General Medical Council Consultation on the routes to the
general practitioner and specialist registers –
NHS Employers’ response

1 Do you agree that the current model for evaluating equivalence by assessing
documents should be replaced by a model based on the four elements set out above?

Don’t know

This is a welcome document which is long overdue. The current CESR route is not
considered as rigorous as CCT, and a disproportionate number of CESR doctors struggle
and end up in Fitness to Practice procedures.

However, the four areas outlined above are understandable but we cannot see how a
system of acclimatisation and workplace evaluation in the UK can be operated without
expecting trusts to employ these doctors. If they are employed, what grade is this at and who
pays? It seems the only real possibility is SAS grades, or if there are any around, clinical
fellow posts (but at what grade and on what pay scale?). Trusts may be looking for different
skills and attributes from these doctors than those which measure up to GMC requirements.
If the doctors are in SAS grades, it is not a lot of difference to the current system whereby
many overseas people in SAS grades think they should be recognised and seek a CESR.
Another alternative is that they apply for a training post – not something many wish to do.

2 Do you agree that the period of acclimatisation should be at least six months in the
previous three years? If not, what would be an appropriate period?

Yes

Not sure how achievable acclimatisation is.

Doctors perform better in environments they are familiar with and this needs to be taken into
account. Familiarity with the NHS is important, but it is distinct from knowledge and
performance. The best way of evaluating doctors is over prolonged periods. We question
whether six months is long enough.

3 Do you agree that applicants should be required to demonstrate their specialist
knowledge by taking a formal test of knowledge in their specialty set by the relevant
medical royal college or faculty?

Yes

In the specialties where this exists.
4 Not all colleges and faculties have existing tests of knowledge in every specialty set at the appropriate level. With this in mind, would it be reasonable to use tests for those specialties they exist for, but to evaluate applicants’ knowledge in other ways where no appropriate test exists?

Yes

Specialist knowledge should be tested by means of a system which reflects our own expectations of UK trainees of knowledge and competence. For example:

i. A requisite number of years of higher specialist training – if six years is the standard for our own Specialty Registrars, why should three or four years training be sufficient for others?

ii. A professional specialist examination e.g. there is now a European plastic surgery examination which is open to all, or Royal College exams.

iii. Evidence of continuing professional development prior to their application e.g. attendance at courses, conferences and evidence of research.

5 Do you think that formal tests of knowledge should NOT be part of the CESR/CEGPR application requirements? If so what other valid and reliable means of assessing applicants’ knowledge should we use?

No

6 Do you agree that successful application for a CESR/CEGPR should require evaluation of performance in practice in the relevant specialty in the UK against prescribed competences at the level of the final year CCT?

Yes

Not sure how achievable workplace evaluation is.

There is a concern about how onerous the process will be for employers. It would be useful to know the aggregate cost to employers and deaneries.

7 Do you agree that the performance in UK practice of CESR/CEGPR applicants should be evaluated by approved specialty (including GP) educational supervisors?

Yes

The system should identify people willing to undertake such work as part of a panel of assessors in each speciality area approved by the GMC for that specific purpose.

However, we question who will pay for evaluation by educational supervisors. Employers are under pressure to maximise consultant efficiency and reduce SPA time. If educational supervisors were to supervise a SAS doctor to achieve CESR, who pays for this SPA time? Employers are not paid for trainee educational supervision time, but the trainee’s salary is at least part paid. This goes some way to compensating for this lost consultant time.

8 How do you think we should ensure assessments are objective and independent?

Not everyone has the skills and attributes to evaluate doctors and standards for trainers should be more rigorous. This may be picked up under the approval of trainers review. It is very important to have external assessors, as an internal assessor may find it hard to fail a doctor who they know well and who they will have to continue to work with.
9 For those specialties for which there wasn’t a formal test of specialist knowledge (see questions 3–5 above), could evidence of performance in UK practice at the same level as the final year of a training programme leading to a CCT provide enough assurance that applicants have the necessary breadth and depth of knowledge?

Yes

Although there is a concern about how onerous evidence of performance in practice would be for employers.

10 Do you agree that applications from figures of genuine international renown should continue to be evaluated on the basis of documentary evidence rather than through evaluating their performance in practice?

Yes

We think this is likely in practice to apply only to a very small number of doctors entering UK practice.

11 Do you agree with the criteria at Appendix G for evaluating applications from doctors of international renown?

Yes

12 Do you think that the proposed new model provides a robust, fair, proportionate and accessible means of evaluating whether doctors possess the knowledge, skills and attributes equivalent to those required for a CCT? If not, why not and what alternative would you propose?

Yes

We are supportive of improving the process for CESR to make it a truly equitable route to the registers, although have concerns about the burden it will place on the service and should ensure that it does have real equivalence to the managed training programme route.

13 Are there particular groups of doctors who could be adversely affected by the proposed model and, if so, how could we reduce or prevent the adverse effects?

No

14 Our report contains 13 specific recommendations for changes to the current CESR/CEGPR process set out here and listed in full at the end of our report. Do you have any other comments on the conclusions of the review and the report recommendations?

There is a difference between fitness to practice and fitness for purpose: the GMC’s role is to ensure that a doctor has the skills to practise, whereas the employer’s responsibility is to ensure that a doctor has the skills to do a particular job in a particular hospital. Just because a doctor has achieved their CCT does not mean that s/he will get a consultant job.

Recognition of qualifications and career progression are distinct. Some doctors apply for CESR in order to have their qualifications recognised, rather than to get a consultant job. It would be useful to have some GMC guidance around how many times a doctor can apply and at what point in a doctor’s career they should apply.
It would also be useful to know how many of those who have gone through CESR have gone onto work in substantive consultant posts.

There will be a lack of CCT opportunities for trainees in five to ten years time. Doctors in trust grade and specialty doctor posts receive very similar training to doctors in training grade posts. In time, these doctors will argue that they have very similar skills to those on training programmes.

Employers believe the same standards of entry onto the register should apply to all doctors new to UK practice, wherever they come from.

It is important to link this review with revalidation, as supporting information needs to be collected for revalidation, as it does for entry to CESR.