</b>	<b>32</b>
<b>The GMC's role</b>	<b>36</b>
Standards and guidance	36
Quality assurance	37
Considering identified trainers for approval	39
The information to be received	40
The scope of practice and revalidation	41
Indicating approval	41
<b>Conclusion</b>	<b>44</b>
Regulatory impact	44
Equality impact	45
Next steps	45
<b>About you</b>	<b>50</b>
Your details	51
Responding as an individual	52
Responding as an organisation	55
<b>Appendices</b>	<b>56</b>
Appendix A: Consultation questions	57
Appendix B: Mapping of the seven areas against GMC educational standards	59
Appendix C: Definition of a trainer in the context of proposals for recognition and approval	61
Appendix D: Task and finish group	63
Appendix E: Glossary	64
Appendix F: Resource implications	65

# About this consultation

The General Medical Council (GMC) is proposing new arrangements for recognising and approving trainers and in particular:

- a** named educational supervisors
- b** named clinical supervisors
- c** lead coordinators of undergraduate training
- d** doctors responsible for overseeing students' educational progress.

We will use our existing standards structured into seven areas. Local education providers such as hospitals and general practices would use the seven areas to show how they identify, train and appraise these trainers. Postgraduate deaneries and medical schools would then use that information to show the GMC what local arrangements are in place to meet our standards.

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## Why the consultation should matter to you

We believe that our proposals provide a structure that will add value while involving minimal additional effort or resource for our partners.

We want to hear from trainers, students and trainees, healthcare providers, deaneries, medical schools and medical royal colleges.

The issues our consultation covers are technical, but we also welcome comments from patients and members of the public.

We need to hear whether we have struck the right balance between:

- a building on the best existing arrangements, and
- b providing a structure so those arrangements become standard in all fields of medical training across the UK.

## Consultation period

The consultation runs from Friday 6 January 2012 to Friday 30 March 2012. We will publish the results in summer 2012.

## How to respond

You can respond to the consultation online at <https://gmc.econsultation.net/econsult/default.aspx>.

Or you can download, complete and return this document to us at:

Trainers consultation  
Education Directorate  
General Medical Council  
Regents Place  
350 Euston Road  
London NW1 3JN

Email: [trainersconsult@gmc-uk.org](mailto:trainersconsult@gmc-uk.org)  
Telephone: 020 7189 5283

If you have any questions or would prefer to respond to the consultation in an alternative format, let us know and we will do our best to accommodate you.

# Background

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We protect the public by ensuring proper standards in the practice of medicine. We do this in several ways.

- By controlling entry to and maintaining the list of registered and licensed medical practitioners.
- By setting the standards for all stages of medical education and training and ensuring that those standards are met.
- By determining the principles and values that underpin good medical practice.
- By taking firm but fair action against doctors' registration where the standards of *Good Medical Practice* have not been met.

This consultation relates to the second of our functions.

## Why we are consulting

Most trainees are very satisfied with their training and their practical experience, largely due to the commitment and enthusiasm of their trainers.

General practice has shown the way in developing a systematic approach to high quality training. This has included the GMC formally approving general practice (GP) trainers of GP registrars. We need now to move towards the same kind of system for those working outside general practice and in undergraduate education.

We intend to take significant steps to enhance the **recognition** of trainers while we obtain the legal authority for GMC **approval** of trainers beyond general practice.

# Executive summary

- 1 We are proposing new arrangements for the recognition and approval of trainers.
- 2 The proposals relate to:
  - a named educational supervisors in postgraduate training
  - b named clinical supervisors in postgraduate training
  - c lead coordinators of undergraduate training at each local education provider
  - d doctors responsible for overseeing students' educational progress for each medical school.
- 3 The proposals therefore would not cover other doctors whose practice contributes to the teaching, training or supervision of students or trainee doctors. That essential contribution is important but does not need to be formally recognised or approved.
- 4 We will use our existing standards for postgraduate training set out in *The Trainee Doctor* and for undergraduate education in *Tomorrow's Doctors* (see Appendix B).

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- 5** We propose to use seven areas originally set out for postgraduate training by the Academy of Medical Educators to provide a structure:
- a** ensuring safe and effective patient care through training
  - b** establishing and maintaining an environment for learning
  - c** teaching and facilitating learning
  - d** enhancing learning through assessment
  - e** supporting and monitoring educational progress
  - f** guiding personal and professional development
  - g** continuing professional development as an educator.
- 6** Local education providers such as hospitals and general practices would use the seven areas to show how they identify, train and appraise trainers in each of the four categories above. Postgraduate deaneries and medical schools would then use that information to show the GMC what local arrangements are in place to meet our standards.
- 7** We already approve GP trainers and our proposals build on these arrangements. We need new legal powers to be able to approve other trainers. In the meantime, we believe that more formal arrangements for recognising trainers will help to make sure that local education providers, deaneries and medical schools are meeting our standards for the seven areas. We do not intend to hold the names of the recognised non-GP trainers but would ensure that the medical schools and the deaneries were doing so.
- 8** Particularly at a time of resource constraint, we aim only to protect and enhance the status of training. We believe that our proposals, which build on existing arrangements, support that aim by providing a structure that will add value while involving minimal additional effort or resource for our partners.
- 9** We want to hear from trainers, students and trainees, healthcare providers, deaneries, medical schools and medical royal colleges. The issues our consultation covers are technical, but we also welcome comments from patients and the public.
- 10** We need to hear whether we have struck the right balance between:
- a** building on the best existing arrangements, and
  - b** providing a structure so those arrangements become standard in all fields of medical training across the UK.

# Context

## The importance of training

- 11 The quality of medical practice and the safety of patients are crucially dependent on the quality of the training provided to medical students and trainees in health and social care settings.
- 12 Training involves developing the knowledge and skills of students and trainees and making links between specific medical tasks and their scientific underpinning. It also involves developing the professionalism of students and trainees including how they relate to patients and to colleagues. It involves explaining, demonstrating, supervising and, perhaps above all, being a good role model of the values and principles set out in our core guidance *Good Medical Practice*.
- 13 Most trainees are very satisfied with their training and their practical experience, largely due to the commitment and enthusiasm of the trainers. Trainers are taught the theory and practice of medical education, and are supported and developed through systems of appraisal and periodic review and through the work of bodies including medical schools, deaneries, medical royal colleges and faculties, the Higher Education Academy, the Academy of Medical Educators (AoME) and the National Association of Clinical Tutors (NACT UK) as well as the GMC.

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**14** General practice has shown the way in developing a systematic approach to high quality training, due to the efforts over several years of GP education directors in postgraduate deaneries, the Royal College of General Practitioners (RCGP) and the former Joint Committee on Postgraduate Training for General Practice (JCPTGP). This has included the GMC formally approving GP trainers so that we now hold a list of approved GP trainers that we use in our regulation of medical education and training. We now need to move towards the same kind of system of approving trainers for those working outside general practice.

## Reviews and developments

**15** Although standards of education and training are high and major progress has been made in recent years, there is still room for improvement.

**16** Some reports have drawn attention to the challenges and shortcomings. We commissioned research from Dr Jan Illing and others on how prepared medical graduates were for starting work as a doctor, and their report stressed the importance of effective training in clinical placements. Professor John Collins made wide-ranging recommendations in his report *Foundation for excellence – an evaluation of the Foundation Programme*. There have also been reports on specialty training particularly in relation to restrictions on working hours. Dr Ian Wilson reported on *Maintaining quality of training in a reduced training opportunity environment* in 2009. Professor Sir John Temple reported on *Time for training – a review of the impact of the European Working Time Directive on the quality of training* in 2010 and recommended: 'Consultants formally and directly involved in training should be identified'; and 'They must be trained, accredited and supported'. Underlying these reports is a concern that

effective training can be compromised by pressures on the health services.

**17** Concerns have also been documented through the quality assurance activities of the GMC and previously the Postgraduate Medical Education and Training Board (PMETB). And our annual national training surveys, which allow individual trainers to highlight issues, have identified areas for improvement.

**18** The Secretary of State for Health has asked Medical Education England (MEE) to consider options through the Better Training, Better Care programme. The task force includes representatives from Northern Ireland, Scotland and Wales. The role of trainers is one of the areas that will be considered.

**19** In April 2011, MEE circulated a set of draft quality indicators for the commissioning of medical education and training in England. Appropriate metrics for undergraduate placements are likely to be based on those developed by NHS Education for Scotland (NES). As MEE stated:

*'...The quality indicators also reflect the metrics being developed by the Joint Academy and COPMeD [Conference of Postgraduate Medical Deans] Training Advisory Group (JACTAG). JACTAG are looking at the desirability and feasibility of developing a nationally (UK) consistent set of measures for quantitatively assessing the quality of medical education and training provided by: an individual training post; a group of posts; and an individual local education provider.'*

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- 20** MEE's draft quality indicators covered, for example, board level engagement in education and training, safe supervision and time for trainers to train. Most directly relevant was selection, appointment and review of trainers with the following measures.
- a** *'Trainers are appointed to the role against agreed criteria.'*
  - b** *'Trainers have appropriate induction into the curriculum that applies to their learners and its requirements of them and of the learner.'*
  - c** *'Trainers are trained and "calibrated" in the assessments that they are required to conduct for their learners (eg work place based assessments).'*
  - d** *'Trainers have their education role and responsibilities included in their job descriptions and their expected competencies defined in their job specification. Their educational role is explored in their NHS appraisal and that role is included in their revalidation as a doctor.'*
  - e** *'Each trainer has current approval, and those who do not adequately fulfil their role as trainers do not continue in that role.'*
  - f** *'The local education provider is able to demonstrate that there is a sufficient supply of trainers/ training posts/ placements to meet deanery and medical school requirements.'*
  - g** *'The LEP is able to demonstrate that the educational development of trainers is integrated in the LEP education plan.'*
  - h** *'The LEP is able to demonstrate that medical education is being discussed meaningfully at trainer appraisal and [that] job plans [are] being designed to accommodate educational activity.'*

- 21** In developing our proposals for recognising and approving trainers, we drew on existing and developing documents and procedures such as:

- a** guidance for trainers including a competence framework produced by the Northern Ireland Medical and Dental Training Agency (NIMDTA)
- b** the responsibilities of educational supervisors and clinical supervisors as identified by NES
- c** development of an agreement setting out the responsibilities of the Wales Deanery, local health boards and individual educational supervisors.

- 22** The proposals to recognise and approve trainers build on our standards for training and our quality assurance activities. They will help to address some of the concerns raised through recent reports and quality assurance activities. And they will fit well with the rest of the Better Training, Better Care programme and with the development of quality indicators.

## Regulatory policy

- 23** Alongside approving GP trainers, the GMC and PMETB (until this merged with the GMC) have for some time set standards for trainers including how they should be trained.
- 24** Current plans for recognising and approving trainers more generally grew out of PMETB's Future Doctors review. The importance of bringing the regulation of specialty trainers in line with that for GP trainers was addressed by working groups on educating tomorrow's doctors and on the role of the regulator. *The Future Doctors* policy statement, published in October 2009, included a commitment:

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*'PMETB will develop a process for the accreditation of all trainers, including those in hospital settings. PMETB will work with interested stakeholders, including the medical Royal Colleges and Faculties, the postgraduate deans and the Academy of Medical Educators.'*

- 25** The issue was then picked up in the GMC and PMETB review of the regulation of medical education and training led by Lord Patel. The final report, published in March 2010, discussed the 'perceived inequality' in the arrangements for GP trainers and for trainers in secondary care:

*'...the learning environment and systems of supervision should be the same in educational terms. Further, those who are recognised as trainers need to be allocated the time and resources necessary for their role, and must be accountable for the way they carry it out... Work towards the accreditation of trainers should build on that already undertaken by the Academy of Medical Educators and others in this area. It must also be proportionate and avoid imposing regulatory burdens which might deter good trainers from involvement in teaching and training.'*

- 26** The GMC has maintained this direction of travel as set out in our *Education Strategy 2011–2013*:

*'By 2013, we will have developed and implemented an approvals framework for all trainers of undergraduate and postgraduate learners, building on the process for selecting, training and appraising GP trainers. It will promote and enhance the value of training both in individual job plans and within the organisations that employ doctors involved in training.'*

- 27** The strategy also states that we will decide whether we should approve the educational environments in which doctors train. We will take this forward separately as part of our review in 2012 of our framework for quality assuring medical education and training.

- 28** We have also been developing proposals on learning and assessment in the clinical environment covering supervised learning events and assessments of progress. These proposals have implications for the role of trainers but are not mandatory standards so do not need to be considered alongside processes for the recognition and approval of trainers.

## Developing the proposals

- 29** We set up a task and finish group to develop proposals for the approval of trainers. The group was chaired by Mrs Enid Rowlands, a member of the GMC. The group included members from all four nations of the UK. It brought together representatives of the GMC, medical schools, postgraduate deaneries, medical royal colleges including the Trainee Doctors Group of the Academy of Medical Royal Colleges, the British Medical Association (BMA), employers, NACT UK, foundation school directors and AoME. A full list is given in Appendix D.

- 30** In addition, we met with a range of UK-wide bodies. These include the BMA Staff, Associate Specialists and Specialty Doctor Committee (the SAS Committee), the RCGP and the Committee of General Practice Education Directors (COGPED), the Conference of Postgraduate Medical Deans (COPMeD) and data managers for the postgraduate deaneries, the Medical Schools Council Education Sub-Committee, NACT UK and the Medical Workforce Forum.

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**31** The work has been supported by desk research on the wealth of existing processes and documents that support the quality of medical training. This has allowed us to reflect on the extensive work of many organisations including:

- a** postgraduate deaneries in England and Wales
- b** NIMDTA
- c** NES
- d** medical schools
- e** medical royal colleges
- f** NHS Employers
- g** the BMA
- h** NACT UK
- i** AoME.

**32** We have also considered the resource implications of existing arrangements, drawing on our own training surveys and an additional survey by NACT UK. We have piloted our proposals with postgraduate deaneries and medical schools. In addition, the proposals build on the existing arrangements for approving GP trainers developed largely by the RCGP and COGPED (see Appendix F).

**33** In developing our proposals, we have taken on board the various contexts in which training takes place including primary, secondary and other professional environments; undergraduate and postgraduate learners; trainers at various grades; and the four nations of the UK.

**34** This work helped to define a trainer and the restricted focus of our proposals for recognising and approving trainers (Appendix C). The group agreed to rely upon the GMC's existing standards for trainers and the top-level structure of seven areas suggested in a document prepared by AoME, itself developed through extensive research and development.

**35** The group's proposals were considered by the GMC's Undergraduate Board and Postgraduate Board, which both include representatives of the GMC's partners in medical education and training. The GMC's Council agreed publication of this consultation document on 14 December 2011.

## The current legal position

**36** We do not currently have statutory powers to approve trainers other than GPs providing training for GP registrars. However, we have powers to promote and establish standards, to secure effective instruction for medical students, to recognise programmes for training of provisionally registered doctors, and to approve courses and programmes for postgraduate training. These powers are enough for us to take significant steps to enhance the **recognition** of trainers while we obtain the legal authority to **approve** trainers beyond general practice.

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**37** Section 5(1) of the Medical Act states: 'The General Council shall have the general function of promoting high standards of medical education and coordinating all stages of medical education.' Section 5(2)(a) states that the GMC shall 'determine the extent of the knowledge and skill which is to be required for the granting of primary United Kingdom qualifications and secure that the instruction given in or under the direction of bodies or combinations of bodies in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent.'

**38** Section 10A states:

- '(1) For the purposes of this Act, "acceptable programme for provisionally registered doctors" means a programme that is for the time being recognised by the General Council as providing a provisionally registered person with an acceptable foundation for future practice as a fully registered medical practitioner.*
- '(2) In connection with recognising programmes for provisionally registered doctors as mentioned in subsection (1) above, the General Council may determine...*
- '(c) the content and standard of programmes for provisionally registered doctors...'*

**39** Section 34H(1) of the Medical Act states: 'The General Council shall—

- (a) establish standards of, and requirements relating to, postgraduate medical education and training, including those necessary for the award of a CCT in general practice and in each recognised specialty;*

- (b) secure the maintenance of the standards and requirements established under paragraph (a); and*

- (c) develop and promote postgraduate medical education and training in the United Kingdom.'*

**40** Section 34I(1) states:

*'In order to secure the maintenance of the standards and requirements established under section 34H(1)(a), the General Council may approve—*

- (a) courses or programmes of postgraduate medical education and training (or part of such a course or programme) which the General Council are satisfied meet, or would meet, the standards and requirements established under section 34H(1)(a);*
- (b) training posts which the General Council are satisfied meet, or would meet, the standards and requirements established under section 34H(1)(a);*
- (c) general practitioners whom the General Council consider to be properly organised and equipped for providing training for GP Registrars;*
- (d) examinations, assessments or other tests of competence.'*

# Objectives for recognising and approving trainers

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41 Having a formal way to recognise and approve trainers is an important step forward. Our objectives are to:

- a help to ensure the safety of patients and trainees and enhance the training environment
- b improve the quality of training particularly in relation to:
  - i assessment decisions

- ii trainers as role models to trainees
- iii the training of trainers
- iv lines of accountability and responsibility
- c improve links between the regulator and the postgraduate deaneries and medical schools that organise local education processes
- d enhance the perceived value and visibility of the training role and focus attention on the professional time needed and on the transparency of the resources available.

**Question 1:** Have we identified appropriate objectives for recognising and approving trainers?

Yes

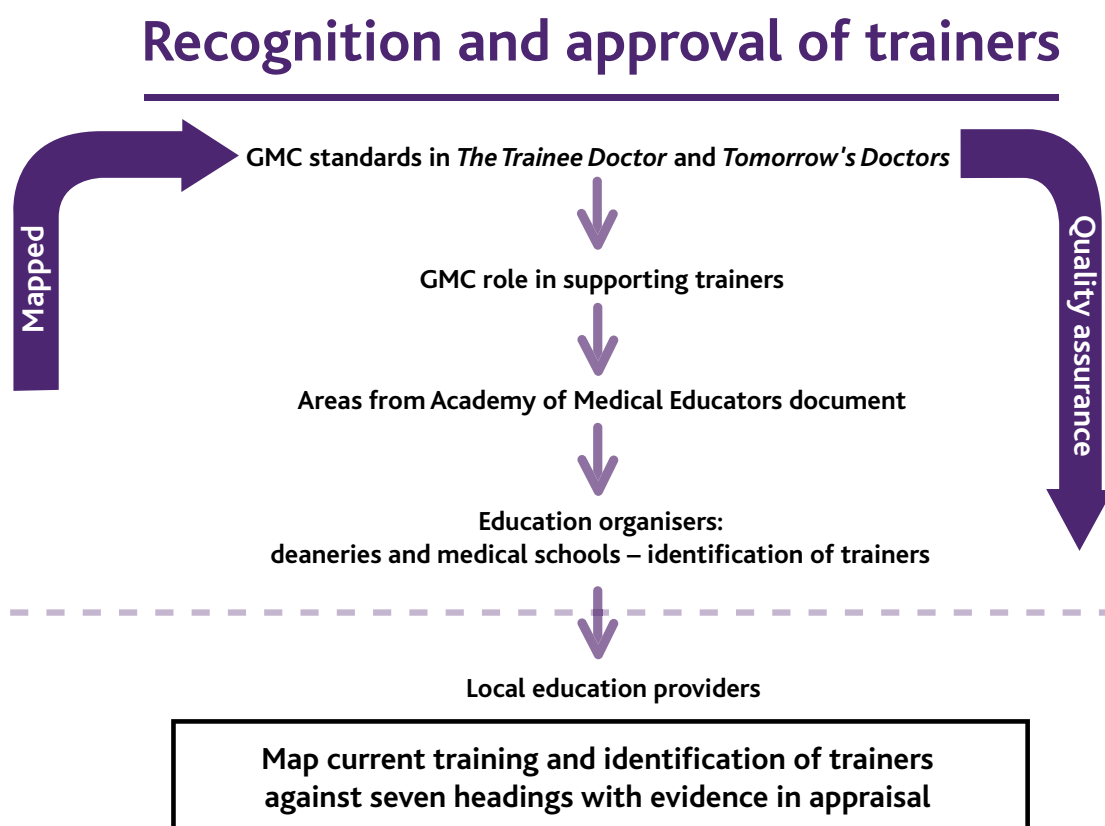
No

Not sure

If not, what should the objectives be?

# Overview of the proposals

42 An overview of the proposals is summarised in this diagram.



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- 43** The keystone will be the GMC's standards for trainers as set out in *The Trainee Doctor* for postgraduate training and *Tomorrow's Doctors* for undergraduate education. The standards apply across primary and secondary care and to training in the independent sector as well as NHS institutions. No additional standards will be developed to introduce the proposed arrangements.
- 44** The broad approach of the GMC's standards is well-established. PMETB's 2006 *Generic standards for training* required that educational supervisors and GP trainers be trained, along with other professionals in supervisory roles. Indeed, PMETB required postgraduate deaneries to provide details of the training received by all educational supervisors and clinical supervisors. *The New Doctor* required that trainers in the Foundation Programme be appropriately appointed, trained and appraised against their educational activities and the deaneries were assessed against that standard from August 2007. Similarly, the requirements in the current 2009 edition of *Tomorrow's Doctors* followed the 2003 edition which stated that all staff should take part in development programmes to promote teaching and assessment skills.
- 45** In addition to the current educational standards for trainers, all doctors need to comply with our professional guidance. *Good Medical Practice* includes guidance on training and has been under review with publication of a new edition expected in late summer or early autumn 2012. *Management for doctors* is also relevant with publication of new guidance expected in early 2012.
- 46** Having already determined the educational standards, we will set out in this document proposals for recognising and approving trainers. As now, we will make the final decisions on the approval of GP trainers of GP registrars.
- 47** In due course, once we have secured the additional legal powers to do so, we will also make the final decisions on the approval of other trainers. For postgraduate training, approval will from that point be required for doctors acting as named educational supervisors and named clinical supervisors. For undergraduate education, approval will from that point be required for doctors acting as the lead coordinators of undergraduate training at each local education provider and for those responsible for overseeing students' educational progress at each medical school. In the meantime, we do not intend to hold the names of the recognised trainers but would ensure that the medical schools and the deaneries were doing so.

## Who will be covered by proposals to recognise and approve trainers?

### Undergraduate education

- Those responsible for overseeing students' progress at each medical school
- Lead coordinators at each local education provider

### Postgraduate training

- Named educational supervisors
- Named clinical supervisors

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- 48** To be recognised or approved, trainers will need to meet the standards we set, as mapped against the seven areas in the *Framework for the professional development of postgraduate medical supervisors* ([www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-4267-31A42C8B64F0D3DE/showMeta/0/](http://www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-4267-31A42C8B64F0D3DE/showMeta/0/)) from AoME. AoME's framework was produced following a request from the UK departments of health to help define training requirements for educational supervisors and to explore options for accreditation and performance review. AoME developed the framework from evidence including a literature review, focus groups, survey data and input from stakeholders.
- 49** AoME's framework covers seven areas:
- a** ensuring safe and effective patient care through training
  - b** establishing and maintaining an environment for learning
  - c** teaching and facilitating learning
  - d** enhancing learning through assessment
  - e** supporting and monitoring educational progress
  - f** guiding personal and professional development
  - g** continuing professional development as an educator.
- 50** These seven areas apply to the training of medical students as much as trainee doctors. In Appendix B, they have been mapped against the standards we set in both *Tomorrow's Doctors* and *The Trainee Doctor*. While AoME's framework includes additional detailed guidance, the standards for recognition and approval are those already determined by the GMC.
- 51** Postgraduate deaneries (or any bodies that acquire the responsibilities of postgraduate deaneries in due course) will be responsible for identifying their trainers. Similarly, medical schools will identify the relevant trainers of medical students. So we are describing both the postgraduate deaneries and the medical schools as 'education organisers'. They will need processes by which to determine how suitable individual trainers are, in terms of our standards as mapped against the seven areas.
- 52** Postgraduate deaneries will continue to give us information about the GP trainers who should be approved. Once we obtain wider legal powers to approve trainers, education organisers will need to supply us with information about all trainers requiring approval.
- 53** In practice, the education organisers will rely on information collected by local education providers, including hospitals and primary care organisations. The local education providers too will need processes to identify, train and appraise suitable trainers that refer to our standards as structured by the seven areas.
- 54** We will then quality assure those processes against our standards as structured in the seven areas.

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**Question 2:** Does adopting the seven areas in the *Framework for the professional development of postgraduate medical supervisors* provide a suitable structure for quality assurance?

Yes

No

Not sure

If not, can you suggest an alternative?

# Scope of the recognition and approval of trainers

**55** Our proposals to set up arrangements to recognise and approve trainers need to be proportionate, so, for example, they will not cover doctors who help to train only intermittently in the course of their daily clinical practice. We will not create extra work for partners unnecessarily, but we do aim at the earliest opportunity to approve many trainers not covered by the current approval of GP trainers.

**56** We have defined a trainer at Appendix C. This starts with some general statements:

- a** A trainer is an appropriately trained and experienced doctor who is responsible for the education and training of medical students and/or postgraduate medical trainees which takes place in an environment of medical practice.
- b** A trainer provides supervision appropriate to the competence and experience of the student or trainee and training environment. He or she is involved in and contributes to the learning culture and environment, provides feedback for learning and may have specific responsibility for appraisal and/or assessment.

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**57** Key characteristics of trainers are therefore being responsible for training in clinical environments, providing supervision and feedback, and contributing to the learning culture.

**58** However, recognition and approval of trainers won't apply to all doctors who are covered by those general statements. Instead, recognition and approval in postgraduate training will apply to the roles of named clinical supervisor and named educational supervisor.

**Named clinical supervisor:** a trainer who is responsible for overseeing a specified trainee's clinical work for a placement in a clinical environment and is appropriately trained to do so. He or she will provide constructive feedback during that placement, and inform the decision about whether the trainee should progress to the next stage of their training at the end of that placement and/or series of placements.

**Named educational supervisor:** a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement and/or series of placements. Every trainee must have a named educational supervisor. The educational supervisor's role is to help the trainee to plan their training and achieve agreed learning outcomes. He or she is responsible for the educational agreement and for bringing together all relevant evidence to form a summative judgement at the end of the placement and/or series of placements.

**59** Deaneries should easily be able to identify which of their trainers our proposals apply to, while acknowledging variations in specialty training arrangements (ie who will need to be recognised and approved as trainers). These trainers should also be known by the trainees. This would fit with the requirements and definitions in *The Trainee Doctor*, the *Gold guide* and the *UK Foundation Programme reference guide*.

**60** Doctors can be a named educational supervisor or named clinical supervisor without actively performing those roles all of the time. They must, though, maintain their skills by continuing to reflect on those roles – for example, through continuing professional development. This will need to be confirmed through their appraisal.

**61** Recognition and approval arrangements for postgraduate training will only apply to named educational supervisors and named clinical supervisors (as defined above). They will not extend to other doctors who are present or on-call and in that sense responsible for supervising the work of trainee doctors in individual sessions.

**62** Named educational supervisors and named clinical supervisors will mostly be working in clinical practice but may sometimes work in areas of medical practice such as public health medicine, occupational medicine and pharmaceutical medicine. Clearly trainers in public health who are not doctors will fall outside the scope of the GMC's proposals but it would be good practice for the education organisers to expect training to the same standard.

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- 63** Named educational supervisors and named clinical supervisors may be GPs, consultants or staff, associate specialist or specialty (SAS) doctors. Recognition and approval will underline their essential contribution and contribute to the fair and equitable recognition of training responsibilities.
- 64** It is important that trainers of medical students are covered. The benefits of recognition and approval in terms of the support and status for trainers should not be restricted to postgraduate training. However, the terms educational supervisor and clinical supervisor are less commonly used in relation to undergraduate training.
- 65** Medical schools should be able easily to identify one or more doctors at each local education provider responsible for coordinating the training of students, overseeing their activities and ensuring these activities are of educational value. In addition, it would be appropriate for schools to identify those responsible for overseeing students' trajectory of learning and educational progress: they might be NHS consultants or clinical academics acting as block or course coordinators for clinical aspects of the course. So recognition and approval of undergraduate trainers would cover the lead coordinators of undergraduate training at each local education provider and also those responsible for overseeing the educational progress of students. Students should also be able to name both these individuals responsible for their training. In practice many of the individuals concerned may already be named clinical supervisors or named educational supervisors in postgraduate training.
- 66** Given the wide variety of training arrangements, we expect that it will not always be clear whether a given individual should be recognised and approved. Wherever there is doubt, we would like to be contacted so that we can give advice and build up a log of borderline training responsibilities. With this evidence base we will be able to consider whether we need to provide more detailed guidance.

**Question 3a:** For postgraduate training, is it appropriate to restrict the proposed arrangements to named educational supervisors and named clinical supervisors?

Yes

No

Not sure

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**Question 3b:** Will people understand the terms 'named clinical supervisors' and 'named educational supervisors'?

Yes

No

Not sure

Any comments on question 3?

**Question 4a:** For undergraduate training, is it appropriate to cover the lead coordinators of undergraduate training at each local education provider as well as those responsible for overseeing students' educational progress at each medical school?

Yes

No

Not sure

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**Question 4b:** Will people understand the terms 'lead coordinators of undergraduate training at each local education provider' and 'those responsible for overseeing students' educational progress at each medical school'?

Yes

No

Not sure

Any comments on question 4?

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

Yes

No

Not sure

Any comments?

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

Yes

No

Not sure

Any comments?

# Management of trainers by local education providers

**67** Local education providers are responsible for the settings in which training is delivered. Local education providers therefore have key responsibilities for organising high quality training and will be critical to the implementation of the proposed arrangements.

**68** Local education providers will need to cooperate with education organisers to ensure that the standards we set are achieved. Education organisers will need to agree with the local education providers where responsibilities lie. It needs to be clear who is responsible for ensuring that each local education provider collects a database of key information for all named clinical supervisors and named educational supervisors. The agreement should also ensure that the relevant education organiser is continually able to access the database.

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- 69** The local education providers will need to make sure that their arrangements satisfy the GMC's standards as mapped against the seven areas in AoME's document. This relates to:
- a** how named educational supervisors and named clinical supervisors are identified
  - b** how their responsibilities are reflected in job plans
  - c** how they are trained
  - d** how they are appraised
  - e** how the local education providers work and share information with the education organisers
  - f** how the local education providers use the resources they receive to support training.
- 70** Local recognition of trainers will help to shine a light on how training responsibilities are supported, for example in job plans, the availability of training for trainers and accountability for resources. This may be particularly helpful for trainers not in consultant or GP posts and for trainers of medical students.
- 71** These processes will add the most value if they draw on sound evidence, bring together information generated from various sources and support existing and potential systems for review and professional development.
- 72** Guidance to help local education providers includes the GMC's documents *The Good Medical Practice Framework for appraisal and revalidation* ([www.gmc-uk.org/doctors/revalidation/revalidation\\_gmp\\_framework.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp)) and *Supporting information for appraisal and revalidation* ([www.gmc-uk.org/doctors/revalidation/revalidation\\_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp)).
- 73** Local education providers will need to ensure that appropriate time is secured for training students and trainees. The BMA and NHS Employers have published *A guide to consultant job planning*, which sets out principles that should also apply to SAS doctors. Among other things, job planning should be 'reflective of the professionalism of being a doctor... consistent with the objectives of the NHS, the organisation, teams and individuals...flexible and responsive to changing service needs during each job plan year.'
- 74** The guide explains that supporting professional activities (SPAs) may include participation in training, medical education, continuing professional development and formal teaching: '*Like direct clinical care, all SPAs should be based on SMART [specific, measurable, achievable, realistic, timed] objectives and measurable outcomes. There should be clarity on the core content and expectations...It should be clear that time set aside for SPA activity should only be spent on those elements identified within the job plan and not on any other activity...Examples of NHS activity carried out in the clinical workplace and which require an SPA allocation may include clinical undergraduate teaching funded by Service Increment for Teaching (SIFT)...*'

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- 75** AoME's *Framework for the professional development of postgraduate medical supervisors* includes examples of supporting evidence and training suggestions for each of the seven areas as well as other helpful guidance. It could assist with the support and development of training of medical students as well as doctors in training grades.
- 76** Local education providers could also consider the GMC's advice on *Developing teachers and trainers in undergraduate medical education*. This covers the selection of teachers and trainers, support and recognition, development and training, and appraisal. There is also advice on *Clinical placements for medical students*, which covers aspects such as patient safety, induction and supervision. While these documents relate to undergraduate education, they may give food for thought on arrangements for postgraduate training as well.
- 77** Local education providers will need to share key information with the education organisers to ensure that good practice is recognised and that shortcomings are identified. In addition, the local education providers will need to consider and respond to information and advice from postgraduate deaneries about the quality of the training provided.
- 78** Local education providers' clinical tutors or directors of medical education will play a crucial role in linking local education providers with education organisers. It will be important to ensure that the responsibilities of clinical tutors or directors of medical education reflect arrangements for the recognition and approval of trainers. These responsibilities must include ensuring that training arrangements are mapped against the seven areas in AoME's *Framework for the professional development of postgraduate medical supervisors* and meet the GMC's standards.
- 79** Local education providers will need to take appropriate action where poor training is identified. Often remediation will resolve the difficulties, especially if they are addressed promptly. If not, it may be possible to agree with the individual that he or she will no longer act as a named educational supervisor or named clinical supervisor. Where agreement is not possible, the local education provider will need to liaise with the education organiser, probably through the clinical tutor or director of medical education. It may be necessary to prevent the individual from acting as a named educational supervisor and named clinical supervisor and remove him or her from the local education provider's database of recognised trainers. Clear appeals procedures will need to be put in place building on existing arrangements.

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**80** The required local education provider processes should largely exist. So the recognition and approval of trainers should help to ensure that current best practice becomes commonplace. We do not envisage that the recognition and approval of trainers will involve significant costs for local education providers, unless existing arrangements for managing the quality of training are not fully developed. There may be some costs in adapting systems to ensure that training arrangements can be mapped against the GMC's standards and the seven areas.

**81** Local education providers may need to work with the education organisers on grandparenting arrangements. This would involve developing databases of named educational supervisors and named clinical supervisors already in place. Local education providers and education organisers will also need to make sure that, over a reasonable period, existing named educational supervisors and named clinical supervisors meet the requirements that will apply to all doctors identified to carry out these roles once recognition and approval are in place. That will include the requirements of the local education providers and education organisers relating to trainers' participation in training.

**82** Some small local education providers will not have an internal infrastructure including directors of medical education. In these specific cases the education organisers may take on the responsibilities of the local education providers to ensure that trainers are properly identified and meet the appropriate standards as demonstrated through their appraisal. The details of how the various responsibilities are fulfilled will be for the local education providers and the education organisers to agree.

### **The responsibilities of local education providers include:**

- a** identifying trainers who meet the criteria for recognition and approval and maintaining databases that can be interrogated by education organisers
- b** supporting trainers and recognising the value of training through:
  - i** job plans
  - ii** appraisal
  - iii** support for the training and professional development of trainers
  - iv** dealing effectively with concerns
- c** taking effective action where training is poor and remediation is not sufficient
- d** mapping their arrangements in point b against the seven areas of AoME's *Framework for the professional development of postgraduate medical supervisors* and ensuring that the GMC's standards are met
- e** liaising with education organisers in accordance with agreed arrangements
- f** identifying the key responsibilities held by clinical tutors or directors of medical education.

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**Question 7:** Have we correctly identified the responsibilities of local education providers?

Yes

No

Not sure

**Question 8:** Should the GMC develop guidance for local education providers?

Yes

No

Not sure

Any comments on questions 7 and 8?

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

Yes

No

Not sure

Any comments?

# Identification of trainers by education organisers

**83** The term 'education organiser' covers medical schools and postgraduate deaneries (or any bodies that acquire the responsibilities of postgraduate deaneries in due course).

**84** The education organisers will be responsible for identifying the trainers who meet the criteria set by the GMC for recognition and approval. Once the legal powers are in place, the education organisers will pass this information to the GMC so that we can approve the trainers, subject to our own checks. In the meantime, the postgraduate deaneries will continue to provide us with information only about GP trainers requiring approval.

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**85** The education organisers must ensure that trainers and training meet the standards we set. Local education providers will need to satisfy education organisers that their processes, such as appraisal, meet the standards required by mapping the processes to the seven areas. Some local education providers may be covered by more than one education organiser – for example, a postgraduate deanery and a medical school – in which case it would not be necessary for the organisers’ quality management activities to be duplicated. As now, the education organisers will be subject to regulation by the GMC.

**86** In identifying the trainers needing recognition or approval, the education organisers will rely upon the databases kept by the local education providers and they will need continual access to that information.

**87** However, the education organisers should not simply accept the information in the local education providers’ databases. They will need to be confident that their identification of trainers who meet the GMC’s standards draws also on their own sources of information which may not have been available to or fully considered by the local education provider in employer appraisals.

This information might include, among other things:

- a the outcomes of any educational appraisals (although these should be reported to subsequent employer appraisals)
- b feedback received about individual trainers (for example, from students, trainees or other colleagues)
- c information about the training completed by the trainers.

**88** The education organisers will also be able to draw on information about the accreditation of trainers by appropriate bodies and derived from periodic professional reviews of the quality of training (which has developed in general practice for example). The royal colleges have well established systems for the training of trainers and the RCGP is closely involved in the existing systems for approval of GP trainers. Information could also be drawn from arrangements associated with AoME and the Higher Education Academy. The recognition and approval of trainers does not interfere with these arrangements, given their important contribution to the standard of training. On the contrary, recognition and approval will sit alongside, be informed by and emphasise the importance of local and specialty arrangements for supporting trainers that comply with the GMC’s standards and that may grant the beneficiaries an additional status conditional on specific professional requirements.

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**89** Education organisers may have concerns about particular trainers who are included in the local education provider's databases. The education organisers will need to liaise with the local education providers to address these concerns, probably through the clinical tutor or director of medical education. As stated above, remediation may be appropriate or it may be possible to agree with the individuals concerned that they should no longer act as named educational supervisors or named clinical supervisors. In the end, the education organisers must recognise only trainers who they are satisfied meet the standards we set and must keep the trainers and the local education providers informed about developments. The education organisers will need to establish appeal procedures against decisions not to recognise individuals as trainers building on existing arrangements.

**90** To carry out these functions effectively, the education organisers will need clear agreements with the local education providers about their respective roles and responsibilities, not least in relation to responding to concerns about individual trainers.

**The responsibilities of education organisers include:**

- a** identifying trainers who satisfy the GMC's criteria and standards for approval
- b** quality managing training arrangements at local education providers (or confirming that another education organiser is quality managing the arrangements) including the local education providers' mapping of the arrangements against the seven areas
- c** reviewing available information before deciding to identify individual trainers
- d** reaching agreements with local education providers on respective roles and responsibilities
- e** passing on information to the GMC about the GP trainers identified; and, once the GMC has the necessary statutory powers, also about the specialty trainers identified
- f** cooperating with quality assurance by the GMC.

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**Question 10:** Have we correctly identified the responsibilities of education organisers?

Yes

No

Not sure

**Question 11:** Should we develop guidance for education organisers?

Yes

No

Not sure

Any comments on questions 10 and 11?

# The GMC's role

## Standards and guidance

**91** The GMC sets the standards that must be achieved by individual trainers and organisations responsible for training. These standards are currently set out in the documents *Tomorrow's Doctors* for undergraduate education and *The Trainee Doctor* for postgraduate training. We will not be setting new standards for the purpose of recognition and approval of trainers. By 2013, we will begin a thorough review of our standards to ensure that they support excellence and are clear, proportionate, measurable and coherent. This may involve some changes to the standards for trainers.

**92** In addition, we issue guidance that might assist local education providers and education organisers. That includes the supplementary advice that we have provided on undergraduate education and the advice to support appraisal. We could issue guidance specifically on the recognition and approval of trainers if that would be helpful.

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## Quality assurance

**93** We quality assure education organisers against the standards that we have set. With the recognition and approval of trainers, that will involve examining how well the processes have been mapped against the seven areas.

**94** We take a range of approaches to quality assure postgraduate deanery processes for the recognition and approval of GP trainers.

- a** We have conducted annual surveys of trainers and trainees.
- b** We can receive information from the deanery reports or the annual specialty reports from the RCGP.
- c** A concern could be identified in our responses to concerns process.
- d** During visits we have interviewed trainees and local faculty who might have a view on the appropriateness of the educational or clinical supervision provided by GP trainers or the process of trainer approval.

**95** Recognition and approval will focus attention on relevant arrangements including the identification and training of trainers and the associated issues of job planning and financial transparency. These issues will be reviewed through the quality assurance systems set out in our *Quality Improvement Framework*. For example, regional programmes of visits will cover the systems in place at medical schools and postgraduate deaneries. Training arrangements could be addressed through a thematic review. The national training surveys will continue to produce evidence that can be considered at both national and regional levels.

The periodic returns from deaneries and medical schools could produce data on readiness and implementation of arrangements for the recognition and approval of trainers. Any problems could be addressed through our responses to concerns process.

**96** In 2011, we published a substantive analysis and report of the results from five years of training surveys. We have decided to survey trainees again in 2012. However, we are aware that the previous trainer surveys had a much lower response rate than those for trainees and, as a consequence, were not as valued by postgraduate deaneries. One element of the relatively low response rate is likely to be due to problems with the database of trainers, which could be resolved when education organisers identify trainers as part of the project on recognition and approval. Given that we would have obtained little additional information, we decided not to survey trainers in 2012, but to take stock of the results so far and take time to consider how best to gather information on trainers' perspectives and experiences. We do not intend to hold the names of the recognised non-GP trainers (before obtaining the legal power to approve them). So we would look to the deaneries to send out the trainer survey about postgraduate training, or possibly to upload via GMC Connect.

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**Question 12:** Should we do an annual survey of trainers?

Yes

No

Not sure

Any comments?

**Question 13:** How can we best gather information from trainers?

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

## Considering identified trainers for approval

**97** As noted above, the Medical Act provides a role for the GMC to decide whether to approve GP trainers identified by education organisers. It is anticipated that approval will continue to be granted to the vast majority of GP trainers. We intend that the requirement for GMC approval (or otherwise) will be extended to non-GP trainers once we acquire the necessary statutory powers.

**98** There will be some circumstances in which we might need to withhold or withdraw approval. In particular, approval of a trainer might be delayed, denied or removed if:

- a** the trainer does not hold valid registration and a licence to practise
- b** the trainer's registration has been removed or suspended by an interim orders panel (IOP) or a fitness to practise (FTP) panel
- c** following an IOP or a FTP panel decision, the trainer is subject to conditions or undertakings that make approval inappropriate
- d** the information supplied for approval is not correct.

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**99** We might withhold or withdraw approval from some doctors in relation to FTP investigations. We will check the registration status of trainers identified for approval and those already approved and consider the outcomes of any IOP or FTP panel hearings. If registration has been removed or suspended, a trainer will no longer be eligible for approval. Also, if following an IOP or a FTP panel decision there are conditions or undertakings on a doctor's registration that rule out training, the doctor could not be approved as a trainer.

**100** We will also need to consider the position should quality assurance processes establish that local arrangements and/or approved trainers do not satisfy the GMC's standards. Should that be the case, we would liaise with the education organisers to resolve the problems. That might occasionally result in the education organisers deciding no longer to identify particular individuals as meriting GMC approval as trainers.

**101** In extreme cases, it is conceivable that we may need to consider withdrawing approval of a medical school or a postgraduate course or programme that is not meeting our standards. (That is a continuation of the current position.)

**102** We also need to be able to withdraw approval from individual trainers where the standards are demonstrably not being met, although we hope and expect that education organisers would always take effective action to prevent this being necessary. Such a decision by the GMC, especially if affecting a collection of trainers, could clearly have serious consequences and would be wholly exceptional. Should we be minded to deny or remove approval of a trainer whose fitness to practise is questioned, it may be necessary for the doctor to be referred to FTP proceedings and a decision on approval would be made in light of the findings.

**103** In addition, issues may arise when we process an application for approval. For example, we may find inaccuracies when we review the information provided or there may be inconsistencies with other information we hold on the doctor – for example, their scope of practice.

## The information to be received

**104** Once the statutory powers are in place to approve non-GP trainers, we propose that the following categories of information will be required for each approved trainer and will be maintained by the GMC.

- a** The trainer's name and registration number – to avoid any confusion about the individual concerned.
- b** Where the training is delivered – so that links can be drawn with concerns (or good practice) at individual sites to take action where necessary. Trainers may train at more than one site.
- c** The education organiser responsible for the trainer – so that we can contact the education organiser where necessary. More than one organiser may be responsible where the trainer trains both students and trainee doctors and/or where the trainer's students or trainee doctors come from more than one medical school or deanery.
- d** Whether the training is provided in general practice, in a hospital setting or elsewhere – to help the GMC to analyse trends and focus regulatory attention on areas of greatest risk or potential benefit.

- 
- e Whether the training is provided to medical students, foundation trainees, specialty including GP trainees or some combination – to help us to analyse trends and focus our attention on areas of greatest risk or potential benefit.

**105** Some of this information will already be required for revalidation and identifying doctors' scope of practice. Other information is needed by postgraduate deaneries and medical schools for their own quality management purposes.

**106** Until we acquire new statutory powers, we intend to maintain the current arrangements relating to the information required from postgraduate deaneries about GP trainers.

## The scope of practice and revalidation

**107** Separate from the identification of trainers by education organisers, doctors have been submitting information to the GMC about their scope of practice, including their role in delivering training, in preparation for the implementation of revalidation in late 2012.

**108** It may in future be possible to align the process of recognising and approving trainers with the revalidation process. This will need further work and discussion following implementation of the recognition and approval of trainers. It is not necessary to achieve that alignment at this stage.

## Indicating approval

**109** Currently, we do not publish the names of the approved GP trainers, although in the interest of transparency we intend to do so in due course.

**110** We think we should aim for a position where approved trainers can be identified through the online List of Registered Medical Practitioners as this is developed in the future. This would help to enhance the profile, standing and visibility of training as a clear statement of the importance we attach to the responsibilities of trainers. However, this is potentially quite complex and is best taken forward in a later phase of work, once the approval of trainers is in place and operating satisfactorily.

### The responsibilities of the GMC include:

- a setting the standards for trainers and education organisers and keeping them up to date
- b providing guidance where appropriate
- c quality assuring training against the standards
- d making reasonable and evidence-based decisions on the approval of GP trainers who have been identified by education organisers (which will apply to specialty trainers once the necessary statutory powers are in place).

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**Question 15:** Are the existing standards for trainers appropriate?

Yes

No

Not sure

Any comments?

**Question 16:** Are the proposed quality assurance arrangements appropriate?

Yes

No

Not sure

Any comments?

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**Question 17:** Are the categories of information we are proposing to collect about approved trainers appropriate?

Yes

No

Not sure

Any comments?

**Question 18:** Should the recognition and approval of trainers be aligned with revalidation?

Yes

No

Not sure

Any comments?

# Conclusion

## Regulatory impact

- 111** High quality training is a prerequisite for high quality patient care.
- 112** The objectives for the recognition and approval of trainers are set out above (paragraph 41). As stated in the *GMC Education Strategy 2011–2013*, approval will promote and enhance the value of training both in individual job plans and in the organisations that employ doctors involved in training.
- 113** The recognition and approval of trainers will involve minimal additional cost since it uses existing standards and guidance, will draw on information that is already collected locally, and will build on the established and developing systems for the approval of GP trainers. Existing systems for identifying named educational supervisors are well developed and no difficulties are envisaged in identifying the lead undergraduate trainers who would be covered by recognition and approval as set out here. The picture may be more patchy in relation to identifying named clinical supervisors. The mapping of existing systems against the seven headings in AoME's document and against the

GMC's standards for trainers has already started, will have minimal cost to complete, and will support more focus on the quality of the training provided. There has already been significant investment to ensure that GP trainers, named educational supervisors and lead undergraduate trainers are properly trained. We expect that it will be possible within current levels of spending on training to also ensure that all named clinical supervisors are properly trained in accordance with our standards. However, reductions in total spending on the training of trainers would no doubt compromise the likelihood that our standards will be met.

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**114** See Appendix F for an assessment of the resource implications of the proposals including the outcome of piloting with postgraduate deaneries and medical schools.

## Equality impact

**115** There are a number of equality dimensions to the recognition and approval of trainers, not least the parity it will bring to the arrangements for GP trainer approval.

**116** The proposals respond to calls for a more fair and transparent process which formally identifies and recognises trainers and the contribution they make. It puts the responsibility on those accountable at local level for ensuring that they provide the necessary time and resources to support trainers both in terms of their training and when they are training others.

**117** Through the local application of the GMC's high level standards and requirements for trainers, the proposed arrangements should help promote greater consistency across the UK, for example, by clarifying lines of accountability and responsibility to ensure trainers are appropriately supported and appraised. Activity will be considered through our *Quality Improvement Framework*.

**118** The proposed arrangements will also ensure that SAS doctors are recognised for their role in training.

**119** As the arrangements develop, it will be particularly interesting to learn more about the demographics of the trainer population. This could be achieved through a periodic trainer survey that draws on the identification of trainers by the education organisers. Alternatively, or in addition, it would be possible to monitor the make-up of approved trainers by using the information collected by the GMC on doctors' gender, age, nationality and ethnicity. Any use of information would clearly need to be proportionate and legal – for example, in view of the Data Protection Act.

**120** We have done an equality analysis, which we will complete in light of the responses we receive to this consultation.

## Next steps

**121** We will introduce arrangements for the recognition of trainers using our existing powers for regulating medical education and training.

**122** We are seeking changes to the Medical Act to secure the most appropriate statutory support for the approval of trainers.

**123** In light of the response to the consultation, and subject to statutory powers, we will therefore proceed to introduce the recognition and approval of named educational supervisors, named clinical supervisors and lead undergraduate trainers as set out in this document, from the academic year 2013-2014. That should give education organisers and local education providers enough time to prepare for implementation. We recognise the pressures on healthcare and professional education systems across the UK and expect that the implementation of recognition and approval will enhance the perceived importance of medical training.

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**Question 19:** Will the proposed arrangements promote and enhance the value of training for individual doctors and organisations that employ doctors in training?

Yes

No

Not sure

**Question 20:** Will the proposed arrangements promote and enhance the value of training in individual job plans?

Yes

No

Not sure

Any comments on questions 19 and 20?

**Question 21a:** What are the main benefits and costs that will arise from our proposals?

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**Question 21b:** Do the benefits exceed the costs?

Yes

No

Not sure

Any comments?

**Question 22:** What will be the impact from the perspective of equality and diversity?

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**Question 23:** What will be the impact from the perspective of patient safety?

**Question 24:** Should we publish guidance on any aspects of the recognition and approval of trainers?

Yes

No

Not sure

If so, on which aspects?

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**Question 25a:** Is it appropriate to expect implementation of our proposals from the academic year 2013/14?

Yes

No

Not sure

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

# About you

# Your details

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Name

Job title (if responding on behalf of an organisation)

Organisation (if responding on behalf of an organisation)

Address (optional)

Email

Contact tel (optional)

Would you like to be contacted about GMC consultations in the future?

Yes

No

If you would like to know about upcoming GMC consultations, please let us know which of the areas of the GMC's work interest you:

Education

Standards and ethics

Fitness to practise

Registration

Licensing and revalidation

## Data protection

The information you supply will be stored and processed by the GMC in accordance with the Data Protection Act 1998 and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

# Responding as an individual

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Are you are responding as an individual?

Yes

No

If yes, please complete the following questions. If not, please complete the 'responding on behalf of an organisation' section.

Which of the following categories best describes you? (Please tick all that are appropriate)

**Doctor**

Clinical fellow/academic

Trainee

Consultant

Consultant locum

GP self-employed

GP salaried

Locum or sessional GP

Staff grade/specialty/associate specialist (SAS) doctor

Locum or sessional SAS

Researcher

Medical director or medical manager

Other doctor (please specify) \_\_\_\_\_

**Trainer or educator**  Educational supervisor

Clinical supervisor

Other trainer or educator (please specify) \_\_\_\_\_

**Other**  Medical student

Member of the public

Other healthcare professional

Other (please specify) \_\_\_\_\_

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**What is your country of residence?**

- England       Northern Ireland       Scotland  
 Wales       Other – European Economic Area       Other – rest of the world

**Information about you**

To help ensure that our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

**What is your age?**

- Under 25       25–34       35–44       45–54       55–64       65 and over

**Are you:**       Female       Male

**Would you describe yourself as having a disability?**       Yes       No

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**What is your ethnic origin?** (Please tick one)

**Asian or Asian British**

Asian or Asian British     Bangladeshi     Indian     Pakistani

Any other Asian background, please specify \_\_\_\_\_

**Black or Black British**

Black or Black British     African     Caribbean

Any other Black background, please specify \_\_\_\_\_

**Chinese or other ethnic group**

Chinese

Any other background, please specify \_\_\_\_\_

**Mixed**

White and Asian     White and Black African     White and Black Caribbean

Any other mixed background, please specify \_\_\_\_\_

**White**

British     Irish

Any other white background, please specify \_\_\_\_\_

# Responding on behalf of an organisation

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Are you are responding on behalf of an organisation?

- Yes  No

If yes, please complete the following questions. If not, please complete the 'responding as an individual' section.

Which of the following categories best describes your organisation?

- |   |   |
|---|---|
| <input type="checkbox"/> Body representing doctors      | <input type="checkbox"/> Body representing patients or public |
| <input type="checkbox"/> Government department          | <input type="checkbox"/> Independent healthcare provider      |
| <input type="checkbox"/> Medical school (undergraduate) | <input type="checkbox"/> Postgraduate deanery                 |
| <input type="checkbox"/> Medical royal college          | <input type="checkbox"/> NHS/HSC organisation                 |
| <input type="checkbox"/> Regulatory body                |   |
| <input type="checkbox"/> Other (please specify) _____   |   |

In which country is your organisation based?

- |  |                                  |   |
|--|----------------------------------|---|
| <input type="checkbox"/> UK wide                   | <input type="checkbox"/> England | <input type="checkbox"/> Scotland                       |
| <input type="checkbox"/> Northern Ireland          | <input type="checkbox"/> Wales   | <input type="checkbox"/> Other (European Economic Area) |
| <input type="checkbox"/> Other (rest of the world) |                                  |   |

## Freedom of information

The information you provide in your response may be subject to disclosure under the Freedom of Information Act 2000, which allows public access to information held by the GMC. This does not necessarily mean that your response will be made available to the public as there are exemptions relating to, for example, information provided in confidence and information to which the Data Protection Act 1998 applies. You may request confidentiality by ticking the box below. We will take this into account if a request for your response is made under the Freedom of Information Act 2000.

Please tick if you want us to treat your response as confidential

# Appendices

## Appendix A: Consultation questions

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- 1 Have we identified appropriate objectives for recognising and approving trainers?
- 2 Does adopting the seven areas in the *Framework for the professional development of postgraduate medical supervisors* provide a suitable structure for quality assurance?
- 3a For postgraduate training, is it appropriate to restrict the proposed arrangements to named educational supervisors and named clinical supervisors?
- 3b Will people understand the terms 'named clinical supervisors' and 'named educational supervisors'?
- 4a For undergraduate training, is it appropriate to cover the lead coordinators of undergraduate training at each local education provider as well as those responsible for overseeing students' educational progress at each medical school?
- 4b Will people understand the terms 'lead coordinators of undergraduate training at each local education provider' and 'those responsible for overseeing students' educational progress at each medical school'?
- 5 Does the scope of the recognition and approval of trainers properly reflect arrangements in all settings including primary and secondary care as well as clinical and non-clinical practice?
- 6 Does the definition in Appendix C properly reflect the training roles of GPs, consultants, SAS doctors and senior trainees?
- 7 Have we correctly identified the responsibilities of local education providers?
- 8 Should the GMC develop guidance for local education providers?
- 9 Should the GMC set a date by which the local requirements for grandparenting must be met by all the trainers who should be covered by these arrangements?
- 10 Have we correctly identified the responsibilities of education organisers?
- 11 Should we develop guidance for education organisers?
- 12 Should we do an annual survey of trainers?
- 13 How can we best gather information from trainers?
- 14 What are the most important topics to ask trainers about?
- 15 Are the existing standards for trainers appropriate?
- 16 Are the proposed quality assurance arrangements appropriate?

- 
- 17** Are the categories of information we are proposing to collect about approved trainers appropriate?
- 18** Should the recognition and approval of trainers be aligned with revalidation?
- 19** Will the proposed arrangements promote and enhance the value of training for individual doctors and organisations that employ doctors in training?
- 20** Will the proposed arrangements promote and enhance the value of training in individual job plans?
- 21a** What are the main benefits and costs that will arise from our proposals?
- 21b** Do the benefits exceed the costs?
- 22** What will be the impact from the perspective of equality and diversity?
- 23** What will be the impact from the perspective of patient safety?
- 24** Should we publish guidance on any aspects of the recognition and approval of trainers. If so, on which aspects?
- 25a** Is it appropriate to expect implementation of our proposals from the academic year 2013–14?
- 25b** If not, on what grounds should implementation be deferred?

## Appendix B: Mapping of the seven areas against GMC educational standards

AoME, the seven areas	GMC, <i>The Trainee Doctor</i>	GMC, <i>Tomorrow's Doctors</i>
1 Ensuring safe and effective patient care through training	'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).	Paragraph 5 Domain 1: paragraphs 26, 27, 28(e)
2 Establishing and maintaining an environment for learning	'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).  'Trainers must be involved in, and contribute to, the learning culture in which patient care occurs' (paragraphs 6.32–6.33).	Paragraph 5 Domain 7: paragraphs 150, 155  Domain 8: paragraphs 159, 162, 164, 166, 167
3 Teaching and facilitating learning	'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).	Paragraph 5 Domain 6: paragraphs 122, 128
4 Enhancing learning through assessment	'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).	Paragraph 5 Domain 5: paragraph 88  Domain 7
5 Supporting and monitoring educational progress	Mandatory requirements for educational supervision: paragraphs 6.3–6.9  'Trainers must provide a level of supervision appropriate to the competence and experience of the trainee' (paragraphs 6.29–6.31).  'Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees' (paragraphs 6.38–6.39).	Domain 9: paragraphs 171, 172

AoME, the seven areas	GMC, <i>The Trainee Doctor</i>	GMC, <i>Tomorrow's Doctors</i>
6 Guiding personal and professional development	Mandatory requirements for educational supervision: paragraphs 6.3.-6.9 'Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees' (paragraphs 6.38-6.39).	Domain 6
7 Continuing professional development as an educator	'Trainers must be involved in, and contribute to, the learning culture in which patient care occurs' (paragraphs 6.32-6.33).  'Trainers must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and sufficient time to train, supervise, assess and provide feedback to develop trainees' (paragraphs 6.34-6.37).  'Trainers must understand the structure and purpose of, and their role in, the training programme of their designated trainees' (paragraphs 6.38-6.39).	Paragraph 5  Domain 5: paragraph 88  Domain 6: paragraph 128

The mapping of the seven areas against *The Trainee Doctor* draws from Annex A of AoME's *Framework for the professional development of postgraduate medical supervisors*.

AoME's Annex also maps the seven areas against:

- a the Higher Education Academy's *The UK Professional Standards Framework for teaching and support learning in higher education*
- b AoME's *Professional Standards*
- c the GMC's *Good Medical Practice framework for appraisal and revalidation*.

# Appendix C: Definition of a trainer in the context of proposals for recognition and approval

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- 1 A trainer is an appropriately trained and experienced doctor who is responsible for the education and training of medical students and/or postgraduate medical trainees which takes place in an environment of medical practice.
- 2 A trainer provides supervision appropriate to the competence and experience of the student or trainee and training environment. He or she is involved in and contributes to the learning culture and environment, provides feedback for learning and may have specific responsibility for appraisal and/or assessment.

## Roles of trainers

- 3 The term trainer incorporates the roles of clinical supervisor and educational supervisor but is not limited to these alone. It also includes all doctors with formally recognised roles in delivering undergraduate and postgraduate medical education locally in the clinical environment, such as clinical teachers, clinical tutors, clinical lecturers, GP trainers, college tutors, specialty tutors, regional advisers, heads of schools, foundation programme directors, specialty (including GP) programme directors and directors of medical education. The trainer may be a consultant, a GP, SAS doctor or senior trainee.

- 4 We are not proposing processes for the recognition and approval of all these training roles. For postgraduate training, recognition and approval will be required for named educational supervisors and named clinical supervisors. For undergraduate education, recognition and approval will be required for the lead coordinators of undergraduate training at each local education provider and for those responsible for overseeing students' educational progress at each medical school.

## Named clinical supervisor

- 5 A trainer who is responsible for overseeing a specified trainee's clinical work for a placement in a clinical environment and is appropriately trained to do so. He or she will provide constructive feedback during that placement, and inform the decision about whether the trainee should progress to the next stage of their training at the end of that placement and/or series of placements.

## Named educational supervisor

- 6 A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement and/or series of placements. Every trainee must have a named educational supervisor. The educational supervisor's role is to help the trainee to plan their training and achieve agreed learning outcomes. He or she is responsible for the educational agreement and for bringing together all relevant evidence to form a summative judgement at the end of the placement and/or series of placements.

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- 7** Some training schemes appoint a named educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged.

### **Lead coordinator of undergraduate training**

- 8** A doctor (or more than one) at each local education provider responsible for coordinating the training of students, overseeing their activities and ensuring these activities are of educational value.

### **Doctor responsible for overseeing students' educational progress**

- 9** A doctor (or more than one) at each medical school who is responsible for overseeing students' trajectory of learning and educational progress.
- 10** The doctor might be an NHS consultant or a clinical academic acting as block or course coordinator for clinical aspects of the course.

## Appendix D: Task and finish group

The consultation documentation has been prepared by the task and finish group on the approval of trainers established by the GMC.

Member	Organisation represented
Mrs Enid Rowlands, Chair	GMC Council member
Dr Joan Martin	GMC Council member
Mr Robin MacLeod	GMC Council member
Dr Hamish Wilson	GMC Council member
Professor Alastair McGowan	COPMeD
Dr Tim Swanwick	COPMeD
Professor Jenny Higham	Medical Schools Council
Professor Val Wass	Medical Schools Council
Dr Katie Petty-Saphon	Medical Schools Council
Mr Chris Munsch	Academy of Medical Royal Colleges
Dr Neil Dewhurst	Academy of Medical Royal Colleges
Mrs Winnie Wade	Academy of Medical Royal Colleges
Mr Bill McMillan	NHS Employers
Dr Scott Hall	Academy Trainee Doctors Group
Dr Andrew Jeffrey	NACT UK
Dr Shree Datta	BMA Junior Doctors Committee
Mr Nick Deakin	BMA Medical Students Committee
Dr Ian Wilson	BMA Central Consultants and Specialists Committee
Dr Nanik Vaswani	BMA Staff, Associate Specialists and Specialty Doctors Committee
Dr Jan Welch	Foundation School Directors
Professor Derek Gallen	AoME
Dr John Jenkins	Chair, GMC Postgraduate Board (ex-officio)
Professor Jim McKillop	Chair, GMC Undergraduate Board (ex-officio)

## Appendix E: Glossary

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**Academy of Medical Educators (AoME):** A professional organisation for all those involved in medical education – the education and training of students and practitioners in medicine, dentistry and veterinary science. AoME published *A framework for the professional development of postgraduate medical supervisors* (2010) ([www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-426731A42C8B64F0D3DE/showMeta/0](http://www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-426731A42C8B64F0D3DE/showMeta/0)) which sets out the seven areas proposed for the recognition and approval of training.

**Approval:** Admission of a trainer to the GMC's list, following his or her identification by an education organiser. The GMC currently approves GP trainers and aims to seek statutory power to approve other trainers in line with the proposals in the consultation document.

**Education organiser:** A medical school or a postgraduate deanery.

**GMC standards for trainers:** The GMC's requirements of trainers as set out in *Tomorrow's Doctors* for undergraduate education and *The Trainee Doctor* for postgraduate training (see Appendix B).

**Identification:** The process by which an education organiser decides on the trainers who come within the four categories set out in this consultation document and who meet the GMC's standards. In the case of GP trainers, the names of identified trainers are passed to the GMC for approval. Subject to statutory change, we propose that the education organisers will in due course pass to the GMC for approval the names of all identified trainers within the four categories who meet the GMC's standards.

**Local education provider:** An organisation responsible for a setting where training is delivered – such as a hospital or a general practice. Under the consultation proposals, the local education provider would maintain a list of the trainers working in the setting and would map its processes for managing training against the GMC's standards for training within the structure of the seven areas in AoME's document.

**Named clinical supervisor:** See Appendix C.

**Named educational supervisor:** See Appendix C.

**Recognition:** The set of processes proposed for the support and regulation of trainers. This covers the responsibilities of the local education providers (including the management of trainers), the education organisers (including identification of trainers) and the GMC (including the approval of GP trainers and the quality assurance of education organisers in this regard).

**Seven areas:** The aspects of training set out in AoME's document *A framework for the professional development of postgraduate medical supervisors*.

**Tomorrow's Doctors:** The outcomes and standards for undergraduate medical education as determined by the GMC, most recently published in 2009.

**Trainer:** See Appendix C.

**The Trainee Doctor:** The GMC's standards for Foundation and specialty including GP training, incorporating outcomes for provisionally registered doctors. Published in 2011, *The Trainee Doctor* integrates the former *Generic standards for specialty including GP training* with *The New Doctor* standards for training in the Foundation Programme.

## Appendix F: Resource implications

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Resource implications may arise in relation to the GMC's responsibilities, the responsibilities of education organisers and local education providers, and the time of individual trainers.

### GMC

GMC staff currently devote around ten days a year to approve around 3,500 GP trainers. In due course, once the GMC acquires the necessary statutory powers, we envisage that around 30,000 trainers would be approved. While we intend to develop more streamlined procedures, we could therefore envisage around 100 days of staff time per year – less than half of a full-time post – to be involved in processing the approval of trainers.

Looking ahead, internal activities to test local recognition activities for the 20 deaneries and 31 medical schools would include:

- requesting information on local processes
- reviewing processes for each (0.5 of a day per organisation)
- sampling activity on quality assurance visits.

### Education organisers and local education providers

The well established arrangements for approval of GP trainers, developed largely by the RCGP and the postgraduate deaneries, have contributed to the high quality of training for GP registrars, with minimal regulatory burden.

The 2009–10 Annual Specialty Report (ASR) to the GMC for general practice stated:

*'Last year's ASR recommended that processes for selecting GP trainers and practices should be reviewed. To this end, the RCGP asked all*

*GP schools to report on current models, recent changes and any evaluations.*

*'In the past practice visits every three years were central to the process of accreditation UK-wide. GP school reports show that while most continue to accredit on a three yearly cycle, a number have adopted a more risk-based approach, relying on self assessments combined with sampling and random and/or triggered visits. Some schools continue to visit regularly but with less frequency – generally every five or even six, rather than every three years. All schools continue to train before appointment, regularly re-train trainers and visit new applicants for trainer status. Increasingly trainer and practice accreditation processes are separate.*

*'A number of schools have opted to continue to visit all practices every three years, believing that the formative element of the visit is too valuable to lose and/or that self assessments are a poor way of identifying problems. Certainly most schools report that their trainers and practices value highly the formative element of the visit and have concerns about its loss. Processes are being developed to try to fill that gap. For example, a school which has moved to a five-yearly visit pattern requires the trainer to attend a mid-way Trainer Quality Management/Teaching Seminar. In another trainers attend an annual review interview. One school has evaluated its new process and submitted a paper for publication in Education for General Practice. Others report that evaluations are underway.*

*'Schools' trainer and practice accreditation approval models were in most key respects remarkably similar for many years. They are now diverging significantly. Developments over the next few years are of interest to the RCGP and COGPED alike. It is hoped that some models of good practice will develop once evaluations of new models are complete and published.'*

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For example, one postgraduate deanery currently devotes 0.5 of a full-time post to support the approval of GP trainers. The deanery arrangements for approving a GP practice involve a one-day quality management visit and a further day writing up the report. Initial approval by the deanery is for two years and that is followed by a three-yearly cycle.

The GMC is very grateful to the postgraduate deaneries who have piloted our proposals for the recognition and approval of trainers: Kent, Surrey and Sussex Deanery, North West Deanery, Northern Deanery and South West Peninsula Deanery.

The GMC asked the pilot deaneries to identify all educational supervisors and all clinical supervisors in their region. The deaneries replied that the educational supervisors and clinical supervisors were already known. However, there have been difficulties in understanding of the terms as well as differences between specialties.

The GMC asked the pilot deaneries to map existing management or quality control systems for trainers (such as the identification of trainers, job planning, training and appraisal) against the seven areas in *AoME's Framework for the professional development of postgraduate medical supervisors* and the GMC standards in *The Trainee Doctor*. All four pilot deaneries had mapped their arrangements against the GMC standards and two had also mapped against the seven AoME areas.

The GMC asked the pilot deaneries to describe the arrangements with local education providers to ensure that fitness to practise cases among trainers are identified. There appeared to be scope for developing formal and systematic ways to share this information between local education providers and the postgraduate deaneries.

Lastly, the GMC asked the pilot deaneries to identify additional costs that would be involved to establish recognition and approval of trainers. They replied

that no additional costs would be required to identify the trainers involved. Mapping of arrangements against the seven AoME areas would require some resource. One deanery intended to scope a system for the revalidation of educational supervisors and clinical supervisors. Another envisaged a trainer portfolio system that might cost around £67,000 to develop over a year. Another saw a need to develop e-learning materials and refresher training and said that the cost of providing training for supervisors should continue to met through its funding allocation.

The GMC is also very grateful to the medical schools who have piloted our proposals for the recognition and approval of trainers: Cardiff University School of Medicine, Peninsula Medical School and UCL Medical School.

The GMC asked the pilot schools to identify lead coordinators (or site supervisors) of undergraduate training at each local education provider. This request did not cause any difficulties.

The GMC asked the pilot schools to identify those responsible at the school for overseeing students' educational progress. Again, this caused no difficulties.

One school questioned whether the level of action proposed would succeed in 'professionalising' medical education.

The GMC asked the pilot schools to map existing management or quality control systems for trainers (such as the identification of trainers, job planning, training and appraisal) against the seven areas in *AoME's Framework for the professional development of postgraduate medical supervisors* and the GMC's standards in *Tomorrow's Doctors* (2009). The schools set out their management or quality control systems and mapped their arrangements against the seven areas. One school outlined a possible approach to recognition and approval, and suggested that if

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an individual has accreditation or another marker of achievement from a credible body it should be taken as read that they meet the criteria in AoME's framework and *Tomorrow's Doctors*.

The GMC asked the pilot schools to describe the arrangements with local education providers to ensure that fitness to practise cases among the relevant trainers are identified. Current arrangements were described.

The GMC asked the pilot schools to identify additional costs that would be involved to establish the recognition and approval of trainers. The trainers were easily identified. Mapping would require some additional work. One school reported an existing staff development budget which is used to enhance the attributes of the school and site coordinators. Another school stated that through appraisals it would expect to see evidence that clinical teachers with significant leadership responsibilities attend teaching update meetings, work towards qualifications and demonstrate scholarship in medical education. The third referred to the cost of creating training resources and also mentioned a BMA estimate that preparing for a GP appraisal takes around 6.25 hours.

## Trainers

The task and finish group considered various initiatives and reports on the time required by educational supervisors and clinical supervisors to teach, train and assess, including surveys of trainers by NACT UK and by the GMC.

3,264 consultants responded to the NACT UK survey which was conducted as a scoping exercise and was reported in May 2011.

- 'How much time have you spent in the last 7 days in 1 to 1 discussions with trainees or dealing with portfolios?' 27.3% reported 1–2 hours and 17.7% reported 2–6 hours.
- 'How much time have you spent in directly supervising clinical care delivered by a trainee?' 15.5% reported 1–2 hours and 25.1% reported 2–6 hours.
- 'How much time have you spent discussing clinical care/decisions with a trainee away from the patient?' 23.3% reported 1–2 hours and 10.4% reported 2–6 hours.
- 'How much time have you spent "senior reviewing" non-elective patients while on call?' 15.0% reported 1–2 hours and 16.7% reported 2–6 hours.
- Asked about other time with trainees, 15.8% reported 1–2 hours and 11.3% reported 2–6 hours.

The GMC's summary report of the *National training surveys 2010* draws out some of the key findings from the survey of trainers which attracted a response rate of 48.5% (14,556 consultants and 2,672 GP trainers).

*'The survey asked trainers how many hours they were contracted in their job plans to spend each week in educational activity and how much they actually spent. Trainers in all roles were, on average, spending more time on educational activities than they were contracted for, in some cases nearly double. The widest discrepancy between contracted and actual hours was for clinical supervisors.'*

### 'In summary

- a *'Clinical supervisors were contracted to spend on average less than two hours a week on educational activity but actually spent nearly three and a half hours.'*
- b *'Educational supervisors were contracted to spend on average less than an hour and a half on educational activity but actually spent nearly three hours.'*

- c *'Training programme directors, directors of medical education and tutors also spent more time on average than contracted on educational activities...'*
- d *'GP trainers were contracted to spend on average less than four and a half hours a week on educational activity but were spending nearly six hours.'*
- e *'GP foundation tutors were contracted to spend less than three hours but were spending nearly four hours.'*

North Western Deanery report:

*'NWD has a large number of trainers, with around 3000 clinical supervisors across 18 LEPs. NWD developed a simple summary spreadsheet for initial reporting from LEPs against the GMC standards... the overall situation as at spring 2010 was:*

*Educational Supervisors:  
78% compliant with GMC standards*

*Clinical Supervisors:  
66% compliant with GMC standards*

*'Following the January 2010 deadline, reporting on this work had been incorporated into core deanery quality management processes...'*

*'Improvement on the spring 2010 figures has been significant. For example one LEP where evidence of compliance was below 40% for ES [educational supervisors] and below 30% for CS [clinical supervisors] in spring 2010 has devoted significant resource and training to this issue as a priority and in March 2011 reported figures of 78% for ES and 58% for CS together with an ongoing improvement plan. Some LEPs have now reported 100% compliance for Educational Supervisors.'*

Cardiff School of Medicine report:

*'In February to June 2011 all honorary teaching staff were asked to complete a questionnaire which asked about their training in teaching / supervising trainees as applicable to both undergraduate and postgraduate students and trainees. There was a 58% response rate, 628 of 1093 responded. A summary of the key points are:*

*'Is undergraduate teaching reflected in your job plan? 69% reported that it was explicitly or implicitly or being considered. 31% stated not at all.*

*'Is your role in teaching and training discussed during your annual appraisal ? 85% said yes.*

*'Qualifications in medical education: only 66, 13%, had completed a postgraduate certificate or diploma or MSc in medical education.*

*'Training: > 56% of respondents indicated that they had done courses such as training the trainers, teaching the teachers, more effective teaching etc. Many had also attended short courses organised by the Wales Postgraduate Deanery, such as on work place based assessments, trainees in difficulty etc.*

*'Appraisal training : 63% had done this.*

*'Equality and Diversity training : 79% reported having done it.'*

The GMC's proposals should support recognised and approved trainers in working with their local education providers and education organisers to establish reasonable expectations. The proposals should also help to ensure that those expectations are met.



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