Training the Future GP

Enhancing delivery of GP Specialty Training

Vision and actions for General Practice Specialty Training reform to transform the future GP

Foreword

This report is the result of evidence review, place-based pilots and extensive engagement with key national stakeholders, patients, doctors in training and educators, with the generous support of the Royal College of General Practitioners' Medical Director for Curriculum and Education. It outlines an exciting vision of how we can reform the delivery of education to general practitioners, better preparing GPs for future practice in different models of care, addressing health inequalities and planetary health, and enhancing areas of clinical care such as mental health.

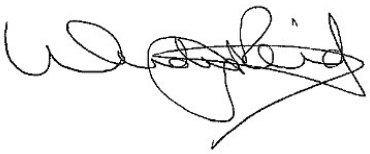
In the decade of HEE leading General Practice Specialty Training, we have overseen the biggest ever increase in the number of postgraduate doctors accepting places to train as GPs in England, by over 50 per cent to 4,032 in the last year. In this time, we have also published two seminal reports in support of English NHS General (medical) Practice. The Primary Care Workforce Commission, led by Professor Martin Roland, outlined a vision for team-based primary care led by GPs. By choice – not by chance, led by Professor Val Wass and co-sponsored with Health Education England by the UK Medical Schools Council, has been applied in every English medical school. Both have received international acclaim.

Throughout this decade, our primary care deans and their teams have continued to innovate and to advocate for high quality GP Specialty Training.

The separation of standard setting by the General Medical Council, and curriculum setting and assessment by the Royal College of General Practitioners (as is similar across specialties), provides a thorough curriculum. This curriculum has recently been updated. The revision, combined with our move to postgraduate doctors in GP training now spending 24-months of the standard 36-month programme (and any extensions) in practice, gives us a unique opportunity to reform the delivery of training so that we can be confident of preparing future GPs for a rapidly changing world.

I am grateful to all involved and to all that were engaged in the work, especially the workstream leads. This report gives an excellent foundation as we create the Workforce Training and Education Directorate of the new NHS England, and prepare the ground for the forthcoming NHS Long Term Workforce plan. The clarity of vision in this report, as in the first two reports, aligns with and incorporates other reports, such as General Sir Gordon Messenger's review on NHS leadership, and Dr Claire Fuller's stocktake on primary care, on which HEE colleagues led the workforce section.

Primary care remains the foundation of universal healthcare and our National Health Service. It is vital that we continue to support a sufficient and sustainable workforce. This report is part of that aspiration and I am delighted to celebrate its publication.



Professor Wendy Reid
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Acknowledgements

As chair of this reform programme I would like to thank HEE's PIC team, the workstream chairs and the primary care deans and their teams for the commitment to delivering this reform report. The scores of people that worked on it and provided input is vast and many did this alongside the COVID and recovery responses. We acknowledge those we managed to record in the appendices but I fear such acknowledgements always inadvertently miss some. If we do, my apologies and thanks.

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Introduction

The world is changing at unprecedented rates and the general practice model needs to change, just as it always has. Our future GPs must be equipped with the right skills and resources to meet the ever-shifting needs of their patients. They must also be provided with a vision for a fulfilling and rewarding career in general practice.

General practice is the bedrock of the National Health Service, with more than 90 per cent of NHS contacts taking place within primary care. General practice in the United Kingdom is internationally renowned, and the UK model of GP Specialty Training (GPST) is seen as an exemplar by many countries seeking to develop a primary care-based healthcare system.

This report seeks to revitalise GP training by outlining a vision of GPST that is fit for purpose and for a future of sustainable general practice careers, ready to best deliver the established curriculum through quality GP training programmes and placements, delivered within available capacity. This reform programme is the product of evidence review, piloting, engagement and reflective review between December 2019 and December 2022.

The most recent significant change to the delivery of GP training came in 2007, with the recognition of general practice as a specialty and GPST programmes replacing Vocational Training Schemes (VTS). The balance of time in practice increased to 18 months of the 36-month training, and the membership examination of the Royal College of General Practitioners (RCGP) became the mandatory standard assessment.

When Health Education England was formed in 2013, recruitment to GPST was challenging, with some areas of the country struggling to appoint any trainees. Since then, a series of innovations have led to an increase in the number of doctors accepting training places to become GPs – from 2,671 in 2014 to 4,000 in 2021 – with all programmes now full. The scale and pace of this expansion has been quite unique.

Health Education England (HEE) has done much to transform the future general practice workforce over the last decade, including the establishment of an independent Primary Care Workforce Commission (Primary Care Workforce Commission, 2015), which set out a vision for the primary care workforce and called for greater collaboration across organisations. That vision is now a reality.

The number of UK graduates going into general practice by choice is set to increase following the commission of By choice – not by chance (Health Education England, 2016), jointly published with the Medical Schools Council, and the expansion of English medical schools. In addition, many excellent international medical graduates are recognising the diverse opportunities available in GP careers. A cohort of additional English medical school students will graduate from the foundation programme in 2025, representing a key opportunity to expand the GP workforce further, which must not be missed.

Alas, all is not rosy. The number of GPs qualifying and entering practice is counterbalanced by the number of established GPs reducing their working week or leaving the profession, with many finding the workload and work intensity unsustainable. This reality provides a moral driver for this reform work: it is vital that doctors joining and training in general practice can see lived examples of rewarding and sustainable careers.

Public and patient satisfaction has fallen, perhaps inevitably with the workforce failing to keep pace with increasing demand. Although satisfaction remains high, this barometer movement should be seen as a storm warning. Descriptions of this emerging situation as general practice being broken are taking a further toll on the morale of GPs, and it is vital that these challenges are addressed to support care for those we serve and to ensure a sufficient and sustainable workforce.

HEE has been funded to combine the expansion of GPST programme numbers with a move to 24 months in general practice during that training. This provides an ideal opportunity to ensure that general practice training is based in general practice, where trainees can learn about general practice, and serve the citizens and patients that general practice best serves, both as individuals and as populations.

GPST is built around the Royal College of General Practitioners (RCGP) curriculum, which is approved by the General Medical Council (GMC) and delivered to its standards. While the RCGP curriculum is UK-wide, and the Certificate of Completion of Training (CCT) transferable across nations, there is increasing recognition of the importance of local contextual learning, regional variations in need, and the different models of supervision available. Additionally, postgraduate doctors in GP training (GP DiTs) report increasing desire to be part of, give value to, and feel valued by the communities they serve.

There is an opportunity to move to a more flexible model of training that meets the needs, skills and experiences of the trainee, as well as the needs and nuances of local populations.

Principles

The principles of this reform work are:

- the development of an adaptable future primary care workforce;
- a place-based approach to educational governance, quality and faculty development, and alignment and integration with local models of care;
- opportunities crafted around the individual needs of the trainee.

These principles would be supported by:

- increased emphasis on the core capabilities of 'being a GP',
- enhanced skills in digital technologies,
- leadership development,
- meaningful quality-improvement activity and skills development,
- more use of credentialing post-CCT for specialised areas of primary care.

Surveys of GP DiTs exiting training showed that doctors are seeking portfolio careers and wish to work flexibly (Dale, et al., 2017), and that an increasing number of GP trainees are seeking less-than-full-time working (Kings Fund, 2022). Current trainees have called for a programme that provides targeted experiences more relevant to their future roles than currently afforded by a fixed 'time' spent in varying medical specialties.

General practice is recognised and valued as a team comprised of many administrative, clinical and managerial colleagues. This reform programme is about future GPs and current specialty trainees, so the focus will necessarily be medical. However, it is in the context of the excellence of the expanding interdisciplinary team in and around practice and primary care networks (PCNs), and the opportunities of integrated care systems (boards and partnerships), not least as outlined in the Fuller Stocktake report (Fuller, 2022).

Furthermore, these reforms are in the context of the ongoing COVID-19 pandemic and its effect on services, care, the workforce and society, and are informed by the development of key drivers including the refreshed HEE Strategic Framework (Health Education England, 2017), the Long-Term Workforce Plan (not yet published), the refresh of the NHS Long Term Plan (NHS, January 2019), and the Messenger Review (Messenger, 2022).

GPST is consistently the most highly rated specialty training programme in the GMC National Trainee Survey. However, newly qualified GPs are less likely to enter partnership and are seeking reduced sessional commitment. While the evidence is that this is due to the intensity of work in general practice in its many guises (Kings Fund, 2022), the GPST reform programme is intended to ensure that the graduates of GPST are best prepared for future service and for varied and sustainable careers.

Process

During the reflective review process, priority areas were identified and workstreams established based upon them. Each workstream, chaired by a senior GP educator, engaged key stakeholders and brought together experts including patients, trainees, educators and providers. The work of these groups included literature reviews, SWOT analyses and theme-specific engagement.

HEE local teams created place-based pilots to test educational models. Some case studies of these pilots are appended to this report. These examples inform the content of the reform discussion and provide key evidence.

Crucially, stakeholders of all types were consulted and engaged with throughout the process, internally and externally, locally and nationally. All priority leads conducted virtual engagement sessions focusing on the workstream areas. These groups were diverse and independent in thought and included GP trainers, GP DiTs, newly qualified GPs and those in later stages of their careers. Through listening exercises, ideas for improvements began to form and existing work was shared that has already changed the way GP training is delivered.

With the demands of COVID-19 taking priority, it was a year after the virtual engagement sessions that a large-scale, face-to-face engagement event was held in London. This rejuvenated the thinking and ideas were able to be tested with a wide range of stakeholders at local level as part of an iterative engagement process. We thank them for their excitement and interest in this work and as such have listed as many as possible in the acknowledgements at the end of this report.

Throughout this report, we refer to postgraduate doctors in GP training as GP DiTs, adopting the terminology most commonly used among those trainees we engaged with.

Themes and opportunities for better care

1. Enhancing generalism

Purpose and context

General practitioners, as a specialty, personify the concept of generalism in medicine for many people, and there is a considerable body of evidence showing that quality of care, health outcomes and satisfaction with care are increased when there is continuity of care.

Continuity is increased when the patient has an ongoing relationship with their GP, who sees them as a whole person and not just as someone with a specific ailment. Indeed, the rapid and large-scale response from general practice to the COVID-19 pandemic was aided significantly by longstanding relationships with the patients and populations we serve.

The citizens we serve are living longer with multiple co-morbidities and often-complex social and care issues, presenting greater need for care of the whole person and not just diseases, conditions, or even single episodes. In response to this need, this reform strand was initially designed around addressing quality of care, compassion and holism.

Alongside this work sits the Health Education England Enhance programme, which seeks to enhance generalist skills across foundation and specialty training, and to deliver the General Medical Council (GMC) Generic Professional Capabilities (GPCs). The overlap of Enhance and this workstream is such that the GPST reform programme will incorporate Enhance.

Table 1 – The intended benefits of the Enhance programme

a) Patients

- To improve patient experience and outcomes, through delivery of more holistic and personalised care.

b) Healthcare professionals

- To support improved stewardship and the delivery of value-based care within the NHS
- To provide access to new learning that students and trainees recognise as important and more self-determined professional development opportunities
- To provide opportunities for multi-disciplinary and multi-professional learning
- To provide access to more varied, flexible and rewarding careers
- To support implementation of a 'shared-leadership' approach.

c) Wider health and care system

- To support a new professional perspective where generalist and specialist skills are valued equally – improving the breadth of healthcare professionals' impact and the culture in which they work
- Enable more flexible workforce planning
- To support delivery of integrated care through place-based, locally focused training aligned with the NHS Long Term Plan and maturing ICS agendas
- To support innovative health and care teams that are diverse, inclusive, encourage widening participation and enable new emerging roles to flourish
- To support workforce retention with improved productivity and wellbeing.

On a practical level, this will mean liaising with the national Enhance team and encouraging local GP educators to engage with the Enhance pilots locally. GP DiTs should be given opportunities to learn with those on Enhance programmes, both on shared placements and in teaching sessions. This would highlight shared learning across medical specialties and emphasise the Enhance aim to embed multiprofessional learning in teams across secondary care.

We heard...

Many people we engaged with feel the role of the GP has become less generalist and less rewarding in recent decades. Increasingly transactional care focused on addressing single conditions has enhanced the care of those conditions, but it has reduced the humanity of interactions.

GP DiTs and established GPs referred to the burden of bureaucracy, including the burden of assessment, and to the need "to increase positivity and joy in primary care working". They also advocate supporting GP DiTs "to bring enthusiasm and innovation into an area that can often focus on the negative".

GPs, GP DiTs and patients consistently spoke about examples of good practice, and of an ethos of providing high quality, holistic and compassionate care to individual patients and local populations. They also talked of the value of continuity of care for patients, and of its value to GPs. Academic evidence demonstrates that continuity of care improves patient satisfaction (Fan, et al., 2005) (Adler, et al., 2010), improves quality of care (Youens, et al., 2021) (Delgado, et al., 2022) reduces hospital admissions (Barker, et al., 2017) and generates many other benefits.

GP educators expect the move to 24 months in general practice to enable longer placements and the development of care relationships with patients during the placement. In contrast to disease-focused models of care and training, respondents advocated for increased training in whole-person (holistic) care and personalised care.

A first-year GP DiT in a place-based pilot in the North West spent three days each week at a practice, and the other two days of the week in specialist rotation. In feedback, the trainee reflected: "I've learnt so much by training in primary care. In a hospital placement you would see very unwell people, but we wouldn't be managing those people in the community. That wouldn't help me understand how to stop people getting to that stage. In the community I've learnt how to catch things early and avoid hospital admissions."

As part of a place-based pilot in the South East, GP DiTs spent two days per week in general practice, two days per week in a specialty such as frailty or paediatrics, and one day per week in GP education time. Trainees spent ST1 and ST2 rotating to a new practice every eight months and to a new specialty every four months, and participants enjoyed forging strong relationships with trainers, experiencing continuity with patients, and gaining an understanding of local pathways while benefiting from a balanced working life.

Priorities and action

Through the GPST reform programme, we will:

- adopt the Enhance programme as it applies to GPST, ensuring that Generic Professional Capabilities are satisfied;
- work with Enhance programmes locally to develop the experiences available to those on Enhance programmes and to GP DiTs;
- support the development of GP-focused Enhance trailblazers;
- adopt longer placements to enable GP DiTs to better understand patients, families and carers, and communities.

Additionally, a pilot of blended learning placements for GP training will augment clinical work and cover core and personalised areas of learning and experience identified as priorities by stakeholders. These placements have the advantage of enhancing capacity in clinical workplaces. A bespoke empirical pedagogy has been created that includes links to the humanities, simulation, leadership, social accountability and quality improvement. Modules have already been created that support learning in several areas identified as priorities in this report, including:

- business and partnership;
- cancer diagnosis;
- digital health;
- equality, diversity and inclusion;
- leadership;
- learning disability and autism;
- mental health;
- population health and health inequalities;
- planetary health.

2. Equity in training

Purpose and context

Tackling the issue of differential attainment is a vital part of this reform programme. Evidence shows that international medical graduates (IMGs), UK graduates from minority ethnic backgrounds and those with other minority protected characteristics experience worse outcomes than white UK graduates.

The 2021 report Bridging the Gap (BAPIO, 2021) states that differential attainment is "simply a manifestation of structural inequalities", and that this manifests as "differential outcomes for doctors due to their age, race, gender, sexual orientation, ethnicity, disability, socio-economic deprivation or influenced by migrant status, rather than motivation, ability, effort or enterprise".

These issues are so significant that HEE has already invested in understanding and addressing them, and our work on differential attainment is already active, building on learning from the Targeted GP Training Programme (Health Education England, 2020), (Health Education England, 2021).

We heard...

In addition to our GPST reform engagement, we have engaged directly with those that have lived experience of the factors that contribute to differential attainment, both nationally and regionally.

Through engaging with our IMG colleagues, we have heard of the challenges they face, including:

- the complexities and costs of immigration and visa systems;
- settling in a different culture;
- joining an overstretched healthcare system;
- adjusting to new workplace cultures and ways of working, including the service role of GP DiTs;
- issues of prejudice and discrimination;
- the personal impact of differential outcomes, including at recruitment, impacting on their allocated training location, subsequent training progression, examinations and assessments.

IMGs also spoke about the additional trauma of seeing differential care outcomes due to systemic inequalities and prejudice affecting patients, including them and their families.

The reality of racism, prejudice and discrimination is further proven by the recent report on Experiences of Racial Discrimination and Harassment in London Primary Care (HEE / NHSEI, 2022).

Priorities and action

We will continue to work to address issues of discrimination, prejudice, bias and specifically racism at individual, institutional and systemic levels, and to reduce differential attainment.

We have introduced the HEE programme for supporting overseas doctors in GPST. The programme has four key elements:

1. Selection/recruitment/placement
    a. Earlier identification of trainees and targeted support
    b. Allocation of placements and supervisors based on needs
2. Enhanced induction programme, including
    a. New to UK practice induction
    b. Supernumerary placements
    c. Simulation training
    d. Additional one-to-one support
    e. e-Portfolio support
3. Educator development
    a. Community of best practice
    b. Cultural competence and safety training
    c. Active bystander and allyship training
    d. Feedback skills
4. Targeted interventions based on educational needs
    a. Communication skills
    b. Exam/Annual Review of Competency Progression (ARCP) support
    c. Peer mentoring
    d. Career advice
    e. Personalised learning plans

We will also work with key stakeholders, educators and trainees to further understand the basis of inequity and to address this, including the recommendations of the BAPIO report as they apply to GPST.

We will also ensure that the delivery of the GP curriculum highlights inequalities in care delivery and ways to address them.

3. Social accountability and serving all communities

Purpose and context

Socially accountable healthcare focuses on the reduction of health inequalities. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

Such differences are striking. For example, life expectancy between the richest and poorest patients differs by approximately 20 years, and there was a significant decrease in life expectancy among the most deprived areas of England between 2015 to 2017 and 2018 to 2020 (Office for National Statistics, 2022). The COVID-19 pandemic brought the reality of health inequalities into stark awareness as the most socioeconomically deprived in our society were disproportionately affected.

GPs are uniquely placed to understand the communities they serve, given their intimate knowledge of their patients' circumstances and the social, cultural and medical factors that influence their health. As trusted figures in patients' lives, GPs have variable power to identify and improve determinants of health that are having an adverse impact, and to influence changes in behaviour. For many patients, help in finding a job can have a more uplifting effect on their health than prescribed medication.

To care for patients holistically, GPs need to understand that the person sitting in front of them is as healthy as they are not just because of what medical condition they may or may not have diagnosed, or how well that condition is treated, but because of a complex interaction of various health determinants, many of which are outside their control. They need to understand the reasons that outcomes differ, and where they can exert influence to reduce inequality.

GPST is an opportunity to address inequities in care. Through this element of the GPST reform programme, we seek to ensure that GPs are supported in their role as catalysts for social change, and that the best care is offered to those most in need.

We heard...

Trainees and educators told us that many of them entered medicine and general practice to do good for individuals and communities, and that many of them aspire to care for those least well-served.

Some we spoke to were concerned that changes to the delivery model of general practice might exacerbate inequalities, and that learning from the pandemic and our collective response to it must address such unintended consequences.

Those we engaged with supported the following application of social accountability.

Figure 1 – A model for socially accountable GP Specialty Training (Patterson & Blane, 2021)

Socially responsible		
Offering high standards of training, producing 'good GPs' to meet the health needs of society	Every GP trainee receives training in the social determinants of health and health inequalities	GP educators have access to teaching and resources to enable them to support health equity-focused training

Socially responsive		
Local GP training programmes identify needs of their populations and deliver specific training to meet these, e.g. care of homeless patients, cultural awareness, language/communication	Trainees can access opportunities for more advanced leadership training	Out of programme opportunities are available to trainees, e.g. HEE employed Health Equity Fellowships

Socially accountable			
Workforce and other initiatives are targeted at areas of socio-economic deprivation, e.g. post-CCT schemes	GP training is co-created and delivered alongside community/third sector partners and patients	Availability of a formal programme of opportunities for trainees to spend time in community social placements, e.g. with charities	Engagement with academic community and other organisations locally and nationally working in the area of health equity, e.g. Deep End GP, Fairhealth

Given the evidence that training practices deliver higher quality care (Ahluwalia, et al., 2020) respondents advocated for expansion in GPST capacity to prioritise underserved and under-doctored areas, especially those with high indices of multiple deprivation.

A place-based pilot in Yorkshire and Humber helped future GPs develop skills and awareness in deprivation medicine and inclusion health, allowing trainees to spend between six and 12 months in practices in the most deprived areas or those which target vulnerable patients. Trainees also did a placement at another organisation, such as mental health or homelessness services, to gain complementary skills. The pilot found that trainees are inspired by opportunities to work in tough areas and make a difference.

Priorities and action

Many general practices cover areas of socio-economic deprivation, and serve disadvantaged and excluded patients and populations. These patients have particular needs and GPs working in such practices need particular experience, knowledge and skills in order to support them.

HEE's primary care deans have created 165 Health Equity Focused Training (HEFT) programmes, providing three-year pilot programmes in areas of deprivation, and continue to identify opportunities for the development of additional HEFT programmes. HEFT consists of a shared national online education programme for all HEFT GP DiTs, combined with training posts in deprived areas, inclusion health, and as part of local communities of practice, local support and networking.

We will further develop post-CCT deprivation-themed fellowships, including the trailblazer scheme, with access to a monthly national trailblazer education programme. There are currently 52 GPs in these fellowships.

We are determined that GPs who complete specialty training are equipped to serve all in our society, including those most disadvantaged. We will work with colleagues in integrated care boards and the new NHS England to support prioritisation of areas of deprivation within primary care estate plans, to ensure sufficient training estate capacity. We will prioritise training capacity expansion to areas of deprivation, including urban estates and remote and rural areas. The HEE redistribution work will support this both regionally and intra-regionally.

We will work to ensure that all GP DiTs gain experience across the spectrum of deprivation, including geographical rotations and longitudinal placements where possible. This reform programme aims to tailor training delivery to the needs of communities within the bounds of the curriculum. Such training will utilise common content and standards while enabling meaningful local application.

When GPs relocate after CCT or later in their careers, they will be supported in continuous professional development by the workforce education and training directorate of the new NHS England and our Integrated Care System-level Primary and Community Care Training Hubs, to understand the needs of patients and populations locally, recognising how these vary across the country.

All GP DiTs will receive training in the social determinants of health and health inequalities, and in advocacy and population health (see below), through the provision of health equity training materials to training programme directors.

4. Improving the quality of training

Purpose and context

As we continue to expand GP training capacity, it is vital to assure the quality of training and to ensure that the quality of clinical care is safe for patients and GP DiTs. There is an opportunity to use training standards and placements to enhance care quality and further address health inequity.

General practice has a proud history of using training levers to improve the quality of care. The pioneers of Vocational Training, as it was then known, applied care and educational quality standards and quality assurance processes. In addition to the high-quality standards of the Joint Committee for Postgraduate Training in General Practice, training practice standards also led to significant improvement in care quality, including robust record keeping, age-sex registers and disease registers.

We heard...

Doctors in training told us that having high-quality placements is important to them. They feel the majority of secondary care placements are not well aligned to the needs of their curriculum, and are often purely about service delivery without more than a nod to their training or becoming better GPs.

Educators fed back that they value the accreditation of the quality-management process but that they see variation between regions with different standards applied, and overlap with Care Quality Commission (CQC) inspection.

Focus groups have highlighted the need for emphasis on wellbeing and empowerment for future careers throughout training, to enhance the quality and impact of learning. Surveys have shown an increasing risk of burnout, including in the first five years post-training (PRUComm, 2022). A focus on prevention during training may enhance the impact and retention rates of our valuable workforce.

The need for future GPs to develop experience in leading and designing quality improvements was also emphasised, along with the need to develop a strong connection with ‘place’. The place-based pilots highlighted ways to connect GP DiTs to the needs of the local population, and embed them in the clinical leadership and permanent workforce within a place.

For example, the place-based pilot in North East London recruited six trainees from diverse backgrounds, all of whom had done their initial medical training outside the UK and who may not otherwise have had a chance to train as GPs. The pilot provided them with opportunities to do more of their training in local communities, testing different selection and support processes as well as new ways to help trainees develop competencies in primary care. Trainees reflected warmly on the opportunity to train outside of hospital settings.

Priorities and action

We will continue to explore options to further reform our placement and delivery model as capacity and funding permit. While there has been much discussion about basing all three years of GPST in general practice, with personalised and targeted placements according to curricula and personal need, there is no current capacity or funding to do so. The unintended consequences and impacts of such a change on the wider system would need to be carefully considered.

We are working to standardise quality management processes in line with the refreshed HEE Quality and Intensive Support frameworks, to share and embed good practice and to reduce bureaucracy. Any practice that is rated as good or outstanding by the CQC will be regarded as an acceptable clinical learning environment, and quality assurance will focus on the educators and the educational environment.

General practice is a team service and education model. Practices are now working together in PCNs. The Nursing and Midwifery Council (NMC), Health Care Professions Council (HCPC), and the GMC have agreed that we can quality manage training at PCN level.

We have commissioned primary and community care training hubs serving every integrated care board (ICB) area. As these mature, we will move to training hubs overseeing PCN-level quality control and use this to expand and diversify our placements, while maintaining and improving quality for all general practice learners.

We also seek to increase the use of innovative placements, including longitudinal placements and those across community, voluntary and digital services.

5. Better wellbeing and mental health care in general practice and the community

Purpose and context

Patients with mental health concerns and patients with formal diagnoses form a significant proportion of those presenting to primary care, and many living with mental ill health experience care that does not meet their expectations. Patients with common mental health long-term conditions (LTCs) deserve high-quality long-term care, similar to that provided for the mostly physical conditions more typically referred to as LTCs.

An increasingly high proportion of the population is being prescribed antidepressants. Around 21.4 million prescriptions were issued between July and September in 2022 in England (NHS Business Services Authority, 2022). GP DiTs need to gain expertise in diagnosing and treating depression, and in de-prescribing when the time is right.

The primary care workforce, including GPs, has a key role in supporting individuals with mental health conditions to fully realise the NHS ambitions laid out in the Mental Health Forward View (MHFV) and the NHS Long Term Plan.

GP DiTs already gain significant understanding of the impact of mental ill health and its management, especially in their general practice placements. The RCGP has renewed its curriculum and there is a strong focus on mental health disorders, learning disability and other related conditions, including through the adoption of the GMC's generic professional capabilities (Royal College of General Practitioners, 2022).

The number of people presenting with mental health problems has dramatically increased since the pandemic and secondary services are not able to offer treatment to everyone who needs it. This has been widely recognised as an enormous challenge, not least because primary care will likely need to manage the majority of this pent-up demand. As the true extent of the mental health impact of the pandemic emerges, it is vital that the future GP workforce is well equipped to manage it.

Working remotely and having fewer face-to-face consultations with patients during the pandemic has affected GP DiTs' experiences of managing patients with mental health issues. While requiring a different approach, this has not all been negative.

Additionally, HEE has partnered in the development of resources for eating disorders, and also in the development of the Oliver McGowan Mandatory Training in Learning Disability and Autism (HEE, Learning Disability Programme, 2022). Oliver McGowan was an autistic teenager who was admitted to hospital having focal partial seizures. Oliver was known to be intolerant to all forms of antipsychotic medication, however he was administered antipsychotic medication against his and his family's wishes. This led to Oliver's brain swelling, resulting in his death. Oliver's parents, Paula and Tom McGowan, believe his death could have been prevented if the doctors and nurses had been trained to understand how to make reasonable adjustments for him.

The Learning Disabilities Mortality Review (LeDeR) Programme (now known as the Learning from lives and deaths – People with a learning disability and autistic people programme) has consistently shown that people with a learning disability have a lower life expectancy and are more likely to have preventable, treatable and overall avoidable medical causes of death compared to the general population. In 2017 the LeDeR Programme's annual report recommended that: "Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with a learning disability and their families." (LeDeR Programme NHSE, 2017, p. 8) Every subsequent LeDeR annual report has made further reference to training needs.

We heard...

Patients told us they want to know their GPs have the required knowledge and skills, but that they perceive mental health knowledge among GPs to be not as strong as it is for physical conditions. This is supported by the GP mental health training survey (Mind, 2018), although this focused on secondary care mental health placements.

At engagement events and in focus groups, some trainees reported negative experiences of acute psychiatry placements, which often were of little relevance to regular general practice and involved trainees providing medical care to psychiatric inpatients. However, we also heard of positive placements in community and psychiatry for the elderly.

Engagement with trainees and educators indicated a desire to learn about conditions they felt were not well covered, such as complex conditions with concurrent physical, mental and emotional symptoms, and non-condition aspects of mental health care including the medicalisation of normal emotions, brief interventions, working with the wider team and risk assessment. They also provided suggestions for additional learning experiences such as eating disorder services, addiction services and third sector services.

As part of a place-based pilot in the North West, a GP DiT developed skills and confidence by working alongside mental health nurses in primary care. The first-year GP DiT spent six months working 1.5 to two days per week alongside three band 6 part-time mental health nurses at a general practice, gaining understanding about the links between mental health and physical health, linking with community mental health and third sector services, and learning how to do brief but safe clinical assessments. The trainee reflected on improved confidence in understanding and managing the links between physical health issues and emotional wellbeing, and less reliance on prescribing medication or referring patients on.

Priorities and action

National figures suggest that only around half of GP trainees undertake training in a mental health setting. The inclusion of mental wellbeing in this reform programme is an indication of the importance we place on enhancing care of citizens with mental health disorders, learning disabilities and neurodiverse conditions.

We see an opportunity for healthcare professionals, including GP DiTs, mental health nursing students and NHS Talking Therapies professionals, to learn together in and with the communities they seek to serve. This might include team-based learning, co-located placements, or sessional secondment. We will work with NHS England and mental health providers to create new learning opportunities.

Our primary care deans will further explore innovative training placements, which could include:

- services not typically used, such as CAMHS, eating disorders, addiction, crisis and dementia provision;
- national charities such as Mind and Beat – The UK's Eating Disorder Charity;
- local charities and third sector organisations;
- homelessness services.

A place-based pilot in the Wirral area saw GP DiTs spend half the week in general practice and the other half in a community service, such as substance misuse services and early intervention psychosis services, supporting people with mental health conditions and those who misuse alcohol and substances. As well as boosting trainees' knowledge of the area and ability to provide holistic physical and mental health care, the experience had the potential to influence their future career plans.

We will work with HEE's mental health leads and key partners to address the additional educational content requirements that have been identified, and support mental health services, charities and third sector organisations to provide training in future.

6. Improving cancer diagnosis and earlier detection

Purpose and context

Cancer treatment and prognosis continue to evolve rapidly. The GPST reform programme has a responsibility to train the future GP workforce to be able to continue supporting patients through referral, investigation, diagnosis and treatment as the patient's trusted physician.

Currently only 54 per cent of cancers are diagnosed in the early stages (stages one and two). This matters because early diagnosis relates to better outcomes for patients. The NHS in England has set an aim to diagnose 75 per cent of cancers in the early stages by 2028. Much of this improvement will come from developments in evidence-based screening, along with timely access to investigations and treatments.

However, there remains a case for improvements in cancer diagnosis to be part of the GPST reform programme in order to increase GP diagnostic ability and improve understanding of the pros and cons of screening, genetic screening and risk assessment.

Restrictions and fears during the early waves of the COVID-19 pandemic delayed patient presentations, reduced screening participation and delayed access to diagnostic investigations and treatment. There is an ongoing backlog due to this disruption that is being tackled at all levels within the NHS.

We heard...

GP trainees and educators highlighted that delays in diagnosis often occur after investigations are requested or referrals made. The two-week wait referral threshold is set to detect symptoms where there is a minimum three per cent risk of a cancer diagnosis. While no system or clinician is perfect, GPs believe that appropriate referrals are made if symptoms fit those referral requirements.

Clinicians are very aware that early presentations are typically vague and often only clear in hindsight, without comparison to the many symptoms that are not due to cancer. All involved said they were clear that they wish to diagnose cancers early and value support to do so.

There was concern about over-investigation and over-diagnosis based on incidental findings, recognising the potential psychological and physical harms of both. On this basis, colleagues stated they would value help to better direct investigations and referrals. They noted that the average GP diagnoses six people with cancer per year but will be referring many times more than that.

Priorities and action

As part of the new NHS England, we want to work with the cancer and diagnostics teams to ensure that our reforms are aligned to developments and best enhance GP understanding to support the early stages of the cancer pathway.

We propose the following initiatives:

- education opportunities to engage with cancer diagnostic academics, including the GRAIL blood test;
- diagnostic support, including the use of risk assessment tools such as QCancer, GPST training packages such as those of Cancer Research, and technology solutions such as C the Signs;
- training in clinical decision-making to enhance diagnostic and referral skills;
- learning about the challenges and harms of overdiagnosis and overloaded referral pathways, and the impact on patients;
- innovative integrated training post (ITP) placements, such as those offered by C the Signs and Cancer Research.

We recognise that the diagnosis of cancer may be a life-limiting condition. We therefore recognise the ongoing need for all doctors in primary care to remain up to date in the area of palliative medicine.

7. Population health

Purpose and context

Good health is vital for the prosperity of the communities we live in. Improvements in life expectancy stalled in the decade before the COVID-19 pandemic due to wide inequalities in health within and between local areas in England (Institute of Health Equity / Marmot, 2020).

Population health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, while reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill health and to address wider determinants of health, and requires working with communities and partner agencies.

Population health continues to evolve as technology develops. The era of big data has helped establish a subdivision of population health: population health management. Narrower in approach and with a focus on using data to analyse and interact with specific populations, population health management will become more prominent as the health industry becomes more data rich. The International Data Corporation predicts that the global 'data sphere' will increase from 33 to 175 zettabytes from 2018 to 2025, with healthcare among the fastest growing sectors because of advancements in healthcare analytics (Reinsel, et al., 2018).

The population-level approach to reducing health inequalities will be a cornerstone of new ways of working through ICBs. Health staff need to feel confident in their skills and abilities to carry out their duties through existing roles, new roles and transformed services, to most effectively meet the health needs of their population. Ensuring we have an integrated approach across health and social care will support the workforce to contribute to the system.

Primary care networks have a role in addressing and improving the health priorities within their communities. In this way, GPs contribute to population health through their interaction with individual patients and their engagement with the PCNs and ICBs in which they work.

The importance of understanding population health was highlighted during the COVID-19 pandemic, when the social determinants of health led to the disproportionate effect of the pandemic on certain groups. Higher rates of mortality in areas of deprivation and the effects of the societal response to the pandemic focused our attention on the health and wellbeing of the population.

We need to enable healthcare staff to collaborate and co-produce with the local population to deliver improved health and wellbeing outcomes (Delgado, et al., 2021).

We heard...

GP DiTs are aware of health inequalities, the importance of preventative health approaches and the challenges of health access for specific groups of the population.

GP DiTs gain awareness of population health through ITPs in community specialities, public health, ICB placements, and their clinical GP placements. Discussions with the multiprofessional team, such as social prescribers, also enhance their knowledge, and some areas have very specific services, such as a healthcare bus for the homeless and sex workers.

GP DiTs form the biggest professional group in the National Population Health Fellowship, which is a multiprofessional programme that places professionals in population health placements focused on health inequalities.

Priorities and action

GP DiTs need to be exposed to placements, learning opportunities and educational events about population health. By promoting this learning, we can ensure our future clinicians understand how to articulate and influence health provision for local populations and tackle health inequalities.

We propose the following initiatives:

- promotion of educational resources about population health, including mandatory adult and child safeguarding;
- peer learning from different health settings meeting local population needs, especially for the GP DiTs involved in the HEFT programmes;
- increasing and varied innovative ITP posts in public health, ICBs, community specialities and prisons, and signposting to third sector services such as shelters for the homeless;
- more GP DiTs doing the National Population Health Fellowship;
- engagement in PCN responsibilities, such as impact and investment-funded activities and carrying out quality-improvement projects;
- experience of clinical leadership and workforce transformation addressing population health within ICBs or PCNs;
- promotion of the importance of health improvement activity, such as management of hypertension and secondary prevention of cardiovascular disease.

It is recognised that a dual Certificate of Completion (CCT) for general practice and public health would be valuable. GPs are responsible for the health of their communities, and those who have gained advanced public health skills through a CCT in public health can offer more when it comes to population health. This is particularly important for GPs involved with integrated services (such as PCNs) that serve large populations.

Historically, GPs with a CCT in public health usually completed their GP training and public health training separately. However, the Medical Act freedoms following the UK's exit from the European Union allow for a training programme that delivers a dual CCT in GP and public health, with both the RCGP and the Faculty of Public Health (FPH) being supportive.

The mapping of the RCGP and curricula demonstrates that there is sufficient overlap to meet the GMC requirement that dual CCT programmes must reduce training time by at least one year. As such, HEE is collaborating with the RCGP and FPH to launch a dual CCT in general practice and public health.

8. Technology in practice

Purpose and context

Developments in technology have reshaped the provision of healthcare. The NHS has successfully sustained advances in the provision of high-quality care, and there have been many transformations in primary care that have improved experiences and outcomes for patients, including:

- full digitisation of patient records, allowing benefits such as patient access to records, analysis supporting health needs assessment, and coordination of healthcare provision;
- computer systems and other technology that support improved patient safety in diagnosis, remote monitoring and prescribing;
- enhanced communication, with patients having access to high-quality information, the ability to book appointments, and the ability to consult using video and chat programmes, all from their computer or smartphone.

The NHS Long Term Plan (NHS, January 2019) set out the ambition for mainstream digitally enhanced care through integrated care records, support for clinicians with digital tools, and enhanced communication with patients.

The Topol Review: Preparing the healthcare workforce to deliver the digital future (Health Education England/NHS, 2019) recommends the future workforce of the NHS will need to have education and training that ensures that technological developments are used most effectively. The delivery of this education and training will also need to make use of digital advances to support all the learning required.

Health Education England's AI Roadmap identified that 29 per cent of artificial intelligence technologies in the NHS are within primary and community care. General practice was the fourth highest clinical area of deployment and general practitioners the second highest direct users of AI technologies (Unity Insights/HEE, 2022). Ensuring that GP learners are prepared for emerging technologies like AI, and understand the importance of data accuracy and its uses, is important for future patient care.

The COVID-19 pandemic led to the very rapid development of remote consulting, through telephone, video and email-based platforms, and there continues to be a significantly higher demand for online and telephone consulting.

There was also a parallel development of online and remote supervision, teaching and learning. Although the initial focus of the NHS during the pandemic was on patient care, there was still a need for support and learning for doctors in training. This was provided through chat groups and virtual communication tools.

We heard...

The increased use of technology to support all areas of training reform has been widely supported by educators and doctors in training, with a consensus forming around the development of a blended approach to teaching and learning that incorporates modules harnessing the advantages of face-to-face and digital methods.

The following areas of learning were considered most important:

- teaching and learning generic IT skills;
- use of technology in enhancing patient care, e.g. remote monitoring;
- remote consulting;
- data collection and analysis to support population health and data-driven innovation and technology;
- communication skills including video consulting and use of social media;
- support for patients who may struggle to use technology, to promote inclusivity and avoid digital exclusion.

Other proposed topics included integration of education into clinical software, and the uses and ethics of artificial intelligence.

There was also a lot of enthusiasm for using innovation in technology to enhance learning and create additional experiences, such as the use of augmented and virtual reality platforms.

Priorities and action

We propose to pursue the following initiatives, working closely with the Technology Enhanced Learning Team:

- Development of a primary care virtual training academy that will bring together all the digital resources in this reform programme, offering an integrated education experience using cutting-edge technology. This academy will be a key mechanism for the delivery of many of the priorities and actions in this report.

- Development of a national virtual learning environment (VLE), with regional and programme sections, to support GP training. This VLE will:
  - host resources for running online and blended programmes covering the GP curriculum, including e-learning modules;
  - enable the facilitation of online teaching and learning;
  - link to other e-learning platforms and resources, including exam support.

- Commissioning and development of technology to support GP training programmes, including:
  - Virtual Primary Care – a package of real recordings of GP consultations, with associated learning guides and links;
  - technology and pedagogy to support the live-streaming of clinical experiences to small and large groups of remote learners, for example the Virtual Clinical Experiences platform;
  - high-fidelity extended reality simulations, focusing on rare but important clinical scenarios;
  - development of a wide range of blended modules across the breadth of the curriculum, including areas that have not traditionally been a focus, such as digital skills, population health, health inequalities and planetary health.

We recognise that providing trainees with an experience of the digital world may require them to be placed in non-traditional settings. This could be done through the establishment of innovative ITP placements within digital primary care teams, or through placements with primary care technological partners (Wang & Horton, 2015).

9. Planetary health in practice

Purpose and context

The climate crisis threatens health at population and individual level. The Lancet has recognised this (Watts, et al., 2018) along with the fact that "tackling climate change could be the greatest global health opportunity of the 21st century". This is because many of the actions needed to tackle the climate crisis, such as reducing emissions and increasing biodiverse green space, also have immediate health co-benefits – for example, through reduced air pollution, access to nature, healthy sustainable diets and increased active travel (Lacobucci, 2016). It is vital that tomorrow's GPs are equipped with the knowledge of how human health is fundamentally predicated on planetary life support systems and the tools to apply sustainable healthcare principles to individual and population health.

The NHS is the largest public sector contributor to carbon emissions in England. In October 2020, in response to the profound and growing threat to health posed by climate change, the NHS became the world's first health service to commit to reaching carbon net zero. Following COP26 in the UK in 2021, HEE committed to educate every future NHS clinician about sustainability and the net zero initiative through the programmes we commission and deliver.

The report Delivering a Net Zero Health Service (NHS, 2020) sets out a clear ambition and two evidence-based targets:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040.
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

Clinicians have a direct influence on the ability of the NHS to meet these targets. This is particularly the case in primary care, where the majority of the carbon footprint comes from clinical activity. Sustainable healthcare is fundamentally aligned to person-centred, evidence-based and cost-effective healthcare, as it is achieved through the application of the following four principles: prevention, patient empowerment and self-care, lean systems and low-carbon alternatives (Mortimer, et al., 2018). These principles can be applied to quality improvement in all clinical areas.

Medicines account for about 25 per cent of emissions within the NHS in England and two thirds of the primary care carbon footprint. They also contribute to the pollution of aquatic ecosystems. Metered dose inhalers are a particular prescribing carbon hotspot in primary care, accounting for 13 per cent (Greener Practice, 2023) of its carbon footprint. Quality improvement in this area boosts respiratory health for patients while reducing the carbon footprint.

Transport accounts for around 14 per cent of NHS emissions, so changes in the way healthcare is delivered – such as via remote consulting and local delivery – along with changes in the way training is delivered, can all work towards meeting the targets.

The COVID-19 pandemic had a huge impact on the way we practice, but also highlighted the inequality both in our healthcare system and in population health in general. It is vital that tomorrow's GPs understand the impact of the climate crisis on exacerbating health inequalities (Institute of Health Equity, 2020) and how to ensure sustainable healthcare addresses this issue.

Each individual primary care encounter can be viewed through the lens of community and planetary health by asking two questions: how does planetary health impact on clinical formulation? And how does clinical management impact on planetary health by using the principles of sustainable healthcare?

The role of the future GP includes:

- protecting and improving the health of populations,
- understanding the wider determinants of health to address inequalities and inequities,
- maximising the effectiveness of resources and services while minimising harm to people and planet through the use of sustainable healthcare principles,
- monitoring and assessing the needs of local population groups,
- communicating risks to individuals and local populations,
- advocating for measures to improve the health of populations and the planet.

We heard...

GP DiTs are deeply engaged in planetary health and in many instances are ahead of their educators. They understand that a rapidly changing climate and biodiversity crisis has a profound impact on our health and the way that we practice medicine, and that training needs to reflect these changing demands.

Sustainable healthcare training is popular and GP DiTs are leading on GP practice and PCN-based quality improvement projects that aim to reduce emissions and improve patient care.

Priorities and action

Teaching on planetary health and sustainability should be embedded in the curriculum. These themes will be priorities for the virtual learning academy and pilot blended learning placements. All GP DiTs should be given regular opportunities through their training programmes to be involved in projects that support the NHS zero carbon commitment, including sustainable quality improvement and leadership activity.

Training programmes and deaneries adapted quickly to remote learning and the remote management of GP training. Educational teams will embed best practice from the COVID-19 pandemic to maintain quality education while minimising carbon emissions. Considerations on environmental impact should be routinely factored into decisions on the delivery of GP training.

10. Leadership, management and strategy in context

Purpose and context

The development of leadership skills among our GP learners is a necessity, to improve current healthcare delivery and to bring about positive change.

Many GP learners will become GP partners or hold leadership roles at national, integrated care system (ICS), PCN or practice level. For current GP learners, the Workplace Based Assessment includes mandatory requirements in relation to leadership, and trainees are encouraged to develop their leadership skills incrementally over the training programme and record any other leadership activities undertaken.

Many trainees have engaged with separate leadership programmes, like Next Generation GP, which aims to engage a new generation of leaders in primary care. In addition, Health Education England and the Faculty of Medical Leadership and Management have produced a Developing Medical Leadership toolkit to support the development of regional leadership programmes for GP learners.

Our future GPs will need to be compassionate, collaborate and inclusive leaders, who are advocates for their patients and their profession. As the health and care system adapts to the formation of integrated care systems, the vision of the GPs at the nexus of health and social care is exciting and promises to deliver seamless care for patients.

This vision should be nurtured, to enable GPs to work across organisational and functional boundaries that allow for relationship building and innovation in primary care (Giordano, 2011).

We heard...

The value of leadership skills is widely acknowledged, and GPs and trainees want to understand how to develop leadership capabilities while working within the NHS.

In focus groups and retention workshops, we heard trainees express concerns about lacking leadership skills as they progressed towards the end of their training. There is a sense that those concerns are not being addressed, given that early career GPs told the Big GP Consultation (Loftus, et al., 2022) that they do not feel adequately trained for system-based healthcare leadership.

Preparation for many of the practical aspects of leading within a GP practice is viewed as lacking, with trainees highlighting gaps in their learning around understanding and managing budgets, change management and human resource issues.

Leadership skills are also required beyond the GP's own practice, and there is a desire among trainees to improve their understanding of population health management, how to lead change at scale and how to build relationships with different providers within the system.

Priorities and action

We are developing and piloting two blended learning modules: one focused on leadership, and the other on management and the business of partnership and running a general practice.

The Big GP Consultation outlined key actions to ensure strong GP leadership across the healthcare landscape of the future, including:

- the provision of specific, relevant and ongoing training to GPs to ensure they have the requisite knowledge and skills to lead in their practice and beyond, as a spiral curriculum throughout their careers;
- training in the knowledge and skills to provide clinical supervision of the wider MDT, including other doctors;
- representation of primary care voices and patient voices at all levels of healthcare leadership and management, including the new ICS structure;
- more equitable distribution of resources within practices, PCNs and across primary care.

We support these recommendations, and additionally propose that GP DiTs should be exposed to leadership opportunities during their training, including opportunities to take responsibility for a particular area while in training practice under supervision. These opportunities should instil GP DiTs with an understanding of resource limitations and advocacy.

Summary

The vision of this work is for a reformed GPST programme that bolsters resilience through pastoral and peer support, and provides continuity of mentorship to trainees. The programme must deliver quality with compassion and a holistic approach, embracing continuity of care and the ability to absorb uncertainty and risk during challenging times.

It is vital that the GPST programme advances an evidence-based agenda on social justice and social partnership, and provides greater contextual training in the broadest of social factors.

Promoting understanding and awareness of mental health issues within primary care is paramount, along with the establishment of a robust mechanism to evaluate physical and mental health outcomes. Other priority areas of focus include cancer diagnosis and technology in practice.

We want to give GP DiTs more control over their lives and work, and to promote the wellbeing of trainees in alignment with the HEE wellbeing agenda.

Ultimately, we want every GP to view training others as a worthwhile endeavour, worthy of their time and attention. Equally, we want every trainee to apply for GPST because they believe that they will receive high-quality, rigorous training that will prepare them for rewarding careers.

Table of actions/recommendations

1. Enhancing generalism:

The adoption of the Enhance programme
The adoption of longer placements
A pilot of blended learning placements

2. Equity in training:

Continue to support overseas doctors in GPST through the HEE programme
Applying the recommendations of the BAPIO report to GPST
Use of GP curriculum to highlight inequalities in care delivery and ways to address them

3. Social accountability and serving all communities:

Support for prioritisation of areas of deprivation within primary care estate plans
Identification of further opportunities for development of HEFT programmes
The further development of post-CCT deprivation-themed fellowships

4. Improving the quality of training:

Exploration of options for further reforms to placement and delivery model
Standardisation of quality management processes in line with the refreshed HEE Quality and Intensive Support frameworks
Expansion and diversification of placements following move to training hubs overseeing PCN-level quality control
Increase in use of innovative placements, including those across community, voluntary and digital services

5. Better wellbeing and mental health care in general practice and the community:

The creation of new learning opportunities through NHS England and mental health providers
The exploration of innovative training placements through charities, third sector organisations and other services not typically used

6. Improving cancer diagnosis and earlier detection:

Education opportunities to engage with cancer diagnostic academics
Training in clinical decision-making to enhance cancer diagnosis and referral
Training in the harms of overdiagnosis
Innovative ITP placements

7. Population health:

Exposure to placements, learning opportunities and educational events about population health
ITP posts in public health, ICBs, community specialities and prisons
Involving GP DiT in HEFT
More GP DiTs doing the national Population Health Fellowship
A dual CCT in general practice and public health

8. Technology in practice

The development of a primary care Virtual Training Academy
The development of a national virtual learning environment
The commissioning and development of technology to support GP training programmes

9. Planetary health in practice

The embedding of teaching on planetary health and sustainability in the curriculum
Opportunities for GP DiTs to be involved in projects that support the NHS zero carbon commitment
Considerations on environmental impact to be routinely factored into decisions on the delivery of GP training

10. Leadership, management and strategy in context:

Exposure to leadership opportunities during GP DiT training
Provision of specific, relevant and ongoing leadership training
Representation of primary care voices and patient voices at all levels of healthcare leadership
Training in knowledge and skills to provide clinical supervision of the wider MDT, including other doctors

Glossary

ARCP	Annual Review of Competency Progression	
ATCF	Accreditation of Transferable Competencies	Allowing those that have trained in relevant specialties to shorten training
CCT	Certificate of Completion of Training	
GP DiT	Postgraduate general practice doctor in training	
GPC	Generic Professional Capabilities	
GPST	General Practice Specialty Training	
HEE	Health Education England	
HEFT	Health Equity Focused Training	
ICB	Integrated care board	
ICS	Integrated care system	
IMG	Integrated training post	
JCPTGP	Joint Committee for Postgraduate Training in General Practice	Predecessor to PMETB and GMC
LeDeR	Learning Disabilities Mortality Review	
MSC	Medical Schools Council	
NMC	The Nursing and Midwifery Council	
PCN	Primary care network	
PMETB	Postgraduate Medical Education Training Board	
RCGP	Royal College of General Practitioners	
VLE	Virtual learning environment	
VTS	Vocational Training Scheme	

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