General Medical Council

Agenda item:	6
Report title:	**Generic professional capabilities – outcome of public consultation**
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Considered by:	**Strategy and Policy Board**
Action:	**To consider**

Executive summary

From 1 July to 27 September 2015, the GMC and the Academy of Medical Royal Colleges consulted jointly on a draft framework for generic professional capabilities (GPCs).

The nine-domain framework aims to identify, simplify and clarify the important core professional capabilities doctors should possess at specialist registration. GPCs will act as an indicative curriculum framework and will for the first time explicitly state educational outcomes required of all postgraduate medical curricula. It will provide medical royal colleges/faculties with the opportunity to integrate and contextualise the GPCs framework across their 65 specialty and 36 sub-specialty curricula. It will also ensure that as requested by the service and Government that common capabilities are addressed consistently across the medical workforce.

The consultation outcome signalled very strong support for the framework with 105 of the 108 (97%) respondents in agreement that GPCs are fundamentally important to UK medical practice. There was also good support for the framework structure generally, with some changes being incorporated in response to comments. On 4 February 2016 the Strategy and Policy Board considered and approved the current draft of the framework at Annex A. The framework reflected the suggestions made by those who responded to the consultation.

Working with doctors Working for patients

Recommendations

Council is asked to:

a Note the current draft of the generic professional capabilities framework, at Annex A, as approved by the Strategy and Policy Board on 4 February 2016.

b Note the consultation outcomes summary and commentary, at Annex B.

c Note that the next stage will be joint work with the Academy of Medical Royal Colleges (AoMRC) to develop guidance for colleges about curriculum integration and assessment of GPCs.

d Note that GPC framework will be operationalised through the GMC *Standards for curricula and assessment systems* currently under review in conjunction with the AoMRC to embed into all postgraduate medical curricula.

Why we are addressing this subject

1 Currently, there are 65 medical specialties in the UK and 36 sub-specialties. For postgraduate training, each discipline has its own curriculum which is set by the medical royal colleges/faculties and approved by the GMC.

2 The case for regulatory action is underlined by the current significant divergence of structure and variability of content across many of these curricula.

3 Analysis of Fitness to Practice (FtP) data identifies that most FtP concerns fall into one or more of the nine core domains described in the Generic professional capabilities (GPCs) framework, at Annex A.

4 Also, several high profile patient safety inquiries have highlighted patterns of individual, organisational, human and systems failure. Key recommendations in such inquiries have been that there is a need to develop consistent and sector wide educational approaches and outcomes which promote and strengthen generic and interprofessional training capabilities particularly in relation to patient safety, professional behaviour and practice. A systemic and hence regulatory approach is therefore required and proportionate.

5 In the GPCs framework, we describe the core educational outcomes that doctors need to demonstrate to achieve a UK Certificate of Completion of Training and show they have the GPCs that are essential to delivering safe, effective and high quality care in the United Kingdom.

6 Our aim has been to develop a framework which places appropriate importance in curricula on developing the person holistically as a rounded, responsible professional with a mature professional identity underpinned by appropriate professional values, behaviours, knowledge, insights, skills, capabilities and experience. The framework places less emphasis on reductive box-ticking of individual tasks or competencies.

This generic approach to professional education was supported in the final report of the *Shape of Training* review which recommended the development of a GPCs framework. The GPCs framework is intended to complement and enhance the specialist curricula content often prioritised by colleges and faculties.

The proposed approach

7   The framework breaks new ground by introducing core educational outcomes which will be generic to all specialty and general practice training in the United Kingdom. This risk-based, outcomes-based approach will simplify and clarify postgraduate medical curricula and allow greater flexibility and economy in local education provision.

8   This unifying approach will also ensure greater consistency in training outcomes across the medical workforce. Further, it will offer the opportunity to reduce the regulatory burden and simplify the curricula approvals process for colleges and faculties.

9   Colleges/faculties will be required to adopt, embed and contextualise the GPCs framework within their curricula.

10   At the heart of the framework are the fundamental principles and professional responsibilities outlined in *Good medical practice* and other professional guidance and statutory requirements.

11   Equality and diversity issues have been addressed in the consultation and in the summary at Annex B.

12   In addition to the consultation, the framework has been the subject of wide engagement with and contribution over several years from key interests including the Education and Training Advisory Board.

Consultation outcome

13   The consultation outcome signalled very strong support for the framework with 105 of the 108 (97%) respondents in agreement that GPCs are fundamentally important to UK medical practice.

14   The vast majority of feedback to the consultation was constructive and provided very positive support. Specific feedback often helped clarify, reduce, avoid duplication or improve the accuracy or focus of the terms or outcomes. Where jurisdictional differences across the UK were noted e.g. Coroner/Procurator Fiscal these differences were acknowledged or incorporated.

15   There was good support for the framework structure, though, in response to comments, we have now incorporated 'communication and interpersonal skills and capabilities' and 'dealing with complexity and uncertainty' in the Professional Skills domain 2. These changes are presentational as the content of these sections largely remains unchanged.

16   Following encouragement from Health Education England and others we have also established a separate domain 4 which further prioritises health advocacy and the importance of capabilities in health promotion and illness prevention.

17   A summary of the consultation outcome and commentary is at Annex B.

Next steps

18   To note the very positive feedback from the joint consultation on Generic professional capabilities. This gives us confidence in taking forward the next steps to work with the colleges on implementation as part of the GMC *Standards for curricula and assessment systems* review

19   On 4 February 2016 the Strategy and Policy Board approved the current draft of the GPCs framework, at Annex A. The Board agreed that the next phase of the work should be the development of the revision of the GMC *Standards for curricula and assessment systems*. Central to the standards revision will be the requirement for future curricula to integrate the GPCs framework.

20   With the Academy, we shall also be supporting the co-production of guidance to ensure colleges and faculties are ready to incorporate the GPCs framework and embed in curricula and assessment frameworks.

21   We will work with the colleges to develop a simple approvals process to ensure all curricula support the generic outcomes outlined in the framework. This will of necessity take a period of time and will be linked to the revised standards for curricula and assessment from 2017.

General Medical Council

M6 – Generic professional capabilities – outcome of public consultation

M6 - Annex A

Draft framework

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Diagram showing the interdependence of the framework

Introduction

1   Currently, there are 65 medical specialties in the UK and 36 sub-specialties. For postgraduate training, each discipline has its own curriculum which is set by the medical royal colleges/faculties and approved by the GMC.

2   The case for regulatory action is underlined by the current significant divergence of structure and variability of content across many of these curricula. Analysis of Fitness to Practice (FtP) data identifies that most FtP concerns fall into one or more of the nine core domains identified in the Generic Professional Capabilities (GPCs) framework. Also, several high profile patient safety inquiries have highlighted patterns of individual, organisational, human and systems failure. Key recommendations in such inquiries have been that there is a pressing need to develop consistent and sector wide educational approaches and outcomes which promote and strengthen generic and interprofessional training capabilities particularly in relation to patient safety, professional behaviour and practice. A systemic and hence regulatory approach is therefore required and proportionate.

3   In this framework, we describe the core educational outcomes that doctors need to demonstrate to achieve a UK Certificate of Completion of Training and show they have the generic professional capabilities (GPCs) that are essential to delivering safe, effective and high quality care in the United Kingdom.

4   Senior doctors, including those on the Specialist Register, need to practice medicine in an effective and professional manner. In practice, the demonstrated acquisition of GPCs will mean that doctors are able to perform to a high professional standard. GPCs will allow doctors to take into account a wide range of factors, such as their professional responsibilities, their environment, the clinical context, patient expectations and effectively understand and manage their own personal characteristics and attributes, while managing clinical risk in dynamic and complex situations. Thus doctors demonstrating the stated GPCs will ensure that patients receive timely, safe and effective care.

5   The GPC framework is a matrix of educational outcomes that describe essential and critical capabilities that underpin core professional practice in the United Kingdom. As such GPCs should be seen as a holistic, integrated educational approach to embedding core professional insights, skills and capabilities across all postgraduate medical curricula.

6   The GPC framework has a series of domains. The domain headings were selected to champion and prioritise areas of clinical or professional importance and to give clarity for curriculum design and development. Under each of the domains, we have outlined specific themes and stated required educational outcomes. At the heart of the framework are the fundamental principles and professional responsibilities of *Good*

medical practice. These key professional responsibilities have been converted into educational outcomes so that they can be incorporated into curricula.

7   The full list of domains is:

■ Domain 1: Professional values and behaviours

■ Domain 2: Professional skills

■ Domain 3: Professional knowledge

■ Domain 4: Health promotion and illness prevention

■ Domain 5: Leadership and team working

■ Domain 6: Patient safety and quality improvement

■ Domain 7: Safeguarding vulnerable groups

■ Domain 8: Education and training

■ Domain 9: Research and scholarship.

Structure of the domains

8   All nine domains are interdependent. All are important. Three domains reflect fundamental areas of professional practice; professional knowledge, skills, values and behaviours. The remaining six themed domains champion and highlight particular critical professional capabilities and all are explicitly framed as educational outcomes. Educational outcomes are technical constructs that are central to the process of curriculum design and development. They clarify the expected outcomes of training and therefore have direct educational implications for organisations and the provision of training. We have organised the domains in a way that prioritises patient safety and addresses service, professional and legal requirements.

9   The themed domains highlight system priorities such as safety or quality improvement and/or discrete professional responsibilities such as training or scholarship. Some of their constituent elements or capabilities may be reiterated or common to other domains. This very limited repetition is reinforcing and intentional and ensures domain coherence.

How the framework relates to education standards

10   The education standards *Promoting excellence: standards for medical education and training*[*] set out requirements for the management and provision of undergraduate and postgraduate medical education and training in the United Kingdom.

11   This framework for generic professional capabilities outlines core professional curricula content and associated outcomes that doctors must demonstrate to practice effectively and safely in the UK.

12   Colleges and faculties will be required to adopt, embed and contextualise the GPCs framework within their specialty curricula.

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[*] General Medical Council. *Promoting excellence: standards for medical education and training* available at: www.gmc-uk.org/education/standards.asp (accessed 18 January 2016)

Domain 1: Professional values and behaviours

The GMC expects doctors to demonstrate appropriate personal and professional values and behaviours. These professional requirements are set out in *Good medical practice* and related guidance.[*]

GMC professional guidance outlines a doctor's fundamental professional responsibilities, including their duty of care to their patients. Doctors have a wide range of other professional responsibilities, relating to their roles as an employee, clinician, educator, scientist, scholar, advocate and health champion. These wide-ranging professional responsibilities include:

- acting with honesty and integrity

- maintaining trust by showing respect, courtesy, probity, dignity, compassion and empathy for others, including patients, carers, guardians, colleagues and others

- ensuring patient confidentiality

- raising and escalating concerns where there is an issue with patient safety or quality of care

- demonstrating openness and transparency in their interactions with patients and employers – known as the professional duty of candour

- being accountable as an employee to their employer

- being professionally accountable within an appropriate clinical governance framework

- managing time and resources effectively

- being able to self-monitor, self-care and seek appropriate advice and support to maintain their own physical and mental health

- demonstrate emotional resilience

- demonstrate situational awareness

- reflecting on their personal behaviour and its impact on others

[*] General Medical Council. *Good medical practice: explanatory guidance* available at: www.gmc-uk.org/guidance/ethical_guidance.asp

- demonstrating awareness of their own behaviour, conduct or health, particularly where this might put patients or others at risk

- demonstrating awareness of their own limitations and understand when and who to refer on to or seek professional advice from

- demonstrating awareness of the behaviour, conduct or health of others, particularly where this might put patients or others at risk

- interacting with colleagues in a way that demonstrates appropriate professional values and behaviours, in terms of supporting colleagues, respecting difference, and working as a collaborative member of a team

- being able to identify and create safe and supportive working and learning environments

- listening to patients/carers/guardians and accepting that they have insight into, preferences for and expertise about their own condition and context

- working within appropriate equality and diversity legislation

- working within appropriate health and safety legislation

- demonstrating a commitment to learn from patient safety investigations and complaints

- maintaining their professional legitimacy and credibility by successfully completing appropriate continuing professional development and statutory and mandatory training

- demonstrating an ability to learn from and reflect on their professional practice and clinical outcomes

- being able to accept constructive and appropriately framed criticism

- being a professional role model.

Domain 2: Professional skills

Practical skills

We have set out below basic practical skills and capabilities that are fundamentally important to safe and effective patient care. Doctors in training must be:

- literate

- numerate

- articulate

- able to give clear, accurate and legible written instructions in English

- able to give clear, accurate and comprehensible verbal instructions in English

- able to make accurate and contemporaneous records of their observations or findings in English

- able to demonstrate an appropriate understanding of the legal aspects of digital and written records

- able to accurately complete legal medical forms or certifications, eg cremation, sickness, insurance

- able to demonstrate an appropriate understanding of information governance, data protection and storage

- able to demonstrate appropriate IT skills, including word processing and data collection.

Communication and interpersonal skills

Due to the complex nature of medical practice, doctors in training must develop high levels of communication and interpersonal skills. Doctors in training must demonstrate that they can communicate effectively, assertively, respectfully and be able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement. They must do this:

- with patients, relatives, carers, guardians and others by:

  - establishing a constructively assertive doctor-patient partnership with the ability to demonstrate empathy and compassion

  - demonstrating effective consultation skills including effective verbal and non-verbal interpersonal skills

  - sharing decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations

  - sharing decision making with children and young people

  - supporting patients in caring for themselves

  - demonstrating effective listening skills

  - demonstrating cultural and/or social awareness

  - communicating effectively and sensitively when breaking bad news, and being well prepared in advance in order to give clear information

  - effectively managing challenging conversations or consultations

  - using an interpreter or translation services where appropriate

  - making arrangements to communicate effectively with someone who has impaired hearing, speech or sight or where there are capacity issues e.g. learning difficulties

  - making appropriate arrangements where patients request to see a doctor of the same gender as themselves

- delivering an honest apology[*] and offering an effective explanation where appropriate

- communicating, consulting and sharing information with carers

- adapting their communication style to suit the individual patient, for example by using email or Skype.

■ with colleagues in the multidisciplinary team by:

- exploring and resolving diagnostic and management challenges

- applying management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations

- ensuring continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover, both verbally and in writing.

■ individually by:

- maintaining appropriate situational awareness and sensitivity to the impact of their comments and behaviours on others.

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[*] General Medical Council. *Openness and honesty when things go wrong: the professional duty of candour* available at: www.gmc-uk.org/guidance/ethical_guidance/27233.asp (accessed 18 January 2016)

Capabilities in dealing with complexity and uncertainty

Doctors in training must demonstrate that they can:

- show appropriate professional behaviour and judgement in a wide range of clinical and non-clinical contexts and circumstances

- manage the uncertainty of achieving specific outcomes in clinical practice

- manage the uncertainty of treatment success or failure

- adapt management proposals and strategies of medical problems to take account of patients' informed preferences, comorbidities and long-term conditions

- make reasonable adjustments as appropriate

- support and empower patient self-care[*]

- respect patient autonomy

- understand that health and well-being is a complex biomedical, psychological and sociological process

- understand the complex relationship between mind and body in illness presentation

- understand the factors impacting on health and well-being

- adapt management proposals and strategies to patients at extremes of age, which includes neonates, children and older people with frailty

- formulate management plans beyond guidelines and produce patient-centred management plans

- manage the personal challenges of coping with uncertainty

- being resilient, diligent and thorough

- understand critical objectives and requirements for successful recovery and rehabilitation

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[*] General Medical Council. *Good medical practice* available at: www.gmc-uk.org/guidance/good_medical_practice/partnerships.asp

- recognise patients with common mental health conditions (eg depression, dementia or delirium), manage them and, if appropriate, refer them to colleagues with relevant expertise

- recognise patients with common medical conditions (e.g. diabetes, asthma or renal failure) outside their specialty and refer to colleagues with appropriate expertise.

Clinical skills

For the many clinical specialties that involve direct patient contact, doctors should demonstrate the following key generic clinical skills.

History taking, diagnosis and medical management

Doctors in training must demonstrate that they can:

- take a relevant patient history including patient symptoms, concerns, priorities and preferences

- perform accurate clinical examinations

- show appropriate clinical reasoning by analysing physical and psychological findings

- formulate an appropriate differential diagnosis

- formulate an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required

- explain clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues

- appropriately select, manage and interpret investigations (e.g. reviewing results)

- understand the role of the chaperone when carrying out clinical examinations particularly those of a sensitive or intimate nature.

Consent

Doctors in training must demonstrate and understand the professional requirements and legal processes associated with consent, including:

- making sure patients are accurately identified

- obtaining valid informed consent from the patient

- considering and addressing mental capacity issues

- safeguarding children and vulnerable adults

- discussing cardiopulmonary resuscitation and patient consent

- protecting and ensuring patient confidentiality

- considering humane interventions: and ensuring that treatment needs, wherever possible, are in line with patient preferences

- the principles of requesting and coordinating organ donation and the factors which determine suitability of patients and successful organ donation.

Prescribing medicines safely

Doctors in training must be able to:

- prescribe safely and use appropriate therapeutic approaches and strategies to make sure medicines are managed effectively and used safely

- review and monitor therapeutic interventions appropriate to their scope of clinical practice

- prescribe antimicrobial drugs appropriately

- prescribe medications and use other therapies in line with the latest evidence

- comply with safety checks, contributing to medication reporting systems, and following other monitoring processes as necessary

- understand the challenges of safe prescribing in people at extremes of age, which includes neonates, children and older people with frailty

- assess a clinical situation to recognise a drug reaction

- manage adverse incidents and therapeutic interactions appropriately

- access the current product literature to ensure medicines are prescribed and monitored according to most up to date criteria

- make an appropriate risk benefit assessment with regard to the patient's preferences and circumstances

- fully recognise if they are prescribing an unlicensed medicine

- correctly counsel a patient on what a medicine is for and share any important safety information.

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Using medical devices safely

Doctors in training must:

- understand the importance of being trained in the use of specialist medical equipment and devices

- know how to safely operate medical devices after appropriate training

- make sure medical devices are used safely by complying with safety checks, contributing to reporting systems, and following other appropriate maintenance, monitoring and reporting processes

- understand the design features and safety aspects associated with the safe use of medical devices.

Humane interventions

Doctors in training must demonstrate compassionate professional behaviour and clinical judgement and intervene appropriately to make sure patients have adequate:

- nutrition

- hydration and rehydration

- symptom control

- pain management

- end of life care

- cardiopulmonary resuscitation when and if appropriate.

Infection control and communicable disease

Doctors in training must demonstrate that they can:

- appropriately prevent, manage and treat infection, including controlling the risk of cross-infection

- work appropriately within the wider community to manage the risk posed by communicable diseases.

Domain 3: Professional knowledge

Professional requirements

Doctors in training must be aware of and adhere to the GMC's professional requirements, including:

- meeting the standards expected of all doctors, set out in *Good medical practice*

- keeping up to date with the GMC's guidance[*]

- participating in annual reviews of performance and/or progression

- working within appropriate quality management and clinical governance frameworks

- understanding risk, its management and mitigation.

In addition, doctors in training must be aware of and understand the importance of adhering to the GMC's professional requirements, including:

- participating in reflective annual appraisal, job planning and performance management including audit of and responsibility for their own clinical outcomes

- the need for all doctors to take part in revalidation, which involves understanding their scope of practice, and the role and responsibility of the responsible officer

- participating in continuing professional development to keep their knowledge, skills and capabilities up to date[†].

National legislation

Doctors in training must be aware of their legal responsibilities and be able to apply in practice any legislative requirements relevant to their jurisdiction of practice, for example:

- employment law, particularly as it relates to them as an employee, including working time regulations

- mental capacity and deprivation of liberty safeguards

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[*] General Medical Council. *Good medical practice: explanatory guidance* available at: www.gmc-uk.org/guidance/ethical_guidance.asp

[†] General Medical Council. *Continuing professional development - Guidance for all doctors* available at: www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp

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- mental health

- the legal requirements about patient and carer involvement in shared decision making

- safeguarding of vulnerable children and adults

- genital mutilation

- equality and diversity, including the nine protected characteristics

- data protection and confidentiality

- health and safety legislation, including the management of radiation and hazardous substances

- transportation legislation including fitness to drive and DVLA notification processes

- establishing and certifying death

- cremation authorisation

- referral to the coroner/procurator fiscal

- any other legislation relevant to medical practice.

The health service and healthcare systems in the four countries

Doctors in training must be aware of and understand:

- the structure and organisation of the health service and system, including the independent sector and the wider health and social care landscape

- the local healthcare system and its relationship to and interaction with social care

- how services are commissioned, funded and audited

- how services are deemed to be clinically effective, cost effective or restricted such as on a 'named patient' basis

- how resources are managed, being aware of competing demands and the importance of avoiding waste

- how services are held publically accountable through political and governance systems, public scrutiny and judicial review.

Domain 4: Capabilities in health promotion and illness prevention

Doctors in training must be aware of and understand:

- the factors affecting health inequalities and the social determinants of health

- the relationship of the physical, economic and cultural environment to health

- basic principles of public health, including population health, promoting health, nutrition, exercise, vaccination and preventing illness

- basic principles of person-centric care, including effective self-management, self-care and expert patient support

- the influence of ageing, dependency, multiple co-morbidities and frailty upon individual and population-level healthcare needs

- the potential harms and risks of health care interventions

- basic principles of global health

- the responsibilities and needs of carers as they play an increasing role in healthcare provision

- how to manage, support and develop the health and social care of local populations through:

  - community engagement

  - family and community-based interventions

  - global and multicultural aspects of delivering evidence-based, sustainable healthcare.

Domain 5: Capabilities in leadership and teamworking

Doctors in training must demonstrate that they can lead and work effectively in teams by:

- demonstrating an understanding of why leadership and teamworking is important in their role as a clinician

- showing awareness of their leadership responsibilities as a clinician and why effective clinical leadership is central to safe and effective care

- demonstrating an understanding of a range of leadership principles, approaches and techniques

- demonstrating an ability to moderate their leadership behaviour to improve engagement and outcomes

- appreciating their leadership style and their impact on others

- thinking critically about decision making, reflecting on decision-making processes and explaining those decisions to others in an honest and transparent way

- supervising, challenging, influencing, appraising and mentoring colleagues and peers to enhance performance and to support development

- challenging and critically appraising performance of colleagues, peers and systems

- promoting and effectively participating in multidisciplinary, interprofessional teamworking

- understanding and appreciating the roles of all members of the multidisciplinary team

- promoting a just and fair, open and transparent culture

- promoting a learning culture.

Domain 6: Capabilities in patient safety and quality improvement

Patient Safety

Doctors in training must demonstrate that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes. To do this, they must:

- raise safety concerns appropriately through clinical governance systems

- understand the importance of raising and acting on concerns

- understand the importance of sharing good practice

- understand basic Human Factors principles and practice at individual, team, organisational and system levels

- understand the importance of non-technical skills and crisis resource management

- demonstrate effective multidisciplinary, interprofessional teamworking

- demonstrate respect for and recognition of the roles of other health professionals in the effective delivery of patient care

- promote and participate in interprofessional learning

- promote patient involvement

- understand risk and its management or mitigation

- understanding fixation error[*], unconscious and cognitive biases[†]

- reflect on their personal behaviour and practice

- effectively pre-brief, debrief and learn from their own performance and that of others

- make changes to their practice in response to learning opportunities

[*] The inability to reassess and consider new possibilities, leading to error and mismanagement of conditions or circumstances.

[†] Patterns of concrete thinking that affect the quality of judgements and decisions by not considering all appropriate circumstances.

■ be able to keep accurate, structured and where appropriate standardised records

Quality improvement

■ design and implement quality improvement projects that improve clinical effectiveness, patient safety and patient experience by:

- using data to identify areas for improvement

- examining information from audit, inquiries, critical incidents or complaints, and implementing appropriate changes

- employing quality improvement methods, such as plan, do, study, act cycles

- understanding the importance of patient and public involvement in decision making at group level and when changes to services are proposed

- engaging with stakeholders, including patients, doctors and managers, to plan and implement change

- effectively measuring and evaluating the impact of quality improvement interventions.

Domain 7: Capabilities in safeguarding vulnerable groups

Doctors in training must demonstrate that they can:

- recognise and take responsibility for safeguarding children, young people and vulnerable adults, using appropriate systems for sharing information, recording and raising concerns, obtaining advice and taking action

- understand the professional responsibilities in relation to procedures performed on minors for non-medical reasons

- understand mental capacity and the importance of protecting the safety of individuals and society

- understand the needs and support required for people with learning disabilities

- understand positive behavioural support and when and how to restrain and safeguard vulnerable adults in distress

- recognise where addiction (to drugs, alcohol or smoking), obesity, environmental exposure or social deprivation issues are contributing to ill health and act on this information

- understand the requirements of the appropriate equality and diversity legislation, including disability discrimination requirements.

Domain 8: Capabilities in education and training

Doctors in training must demonstrate that they can:

- understand that the safety of patients must come first and that the needs of education must be considered in this context

- provide safe clinical supervision of learners in the workplace at all times

- provide safe clinical supervision of other doctors in training

- plan and deliver effective education and training activities

- take part in their own induction and orientation, and that of new staff

- take part in patient education

- respect patients' wishes about whether they wish to participate in the education of learners and doctors in training

- provide supportive developmental feedback, both verbally and in writing to learners and doctors in training

- create effective learning opportunities for learners and doctors in training

- evaluate and reflect on the effectiveness of their educational activities

- promote and participate in interprofessional learning

- assess fairly and objectively the performance of learners and other doctors in training

- give timely and constructive feedback on any education opportunities

- understand how to raise concerns about the performance or behaviour of a learner or other doctor in training who is under their clinical supervision

- participate in national surveys and other quality control, quality management and quality assurance processes as required by the regulator

- understand and demonstrate they understand the responsibilities of a clinical trainer

- meet any regulatory or statutory requirements as a clinical trainer or educator.

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Domain 9: Capabilities in research and scholarship

Doctors in training must demonstrate that they can:

- keep up to date with current research and best practice in the individual's specific area of practice, through appropriate continuing professional development activities and their own independent study and reflection

- practise in line with the latest evidence

- conduct literature searches and reviews to inform their professional practise

- critically appraise and interpret scientific/academic literature

- understand the role of evidence in clinical practice and decision making with patients

- locate and use clinical guidelines appropriately

- demonstrate an understanding of scientific methods

- understand basic research principles and concepts

- understand the principles of recruitment into trials and research programmes

- understand basic principles and ethical implications of research governance

- understand informatics

- understand genomics

- understand stratified risk and personalised medicine

- draw from public health epidemiology[*] and other data sources and large scale reviews

- appreciate the role of both qualitative and quantitative methodological approaches in scientific enquiry

- communicate and interpret research evidence in a meaningful way for patients to support them making informed decisions about treatment and management.

[*] The study of how often diseases occur in different groups of people and why.

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M6 – Annex B

Summary of responses to the consultation and commentary

1   Of the 108 responses received to the consultation, which we ran jointly with the Academy of Medical Royal Colleges, a large majority of 105 (97%) agreed that generic professional capabilities (GPCs) are important to medical practice in the United Kingdom.

2   There was strong support for the proposed ten-domain structure with agreement from 71 of the 96 (74%) who responded.

3   The majority also described the framework as 'easy' or 'very easy' to read and navigate, and most indicated that they understood all of the terms used.

4   In addition, we received wide ranging suggestions for changes to the wording, emphasis and domain structure of the framework. These are described in this summary.

5   Whilst the BMA agreed '… in general, that doctors should have the capabilities that are listed in the ten domains…' it said that 'many of these capabilities, however, reflect the principles that are set out in *Good medical practice* and the explanatory guidance which expands on those principles. We therefore do not believe that they need to be listed in a separate and very detailed framework for the purposes of assessment.'

6   Our response to this issue:

a   The purpose of the GPC framework is to provide an indicative core curriculum for postgraduate specialty medical education.

b   The framework is deliberately set at a high level so that those preparing indicative curricula such as the medical royal colleges/faculties have the flexibility to embed and contextualise its elements to the specific context of their specialties. We describe the educational outcomes that all doctors need to demonstrate to achieve a UK Certificate of Completion of Training (CCT) and so show they have the generic professional capabilities (GPCs) that are essential to delivering safe, effective and high quality care.

c   In response to the points which the BMA and others made about the how the framework aligns with and relates to *Good medical practice* (GMP) - GMP is explicitly embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The comments we have received and changes made to the framework

7   Of the 96 who responded to the question, *Do you agree with the ten domains we have separated the framework into,* 71 (74%) said they did. For example the Faculty of Intensive Care Medicine said that the separation of the framework into domains makes it easy to read and digest and will also facilitate its incorporation into curricula.

8   A postgraduate medical institution said that it was pleased to see that professional values and behaviours are at the core of the framework, and two respondents (an individual and a medical educator) thought the ten domain structure fitted well with the domains of *Good medical practice.*

9   Among the 7% of respondents who did not fully agree with the domain structure, the Royal Colleges of Obstetricians and Gynaecologists and Paediatrics and Child Health considered that the first four domains were truly generic - and that the other domains were more like applications, or sub-sets, of those capabilities.

10   The Education and Training Committee of the British Geriatrics Society said that it found the structure complex and confusing. They suggest either dividing it by the four domains of GMP instead or dividing into six 'external' domains (last six domains) and threading through the first four domains.

Our response

11   The importance of the GPC framework is in that the capabilities are mutually interdependent as reflected in the diagram in Annex A, page A2.

12   From the helpful comments received, we do accept that there are elements of the framework which can be consolidated or strengthened to emphasise their importance in terms of patient safety and service. Therefore, we think the original two domains covering communication and interpersonal skills, and capabilities in managing complexity and uncertainty would be better represented as sub-sets of domain 2 covering core professional skills.

13   We also agree with the view expressed by Health Education England that capabilities in promoting health and preventing illness should have its own domain. Whilst these elements were already covered within the domain 3 structure, we have now created a new domain 4 to prioritise the importance of the health advocacy role of doctors.

14 In the light of these changes, we have been able to reduce the original ten domains to nine domains.

Responses to the questions we posed on each of the ten domains

Do you agree with domain 1: Professional values and behaviours and its associated outcomes?

15 Of the 95 respondents who answered this question, 81 (85%) agreed.

16 NHS Education for Scotland commented that this domain is at the heart of medical practice. COPMeD agreed that it is 'absolutely at the core of medical practice now and for the future'. NHS Employers highlighted that 'Employers considered this the joint second most important and relevant domain alongside Professional Skills. The domain needs to encourage greater emphasis on effective apology, the reduction of defensive behaviour and the role of compassion'.

17 The Royal College of General Practitioners added that '…the development of professional expertise throughout training must be underpinned by the doctor's capability to understand his/her own values and develop insight into his/her behaviours… It often begins with developing a deeper understanding of the professional self, through reflective practice. It then expands to incorporate relationships with patients and with colleagues within multi-disciplinary teams and, ultimately, the wider healthcare system.

18 Four respondents (three organisations and one individual) expressed concern over how emotional resilience can be developed, measured and assessed.

19 One respondent (individual doctor in training) questioned the content: 'raising and escalating concerns' and 'being accountable to the employer' - can these be done in a culture with a lack of whistle blowing? And self-monitoring and referring re mental health is complex. What if the doctor fails to meet this as they are unwell and unable to self-refer?'

Our response

20 In describing professional values and behaviours in this domain, we have ensured that *Good medical practice* is explicitly embedded at the heart of the GPC framework.

21 We recognise the complexity around self-reporting of serious health problems. That is why we have built in complementary outcomes which also place a responsibility on doctors to recognise ill health or poor performance of other doctors as an added protection to address this lack of personal insight.

Do you agree with domain 2: Professional skills and its associated outcomes?

22   Of the 94 responses received to this question, some 80 (85%) of organisations and individuals were in agreement with the purpose of domain 2.

23   COPMeD stressed that 'these skills are essential for all doctors', whilst Health Education Kent, Surrey and Sussex said that 'The skills listed in this domain are all of obvious importance for the medical profession, but nonetheless worthy of inclusion as part of a comprehensive baseline'.

24   NHS Employers said – 'Employers considered this the second most important and relevant domain alongside Professional values and behaviours with nine out of ten employers ranking this as highly relevant to postgraduate training'. NHS Education for Scotland considered that 'These are skills that will apply to all doctors and benefit from being made explicit in this manner…'.

25   An individual doctor was concerned that 'The list of clinical skills, and prescribing medicines, reflects basic elements of training curricula at undergraduate and postgraduate level and it is uncertain how setting this out in this way adds value to this.'

Our response

26   By clearly setting out the most basic and minimal expected levels of practice we are establishing fundamental baseline levels of proficiency which will help clarify minimum acceptable standards and so help in the diagnosis and management of poor or sub-optimal performance.

27   In response to comments, we have now incorporated the original domains of communication and interpersonal skills and capabilities in dealing with complexity and uncertainty. We have done this as they are fundamental and universal professional capabilities. The education outcomes for these elements have not been substantially changed but we now feel that they are better positioned in domain 2.

Do you agree with domain 3: Professional knowledge and its associated outcomes?

28   Of the 92 responses to this question 72 (78%) agreed with domain 3.

29   NHS Education for Scotland said 'The four stems of GMC requirements, national legislation, the healthcare system and promoting health and their associated outcomes provide clear guidance of the wider knowledge, beyond that which is specialty specific, that is required for all medical practice.'

30   A medical educator said 'I particularly endorse the explicit mention of knowledge of the healthcare system' and a number of comments were made about points under

this subsection. The Royal College of Physicians said its 'members and fellows have identified an understanding of the commissioning and funding of services as an area where they would like more support' so they 'strongly support the inclusion of this as a capability' and have produced guidance and a report, recommending that 'physicians get involved in this and develop their understanding.'

31   Another medical educator thought the domain was 'systematic and protocols driven', demanding 'not much more than compliance'.

32   Five respondents commented that although it is important to broadly understand the healthcare system, it is a complex area and it is unrealistic to expect the understanding described.

33   NHS Employers said that 'care will be needed in ensuring that relevant knowledge to particular specialties at different stages of training is translated appropriately through curricula.'

34   Two said that the level of understanding required isn't defined, which could impact on the success of delivery; another stressed that the requirements must be articulated clearly, or they could be misinterpreted.

Our response

35   We agree that further articulation of the outcome requirements and the level of capability expected at each stage of training will be needed. Working with the Academy, we propose to develop guidance to assist colleges/faculties and others preparing curricula, doctors in training and others involved with the organisation and provision of specialty training.

36   During development of the framework, there was extensive input from the service. A frequent criticism was that curricula had historically focused on clinical content and largely neglected important service based and legal requirements.

37   We agree with Health Education England's comment that health promotion and illness prevention element should have its own domain. Accordingly, we have created a separate domain 4 as this will champion a critical area of health policy and highlight the doctor's role as a health advocate.

38   We have incorporated changes on the basis of the helpful suggestions made about particular aspects of domain - some examples as follows:

Professional requirements

39   We have added 'quality management' to 'working within an appropriate clinical governance framework'. (Royal College/Faculty)

National legislation

40   We have changed 'National legislation' to 'legislative requirements relevant to their jurisdiction of practice'. (NIMDTA)

41   We have added 'Procurator Fiscal' to 'coroner' to acknowledge the position in Scotland. (Royal College of Physicians and Surgeons of Glasgow and others)

42   We have extended 'mental capacity' to 'mental capacity and deprivation of liberty safeguards' in light of the Supreme Court ruling of April 2014. (British Geriatrics Society – Policy committee/SAC)

43   We have added 'any other legislation relevant to medical practice' as the last bullet. (NIMDTA)

The healthcare system

44   We have amended the sub heading to read 'The health service and healthcare systems in the four countries' to acknowledge the differences across the UK (Academy Patient/Lay Group, doctor)

New domain 4 – Capabilities in health promotion and preventing illness

45   We established this domain in light of the suggestion made by Health Education England and others that '…consideration could be given to this being a domain on its own to reflect the importance of prevention in the Five-Year Forward View and various mandates.'

46   The Health Foundation thought that health promotion and preventing illness 'is an increasingly important area' and an area in which '…all doctors need to have knowledge and skills'.

47   A medical educator applauded the explicit inclusion of global health perspectives.

48   In respect of public health, an education manager said the 'public health role should be grasped by all to "make every contact count" – patients and the public value the opinion of doctors' and they should 'leverage that opportunity to deliver healthcare messages.'

49   We have incorporated a number of additions to the section including:

■   population health (relates to part of the competence for public health (NHS/HSC organisation)

■   nutrition (The Association for Nutrition)

- the social detriments of health (Royal College of Physicians)
- the influence of ageing, dependency, mult-morbidity and frailty upon individual and population-level healthcare needs.' (The British Geriatrics Society).

Do you agree with domain 4: Communication capabilities and its associated outcomes? (Now incorporated as an element of domain 2 covering professional skills.)

50 Of the 92 respondents to this question, 77 (83.7%) agreed with the content in this domain.

51 Health Education Kent, Surrey and Sussex said that 'this area is clearly of great importance. The skills listed are clear, appropriate and sensibly laid out and form a comprehensive account of the different aspects of communication.'

52 Three respondents mentioned the importance of communication skills in the context of working with disadvantaged groups. The explicit mention of the use of an interpreter was welcomed.

53 Three respondents suggested revising the text so that it was not gender specific and reflected that either gender may reasonably ask for a doctor of the same gender for certain issues. However, comments were received from the Royal College of Obstetricians and others to the effect that such arrangements may pose particular challenges in emergency settings. In our explanatory guidance, _Intimate examinations and chaperones (2013)_ we recognised similar resource constraints in relation to the availability of chaperones of a specific gender.

54 The importance of the ability of a doctor to adapt their communication style to suit the individual patient was also emphasised by three respondents. This may, for example involve using email or Skype.

55 It was also suggested that the framework would benefit from an outcome focused on the importance of communication with patients in relation to management of long–term conditions.

56 One respondent said that the term 'deliver an apology', may not lead to a genuine apology. 'You cannot 'deliver an apology' you can only offer it!... The words and sentences are all very formulaic and will invite a mechanical and technical response which will not drive the important values we are trying so hard to instil.'

Our response

57 We have changed the outcome, 'making appropriate arrangements where culture does not permit certain conversations with a male doctor' to 'making appropriate arrangements where patients request to see a doctor of the same gender as themselves'.

58   In the light of comments, we also made some additions as follows:

- 'sharing decision making with children and young people'

- 'supporting patients in caring for themselves'

- 'making arrangements to communicate effectively with someone who has impaired hearing, speech or sight or where there are capacity issues e.g. learning difficulties'

- 'adapting their communication style to suit the individual patient, for example by using email or Skype.

Do you agree with domain 5: Capabilities in leadership and teamworking and its associated outcomes?

59   There is a high level of support for this domain and its associated outcomes. Of the 91 who responded, 77 (84.6%) agreed.

General comment from Faculty of Medical Leadership and Management

60   'The evidence for leadership and leadership development shows, in a well-led healthcare organisation, all staff, and doctors in particular, will contribute significantly to the leadership effort, at all levels. This includes the leadership and management of effective clinical governance systems and processes. Good medical leadership impacts positively at three levels: the patient; the organisation; and the individual. We invited a sample group of our membership to contribute to this submission. Those who responded agreed, in principle, that domain 5 and its associated outcomes accurately reflect the leadership and management aspects of a doctor's responsibilities, particularly in the light of Francis and others, with some additional observations.

- All of these expected capabilities will, at some point, clash with the 'doctors know best' ethos, including rejecting the expert opinions of specialists from other, non-medical fields (for example, economists and strategists in consumer behaviour).

- Direct leadership is not a readily recognised term across care disciplines. Recognising different styles of leadership is important, as doctors have responsibility to shape systems as well as work within them for the benefit of patients.'

Other comments in support

61   NHS Employers – 'Employers, again, rank this highly, knowing that many trainees are currently progressing onto the specialty register feeling 'unprepared' for the leadership and management responsibilities that their first substantive consultant

post will bring. Greater consistency across specialties in developing the knowledge, skills and standards set out in this domain will help to support this smooth transition.'

62   COPMeD said 'This is very welcome and embeds the principles of the doctor as leader within the core attributes of the profession.'GLADD said 'This is a well thought out section.'

63   The National Clinical Advisory Service agreed in principle but said they would be interested in finding out more about how some of these outcomes can be operationalised.

64   However, there were some concerns. A doctor and medical educator said that 'If they don't understand leadership, how will they be helped to do so and what will this look like?'

65   The Medical Protection Society was concerned about terms we have used such as 'fixation errors' and 'cognitive biases' as they felt these could be misunderstood by doctors in training.

Our response

66   We have further strengthened the wording in respect of the leadership and teamworking elements. In doing so, we have highlighted themes including the need for doctors in training to demonstrate an understanding of why leadership is important, the importance of promoting an open and transparent culture and the appreciation of the role of the multi-disciplinary team.

Do you agree with domain 6: Capabilities in patient safety and quality improvement and its associated outcomes?

67   There were 90 responses to this question and of these, 75 (83.3%) agreed with domain 6.

68   COPMeD said that 'these are of great and increasing importance in modern healthcare, and there is a need to recognise the practical implications of delivering the standards'.

69   A consultant noted 'Largely a good section focused around current thinking in relation to Human Factors and Quality Improvement methods, so may need review in future or careful wording to allow openness to new ideas'. There were several other expressions of support for including Human Factors as an important theme.

70   There was one respondent who disagreed with the domain (Newcastle University). They said the Human Factors principles need better explanation. They also said this domain needs to cover the critical importance of systems thinking – '..there is an

over-emphasis on individuals within this section and under-emphasis on the role of systems in safety.'

71   Of the respondents who were unsure, it was noted that there is overlap between domain 6 and other domains.

72   The Royal College of Obstetricians and Gynaecologists said that 'All the items/capabilities in this domain are important, although there is a discussion to be had as to whether they should be isolated into one domain or reflected in all domains'.

73   In terms of equalities, one respondent noted that domain 6 should include 'understand that reasonable adjustments may be needed to ensure safe and quality care'.

Our response

74   We have highlighted the outcomes in domain 6 to champion elements which are critical to safety. But as the domains of the framework are interdependent some overlap is inevitable. The framework is a matrix reflecting the complexity of high level professional practise.

75   As a signatory to the Human Factors in Healthcare Concordat, published in November 2013 by the National Quality Board, we are committed to ensuring that the principles and practices of Human Factors are embedded in training curricula – we have honoured this pledge through the GPC framework.

76   We have added an outcome on reasonable adjustments to the managing complexity and uncertainty element of domain 2.

77   We have made some further changes to domain 6 in response to the following comments. For example:

-    We have explicitly acknowledged the importance of Human Factors at organisational and system level (Education and Training Committee of the British Geriatrics Society).

-    In respect of the point 'understand multidisciplinary, interprofessional team working' we have as suggested qualified this with the following - 'demonstrate respect for and recognition of the roles of other health professionals in the effective delivery of patient care' (Centre for the Advancement of Interprofessional Education (CAIPE)).

Do you agree with domain 7: (Now included within domain 2 which covers professional skills.) Capabilities in dealing with complexity and uncertainty and its associated outcomes?

78 There were 91 responses to this question and of these, 81 (89%) agreed with the domain.

79 For example, '… modern generalist medical care requires doctors to develop the capability to manage a complex population of patients with multiple and complex health-related problems which interact and vary over time. This requires the ability to manage uncertainty, deal with poly-pharmacy and to lead, organise and integrate a complex suite of care at the individual, organisational and system levels'. (Royal College of General Practitioners)

80 'Of all the domains included in this consultation, I particularly favour this domain as dealing with complexity and uncertainty is intrinsic to medical practice and in the majority of our interactions with patients and indeed colleagues.' (Individual Medical educator)

81 Some respondents who agreed with domain in principle noted that it can be an area that is difficult for new consultants, as well as doctors in training. One respondent said that this will require significant change in curriculum and training to make sure all trainees are competent and capable in dealing with complexity and uncertainty. (Royal College of Paediatrics and Child Health)

82 Two respondents were not sure how this domain connects across wider concepts of professionalism. (Individual doctor and Health Education England)

83 One respondent agreed that this is an important area of medical practice, but that many of the outcomes described in this section are specific areas of professional knowledge (domain 1) and skills (domain 2) which could be incorporated into those domains, and some outcomes might be better in other domains. (Health Education Kent, Surrey and Sussex)

Our response

84 Dealing with complexity and uncertainty is a critical professional capability. It is essential that doctors are trained to understand the challenges, demonstrate insights and act appropriately. CCT holders must have the capability and confidence to apply good professional judgement across the wide range of medical conditions, contexts and circumstances they may encounter.

85 We agree with the view that the elements of the manging complexity and uncertainty domain as set out in the consultation would more appropriately fit within domain 2

which covers professional skills. Accordingly we have moved the content to that domain.

86   We have made a number of additions and changes to the content on complexity and uncertainty – for example we have:

■   strengthened the point about management of medical problems to read – 'adapt management proposals and strategies of medical problems to take account of patient's informed preferences, comorbidities and long term conditions' (Royal College of Physicians, Newcastle University)

■   added that 'doctors should be able to understand the factors impacting on health and well-being' (British Geriatrics Society)

■   amended the bullet '….patients at extremes of age, including frail elderly people' to 'older people with frailty' (British Geriatric Society)

■   added 'support and empower patient self-care.

Do you agree with domain 8: (Now domain 7 in the revised framework at Annex A) Capabilities in safeguarding vulnerable groups and its associated outcomes?

87   Of the 90 responses received to this question, 78 (86.7%) agreed with the domain.

88   Two respondents said the inclusion of the domain was justified given the importance of adult safeguarding to medical practice. The Royal College of General Practitioners suggested that we highlight the Intercollegiate Guidelines for Safeguarding.

89   Whilst it felt that the statements in this section were good in principle, Health Education East Midlands requested clarity on Level 3 safeguarding training and whether this is simply generic training that is needed or a specific requirement.

90   The Royal College of Obstetricians and Gynaecologists said that the promotion of greater understanding by all specialists of vulnerable groups will aid better management of individuals in these groups. However they said that it is important to distinguish between the recognition of a condition and being the right person to deal with it - or not.

91   The British Geriatrics Society suggested that the inclusion of a reference to the Deprivation of Liberty Safeguards would be helpful given the Supreme Court ruling of April 2014.

92   The Royal College of Physicians identified that there is nothing in the framework on inclusion health in particular the needs of homelessness people, gypsies and travellers, vulnerable migrants and sex workers.

93   Among those who answered that they were unsure, a number of respondents felt the generic nature of the statements failed to reflect that the level of understanding in this area may vary from doctor to doctor. 'Principles and understanding of safeguarding are very important. However, the understanding needs to be appropriate to the individual's clinical practice including specialty and level of training. In seeking to make generic statements this aspect is not fully reflected in the outcomes.' (individual doctor and LETB/Deanery)

94   Three respondents felt the capabilities in this area could either be absorbed into another domain, or it was not necessary to list them separately. This correlates with some of the comments who responded 'yes'.

95   NHS Education for Scotland felt that the generic outcomes outlined in the rest of this framework if applied by doctors when they are dealing with vulnerable adults and children will ensure that these groups receive the best possible care.

Our response

96   We agree that it is important that understanding safeguarding needs to be appropriate to the individuals' clinical practice including specialty and level of training. That is why the framework is designed to enable colleges/faculties to embed and contextualise it to the needs of their particular specialties.

97   We have made a number of amendments to the domain in light of the comments received.

98   For example, we have changed 'Understand the requirements of the *Equality Act 2010*, including the disability discrimination requirements' to respect jurisdictional differences. This element now reads *'understand the requirements of appropriate equality legislation...'* (NIMDTA).

99   In addition to domain 7, we have also cross-referenced safeguarding of vulnerable children and adults in domains 2 and 3.

100 We have as suggested made reference to the Deprivation of Liberty safeguards.

101 We shall address separately in the proposed implementation guidance, the question of Level 3 safeguarding guidance. We shall also consider whether the outcomes need expansion to include particular groups, for example homelessness people, gypsies and travellers, vulnerable migrants and sex workers.

Do you agree with domain 9 (now domain 8 in the revised framework at Annex A): Capabilities in education and training and its associated outcomes?

102 Of the 89 responses received, 75 (84%) agreed, with only 4 respondents stating they did not agree. The general message we received is that the domain will help to promote a culture of support and learning.

103 Health Education Kent, Surrey and Sussex said 'This is a highly appropriate area of professional practice for inclusion as a separate domain. Training is one of the cornerstones of medical practice and trainees play a significant role in the provision of training and are required to develop the skills to be used when they move on to senior posts. The list of outcomes gives a clear and concise account of the key skills to be developed.'

104 NHS Education for Scotland commented that 'This domain fits very well with the new *GMC Promoting excellence: standards for medical education and training*, and we welcome its inclusion into this framework. There does need to be a balanced approach here. There should be awareness of the issues and possibilities, but not an expectation that the trainee will demonstrate evidence of understanding of this section in every case they manage.'

105 The Faculty of Intensive Care Medicine said the structure of its curriculum includes special skills modules, one of which will be education and that 'This framework will be extremely useful in its development'.

106 Some comments received suggested a need for further definition or more clarity around certain elements of the domain. Comments included:

- 'It is not clear……whether the example of "create effective learning opportunities" is meant to apply to the trainee him/herself (i.e. self-learning opportunities) or to learners under the trainee's supervision.' (Royal College/Faculty)

- '… what is meant by "take part in induction and orientation" means is that for themselves or that of new staff? If patient education and public education is not addressed here then it needs to be picked up elsewhere..' (Education for Health)

- One Royal College/Faculty noted, 'These are important principles, but again our respondents have pointed out that teaching is covered in other areas and training and recognition of abilities are already part of GMC [expectations as part of the] recognition of trainers; some have questioned whether this domain is necessary'. This was echoed by an individual doctor in training.

Our response

107 We would stress that this domain is fundamentally about the critical responsibility of a CCT holder in ensuring patient safety through safe clinical supervision of learners and other doctors in training in the workplace.

108 The outcome on creating learning opportunities applies both to doctors in training themselves and the learners under the trainee's supervision.

109 We understand the importance of participating in induction and orientation to new working environments and the importance of orientating others to new places of work.

110 We have made some changes to the wording in the domain in light of comments received – some examples as follows:

- the addition of 'promote and participate in interprofessional learning' (CAIPE)

- the addition of 'respect patients' wishes about whether they wish to participate in the education of doctors in training' (Royal College of Radiologists)

- the amendment of the bullet covering patient safety to: 'understand that the safety of patients must come first and the needs of education must be considered in this context' (Royal College of Physicians)

- we have changed 'give feedback early and objectively on the education opportunities received' to 'give timely and constructive feedback on any education opportunities.' (NIMTDA)

Do you agree with domain 10 (now domain 9 in the revised framework at Annex A with 'scholarship' added to the title): Capabilities in research and scholarship and its associated outcomes?

111 Of the 90 responses received, 75 (83%) agreed with this domain.

112 A Royal College/Faculty commented 'Our respondents agree that a grasp of basic research is essential for up to date evidence based practice and this should be encouraged in doctors in training. Some have questioned whether this requires a domain and whether this could be incorporated in other domains.'

113 Queen's University Belfast Medical School commented: 'We feel that there should be some additional detail in this section, in particular to include an appreciation of the role of both qualitative and quantitative methodological approaches to research.'

114 The Royal College of Paediatrics and Child Health supported our view that an understanding of research governance is important. They commented that currently this is delivered with the majority of doctors in training undertaking general clinical practice training, and that, accordingly, this makes them potentially ready to participate in network research.

115 Whilst the BMA agreed that doctors as scientists should understand research principles, it noted that '…. doctors are not necessarily researchers. We do not believe

that the capabilities listed in this domain need to be listed in a separate and very detailed framework…'

116 Among those who disagreed, one Royal College/Faculty stated that they fully supported inclusion of research capabilities. However, they did not fully agree with the way the domain was currently written and commented that 'The first two examples are not related to research as we understand it, but rather with keeping up-to-date and being fit to practise'.

117 There were ten respondents that answered not sure to the question. Three of the comments indicated that research may not be for everyone, or that not all doctors were necessarily researchers. One Medical educator said 'I would not be happy to have this as a framework by which an evaluation will be made on a particular trainee or practitioner'.

Our response

118 During the development of the framework, there was general concern expressed from many quarters of the need to raise the academic and critical appraisal skills of the medical profession to ensure rational, evidence-based practice and scholarly enquiry.

119 We are not seeking to train all CCT holders as formal researchers, but we do expect them to have a broad and robust understanding of scientific methods and evidence based practice.

120 On the point about the role of both qualitative and quantitative methodological approaches to research we will address this in the implementation guidance.

121 To reflect that the domain is about doctors in training keeping up-to-date and being fit to practise', we have extended the title to include 'scholarship'.

122 We have made some additions to the domain in light of comments received including:

- 'keep up to date with current research and best practice in the individual's specific area of practice, through appropriate continuing professional development activities and their own independent study and reflection' (Joint Committee on Surgical Training)

- 'understand the role of evidence in clinical practice and decision making with patients' (Newcastle University)

- 'understand informatics' (Medical Schools Council)

- 'understand genomics' (Medical Schools Council).

Assessment

123 There was a strong consensus with 80 of the 93 respondents (86%) indicating that it is important to assess GPCs. Furthermore, the majority of respondents agreed that GPCs could be assessed, but stressed the importance of avoiding 'tick box' type assessments in favour of more qualitative-based assessment methods such as reflective portfolios, structured trainers reports or 360 degree appraisal.

124 A small majority of respondents agreed that current assessment methods could be used to assess GPCs, including methods developed by Royal Colleges or organisations associated with them e.g. Royal College of Paediatrics and Child Health, Royal College of Surgeons Edinburgh, Faculty of Medical Leadership and Management.

125 However a few respondents considered wholly new assessments might be required.

126 Many said that they wished to see guidance or common approaches developed to support the assessment of GPCs.

Our response

127 We will be providing further advice on assessment as part of the revised standards for curricula and assessment (subject of consultation in 2016) and the general guidance we will develop to assist colleges/faculties and others prepare for implementation of GPCs in 2017.

128 We agree it would be helpful and important to develop common approaches to assessment of GPCs.

Other themes which respondents felt we should include in the framework

129 We received 90 responses to the question, *Are there any other themes you think we should include in the framework?* Of these 37 (41%) answered 'yes', 40 (45%) answered 'no' and thirteen were unsure.

130 Suggestions for other themes included:

- a domain for technical competency in generic practical skills (individual Consultant)
- development of resilience, conflict resolution, self-awareness and the ability to reflect properly (Health Education England)
- a domain specific to patient and public involvement (Newcastle University)
- more emphasis on 'patient centric care' and the concept of professionalism in medicine (British Geriatrics Society)

- including children making decisions about themselves (Royal College of Paediatrics and Child Health)

- raising concerns about patient safety (British Medical Association and individual Consultant)

- communicating with families at the time of and after death (NHS Education for Scotland)

- professional relationships with patients (Royal College of Radiologists)

- dealing with doctors who are struggling (individual doctor)

- continuity and consistency of care (Epsom and St Helier UH NHS Trust).

Our response

131 Some of these points have been incorporated, eg:

- sharing decision making with children and young people is now included in domain 2 under Communication and interpersonal skills

- person-centric care is now included in domain 4.

132 Some points we felt were already covered sufficiently in the framework or will be picked up elsewhere, for example:

- technical competency in generic practical skills – domain 2 is about practical skills, and any specialty specific technical skills will be addressed by the college/faculty curricula based on the framework

- communicating with families at the time of and after death – domain 2 'Communication and interpersonal skills' already covers the key essential areas of communication.

Themes which respondents thought we should remove from the framework

133 We received 91 responses to the question *Is there anything you think we should remove from the framework?*

134 53 (58%) thought that nothing needs to be removed, 17 (19%) suggested there were some themes that could be removed, and 21 (23%) weren't sure.

135 Suggestions for change included incorporating 'outcomes for research' and reducing the repetition and detail.

Our response

136 We have renamed domain 9 'Capabilities in research and scholarship'.

137 By the complex nature of this interdependent framework, we believe that

repetition is necessary and reinforcing in places.

Patient safety

138 Of the 92 who responded, 64 (70%) broadly agreed that we have sufficiently addressed patient safety in the framework. Those who disagreed accounted for 7% and those who indicated they were not sure 23%.

139 There was strong support for the emphasis on Human Factors, risk management and quality improvement methodology from NHS Education for Scotland and Health Education East Midlands.

140 The Royal College of Physicians said that safety should cut across all of the GPC domains, whilst the Royal College of Paediatrics and Child Health argued that recognition of the need to inform and engage patients could significantly enhance safety.

141 A consultant stressed that the framework needs to consider the relationship between patient safety, quality, professional standards and the constraints of working within a resource limited health system…. and that this would be more appropriately discussed in the next consultation on revised standards for curricula and assessment.

142 HEE referred to its Commission on education and training for patient safety which recently put out a call for evidence.

143 Some who disagreed thought that more emphasis is needed 'on continuity of care' (Epsom and St Helier NHS Trust) and 'on behaviours, professionalism and the resulting effects on patient safety' (Royal College). Newcastle University felt that patient and public role could be strengthened, eg encouraging and supporting patients to contribute to their own safety through effective clinical interactions and communication skills.

144 Those who answered that they were unsure included the Medical Schools Council. They stressed 'it is important that the risks to patient safety from the actions of the training are balanced with the future risks to patient safety of training not involving enough responsibility for individuals to develop their skills.'

145 The Health Foundation noted that 'as currently expressed, the capabilities on safety are quite limited. For instance, while it is of course right to highlight the importance of raising and acting on concerns, the Health Foundation's work in the field of patient safety has found that greater focus must be given to the conditions that lead to harm, not just past cases of harm themselves'.

Our response

146 We believe that by the very nature of its interdependent matrix structure and the highlighting of safety and service based themes, the framework fundamentally promotes educational outcomes which prioritise patient safety and *Good medical practice*.

147 The framework is complementary to the GMC's wider standards and guidance which have safety and professionalism at their heart.

Equality and diversity

148 Of the 91 respondents who answered this question, 67 (74%) agreed that we had sufficiently addressed equality and diversity in the framework. COPMeD said that more specificity would be counter-productive. Health Education Kent, Surrey and Sussex described the section as comprehensive.

149 There were seven respondents who felt that we had not sufficiently covered equality and diversity including a staff and associate specialist grade doctor. Health Education East Midlands said that we needed to distil the generic aspects of people who are disadvantaged by particular characteristics, vulnerability due to age or disability or cultural issues.

150 In terms of the legal implications, two colleges indicated that they would like guidance on fulfilling the public sector equality duty in the training programme implementation phase. One respondent (NHS/HSC organisation) asked for a definition of equality and diversity and how the law relates to health inequalities and safeguarding children and vulnerable adults.

151 There were 17 respondents who were not sure whether the equality and diversity content was sufficient. For example, the BMA said 'the concepts of equality and diversity are complex and it is difficult to reflect that complexity adequately in a list of simple statements.' They also observed that implications may vary between different areas of practice and between different geographical areas of the UK.

152 GLADD responded that it did not want training that covers only the legal aspects of equality and diversity and would like to see one that also covers clinical care where relevant.

Our response

153 Equality and diversity is embedded throughout the framework. Equality and diversity is also prioritised as one of the new standards for training - *Promoting Excellence* - and will be a central element in both the revised standards for curricula and assessment and the new GMC Quality assurance framework.

154 In response to the concerns raised by some respondents, we will be considering the practical advice we might include on equality and diversity in guidance to assist colleges/faculties and others with the implementation of GPCs in 2017.