

General  
Medical  
Council

# Recognising and approving trainers: the implementation plan

August 2012

General  
Medical  
Council

Regulating doctors  
Ensuring good medical practice



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# Executive summary

1 New arrangements for the recognition of trainers will be in place from 2013–14. The statutory requirements for GMC approval of GP trainers remain in place. In addition, postgraduate deans and medical schools will formally recognise medical trainers playing four specific roles.

2 The arrangements relate to the following.

## **Undergraduate education**

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

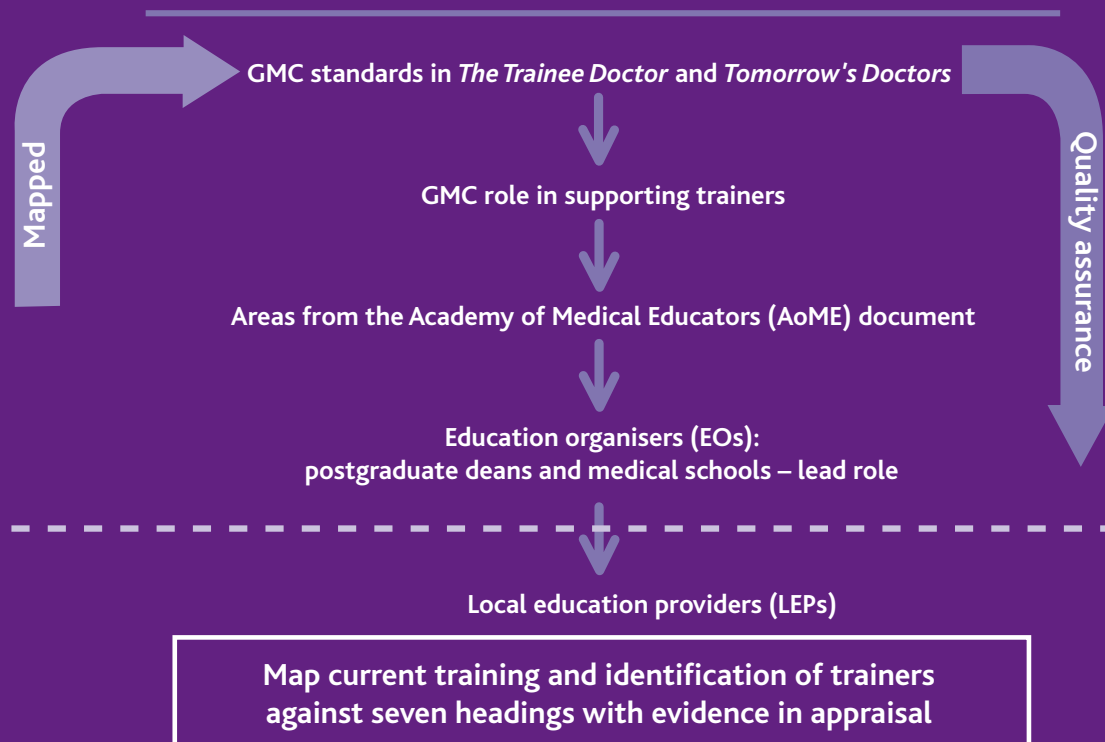
## **Postgraduate training**

- Named educational supervisors
- Named clinical supervisors

3 Therefore, the arrangements will not cover other doctors whose practice contributes to the teaching, training or supervision of students or trainee doctors. That essential contribution needs to be properly resourced and supported by local education providers, postgraduate deans and medical schools; but their roles will not need to be formally recognised. The GMC aims to provide regulation that is focused, proportionate and pragmatic.

4 This diagram summarises the arrangements.

## Recognition and approval of trainers



- 5 We will use our existing standards for postgraduate training set out in *The Trainee Doctor*<sup>1</sup> and for undergraduate education in *Tomorrow's Doctors*<sup>2</sup> (see Appendix B). In addition, medical trainers must follow the GMC's professional guidance as trainers and more generally as doctors – they must be positive role models demonstrating good medical practice.
- 6 We propose to use seven areas originally set out by the Academy of Medical Educators (AoME) 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.

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- 7** To implement the arrangements locally, key responsibilities lie with two sets of organisations. In most cases, the recognised trainers will be managed by LEPs such as NHS hospitals. However, the lead responsibility for recognising trainers will lie with education organisers (EOs), ie medical schools for the undergraduate trainers and postgraduate deans for the postgraduate trainers. In practice there will be substantial overlap between these two groups of trainers. The EOs will need to work together to share information and minimise inconvenience to the trainers concerned.
- 8** The LEPs' responsibilities cover the following.
- a** Identifying trainers currently in the roles requiring recognition and choosing recognised trainers to perform the four roles.
  - b** Ensuring that sufficient trainers are in post and available to train.
  - c** Supporting trainers through:
    - i** job plans
    - ii** appraisal and revalidation
    - iii** support for the training and professional development of trainers
    - iv** dealing effectively with concerns and difficulties.
  - d** Taking effective action where training is poor and remediation is not sufficient.
  - e** Mapping their arrangements against the seven areas of AoME's *A Framework for the Professional Development of Postgraduate Medical Supervisors*<sup>3</sup> and ensuring that the GMC's standards are met.
  - f** Liaising with EOs in accordance with agreed arrangements eg on establishing databases of recognised trainers which can be accessed by both LEPs and EOs.
  - g** Being accountable for the use of the resources received to support medical education and training.
- 9** The responsibilities of the EOs include:
- a** Taking the lead role in recognising trainers, including establishing criteria and processes consistent with the GMC's standards and requirements.
  - b** Reaching agreements with local education providers on respective roles and responsibilities.
  - c** Quality managing training arrangements at local education providers and their job planning for training in light of the GMC's standards and the seven AoME areas.
  - d** Reviewing available information before deciding to recognise individual trainers.
  - e** Passing on information to the GMC about the GP trainers identified; and, once the GMC has the necessary statutory powers, also passing on information about other trainers requiring GMC approval.
  - f** Reporting regularly to the GMC on the adequacy of the job planning at each LEP in their area and generally cooperating with quality assurance by the GMC.
- 10** We are content for LEPs and EOs to agree a different allocation of responsibilities between themselves but EOs will need to ensure that all the tasks are performed.

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- 11** The new arrangements build on the existing procedures by which we approve the GP trainers of GP registrars. We will 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, postgraduate deans 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. The key regulatory relationship will be between the GMC and EOs but we will look to EOs to make sure that LEPs are meeting their responsibilities to support trainers and provide training of a high quality.
- 12** We do not expect that it will be possible for EOs to demonstrate in the first year that all the trainers in the four roles are fully compliant with the criteria and systems that they will be establishing. But it is important, quickly, to establish those criteria and systems, to identify the trainers who will need to be recognised, to provide support to them to collate required information and to collect the relevant information about them. Initially, that will constitute 'provisional recognition' of the trainers concerned. But that status will be time-limited. In any case, as now, all medical trainers must meet the standards for trainers laid down by the GMC and the education organisers must take urgent action if they understand that specific trainers fall short, without waiting for the new systems to be established.
- 13** The GMC has identified the following milestones for EOs:
- a** to submit to the GMC a timeline for implementation for trainer recognition – by 31 December 2012
  - b** to confirm that criteria and systems are in place and ready for data entry – by 31 July 2013
  - c** to confirm that full information has been entered for all medical trainers in the four roles in light of the EO criteria and that the trainers have all been categorised as provisionally or fully recognised – by 31 July 2014
  - d** to confirm that all medical trainers in the four roles, or entering any of the four roles, are fully recognised, ie have met the EO criteria, without use of interim concessions – by 31 July 2016.
- 14** Particularly at a time of resource constraint, we aim to protect and enhance the status of training. We believe that the new arrangements build on existing arrangements and provide a structure that will add value while requiring limited additional effort for trainers or resource for our partner organisations.

# The regulatory context



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## The importance of training

- 15 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.
- 16 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*.<sup>4</sup>
- 17 Most trainees are 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. They are supported by a range of expert bodies including medical schools, postgraduate deans, medical royal colleges and faculties, the Higher Education Academy, the Academy of Medical Educators and the National Association of Clinical Tutors (NACT UK), as well as the GMC.
- 18 General practice has led the way in developing a systematic approach to securing high quality training. This is thanks to the efforts over several years of GP postgraduate education directors/ GP Deans in postgraduate deaneries, the Royal College of General Practitioners (RCGP) and the former Joint Committee on Postgraduate Training for General Practice (JCPTGP). Also, the GMC formally approves GP trainers and holds

a list of approved GP trainers as part of our regulation of medical education and training. We now need to move towards the same kind of system for trainers outside general practice.

## Reviews and developments

- 19 Although standards of education and training are generally high and major progress has been made in recent years, there is still room for improvement.
- 20 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*.<sup>5</sup> 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*<sup>6</sup> 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*<sup>7</sup> 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 educational support, training and supervision can be compromised by pressures on the health services.

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**21** Concerns have also been documented through the quality assurance activities of the GMC and previously the Postgraduate Medical Education and Training Board (PMETB). Our annual national training surveys, which allow individual trainers and trainees to highlight issues, have identified areas of concern and for improvement while demonstrating widespread trainee satisfaction.

**22** The Secretary of State for Health (England) asked Medical Education England (MEE) to consider options through the Better Training, Better Care programme. A task force was established including representatives from the GMC and from Northern Ireland, Scotland and Wales.

**23** In April 2011, MEE circulated a set of draft quality indicators for the commissioning of medical education and training in England. They covered board level engagement in education and training, safe supervision, time for trainers to train and the selection, appointment and review of trainers.

**24** In developing the GMC's approach to recognising and approving trainers, we drew also on 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 NHS Education for Scotland (NES)
- c** development of an agreement setting out the responsibilities of the Wales Deanery, local health boards and individual educational supervisors.

**25** In short, the arrangements to recognise and approve trainers build on our standards for training and our quality assurance activities and on processes already developed across the UK. The new arrangements will help to address some of the concerns that have been raised. They will fit well with the rest of the Better Training, Better Care programme and with the development of quality indicators.

## Regulatory policy development

**26** Alongside approving GP trainers, the GMC and PMETB (until it merged with the GMC) have for some time set standards for trainers including how they should be trained.

**27** The arrangements for recognising and approving trainers grew out of PMETB's Future Doctors review. The importance of bringing the regulation of specialty trainers into line with that of 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: '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.'<sup>8</sup>

**28** 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

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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.'

- 29** Following the merger, the GMC maintained this direction of travel 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.'<sup>9</sup>
- 30** The *Education Strategy 2011–2013* also stated that we would decide whether we should approve the educational environments in which doctors train. We will take this forward separately as part of our review of our framework for quality assuring medical education and training.

## Developing the proposals for recognising and approving trainers

- 31** 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's Council. 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 and faculties 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.
- 32** 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.
- 33** The work was supported by desk research into 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 and faculties
  - f** NHS Employers
  - g** the BMA
  - h** NACT UK
  - i** AoME.

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- 34** We also considered the resource implications of established arrangements, drawing on our own training surveys and an additional survey by NACT UK.
- 35** In developing the arrangements for recognising trainers, we have taken on board the various contexts in which training takes place including primary, secondary and other professional environments; clinical and non-clinical aspects of medical practice; within and beyond the NHS; undergraduate and postgraduate learners; trainers at various grades; and the four nations of the UK.
- 36** This work helped to define the focus of our arrangements for recognising trainers. 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.
- 37** We piloted our proposals with postgraduate deaneries and medical schools. The results suggested that our proposals were pragmatic, feasible and affordable, subject to the investment that the medical schools and the postgraduate deaneries, and the local education providers, have already made in supporting and training trainers. In any case, the proposals build on the very successful arrangements for approving GP trainers developed largely by the RCGP and COGPED. The pilot report is available on our website ([www.gmc-uk.org/education](http://www.gmc-uk.org/education)).
- 38** The GMC's Council agreed publication of proposals for consultation from 6 January to 30 March 2012. We received and analysed 270 responses. In addition, we organised a series of seven events to discuss the proposals and other issues, which were attended by 187 participants. The responses and comments largely supported the proposals. A report of the consultation was considered by the GMC's Council on 18 July 2012 and is available on our website. The Council also agreed the way forward as set out in this implementation plan.
- 39** Throughout the policy development, we have carefully considered the implications for equality and diversity. We have for example been concerned to ensure that SAS doctors are appropriately supported and appreciated for their contribution to training. Respondents to the consultation stressed the importance of ensuring that the arrangements do not disadvantage trainers who are female or who work less than full time. A full equality analysis has been prepared and is available on our website.

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## The difference between recognition and approval

- 40** The GMC does 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 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 those working in general practice (see Appendix A).
- 41** Once we have secured the additional legal powers to do so, we will approve and hold the names of non-GP trainers as well as the GP trainers. In the meantime, we do not intend to hold the names of the recognised non-GP trainers but will ensure that the medical schools and the postgraduate deans are doing so.

# Objectives for recognising and approving trainers

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- 42** 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 as well as students and trainees, and enhance the training environment
  - b** improve the quality of training particularly in relation to:
    - i** trainers as positive role models, demonstrating good medical practice
    - ii** teaching and feedback
    - iii** assessment decisions
    - iv** the training of and support for trainers
  - c** improve links between the regulator and the education organisers ie postgraduate deans and undergraduate medical schools
  - d** clarify lines of accountability and responsibility for training and the roles of the education organisers, local education providers and other professional and educational bodies
  - e** 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
  - f** minimise the regulatory burden on individual trainers and training organisations in the context of appraisal and revalidation.

**The scope:**  
who needs to  
be recognised  
or approved?



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**43** The arrangements to recognise and approve trainers need to be proportionate. They deliberately do not cover all doctors involved in training in the course of their daily clinical or medical practice. Nor do they cover the essential role of trainers from other healthcare professions and walks of life. The crucial contribution of trainers outside the scope of recognition and approval, and the importance of developing their training skills, also need to be acknowledged and supported by education organisers and local education providers.

**44** However, the arrangements do need to reflect the variety of training environments, wherever medical students and trainees are placed for clinical or medical practice. So the scope is not limited to the NHS but will also cover any placements in the public, private or voluntary sectors. It covers placements across the range of medical practice including hospital, GP and community settings, public health, occupational medicine, pharmaceutical medicine and so on.

### What is a medical trainer?

**45** A medical 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.

**46** A medical 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.

### Who will be covered by the arrangements?

**47** Four medical trainer roles – two in undergraduate education and two in postgraduate training – will be performed only by recognised or approved trainers who are registered medical practitioners holding a licence to practise.

#### 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

### Undergraduate education

**48** Medical schools will identify and recognise one or more doctors at the school who are responsible for overseeing students' trajectories of learning and educational progress. They might be NHS consultants or clinical academics acting as block or course coordinators.

**49** Medical schools will also identify and recognise one or more doctors at each local education provider responsible for coordinating the training of students, supervising their activities and ensuring these activities are of educational value.

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- 50** Medical schools may wish to recognise one lead coordinator with responsibility for their students' general practice placements, rather than a separate coordinator for each general practice. Similarly, medical schools may agree that in areas other than general practice a group of small LEPs will share a lead coordinator. By contrast, for a large LEP the medical school may think it appropriate to recognise more than one lead co-ordinator for example to cover specific sites or departments.
- 51** Medical schools may vary in their approach to recognising trainers and in the number of individuals they recognise. We hope that the benefits of recognition, such as ensuring that the individuals are appropriately trained, will discourage schools from a very restrictive approach. In any case, as *Tomorrow's Doctors*<sup>2</sup> states: 'Medical schools must make sure that everyone involved in educating medical students has the necessary knowledge and skills for their role' (paragraph 148).
- 52** Students should be able to name both the trainer at their medical school who is responsible for overseeing their progress and the LEP lead coordinator who is responsible for their training.

## Postgraduate training

- 53** Recognition and approval of medical trainers in postgraduate training will be necessary for the roles of named clinical supervisor and named educational supervisor.
- 54** A named clinical supervisor is a trainer who is responsible for overseeing a specified trainee's clinical work throughout a placement in a clinical or medical environment and is appropriately trained to do so. He or she will provide constructive feedback during that placement. He or she will lead on providing a review of the trainee's clinical or medical practice throughout the placement that will contribute to the educational supervisor's report on whether the trainee should progress to the next stage of their training.
- 55** A named educational supervisor is 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 or series of placements. Every trainee must have a named educational supervisor. The educational supervisor helps 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 or series of placements.

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- 56** Some training schemes appoint a named educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged and only the merged role needs to be recognised.
- 57** Arrangements should fit with the requirements and definitions of educational supervisors and clinical supervisors in *The Trainee Doctor*<sup>1</sup>, the *Gold Guide*<sup>10</sup> and the *UK Foundation Programme Reference Guide*.<sup>11</sup> However, the GMC is using the additional word 'named' in this context:
- a** To emphasise the responsibility of specific supervisors for specific trainees.
  - b** Generally to encourage consistency in the coverage of the arrangements for recognition.
  - c** More specifically to stress the boundary between the named clinical supervisors requiring recognition and the supervisors of trainees for particular sessions who will not require recognition (although they are, more loosely, providing 'clinical supervision').
- 58** Each trainee should be able to identify the named educational supervisor and named clinical supervisor currently responsible for their training.
- 59** Named educational supervisors and named clinical supervisors will sometimes work in areas of medical practice such as public health medicine, occupational medicine and pharmaceutical medicine. While the definitions above will identify who needs to be recognised, the GMC is not insisting on the universal use of terms that will fit most circumstances. In some areas, the word 'clinical' will not be appropriate so that a term other than 'named clinical supervisor' may be preferred. 'Named placement supervisor' is one possibility. Educational supervisors and clinical supervisors who are not doctors will fall outside the scope of the GMC's recognition and approval arrangements but it would be good practice for the education organisers to expect training of the same quality.
- 60** Recognised or approved trainers 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 appreciation of training responsibilities.

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- 61** Criteria for recognition as named educational supervisors or named clinical supervisors will need to be determined by EOs in light of the GMC's standards, specialty expectations and other guidance. The criteria must be justifiable and non-discriminatory. The case for criteria restricting these two training roles to higher level posts or to specialist/GP registration is stronger:
- a** where the trainee is at a later stage of training
  - b** in relation to named educational supervisors rather than named clinical supervisors.
- 62** Recognition will be a prerequisite for medical trainers acting as a named educational supervisor or named clinical supervisor. But individual recognised trainers may not be suitable to perform specific training roles.
- 63** GP trainers of GP registrars continue to be approved by the GMC. The postgraduate EOs need to identify the GP trainers who meet the GMC's standards, in the structure of AoME's seven areas, as determined through local processes and to submit their names to the GMC for approval.

## Other points to consider in recognising trainers

- 64** Doctors can be recognised trainers without actively performing any of the four roles, if they comply with the requirements set by the relevant education organiser. Recognised trainers must, though, maintain their skills by continuing to reflect on training responsibilities – for example, through continuing professional development. This will need to be confirmed through their appraisal.
- 65** Some individuals may need to be recognised or approved for more than one role. Often one trainer acts as both a named clinical supervisor and a named educational supervisor at the same time, both roles requiring recognition by the relevant postgraduate EO in a single process. Or a trainer may be both a named educational supervisor for some trainees and also an LEP's lead coordinator for student placements, in which case he or she would need to be recognised by both the postgraduate EO (the postgraduate dean) and the undergraduate EO (the medical school). The dean and the medical school would work together to share information where possible and minimise inconvenience to the trainer.
- 66** Given the wide variety of training arrangements, including non-NHS and non-clinical environments, it will not always be clear whether a given role needs to be filled by a recognised or approved trainer. Wherever there is doubt, we would like to be contacted at [quality@gmc-uk.org](mailto:quality@gmc-uk.org) 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.

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## Training roles outside the scope of recognition

- 67** Recognition and approval will be required only for doctors performing the four roles identified. They will not be required for other doctors who make important contributions as trainers.
- 68** In addition to the roles requiring recognition, medical trainers also include doctors with other formal roles in delivering undergraduate and postgraduate medical education locally in the clinical or medical environment, such as clinical teachers, clinical tutors, clinical lecturers, college tutors, specialty tutors, regional advisers, heads of schools, foundation programme directors, specialty (including GP) programme directors and directors of medical education. In addition, many doctors act informally as sessional supervisors, overseeing the work of trainees in a particular session, perhaps at night or in a very specialised aspect of clinical practice.
- 69** Individual doctors in these various formal and informal training roles – or not in any training role – may be recognised where they have met the criteria set by the education organiser. But recognition or approval is required by the GMC only in relation to the four roles identified.
- 70** In addition, students and trainees will be trained by non-medical trainers, from other healthcare professions and from other fields. Their contribution is essential to training for contemporary medical practice. Nothing in the arrangements for recognition and approval should prevent the widespread use of non-medical trainers of a good quality, who are appropriately managed and supported.
- 71** It is important that all trainers feel that their contributions are valued and supported. EOs should ensure that all trainers are properly trained and may wish to establish systems parallel to recognition for specific roles or groups, bearing in mind the relevant professional standards and guidance. LEPs should provide all trainers with the time and other resources needed to carry out their training responsibilities and should review and support their performance through appraisals and opportunities for personal development.

# What counts: GMC standards, AoME areas, EO criteria

- 72** The keystone will be the GMC's standards for trainers as set out in *The Trainee Doctor*<sup>1</sup> for postgraduate training and *Tomorrow's Doctors*<sup>2</sup> for undergraduate education. The standards apply across primary and secondary care and to training in NHS and non-NHS institutions. The standards will continue to apply to all medical trainers, whether they are approved, recognised or neither.
- 73** The broad approach of the GMC's standards is well-established. PMETB's 2006 *Generic standards for training*<sup>12</sup> 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*<sup>13</sup> (which set the standards for the Foundation Programme) required that trainers in the Foundation Programme be appropriately appointed, trained and appraised for 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*<sup>2</sup> followed the 2003 edition which stated that all staff should take part in development programmes to promote teaching and assessment skills.
- 74** In addition to the current educational standards for trainers, all doctors need to comply with our professional guidance. *Good Medical Practice*<sup>4</sup> has been under review with publication of a new edition expected by the end of 2012. *Leadership and management for all doctors*<sup>14</sup>, in effect from March 2012, also includes guidance on training. Medical trainers must follow the GMC's professional guidance as it touches on training and also, like all doctors, as it relates to clinical or medical practice more generally, particularly given that they are role models to their students and trainees.

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- 75** To be recognised or approved, trainers will need to meet the standards we set, as mapped against the seven areas in *A Framework for the Professional Development of Postgraduate Medical Supervisors*<sup>3</sup> (available at [www.medical-educators.org](http://www.medical-educators.org)) 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.
- 76** AoME developed the framework from evidence including a literature review, focus groups, survey data and input from stakeholders.
- 77** 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.
- 78** Named clinical supervisors will need to meet the GMC's standards in relation to five of the seven AoME areas: the first four areas as well as the last one. Similarly, it will be possible for doctors not performing any of the four roles to become recognised by meeting the GMC's standards in those five areas. But trainers performing the other three roles requiring recognition (ie those responsible for overseeing students' progress at each medical school, lead coordinators of undergraduate education at each local education provider and named postgraduate educational supervisors) will need to meet the standards in relation to all seven areas of the AoME framework.
- 79** From 2013-14, GP trainers requiring GMC approval will need to be considered in the context of the seven AoME areas (or the five areas where they are acting as named clinical supervisors only).
- 80** The seven AoME 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*<sup>2</sup> and *The Trainee Doctor*<sup>1</sup>. While AoME's framework includes additional detailed guidance on each of the seven areas, the standards for recognition and approval are those already determined by the GMC.
- 81** EOs have lead responsibility for trainer recognition. This includes developing criteria by which to determine whether trainers meet the GMC's standards, including requirements for the training of trainers and for reviewing and reflecting on their performance.

# What trainers need to do



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- 82** The arrangements for recognition do not change the standards that trainers are expected to meet. These continue to be set out in *Tomorrow's Doctors*<sup>2</sup> and *The Trainee Doctor*<sup>1</sup> as well as *Good Medical Practice*<sup>4</sup> and *Leadership and management for all doctors*<sup>14</sup>.
- 83** In order to perform one of the four roles covered by recognition, medical trainers will need to comply with the arrangements set by the education organiser involved, which will be working with the local education provider. The EO will need information about the training received by trainers and about the processes for reviewing and reflecting on their performance (eg educational appraisal and/or whole-practice appraisal). The EOs may also draw upon other sources such as accreditation granted by professional bodies or organisations that support trainers.
- 84** Doctors who are not performing any of the four roles may also wish to seek recognition and, again, would need to comply with the arrangements set up by the EO.
- 85** Training is an aspect of *Good Medical Practice*<sup>4</sup> and an important element of doctors' scope of practice, covered by doctors' whole-practice appraisals. Doctors will therefore need to keep supporting information about their training which can be used both to support appraisal and to obtain recognition as a trainer. Appraisals will contribute to recognition as a trainer. Being a recognised trainer will be relevant to appraisal.
- 86** Revalidation will cover training activities in the same way as it will cover other aspects of medical practice. In due course, the GMC will consider the scope for bringing the processes of revalidation and recognition closer together.
- 87** Trainers will also need to agree job plans that are consistent with their responsibilities. These will need to be reviewed annually.
- 88** Trainer recognition is not a 'tick-box' exercise. Beyond meeting the minimum standards, trainers are expected to develop their skills and competence, and to consider opportunities for career progression as trainers, supported by the processes involved in trainer recognition.
- 89** The statutory requirements for GMC approval of GP trainers remain in place and the GPs concerned will need to comply with the requirements set by the EO.

#### **Recognition: What's in it for trainers?**

- The status of official recognition
- Support for training in job plans
- Help with appraisal and revalidation
- CPD points through training as a trainer
- A stronger case for professional awards
- Career development.

# LEPs managing trainers

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**90** Local education providers are responsible for the settings in which training is delivered.

**91** Local education providers therefore have key responsibilities for organising high quality training and will be critical to the implementation of the arrangements for recognising trainers.

**92** Recognition of trainers will help to shine a light on how training responsibilities are supported, for example in job plans, appraisal, 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.

**93** The required processes should largely exist already. So the recognition and approval of trainers will 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 AoME areas.

**94** 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 specific responsibilities lie.

**95** EOs may agree to take on some of the responsibilities of local education providers. Some small local education providers such as individual general practices will not have an appropriate internal infrastructure. The details of how the various responsibilities are fulfilled will be for the local education providers and the education organisers to agree – with the EOs accountable to the GMC.

### Information about trainers

**96** The LEP and the EO will need to agree arrangements for collecting key information for all trainers who are recognised or needing or seeking recognition. We do not wish to mandate specific responsibilities in ways that would disrupt arrangements that are working well.

**97** The agreement should ensure that both the EO and the LEP have appropriate access to the information in real time. Some information should be in databases with shared access for appropriate individuals at the LEP and the EOs as well as the trainers concerned. Other information may not be available to all parties (whether or not held in the same system). Confidentiality and data protection must be respected.

**98** It will be important to avoid unnecessary duplication of effort and where possible to make use of existing data eg from trainers' supporting information for appraisal, e-portfolios, HR systems and records of training received.

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**99** The agreements between LEPs and EOs will need to determine the information to be collected about individual trainers. While not wishing to be prescriptive, datasets could cover:

- a** name, GMC registration number and contact information
- b** dates of initial recognition/approval and of renewals or reviews
- c** specific training roles, covering the four roles requiring recognition, and dates of periods when these roles have been performed
- d** job planning (including supporting professional activities (SPAs) where relevant)
- e** training received
- f** qualifications or accreditation as a trainer including information related to the arrangements of royal colleges and faculties
- g** feedback from trainees/students and others
- h** any information for and from educational appraisals
- i** information for and from whole-practice appraisals
- j** other information bearing on suitability for recognition eg educational supervisor reports
- k** information to be required in the future by the GMC in relation to trainers requiring approval (see paragraph 151 below)
- l** information that would provide a base for the GMC trainer survey

**m** equality and diversity monitoring data – eg age, gender, ethnicity and disability of the trainer.

More generally, LEPs could consider the 'Recommended data set for reports on supervisor status in local education providers' at Annex B of the *AoME Framework for the Professional Development of Postgraduate Supervisors*.<sup>3</sup>

## Running systems, meeting standards

**100** 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 may have implications for:

- a** how trainers are chosen to carry out the four roles
- 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.

**101** 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.

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**102** Guidance to help local education providers includes the GMC's documents *The Good Medical Practice Framework for appraisal and revalidation*<sup>15</sup> and *Supporting information for appraisal and revalidation*<sup>16</sup> (available at [www.gmc-uk.org/revalidation](http://www.gmc-uk.org/revalidation)).

**103** AoME's *A Framework for the Professional Development of Postgraduate Medical Supervisors*<sup>3</sup> 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.

**104** Local education providers could also consider the GMC's advice on *Developing teachers and trainers in undergraduate medical education*.<sup>17</sup> 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*<sup>18</sup>, 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.

**105** Local education providers will need to take appropriate action where poor training is identified or there are other relevant concerns about a trainer. Often remediation of the trainer 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. It may be necessary to prevent the individual from acting in a specific role or to remove him or her from the database of recognised trainers. Clear appeals procedures will need to be put in place locally building on existing arrangements.

**106** Local education providers may need to work with the education organisers on interim arrangements in respect of previous training and development, and moving towards full recognition for all concerned.

**107** 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 questions, information and advice from EOs about the quality of the training provided.

## Job planning for training

**108** GMC training surveys and other research demonstrate that trainers do not always have sufficient time to train. The 2011 *Guide to consultant job planning*<sup>19</sup> published by the BMA and NHS Employers for England clearly sets out an appropriate framework for addressing the problem. 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.' The guide explains that SPAs may include participation in training, medical education, continuing professional development and formal teaching.

**109** While the 2011 guide applies to consultants in the NHS in England, all LEPs must be able to demonstrate that all trainers are granted the time they need to train and that time identified for training is used for training.

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- 110** The time commitments will vary from individual to individual but must be clearly spelled out in job plans for all trainers active in any of the roles requiring recognition and also where relevant for other trainers (eg sessional supervisors).
- 111** As the guide states: 'time set aside for SPA activity should only be spent on those elements identified within the job plan'. Time actually spent training must be monitored against the expectations in the job plans. Job plans must be reviewed annually to ensure that training is protected.
- 112** Clearly LEPs and EOs will be concerned not only to ensure that appropriate time is available for training but also that the time is well used – effective systems for quality control and management need to sit alongside arrangements for job planning. '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...'
- 113** LEPs must also ensure that sufficient numbers of trainers are available bearing in mind the job plans agreed and the willingness of senior medical staff to train. This may in turn have implications for the SPAs that LEPs are content to agree.
- 114** LEPs should identify and share good practice eg in relation to the provision of time in job plans as well as accountability for that provision. For example, psychiatric training involves an allocation of one hour per week of personal supervision<sup>20</sup>. Also, job planning may incorporate a team or departmental perspective allowing consideration of the extent to which training time should be spread around the available trainers or concentrated on particular individuals. Dr Ian Wilson usefully categorised aspects of training in four levels: active, intrinsic, trainee administration and programme organisation. He suggested auditing the uses and categories of SPAs.<sup>6</sup>
- 115** The need to identify and protect time must be clearly covered in the agreements between EOs and LEPs. The agreements should also refer to the funding received by LEPs to support education and training.
- 116** At the time of writing, the BMA and NHS Employers were negotiating a companion volume on job planning for SAS doctors based on similar principles to those set out in the consultant version.

### Recognition: what's in it for LEPs?

Dr Ian Wilson pointed out that employers benefit from being good training organisations:

- 'Recruitment and retention of the best consultants is likely to be enhanced by ensuring that training and education are core, supported objectives.'
- 'Employers do gain both credibility and expertise from providing high quality training and having high quality trainees.'
- Effective LEPs avoid 'sanctions for poorly performing organisations such as removal of training status where an organisation is not providing sufficient support for training departments, or collecting and acting on quality or monitoring data.'<sup>6</sup>

And in any case:

- trainees make a major contribution to service
- LEPs receive funding to support their training functions
- clarifying the responsibilities of individual trainers may enable LEPs to take a more focused approach to job planning and training trainers
- LEPs' contributions to the NHS Litigation Authority in England may be discounted where training is provided effectively.

Most fundamentally, as NHS Employers stated in their response to the consultation:

- 'It is likely that appropriate training and supervision for trainees will reflect in improved patient outcomes across a raft of quality measures.'

### The responsibilities of local education providers include:

- a Identifying trainers currently in the roles requiring recognition and choosing recognised trainers to perform the four roles.
- b Ensuring that sufficient trainers are in post and available to train.
- c Supporting trainers through:
  - i job plans
  - ii appraisal and revalidation
  - iii support for the training and professional development of trainers
  - iv dealing effectively with concerns and difficulties.
- d Taking effective action where training is poor and remediation is not sufficient.
- e Mapping their arrangements against the seven areas of AoME's *A Framework for the Professional Development of Postgraduate Medical Supervisors*<sup>3</sup> and ensuring that the GMC's standards are met.
- f Liaising with EOs in accordance with agreed arrangements eg on establishing databases of recognised trainers which can be accessed by both LEPs and EOs.
- g Being accountable for the use of the resources received to support medical education and training.

# EOs recognising trainers



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**117** The term education organiser (EO) covers medical schools and postgraduate deans. (We use the term 'postgraduate dean' to acknowledge the various and developing arrangements across the UK for postgraduate training. The deans will need to make sure that the responsibilities we set out are met but need not be personally involved in running the processes.)

**118** EOs will have lead responsibility for recognising trainers eligible for the four roles. Once the legal powers are in place, EOs will pass information to the GMC so that we can approve the trainers, subject to our own checks (as described later – paragraphs 145 to 150). In the meantime, the postgraduate deans will continue to provide us with information only about GP trainers requiring approval.

## Setting criteria

**119** The GMC's standards for trainers and the AoME's seven areas provide a structure and a set of principles for recognition and approval. However, it is for the EOs to determine the precise criteria by which to judge whether those standards have been met by trainers, including any requirements for specific skills or qualifications or for training, accreditation by external agencies or review and reflection. The GMC will not be mandating specific training courses or approaches. These detailed requirements should be determined by the EOs in light of best practice and guidance eg from specialty or professional organisations. The criteria must be demonstrably fair and equitable and not set indefensible hurdles for particular groups of doctors eg in relation to disability, external responsibilities, the hours that trainers work or their career path.

## Making decisions about trainers

**120** In identifying the trainers needing recognition or approval, EOs will rely largely upon the databases kept by the local education providers and they will need access to that information (unless they hold the database, in which case the LEPs will need access).

**121** However, EOs may not be able to rely solely on the information in the local education providers' databases. They will need to be confident that their recognition of trainers draws also on any other sources of information which may not have been available to or fully considered by the LEP in populating the database or in employer appraisals eg where concerns have been raised with a postgraduate dean.

**122** Also, EOs will draw on any information available about the accreditation of trainers by appropriate bodies or derived from periodic professional reviews of the quality of training, which may or may not be fully covered by the LEP database. The royal colleges and faculties have well established systems for training trainers and the RCGP is closely involved in the existing systems for approval of GP trainers. Information could also be drawn from arrangements associated for example with AoME or 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, specialty and other professional arrangements for supporting trainers that comply with the GMC's standards. The EOs will need to ensure that there are processes for considering these sources of information eg through whole-practice appraisals by LEPs or through review of e-portfolios.

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**123** EOs may have concerns about particular trainers who are included in databases held by LEPs. The EOs will need to liaise with the LEPs to address these concerns. As stated above, remediation may be appropriate or it may be possible to agree with the individuals concerned that they should no longer act in specific training roles. In the end, EOs must recognise only trainers who they are satisfied meet the standards we set and must keep the trainers and the LEPs informed about developments. EOs will need to establish procedures for appeals against decisions not to recognise individuals as trainers, building on existing arrangements.

## Coordinating responsibilities

**124** To carry out their functions effectively, EOs will need clear agreements with LEPs about their respective roles and responsibilities, not least in relation to responding to concerns about individual trainers and maintaining information about recognised trainers.

**125** The undergraduate EOs (medical schools) will need to recognise the trainers who oversee students' progress at their school and also the lead coordinators of training at each LEP where their students have placements. The postgraduate EOs (deans) will need to recognise the named educational supervisors and the named clinical supervisors based at the LEPs in their geographical area. Where a postgraduate EO arranges a placement with a supervisor outside their area, the responsibility for recognising the supervisor will lie with the EO covering the LEP where the placement is held.

**126** Where trainers carry out both undergraduate and postgraduate roles requiring recognition, they will need to be covered by both the relevant undergraduate EO and the relevant

postgraduate EO. While each EO is responsible for granting, denying, renewing or withdrawing recognition to or from its trainers, in practice EOs will need to work together and share information where possible to avoid unnecessary duplication of effort for the trainers. The same applies should a trainer work in more than one LEP which are covered by different EOs. Similarly, where a trainer moves between LEPs covered by different EOs, the EOs should minimise the demands on trainers that arise from transferring the responsibility for recognition, recognising that there may be some variation between EOs in their criteria for recognition.

**127** GMC approval for GP trainers (and, in due course, other trainers) applies UK-wide. However, the responsible postgraduate dean may decide it is necessary to inform the GMC that an individual GP trainer should no longer be approved. A GP trainer will not be approved by the GMC without a positive recommendation from the relevant dean.

## Quality management of training

**128** EOs will have contracts or agreements with LEPs giving them opportunities to ensure that LEPs manage training in accordance with the standards we set. Working with the GMC, EOs will be prepared to take effective action where necessary to maintain standards, which may even involve removing trainees or students from particular LEPs.

**129** LEPs will need to satisfy education organisers that their processes, such as appraisal, relate to the standards required by mapping their processes to the seven areas. Some LEPs may be covered by more than one education organiser – both a postgraduate dean and a medical school

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– in which case it would not be necessary for the EOs' quality management activities to be duplicated. EOs will continue to be subject to regulation by the GMC.

**130** EOs need to consider the time available for training thoroughly through their visits and other quality management activity. They should regularly collect information from LEPs about the adequacy of the time for training in job plans and report their findings to the GMC (see paragraph 138).

**131** EOs should ensure that LEPs clearly set out how the funding they receive to support education and training is used for that purpose.

**132** The GMC will then expect EOs to report regularly on the adequacy of job planning for training and also to demonstrate that:

- a** their agreements with LEPs cover job plans and the adequacy of time as well as transparency in the use of funding for education and training
- b** LEPs effectively monitor trainers' job plans and the time doctors devote to training and report findings to the EO
- c** EOs know what happens to the funding that LEPs receive for education and training.

**133** Some training may fall outside the scope of these specific arrangements eg where trainers are not subject to NHS arrangements for job planning, or where LEPs do not receive funding for education and training through the normal routes. Nevertheless, EOs must ensure that all LEPs can demonstrate that trainers have the time they need, including LEPs across the UK and LEPs both within and outside the NHS. This relates to all trainers whether or not they are consultants and whether or not they are recognised/approved.

**The responsibilities of education organisers include the following:**

- a** Taking the lead role in recognising trainers, including establishing criteria and processes consistent with the GMC's standards and requirements.
- b** Reaching agreements with local education providers on respective roles and responsibilities.
- c** Quality managing training arrangements at local education providers and their job planning for training in light of the GMC's standards and the seven AoME areas.
- d** Reviewing available information before deciding to recognise individual trainers.
- e** Passing on information to the GMC about the GP trainers identified; and, once the GMC has the necessary statutory powers, also passing on information about other trainers requiring GMC approval.
- f** Reporting regularly to the GMC on the adequacy of the job planning at each LEP in their area and generally cooperating with quality assurance by the GMC.

# The GMC's role in regulating trainers

## Standards and guidance

**134** 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*<sup>2</sup> for undergraduate education and *The Trainee Doctor*<sup>1</sup> 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.

**135** In addition, we issue guidance that might assist local education providers and education organisers. This includes the supplementary advice that we have provided on undergraduate education and the advice to support appraisal.

## Quality assurance

**136** We quality assure education organisers against the standards that we have set. With the recognition and approval of trainers in place, this will involve examining how well the local processes satisfy our standards and have been mapped against the seven areas.

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

- a We conduct annual training surveys.
- b We can receive information from the deanery reports or the annual specialty reports from the RCGP.
- c A concern could be identified through our responses to concerns process.
- d During visits we interview 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.

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**138** Recognition and approval of trainers 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*.<sup>21</sup> For example, regional programmes of visits will cover the systems set in place by medical schools and postgraduate deans. Training arrangements could be addressed through a thematic review of the arrangements across undergraduate and postgraduate education and throughout the UK. The national training surveys will continue to produce evidence that can be considered at both national and regional levels. The periodic returns from postgraduate deans and medical schools could produce data on readiness and the implementation of arrangements for the recognition and approval of trainers including job planning. Any problems could be addressed through our responses to concerns process.

**139** In any case, postgraduate deans must let the GMC know about some specific situations: when there are trainee or patient safety issues, when the deanery is planning to withdraw trainees from an NHS or other site due to concerns about the quality of training or patient or trainee safety, or when NHS or non-NHS partners are defaulting on action plans to address gaps in meeting our standards. Medical schools should also inform the GMC about poor standards found on undergraduate placements.

**140** The GMC can take effective action to maintain compliance with our standards. If we had concerns about training or supervision at an LEP, we would seek information from the education organiser about the quality management mechanisms they have in place. We might ask for specific information and suggest that the LEP be jointly visited by the EO and the GMC.

In any case, we publish the results of our quality assurance visits and associated activities on our website and lay down recommendations or requirements as appropriate. Where necessary we have the statutory power to withdraw approval for postgraduate programmes and training posts as well as GP trainers and we can prevent medical schools from issuing primary medical qualifications.

**141** Conversely, the developmental and decentralised approach that the GMC is taking to the recognition of trainers will allow us to identify and disseminate good and interesting practice.

**142** We will in any case monitor progress on implementation of the arrangements for trainer recognition (see paragraphs 160–164). The separate equality analysis sets out our intentions with regard to monitoring from the perspective of equality and diversity, for example through the national training surveys.

**143** The GMC will continue to ensure that time for training is considered at the UK level drawing on the information to be collected from the EOs and other sources.

**144** In 2012 we started a review of our approach to quality assurance which may result in changes in due course.

## Considering trainers for approval

**145** 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 will be extended to non-GP trainers once we acquire the necessary statutory powers.

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**146** There will be some circumstances in which we might need to withhold or withdraw approval, particularly given trainers' responsibilities as role models to students and trainees. 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 full or correct.

**147** 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.

**148** 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 this 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 recommend particular individuals for GMC approval as trainers.

**149** 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 would be necessary for the doctor to be referred to FTP proceedings and a decision on approval would be made in light of the findings.

**150** 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.

## The information to be submitted about trainers requiring GMC approval

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

- 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 good practice or concerns at individual sites and action taken 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

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than one EO may be responsible where the trainer trains both students and trainee doctors or works at more than one LEP under different EOs.

- 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.

**152** Providing this information should not be overly demanding for EOs. Some of this information will already be required for revalidation and identifying doctors' scope of practice. Also, information will be needed by postgraduate deans and medical schools for their own purposes.

**153** We will in any case review our information requirements before extending GMC approval beyond GP trainers.

**154** These intentions do not affect the current arrangements relating to the information required from postgraduate deaneries about GP trainers.

## The scope of practice and revalidation

**155** Separate from the recognition of trainers by education organisers, doctors have been collecting information about their scope of practice, including their role in delivering training, in preparation for the implementation of revalidation in late 2012. Training is clearly an aspect of medical practice relevant to revalidation as well as appraisal.

**156** 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

**157** Currently, we do not publish the names of the approved GP trainers, although in the interest of transparency and promoting the importance of training we intend to do so in due course.

**158** We are aiming 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.

**159** However, this is potentially quite complex and will be taken forward in a later phase of work.

### 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 and taking effective action where training is poor.
- d Making reasonable and evidence-based decisions on the approval of GP trainers who have been identified by education organisers (which will apply to non-GP trainers once the necessary statutory powers are in place).

# Implementing recognition

**160** The GMC will take a realistic and staged approach to recognising and approving trainers in light of the consultation response and appreciating the other pressures on trainers, EOs and LEPs.

**161** Key principles have been identified for implementation:

- a** Trainers are already required to meet the standards set by the GMC in *The Trainee Doctor*<sup>1</sup> and *Tomorrow's Doctors*<sup>2</sup> and the regulator (the GMC and formerly PMETB) has required evidence of training for trainers. EO and LEPs must take effective action

immediately if they are concerned that any trainers do not meet those standards. EOs need to ensure that arrangements for all trainers in the four roles are brought into line with those generally in place for educational supervisors and GP trainers.

- b** The statutory arrangements for GMC approval of GP trainers of GP registrars remain in place and are developing. Nothing in the implementation of trainer recognition should compromise EOs' commitment to the system for approving GP trainers.



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- c EOs will develop criteria by which to determine whether trainers meet the GMC's standards, including requirements for the training of trainers. EOs may also define interim concessions to acknowledge previous receipt of relevant training and development (but not simply to accept past experience of providing training as a substitute for demonstrable skills development). These would incorporate the need for effective arrangements to review and reflect on training performance and link to the collection of supporting information for appraisal. It may be appropriate to provide or require top-up training for established clinical supervisors or educational supervisors. And EOs will need to establish systems to collect data in light of their criteria and any interim concessions. They will also need to provide support to trainers requiring recognition to help them understand and comply with the new EO arrangements eg to compile the information required.
  - d Some trainers in the four roles may not be able to meet all the EO criteria in the short term and will need to be 'provisionally recognised'. EOs will need to monitor their progress so that all trainers in the four roles are fully recognised by 31 July 2016.
  - e EOs will also record information about other doctors who are recognised or moving towards recognition as trainers.
  - f The GMC needs to be satisfied that steady progress is made on trainer recognition and on EOs being able to confirm that their own criteria are being met.

**162** The GMC has identified the following milestones for EOs:

- a to submit to the GMC a timeline for implementation for trainer recognition – by 31 December 2012
- b to confirm that criteria and systems are in place and ready for data entry – by 31 July 2013
- c to confirm that full information has been entered for all medical trainers in the four roles in light of the EO criteria and that the trainers have all been categorised as provisionally or fully recognised – by 31 July 2014
- d to confirm that all medical trainers in the four roles, or entering any of the four roles, are fully recognised ie have met the EO criteria, without use of interim concessions – by 31 July 2016.

**163** In due course, once the statutory powers are achieved, EOs will need to submit for GMC approval the names of all recognised trainers. All doctors in or entering any of the four roles will need to have been approved by the GMC.

**164** The GMC intends to review and publish the timelines submitted by the EOs and to monitor and publish information about their progress against the EO timelines and GMC milestones.

# Appendices

## Appendix A: What the Medical Act says

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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.

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.'

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...'

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.'

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.'

## Appendix B: Mapping of the seven AoME 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*<sup>1</sup> draws from Annex A of AoME's *A Framework for the Professional Development of Postgraduate Medical Supervisors*<sup>3</sup>.

AoME's Annex also maps the seven areas against:

- a the Higher Education Academy's *The UK Professional Standards Framework for teaching and supporting learning in higher education*<sup>22</sup>
- b AoME's *Professional Standards*<sup>23</sup>
- c the GMC's *Good Medical Practice framework for appraisal and revalidation*.<sup>15</sup>

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