General Medical Council

Visit report on general practice programme

This visit is part of the Northern Ireland National review.

Our visits check that organisations are complying with the standards and requirements as set out in *Promoting Excellence: Standards for medical education and training.*

Summary

Education provider	Northern Ireland Medical and Dental Training Agency (NIMDTA)
Programmes	General practice
Date of visit	16 February 2017
Overview	During the visit we met with doctors in training and trainers, in primary and secondary care settings, and the NIMDTA general practice (GP) education management team. All doctors in training referred to in the report are on a GP training programme. We met with education supervisors, who in a primary care setting are referred to as GP trainers and clinical supervisors, who in secondary care are referred to as clinical supervisors by NIMDTA and within this report. NIMDTA had previously found that the GP training programme was oversubscribed but in recent years there has been a significant decrease in applications. Rota gaps have put a strain on services in specialty training, but the doctors in GP training have been protected and their education maintained. Overall it was a positive visit and the doctors in training are happy with their experience and support in the programme. However it was apparent the role of the clinical supervisors is isolated from the rest of the programme based on them not being able to access e-portfolio systems, nor receiving

	any specific formal training for their role in the GP programme.

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. These should be shared with others and/or developed further.

Number	Theme	Good practice
1	Theme 2: Education governance and leadership (R2.8)	There was evidence that the GP education management team at NIMDTA is responsive to feedback from doctors in training about their curricula coverage and had made improvements such as the introduction of the ECHO programme (dermatology).
2	Theme 5: Developing and implementing curricula and assessments (R5.9h)	Throughout the visit we consistently heard that training is being protected against markedly increasing service pressures.

Areas that are working well

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

Number	Theme	Areas that are working well
1	Theme 1: Learning environment and culture (R1.21) Theme 2: Education governance and leadership (R2.15)	The doctors in training we met relayed a positive experience of their general practice training, in particular the support of their GP trainers.
2	Theme 4: Supporting Educators (R4.1; R4.6)	The GP trainer approval and reapproval process appears to be effective.
3	Theme 5: Developing and implementing curricula and assessments (R5.9)	The quality of supervision and access to out of hours training is robust.

Requirements

We set requirements where we have found that our standards are not being met. Each requirement is:

- targeted
- outlines which part of the standard is not being met
- mapped to evidence gathered during the visit.

We will monitor each organisation's response and will expect evidence that progress is being made.

Number	Theme	Requirements
1	Theme 1: Learning environment and culture (R1.1-R1.3)	Doctors in training in secondary care must have clear guidance on what to do if they have any concerns about patient safety, and what formal protocols need to be followed.
2	Theme 2: Education governance and leadership (R2.6)	NIMDTA's GP education management team must have a clearer process to manage and control the quality of training delivery within a secondary care setting for clinical supervisors and doctors in training.
3	Theme 2: Education governance and leadership (R2.14) Theme 4: Supporting Educators (R4.5)	Clinical supervisors for doctors in GP training in hospital posts must have appropriate training and means to be able to provide feedback on the performance of GP doctors in training.

Recommendations

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

Number	Theme	Recommendations
1	Theme 2: Education governance and leadership (R2.17) Theme 3: Supporting	The formal process of transfer of information about doctors in training between relevant organisations currently in place should be used reliably and effectively to share information on

	learners (R3.14)	progression, particularly when they are moving on to the next stage of training.

Findings

The findings below reflect evidence gathered in advance of and during our visit, mapped to our standards.

Please note that not every requirement within *Promoting Excellence* is addressed. We report on 'exceptions', eg where things are working particularly well or where there is a risk that standards may not be met.

Theme 1: Learning environment and culture

Standards
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.*

Raising concerns (R1.1) and Educational and clinical governance (R1.6)

1 We heard at the visit that doctors in training are comfortable about raising concerns with their supervisors but are unaware of the formal processes and when they should be used. In particular, for those in hospital placements.

2 We were told by clinical supervisors that the process for raising concerns at the moment is informal across sites and that they feel most doctors in training would be comfortable raising any issues with the senior doctors.

3 The process of raising concerns is covered in the Northern Ireland Medical and Dental Training Agency (NIMDTA) induction for all doctors in training.

Requirement 1: Doctors in training in secondary care must have clear guidance on what to do if they have any concerns about patient safety, and what formal protocols need to be followed.

Dealing with concerns (R1.2) and Learning from mistakes (R1.3)

4 We were told of instances by doctors in training where the clinical supervisors and training programme directors (TPD) offered support in the form of teaching following an incident.

5 Doctors in the training informed us that as part of their induction programme they are told about the concerns process and how it is followed up.

6 We heard that doctors in training have a debrief following a concern but that this varies across sites and departments. We learnt from clinical supervisors that due to the short rotations on the training programme, doctors in training may have left the post or specialty when it came to receiving learning from a concern. The TPDs we spoke with also mentioned that feedback from a concern varied by site.

Appropriate capacity for clinical supervision (R1.7) and Appropriate level of clinical supervision (R1.8)

7 Doctors in training we spoke with said that there is always a suitable level of clinical supervision during their training. They felt that at times they have had to provide guidance to some clinical supervisors in secondary care who were not fully aware of the GP curriculum learning requirements. We heard arrangements were then made to ensure outcomes were being met.

Identifying learners at different stages (R1.10)

8 We were told by doctors in GP training in secondary care that they are identified as being in GP training on rotas, but there is little difference in their training to other specialty doctors in training as they have similar learning outcomes.

9 We heard from educational supervisors that staff within GP training practices are used to having doctors in training at different levels within the organisation so are aware of the differences and their capabilities.

Taking consent appropriately (R1.11)

10 Doctors in training in secondary care said that they do not have to undertake or take consent for tasks they do not feel comfortable with.

Rota design (R1.12)

11 We heard from doctors in training that teaching in rotas is organised to make sure it is relevant to them and they are able to access this without problems. Clinical supervisors in psychiatry and paediatrics said they value having doctors in GP training within their rotas as it provides useful insight for their future career as a GP.

12 We were told about rota gaps by the GP education management team and heard that previously the GP programme had been well subscribed which is no longer the case therefore rota gaps have increased. The GP education management team also told us that doctors in training are leaving the programme at short notice which is an additional reason for the rota gaps. NIMDTA is aware of this and different strategies are in place to encourage doctors in training to stay. Health and social care trusts

(HSCT) are having to recruit more locums to cover the gaps, but doctors in training said that they always have appropriate supervision in place.

Induction (R1.13)

13 We heard from doctors in training that though the induction to the GP programme is good there are variations in the quality of inductions they receive when in secondary care at hospitals. They said that some secondary care inductions were brief and they were told to learn on the job, where others were more thorough and in depth.

Handover (R1.14)

14 Doctors in training spoke highly of the handover processes in their obstetrics and gynaecology rotations and when working out of hours (OOH). They said that it is very thorough and clear.

Protected time for learning (R1.16)

15 Most of the doctors in training said they are able to access their teaching sessions and time for this is protected. We heard of instances where doctors in training in secondary care did not have teaching scheduled in their rota but were told this varied dependant on specialty. The doctors in training did mention that it is easier to access protected teaching time in primary care than in secondary care setting.

16 We were told that a majority of GP regional days are either set in Belfast or Antrim which is difficult or a long commute for some doctors in training from trusts that were further out to attend. We heard that majority of doctors in training are released to attend the regional days.

17 We heard from training programme directors (TPD) that there were rarely any problems with doctors in training accessing teaching and their teaching time is always protected.

Adequate time and resources for assessment (R1.18)

18 Doctors in training told us they are able to complete assessments, however we heard there are some difficulties for those in less than full time training when completing their assessments as the assessment schedule is designed for doctors in full time training. We heard there is good support provided by GP practices and NIMDTA for doctors in training that were taking the applied knowledge test (AKT), and that GP trainers were proactive in providing pastoral support during this time. Some doctors in training told us that mock clinical skills assessments (CSA's) are held to prepare learners.

Accessible technology enhanced and simulation-based learning (R1.20)

19 Doctors in training in secondary care told us they have some exposure to simulation training while in accident and emergency placements and when undertaking life support training.

Access to educational supervision (R1.21) and Educational supervisors for doctors in training (R2.15)

20 Throughout the visit we heard from doctors in training that they receive good support from their GP trainers and appreciate the close working relationship which aids their learning. They told us that teaching is appropriate to the general practice curriculum and the training experience is relevant and tailored.

Area working well 1: The doctors in training we met relayed a positive experience of their general practice training, in particular the support of their GP trainers.

Theme 2: Education governance and leadership

Standards
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.*

Quality manage/control systems and processes (R2.1) and Accountability for quality (R2.2)

21 TPDs informed us that when the national training survey results come out they are analysed by locality to see where there are issues. TPDs told us to date they have not had anything highlighted in the survey that they were not previously aware of.

22 We were told by the GP education management team that the Director of Postgraduate GP Education sits on the quality management group at NIMDTA to hear any issues within secondary care that may affect doctors in training in GP. It was not clear how the group deals with issues and management of clinical supervisors in hospital as part of the GP programme.

23 We heard about new innovations from TPDs and the GP education management team to aid and encourage doctors in training to stay within the specialty. The GP education management team recognised that there are a limited number of specialties that can be covered during the GP training programme but assesses the needs of doctors in training and their feedback. In response to feedback from doctors in training, the GP education management team has recently introduced ECHO (Extension for Community Healthcare Outcomes) in dermatology and are in discussions with psychiatry. Doctors in training told us they had found the ECHO dermatology placement to be valuable. The GP education management team told us they are trying to keep up to date with the changes for GP and to encourage doctors in training to remain in the specialty as a career. They currently have a doctor in training on the Achieve Develop Explore Programme for Trainees (ADEPT) programme who is looking into quality improvement for the profession.

Considering impact on learners of policies, systems, processes (R2.3) and Recruitment, selection and appointment of learners and educators (R2.20)

24 We were told by the GP education management team that when doctors in training apply for placements they are asked to provide a preference with ranking and then NIMDTA tries to ensure that they are placed within one of their preferred locations where possible as an incentive to stay within the programme. Though we were told by the GP education management team that Health Education England take ownership of recruitment for the GP programme within the UK.

Evaluating and reviewing curricula and assessment (R2.4)

25 At the end of the GP training programme doctors in training are asked by NIMDTA to provide feedback on their training.

Systems and processes to monitor quality on placements (R2.6)

26 We were told there is a three year cycle of quality management visits to training practices in primary care to gain/retain deanery approval. At these visits the GP education management team speak to doctors in training and GP trainers about education and work closely with the practice manager to ensure that the required criteria are met and maintained. We heard practice managers are invited to other training practice visits as an opportunity to learn and share ideas.

27 We were informed by the GP education management team that there were not equivalent visiting for placements within a secondary care setting for GP training specifically but that TPDs or a local GP trainer are invited to attend NIMDTA hospital visits if there are GP doctors in training at the specialty unit. The main way that quality would be checked in secondary care was through the NTS and local surveys by NIMDTA which were analysed with red outliers followed up through the respective specialty visits.

28 We were informed by the GP education management team that there are 17 federations of practices within Northern Ireland who are looking at service delivery. The GP education management team is considering having these as GP training practices and have been in discussion with the GMC approvals team about this. They hope to move towards a bespoke hub arrangement so doctors in training have a variety of experiences and are not based at one practice. They feel this would improve the quality of training and keep doctors in training within the programme.

Requirement 2: NIMDTA's GP education management team must have a clearer process to manage and control the quality of training delivery within a secondary care setting for clinical supervisors and doctors in training.

Sharing and reporting information about quality of education and training (R2.8) and Seeking and responding to feedback (R1.5)

29 We were told by TPDs that doctors in GP training tend to be vocal in their opinions and provide honest feedback to them directly and through Intrepid and their end of programme survey done by NIMDTA. We were also told there are trainee representatives for each year group who feedback to NIMDTA and TPDs. Doctors in training said they feel comfortable to approach their TPD if they have any issues with their training.

30 We heard that following feedback from those in secondary care about not having sufficient exposure to dermatology and otolaryngology, the GP education management team had created taster sessions for doctors in training and also introduced a dermatology ECHO which they have valued. The ECHO dermatology programme provides enhanced training to doctors in GP training about the diagnosis and treatment of complex skin disorders, doctors in training are able to access a centralised hub to discuss cases and receive information about skin disorders and the referral process.

Good practice 1: There was evidence that the GP education management team at NIMDTA is responsive to feedback from doctors in training about their curricula coverage and had made improvements such as the introduction of the ECHO programme (dermatology).

Clinical supervisors for doctors in training (R2.14)

31 When asking the clinical supervisors about their knowledge of the GP curriculum we were told that this was led by the doctors in training which was also reiterated by the TPDs and the doctors in training we met. We heard that there have not been any problems with doctors in training meeting their learning outcomes while in secondary care placements. The clinical supervisors currently do not have access to the e-portfolio system unless it is accessed by the doctor in training.

32 In the 2016 NTS results, in relation to protected time with your clinical supervisors or other member of the secondary care healthcare team, 40% of doctors in training said they did not receive any and 30% said they get 0-1 hours a week.

Requirement 3: Clinical supervisors for doctors in GP training in hospital posts must have appropriate training and means to be able to provide feedback on the performance of GP doctors in training.

Sharing information of learners between organisations (R2.17)

33 We were told by GP trainers at the visit that due to the close connections with other trainers in Northern Ireland any issues with a doctor in training would be discussed with their next trainer informally. The GP trainers said that serious issues would be escalated to TPDs who would review specific areas on the doctor in training's e-

portfolio. GP trainers were also able to make comments in the educator's notes section in their e-portfolio and we were told by the GP education management team that that they also share information through the annual review of competence progression (ARCP) outcomes. We did hear at the visit there is development work to formalise this process which is encouraged.

Recommendation 1: The formal process of transfer of information about doctors in training between relevant organisations currently in place should be used reliably and effectively to share information on progression, particularly when they are moving on to the next stage of training.

Theme 3: Supporting learners

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

Learner's health and wellbeing; educational and pastoral support (R3.2)

34 At the visit, clinical supervisors told us that they ensure they give the necessary support for the wellbeing of a doctor in training and that learners get an opportunity to go through any specific cases in teaching sessions to discuss the situation and share experiences with a group. We were told the obstetrics and gynaecology department has a close working relationship with pastoral care due to the nature of the specialty and doctors in training have a support group that meets regularly. Doctors in training were aware of who to contact if they had an issues with their health or wellbeing.

Undermining and bullying (R3.3)

35 We were told by doctors in training in secondary care posts that if they were being treated badly they would accept this treatment as placements were for a maximum of six months. The doctors in training said they feel that there is a culture amongst doctors not to raise bullying and undermining issues in fear of looking weak, and that the community is small which made them feel that being seen to raise issues could impact on their career prospects.

36 Clinical supervisors told us that although there isn't specific bullying and undermining awareness training, they equip learners with tools to recognise when they are being bullied such as through conflict and assertiveness tutorials. This training is delivered by a company outsourced by NIMDTA or as part of the induction. The clinical supervisors told us that they encourage doctors in training to raise issues with them or their GP trainer and to date no issues had been raised.

Information on reasonable adjustments (R3.4)[*] and Reasonable adjustments in the assessment and delivery of curricula (R5.12)

37 Doctors in training felt any reasonable adjustment requests are dealt with appropriately for themselves or other colleagues, including for assessments and curriculum delivery.

Supporting less than full-time training (R3.10)

38 The doctors in training we met said they were able to get less than full time (LTFT) training posts and the process was straightforward. We heard that where possible LTFT doctors in training are complemented to fit one rota, for example having two 60% LTFT posts which could be beneficial to the placement. Trainers and supervisors told us that the process ran quite smoothly.

39 The GP education management team informed us that each LTFT application is reviewed against the NIMDTA criteria and if the application meets the criteria it is granted. The training programme is then reviewed and posts moved around accordingly to accommodate the LTFT post. The GP education management team said that each doctor in training on a LTFT post will receive an individual tailored programme.

40 We were told to date the GP education management team have not refused a LTFT request for a doctor in GP training. They have been flexible in trying to accommodate requests based on their resources and being fair to all doctors in training. The GP education management team said there are a high number of doctors in training on maternity leave which we were told is challenging.

Support on returning to a training programme (R3.11)

41 We heard that doctors in training have had difficulties in accessing keep in touch (KIT) days after maternity leave. They told us that they felt out of sync from their training and that having days to come into work before they were due to start helped prepare and refresh them on current processes and systems. They mentioned that this has been raised at the trainee forum.

42 The GP education management team told us that there is a process to access KIT days and if the requirements for this are met then KIT days are arranged accordingly.

[*] The Equality Act 2010 does not apply to Northern Ireland. The Equality Act 2010 is in force in the rest of the UK, but the Disability Discrimination Act 1995 and the Special Educational Needs and Disability (NI) Order 2005 remain in force in Northern Ireland.

43 GP trainers and TPDs we met appreciated that doctors in training returning from leave can feel isolated and out of sync but told us they are able to access KIT days and meet with the TPD to introduce them back to their training programme group.

Study leave (R3.12)

44 We heard from doctors in training that they are able to access study leave for courses and to prepare for exams. Doctors in training had also used study leave to gain additional time with their GP trainers.

Feedback on performance, development and progress (R3.13)

45 GP trainers and clinical supervisors said there are opportunities for feedback to doctors in training on cases, this feedback is on a one to one basis and includes information about their e-portfolio entries.

Support for learners in difficulties (R3.14)

46 The TPDs said that the trainee support process has improved with more involvement with occupational health. TPDs also offer training to trainers on managing trainee support. We were told that the NIMDTA administrative team offers support and sign posting to the most suitable person to offer guidance on each individual case.

Recommendation 1: The formal process of transfer of information about doctors in training between relevant organisations that is currently in place should be used reliably and effectively to share information on progression, particularly when they are moving on to the next stage of training.

Meeting the required learning outcomes (R3.15)

47 Doctors in training in secondary care told us that they have to be proactive if they felt that they may not be meeting their learning outcomes by talking to their clinical supervisors to get more experience of clinics. They told us that certain specialities eg otolaryngology and dermatology are not covered during their placements but they are offered taster sessions for these specialties to gain exposure.

48 When asking the clinical supervisors about their knowledge of the GP curriculum we were told that this was led by the doctors in training which was confirmed by the TPDs. Please also refer to R1.8 regarding access to appropriate clinical supervision.

49 We were told by GP trainers if they did feel that a doctor in training was not going to meet the curriculum requirements, the cohort of GP trainers is dedicated and the close relationship between doctors in training and GP trainers means that gaps in training (perhaps from previous secondary care placements) could be identified and fixed.

Career support and advice (R3.16)

50 We heard from GP trainers and doctors in training in primary care that some practices involve the doctors in training in management meetings that include GP planning, staffing and crisis planning to cover the management aspects of their training and prepare them for when they gain their certificate of completion of training.

51 The TPDs told us at the visit that there has been a significant decline in doctors in training applying to GP. They perceived that that doctors in training do not want to become GP partners, which adds to the low morale amongst doctors in training. One of the TPDs told us that they have recently been appointed to a new role in GP career development where they will speak to doctors in training about the different opportunities within the specialty to try and increase interest for those to stay on to practise as a GP.

Theme 4: Supporting Educators

Standards
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.*

Induction, training, appraisal for educators (R4.1) and Recognition of approval of educators (R4.6)

52 The clinical supervisors we met felt a lot of their role is based on intuition and there is no formal training in place. They have been offered courses at Health Education which have been good but found other courses not very helpful. Their educational appraisal for their role is part of their annual appraisal.

53 GP trainers told us they have meetings with other trainers three times a year where there is a range of experts and speakers from NIMDTA who go through various aspects of the role and any developments to the specialty or the curriculum. We heard that doctors in training are also invited to these sessions to talk through their experience of training. The GP trainers told us that this also acts as a forum to discuss any issues, and although they found the education part of these sessions is not as rewarding, overall it is a valuable experience.

54 We were also told that NIMDTA manages local training development days. GP trainers said these days are well organised and give an opportunity to sit in on practice revalidation visits as part of their trainer reaccreditation. The TPDs we met said they had no way to assess if clinical supervisors were doing a good job unless they heard it informally from doctor in training – this is also linked to requirement two.

55 We were told that there is a one day ARCP training session following by a half day where trainers are able to observe a panel. NIMDTA and GP trainers feel this is a useful tool for trainers to see a variety of e-portfolio submissions.

56 We found the pre-visit documentation on the trainer approval process to be robust, which is what we also heard from GP trainers. During the visit we were told by GP trainers that the process for approval and reapproval of trainers is working well. We also heard from trainers that they have a consistent understanding and oversight of the approval process that involves an assessment of the full scope of practice and facilities with effective follow up.

Area working well 2: The general practice trainer approval and reapproval process appears to be effective.

Time in job plans (R4.2)

57 We heard from clinical supervisors that they do not have recognised time for teaching in their job plans, however we heard that their supervision role is recognised and would be remunerated. The clinical supervisors said that NIMDTA have offered financial reimbursement to them for each allocated doctor in training they supervise. We heard from TPDs that work is underway to ensure allocated time in job plans for clinical supervisors in secondary care posts.

Working with other educators (R4.5)

58 During our visit, the TPDs told us that most GP trainers want to do the role actively whereas the clinical supervisors had to be encouraged.

59 We were told that the TPDs try and coordinate amongst the five trusts by talking to each other and creating a common model and working on each trust's strength. They told us that they have clear systems in place to share information from one practice to another when there are issues with doctor in training and that they ensure conversation between GP trainers take place. We were told GP trainers are able to share information through educators notes in the e-portfolio. We heard that clinical supervisors are not able to access the e-portfolio system to document learners performance and can only view if a doctor in training accessed the system while with their clinical supervisor. We are aware that the e-portfolio system is managed by the Royal College of General Practitioners and that NIMDTA does not have control of who is able to access the system.

Requirement 3: Clinical supervisors for doctors in GP training in hospital posts must have appropriate training and means to be able to provide feedback on the performance of GP doctors in training.

60 We were told by GP trainers that practice managers are invited to NIMDTA visits to GP practices as part of the approval for training process, as an opportunity to learn and share ideas.

Theme 5: Developing and implementing curricula and assessments

Standard
S5.1 *Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required by 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.*

Training programme delivery (R5.9)

61 During the visit, the doctors in training were positive about their out of hours (OOH) experiences, especially the flexibility and ease of access of the process. They mentioned good supervision arrangements are in place with their OOH trainer who provides 1:1 supervision until the doctors in training feel more comfortable. We were told that all OOH trainers are GP trainers and are able to provide an educational debrief following OOH sessions.

62 Trainers and TPDs we spoke with felt that the OOH experience added value to the educational experience for doctors in training. TPDs valued the supervision provided through OOH, with adjustments made to suit the competence levels of doctors in training. We heard that telephone triage is an area which is becoming more of a service need and that trainers and TPDs are developing more training in this area to best meet demand.

Area working well 3: The quality of supervision and access to out of hours training is robust.

63 Clinical supervisors told us that they cater the training to the needs of the doctors in training and get them access to experience and clinics based on curriculum requirements or personal interests. Doctors in training also suggested that they need to be proactive in meeting learning outcomes by raising issues with their clinical supervisor.

64 The GP trainers said that they are able to offer considerable support and guidance to training as they work closely with doctors in training in the practice setting.

65 We heard from the GP education management team that there has been a decrease in applications to the GP programme and those gaps in the programme cause gaps in rotas. Despite this we heard that service delivery is predominantly managed by locums and that teaching is protected which, under the circumstances, is a strength to the management and delivery of the programme.

Good practice 2: Throughout the visit we consistently heard that training is being protected against markedly increasing service pressures.

Mapping assessments against curricula (R5.10)

66 We were told by doctors in training that assessments are working well though they had to lead their clinical supervisors through the assessment process. Doctors in training told us there are regular Thursday teaching sessions where they work through the curriculum together and trainers attend to discuss aspects of the curriculum in relation to exams and assessment.

67 GP trainers mentioned that although doctors in training pass the AKT and CSA in the final year, doctors in training would be better prepared for practice if they had a further year of training. Across the course of the visit, educators did tell us that the GP programme would benefit from being extended by a year for doctors in training to gain a better breadth of experience. GP trainers felt that doctors in training would worry about passing assessments in their final year which would become their focus over the rest of their learning. TPDs suggested that having a summative assessment during secondary care placements would be more useful, to ensure that learning during secondary care placements is relevant to general practice.

Examiners and assessors (R5.11)

68 GP trainers told us they would value a yearly update on any changes to exams or assessments as updates tended to be informal or shared during GP trainer meetings. We heard that it could be confusing for clinical supervisors who were managing a number of assessments at one time, which included assessments for specialty doctors in training too. Clinical supervisors are not able to access the RCGP e-portfolio system to ensure that assessments were completed and competencies were relevant.

69 TPDs told us that the ARCP process is in June, we heard that TPDs attend ARCP panels and invited the associate director (AD) and GP trainers to attend and observe. GP trainers found it valuable to attend these sessions and have the opportunity to see a variety of e-portfolio submissions. ARCP panels are chaired by ADs, and in order to be a panel member there is a one day training session and a half day observation of panels.

70 Doctors in training told us there is a set list of requirements to complete for the ARCP provided by NIMDTA. We heard there is not clear guidance on the number of learning logs that doctors in training have to complete, and they feel this can be a 'tick box' exercise. GP trainers and TPDs told us that the RCGP recommended a certain number of learning logs per week, and it was the GP trainers' and TPDs' understanding that the deanery recommended two per week, however the focus for doctors in training should be on quality over quantity. We heard that doctors in training are encouraged to write reflective learning logs and receive additional training on how to do this.

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