

General practice education and training in the UK – a thematic review

Introduction

This report provides a snapshot of medical education and training in general practice (GP). It is based on visits to five locations across the four nations of the UK in 2016 and 2017, and is aligned with the themes set out in our [*Promoting excellence: standards for medical education and training*](#).

Why did we review GP education and training?

We wanted to better understand how GP programmes are quality managed in different locations across the UK; and how governing bodies provide support for, and contribute to, training.

While we hold detailed evidence on GP training posts in secondary care, from a range of data including our national training surveys (NTS), historically our information on GP training within primary care settings has been more limited.

In 2016 we were able to bring together aggregated results from three years of NTS results, for the first time. This gave us an opportunity to examine data on individual GP surgeries, explore how education and training is delivered in England, Northern Ireland, Scotland and Wales, and check whether our standards are being met.

What did we do?

This review was primarily a qualitative piece of work with evidence collected through the various meetings with the stakeholder groups in the areas detailed above. All meetings with doctors in training and clinical or educational supervisors required a minimum of three attendees to ensure we could triangulate our findings. We recognise that the sample size for this review was limited in terms of the total number of GP doctors in training.

We take a risk-based approach to quality assurance. We wanted to review a cross-section of programmes that had a range of challenges, were delivered in diverse environments, and in different areas of the UK. When deciding where to visit we looked for evidence of potential issues, as well as areas that appeared to be working well. We used our National

Training Survey and evidence submitted by the RCGP on an annual basis and HEE and Deaneries as part of our ongoing monitoring.

We identified five GP training programmes to visit:

- Durham and Tees Valley
- Glasgow South
- Gwent
- Luton
- Northern Ireland

To understand the experience of doctors in training in GP, we conducted an analysis of our existing evidence, a desktop review of additional data, and conversations with those involved in managing, delivering and receiving GP training. Our visits to the five training programmes allowed us to triangulate our findings. Prior to the visit we carried out detailed analysis of GMC survey results, CQC reports, Annual Specialty Reports submitted annually by the RCGP, deans reports, progression data and exam results to identify aspects to interrogate further, and inform our questioning on the visits. The visits we carried out formed the final piece of evidence gathering for this project. This report has been written based on the evidence we collected and analysed before and during the visits. We acknowledge that stakeholders will have carried out further work since the visit was completed including the 2017 National Training Survey but our process is not designed to include subsequent evidence.

Key Findings

- Throughout all of the training programmes we visited, doctors in training spoke very positively about their placements in primary care. We heard that GP practice placements tended to be well organised and well run, and this time was the most valuable in preparing trainees for the workforce.
- Out of hours (OOH) services in some of the areas we visited were struggling and there were inconsistencies in how this training was supervised and delivered. OOH is a vital part of GP training, valuable for meeting competences and readying doctors for the workforce, but service pressures meant that education was not being prioritised. We heard that some out of hour's services were delivered but not well managed because of a lack of resources, with accountability and governance unclear.
- We recognise that there is a clear strategy for the recruitment of GP doctors in training across the four nations of the UK and much work has been done in this area. We heard during our visits from GP doctors in training and GP trainers that

they were unaware of the UK wide strategy and were concerned about workloads during training and after certification, and that this could be putting off some from entering the specialty. We acknowledge the devolved nature of health care, the competitive recruitment by nations and the role of UKMERG is co-ordination, but more could be done to communicate recruitment strategies and initiatives with those directly involved with training.

- As part of their GP education, doctors in training have access to regular GP Specialty Training Programmes. Doctors in training described these as good for networking and meeting other doctors in training, especially when in a Specialty care placement where they can feel isolated and separated from GP Training.

We have identified several requirements and recommendations, details of which can be found on pages 34-40, and which we expect to be delivered by the RCGP and Deaneries/HEE Local Offices. We will work with the relevant organisations to ensure the requirements and recommendations are delivered. We will seek action plans from the relevant organisations to demonstrate the plans in place and will monitor these requirements and recommendations on an annual basis through our ongoing monitoring systems.

Findings

THEME 1 Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.



Induction

- 1** We heard that induction into the GP training programme was generally good. Inductions were regarded as a good opportunity for doctors in training to get to know each other. Doctors in training we met across sites and programmes stated that the inductions they had attended included information about the e-Portfolio and assessment with a focus on how to complete reflective entries for their learning logs. Doctors in training commented that more time should have been spent on the curriculum and during their inductions, as they were not always clear on how to link their competences to their e-Portfolio. Doctors in training in secondary care placements sometimes found it difficult to get time to attend specific induction for GP training separate from the induction for their own specialty post.
- 2** We found that some training programmes had created supplementary inductions for doctors in training who had been identified during the recruitment process as needing additional support – this could include career-change doctors, doctors in training who had low attainment scores in the recruitment process and international medical graduates. We heard these inductions were interactive and practical, with tailored learning around communication and consultation skills and comprehensive information regarding how the NHS system worked. Some doctors in training attended these sessions with their educational supervisors – trainers based in primary care, referred to as ‘GP trainers’ for the remainder of this report – which helped embed learning and strengthen relationships. The doctors in training we met who had attended these enhanced inductions spoke positively about the experience.

- 3 Interventions such as these were supported by recent [GMC commissioned research into fair training pathways](#). This found that a strong, supportive relationship with an educational supervisor, timely feedback and tailored support can be critical to the successful progress of doctors with protected characteristics who face additional hurdles to complete medical training successfully.

Reporting patient safety concerns

- 4 All the training programmes we visited had systems for reporting concerns; however some were more informal than others. All doctors in training that we spoke with stated they would be comfortable discussing any patient safety concerns with their GP trainer, clinical supervisor, other senior staff, such as consultants, and their training programme directors (TPDs) or GP practice managers. Doctors in training in secondary care posts would report to their clinical supervisor, consultants or nursing staff, or they could raise a concern through reporting systems like Datix. The system for reporting concerns in a secondary care context would often vary depending on the department. If a doctor in training was involved in a serious incident, they would also be expected to complete a reflective serious incident analysis for their e-Portfolio.
- 5 Doctors in training were sometimes unclear on the process that was followed after concerns had been raised, and we heard that feedback on concerns about patient safety was not always received. However, we heard that doctors in training who had raised patient safety concerns felt supported through the process. Doctors in training we met would welcome more opportunities for feedback and reflection following serious incidents.

Feedback on training programmes

- 6 We heard that training programmes sought feedback from doctors in training and GP trainers, using the national training survey and end-of-post feedback; however the method of collecting feedback was not consistent across the programmes we visited. Some programmes used the GP Specialty Training Programmes to gather feedback and soft intelligence, and others conducted local surveys to inform changes to their programme. The ARCP process was also a source of information regarding how the programme was progressing.
- 7 The strong relationship between doctors in training and their GP trainers meant most doctors in training working in a GP practice would provide feedback directly in tutorial sessions on an informal basis. GP trainers stated they would also approach the TPD, associate postgraduate dean or head of the GP school (or equivalent) to raise concerns, including if there were problems in the relationship between the GP trainer and doctor in training. In most instances, any issues would be discussed directly with the doctor in training and their GP trainer with guidance sought from

the GP school or equivalent. Serious issues could be escalated to the deanery or HEE local office, with most problems addressed locally.

- 8** Some training programmes we visited had a policy that GP training practices required two GP trainers. The education management teams we spoke to told us that a two-trainer practice provided a means of intra-practice quality control and feedback, and trainers in GP told us that the two-trainer system made the delivery of education easier. We heard this offered more flexibility for both GP trainers and learners, as doctors in training could receive educational or clinical supervision from multiple people.
- 9** GP trainers similarly told us that having a GP trainer colleague in the same practice meant that the teaching provided could be checked for consistency including the benchmarking of assessments. The training programmes with a two-trainer minimum told us that this policy had reduced the number of concerns they had previously received regarding the quality of education they were providing. The close peer support could increase a GP trainer's confidence, including in providing difficult feedback to doctors in training. Recent research into fair training pathways highlighted peer support for educators as being beneficial as part of ensuring doctors are aware of educational expectations and when to take action where they are not being met.
- 10** There were concerns raised around the system for seeking feedback on secondary care placements and the interaction of secondary care with the training programmes. Some doctors in training described completing end-of-post feedback in secondary care posts and seeing changes made to their placements as a result, but we also heard from clinical supervisors who were unclear on whether their placements were working well for GP doctors in training. Some training programmes we visited had created a role for an individual experienced GP educator to advocate for GP doctors in training in secondary care placements. At the time of our visits, these positions were in the process of being established and their effectiveness had not been tested.
- 11** We were unclear on the threshold for escalation to the deanery or HEE local office and heard of issues that had been escalated but were not resolved for extended periods of time. Doctors in training we met were not aware of their representatives at the deanery or HEE local office level, and did not have access to formalised feedback sessions such as a trainee forum. Doctors in training described positive relationships with their GP trainers or TPDs and felt their issues were listened to, even if they were not addressed.

Educational supervision

- 12** All of the people we spoke with during the course of our visits valued the close relationship between doctors in training and GP trainers. We consistently heard that the protected weekly teaching and tutorials with GP trainers while in GP were the

most valuable educational time. Every doctor in training we spoke with had a named GP trainer, and we heard that their trainers had an in-depth knowledge of the GP curriculum, which helped focus a doctor in training's learning. We also heard that some training programmes were set up so a doctor in training would have the same GP trainer for all three years of the programme: the doctor in training would work in the GP trainer's practice during GP placements and would continue contact in secondary care posts. This was felt to be good for continuity of teaching and building relationships.

- 13** We heard from GP trainers that the role provided a personal and professional benefit, although this often required working without full financial compensation. GP trainers told us they valued having doctors in training in their practices, as it meant it helped them to keep up with their continuing professional development. We consistently heard that GP trainers learned as much from their doctors in training as they had taught them.
- 14** As well as being able to approach GP trainers with any feedback or concerns, doctors in training and trainers described a close relationship including a lot of 1:1 interaction. This 1:1 time was used for education, relationship building, case review and also pastoral care. GP trainers told us that the apprenticeship model allowed for progress to be observed over an extended time period and for greater flexibility in teaching styles. We heard that GP trainers provided a high level of support to doctors in training throughout the programme.
- 15** Doctors in training felt well supported and that their educational needs were being met. We heard that this close relationship meant that training could be adapted to suit the needs of the doctor in training, including tailoring to individual family circumstances by modifying a programme for less than full-time (LTFT) training. The GP trainer role could also involve mentoring, with many GP trainers stating that mentoring relationships continued even after a doctor in training had graduated.
- 16** Doctors in training told us that GP trainers would meet with them for regular timetabled sessions as well as on an ad-hoc basis to provide teaching and support. We heard that the feedback received from GP trainers was relevant and timely and enabled doctors in training to make a link between their experiences and the GP curriculum. Learning was also easily tailored due to the close relationship, and GP trainers were able to identify issues – whether personal or professional – and create bespoke solutions.
- 17** GP trainers reported some deterioration in the quality of their educational supervision relationship with doctors in training whilst in secondary care placements. This was not only because contact was less frequent between doctors in training and GP trainers, and but also because of issues in communication between clinical supervisors and GP trainers. Therefore, it was more challenging to gain contemporaneous feedback on the educational and professional development of these doctors in training.

Clinical supervisors in secondary care

- 18** Doctors in training we spoke to had named clinical supervisors while in secondary care placements; however we heard that frequently the supervisor would change mid-placement or they would occasionally never meet with the named person. Doctors in training were encouraged to have formalised meetings with their clinical supervisors at the start and end of each secondary care placement, and to use this time to discuss their needs as a GP doctor in training. Their clinical supervisors would be consultant doctors with a qualification relevant to the post specialty.
- 19** Doctors in training were able to receive clinical supervision during their placements by approaching other specialty supervisors, even if their named supervisor was not available. Similarly, the named clinical supervisors could discuss the doctor in training's progress with other specialty supervisors but there was a definite disconnect in the relationship between a doctor in training and the named clinical supervisor in some cases.
- 20** Doctors in training and GP trainers we spoke with felt that clinical supervisors in secondary care placements were not sufficiently familiar with the GP curriculum. There was a general recognition that clinical supervisors were also responsible for meeting the curriculum outcomes related to specialty doctors in training and we heard the GP curriculum could seem difficult for clinical supervisors to access when their workloads were already overburdened. We were unable to find examples of a close relationship between a clinical supervisor in secondary care and a GP trainer in primary care.
- 21** We heard that some clinical supervisors were proactive in meeting with their doctors in training and some were adept at tailoring the secondary care placements to fit the training needs of GP, including providing relevant feedback and tailoring work place based assessments to be more relevant to GP. We heard that emergency medicine, geriatric medicine and paediatrics were specialties that would adapt their teaching to be more GP centric, with some recognising that good training also meant good service was delivered. We heard that most educational interactions with clinical supervisors in secondary care were led by the doctors in training who were also expected to connect their secondary care experiences to their curriculum.
- 22** The TPDs we met described issues with establishing formalised relationships and feedback processes with secondary care clinical supervisors. Some training programmes had created a condensed version of the GP curriculum to provide to clinical supervisors, others had held meetings and workshops for secondary care educators to increase familiarity with GP Training requirements but were hampered by low attendance, often due to service pressures. We heard from clinical supervisors that they were not aware of the contents of the GP curriculum, and did not know if the feedback they were providing was relevant. We heard from doctors in training, GP trainers and TPDs that the feedback on doctors in training in

secondary care was a tick-box exercise with few links to the GP curriculum. We also heard that clinical supervisors would value more input on the quality of their clinical supervision reports, but did not know how to seek this feedback.

GP Specialty Training Programmes - teaching sessions

- 23** As part of their GP education, doctors in training have access to regular GP Specialty Training Programmes teaching sessions. These sessions are run by the training programme and generally incorporate training and information relevant to the specialty. Doctors in training described the teaching as a good time for networking and meeting other doctors in training, which could help them feel more like a GP doctor in training rather than a specialty doctor in training while in secondary care placements.
- 24** Doctors in training also described the teaching sessions as a good time for networking and meeting their peers, and we heard from TPDs that the teaching sessions presented a good opportunity for gathering feedback or soft intelligence on how the programme was running or for identifying any issues in placements. We heard from doctors in training that the teaching sessions were easy to attend while in GP placements as the sessions were built into practice days and planned well in advance. Some doctors in training, particularly in remote or rural placements, told us that attending the teaching sessions could be difficult as it required extensive travel to attend and we heard that locally delivered teaching sessions would address this issue.
- 25** All doctors in training we met described difficulty in attending GP Specialty Training Programmes training sessions from secondary care placements. However some secondary care placements, especially psychiatry and emergency medicine, had included protected time to attend this teaching. We heard that doctors in training in acute medical placements were the most likely to not be able to attend teaching sessions. Most doctors in training told us that service provision was frequently prioritised over attending these sessions.
- 26** Doctors in training in secondary care were generally required to take study leave to attend GP Specialty Training Programmes teaching sessions and we heard variation on how much notice needed to be given. Some doctors in training we met felt that because the teaching had been planned in advance, their placements should have been tailored to accommodate these sessions. Doctors in training sometimes felt the process of applying for study leave was deliberately obstructive and they would have valued a more supportive approach to this process. We heard that some doctors in training could apply for study leave in advance but have this cancelled at very short notice; even on the day of the teaching. We heard that the training sessions for other specialties were often run on the same day as the GP Specialty Training Programmes release, and secondary care specialty doctors in training were prioritised. As a result GP doctors in training could be required to skip their own training to cover secondary care work.

- 27** We heard from doctors in training that they still valued secondary care placements as offering good experience; however their access to education was frequently impeded in these posts. There was an understanding that secondary care posts have broader issues beyond not tailoring training to GP doctors in training, and we heard that there is not enough staff to cover the workload. These concerns could be exacerbated by training posts not being filled or doctors in training being away due to sick leave or other issues. Most GP doctors in training were included in the middle grade rota, sharing with core medical doctors in training. However sometimes doctors in training in their second foundation year were also included in the rota.
- 28** In some training programmes we visited, we heard that the TPD or associate postgraduate dean had been proactive in protecting teaching time, and some changes had been made to secondary care placements to prioritise GP Specialty Training Programmes teaching. The medical education management teams we met knew that GP Specialty Training Programmes teaching was a vital part of the training process and we heard there was work being completed on ensuring a minimum attendance amount was included in contracts or guaranteed release to these sessions.

Bullying and undermining

- 29** The doctors in training we met were not sure of the formal process for reporting concerns about bullying and undermining which may arise during the training programme. All doctors in training we spoke to told us they could approach their clinical supervisor or GP trainer. Alternatively, some doctors in training stated they would speak directly to their TPD in the first instance. GP trainers and clinical supervisors told us that if they could not manage the concerns themselves, they would feel comfortable approaching the TPD, but were not clear on whether there was a formalised process for referring concerns.
- 30** We heard from the senior management that there were set processes for managing concerns about bullying and undermining, but these processes varied between training programmes. Some programmes would meet with the person affected and the GP trainer and sometimes the practice manager if the concerns arose in a primary care setting. For secondary care posts, they would meet with the clinical supervisor and with the doctor in training; the process was managed by the TPD and the director of medical education in conjunction with clinical leads in the specialty.
- 31** We were told that doctors in training could be reluctant to raise concerns and engage in the process as they found it stressful and would worry it would jeopardise their career prospects. In most instances, if a concern was raised, the doctor in training would be moved out of the post or practice. We heard from doctors in training who had experienced bullying and undermining that the process was quick and the TPD tended to be very responsive. If concerns could not be

resolved locally or by the TPD, the process for escalating issues to the deanery or HEE local office level was not clear, and varied between training programmes we visited.

Succession planning

- 32** We heard that the retention of GP trainers will be important for the future of the specialty and that more work and future planning is required in this area. We also heard it would be beneficial if more time for non-clinical subjects could be provided, which would help doctors in training gain knowledge of how GP practices and partnerships work and encourage them to go into partnership. We heard that training programmes did not have any time to specifically focus on preparing doctors in training to work as a GP after certification. GP trainers and training programme staff told us that most doctors in training go into locum work or work as salaried GPs after certification with few entering as a GP partner immediately after training.

THEME 2

Educational governance and leadership



S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

Interface with secondary care placements

33 During our visits, we heard that there was significant variation in how GP training programmes interacted with secondary care placements. In some programmes we found there was a robust quality management system for secondary care placements. TPDs had formed hospital visiting teams with set visit schedules, and had good working relationships with clinical supervisors and directors of medical education. We heard that in some training programmes there were annual hospital visits and that the training programme staff worked through feedback and end-of-post surveys and spoke with departments that were having issues releasing doctors in training for GP Specialty Training Programmes teaching. Other programmes we visited told us they would conduct specialty-focused visits and would ensure they spoke with GP doctors in training about their training concerns. During these visits, we heard that training programme staff would discuss how to make secondary care posts more relevant to GP doctors in training, including telling secondary care staff to ensure GP doctors in training attended outpatient sessions. There could be more joined up working between primary and secondary care placements and training programmes could do more to ensure GP doctors in training have a clear understanding of the experience they will receive in secondary care placements.

34 Across all training programmes we visited, we heard that there were not strong relationships with clinical supervisors in secondary care placements and the training programme. In some programmes, we heard that work was being undertaken to form stronger links. TPDs had met with clinical supervisors to discuss the GP curriculum and to provide feedback on clinical supervision reports but, as mentioned before, service pressures meant that it was difficult for secondary care clinical supervisors to attend such meetings. There was awareness that secondary

care placements frequently relied on GP doctors in training for service provision, however they were not receiving optimal and relevant teaching and clinical supervisors did not feel connected to the GP curriculum and e-Portfolio. The people we spoke with had an understanding that this disconnect could be because clinical supervisors in secondary care were also responsible for understanding and implementing the requirements of the curricula of specialty and foundation doctors in training as well as GP doctors in training. We heard that clinical supervisors were under increasing workload and service pressures.

- 35** Some programmes and secondary care specialties had appointed champions for the GP curriculum who tailored placements to meet the needs of GP doctors in training specifically. We heard positive feedback from doctors in training who were in secondary care placements with clinical supervisors who had previously trained as GPs, as they had an innate knowledge of their training needs and had made changes to the placements accordingly. We could not identify how this good practice was being shared between secondary care placements or by the training programme.
- 36** We heard from some training programmes that meetings with secondary care providers of GP training posts were discussed at quality assurance meetings with the deanery/HEE local office, and that any issues that were serious could be easily escalated to an associate postgraduate dean or Head of School (or equivalent) who could then liaise with the Trust. However, we also heard that issues were generally managed locally and that some deaneries/HEE local offices were not responsive to concerns.

Contents of secondary care placements

- 37** The doctors in training we met frequently felt their placements in secondary care posts could be improved. There was a view that the time spent in these posts would be more valuable if they were shorter and with more variety. We heard from TPDs, GP trainers and doctors in training that their time in secondary care disengaged them from the GP training programme. Doctors in training considered they were being used for service provision, and frequently could not identify how their secondary care placements would be relevant to their GP career.
- 38** Some doctors in training told us they did not feel the posts were in line with the GP curriculum although they could find the time enjoyable. The doctors in training we met in the ST3 year were more able to look back and see the value of their previous secondary care placements to their time in GP, but ST1 or ST2 doctors in training in hospital posts struggled to make this connection.
- 39** GP doctors in training told us that core medical training included a specific requirement for specialty doctors in training to attend a certain number of clinics, and GP doctors in training would as a result be left on wards to cover while CMT

(Core Medical Training) doctors in training went for teaching, meaning that they missed their own GP specialty teaching sessions.

- 40** We heard that doctors in training had to swap shifts between themselves to have study leave or attend exams, and the doctors in training we met felt this could be better organised. The feeling of isolation from their training programme was increased if doctors in training had difficulty attending the GP Specialty Training Programmes teaching due to service provision requirements.
- 41** Some of the doctors in training we met had completed variable amounts of specialty training prior to embarking on the GP training programme. We heard that although some training programmes do cater for a doctor in training's previous work experience, preferences and personal circumstances, there were instances where this previous training had not been considered and there was little flexibility. This meant that some secondary care placements would repeat prior training experiences. For example we heard doctors in training had completed CMT and then, as part of their GP secondary care placements, they were allocated to six months on a medical rota.
- 42** We heard from TPDs and GP trainers that secondary care placements could enable struggling doctors in training to pass or get by with positive feedback from their clinical supervisors. Most people we spoke to felt that this was because secondary care clinical supervisors did not have an understanding of how GP operates, meaning that the feedback they provided to doctors in training was more specialty-focused and not linked to the GP curriculum. Many GP trainers told us that they had met doctors in training who received positive feedback during their secondary care posts, but when they moved to primary care, where the assessment process was much more closely supervised and more relevant to GP, these doctors in training suffered a sharp drop in confidence and felt less satisfied with their training as their competence was assessed as being significantly lower. This resulted in the GP trainer needing to spend more time on pastoral care and education to improve the competence and confidence levels of their doctor in training.
- 43** We heard that secondary care posts worked well when the individual departments had looked closely at supervision arrangements for GP doctors in training and directly linked their training to the GP curriculum. We heard from doctors in training at all training programmes that paediatrics, psychiatry, obstetrics & gynaecology, and emergency medicine were the most valuable in terms of informing work when in GP, and included linking the patients that they treated more closely with the learning objectives from the GP curriculum. Doctors in training told us that they valued clinic time as it informed the referral pathway while in GP.
- 44** We also heard that some secondary care placements had 1:1 clinical supervision, which was highly valued by doctors in training. Some doctors in training enjoyed being able to undertake a variety of specialties during their secondary care placements and found that clinics or community placements were especially useful.

Although we heard that some programmes were not flexible with secondary care placements, doctors in training valued the variety within GP training, and enjoyed experiencing different hospitals or GP practices. We heard positive feedback from doctors in training about placements that had tailored their rotas to maximise clinic time, as this was most relevant for informing the referral process while working in primary care.

- 45** The specialties that doctors in training found most educationally rewarding tended to be diabetes and endocrinology, community healthcare, paediatrics, and psychiatry. We heard that there were some specialty placements that were interesting and enjoyable but offered little relevance to GP as they were too specialised – these included renal surgery, spinal surgery and some aspects of neonatology.

Out-of-hours training – supervision arrangements and feedback

- 46** Out-of-hours (OOH) training forms a core part of the GP curriculum, however there were inconsistencies in how this training was supervised and delivered. For induction, we heard that some training programmes and/or OOH provider organisations offered robust induction systems for OOH, where doctors in training were automatically enrolled or were provided with information to access the system independently. Doctors in training would occasionally attend induction after their first OOH shift had been completed; however most attended some induction before starting OOH practice. In other areas, doctors in training would arrive on site and be allocated to a room and a patient list, with little practical induction prior to beginning their first shift.
- 47** We heard that most training programmes ensured that doctors in training had access to a named OOH clinical supervisor who was approved by the deanery/HEE local office and trained appropriately. In some areas, the training of OOH supervisors was delivered by the local OOH provider, and this information was communicated to the training programme.
- 48** The robustness of the OOH clinical supervisor appointment process varied between providers, with some requiring calls and note reviews with a long and structured interview process, whilst other programmes automatically approved GP trainers and clinical supervisors as OOH supervisors. We heard from all training programmes that it was difficult to increase the number of supervisors available for OOH training, and that although there was educational benefit there was little financial incentive for supervisors to take on these roles.
- 49** There was some variation on how doctors in training would be checked for their competence when working in OOH. For more established OOH systems, a 'RAG' (red, amber, green) rating system would be used. If a doctor in training was rated red, they would complete their OOH shifts under full clinical supervision with a clinical supervisor listening in on all telephone calls and closely monitoring any

patient consultations, providing feedback as necessary. This supervision would be reduced as competence progressed, until eventually the doctor in training would have access to a remote clinical supervisor on call for the entire shift when they had achieved a green rating. We heard that competences were discussed with individual doctors in training, and if a green-rated doctor in training did not feel comfortable with remote supervision they were able to turn down shifts.

- 50** For other training programmes, a doctor in training would go through a brief induction process and begin telephone triage in OOH without direct clinical supervision. We were informed that the computer systems used by some OOH providers showed the RAG ratings, but we were not assured that the system for establishing the competence of doctors in training was universally robust or that the supervision provided was adequate.
- 51** We heard there was some variation in the quality of supervision provided for OOH sessions. For more organised OOH service providers, the clinical supervisor for a shift could be the appointed GP trainer, or a doctor in training could arrange shifts to ensure they worked with the same clinical supervisor for multiple sessions. This allowed a closer working relationship and both supervisors and doctors in training described the numerous benefits of close 1:1 supervision in an OOH session. This meant that feedback was more relevant, OOH sessions were more aligned to the GP curriculum and competences, and GP trainers could directly observe the progression of their doctors in training during these sessions.
- 52** Although most doctors in training told us they could contact a clinical supervisor when necessary, we heard that for some OOH shifts the supervisor would change mid-shift without notice, or doctors in training assumed supervision was available but could not give a definitive name or location to contact if they had an issue. We also heard of instances where doctors in training made OOH house calls without a clear process to check in safely with their supervisor after the visit had ended. Doctors in training and GP trainers told us they would know how to escalate a concern if any patient safety issues were raised; however these processes were not formalised and in some instances the people we met did not know who had responsibility for safeguarding doctors in training and patient safety in an OOH setting.
- 53** We heard there was some variability on the integration of handover and feedback into the OOH shifts. Some programmes had feedback times built into every OOH shift but, if the shift was hectic, and the supervisor and/or doctor in training was too busy, this would be collected by phone or email within a week of the shift being completed. There was a clear feedback pathway, and the doctors in training and GP trainers told us this made the OOH experience more relevant as OOH work could easily be linked to their training e-Portfolio records. We also heard that some doctors in training were given the opportunity to feedback on the performance of their clinical supervisors, and that this information had been used as part of the

supervisors' appraisal process and to re-train some clinical supervisors where necessary.

- 54** Where supervision arrangements were unclear or changeable, we also heard there was not a robust system for collecting feedback or there was a risk that cases were not being reviewed adequately. Although we heard there was a benefit to doctors in training working on their own immediately – this prepared them further for working independently after completing their training – we could not see evidence of case review or robust feedback. Doctors in training felt they were working within their competence, and that they could escalate concerns to a supervisor if necessary; however this relied on the doctor in training's own awareness of their competence and involved little or no quality management of the calls being handled and patients being assessed. This also meant doctors in training received minimal educational benefit from these sessions, although they were encouraged to write reflective learning logs about their OOH session which would be reviewed, later, by their GP trainer as part of their e-Portfolio. The delay to or absence of review could potentially risk patient safety.
- 55** The GP trainers we met were responsible for monitoring the access to OOH training, checking competences and matching these to the requirements in the e-Portfolio. Some educational supervisors described this process as a tick-box exercise, stating that, if there was little feedback from an OOH clinical supervisor, the OOH experience was more about counting the number of hours completed than assessing the educational benefits. We also heard that there was a tendency for feedback to be overly positive, which would be received well by the doctors in training but did not however provide opportunities for constructive criticism and learning.
- 56** The current requirement for OOH training is for a GP doctor in training to complete 12 sessions, each of four to six hours, per calendar year, which is interpreted by most to amount to 72 hours per calendar year. GP trainers and training programme management considered that 72 hours should be a minimum. The provision of OOH training varied between programmes; most were completed at telephone triage centres, GP emergency clinic centres or as part of home visits. However, some programmes had accessed ambulance services, paramedics and nurses as providers of OOH training. GP trainers and OOH providers we met told us that doctors in training should not have issues accessing the required shifts for OOH training; in some programmes the hours would be automatically assigned but for most this required the doctor in training to proactively book their OOH hours.
- 57** There was some inconsistency with the impact of not completing the required amount of OOH training prior to ARCP panels. We heard that if a doctor in training had not completed OOH sessions but could provide evidence that sessions were booked (as the panels often occurred well before the end of a training placement), they would be given a satisfactory panel outcome. However, some programmes

would issue an outcome 5 and this outcome would be reviewed after the OOH sessions had been completed.

- 58** We found that the ARCP outcome depended on the stage of training: ST1 or ST2 doctors in training could have booked sessions; however for the final ARCP panel review in ST3 all OOH sessions needed to be completed before the panel review. We heard that some OOH sessions were completed in a very short time frame prior to the ARCP, but this tended to be the exception. Some ARCP panels felt that completing OOH training in a short time frame would not show competence progression over time, and doctors in training would receive negative outcomes at the ARCP. This was not consistent practice across the programmes we visited.
- 59** The quality assurance mechanisms for OOH training were also not clear. We heard that issues could be identified by local governance groups, through our national training survey and through exit surveys. Most feedback was collected informally and resolved locally. We found that the people we met were not clear if there were standards for the provision of OOH training, and quality assurance was dependent on the proactiveness of the training programme or deanery/HEE local office.
- 60** We found that the OOH service nationally was struggling, with doctors in training frequently required solely for service provision. We heard that services were delivered but not well managed because of a lack of resources, with accountability and governance not clear. We heard that OOH is a vital part of training for GP, as it was valuable for meeting competences and readying doctors in training for the workforce but service pressures in several programmes we visited meant that education was not being prioritised. Due to the limited number of hours that doctors in training spent in OOH settings, OOH service organisations did not require GMC approval to be providers of GP training.

COGPED

- 61** We heard that there could be more clarity around the roles and responsibility of those involved in multiple committees on COGPED. We also heard it was a positive development that COGPED and the RCGP are working closer together.

Links with the RCGP

- 62** We heard that there were differences across training programmes regarding their relationship with the RCGP. Some training programmes had close relationships, including representatives on various RCGP boards, and held regular meetings to discuss RCGP feedback, themes and good practice. Training programme management told us that the RCGP's analysis and quality assurance of ARCP panel reports/outcomes and the e-Portfolio provided yearly feedback, which was useful for GP trainers and for the local assessment of standards for trainers.

- 63** We heard that some GP trainers had close links to the RCGP but these tended to be through local networks and were not consistent; there were no clear formal relationships between the RCGP and individual deaneries/HEE local offices.

Quality management processes

- 64** Each training programme we met felt they had clear local processes for the escalation of concerns and a close working relationship between the postgraduate deans, the Head of School (or equivalent), TPDs and GP trainers. We heard that small issues tended to be resolved locally, but that there was a distinct difference in engagement between programmes and their deanery/HEE local office. We heard that some deaneries/HEE local offices conducted robust quality assurance cycles, including annual reporting, quarterly reviews and scheduled site visits, which integrated a GP focus within existing specialty education reviews. However, this was not consistent across all four nations and tended to focus on secondary care specialties, with only a few programmes completing quality reviews of GP training practices.
- 65** We heard that some programmes had facilitated meetings between TPDs to encourage and share good practice, however this tended to be organised locally with little input from the deanery/HEE local office. We heard that quality management systems were more established for other specialty programmes, and more work needed to be undertaken to prioritise the needs specific to GP doctors in training. Some GP doctors in training were involved in the quality management process, but many were not aware of the feedback mechanisms from the deanery/HEE local office for concerns about the delivery of their training.

Quality of the training scheme

- 66** We asked the programmes we visited how they sought feedback on the quality of their training scheme. We heard that the end-of-post feedback and feedback through our national training survey were valuable sources of information, as well as locally run doctor in training surveys, doctor in training exam results (CSA and AKT), separate RCGP and HEE annual reporting cycles and local quality team management processes. This information was monitored by the local quality team at the deanery/HEE local office. We also heard that training programmes would monitor exam pass rates and look at curriculum outcomes being achieved. The ARCP panel process was a useful source of feedback on the quality of educational supervision reports and, at some programmes, the panel chair for the ARCP frequently provided valuable feedback to GP trainers and clinical supervisors, but this was not consistent and the quality and quantity of such feedback were very variable.
- 67** The process for collecting feedback on training schemes was sometimes formalised, with some programmes holding regular trainee forums; however some doctors in training expressed that they were neither aware of these trainee forums nor knew

who their representatives were. Nevertheless across the programmes we visited, we heard that doctors in training would be happy to speak to TPDs about any issues.

Equality and diversity

- 68** We heard that some deaneries/HEE local offices produced an equality and diversity report, or had an officer to maintain data, whereas others did not actively collect equality and diversity data, instead relying on information from our national training survey. The RCGP centrally collects equality and diversity data relating to the MRCGP (Membership of the Royal College of General Practitioners) exams and progression covering a wide range of protected characteristics.
- 69** We found that where the data is gathered by deaneries and HEE local offices it is not utilised as well as it might be. The focus tended to be on the identification of individual performance issues rather than broader concerns looking at the progression of cohorts of doctors with shared characteristics to consider how their experience of training might be affecting their performance. Research into differential attainment suggests groups of doctors who share protected characteristics face additional barriers to success. Understanding the circumstances affecting individual doctors, including social, cultural and environmental barriers, and tailoring support for them can help mitigate the additional barriers they face.
- 70** Data published by the GMC shows variation in the outcomes of doctors associated with their demographic characteristics, for example Black and Minority Ethnic doctors who graduated from a UK medical school passed 77.1% of attempts at the MRCGP exams, whereas White UK graduates passed 91.8% of their exam attempts. Similarly, within the 25–29 age band 88.2% of men passed their MRCGP attempts compared with 92.6% of women.
- 71** Similar differences can be seen across all medical education and training – the causal factors are not clearly known and are likely to be multifactorial and complex. However, some organisations providing training and education are actively engaged in developing strategies to try to address these issues. We would encourage these organisations to work together to share their experiences, and the impact of their interventions. All organisations delivering education and training are responsible for taking action to promote fairness within medical education.

Training for supervisors/feedback on supervision

- 72** The process for gathering and providing feedback to GP trainers and clinical supervisors was not standardised across the training programmes we visited. We found that doctors in training could always approach their TPD to give feedback on their supervision, and that our national training survey or local surveys would provide some feedback on the provision of clinical or educational supervision;

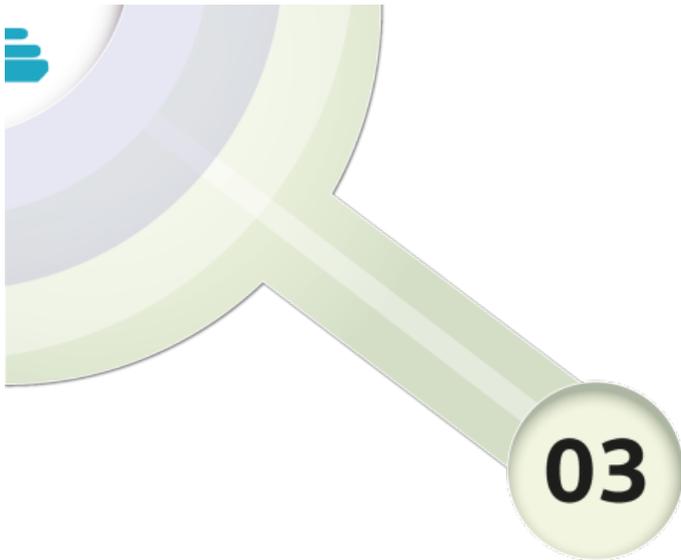
however this was limited for primary care practices with fewer than three doctors in training.

- 73** Deaneries and HEE local offices hold regular training and refresher courses for GP trainers and frequently, but not consistently, include feedback from doctors in training, ARCP panels and supervising trainers as part of the GP trainer reaccreditation process. If it became apparent that a training practice did not meet acceptable standards, we heard some training programmes would request a visit from the deanery/HEE local office with a view to initiating remedial help and/or removing approval. As most adverse training issues had been identified in single-trainer practices, we heard that some training programmes had mandated two trainers in practices, and this had been successful in providing additional support for educational supervisors as well as doctors in training.
- 74** We found that if there were concerns about a GP trainer, the TPD or associate postgraduate dean would move doctors in training and possibly stop the GP trainer from supervising along with providing remedial help. This could be on a short-term basis or permanently. The system differed in the areas we visited, being tailored to the concerns or issues on an individual basis.
- 75** It was considered that the quality of clinical supervision in secondary care was varied but improving. We heard that most clinical supervisors had received training, but this training could be better focused and include both secondary care and GP curricula. Some training programmes had facilitated meetings with clinical supervisors on a 1:1 basis to discuss the GP e-Portfolio and provide personalised feedback, which had been received well but was difficult and costly to organise.
- 76** We heard that around 75% of clinical supervision reports met the standards set by the RCGP, and that the report layout was being changed to fit better with GP competences. Clinical supervisors in secondary care posts told us they would value feedback on their clinical supervision, and were not aware of the appropriate methods to seek feedback. We heard that some clinical supervisors asked their doctors in training directly and informally, and others had received valuable input from GP trainers in response to their clinical supervision reports; however this was not a common occurrence. Training programmes told us that LEPs would respond if there were concerns about a clinical supervisor and some training programmes had tried to ensure clinical supervisors in secondary care posts were only responsible for one GP doctor in training at a time to reduce the burden of GP education. Deaneries/HEE local offices and RCGP need to work collaboratively to review the consistency of clinical supervision reports.
- 77** Some training programmes had spent a considerable amount of time ensuring clinical supervisors were allocated 0.25 SPA (Supporting professional activities) per doctor in training; however this was a work in progress. Some training programmes had an associate postgraduate dean nominated for a defined geographical area to

safeguard educational time and promote GP training in various secondary care departments.

Support for less than full-time doctors in training

- 78** We found that there was a significant percentage of Less than Full time (LTFT) GP doctors in training in LTFT training. We heard that LTFT training tends to be easy to facilitate in primary care, with more support provided to doctors in training. Organising LTFT training in secondary care was more difficult. Secondary care posts could be tailored to LTFT, with some posts job sharing between two LTFT doctors in training – if both LTFT doctors in training were working at 60%, the joint working meant that secondary care placements benefited from an additional 20% over the expected allocated time. However, other secondary care posts would only allow a 50% rotation, which limited options for doctors in training in LTFT. GP trainers told us that for doctors in training there could be a drop in confidence if a doctor was returning to a GP practice placement after a long break. This meant that the GP doctor in training would need extra support and sometimes extended consultation times in primary care, as well as more 1:1 education and training time. However, this transitional working pattern was not easily provided in secondary care.
- 79** We heard there are some instances in secondary care where preferences for LTFT posts could not be matched with the posts available; however this was rare as many secondary care rotas were filled by locum doctors, and placements could be adapted. Most programmes we visited had a set return-to-work process, including adaptations such as not managing on-call duty for an agreed length of time. This was carried out in conjunction with the primary care practice or the clinical supervisor in secondary care.
- 80** The LTFT doctors in training we met generally found the process of accessing training easy and that the programmes tailored placements to their needs. We heard that organising assessments in LTFT training could be more difficult and GP Specialty Training Programmes teaching attendance was a challenge depending on their schedule. We heard that training programmes tended to be responsive if issues were raised around assessments for LTFT doctors in training. Some GP trainers told us that training an LTFT doctor could feel like the pressure was on the supervisor to prepare the LTFT doctor in training for assessment, rather than focusing on educational delivery. Doctors in training we met told us that the number of WPBAs required in LTFT training was not clear, including ARCP panel requirements, while training part-time.



THEME 3 Supporting learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

What's working well

- 81** In addition to areas mentioned earlier in this report, the doctors in training we met felt there were many positives about their training programme. They felt that the structure of the programme was beneficial, and they valued their GP Specialty Training Programmes teaching as educationally and socially valuable. Throughout all of the training programmes we visited, doctors in training spoke very positively about their placements in primary care. We heard that GP practice placements tended to be well organised and well run, and this time was the most valuable for preparing them for the workforce.
- 82** We consistently heard that the programme staff – TPDs and administrators – were clear on expectations, happy to have formal or informal conversations, and knowledgeable and supportive. The close relationship between TPDs and doctors in training was evident in all of the programmes we visited, with some describing their TPD as a role model for education and a person they could approach to discuss any concerns they had about their training experience.

Challenges of training

- 83** As discussed earlier in this report, many of the concerns we heard from doctors in training about the programme related to their experiences in secondary care. Many of the GP doctors in training we met in secondary care posts were not satisfied with their placements, and wanted more flexibility to access specialties which would be relevant to their time in GP. Doctors in training understood that there was a need to provide a service, but felt that, as GP doctors in training; they were more likely to be covering ward work while specialty doctors in training would be prioritised for education and for clinic time.

- 84** GP doctors in training also told us that for some placements they were treated like specialty doctors in training, which would mean better specialty educational opportunities but a perceived distance from being a GP doctor in training. This isolation could be compounded if they were not able to access GP Specialty Training Programmes teaching or clinic time, and we met doctors in training who told us there were no networks to meet other GP doctors in training during specialty placements. GP Doctors in training felt they would have benefited from better peer support. Unfortunately reduced access to GP Specialty Training Programmes resulted in not being able to meet up with their peers.
- 85** Secondary care placements usually make up 18 months of the three-year GP training programme. We heard from TPDs and from doctors in training, across all training programmes, that it would be beneficial if doctors in training could spend less of their training time in secondary care, and increase the time spent in GP.
- 86** We heard from a number of doctors in training that they felt three years of training was not long enough to produce a competent GP due to the challenging and changing nature of the role of a GP. However this was not universally agreed. We heard that some training programmes had included an additional year of training; but this generally included an extra year in secondary care and was considered by some doctors in training to be primarily for service provision.

Support for learners

- 87** We found that the training programmes we visited provided very good support for doctors in training, although the support mechanisms were sometimes not formalised. We heard that training programmes could be proactive in identifying learners who may need support, utilising the recruitment scores to approach doctors in training and offer services. The issues which resulted in a need for additional support included recurrent health problems and doctors in training returning to work after a long absence, for example sickness and maternity leave.
- 88** We heard that the recruitment process for GP training could be used to identify if a doctor in training had high educational or support needs. We heard from training programme staff that if a doctor in training needed additional support during recruitment they would tend to need additional support throughout their time in the training programme.
- 89** Training programme staff we spoke to told us that issues identified in recruitment tended to continue when doctors were training. We heard that some GP doctors in training had high educational needs, with specific concerns about international medical graduates who were training in GP but who did not have any prior experience or knowledge of how the NHS or GP worked. These issues were less pronounced if international medical graduates had completed the Foundation Programme. We visited some training programmes who had high numbers of

international medical graduates and had provided tailored linguistic and cultural training to assist with the transition to practice, which was an area of good practice.

- 90** Doctors in training we met were not always clear on the specific support available to them but we heard they were always able to approach their GP trainer or TPD if they had concerns about themselves or their colleagues. We heard that doctors in training felt supported and able to discuss concerns, and that training programme staff felt that doctors in training would be comfortable self-referring for support, including counselling, if needed.
- 91** We heard that some programmes were very proactive in addressing support needs for doctors in training. Training programmes used various tools to identify doctors in training who were in difficulty, including WPBA multi-source feedback, patient satisfaction reports, learning logs and reports from secondary care placements. When concerns were identified, the TPD would meet with the doctor in training, supervisors and other practice or hospital staff to establish the best course of action. We heard that training programmes would offer support directly to doctors in training, and most would take up this offer. The close relationship between doctors in training and GP trainers was cited as a great way to identify and talk through issues.
- 92** We heard that most support was provided locally by the training programme, with some delays if support was required at deanery or HEE local office level. GP trainers and clinical supervisors we met had sometimes not heard about the professional support units at their local deanery or HEE local office. We heard that targeted occupational health support was available; however formal occupational health consultations could take an extended amount of time to book and complete.
- 93** We also heard there were issues with the transfer of doctors in training between deaneries or HEE local offices, and some GP trainers and TPDs we met told us that doctors in training could be transferred into a new training programme or even LEP within the same training programme without details about support previously required, or possibly needed, being provided by the transferring organisation. The process for the transfer of doctors in training between training programmes was centralised, which meant that an application for transfer could be approved but delays happened if the receiving programme did not have vacancies or posts suitable for the doctor in training.

THEME 4

Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.



What's working well

- 94** We met several groups of dedicated and motivated educators during our visits. GP trainers told us they enjoyed the ability to work closely with doctors in training, as they could monitor and control their learner's workload and could vary their training strategies. Like doctors in training, educators valued the 1:1 apprenticeship model as the training experience was personalised. GP trainers informed us that the close working pattern enabled them to see inexperienced but motivated doctors in training develop into fully competent GPs over time, which was described as incredibly rewarding for an educator. Clinical supervisors in secondary care posts told us that GP doctors in training tended to be more experienced than other specialty doctors in training. GP doctors in training had a better understanding of community care and an emphasis on reflective practice – this provided an alternative perspective and a different method of consultation, which was valued by clinical supervisors.
- 95** GP trainers also found that having a doctor in training encouraged them to keep up with their own professional development and brought fresh new perspectives to their own practice. We also heard that being a GP trainer was good for recruitment, as doctors in training frequently stayed in their training practice after certification, with some opting to become partners. Educators valued the peer support provided by being part of the GP training faculty, and told us that being involved in the training of doctors meant they were better able to network in a part of medicine that can be isolating.

Challenges of training

- 96** The biggest issue challenging training was said to be recruitment and selection, but there was significant geographical variation in these difficulties. Educators we met felt that, for the most part, training was well protected. We heard that when doctors in training moved to an area they were likely to stay there after certification, but it was difficult to attract doctors in training in the first instance. Many of the training programmes we visited have not been able to fill the allocated spaces on their programmes. Some areas had introduced a salary supplement scheme to attract candidates; however this did not necessarily ensure a sustainable workforce or good-quality applications. There was recognition that attracting recruits to one programme often meant taking them away from a neighbouring area.
- 97** We heard that foundation doctors in training tended to enjoy their placements in GP, and that more foundation places would be welcomed by GP trainers. GP trainers we met recognised the need to be ambassadors for GP and accepted that there was a difficult balancing act between protecting doctors in training from the stress of the GP workload and practice commitments, and also preparing them for the 'real world' after certification.
- 98** There were concerns that Brexit could further impact recruitment difficulties, and an understanding that problems with recruitment would have an increasing impact on other issues in both GP and in secondary care, including rota gaps and workload. Training programmes felt that the process for recruitment and allocation of doctors in training was not transparent, and would value more information on the decisions made by the central national recruitment office.
- 99** Doctors in training we met were aware of the difficulties in recruiting to the GP specialty, and were concerned about the workload during training and after certification as this could well be a factor in putting people off entering the specialty.
- 100** We heard that there is a negative view of GP from other medical colleagues; doctors in training had even been told by consultants that GP was for people who were not intelligent enough for other specialties. GP Trainers were concerned that a career in full-time GP was not flexible enough as there was an awareness that many doctors in training were looking for a portfolio career.
- 101** There were concerns that doctors in training were being put off by the high workload of GP, with many initially opting to work as locums rather than enter into partnerships or long-term salaried positions straight after training. Although the experience was professionally rewarding, we heard that being an educator was challenging and pressures on time and space in practice were beginning to make it a less financially viable option.

Training for supervisors

- 102** All deaneries/HEE local offices have training courses for qualified GPs who want to become GP trainers. We heard that, after completing this training, GP trainers undergo regular accreditation against agreed standards; the processes for accreditation and the standards varied across the United Kingdom. Training programmes appeared to be adhering to the GMC standards for appraisal and training of primary care based GP trainers, although training of clinical supervisors of secondary care posts could be improved.
- 103** We heard that deaneries/HEE local offices ran trainer workshops throughout the year with a minimum level of attendance. Trainers we met described these workshops as valuable for networking and for the benchmarking of assessment standards. These workshops were also a good opportunity to discuss curriculum changes from the RCGP and to collect feedback for the deanery/HEE local office. GP trainers described a high level of peer support for training difficulties, and some training programmes had mandated a two-trainer practice, as discussed earlier in this report.
- 104** Due to the partnership model, we heard that supervision was built into practice timetables and most GP trainers had been trainers for many years. Unlike clinical supervisors in secondary care, GP trainers do not have job plans with allocated educational time; however they made time for GP training with the cooperation of their partners and colleagues in their GP practice.
- 105** Some training programmes required GP trainers to participate in GP Specialty Training Programmes teaching, mapped to the curriculum. We heard that trainers sometimes received feedback as part of the ARCP panel process, and in visits from the training programme as part of their accreditation and reaccreditation. The GP trainers we met were aware of the appraisal process and its requirements.

THEME 5 Developing and implementing curricula and assessments



- S5.1** Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.
- S5.2** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

E-Portfolio and GP curriculum

- 106** Doctors in training we spoke to told us that the curriculum was difficult to use. We heard that the size of the curriculum was intimidating and that many doctors in training felt overwhelmed. Some doctors in training relied on the advice of their GP trainers to link their educational experiences to the relevant parts of the curriculum and to ensure they had completed their competences. We heard that some doctors in training refer to the GP curriculum as a resource for revising for exams and to complete gaps in the e-Portfolio.
- 107** We found doctors in training considered completing the e-Portfolio to be one of the most difficult parts of the training process. We heard that it was time consuming having to ensure GP trainers and clinical supervisors were contacted to complete assessments, and there was mixed guidance on how many learning logs were required.
- 108** Despite guidance to the contrary from the RCGP to deaneries/HEE local offices, we heard from most doctors in training that they had been told that at least one learning log was required per week while in secondary care posts, and three per week were required in GP placements. We heard that writing learning logs takes between 30–45 minutes to complete, and doctors in training could not always see the point of writing them. We found that doctors in training were not clear on what would happen if they had completed fewer than the stated number of learning log entries per week. Many doctors in training believed that they may fail at the ARCP panel stage if not enough learning logs had been completed. It was not generally understood that the quality of the learning log entry was more important than the number of logs needed. Even when the concept of quality over quantity was

understood by the TPDs and GP trainers, quantitative targets were still set for doctors in training to complete.

- 109** We found that the requirements for learning logs and other e-Portfolio activities varied between deaneries/HEE local offices, with some areas requiring a certain number of significant event analyses and/or an audit/quality improvement project, but these activities were not mandatory in other areas in the country. Doctors in training were not aware if these requirements were local or were specified by the RCGP.
- 110** We heard that most training programmes included some information about the e-Portfolio during induction, but more time learning how to use it appropriately would be valued by doctors in training. Doctors in training told us that having more allocated time to complete e-Portfolio work would be useful and that the feedback and follow-up reading provided by GP trainers was useful, relevant and interesting. However doctors in training often did not have time to complete the recommended follow-up work.
- 111** Doctors in training felt that their GP trainers were aware of how to interact with the e-Portfolio and curriculum and were adept at linking learning logs to relevant competences even if the doctors in training themselves were not sure how their learning was related. Doctors in training valued the multi-source feedback (MSF) tool, the patient satisfaction questionnaire and the consultation observation tools (COTs) as valuable learning tools and this was echoed by the GP trainers that we met.
- 112** We heard that e-Portfolio training is available for some secondary care clinical supervisors but this was managed locally on an individual basis. Training programme directors told us that clinical supervisors in secondary care change frequently, and sometimes the LEP does not inform the training programme that supervision arrangements have changed. Some doctors in training had been encouraged to run an 'introductory course' on the e-Portfolio with their clinical supervisor at the beginning of their placements in secondary care to help the supervisor understand the e-Portfolio requirements. Unfortunately this was frequently not possible due to service pressures.
- 113** Some clinical supervisors found the e-Portfolio system to be useful and had adapted it for their specialty doctors in training, but otherwise we heard that clinical supervisors rarely engaged with the e-Portfolio, and clinical supervision reports written in the e-Portfolio tended to lack detail or have a specialty focus. We heard from GP trainers that clinical supervisors were reluctant to put anything negative into e-Portfolio feedback, meaning that it was difficult to complete an educational supervisor's report (ESR). GP trainers were reliant on clinical supervisor feedback when doctors in training were working in a secondary care setting. Clinical supervisors were also not aware they could include comments in their feedback to doctors in training through the e-Portfolio.

114 GP trainers had mixed views about the e-Portfolio and curriculum. We heard that it was sometimes difficult to get doctors in training to engage with e-Portfolio work, but it could be good in helping to identify struggling doctors in training. However, even well-performing doctors in training were not always adept at meeting the e-Portfolio requirements. Some GP trainers we met felt that the curriculum was too broad, and that the time frame for training was too short to meet all the competences – this meant that completing e-Portfolio requirements felt more like counting numbers, rather than ensuring competences were met. We heard that doctors in training would finish their training as competent GPs, but not necessarily confident.

Workplace-based assessments (WPBAs)

115 Doctors in training told us that WPBAs were easy to complete in their GP placements but more difficult in secondary care placements. We heard this was impacted by the clinical supervisors not being aware of GP training requirements and the GP curriculum. Doctors in training would need to be proactive to ensure that assessments were completed in time, and we heard that GP trainers or TPDs would step in if a doctor in training was falling behind. In Specialty placements, most WPBAs were completed by “a registrar” in secondary care, and GP doctors in training in secondary care felt these were not valuable learning experiences, but merely box-ticking exercises.

116 We heard that, in hospital posts, MSF was useful, but case-based discussions (CBDs) were redundant in secondary care as GP doctors in training frequently did not have protected time to have a good-quality discussion with their clinical supervisors. Doctors in training and GP trainers told us that CBDs were valuable in GP placements to discuss learning. We heard that COTs were the most valuable educational resource for doctors in training as they were able to observe their own consultations and take direct feedback from these observations.

117 Educators sometimes received feedback on their written assessments as part of the ARCP panel process, during training practice visits as well as from some proactive doctors in training. We heard that some training programmes complete benchmarking exercises for the work place based assessments for GP trainers using RCGP guidance, and that the results of the benchmarking could be used as part of the reaccreditation process for trainers.

118 Clinical supervisor reports were not considered to be a valuable way to recognise difficulties about a doctor in training; however we heard from clinical supervisors that they would value feedback on their reports to tailor their teaching. There was a view that secondary care clinical supervisors were not aware of the GP style of consulting, meaning GP doctors in training were assessed on specialty competences instead of their own curricula requirements.

119 Clinical supervisors in secondary care reported scoring doctors in training in GP in comparison with specialty doctors in training at the same year level: second year GP doctors in training would be scored in comparison to core medical doctors in training in their second year, for example. The impact of this was doctors in training might begin GP placements having experienced higher grades, scoring highly in specialty-focused assessments, and then experience a perceived drop in competence as they were being assessed from a GP perspective. This could also damage the relationship between doctors in training and GP trainers, who were perceived to be harsher in their assessments compared with clinical supervisors in hospital posts.

Educational supervision reports (ESR)

120 We were told that completing the ESR was a time-consuming process for GP trainers but a valuable method for ensuring that doctors in training were developing competence. GP trainers would review the contents of the e-Portfolio, including the written learning log entries and clinical supervisor's reports, to make judgements on progression.

121 We heard that clinical supervision reports were only occasionally useful for providing feedback if they were completed appropriately. GP trainers found that the MSF tool was the most useful source of information while doctors in training were in secondary care posts. During primary care placements, if the GP trainer was working directly with the doctor in training, they would complete the majority, if not all, of the assessments themselves. GP trainers relied on their 1:1 interactions with the doctors in training to provide the information for writing the ESRs. Trainers were not aware that ESRs were randomly reviewed by the RCGP, as part of their quality management strategy of GP training; however we heard from TPDs that the RCGP feedback could be used for the re-education of trainers in some instances, if the quality of their written report was not good.

Annual Review of Competence Progression (ARCP)

122 We heard that learners and educators would value guidance on which were compulsory ARCP requirements and which were optional or specified by the local deanery/HEE local office. The front page of the e-Portfolio includes the timeline and minimum requirements. We heard that the process for collating all the information and evidence required for the panel review was lengthy, and could be repetitive, as learning needed to be reflected on and linked to various items within their e-Portfolio. We heard that the timing for some ARCP panels was set locally, with no standardisation across the four nations, which could potentially impact the outcomes for some doctors in training especially those in LTFT training. If a deanery/HEE local office set panel dates earlier than most, their doctors in training needed to complete requirements in a shorter time frame than their peers.

- 123** Doctors in training felt that the panel outcomes were not necessarily clear, and noted there was some variation between deaneries/HEE local offices. Some localities would issue an outcome 5 if information was missing, and ask for a resubmission, while others would await the missing information and give an outcome 1 instead. The Gold Guide guidance is provided with only some doctors in training and educators knowing how and where to access this information. We heard that work was being considered to standardise training of ARCP panel chairs and members across the United Kingdom so that panel outcomes were consistent and fair regardless of the geographical location of the training programme.
- 124** The local training programmes we visited had organised their own training for ARCP panel members. The membership of ARCP panels varied, with most training programmes trying to ensure there was lay representation. We found that TPDs were frequently panel members and programmes were working to make sure GP trainers completed some ARCP panel work to familiarise themselves with the process. Training for ARCP membership varied, with most panel members seeming to learn how to participate from observation. Some training programmes had created desk-based guides to ARCP panel membership, and others included ARCP information and calibration in their regional trainer's days or training workshops.
- 125** Work to standardise the ARCP panel process was in its infancy and again depended on the proactiveness of the deanery/HEE local office. Some localities had set up quality monitoring processes and were actively checking doctors in training progression. Training programmes tended to rely on the quality management and central checking of ARCP panel reports and outcomes, completed by the RCGP, and stated that the feedback from ARCP panels and RCGP central checking was useful for the professional development of GP trainers. We heard that there were issues with the results of RCGP quality management as there was a large time delay between the ARCP panels issuing their outcomes and the RCGP communicating its findings to deaneries/HEE local offices. We were not able to find a process for closing this gap, to ensure live feedback especially for significant concerns.

Good practice, requirements and recommendations

Here we have summarised how the organisations and programmes we reviewed comply with the standards and requirements as set out in [Promoting excellence: standards for medical education and training](#).

Areas of good practice

We note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further.

Number	Theme	Good practice	Related Paragraph
1	Learning environment and culture (S1.2, R1.13)	Individual GP training programmes have created tailored inductions in response to the needs of doctors in training, including The Closing the Gap scheme at Durham and Tees Valley and the STEP scheme at Glasgow South. These programmes are well received by doctors in training.	2, 3

Areas working well

We note areas where we have found that not only are our standards met, but they are well embedded in the organisation.

Number	Theme	Areas working well	Related Paragraph
1	Learning environment and culture (S1.2, R1.22)	The collaboration between Training Programme Directors and GP trainers is working well, particularly around peer support.	7
2	Learning environment and culture (S1.2, R1.22)	The policy of encouraging training practices to have two or more GP trainers in primary care offers good support and contingency arrangements for trainers and for doctors in training, particularly where the trainee and/or trainer may be experiencing concerns with the way the training is progressing. This arrangement also facilitates quality improvements in training.	8, 9

3	Supporting learners (S3.1, R3.5, R3.13)	The 1:1 apprenticeship model of training in GP settings creates good working and educational relationships. When working well, this relationship enables close scrutiny of doctors in training and ensures problems are flagged early, timely remedial solutions are put in place and support is given to enact changes. It was highly valued by doctors in training and GP trainers.	14, 94
4	Supporting learners (S3.1, R3.5)	Doctors in training valued their ability to attend GP Specialty Training Programmes teaching sessions.	23, 24, 25
5	Educational governance and leadership (S2.1, R2.16)	Some training programmes had appointed a champion for the needs of GP doctors in training in secondary care posts, which was producing positive results.	35
6	Educational governance and leadership (S2.3, R2.9)	The RCGP is proactive in collecting and analysing data on the progression of GP doctors in training by their protected characteristics. They are actively engaged in understanding issues which may influence the success of these doctors and in developing support or other interventions.	68
7	Supporting learners (S3.1, R3.5)	Doctors in training valued the placements in primary care settings during their training programme.	81
8	Supporting learners (S3.1, R3.1)	GP doctors in training felt well supported by their local GP training programmes.	83
9	Supporting educators (S4.1, R4.1)	GP trainers in primary care are meeting the requirements for trainer accreditation.	102

Requirements

We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards.

In the context of this thematic review the requirements have been set where we have found evidence that our standards are not being met during at least one of our visits. Organisations involved in the review have been given the opportunity to respond to the requirements and recommendation in their formal responses which are published alongside the report.

We accept that our findings are based on judgements made on a small sample of visits. However, these findings may be indicative of wider issues that we will wish to explore across all deaneries and HEE offices. We will therefore work with each deanery and local office on how we can assure ourselves that standards are being met in these areas, in a proportionate way.

Number	Theme	Requirement	Responsible Organisation	Related Paragraph
1	Supporting educators (S1.1, S1.2, S4.1, S4.2, S5.2)	The RCGP and organisations responsible for GP training work collaboratively with others to improve the consistency of educational supervision reports.	Deaneries/HEE local offices and RCGP	66, 72, 120
2	Supporting educators (S1.1, S1.2, S4.1, S4.2, S5.2)	The RCGP and organisations responsible for GP training must work collaboratively to review the consistency of clinical supervision reports	RCGP and deaneries/HEE local offices	76, 121
3	Supporting educators (S1.1, S1.2, S4.1, S4.2, S5.2)	All deaneries/HEE local offices and LEPs must ensure they support clinical supervisors in secondary care so they can support the learning needs of GP doctors in training.	Deaneries and HEE local offices	22
4	Learning environment and culture (S1.1, S1.2, R1.7, R1.8,	Training agencies must, have robust clinical and educational governance systems so that GP doctors in	Deaneries/HEE local offices	52, 93

Number	Theme	Requirement	Responsible Organisation	Related Paragraph
	R1.9)	training, when asked to work or attend outside of their contracted primary care environment, can do so in a way which ensures their own and their patients' safety.		
5	Learning environment and culture (S1.1, R1.7)	All deaneries/HEE local offices and LEPs must ensure there are systems in place to ensure a balance is maintained between service provision and education, to ensure that doctors in training are receiving valuable educational opportunities.	Deaneries/HEE local offices	25
6	Supporting learners (S3.1, R3.1)	There must be robust measures put in place to ensure the safety of GP doctors in training when working alone.	Deaneries/HEE local offices and LEPs	52
7	Supporting learners (S3.1, R3.12)	Training programmes, deaneries/HEE local offices and LEPs must ensure that doctors in training have access to the GP Specialty Training Programme teaching sessions or equivalent learning opportunities.	Deaneries/HEE local offices and LEPs	25
8	Developing and implementing curricula and Assessments (S5.2)	Training for ARCP (Annual Review of Competence Progression) panel members and chairs must be designed to ensure consistent and fair outcomes.	Deaneries/HEE local offices	127

Although the RCGP does not have direct responsibility for all of the above requirements we would hope that they would be able, in consultation with deaneries/HEE local offices to take a lead in setting standards and providing guidance in many of the areas listed here.

Recommendations

We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.

Number	Theme	Recommendations	Responsible Organisation	Related Paragraph
1	Learning environment and culture (S1.2, R1.5)	Feedback on educational and professional concerns and issues raised about individual GP doctors in training must be shared with GP trainers and clinical supervisors by the GP training programme and deanery/HEE local office in a systematic way, as appropriate.	Deaneries/HEE local offices	64
2	Educational governance and leadership (S2.1, S2.2, R2.14, R2.15)	All deaneries/HEE local offices and LEPs should ensure that feedback is provided to doctors in training following training sessions in an out-of-hours setting.	Deaneries/HEE local offices/LEPs	53
3	Educational governance and leadership (S2.3, R2.9)	Training programmes and deaneries/HEE local offices should make better use of the data they or others collect on individual attainment to identify local concerns around the lower attainment of doctors in training who may share protected characteristics, and to develop interventions designed to address these issues.	Deaneries/HEE local offices	69
4	Supporting learners (S3.1, R3.1, R3.5)	In order to provide clarity on requirements the RCGP and national training organisations (HEE, NES	RCGP and Deaneries/HEE local offices	46 - 60

Number	Theme	Recommendations	Responsible Organisation	Related Paragraph
		(NHS Education for Scotland)) should collaboratively review how competencies are developed in would ensure compliance with GMC standards on fair training pathways.		
5	Supporting learners (S3.1, R3.5)	Deaneries/HEE local offices should review the placements within training programmes on a regular basis to make sure that they are continually aligned with the needs of the GP curriculum.	Deaneries/HEE local offices	45, 86
6	Supporting learners (S3.1, R3.7)	Deaneries and HEE local offices should review the timing of Annual Review of Competency Progression (ARCP) panels to ensure sufficient flexibility so the timing of panels does not disadvantage some doctors in training or potentially distort outcomes. This includes those in less than full-time training.	Deaneries/HEE local offices	122
7	Supporting learners (S3.1, R3.7)	All deaneries/HEE local offices should ensure that assessment requirements are clear for doctors in less than full-time training. This should include any requirements for ARCP assessment.	Deaneries/HEE local offices	80
8	Supporting educators (S4.1, R4.5)	The standards for workplace-based assessments performed for the WPBA, part of the RCGP Tripos*, should be benchmarked to ensure that assessments undertaken in secondary care	RCGP and deaneries/HEE local offices	117

Number	Theme	Recommendations	Responsible Organisation	Related Paragraph
		are applicable to GP training. *Recommendation 9: GP Specialty Training consists of a tripos of three components: the applied knowledge test (AKT); clinical skills assessment (CSA); and the workplace-based assessment (WPBA).		
9	Supporting educators (S4.2, R4.5)	GP trainers and clinical supervisors should receive clear and concise feedback following the ARCP	Deaneries/HEE local offices	66
10	Developing and implementing curricula and assessments (S5.2, R5.9)	The RCGP should ensure that the training record provides a platform that encourages interaction and provides clarity on training expectations in primary and particularly in secondary care placements.	RCGP	115
11	Developing and implementing curricula and assessments (S5.2)	National requirements for ARCP panels should be reviewed and standardised where appropriate to ensure consistency across the United Kingdom, including better explanation of the quality and quantity of learning logs to be completed.	Deaneries/HEE local offices/COPMED working with RCGP	123, 125

Annex I

Organisations involved in GP training

The Royal College of General Practitioners (RCGP)

The RCGP is the professional membership body and guardian of standards for doctors in training in primary care in the United Kingdom. The RCGP has the following responsibilities in relation to training:

- providing advice and guidance about current training regulations
- keeping a register of doctors in training, in collaboration with postgraduate deans, and recommending doctors in training for the award of the certificates of completion of training (CCT)
- working closely with the regulatory bodies on matters affecting training
- developing, maintaining and setting the curricula and assessments for GP doctors in training in accordance with the [GMC standards for curricula and assessment](#), including management of the applied knowledge test (AKT), clinical skills assessment (CSA) and workplace-based assessment (WPBA)
- monitoring and reporting on the progress of doctors in training through the training programmes, to maintain details of their experience and to provide externality to the annual assessment process.

Committee of General Practice Education Directors (COGPED)

COGPED offers a forum for Postgraduate GP Directors to meet and share good practice. COGPED is a subcommittee of the Conference of Postgraduate Medical Deans (COPMeD).

GP Specialty Advisory Committee (GP SAC)

The GP SAC is the national committee which develops and oversees policy in all areas of work relating to specialty training for GP, GP assessment and certification. This includes oversight of all RCGP committees relating to training and assessment, which report directly to the GP SAC. Members of the Committee are drawn from the RCGP and from relevant external organisations, and it is co-chaired by the RCGP and COGPED.

Deaneries and Health Education England

Health Education England (HEE), the Wales Deanery, the Scotland Deanery, and the Northern Ireland Medical & Dental Training Agency are the national bodies responsible for

the education and training of doctors in the NHS. HEE administers its functions via four local education and training boards, which are subdivided into 13 HEE local offices.

Deaneries and HEE local offices are responsible for the design and delivery of general practice training programmes within a defined geography including workplace-based experience, based on the approved curriculum and assessment systems and in line with [GMC standards for education and training](#). This includes funding and managing the quality of training, and supervision of and support for doctors in training. Each programme must enable doctors in training to meet the curriculum and assessment requirements, but can be tailored to the services of local education providers (LEPs), providing a balance is maintained between service and education.

The Lead Dean

The Lead Dean for General Practice is also the lead for two other medical specialties and subspecialties. He is a member of the COPMeD and therefore has a four nation-view for all the specialties he leads on. He is involved in the overview of the specialty and is a source of reference, guidance and advice on all training and curriculum issues.

Secondary Care Placements

During the review we did not visit any secondary care placements and did not specifically meet with groups of GP doctors in training who were in secondary care placements, or supervisors and placement managers from secondary care. We also did not meet with any doctors in training from other specialties who train alongside GP doctors in training during secondary care placements. We note that the link between primary and secondary care is an area that requires further exploration in our future QA activity.

During the review we did meet with clinical supervisors from secondary care placements but we did not seek the views of other doctors in training within those specialties, whose career intention was not GP. During our other Quality Assurance activities, such as National and Regional reviews, we explore the relationship between GP doctors in training, trainers in acute settings and those who organise and manage training. Further information on these reviews and the finds can be viewed [here](#).

Team leader	Dr Steve Ball
Visitors	Dr Rosie Luszkat, Dr Ruth Heseltine, Dr Jonathan Foulkes, Ms Elaine Tait
GMC staff	Hannah Watts, Anna Palmer-Oldcorn, Chris Lawlor
Visit dates	<p>24 June 2016: meeting with Postgraduate Lead Dean</p> <p>29 June 2016: meeting with Director of Postgraduate GP Education</p> <p>11 July 2016: Meeting with SAC Chairperson</p> <p>14 July 2016: meeting with Trainee representative RCGP SAC</p> <p>2 August 2016: meeting with COGPED Chairperson</p> <p>5 October 2016: visits to Durham and Tees Valley</p> <p>27 October 2016: visit to Gwent</p> <p>22 November 2016: visit to Luton</p> <p>7/8 December 2016: visit to Glasgow</p> <p>7 February 2017: meeting with RCGP</p> <p>7 February 2017: meeting with Chief Examiner, RCGP</p> <p>January/February/March 2017 – Northern Ireland National Review</p>