

Annex 7

**Education and training for general practice:
a joint curriculum statement**

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a joint curriculum statement from the Royal College of
General Practitioners and the Committee of GP
Education Directors**

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1. Introduction

The curriculum statements of the Royal College of General Practitioners (RCGP) have been written to inform that period of postgraduate training between acceptance onto a general practice training programme and the award of a certificate for independent practice. This is usually referred to as vocational training for general practice in the United Kingdom and specific training for family medicine elsewhere in the European Economic Area.

For many years GPs have been ambivalent about writing a curriculum for general practice arguing that the subject matter is too broad to be defined within a single document and that the competencies of the discipline can only be defined and acquired through the performance of the job itself. But medicine, even general practice, is more than a craft to be learned through apprenticeship but a subtle blend of art and applied science and it is that very complexity that provides a need to codify the professional knowledge, skills and attitudes required in order that professional boundaries may be defined and teaching and learning directed appropriately and efficiently.

According to Stenhouse (1), the father of curricular theory, a curriculum is:

an attempt to communicate the essential features and principles of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice

A curriculum describes the course or the journey of learning and is built from a number of components; the rationale for the learning, the learning content, learning outcomes, strategies and resources. It also describes in broad terms the assessment that will be applied to and by the learner and the evaluative process that will be applied to the learning events.

Who is the RCGP Curriculum written for?

From the above definition it is clear that a curriculum has three principle target audiences, the users, the regulators and the academically interested. It will be used and read differently by each group. To have any credibility it must be a document for learning, but of course, the document must be acceptable to regulators before it reaches the hands of the users. Each group has to accept the needs of the other and appreciate the inevitable tensions in the text.

A curriculum for the academic community is both an historical and reference document summarising the aims, objectives and processes of an educational programme at a particular point in time. Learners on the other hand, driven either by the imperative of assessment or vocational aspiration, will look for the elements of knowledge, skills and attitudes that will enable them to demonstrate, or reach, the required competencies. Teachers in turn, as facilitators or managers of learning, will use a curriculum as a guide or framework, coloured by the pragmatism of professional practice, on which to base negotiations with the learner. Assessors, on behalf of the regulatory authority, examine the curriculum for learning outcomes that they can translate into tests, and for them, the stated learning outcomes are rich seams. The regulatory authority signs off a curriculum as a social contract between the profession and the public.

The RCGP curricular framework

In the RCGP curriculum statement *Being a General Practitioner*, the generic professional competencies necessary for UK general practice are described. These competencies are steeped in the reality of European professional practice and taken from the European definition of family medicine as developed by the World Organisation of Family Doctors (WONCA) and the European Academy of Teachers in General Practice (EURACT). The Royal College of General Practitioners and the Committee of General Practice Education Directors are agreed that these generic competencies should form the foundation of a curriculum for postgraduate general practice education and training.

Competence and competencies

Throughout the curriculum document the term **competence** will be used to describe a stage on the way to expertise, specifically *the ability to use knowledge, understanding, and practical and thinking skills to perform effectively to the national standards required in employment*. An individual who is competent, has therefore, by definition, attained these defined standards.

Competency is a more problematic concept as the term has been used variously by different authors and in different contexts. Indeed competency-based training and education has in recent years acquired a bad name with critics accusing it of being overly simplistic, atomistic and reductionist (2-5). Despite these reservations, a competency-based approach to education and training can be made to work and is applicable to the professions as to any other occupation. A competency can be conceptualised in three ways (4):

- task-based
- a generic attribute
- holistically defined in context

The task-based or behaviourist competency model is the one often adopted when competency-based training and assessment is being discussed: “Competency-based assessment measures what doctors can do in controlled representations of professional practice” (6). This brand of competency-based education focuses on discrete behaviours associated with the completion of discrete tasks. Indeed, this is its appeal in that the model is both simple and clear. But such an approach to professional education is generally agreed to be conservative and reductionist, ignoring as it does, underlying attributes, group processes, context, the complexity of performance and the role of professional judgement and is therefore inappropriate for describing the complexity of professional work.

An alternative approach, that of treating competencies as general personal attributes is popular in the management field and can be found, for example, throughout the leadership literature e.g. Goleman (7). But we know that expertise is context-specific and general attributes may not be applicable in certain circumstances. General attributes are also unhelpful in the design of training programmes or for the purposes of wider accountability.

In the RCGP Curriculum, competencies are described as general attributes within a context incorporating both understanding and judgement: that is “as a complex structuring of attributes needed for intelligent performance in specific situations” (4). This holistic approach is adopted throughout the Curriculum with competencies forming the building blocks of professional competence (see Box 1). Within the curriculum document each special topic or disease-specific area also describes the unique knowledge or skills required to deliver the competencies in that particular context.

Box 1

The building blocks of competence



Topic areas

Being a General Practitioner describes the holistic competencies required for UK general practice.

Subsequent curriculum statements explore the major topic and disease areas and elaborate on the knowledge, skills and attitudes that will enable to practitioner to demonstrate the major competencies in these specific contexts. These statements will facilitate conversations between teacher and learner and offer the route map, milestones and signposts along the learning journey.

Each topic is constructed in the same way. An initial statement of why the topic has been placed in the Curriculum with a description of its primary care epidemiology. A section on the UK priorities describes the relevant imperatives that drive the service in the UK, such as National Service Frameworks, NICE guidelines etc. Learning outcomes focus on the knowledge, skills and attitudes that are required to demonstrate the competence in that topic area. It is from here that the majority of learning conversations are expected to result and from which assessments will be designed. Illustrative exemplars are provided as to how teaching and learning relating to this section of the Curriculum may be approached. Each topic section will conclude with a list of learning resources and credits. Very importantly it will be dated and reviewed at defined intervals by a nominated individual or institution, who will act as a 'guardian' for that particular Curriculum section, to reflect changes in evidence and practice.

The learning journey

The learning journey for each family doctor starts before medical school and finishes when she or he stops practising. The RCGP Curriculum however, concentrates on the journey that takes the individual from the beginning of specialty training for family medicine until they are certificated as a competent independent practitioner. This journey takes the learner through the home territory of primary care with forays into specialty fields relevant to UK general practice. Subsequent sections of this statement go on to describe how that journey will be orchestrated, defining the principles that will underpin both the teaching and learning that will take place, and the design of training programmes that will enable the delivery of the learning outcomes stated in the Curriculum.

2. Training programmes for general practice

The current situation

The Royal College of General Practitioners and others have long made the case for radical changes to the structure of GP training (8, 9). Criticism has focussed on two main areas; the educational content of the two years spent in hospital-based training, and the rigidity of the overall programme length (10-12). As at 2005, an insufficient 12 months of training for the speciality of general practice actually takes place in primary care with the bulk of GP training situated in a selection of SHO posts in various secondary care specialities. Many of these posts, though satisfactory for speciality training, are not 'fit for purpose' for general practice and evidence shows that general practice registrars find themselves inadequately prepared for independent practice on exiting training and are reluctant to take up substantive posts (13, 14).

Departments of Postgraduate General Practice manage the funding for the final GP training year. Acute Trusts and the Deanery hold funding for the SHO component of training jointly. This has affected the ability of GP departments to influence the structure, quality and content of the first two years of the GP training programme; a situation that has served to maintain the status quo since the inception of vocational training for general practice for over thirty years.

Following the three year training programme, doctors new to general practice currently benefit from a period of Higher Professional Education, a two year envelope during which funded opportunities for further training can be accessed whilst in practice.

Two major policy changes impact on the design of future training programmes – Modernising Medical Careers (MMC) and the regulatory framework which will come into force when the Postgraduate Medical Education and Training Board (PMETB) assumes its full functions.

Modernising Medical Careers (MMC)

Modernising Medical Careers has led to the development of a new training programme for all doctors in their first two years post-qualification. This Foundation Programme aims to provide a generic and broad-based education. Postgraduate specialty training programmes will follow thereafter, and one of which will be the speciality of general practice.

The Royal College of General Practice, the Joint Committee on Postgraduate Training for General Practice and the Committee of General Practice Education Directors have all agreed that the general practice specialty training programme will commence on successful completion of the Foundation Programme and should remain a minimum of three years duration.

There is now an opportunity for general practice to develop an integrated training programme which is fit for purpose and for the needs of the NHS in the 21st century. A seamless progression from the Foundation Programme into a three-year specialty training programme will be followed by in-service Higher Professional Education leading onto a career lifetime of continuing professional development.

Postgraduate Medical Education and Training Board

In parallel with the restructuring of all medical training programmes, comes a change to the regulatory framework that governs medical training. When the Postgraduate Medical Education and Training Board (PMETB) assumes its powers in October 2005, the previous Vocational Training Regulations are repealed. PMETB then becomes the body to approve general practice training programmes and the regulation under which it does so is incorporated in article 5 of the *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* (15). At first sight this does not appear to vary substantially from the current (2005) regulations but there are a number of significant differences.

The first of these is in paragraph 5(c)(i), which indicates that training for general practice will include at least twelve months as a GP registrar with an approved trainer. The Board has itself to approve the trainer; this applies to no other category of teacher in this order.

Furthermore, in paragraph 5-1(c)(ii), the Order requires that trainees undertake 'a period or periods amounting to at least 12 months employment in a post (or posts), in a specialty or specialties which the Board has prescribed for this purpose'. This requirement replaces the current 'short-list' specialties, two of which must be occupied for a minimum of six months (16). The new regulation does not require this placement or "post" to be in a hospital and clearly the key to this segment of the training will be the approval by the new competent authority, the PMETB.

The remainder of the training i.e. one further year to complete the period of three years, may be completed in either of the first two categories (paragraph 5-2).

General practice is thus freed from the regulatory requirement to have its training programme necessarily delivered in secondary care and in particular from the need to have the training placement approved by specialist Royal Colleges. This does not mean that there should be no secondary care element to GP training, but it does allow that experience to fundamentally change. Elsewhere in the Order, PMETB is required to set out standards for the requirements for entry into training, curriculum design, outcomes to be achieved and the assessment processes to be used during and on completion of the period of training. In doing so, the Board has indicated that it will be seeking advice from each of the Royal Colleges in relation to their own training programmes. This, and the much greater freedoms in the organisation of the programme, provides a great opportunity to create a fit for purpose new specialty training programme for general practice.

The future role of the general practitioner

As with all other specialties, and indeed professional groups within the NHS, the role of the general practitioner is changing rapidly. The new GMS contract for general practice allows GPs more flexibility over their work arrangements, but retains the current broad clinical remit of the general practitioner. The contract encourages more explicit patient care pathways, integrated working across the system, and better developed clinical relationships. The move towards flexible portfolio careers for the workforce, in particular for GPs, may challenge the evolving functions of general practice, although the application of quality standards, appraisal and revalidation may act to consolidate recent developments.

The creation of GPs with a special interest will build on the foundation of vocational training. Guidance from the Department of Health for Primary Care Trusts (PCTs) implementing a scheme for GPs with special interests emphasises that primary care organisations will need to ensure that the GP is a competent and experienced generalist, as well as having the specific competencies and experience for the special interest area. The value of primary care to a cost effective health care system (17) has been demonstrated, and it is vitally important to ensure that a general practice service to patients is not compromised. The key elements of the clinical generalist in the community will remain, and in a primary care driven NHS, are likely to become increasingly important (18).

Specialty training for general practice

A radical review of speciality training for general practice is now required and any future training programme for general practice must be designed around its ability to deliver the competencies described in *Being a General Practitioner* and subsequent curriculum statements. A framework for such a programme has already been developed by a working party of the College and approved by the JCPTGP (19) and this joint curriculum statement draws on, and develops the principles outlined in that document.

Key to the development of a new specialty training programme is that learning should be based in an environment relevant to the final professional destination of the learner and be supported by a mentor or supervisor who acts both as professional model and as a facilitator for learning. It can be reasoned that general practice education should be based, but not necessarily entirely delivered, in general practice with the help and support of a fully trained general practitioner with specific educational skills.

Though the training itself should be based in general practice this does not preclude attachments in other health care settings where the concentration of clinical material offers learning opportunities which might take months or years to achieve in a general practice placement. For this reason a significant part of GP training will need to continue to take place in a secondary care setting. Such attachments must be planned, relevant, appropriately supervised and guaranteed to provide the learner with sufficient time to reflect on practice and develop a clear understanding of what has been learnt and how it can be applied effectively to a general practice setting.

The learning plan will also need to be modified during any individual's training to accommodate new experiences and changes in emphasis. Furthermore, since the programme should reflect both the needs of the learner and the learner's progress, the duration of training will accordingly, need adjustment. Principles underpinning teaching and learning for general practice are covered in more detail in section 3.

A number of models for the structure of training programmes for general practice have already been developed including programmes based entirely in general practice (20) and where it has been possible, deaneries have already built numerous fit for purpose innovative SHO and Senior GP registrar posts. Early experience of general practice helps to keep a GP focus during the hospital experience and the evaluation of such posts has been positive (14, 21-23). New speciality training programmes for general practice should build on that success.

It would be inappropriate for the Royal College to dictate the structure of all UK training programmes as clearly one size will not fit all. Training programmes will need to be tailored to the learner and postgraduate deaneries should be allowed the freedom to adapt curriculum delivery to meet the needs and the opportunities that present themselves within the local health community.

Certain principles can however be defined, and it is the view of the Royal College of General Practitioners and the Committee of General Practice Education Directors that individual speciality training programmes for general practice must conform to the following criteria. Examples of representative programmes are supplied in Box 2.

RCGP Criteria for Speciality Training Programmes for General Practice

A. Selection to GP specialty training will be through a national process based on a national person specification.

The national person specification and recruitment processes are described in detail in section 6 of this joint curriculum statement.

B. Specialty training programmes for general practice will be a minimum of three years duration.

The three-year training specialty envelope is defined as commencing on satisfactory completion of a two year Foundation Programme. Exit from, and subsequent entitlement to certification from specialty training will be subject to satisfactory performance in the RCGP assessment programme (q.v.).

C. Programmes will comprise a *minimum* of 18 months full time (or part-time pro rata) in a training practice under the supervision of a general practice trainer.

Each training practice, will meet both high professional and educational standards. All trainers and educational supervisors will be trained to be competent in teaching and assessment and the delivery of the curriculum will be monitored through regular quality assurance. Time spent in practice may be divided up within the three-year training envelope and will normally entail time spent in more than one practice.

D. Programmes may include a *maximum* of twelve months in individual hospital speciality posts selected on the basis of capacity to deliver the competences defined in the RCGP Curriculum.

Trainees transferring from other specialty training programmes may substitute relevant previous experience for a maximum of the twelve months hospital specialty component of GP training programme. In order to obtain the broadest possible training, it is desirable that experience in any one secondary care speciality will not exceed four months.

E. Innovative training posts will be developed to ensure a broad base of GP-relevant primary care experience, and the exploration of the primary-secondary care interface.

Such posts may be based in general practice with secondments to other primary care organisations e.g. drug and alcohol teams, hospices, or to acute services e.g. outpatients, day hospital.

Alternatively, such posts may be secondary-care based but focussed on the needs of the general practice trainee e.g. posts structured around out patients and chronic disease, or the exposure to general practice relevant sub- specialities such as dermatology, rheumatology, ophthalmology and ENT.

F. The final 12 months of GP training programmes will be sited in general practice.

Training programmes should finish with time spent in the role for which the trainee is being prepared. Dependent on learning needs, GP-based innovative training posts may also be appropriate at this stage.

G. Programmes will be built around a personal development plan, which will be orientated to meeting the learning outcomes defined in the RCGP Curriculum.

Learning should aim to produce a reflective self-educating practitioner and independence must be fostered in the learner over time. Learners will at different rates and with different styles, and education planning should accommodate this wherever possible. Learning is enhanced when learners are actively involved at all stages, identifying their needs, planning, implementing and evaluating their programme.

H. Programme directors will oversee the local delivery of training programmes.

The role of programme directors (course organisers) in the management of curriculum implementation is discussed in detail in section 4.

I. A Primary Care Organisation should be the employer for the length of the programme.

The role of the Primary Care Organisation in the management of curriculum implementation is discussed in detail in section 4

J. Programmes will be subject to in training and end-point assessment that is valid, reliable, feasible and acceptable with an educational impact rooted in delivering the learning outcomes of the curriculum.

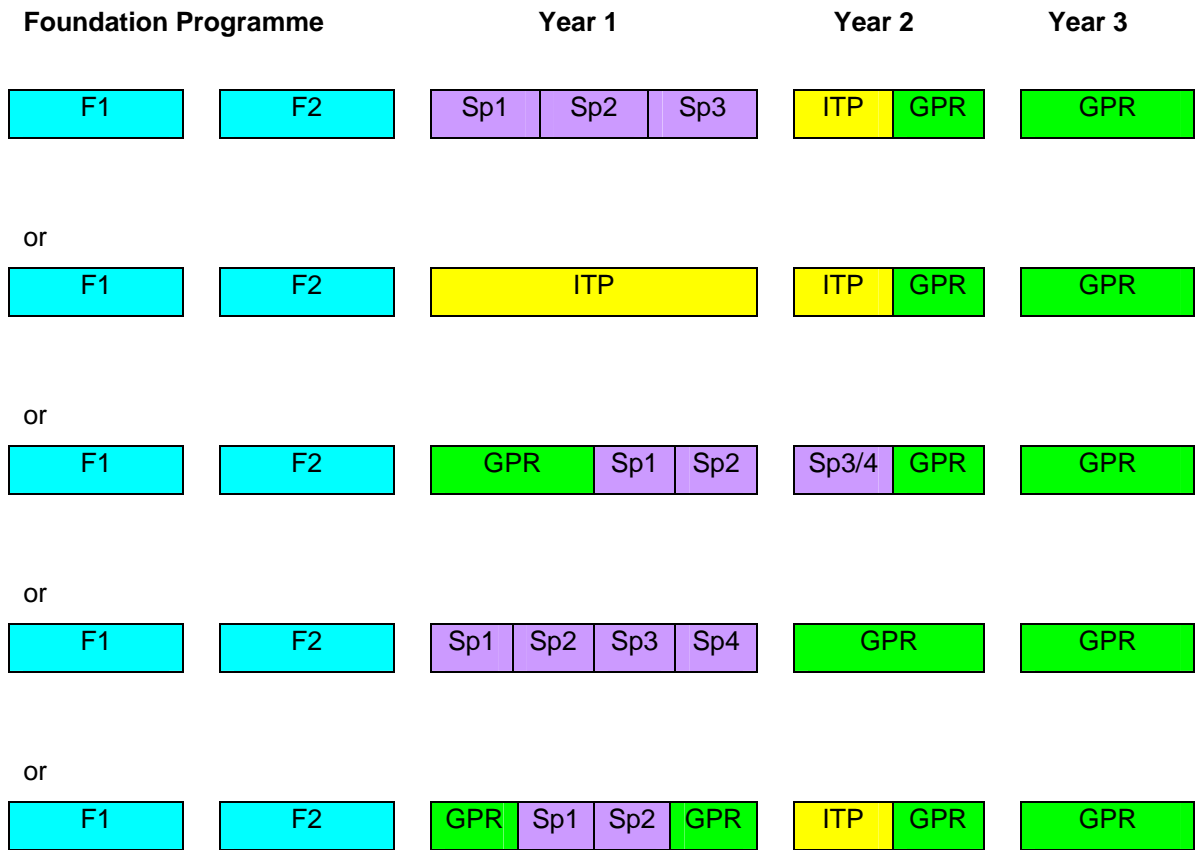
Details of the RCGP Assessment programme for specialty training are provided elsewhere.

K. Training programmes will be followed by a period of supported professional practice, normally of two years duration

A period of Higher Professional Education for GPs new to general practice will enable release from service commitment in order to meet personal development needs including the development of 'special interest' competencies.

Box 2

Illustrative training programmes in general practice



F1= first year of foundation programme

F2 = second year of foundation programme

Sp = hospital specialty post

ITP= innovative training post

GPR = GP registrar post

3. Teaching and learning for general practice

Introduction

The delivery of a curriculum for general practice will occur primarily at work. A substantial proportion of the training envelope is expected to take place in general practice itself, although it is recognised that a wider training experience, incorporating time spent, and competencies gained, in secondary care will form an important contribution to the development of the future general practitioner.

The primary pedagogical relationship will be between a trainer (educational supervisor) and the learner, and this relationship will be embedded in active, professional practice. It is expected that each training practice, or department, will meet both high professional and educational standards. All trainers and educational supervisors will be trained to be competent in teaching and assessment and the delivery of the curriculum will be monitored through regular quality assurance.

In addition to training in the workplace, the learner will also participate in the formal learning opportunities provided through departmental teaching sessions and vocational training scheme seminars and day release activities.

Again, it is not the place of this document to dictate precisely how the curriculum should be delivered at the individual level, and the professional integrity of the trainer, course organisers and programme directors should be respected. However, it is recommended that teaching and learning should be organised with attention to the principles described below.

Teaching and learning

Adult learning

The concept of andragogy or the “art and science of helping adults learn” (24) encapsulates a body of literature and educational thought stemming back to the beginning of the twentieth century. It is predicated on a number of assumptions about how adults engage with the learning process. Though contested by other educational theorists, andragogy provides a useful framework by which to consider learning and by inference structure a programme of teaching. Adult learning then, is most likely to be effective when it is:

Self directed

As an individual matures, his or her self concept moves from one of total dependency to increasing self-directedness. There is a deep seated need for adults to be self-directed, and if they are not allowed to be so, tension, resentment and resistance will result. In other words, adults, are in charge, and will want to remain in charge, of their own learning. Self-direction is not a constant attribute however, and faced with a

new situation, it should be recognized that even the adult learner will want to be told what to do rather than have to find out for themselves (25).

Experiential

Experience provides the principal resource for adult learning. Adults have a broad base of experience and it is into this bedrock that they sink, or “connect” new ideas. Furthermore, adults define themselves by their experience and if this experience is ignored the learner will feel neglected and undervalued.

Experiential learning is an iterative process, situations can be revisited again and again and something new can be gained each time. General practice learners will bring a huge quantity of prior and highly relevant experience to training. The role of the trainer is to help connect up those experiences with new ones and in doing so provide a fresh outlook on old situations.

Needs-based

An adult's readiness to learn is strongly related to the tasks required for the performance of his or her evolving social role. Adults learn most effectively when the circumstances make it necessary to do so. In general practice training, there will be a readiness to learn about different issues at different stages of training.

A “trajectory” of learning needs will develop throughout the training period, unique to that individual learner and related to his or her engagement with workplace practices and emerging responsibilities. On the day-to-day level, there will be a hunger for new knowledge and skills driven by discomfort generated by situations which the learner finds difficult. Sensitization of the learner to these moments of discomfort, or need, is vital to continuing professional development (26), and trainers should ensure that these opportunities are used to best educational advantage. The ability to identify one's own learning needs is a skill central to life-long learning and the learner should be encouraged in this regard at every available opportunity.

Problem centred

Adults want to apply tomorrow what they learn today. The appropriate units for teaching and learning in general practice are therefore not subjects, but situations. It follows therefore that problem-centred teaching and practically-orientated learning episodes are more likely to be effective than subject-orientated set tutorials (27).

The learner's readiness to learn does not have to be awaited passively, it can be stimulated, and another of the trainer's tasks will be to supply that stimulation, providing a graded exposure to increasingly complex situations and emersion in the richness of the discipline of general practice.

The role of reflection

Kolb (28) described a cyclical process of experiential learning in which the individual undergoes an experience, comes away and reflects on that experience, tries to make sense of what happened on the basis of theoretical considerations available to them and connects up what happened with what they already know. Then, equipped for the future, prepares for the next experience. A similar mechanism, but occurring minute-by-minute, was propounded by Schön (29) as the basis for the acquisition of professional knowledge. Through such reflection 'on practice' and reflection 'in practice' learners continually remodel their professional behaviours.

General practice educators should ensure that their learners are provided with the opportunity to reflect, through diaries, feedback, debriefing sessions and peer discussion groups. Through reflection, sense is made of past events, experience reframed and future strategies for interacting with the world are formulated.

Informal and formal learning

Learning for general practice, will take place through both formal and informal processes.

Formal learning, defined as taking place in an institution, as a result of instruction (30) will be accessed through planned tutorials, vocational training scheme and departmental training programmes and external courses. In structuring these formal educational sessions, attention should be paid to the principles outlined above and the holistic competences and contexts outlined in the Curriculum. Delivery of formal programmes is likely to be most effective where didactic teaching through lectures and seminars is counterbalanced with opportunities for learners to engage with topics in small groups, through problem solving and mutual enquiry.

The greater proportion of learning however is likely to take place informally in the workplace, where it may be *implicit, reactive* or *deliberative* (31).

Implicit learning is defined as "the acquisition of knowledge independently of conscious attempts to learn and in the absence of explicit knowledge about what was learned" (32). This form of learning emphasises the role of the trainer in providing modelling opportunities and a high quality professional environment, in which learning opportunities arise perpetually through observation and participation in exemplary professional practice.

Deliberative learning occurs where time is set aside specifically for the purpose, such as a debriefing session following a clinic, ward-round or surgery. For many years this has been a central, and highly important element of training for general practice.

Reactive learning sits between the two extremes and occurs “where the learning is explicit but takes place spontaneously in response to recent, current, or imminent situations without any time being specifically set aside for it” (31). Again, the role of the trainer is to provide an invitational environment in which learners can access information from all members of the team when it is most needed.

Education, service and apprenticeship

Training for general practice may be conceptualised as an apprenticeship (26), a pupil working alongside a master in the workplace in a bounded training relationship. As such, it is important that education and service are blended in order to allow professional growth through “legitimate peripheral participation in a community of practice” (33). Experience not only allows acquisition of skills through rehearsal, but by graded participation in professional practice the learner acquires the language, behaviours and ways of thinking of the profession. Time on the job is important; professional development is as much about *being as doing*.

Satisfactory professional progression may be enhanced by “how the workplace invites and structures individual's participation in work” (34). For many years, training practices have provided an exemplar of an invitational organisation, giving doctors permission to learn and structuring their experience appropriately. As the training period progresses, increasing participation becomes the primary motivation for development. The learner's sense of professional identity is enhanced as he or she offers graded contributions, from low to high value. Central to this process is the need for the maintenance of self-esteem and feedback, and support and confidence-building measures must accompany the training process (35-37). “In at the deep end” is a high risk pedagogical strategy.

Increasing participation in social practice results, not just in knowledge acquisition, but in knowledge production, and this too is an essential part of the development of professional identity (38). All learners should have the opportunity to develop new ideas and to mould the working practices of their environment through, for instance, audit, research or service redesign. By doing so, they not only legitimise their own participation but shape the very community into which they are being absorbed.

Training practices and teaching units should further ensure that the apprenticeship provided is *expansive* (39), that is a broad-base of experience is obtained both from within, and outside the immediate working environment. This may entail, time spent learning from other professionals, courses of formal learning, visits to other practices and so on.

Inter-professional and multi-professional learning

Primary care is a multi-disciplinary activity and this should be reflected in the delivery of training programmes for general practitioners. Opportunities will exist for multi-professional learning - where two or

more professions learn together - and these are most likely to occur, and for subsequent learning to be effective, in the workplace (40). Inter-professional learning opportunities should also be developed, enabling trainee doctors and primary care nurses to “learn together with the object of cultivating collaborative practice” (41) and this may be achieved through both formal and informal elements of training.

Preparation for life-long learning

The training envelope described is just the start of a career of life-long learning. We need to continue to learn because we cannot learn everything that we will be required to know during our career; there is not the time, and many things remain unforeseen. Continuing professional development is an essential component of the professional activity of any GP, a process that aims to maximise the learning opportunities that present themselves during the course of working life. The ability to remain alert to these opportunities and to take appropriate action are skills that can be learned and should be encouraged throughout any initial planned period of training.

Assessment

Assessment has been traditionally been divided into two broad functions, formative; assessment *for* learning, and summative; assessment *of* learning. However, though the timing and application may be different, the methods are often the same (42).

Formative assessment

Formative assessment will be an ongoing developmental process. It will take place during the course of teaching and used to feedback into both the teaching and learning processes. By identifying and surfacing learning needs, they can be dealt with more effectively. A number of semi-structured methods are available to assist in the formative assessment process and these are described elsewhere (43). Trainees will be encouraged to keep a developmental portfolio of learning needs and to exit training with a personal development plan to take forwards to their first NHS professional appraisal.

Summative assessment

Summative assessment in its generic sense is designed to answer the question “what has been learned”. In general practice training it has also been used more specifically to describe the end point assessment process.

A new valid and reliable licensing assessment will accompany the implementation of the curriculum for general practice and it is intended that this will comprise a mixture of assessment methods including a machine-marked test of applied knowledge, a simulation and a portfolio of workplace assessments. Whilst standardised testing will enable reliable measurement of core knowledge and skills, workplace assessment will enable the richness of the trainee’s performance to be captured in a number of areas of professional practice.

Assessment of the training programme will be competency-based and derived from the holistic competencies and competency areas described within this curriculum document. The principles and standards underpinning the assessment will accord with those set out by the Postgraduate Medical Education and Training Board (44) Full details of the assessment programme are described elsewhere.

4. Managing curriculum implementation

The RCGP Curriculum will be delivered through the Departments of General Practice of the UK Deaneries. Each department is lead by a Director (or Dean) of Postgraduate General Practice Education who manages a network of GP trainers and educators. The roles of the different members of the educational network and their responsibility for curriculum implementation is described below.

Trainer

The GP trainer provides educational supervision to one or more GP learners. It is the responsibility of the trainer to oversee the educational progress of the learner. To deliver the learning outcomes defined in the Curriculum and maintain the learning environment or training practice to a standard of quality defined by the Deanery. The trainer is also responsible for the assessment of the learner, both formative and summative, although trainer judgement will only form one part of an overall assessment strategy. Trainers may be assisted by, or receive input from, other educationalists who may act to supervise certain aspects of the learner's practice e.g. out of hours training, family planning.

Programme director (course organiser)

It is the role of the programme director or course organiser to design and maintain educational programmes for learners in general practice. Normally these will be of three years duration and involve a variety of general practice, hospital and innovative posts.

Programme directors will also run day seminars and courses to meet the needs of learners in their programme in relation to the delivery of the RCGP Curriculum statements.

Directors of Postgraduate General Practice Education

Directors of Postgraduate General Practice Education maintain overall responsibility for the delivery and quality assurance of educational programmes and supervision. They are responsible for recruitment to training programmes, and for judgements made on the progress of learners through such programmes. In future GP Directors will be responsible for ensuring that training programmes are delivering the learning outcomes of the RCGP Curriculum.

GP Directors are further responsible for the implementation of national policies and initiatives, the professional development of their educator network and are assisted in the delivery of programmes and policies at a local level by a network of Associate Directors.

Primary Care Organisations (Trusts)

As of 2005, Primary Care Trusts deliver the funding for GP registrar placements whilst the deanery and Acute Trusts manage the funding of Senior House Officer placements. With the redesign of fit for purpose training posts for general practice training, it is the view of the RCGP that the more appropriate route for the delivery of funding for the entire three year programme would be through Primary Care Organisations (Trusts) in collaboration with the Departments of Postgraduate General Practice of the UK Deaneries.

5. Clinical supervision and patient safety

A system of deanery-based quality assurance of training practices and trainers has been in place for many years built on standards defined by the Joint Committee on Postgraduate Training for General Practice. Deanery quality assurance processes examine both the practice as a suitable environment in which to learn but also the clinical standards of the doctor, level of supervision and regard for patient safety. Such quality assurance mechanisms will be built on and developed in accordance with direction from the Postgraduate Medical Education and Training Board.

Similarly in the secondary care environment, hospital posts are subject to monitoring by the deanery, and the deanery itself, subject to a national programme quality assurance currently orchestrated by the Joint Committee on Postgraduate Training for General Practice. Again, it is envisaged that these mechanisms be sustained in accordance with guidance from the Postgraduate Medical Education and Training Board.

6. Selection for general practice training programmes

Roles and responsibilities

Training in general practice, in the UK is managed by the Postgraduate Deans and Directors of Postgraduate General Practice Education who are members of the Committee of Postgraduate General Practice Education. Postgraduate deaneries each cover geographical areas served by a number of primary care organizations.

The Deans and Directors' principal responsibilities are to:

- Deliver and quality assure the training programmes for the specialty of general practice.

- Connect the recruitment, appointment and workforce planning of all GP training grades in the NHS across the four countries of the UK.
- Increase flexibility within training programmes for general practice
- Ensure the most appropriate training for each individual.
- Provide careers advice for aspiring GPs including doctors who wish to change career.

A national recruitment office works on behalf of all deaneries in England and reports directly to the Committee of GP Education Directors (COGPED). Scotland, Wales, Northern Ireland have separate arrangements. The National Recruitment Office (NRO) is supported by a national recruitment steering group and three subgroups, which cover issues of probity, procedures and process. The intention is to develop a standardized national approach to recruitment for general practice across all deaneries, which will be performance-managed through the NRO. Recruitment to GP training is advertised and co-ordinated through the NRO via the web site www.gprecruitment.org.uk where information can be found about deanery and scheme profiles to help applicants make an informed choice.

Further information about training for general practice, previously available within the Statement of Fees and Allowances (the 'Red Book'), has been revised and published as 'The GP Registrar Scheme – Vocational Training for General Medical Practice' (the 'green guide') (45).

Recruitment and selection

The NHS is now clearly expected to demonstrate the characteristics of a modern employing organization that is:

- All recruits to the workforce should be appointed with due regard to equal opportunities.
- The ethos of 'learning for life' should be visible through continuing professional development.
- Quality career guidance should be available for all employees and at all training levels.
- Learning needs to take place across professional and organizational boundaries.

A planned system of appointment to general practice training programmes is described. It is anticipated that this will evolve into a national standardized process by August 2007.

An annual (or biannual) national advertisement for all deaneries will describe the training opportunities available to doctors wishing to prepare for a career in General Practice. Vacancies will allow for standard rotations; shortened and extended programmes; allocations of training posts to facilitate the return to general practice of previously 'trained' colleagues and 'special' training for doctors who require updating or a period of 'targeted' supervision and assessment. There will be increasing availability of flexible training.

Advertisements will be placed in a prestigious medical journal and on the NRO web site. Details will include contact points for:

- Application to join a GP training programme
- The variety of training opportunities available within each deanery
- Flexible training and GP returners
- Vocational Training Schemes offering training rotations
- Arrangements for informal visits to schemes prior to interview.
- Other initiatives that may vary from deanery to deanery.

Structured applications will be closely linked to a national person specification (see Box 3) and structured references will be requested including one from the most recent employer. A move to mandatory on-line applications is anticipated sometime in 2005. Medical qualification, registration with the General Medical Council and satisfactory completion of the pre-registration house year (or its equivalent) should be established prior to application. From the training intake of August 2007 it will be mandatory for all doctors to have successfully completed a two-year foundation programme (or equivalent). 'Job offers' will be made subject to a previous criminal convictions inquiry, health check and suitable references.

The competencies expected of the successful general practitioner have been described (46) and should enable the prospective General Practice registrar to answer the key questions:

Is general practice the right career for me?

Am I the right sort of doctor for general practice?

At present most deaneries actively discourage multiple applications. It is anticipated that, once online applications become established, doctors will only be able to submit one application in response to a national advertisement. A system of ranking candidates and a national clearing process for candidates assessed as 'appropriate for training' is evolving and should be established by 2007. An MCQ paper testing basic medical knowledge is currently under evaluation and may be set as part of the selection process. Behavioural competencies expected of general practitioners will be assessed partially from applications but more thoroughly at interview.

Training of everyone undertaking short-listing, interviewing and selection are under development and will be monitored by the NRO. Short-listing, to national standards, will be conducted by a panel drawn from GPs, hospital consultants, administrators and lay members who constitute part of the deanery appointments process.

Selection centres will involve candidates attending for at least half a day of assessment exercises and interviews. These evaluative processes usually comprise a series of job related exercises that are intended to simulate the major components of the skills and abilities underlying the target job role. The different exercises are observed and assessed by trained assessors on various job-related competencies. Prospective GP registrars will have the opportunity to demonstrate that they have reached a point in their professional development which confirms they are capable of attaining, within an appropriate training period, the standards and competencies required for independent general practice.

The final ranking of candidates will take place after interviews have been completed. A matching process will ensure that the highest ranked candidates are offered training placements. Feedback will be available to enhance appropriate training for successful candidates and to support unsuccessful candidates. Employment contracts and educational agreements will be exchanged once posts have been agreed. Placements in general practice posts will be determined 'locally' between GP course organisers, trainers and registrars. Flexibility to move between vocational training schemes and/or deaneries will depend on availability of placements, funding from NHS budgets, agreement by the Directors and satisfactory performance of the registrar in each post. Inter-deanery transfers are not supported unless the doctor in training has successfully completed 12 months and is able to confirm 'convincing' personal or professional reasons that did not exist before acceptance on to the original training programme.

A tracking protocol is conducted by each deanery to provide data on:

- Choice of general practice as a career
- Demography of applicants and appointees to training
- Progression through training
- Summative assessment
- Recruitment and retention
- Informing future training requirements to meet the needs of the NHS
- The developmental needs of doctors in training.

The system of multiple applications with several interviews and the risk of inappropriate or unsuccessful training for some doctors is now being replaced by a modern equal opportunities-based process that is equitable and more appropriate to identifying doctors who are capable of becoming successful general practitioners.

Box 3

The national person specification for selection for general practice training

National Person Specification for General Practice Training

Eligibility Criteria for Long listing by Application Form

EITHER be registered with the GMC at the time of application without restriction on general practice training,

OR

have passed both parts of the PLAB and be eligible for limited registration at the time of application without restriction,

OR

Be eligible for limited registration at the time of application without restriction.

Previous experience as defined by JCPTGP (PMETB) is appropriate for the level of training post applied for.

Able to legally work in the UK and hold or be eligible to hold relevant immigration status in accordance with Home Office and Department of Health regulations.

Does not have any unexplained career gaps.

All sections of the application form should be fully completed according to the written guidelines.

Applicants should note the entire selection process will be conducted in English.

Core Competencies by Short List or Assessment

Criteria	Competencies
Empathy and Sensitivity	<ul style="list-style-type: none"> • Capacity and motivation to take in patient/colleague perspective • Treats patient(s) with sensitivity and personal understanding • Is empathetic and checks patient needs are satisfied • Generates safe/ understanding atmosphere
Communication Skills	<ul style="list-style-type: none"> • Engages patients/colleagues in equal/open dialogue. Clarity in both verbal & written communication • Uses different questioning styles and probes for information to lead to root cause • Capacity to adjust behaviour/language (written/spoken) as appropriate to needs of differing situations
Clinical Knowledge and Expertise	<ul style="list-style-type: none"> • Capacity to apply sound clinical knowledge and awareness to full investigation of problems • Makes clear, sound and proactive decisions, reflecting good clinical judgment
Conceptual Thinking and Problem-solving	<ul style="list-style-type: none"> • Thinks beyond the obvious to get to root cause • Use of lateral thinking and insight • Is open to new ways of thinking • Can judge what is important from a mass of information
Professional Integrity	<ul style="list-style-type: none"> • Capacity and motivation to take responsibility for one's actions • Admits when mistakes are made • Respects / defends contribution and needs of all
Coping with Pressure	<ul style="list-style-type: none"> • Recognises own limitations and 'shares the load with others' • Calm under pressure and able to 'switch-off' outside work • Able to develop appropriate coping mechanisms and is prepared to ask for help
Personal Organisation Administration Skills	<ul style="list-style-type: none"> • Able to organise a mass of information in a structured and planned manner • Can prioritise conflicting demands and delegates when necessary • Effective time management and use of IT systems
Managing Others and Team Involvement	<ul style="list-style-type: none"> • Demonstrates a collaborative style • A skilled negotiator, able to motivate others • A team player who contributes to and facilitates decision-making and develops trust • Views self as part of larger organization • Uses resources efficiently

Desirable Requirements

Commitment to working in Deanery Area

Employer Checks

All appointments will be subject to satisfactory references, criminal record and occupational health checks, and proof of membership of a medical defence organization prior to taking a post in general practice.

Employers may require IELTS level 7.0.

Trainees may be required to hold a current valid Driving Licence or give evidence of proposed alternative as a means of providing emergency and domiciliary care.

7. Equality and diversity

Selection for general practice training will be conducted in accordance with best equal opportunities practice and a programme of continuous monitoring will be established to ensure that this policy is adhered to.

In delivering the curriculum, educationalists and educational managers must be mindful of the diverse needs of learners and the multi-cultural, multi-ethnic and multi-faith nature of the NHS workforce. All reasonable steps should be taken to ensure that the broadest possible curriculum is delivered flexibly to all learners and that no individual or group is disadvantaged. A policy of inclusion will be adopted by deaneries that values diversity, ensuring that all learners, irrespective of age, ability, gender, ethnicity, language and social background have access to learning and participatory practices appropriate to their needs.

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Annex 8

Specialist Training for General Practice: Implementation Strategy for August 2007

<p style="text-align: center;">Specialist Training for General Practice: Implementation Strategy for August 2007</p>

EXECUTIVE SUMMARY

General practice training must change if it is to meet the challenges for primary care in a Patient-led NHS. From August 2007 speciality training programmes for general practice will:

- Comprise a three-year integrated programme supervised from general practice.
- Contain a minimum of 18 months in the general practice setting
- Incorporate brief hospital attachments that are relevant to general practice and capable of delivering competencies defined in the RCGP curriculum
- The above activity is predicated on sufficient funding being made available.

Specialist Training for General Practice: Implementation Strategy for August 2007

1. Introduction

1.1 General practice training, fossilised in regulation for over 25 years, must change if it is to meet the challenges for primary care in the new NHS. Achieving the aspiration of “Commissioning a Patient-led NHS”¹ will depend on a general practitioner workforce fit for purpose, committed to patient care delivered in the community through effective health care teams and which supports the concept of patient self care and encourage feedback.

1.2 The postgraduate training of all doctors is undergoing major and unprecedented change with substantial revisions underway to training programmes in all specialties. The opportunity to improve specialty training for general practice has never been greater, but there are great risks that the discipline of general practice will not be ready to respond to the new challenge or that it will simply be sidelined whilst other specialty programmes are being redesigned.

1.3 The driver behind these changes is *Modernising Medical Careers* (MMC), a major reform of postgraduate medical education led by the United Kingdom’s Departments of Health, comprising a new competency-based training programme in the first two years of a doctor’s postgraduate experience - the Foundation Programme - and a streamlining of specialist training programmes. The government has stated² that this reform “...offers the opportunity to develop a new and better approach to GP training....which is a significant improvement over existing arrangements”.

1.4 The Royal College of General Practitioners (RCGP) and others have long made the case for radical changes to the GP training programme^{3,4}. Of particular concern has been its extreme brevity, the educational content of the two years spent in hospital based training - six-month posts dependent on specialty college approval - and the rigidity of the programme length. There is mounting evidence that, as a consequence of these inadequacies, registrars find they are unprepared for independent practice on exiting training and are reluctant to take up substantive posts^{5,6}.

1.5 The old regulatory framework has now been replaced⁷, and supervision of all specialty training programmes is a function of the Postgraduate Medical Education and Training Board (PMETB). This body has to give approval to curricula for training, programmes of delivery, and processes of assessment, and has indicated that it will seek these from each royal college. Later this year, the RCGP will submit to PMETB a detailed competency-based curriculum for the new

¹ Department of Health (2005) *Creating a Patient-led NHS. Delivering the NHS Improvement Plan*. London: Department of Health

² Department of Health (2004). *Modernising Medical Careers - The Next Steps*. London: Department of Health

³ Royal College of General Practitioners (2004). *Education and Training for General Practice*. London: RCGP

⁴ Little P. What do Wessex general practitioners think about the structure of hospital vocational training? *British Medical Journal* 1994;308:1337-1339

⁵ Sibbett C, Thompson W, Crawford M, McKnight A. Evaluation of extended training for general practice in Northern Ireland: qualitative study. *BMJ* 2003;327:971-973

⁶ Bowler I, Swanwick T. Extended training in general practice: senior general practice registrars in the London deanery. *Education for Primary Care* 2005; 16:134-140.

⁷ *The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003* The Stationery Office; 2003

general practice specialty training programme. Any future GP training programme must be designed around its ability to deliver the curriculum competencies.

2. Specialty training for general practice

Modernising Medical Careers moves into the phase of developing 'run-through' specialty training in August 2007. The RCGP in conjunction with the Committee of General Practice Education Directors (COGPED) has already produced a position paper on its proposals for a new pattern of specialty training for general practice, the key elements of which are:

Selection

- Specialist training for general practice will start at the successful completion of Foundation training.
- Selection into GP training should be via an agreed UK-wide selection process.
- Entry into GP training will normally be direct from Foundation Year 2 for those applicants who are certain of their career plans, but may also be made from a suitable first year of specialty training in another specialty (ST1)

Programme structure and content

- Appointment to a GP training programme will be through a national selection process.
- Specialist training programmes in general practice will be a minimum of 3 years duration.
- Educational supervision in practice throughout the programme will normally be undertaken by a GP trainer.
- The educational supervisor will be responsible for regular appraisal of progress through the programme, with revision of the PDP where appropriate.
- The design of the programme should encourage learner-led education and patient-led service. Therefore, it will need to develop even better systems for "feedback"; learning lessons from experience, and adapting the educational approach in preparing learners in a changing environment. It will need to involve patients, peers and competent staff in assisting the development of learners' competencies and capabilities as future GPs.
- The programme should include a minimum of 18 months as a participatory learner in general practice.
- GP training programmes will be based in, or orientated to general practice and managed by a Speciality Programme Director (vocational training scheme course organiser).
- Specialty experience outside the primary care setting should be selected on the basis of capacity to deliver curricular competencies.
- Clinical supervisors in all settings will need appropriate skills and training.
- Programmes will have a personal development plan, which will be orientated to meeting the learning outcomes defined in the curriculum.
- Programmes will be subject to a national assessment programme defined by the RCGP.

Programme administration

- GP training programmes will be designed, delivered, administered and quality controlled by UK deaneries.
- Where ST1 posts in other specialty training programmes are accepted for GP training, such posts should be constructed to meet the RCGP curricular competencies and be supervised and monitored from general practice.

Employment arrangements for doctors in GP programmes should ensure continuity of employment during the three-year programme, be based in primary care, and have standard terms and conditions of service across the UK.

Movement into training from other specialty streams would require selection and the Article 11 process of judgement of equivalence, as approved by PMETB, unless they are compatible with Article 10.

Higher Professional Education

- After obtaining a Certificate of Completion of Training a GP should undertake two years within a supported higher professional education (HPE) programme which should enable release from service commitment in order to meet personal development needs, including the development of necessary competencies to deliver special clinical interests, education and/or research, or clinical management, as well as the personal transition to a long-term commitment to and responsibility for general practice

3. Quality criteria for training programmes

3.1 Specialist training for general practice, unlike that for any other specialty, is still constrained by a legally defined length. Although defined in regulation as a *minimum* of three years, this has to all intents and purposes always been the *maximum* available. In such a short training programme, it is important to ensure that all placements are relevant to the learning outcomes of the RCGP curriculum.

3.2 Programmes will need to recognise the competencies that will have been acquired during the Foundation programme, and contain an appropriate balance between service and education, and hospital and general practice. The content of hospital placements should deliver added value and competencies which build on prior experience. A focus on specialties not previously experienced, and of relevance to general practice, for example with such specialties as ENT, ophthalmology, rehabilitation medicine or dermatology should be considered.

3.3 The shape of patient services provision may change, as indicated in “the Commissioning a patient-led NHS”⁸ with plurality of providers. This will require strengthening the systems of quality control and quality assurance of educational programmes to ensure the criteria for accrediting learning environments meet the PMETB standards and support multi-professional learning.

3.4 In constructing training programmes the length and configuration of hospital placements must also be reviewed bearing in mind that the concentration of clinical material in secondary care may offer learning opportunities which might take months or years to achieve in general practice. Programmes should reflect the experience gained from the many innovative training posts that have been developed over the last few years⁹ and from Foundation Programme placements.

3.5 Minimum standards for a GP training programme are defined in the PMETB Order. The RCGP has already adopted temporary approval criteria, based on existing arrangements in order to ensure a smooth transition. These criteria however are no longer fit for purpose and are of limited usefulness to GP Directors in the design of future programmes.

3.6 It would be inappropriate to dictate the fine structure of all UK training programmes as clearly one size will not fit all. Programmes must be tailored to the learner and postgraduate deaneries allowed the freedom to adapt curriculum delivery to meet the needs and opportunities

⁸ <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningAPatientledNHS/fs/en> accessed 21/12/05

⁹ Worrall P (2003). Innovative Training Posts: Third Cohort Evaluation. Leicester: Three Deaneries.

that present themselves within the local health economy. Examples of possible models are shown as appendix 2. From the evidence accumulated through the RCGP curriculum review¹⁰, certain principles have been agreed and specialty training programmes approved by RCGP, in conjunction with COGPED. Programmes should conform to the criteria outlined in paragraph 2 and further developed below. In addition, the GP training programmes will encompass the core standards that the Healthcare Commission, General Medical Council (GMC)(Good Medical Practice) have identified, e.g. Patient Safety; Clinical and Cost Effectiveness; Integrated Governance; Patient focus; Accessible and Responsive Care; Care environment and Amenities; and Population medicine and self care.

- A. *Specialty training programmes for general practice will be a minimum of three years duration.*

The three-year training specialty envelope is defined as commencing on recruitment through the national process after satisfactory completion of a two year Foundation Programme. Exit from, and subsequent entitlement to certification from speciality training will be subject to satisfactory performance in the RCGP assessment programme.

- B. *Educational supervision in practice throughout the programme will normally be undertaken by a GP trainer.*

In order to ground the entire three-year training programme in general practice, the educational supervision of individual trainees should normally be undertaken by a GP trainer. Training practices, themselves, will meet both high professional and educational standards. All trainers and educational supervisors will be trained to be competent in teaching and assessment and the delivery of the curriculum.

- C. *The programme should include a minimum of 18 months as a participatory learner in general practice.*

Time spent within general practice may be divided up within the three-year training envelope and will normally entail time spent in more than one practice. A longer term RCGP strategy is to move the majority of general practice training into the GP setting.

- D. *GP training programmes will be based in, or orientated to general practice and managed by a Programme Director for the duration of the individual programmes.*

Coordination and adaptation of the programme to the individual's needs is essential and VTS course organisers are ideally placed to step into this role.

- E. *Specialty experience outside the primary care setting should be selected on the basis of capacity to deliver curricula competencies.*

i) In order to obtain the broadest possible training, it is desirable that experience in any one secondary care speciality will not normally be less than three months and essential that it does not exceed six months.

ii) Innovative training posts should be developed to ensure a broad base of primary care experience and the exploration of the primary/secondary care interface. Such posts may be

¹⁰ RCGP <http://www.rcgp.org.uk/corporate/responses/curriculum/docs.asp> accessed 15 November 2005

based in general practice with secondments to other primary care organisations e.g. drug and alcohol teams, hospices, or to acute services e.g. outpatients, day hospital. Alternatively, such posts may be secondary-care based but focussed on the needs of the general practice trainee e.g. posts structured around out patients and chronic disease, or the exposure to general practice relevant sub- specialities such as dermatology, rheumatology, ophthalmology and ENT.

- F. *Programmes will be built around a personal development plan, which will be orientated to meeting the learning outcomes defined in the curriculum.*

Within the constraints of ensuring service delivery, GP training programmes will be flexible enough to be adapted around the evolving needs of the individual trainee. Training will be participatory and rooted in service but will also aim to foster produce independent, reflective and self-educating practitioners.

- G. *Programmes will be subject to a national assessment programme defined by the RCGP.*

Details of the RCGP assessment programme for specialty training are expected in 2006. The programme must be valid, reliable, feasible and acceptable with an educational impact rooted in delivering the learning outcomes of the curriculum.

4. Service impact and hospital placements

4.1 Service delivery must remain a key component of all elements of specialist training for general practice, in order to reinforce the learning that is acquired¹¹. The word *supernumerary* is often applied to the general practice component of GP training because it is understood that the practice, as the host organisation, must be able to deliver adequate service to its patients if the trainee is absent for any reason. This is not the same as saying that the trainee does not deliver service; there's a trade-off between the service that is provided by the trainee and the reduction of service provided by their trainer in order to give supervision. In addition, there is a need to appreciate the difference between delivery of today's service by the workforce and the planning of tomorrow's patient services with a competent and fit for purpose workforce. There is an obligation on service and systems to facilitate the training of future GPs.

4.2 A superficial glance at the above criteria might indicate that there could be a reduction in hospital service by those undergoing general practice training if this strategy were adopted. There are, however, a number of factors that suggest that this is *not* the case. These are:

- By August 2007 all UK graduates entering specialist training for general practice will have undergone Foundation training. They will have experienced at least five other hospital-based specialties, and will have been assessed as competent to manage the acutely ill patient. GP trainees will therefore be able to contribute to the general service load by participating in hospital rotas thus helping to ensure European Working Time Directive compliance. Of course, in some specialties the service that can be delivered will be limited, as the doctors concerned will be in their first post in that specialty, but this has always been the case for GP hospital placements.
- The introduction of the Foundation programme itself will result in an increase in the number of months a junior doctor, training for a career in general practice, spends in the hospital setting, as a result of the new second Foundation year.

¹¹ Swanwick T, Plint S From supernumerary to supervised professional practice. *Education for Primary Care* (accepted for publication 2005)

- Many of the activities currently carried out by doctors in hospital at this stage in the training could be more appropriately carried out by other staff, particularly specialist nurses.

4.3 It will be important to ensure that in implementing these changes care to patients is not compromised and, wherever possible, changes are staged. It will be important for the general practice community to engage at a local level with all stakeholders in the development of a new GP training programme. As new programmes are constructed it is vital that there is constructive engagement with primary and secondary care service providers and commissioners, so that appropriate service delivery becomes a key component of the training placement. With the increased movement of care into primary from secondary care consideration should be given to the growing service needs in the community. A further key relationship with the primary care organisation is ensuring that the product of the local training programme meets local primary care workforce requirements.

The key issues in analysing the service and financial impacts are listed in appendix A to this paper.

5. Data requirements

5.1 Information obtained at the time of Trust post conversions indicated that there is a shortage of SHO posts available to GP programme directors with only about 50% of those needed for three-year GP training programmes. More accurate and up-to-date data needs to be collected from the GP Directors, in order that a clearer picture of any service impact brought about as a result of the new GP training programme.

5.2 Nationally, a proportion of the GP training budget has been used to develop innovative schemes and extensions to the general practice phase of vocational training. Accurate data is needed in order to calculate additional funding allocation or re-badging required to fund a minimum of 18 months in general practice in all programmes of specialist training for general practice.

5.3 Accurate and up-to-date forecasting is required with regard to training capacity, particularly in the light of the increasing volume of Foundation Programme placements in general practice.

6. Funding implications

6.1 If the current funding model persists it will be necessary to secure funding for extending general practice placements to 18 months. This will have to come through a process of money following the trainees into a primary care placement, and a consequential reduction from training funds currently in secondary care, or by the allocation of new funding (this has been the process followed in Wales and Scotland).

6.2 Funding of GP registrar placements is already managed highly effectively by GP directors in postgraduate deaneries and the mechanisms already in place, could easily be adopted for the management of part or all of the GP training programme.

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UK Committee of General Practice Education Directors
October 2005

APPENDIX 1

Financial impact

- 2500 GP trainees per year (current number 2600 likely to reduce)
- RCGP/COGPED policy for 2007 to move to 18/12 in GP needs 1250 extra funded GPR year slots.
- The RCGP aspiration is to move to 24/12 in GP in the future will require 2500 extra funded GPR year slots.
- If 1250 slots were to be funded with new money it will require a maximum (based on £84k per GPR year) of £105m. 2500 would need £210m.
- Up to 1/3 of GPRs were offered extra 6/12 “innovative training” from GP funding outside the 3 year envelope. As funding has been squeezed this has reduced. This could offset part of overall cost \equiv 833 GPR years (£69m) maximum, probably less.
- These doctors are currently in the system and would be occupying posts at SHO level. Making money follow the trainee is a neutral cost option; requires moving 50% from hospital Trust salary funding and 50% Deanery based funding.
- This will not impact until 2008 earliest and 2009 onwards for main impact. There will be an increase in numbers of doctors at this level as a result of increases in medical school output – some of the increased funding for these doctors could be predicated to general practice training.
- Wales has proposed a programme of 2 years in GP (during one year there will be attachments) and 3 x 4/12 in hospital, Scotland is planning 18/12 SHO and 18/12 in general practice – NI is likely to follow England.

Service impact

- 2500 GP trainees per year (current number 2600 likely to reduce)
- “Standard” 3 year VTS (2 years SHO1, 1 year GPR) needs 5000 SHO annual slots.
- Current real allocation of SHOs to GP training estimated at 60% (firmer data to be collected) of 5000 = 3000 slots. Remainder have overseas training or change from other specialty programmes; these specialties must manage their excess junior SHO workforce – common ST1 may address a number of these.
- RCGP/COGPED policy for 2007 to move to 18/12 in GP removes 1250 annual slots.
- The RCGP aspiration is to move to 24/12 in GP in the future, this would reduce 2500 annual slots.
- With the extra F2 hospital service GP specialty trainees will spend minimum of 8/12 and maximum of 12/12 at SHO1 level, prior to entering GP training – assume 80% 8/12, 20% 12/12 – this provides an extra 1830 annual slots of service.

- In terms of numbers of SHO1 placements the impact of the GP proposal for 2007 is no reduction from doctors in training.
- In terms of numbers of SHO1 placements the impact of the RCGP proposal for 24/12 in general practice is a small reduction in the GP contribution, approximately \equiv 770 annual slots. This is likely to be at the same time as an increase in numbers of junior doctors.
- A further impact is likely to be in the content and length of posts – four months will be the norm, and three months for a minority. Specialties used will be predominately orientated towards chronic diseases.
- Although all GP SHO work is at SHO1 level in relation to the specialty, these doctors will be increasingly experienced in hospital medicine and will be able to contribute fully to general “rota-compliance” duties, and be a valuable member of the specialty team.

APPENDIX 2

GP registrar numbers and assigned SHO posts August 2005 (England)

A survey of GP directors has been made to ascertain how many of the current SHO pool are actually **currently** assigned to GP training. This is not a full picture, but gives a reasonable “snapshot”.

GP Directors were asked:

- a. How many GPR training places were you allocated this financial year?
- b. How many SHO posts were assigned to GP training, for allocation by Schemes, at 1st August?
- c. Were you able to fund any 6 month middle year ITP during this financial year, and if so how many?
- d. Were you able to fund any 6 month GP only middle year placements (ie 18/12 in general practice) during this financial year, and if so how many?

General practice training is currently 3 years in duration, 1 year as GPR, and 2 years as hospital SHO. Therefore each GPR requires 2 years of hospital posts.

Results:

Deanery	GPR numbers	SHO needed (6/12 posts)	SHO assigned	%
KSS	247	494	68	14
SYSH	97	194	82	42
LNR	73	146	70	49
Yorkshire	237	474	146	31
Wessex	284	568	200	35
Oxford	111	222	90	41
Northern	221	442	150	34
London	378	756	266	35
Trent	123	246	127	51
North Western	186	392	102	26
Eastern	224	448	195	43
West Midlands	303	606	277	46
Total	2484	4988	1773	36

This means that in the Deaneries listed there is a large shortfall in **GP allocated** SHOs, currently made up of those in out-of-programme posts, and a considerable number in basic specialist training who fail to get an NTN. A number of Directors have funded hospital placements out of GP moneys to meet the *shortage* of GP SHOs.

APPENDIX 3

Examples of possible models of programme structure

1. A simple programme model (1) would be to increase the current GP registrar full-time placement to 18 months, reducing the current hospital SHO component to 18 months. However, shorter (three or four month) placements, such as have been developed for the Foundation Programme, would allow a wider range of specialties to be experienced. This type of programme development is under consideration in Scotland, where funding has been secured for the extra six months of GP based training.

Model 1

6/1 GPR	18/1 hospital placements	12/1 GPR
Introductory GP placement and development of personal learning plan	3-6 month placements of appropriate content	Final GP placement and nMRCGP assessment

2. In Wales there is a plan to move two years of the training programme into general practice, with a full year of GP training, a year of 3 x 4/12 posts in hospitals and a further year of GP based training with release into appropriate learning environments, such as clinics (Model 2). This plan for training has been worked out in the Welsh Deanery in conjunction with plans for other specialty programmes.

Model 2 (Wales)

12/1 hospital placements	12M GP Supervision	12/1 GPR
3 x 4/12 Hospital placements	GP supervision with appropriate attachments	Final GP placement and nMRCGP assessment

3. A more radical proposal (model 3), building on the innovative training post experience, would be a year full-time in general practice and a year full-time in relevant short (four month) hospital placements. The remaining year would be spent in general practice with secondments into secondary care and community settings. This would have the advantage of enabling the trainees to contextualize their experiences in secondary care, working with their general practice education supervisor. Learners will be able to reflect on what they have experienced in hospital and develop a clear understanding of what has been learnt and how it can be applied effectively to a general practice setting. Capacity issues in this model could be addressed through a 'slot-sharing' scheme.

Model 3

4/12 GPR	12/12 hospital placements	12/12 innovative training posts	8/12 GPR
Introduction and PLP	3-6 month placements of appropriate content	GP-based posts with structured secondments to hospital or community settings	Final placement with nMRCGP assessment

In all cases entry would normally be from F2, with doctors signed off as having attained all the Foundation competencies. Selection will be through the COGPED national selection process. Selection could also be made during a suitable first year of specialty training - ST1 (community) - in which case the remainder of programme will be reduced to two years with the reduction applied where the ST1 placements have been undertaken.

Other models

Other innovations will include programme configuration around primary care providers rather than hospitals; registrar training to include education supervision from other trained members of the primary care team, and facilitated learning sets to replace postgraduate centre release courses. There will be new opportunities for training in intermediate care centres, and from a number of independent providers. It will be important that a variety of programme structures are piloted in order to develop and propagate best practice, and that all placements are properly supervised and quality assured.

