

## Annual specialty report (ASR) 2015

### Purpose and use

The ASR provides the GMC with an overview of medical specialty education and training from the perspective of the Medical Royal Colleges or Faculties who represent the profession and have a key role in managing and improving the quality of specialty training for doctors.

The ASRs feed into the quality assurance processes and are reviewed in conjunction with annual reports provided by Dean's and Medical Schools as well as evidence from our visits, surveys and other sources. Concerns raised in the ASRs are used to inform our quality assurance activities including regional reviews, check visits, small specialty reviews and enhanced monitoring. Issues in the ASR may also inform education policy developments.

### Submitting your report

The deadline for submission is **31 March 2016**. Please submit your completed ASR by uploading it into your GMC Connect ASR 2015 folder. If you do not have access to GMC Connect or you have any other questions please email [quality@gmc-uk.org](mailto:quality@gmc-uk.org). If your response requires extra rows, right click on the grey bar on the left hand side at the same level as the table and select 'Insert'.

### Question changes for 2015

We have added questions about NTS Programme Specific Questions and progression data (exams, ARCP) in order to improve our understanding of the evidence at a programme or specialty level. We would also appreciate for you to identify where you can specific locations that your response regards. This will help us to triangulate our data sources and best respond to the item.

### Requested updates

You may find that some of the tables (relating to curriculum updates and small specialty reviews) within your ASR have been pre-populated with information that you have previously raised with us. We would like an update on these points in your next ASR submission. You can also provide information on additional items as you feel necessary.

## **Serious concerns**

If you become aware of a serious concern affecting patient safety such as doctors in training working beyond their competence or the educational environment such as undermining please report this to us as soon as possible and do not wait for your ASR submission. You can contact us on [quality@gmc-uk.org](mailto:quality@gmc-uk.org).

## **Contact details**

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## **Quality assurance - Concerns**

- 1 Please detail any concerns relating to the quality of specialty education and training at a National, Deanery/LETB, Training Programme or LEP level where you don't consider improvement to be acceptable

We do not require you to report concerns which have been resolved or which you are working with the Deanery/LETB to resolve.

- Themes: Please identify the most relevant theme(s) to summarise the concern. You may wish to choose from one of the following themes we have identified from previous ASR submissions:
  - Training programme's coverage of the curricula
  - Inadequate training experience eg due to rota gaps
  - Educational supervision eg lack of time for training available
  - Resources to support for wider educational activity eg Exam centres & examiners
  - Assessments systems - exams / WPBAs
  - Clinical supervision
  - ePortfolio
  - Access to educational resources eg Study leave
- Specialty: Please note all affected specialties. If the issue affects all specialties managed by your college/faculty please state "College/faculty-wide".
- Location: Please provide sufficient location detail to help us target the concern, including the relevant Deanery/LETB, Training Programme Reference and LEP. If the concern relates to multiple locations please list all of them.
- Evidence: For us to investigate concerns please provide the source and an outline of the evidence supporting your concern.
- Action and outcome: Please describe what action you or another party such as the LETB, have taken or plan to take in order to address the concern and the outcomes if known.

- Suggested action: Please outline any action you suggest for your college/faculty or another body to take.

Description	Evidence	Action taken and outcome	Suggested action
In this section we provide an update on three areas of concern at national level and summarise the work being done to address those concerns.			
<b>Recruitment</b>	<p>We have reported often on difficulties recruiting sufficient good quality applicants into GP specialty training. We have referred to aspects of undergraduate education and foundation training that discourage applications for GP training - those exiting medical school and in foundation training are simply not choosing to train in general practice, possibly because of the negative image of the specialty promulgated by some medical schools. We have reported on the link between numbers of GP placements in F2 and applicants for GP specialty training. We have referred to the pressures on GP educators of accommodating learners at different stages of their medical education and on the dangers of reducing the standards for entry to training in response to recruitment difficulties.</p> <p>Of course general practice is not the only specialty with recruitment problems. Young doctors' career choices are increasingly taking them out of the UK workforce for a time, out of training into non-training grade posts or even out of medicine altogether. As the UKFPO's 2015 report notes, only 52.0% of completing F2s said they were going to progress directly into specialty training in the UK. This compares to 58.5% in 2014, 64.4% in 2013, 67.0% in 2012 and 71.3% in 2011.</p> <p>But at all stages of training the figures look particularly bleak for general practice.</p>	<p>During the reporting period, measures put in place for recruitment into programmes starting in 2016 included:</p> <p><b>Twice-yearly recruitment</b> The establishment, in 3 of the 4 nations, of a twice-yearly recruitment process to create greater flexibility for applicants. For the last two years there has been an exceptional additional round in September.</p> <p><b>Direct Pathway</b> The trialling of a process in which candidates who score above a certain level at Stage Two recruitment will not be required to sit Stage Three.</p> <p><b>Geographical preference</b> Allowing applicants to preference at a more detailed geographical level during Round 1, e.g. Coventry and Warwickshire or Birmingham rather than the West Midlands, giving the applicant a more informed choice, and meaning that s/he is more likely to accept a post.</p> <p><b>Transferable score</b> The applicant score at recruitment will now be a UK rank rather than specific</p>	<p>We urge Government to continue to act to aid recruitment and retention in GP training.</p> <p>HEE's decision to end the Broad Based Training Programme is misguided. Trainee feedback has been extremely positive and the Programme has been a fruitful source of GP trainees.</p>

- Of the F2s who finished training in 2014, only 20.8% were appointed to GP specialty training;
- The GMC's 2015 report on the state of medical training shows very starkly that the numbers entering the Specialist Register far exceed those entering the GP register;
- As the table below shows, while the number of training vacancies continues to rise, the number of applicants continues to fall with all four countries of the UK experiencing recruitment difficulties for the August 2016 intake, including Northern Ireland where recruitment has, historically, been buoyant.

**Figure 1: GP training Application and Advertised Vacancies 2009 – 2016**

Applications	UK Graduates	Non UK	Total	Vacancies
<b>2009</b>	3503	3012	<b>6515</b>	3344
<b>2010</b>	3699	2638	<b>6337</b>	3318
<b>2011</b>	3706	1884	<b>5590</b>	3256
<b>2012</b>	4007	1908	<b>5915</b>	3204
<b>2013</b>	4318	1712	<b>6030</b>	3350
<b>2014</b>	3922	1553	<b>5475</b>	3500
<b>2015</b>	3696	1415	<b>5111</b>	3612
<b>2016</b>	3483	1380	<b>4863</b>	3770

to the LETB/Deanery where the applicant participated in the selection process. This will allow applicants to preference locations in adjoining LETB/Deaneries with fewer entering clearing.

**Accreditation of transferable competencies**

Two further specialties, ACCS and Emergency Medicine, have been added to the list of ATC specialties. The list of approved specialties may be extended.

**Deferment**

In England, Scotland and Wales, from 2016, applicants will be able to defer entry to training, for non-statutory reasons for a maximum of one year.

**Foundation Competency**

Applicants will have increased time to prove foundation competency for the 2016 recruitment round.

**Foundation Year 2 GP**

Applicants unable to demonstrate foundation competency during recruitment will be offered the opportunity to apply for a six or 12 month, primary care-focused Foundation Programme which will provide a route to an "Alternative Certificate to Foundation Competence".

**Pre-Specialty Training GP**

In an increasing number of LETBs, applicants who have foundation competencies but are not successful at

		<p>GP selection are being offered a period of Pre-Specialty training giving them NHS experience and an insight into GP training. Over the course of a year they are given support in making a second GP application.</p> <p><b>Global Health Programmes</b></p> <p>A Global Health Fellowship, offered in four LETBs/deaneries gives trainees Out of Programme Experience between ST2 and ST3. Under the scheme, GP training will be extended by 12 months. Those also doing the Diploma in Tropical Medicine will have their training extended by 15 months.</p> <p><b>Regional roadshows/liaison with GP societies/the Medical Schools Council</b></p> <p>Involving RCGP faculties and GP societies in promoting GP as a career. An RCGP Strategy Working Group is developing relationships with GP Societies in medical schools across the UK.</p> <p><b>Induction and Refresher scheme</b></p> <p>The introduction of a new, Portfolio route.</p> <p><b>10 Point Plan</b></p> <p>Continuation, with HEE, NHSE and BMA of work on the 10 Point plan.</p> <p>A range of other proposals to encourage young doctors into general practice are being considered. They are at various stages of development and include:</p>	
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		<ul style="list-style-type: none"> <li>• Out of programme opportunities</li> <li>• Giving applicants the option to defer GP training and try another specialty and being allowed to return to GP at a later date</li> <li>• International recruitment is being explored; HEE is hosting recruitment events and selection centres in targeted countries <ul style="list-style-type: none"> <li>• New financial incentives are being offered to encourage trainees to train in under-doctored areas.</li> </ul> </li> </ul>	
<p><b><u>Professional vs. educational requirements at ARCP</u></b></p>	<p>Last year we alerted the GMC to concerns that the application of additional professional requirements at local and national level, linked to trainee revalidation, over and above the educational evidence required by ARCP panels, was resulting in inequity for GP trainees and a skewing of our own ARCP QM data. During this reporting period, for example, trainees across the UK who did not complete the GMC NTS were given an outcome 2 or 5.</p> <p>We understand that the GMC's view is that it is appropriate for an educational assessment to be used to monitor, in doctors in training, the development of professionalism and an understanding of domain 2 of Good Medical Practice. However, a tendency to add further professional requirements, at local and national level, into what is primarily an educational process can result in confusion and inequity. The ARCP process was developed as a tool to evaluate educational progress and the introduction of trainee revalidation has resulted in a situation where original purpose and intention have been hijacked by a new</p>	<p>GP schools provided helpful and thought provoking comments on this question. Many take the view that a pragmatic response is needed and that separation is neither feasible nor advisable, there being considerable overlap and commonality between the two with linkage helping to embed trainee understanding of professionalism beyond CCT, and to emphasise that training is essentially preparation for independent practice. One school writes '<i>The ESR produced is synonymous with the appraisal document generated from a meeting between the appraiser/appraise. The tools for appraisal are the ones used in our educational toolbox such as MSF, PSQ and there should be greater</i></p>	<p>Accepting that there is an overlap between the educational and professional and that it is important that trainees have a sophisticated understanding of the latter, the answer may be to embed new professional requirements within the GP curriculum, including its fitness to practise element. This would, to a certain extent, ameliorate the problems currently experienced by the management of a dual purpose process. It would not, however, remove the problem of</p>

	<p>process.</p> <p>To aid the debate we asked GP schools for their views; specifically, if they thought there should be separation between educational and revalidation requirements and, if not, how and if they should be accounted for in the GP curriculum.</p>	<p><i>alignment between the e-portfolio and the appraisal documentation needed post-CCT'.</i></p> <p>However, amongst those comfortable with the link, there were concerns that the methods by which some trainees were being asked to demonstrate professionalism were over-prescriptive: the request to obtain a specific certificate in Child Safeguarding being one example. Instead guidance on demonstrating competence and capability more generally is considered by most to be more appropriate.</p> <p>Many schools want continued separation arguing that increased regulatory content in an educational process risks the educational assessment mutating into a tick box exercise, when it should be primarily learner centred and formative. There is concern that this could, in turn, lead to further erosion of the supportive role of the educational supervisor who will increasingly be seen as an agent of GMC regulation. Others note that a</p>	<p>the imposition, in short order, of new requirements nationally or locally with the consequent compulsion on colleges to play catch-up in the incorporation of curriculum changes and applications for GMC approval of those changes. We understand that new GMC guidance/standards may help to address these issues.</p> <p>In conclusion and as we said in last year's ASR, definitive guidance from the GMC is needed on the application of new professional requirements, their relationship to the ARCP process, college curricula and the circumstances in which an unsatisfactory ARCP outcome should be awarded. At the very least, considered and careful consultation on future changes to professional requirements is needed</p>
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		<p>trainee can satisfactorily complete educationally but demonstrate problems relevant to revalidation and that, in these circumstances, it is the role of the Responsible Officer, not the ARCP panel, to prohibit progress.</p>	<p>at a national level before they are imposed.</p>
<p><b><u>OOH GP training</u></b></p>	<p>It is vital that GP trainees have access to good quality training in OOH general practice. To inform this Report, GP schools again provided information on OOH training, specifically on capacity and curriculum coverage.</p>	<p>There appears to be some improvement in provision compared with previous years with all schools reporting that they have sufficient capacity. However, the sorts of problems highlighted previously persist: there is little or no flexibility or spare capacity in the system; a number of LETBs/ deaneries don't have enough OOH clinical supervisors; changes of provider and new contracts may ignore training needs, and providers sometimes cancel OOH sessions at short notice. Almost all schools report that trainees are able to acquire the necessary competencies, but a minority, that there are problems obtaining OOH shifts that provide adequately relevant and challenging experience. One, for example, reports that a provider is reluctant to</p>	<p>COGPED has reviewed the approvals process for both the clinical learning environment and GP supervisors (more details are given below) and the scope of this work has included the OOH clinical setting and clinical supervisors.</p> <p>The Deanery OOH Leads (DHOOLs) group continues to share information on provision and delivery of OOH training, together with implementation of QA processes supported by COGPED.</p> <p>As new models of urgent</p>

		<p>take ST1s because of their '<i>perceived lack of service benefit</i>'.</p> <p>In response to the question '<i>what are you doing to ensure sufficient training sessions in OOH?</i>' a number of schools reported that early engagement with providers is key. One suggested that a '<i>shared induction passport</i>' would help where providers are unwilling to take trainees who have not completed site/provider-specific induction, and another that, to try to deal with a dearth of OOH clinical supervisors, it is moving to a model where a core group of GPs trained in OOH supervision give support to a larger group of supervising clinicians. One school has developed, and another is developing, an online OOH clinical supervisor training module to enable prospective supervisors to train at a time that suits them.</p>	<p>care emerge it will be important that service redesign (and the attendant contracting) take sufficient account of the training requirements of GP specialty trainees to ensure adequate and appropriate provision.</p> <p>OOH training continues to be a high priority and an area of risk both with regard to training capacity and patient safety if supervision is inadequate. We hope, as stated in previous ASRs, that the GMC will include GP OOH training in any future, GP focused QA review and will, as part of that review, scrutinise OOH training providers.</p>
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## 2 Externality

Please comment on your college's / faculty's involvement in the LETB/Deanery externality processes including an assessment of any issues around the delivery of the process itself or any concerns which have been identified in the quality of training through your external advisors (if not covered above)

Description	Outcome
This section of our Report relates to national/specialty-side issues. Section 5, below, amplifies this section with an update on the role of the team of RCGP trained and quality assured external advisors (EAs). The RCGP's annual report (2014-15) on its QA of the ARCP process which contains anonymised LETB/department data is appended to this report.	
The GMC is considering externality in its review of curriculum and assessment standards. In this context, for the purposes of this Report, GP schools were asked for information on external input into their QM/QC activities. Schools were sent JACTAG guidance on externality* which relates only to external advice from medical specialists but contains some helpful principles. Schools were asked to respond with reference to that guidance.	There continue to be significant differences in the way in which GP schools use external representatives in their QM/QC of GP training. It also appears that there has been some decrease in the use of externals since 2010, possibly as a result of resource pressures and/or because of HEE's desire to bring general practice in line with other specialties. At the time of the 2010 survey, GP
What schools reported has, as far as possible, been compared with the findings of a more detailed COGPED survey of 2010 (table 2, below, is a summary of its headline findings). The conclusions of that survey are out of date but help to illustrate the wide range of GP QM/QC activities into which external representatives input. The 2010 survey covered a broader range of activities and asked a more detailed series of questions than the 2014-15 GP school questionnaire. For this reason, and because the level of detail in LETB/department responses varied and geographical configurations have changed, direct comparisons with 2010 are difficult. Nevertheless, we hope the information here provides the GMC with some indication of how GP schools are managing externality and some interesting examples of how externals are used.	

- \* [http://www.aomrc.org.uk/doc\\_view/136-jactag-guidance-external-advice-from-medical-specialists](http://www.aomrc.org.uk/doc_view/136-jactag-guidance-external-advice-from-medical-specialists)

In accordance with Gold Guide requirements, lay people are involved in scrutinising the ARCP process in all GP schools. In most they are present at all panels but, in a minority, participate only in panels attended by the trainee. As was reported in 2010, lay people are used in almost all GP schools as QM visitors and/or in some form of QM governance. 13 LETBs/ deaneries report using lay people to assist with trainee selection, a figure which may not be entirely accurate and merits further scrutiny as it is not compliant with standard 4.4 of *The Trainee Doctor*. Six LETBs/ deaneries use lay people in the recruitment of senior educators, which is a new development, not found in 2010. A majority have lay representation on the school board (or its equivalent). In one, a lay person chairs the Board, and in another the Trainer Selection Committee.

Trainees participate in fewer processes than lay people but in six schools join QM visits and/or sit on post/ programme approval committees. Seven schools report that they have trainee representation on the School Board. In two, trainees participate in trainee recruitment and in one a trainee attends ARCP panels. In another, trainees are encouraged to observe ARCP panels. Trainees participate in the selection of senior educators in two GP schools.

10 schools, more than in 2010, report that GP practice approval visit teams include practice managers (using practice managers in this way is long established in GP QM), and two that the school board includes a practice manager. In one, practice managers occasionally participate in ARCP panels.

Interesting examples of the use of external representatives, reported by schools include the following:

- Each school presents an annual report to a LETB Quality Scrutiny Board comprised predominantly of lay and trainee representatives;
- There is cross-specialty observance on ARCP panels to promote learning and sharing of good practice;
- The School Board in two LETBs is chaired by a practice manager;
- Lay people participate in the appointment of a wide range of GP educators - trainers, TPDs, careers advisors and Associate GP deans.

GP schools also provided information on the involvement of RCGP representatives (other than RCGP EAs) within

schools were complying with national requirements (*The Trainee Doctor*, GP-specific standards and JACTAG guidance) and there was no appetite for additional COGPED-specific guidance.

These variations in practice may now merit some further scrutiny, in the context of LETB/ deanery practice more widely. In this context we note the absence, from *Promoting Excellence*, of reference to lay or any other form of external input into the QA and QM of training though the GMC's Quality Improvement Framework, which we understand is also being reviewed, does refer to LETB/ deanery use of externality. JACTAG guidance refers only to the use of external medical specialists and the Gold Guide to the use of external

local governance and QM. RCGP representatives are sourced from the local RCGP faculty in all but one LETB/academy, 11 schools, significantly fewer than in 2010, have one or two RCGP representatives on the school board. It appears that six schools may no longer have a school board or its equivalent and this merits further investigation. RCGP representatives are used by a minority of LETBs/academies to support other forms of decision making: in one when meeting outcome 4 trainees to assist in career planning; in another there is an RCGP representative on the trainer selection committee. Two LETBs report using the local RCGP faculty representatives in trainee recruitment and one in some ARCP panels.

Eight schools report that their external representatives are formally recruited and inducted, five that they are regularly appraised and the majority that their lay advisors, but not other groups of externals, receive regular training. All bar two schools report that external advisors submit formal reports on the activities in which they participate and that these are considered by the GP school board or the Head of School (HoS) and the comments collated and used, where appropriate, to make changes to processes. A number of schools report that the work of their external representatives is informally appraised, for example, in the form of oral feedback from the chairs of the panels in which they have participated. So, while some form of monitoring is taking place in all LETBs/academies, its form and function varies significantly.

Only three schools report that they use patient, as opposed to lay, advisors in QM. More detailed questioning would be needed to find out what precise role patients play.

GP schools were also asked if they had any other thoughts on the value or otherwise of external representatives. Responses focused on lay advisors and comments were positive: lay people are particularly good at reminding GP school teams of the core purpose of the activity in which they are participating; they are seen as useful in “authenticating” contentious decisions, in particular in relation to QM visits and ARCP appeals, and in supporting the school when there are pressures from national organisations which may compromise training quality. It was not a surprise to hear that, while on the one hand some schools support lengthy appointments for lay people, thus giving them the time to build up expertise and relationships with the GP school, others caution against lay advisors becoming too close to the work of the school which risks their losing their true externality.

representatives in recruitment and the ARCP process. We know that the GMC is consulting on college use of lay input into the development of College curricula and assessments and that a broader and more explicit role for colleges is envisaged.

The College welcomes moves to strengthen and formalise its role, but it must also be understood that any enhanced role is likely to have resource implications. The GMC should bear in mind that not all colleges will be in a position easily to fund significant additional activity.

In conclusion, it is our view that a broader consultation by the GMC, and national guidance may be needed in relation to externality in the QA and QM of undergraduate

Total 19 Deaneries	Lay	Practice Manager	Clinical (non- medical)	Director / AD outside Deanery	GP- RCGP	GP Trainee	Consultant - within Deanery	Dean / Assoc Dean outside Deanery	Other Specialty trainee
School Board or STC	19	2	6	1	19	19	12		
QM Hospital Posts	12	3	3	3	5	9	14	2	3
QM GP Posts	13	7	3	2	10	9	3	1	1
ARCP Panels	18	3	3	3	11	2	3		
Appeals	15	6	5	11	8	9	9	7	10
Recruitment	18	12	4	6	6	7	7	3	1
QC Programmes (9)	5	2	1	0	4	9	2	1	1
Appraisal(7)	3				1		1	1	

**Table 2: COGPED 2010 survey of externality in GP school quality management**

and postgraduate education more widely, not just in relation to the role of colleges in the QA of curricula and assessment delivery, and in particular on the role it should play in deanery/LETB QM/QC.

**3 Please provide any comments on the results of assessment of the Progression Reports published by the GMC**

The GMC publish reports showing ARCP outcomes and examination results for different groups of doctors across the UK. We would be interested in any observations or analysis you have on this data and any insight into the root cause of regional variations within your specialties. Please highlight any actions you are undertaking to understand or address any concerns you may have identified about the quality of training being delivered. You can view the reports here: [Postgraduate progression reports](#).

<b>Report name</b>	<b>Comment</b>	<b>Action</b>
The link between postgraduate training bodies and exam results during postgraduate training	These reports provide additional information relevant to our comments on the <i>MRCGP</i> (from page 32 onwards) and work we have been doing and reporting on for several years, following the Judicial Review, to support trainees in difficulty.	None of these reports have currently led to new actions being carried out by the RCGP, as rather than providing entirely new information they support our understanding of issues that we are already exploring.
The link between postgraduate training bodies and annual progress reviews		
The link between postgraduate training bodies and applications onto specialty and GP training programmes	This report provides additional information relevant to our comments on <i>recruitment</i> on page 4.	However, we recognise that these are a potentially valuable initiative and will continue to keep them, and our use of them, under review.

#### 4 Programme Specific Questions (National Training Survey)

Please comment on the outcome of any analysis you have undertaken of your Programme Specific Questions in the National Training Survey highlighting any areas of concern or requiring further investigation which have been identified particularly around your curricula or assessment systems.

We understand that the priority when deciding on NTS output is training providers and LETBs/deaneries. We welcome the inclusion of, and reporting on, speciality/programme-specific questions, though we have, to date, been able to make only minimal use of the data they generate and are still considering how best to phrase programme specific questions and how we might use the survey outputs more generally. We need to give some thought to how we could improve the specificity of the wording in some of those questions and we must ensure that the questions

are consistent with GP-specific standards\*. It is also the case, however, that asking exactly the same questions over repeated years can help to identify trends and, therefore, inform the focus of the RCGP's QA/QM activities. It would be helpful if the GMC could also provide reports broken down into training year by LETB/academy data to enable GP schools to pinpoint where problems lie. Further, even though the GMC is now providing multi-year, aggregated data, it has always been the case that, without being able to drill down to programme level (which risks identifying individuals), the survey data is only partially helpful.

Turning to what the data from the programme-specific questions shows: 10% of trainees in ST3 reported receiving no '*protected time each week for relevant learning*' with their educational supervisor and a similar percentage only around one hour each week. This may show that some practices are not conforming with GP-specific standards which state '*In the GP practice, trainees must be given three educational sessions each week. This must include four hours of facilitated learning time at least two hours of which must be designated tutorial time, delivered by the educational supervisor/named clinical supervisor or, with adequate planning and supervision, another member of the primary healthcare team*'. It is likely, though, that it is because a significant number of ST3s are working, not with their educational supervisor, but with a GP clinical supervisor in a different practice. Without a further breakdown of the data by training year and LETB/academy and unless trainee responses can be probed further, it is not possible to conclude with any certainty that educational supervision and clinical supervision are falling significantly below what is required by the standards. Nevertheless, this is an area that may merit further investigation.

More GP ST4s than ST3s report that they have had little help preparing for the CSA over the course of their training programme. This, on the face of it, seems odd. The CSA can be taken from ST3 onwards and, while a great deal of national guidance is available to assist trainees, locally delivered courses/activities tend to be offered once a trainee has failed, so during ST3. GP ST4s, who will almost always be training in a GP practice, will usually be either high fliers in extended programmes or in standard four year programmes (mainly in Scotland). It is possible that some trainees, defined as ST4s by the NTS are, in fact, ST3s in extended remedial programmes and it is possible that this group may seek to attribute failure to factors over which they have no control. It is also possible that in recent years there has been more and better CSA support from which the current high-flying ST4 cohort did not benefit. It is also possible, of course, that trainees have failed to read the survey question with care and answered in respect only of their current training year rather than the entirety of the training programme. Again, it would be

\* <http://www.rcgp.org.uk/training-exams/~/media/Files/GP-training-and-exams/Information-for-deaneries-trainers-supervisors/Guidance-for-deaneries-on-standards-for-GP-training-Jan-2014.ashx>

necessary to drill down further into responses to draw firm conclusions.

Other aspects of the NTS data seem contradictory. For example, almost all ST3s and ST4s report receiving support with WPBA but 50% and 70% respectively receiving no '*dedicated training*' from their LETB or any other organisation for WPBA. As WPBAs are undertaken on a one-to-one basis with the GP trainer guiding the trainee if needed, no specific coaching or training should be necessary and it could be that the latter question in the NTS is extraneous.

Mindful of the GP-specific standard '*Trainees must be supported to acquire generic professional skills at all stages of training. This will include training and participation in audit, significant event analyses and other quality improvement activities*' we are pleased to note that, by the end of ST3 and even more so by the end of ST4, most trainees reported having participated in significant event analyses, clinical audits and other quality improvement activities.

We also welcome data that shows that very few GP trainees report experiencing barriers to undertaking the training required to fulfil learning objectives and that clinical exposure to care of the acutely ill, those with mental health problems, children and young people and the elderly/those with multiple morbidity was generally reported to be good. Antenatal and perinatal care experience appears to be more difficult to come by. **DN: what more can be said about this – do we know about it, is anything being done?**

## Quality assurance – Good practice

### 5 Good practice

We have developed an enhanced programme to promote, identify and share areas of good practice. We have published areas of good practice identified through our quality assurance activities on a [new webpage](#).

Please let us know about initiatives that you have successfully implemented since your last ASR submission; providing evidence to demonstrate the positive outcomes. Good practice is defined in our Quality Improvement Framework as 'areas of strength, good ideas and innovation in medical education and training'. This includes new approaches to dealing with a problem from which others might learn. This

could be an initiative implemented across the college as a whole eg the validation of educational supervisors training in a bid to identify a benchmark for trainer standards, or within one deanery or LETB eg consultant residency posts in Health Education North West.

- Specialty: Please note all affected specialties. If the issue affects all specialties managed by your college/faculty please state "College/faculty-wide".
- Location: Please provide sufficient location detail to help us further identify the good practice, including the relevant Deanery/LETB and LEP. If the good practice relates to multiple locations please list all of them.

<u>Description, evidence and development of actions</u>	<u>Other potential uses</u>
<p><b>Governance and coherence in the QA/QM of GP training</b></p> <p>A GP SAC, set up, and jointly chaired, by the RCGP and COGPED, met for the first time in January 2015. It has oversight of the GP curriculum, assessments, QM, certification and support for trainees and educators. In May 2015 a formal reporting relationship between the NRO and the SAC was established. The creation of the SAC represents a significant and positive change in the governance of GP training, bringing the RCGP and COGPED together in a more collaborative relationship, and so helping to ensure consistency of training across the four nations, and aligning general practice more closely, in governance terms, with other specialties.</p>	
<p><b>Review of the RCGP's role in the QA/QM of GP training</b></p> <p>As the GMC knows, the way in which GP training is quality assured and managed continues to be different from other specialties. Other colleges have long had a presence in hospital trusts of college-badged educators (college tutors, specialty or regional advisers) in theory, at least, able to take an independent view of training. Further, in other specialties HoS are joint college/deanery appointments. Currently almost all GP school boards (or their equivalents) include members who wear a nominal RCGP "hat" usually because they were sourced from a local RCGP faculty, but they have no formal links with central College and their role is generally confined to membership of the school board. RCGP faculty boundaries do not map easily onto LETB/deanery boundaries.</p>	The RCGP model for the college role in the QA/QM of specialty training could be adapted and adopted by other specialties.

Repeated attempts over the years to strengthen the role of RCGP representatives in local QM have been unsuccessful for a variety of reasons including lack of resource to properly train and monitor them, deanery and faculty boundaries that are not contiguous and lack of enthusiasm for the task on the part of individual faculty representatives. So the RCGP relies, for much of its QA/QM information on GP HoS who are local appointments and so, in theory, constrained in the type and amount of information they can provide. The RCGP will continue to review how it might enhance its influence locally but sees no immediate prospect of being able to fund and manage the sort of networks that exist in other specialties.

With the support of COGPED, and in the context of Gold Guide requirements, the RCGP has, for some years, done a bi-annual review, or quality check, of a sample of ARCP outcomes, ESRs and CSRs. Its methodology has been described in detail in previous ASRs and has been commended by the GMC as a model for emulation by other specialties. A summary of the themes emerging from the process this year is given later on in this Report. While the methodology ensures consistent national standards and has provided stimulus to promote change locally, it is also administratively burdensome for the College and GP schools, involves some duplication of activity and is out of line with processes in other specialties. So, the RCGP and COGPED have been reviewing this activity and the RCGP's role in the QA/QM of GP training more generally with a view to ensuring that it is proportionate, consistent and sympathetic to the regulatory, and financial framework within which it operates. The review has been undertaken on the understanding that the GMC, in reviewing its curriculum and assessment standards may give colleges an enhanced role in the QA of curriculum and assessment delivery. A set of principles and suggested processes, described below, has been approved by the SAC, shared with the GMC and will be further developed. It is hoped that the new approach to College QA of training will enable a greater flexibility and ability to focus quickly and forensically on areas of risk.

### Principles

- i. RCGP QM should focus on reviewing the QM and quality control (QC) activities undertaken by LETBs/academies and not duplicate those activities.
- ii. RCGP QM should take a risk based approach and involve sampling and formative feedback and not universal checking.
- iii. RCGP QM will be virtual, paper based and, when appropriate, involve visits to deaneries/LETBs.

- iv. RCGP QM should aim to identify outliers to assist deaneries/LETBs in offering targeted support.
- v. RCGP QM activities should sit firmly within GMC standards, including its Curriculum and Assessment Standards as well as *RCGP/COGPED Guidance for Deaneries/LETBs on the Standards for GP Specialty Training*<sup>\*</sup>, which are a GP-focused version of the GMC's *The Trainee Doctor*.
- vi. RCGP QM should continue with a regular but much smaller remote sampling of the quality of the supporting information for decisions made by ARCP panels. This will include the quality of the evidence upon which the educational supervisor's review is based, and the quality of the evidence available to ARCP panels. However, all efforts should be made to ensure that the focus of the RCGPs QM is on the quality of outcomes and not compliance against a set of checklists.
- vii. Decisions on the focus of RCGP QM each year should be ratified by the SAC, drawing on a proposal from the QMTS committee. This focus will be communicated to all deaneries/LETBs within a fortnight of the ratification. The chosen focus should be evidence based, and the factors identified will be informed by, amongst other things, perceived risks which may arise from changes in assessments, data collected from deaneries/LETBs by means of the annual RCGP GP Schools Questionnaire<sup>†</sup>, the results of previous year's QM activities and by the results of the GMC's National Trainee Survey.
- viii. Heads of School (or equivalents in the devolved nations) must support and actively engage with the RCGP's activities. This will include completing the RCGP questionnaire fully and with care and to any reasonable deadline set to enable the RCGP to focus its QM activities fairly and proportionately.
- ix. RCGP QM activities should continue to be undertaken on behalf of the RCGP by a trained team of specialists - RCGP External Advisors (EAs) who should be appointed in line with the GMC recommendations and receive adequate training from the RCGP. They should receive regular and relevant update training and undertake benchmarking activities to ensure they are carrying out their activities against the currently published standards. Their RCGP QM activity should form part of their annual NHS appraisal.

#### Processes

- i. RCGP to complete an Annual Specialty Report to the GMC, in consultation and cooperation with COGPED and GP schools.
- ii. RCGP to review GP School ARCP reports on a three yearly rotational basis and also to undertake risk based reviews of individual GP Schools. Such individual reviews might arise from concerns from unusual or outlying

<sup>\*</sup>[rcgp.org.uk/training-exams/mrcgp-information-for-deaneries-supervisors-and-trainers.aspx](http://rcgp.org.uk/training-exams/mrcgp-information-for-deaneries-supervisors-and-trainers.aspx)

<sup>†</sup> Although the term "GP School" is used in England, the term is also meant, in this document, to apply to the equivalents of GP Schools in the devolved nations.

<ul style="list-style-type: none"> <li>iii. ARCP results, reports from EAs or other unforeseen significant events.</li> <li>iv. RCGP to undertake cyclical routine and targeted visits to individual LETB/deanery ARCP Panels to check on panel function and compliance with RCGP guidance and GMC standards.</li> <li>iv. RCGP to review deanery/LETB use of externality in the ARCP process and in governance of GP training (e.g. membership of school boards).</li> <li>v. RCGP to undertake under the guidance of the SAC a further relevant annual analysis of the quality of a sample of specific areas of the MRCGP WPBA. For example, this might include a review after a change in assessments (such as the quality of assessment and feedback after the introduction of CEPS) or a review of the evidence used by ESs to judge a trainee's competence in a specific area such as OOH care.</li> <li>vi. RCGP to develop standards for Deanery/LETBs for reviewing ESRs by LETBs/deaneries, and for giving ES feedback on their ESRs.</li> </ul>	
<p><b>Quality management of the ARCP process</b></p> <p>The RCGP continues to quality assure/manage GP school ARCP panel reviews. A sample of ARCP Panel reports and associated Educational Supervisor Reports (ESRs) and Clinical Supervisor Reports (CSRs) are reviewed. Evidence in the Trainee ePortfolio(TeP) is also scrutinised to see if it supports the ARCP outcome awarded. Any ARCP panel reports thought to have insufficient evidence are double checked. Specifically, a team of RCGP appointed and trained External Advisors (EAs):</p> <ol style="list-style-type: none"> <li>1. observes a sample of ARCP panels across the UK (during the summer months as winter panels tend to review relatively small numbers of trainees, and are not representative of normal panel activity);</li> <li>2. participates in the central checking of a sample of ESRs and ARCP panel reports. The samples include all unsatisfactory outcomes (Outcomes 2, 3, 4 and 5, but excludes Outcome 5s awarded solely because of the absence of a Form R), and 10% of all ARCP Panel reports with satisfactory outcomes (Outcomes 1 and 6) in line with Gold Guide requirements. All OOP Outcomes (Outcomes 7, 8 and 9) are excluded.</li> </ol> <p>The RCGP analyses the data collected, reports on national trends and provides GP schools with information that enables them to compare their outcomes with others. Schools are invited to comment on the data.</p>	<p>The model could be used by other specialties to quality assure ARCP processes.</p>

Below, we report on some of the themes arising from this year's QM activity. A more comprehensive report with anonymised, individual GP school data, is appended\*.

Figure 2 provides headline data for the past five years and shows that the percentages of ARCP panel reports with sufficient evidence remains high and relatively consistent. The percentage of ESRs of acceptable quality once again increased, with significant improvement in this area being demonstrated over the past five years. However, the number of ARCP panel reports lacking recent ESRs (those written in the two months preceding the ARCP), though still very low, was higher than in the previous year. The standard of CSRs is also improving. In 2015 approximately 85% of CSRs written by GPs and 72% of those written by hospital specialists were found to be acceptable. The RCGP's Assessment Team is currently reviewing the format of the CSR.

Year	ARCP Outcomes quality managed (#)	Unsatisfactory ARCP outcomes (%)	ESRs Deemed Acceptable (No Recent ESRs excl.) (%)	No Recent ESR* (%)	ARCP outcomes with sufficient TeP evidence (%)	CSRs found to be acceptable (%)
2010	1852	53.2%	62.3%	8.6%	90.3%	-
2011	2787	66.6%	69.5%	9.4%	88.6%	52.7%
2012	2390	64.1%	72.3%	8.1%	94.1%	77.3%
2013	3414	68.5%	70.7%	6.0%	94.7%	74.5%
2014	3140	68.8%	74.5%	8.3%	93.0%	62.7%
2015	3544	67.5%	75.8%	9.3%	93.5%	77.7%

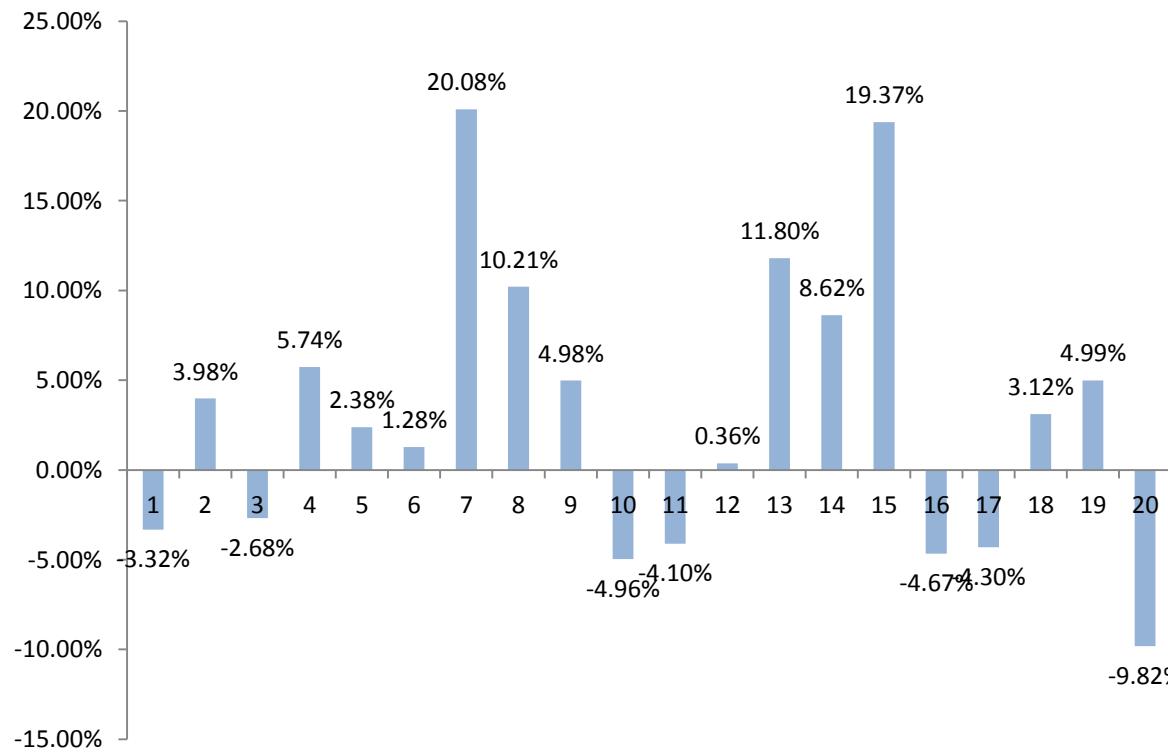
Figure 2. Summary of national statistics: 2010-2015

\* Report on the 2015 Quality Management Sessions, RCGP March 2016

\*ESR more than two months old at time of ARCP panel

Significant differences are observed between training year, in the number of unsatisfactory outcomes awarded; by far the largest number of unsatisfactory outcomes are awarded at the end of ST3. The College's QM report explores what might lie behind these differences. The number of outcome 5s awarded (11.58% in 2014-15), though lower than last year, remains high for reasons discussed earlier in this report.

Variations between LETBs/deaneries in levels of satisfactory and unsatisfactory outcomes awarded are also observed. Although most LETBs/deaneries awarded satisfactory or unsatisfactory outcomes within  $\pm 10$  percentage points of the national average, four did not, as shown in figures 3 and 4 below.



**Fig. 3. Variation in percentage of satisfactory ARCP panel review outcomes by anonymised deanery/LETB: 2015. Represents national**

average (=76.08%) subtracted from deanery/LETB proportion of reviews with a satisfactory outcome (outcomes 1 and 6). 0 = national average.

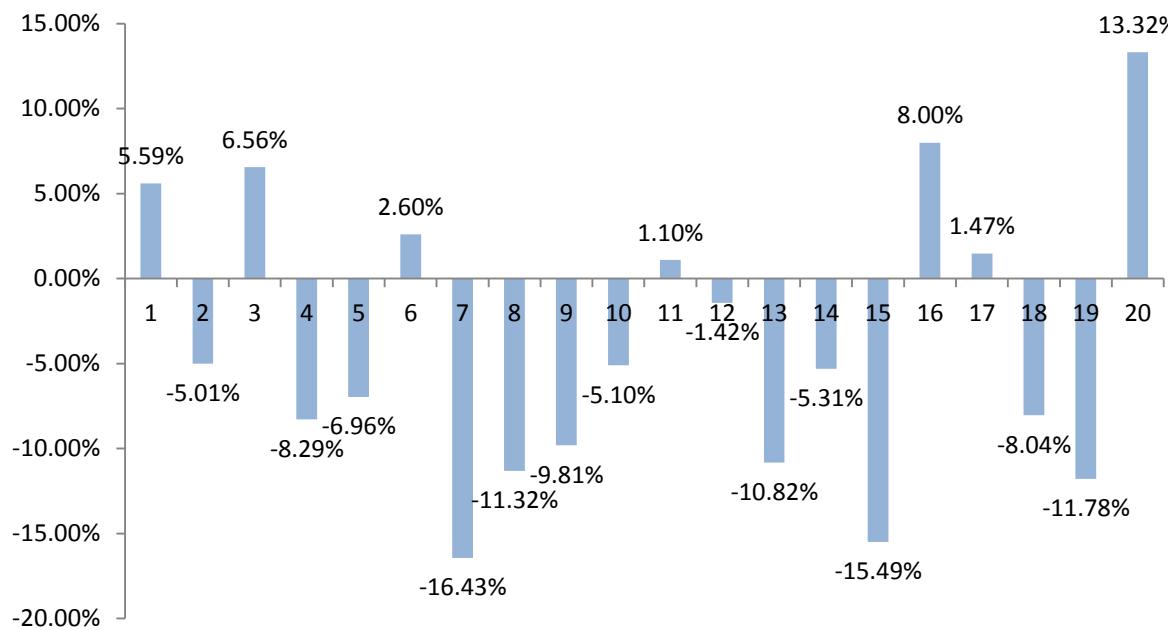


Fig. 4. Variation in percentage of unsatisfactory ARCP panel review outcomes by anonymised deanery/LETB: 2015. Represents national average (=20.04%) subtracted from deanery/LETB percentage of reviews with an unsatisfactory outcome (outcomes 2, 3, 4 and 5). 0 = national average.

Other themes emerging from the RCGP's oversight of the process this year were as follows:

- Slightly under half of LETBs/deaneries visited reported that ARCP panels experienced time pressures, sometimes because of poor pre-screening or inadequate pre-panel administration;
- The majority of LETBs/deaneries do some form of pre-screening to ease time pressures during panel meetings. Some inadequate recording of the decisions reached during pre-screening was observed, resulting in confusion during panel meetings and complaints from trainees which, in some cases, resulted in the cessation of screening altogether;
- Wide variations between LETBs/deaneries in the type of feedback to educational supervisors on the quality of

<p>ESRs (in some individualised and in others only generic); in the methods for delivering feedback (written and oral); and in those who receive it (in some cases, only new ESs, in others only a sample). In some LETBs/deaneries pressure of work and very large numbers of panels prevent feedback being provided at all;</p> <ul style="list-style-type: none"> <li>➤ Some examples of panels awarding satisfactory outcomes in the absence of a CSR;</li> <li>➤ A reduction in the number of trainees using inappropriate assessors;</li> <li>➤ Some examples of ESRs failing to record suggestions for an ST3's further development post-CCT;</li> <li>➤ Some examples of trainees being required to complete a specified number of learning log entries or SEAs not consistent with RCGP guidance;</li> <li>➤ Marked variations both between and within LETBs/deaneries in the quantity and quality of evidence detailing a trainee's competence in OOH activity.</li> </ul>	
<p><b>GP-specific training standards</b></p> <p>In May 2015 the GMC published <i>Promoting Excellence: standards for medical education and training</i>. We understand the GMC now expects Royal Colleges to define, in the context of <i>Promoting Excellence</i>, standards for their own speciality. GP-specific standards already exist in the form of COGPED/RCGP developed '<i>Guidance for Deaneries/LETBs on the standards for GP specialty training</i>' published in 2008, and last updated in January 2014. They are compatible with, and build on, the standards in the precursor to <i>Promoting Excellence - The Trainee Doctor</i>.</p> <p>The COGPED/RCGP guidance must be updated if it is to remain useful and current. As <i>Promoting Excellence</i> has received support from the GP training community revised GP-specific guidance will not need to be as detailed as the previous document and can be drafted to be read 'beside' the GMC document, with GP-specific clarification/amplification of individual standards where necessary. The new guidance will also take into account HEE's new, high level quality framework and the Academy of Medical Educators <i>Framework for the Professional Development of Postgraduate Medical Supervisors</i>. To allow for the new organisational structures in primary care, it will include standards covering a range of GP training environments (single practices, multiple practices, CEPNs and OOH centres) and GP educators (named clinical supervisors, OOH clinical supervisors and educational supervisors). We will also need to consider if and how new GP-specific guidance should subsume, or at the very least be consistent with, the new COGPED guidance on GP trainer and training environment approval (see below).</p>	

<p>COGPED and the RCGP will draw up revised guidance during 2015-16 and report in more detail in the next ASR.</p>	
<p><b>GP trainer and practice approval processes</b></p> <p>COGPED, supported by the RCGP, has drawn up a unified, UK-wide process and national data set for the approval of GP educators and GP educational environments. The drivers for this work are described in the 2013-14 ASR. To assist COGPED in its planned review of the process, and for the purposes of this Report, all GP schools were asked to comment on its implementation. The detail of schools' responses will be reviewed by COGPED.</p> <p>The new process acknowledges HEE's desire to minimise differences between the management of specialties and sits more comfortably with the GMC's approach to quality assuring training. It formalises the separation of processes for trainer approval from those for training environment approval, a separation that was becoming the norm across the UK in any event and is a sensible response to organisational transformation in primary care with wider federation, the amalgamation of practices and a need to approve a variety of training environments, including OOH providers and multiple partnerships. This separation enables the approval of trainers to focus clearly on the individual and his or her development, ensuring better integration with appraisal systems as well as congruence with systems in secondary care. It is also congruent with the structure of <i>Promoting Excellence</i>. Equally, shifting responsibility for educational process and environment to providers brings congruence with other regulators and acknowledges that GPs are increasingly working and training in larger organisations.</p> <p>A set of minimum requirements are described for the circumstances in which an approval visit must take place, the duration of approval, the data to be considered as part of the approval process, the composition of a visiting team and governance of the approval process. It also prescribes a standardised appeal process. It does not, however, require GP educators to conform to an identical set of requirements for the education and qualifications that make them eligible to train. This was not considered feasible or desirable in the short term. All GP educators are expected, of course, to meet GMC requirements and to comply with RCGP/COGPED GP standards.</p> <p>The process is also written to be flexible enough to allow local factors, including geography, to influence</p>	

<p>implementation. However, most schools have confirmed that it is sufficiently generic to mean locally-mandated adaptations have not been necessary. All but small minority of GP schools report that they comply with the new process. This is not surprising, given that the requirements of the process codify what has been in place in most parts of the UK for many years. Importantly, however, its implementation should ensure consistency UK-wide in the future and so both guard against a reduction in standards and help to ensure the “portability” of educator approval between LETB/deaneries. Where compliance is less universal is in relation to the use of the recommended forms. Schools report that they have not altered paperwork, either because of other changes at national level (for example the publication of Promoting Excellence), or at local level (for example changes to LETB’s QA processes across all specialties; embargos on new developments and changes to IT systems), which would have meant further reworking. One school expresses concern at the level of detail in the forms contending an excess of paperwork changes the nature of the approval process from a reflective iterative one to a paper filling exercise that could discourage applicants from applying to train to become GP trainers and other forms of GP clinical supervisor.</p>	
<p><b>Quality management of applications for a GP CCT</b></p> <p>The GMC continues to require the RCGP to check, in detail, every GP CCT application. As such the RCGP does not QM or QA the CCT process, but acts as an administrative proxy for the GMC.</p> <p>The review of the RCGP’s role in the QM of GP training more generally, which we describe above, has brought into sharp focus the question of whether or not undertaking these detailed checks is an appropriate role for a royal college and, if at some point in the future, the RCGP, as the body holding specialist knowledge of the specialty of general practice, should assume a QM/QA role in relation to CCTs more akin to its ARCP QM activities. As an aside, we would say that it continues to be our view that the detailed assessment of applications for CEGPRs and the provision of recommendations on further training needs should continue to be undertaken by the RCGP, as those activities require specialist knowledge of postgraduate training curricula and assessments and specialist skills in deciding whether or not non-UK programmes provide equivalent or similar experience.</p> <p>For now, the RCGP will continue to check all CCT applications as the GMC’s Specialist Applications Team sees value in this activity. However, cognisant of the burden these checks place on LETB/deanery staff, and of the</p>	<p>The principles described here and the proposed alterations to the way in which CCT and CEGPR applications are considered are directly relevant other specialties</p>

<p>duplication of work entailed, the scope of the administrative checks made of every application has already been reduced and thought will be given, in consultation with the GMC, to some further rationalisation. The RCGP's GPSA Unit has also done an analysis of CCT applications by LETB/deanery to determine where most errors occur, with a view to focusing more attention on these regions in the future. A full analysis is being conducted over the calendar year 2016.</p> <p><i>RCGP Guidance on the content of specialty training programmes in general practice intended to lead to the award of a CCT</i><sup>*</sup> has been revised, in consultation with COGPED, and published.</p>	
<p><b>Equality and Diversity</b></p> <p>The College and COGPED continue to consider and act on the recommendations in the JR judgement on the MRCGP CSA<sup>†</sup> and to work to comply with the requirements of the Equality Act more generally. It is important that both organisations and GP schools retain an appropriate focus on E&amp;D and continue to record carefully the work done in this area.</p> <p>The RCGP's E&amp;D Programme Board - the former an internal group, with external scrutiny – and an E&amp;D Advisory Group - a wider group bringing together a range of stake holders, including the British Association for Physicians of Indian Origin (BAPIO), British International Doctors Association (BIDA), the BMA, COGPED, GMC and Stonewall – met and completed their work during the reporting period. The result was an Action Plan for E&amp;D College-wide in relation, both to areas where the College has a PSED, and to College activity more generally. Policies, processes and documentation relating to the PSED have been drawn up. All RCGP staff, GP leads and committee members have been asked to complete an online training module that explains the relevance of the PSED to the work of the</p>	<p>The lessons learned by the RCGP in the wake of the JR of its exam are directly relevant to the postgraduate exams offered by other medical royal colleges. We are aware that not all medical royal colleges accept that they have a PSED in respect of their public functions. We would urge them to consider carefully the work being done by the RCGP which we think is good practice that they</p>

<sup>\*</sup> [rcgp.org.uk/training-exams/entry-to-gp-the-register/certificate-of-completion-of-training-cct-guidance-for-gp-trainees.aspx](http://rcgp.org.uk/training-exams/entry-to-gp-the-register/certificate-of-completion-of-training-cct-guidance-for-gp-trainees.aspx)

<sup>†</sup> LexisNexis. R (on the application of BAPIO Action Limited) v Royal College of General Practitioners and another. <http://lexisweb.co.uk/cases/2014/april/r-on-the-application-of-bapiroaction-limited-v-royal-college-of-generalpractitioners-and-another>.

College. As of March 2016 25 of the 29 non staff in key roles at the College, 30 of the 37 senior employed staff, as well as 8 other staff, had completed the training.

Organisations with public duties are no longer obliged by law to undertake formal Equality Impact Assessments (EIAs) on new or amended policies. However, it is accepted that it is generally good practice to do this in some form. So, with the support of an E&D consultant, discussions on the introduction of an appropriately light touch RCGP EIA process have continued throughout the reporting period, with reference to similar work being undertaken by the GMC and Departments of Health, and taking into account EHRC guidance. The College will ensure that equality is always considered when developing new policies, and decisions recorded and retained in the event of challenge. The College is also in the process of ensuring that its literature uses Equality Act defined terminology for Protected Characteristics.

During the reporting period a joint RCGP/COGPED group met to consider the implications for LETBs/academies of the JR outcome. Though the judgment did not state this, it is the view of COGPED and the RCGP that, because the group differences in MRCGP performance are replicated at all stages of GP training, support and remediation for struggling trainees is relevant throughout training from recruitment to formal assessment. In this context, the group drew up a series of proposals aimed primarily at improving educational outcomes for trainees but also intended to mitigate the potential for future legal challenge. Those proposals cover, in summary, the following:

- The monitoring of protected characteristics during the recruitment process, the use of a diverse panel of recruitment assessors; the production, from time to time, of Recruitment Equalities Impact Reports;
- Identifying at risk trainees as early in training as possible, and possibly before assessments have been failed, the design and targeting of support towards groups identified as most likely to struggle, and the allocation of trainees to programmes, not only on the basis of merit, but with adjustments to avoid the geographical clustering of struggling trainees and/or to ensure that trainees at risk are supported by the most experienced practices and educators;
- A focus on continued research on the effectiveness of interventions and the sharing of information between deaneries /LETBs on good practice.

would be well advised to emulate.

Some of the recommendations of the joint COGPED/RCGP group may be contentious but it is our view that they are consistent with the PSED of LETBs, deaneries and the RCGP. Some of what is described may also risk being labelled as having the potential to stigmatise certain types of trainee. It is important that national and local support arrangements are sensitive to this possibility. It is also extremely important that these recommendations are taken forward systematically. The College and COGPED will provide an update in future ASRs.

<p>At the time of writing a BMA-led working group on assessment fairness has been convened and a final report, covering similar issues is awaited.</p>	
<p><b>Local interventions to support struggling GP trainees</b></p> <p>Schools report that the number of trainees in difficulty continues to rise. Since 2010 GP ASRs have reported on the support GP schools give to struggling trainees. This information has been collated into a report and shared widely*. We will continue to document this provision in the context of the recommendations of the RCGP/COGPED working group described above. For this ASR we asked schools to tell us about new interventions and any evaluations of interventions.</p> <p>In most schools support arrangements remain unchanged but the focus continues to move from remediation to prevention and so to the early identification of at risk trainees. A number of schools also report that processes for identifying and monitoring struggling trainees have been formalised, enabling them more easily to demonstrate compliance with the Equality Act. There are reports of inter-deanery integration of services to share good practice, maximise the use of resources and, it can be inferred, bring general practice in line with other specialties. There have been very few formal evaluations of interventions. Examples of new practice reported include the following:</p> <ul style="list-style-type: none"> <li>• A programme to build self-awareness and resilience throughout the programme delivered by a team of psychologists;</li> <li>• An online coaching package for CSA fails, including online modules, group discussion forums and 1-2-1 web based video support;</li> <li>• A six-day course for ST1 IMGs focusing on consulting skills and contentious areas of clinical practice, including teenage health, elderly care, end of life care, domestic violence and medical ethics. Teaching methods include interactive sessions, role play, problem solving and reflection. Media resources are used to promote familiarity with the English language and “culture”, for example Katy’s Story: Channel 4 news, 10-minute account: a real-life</li> </ul>	<p>It appears that there is currently little evidence of the effectiveness of the interventions described. There is clearly much to be gained from evaluations and the sharing of good practice. Any evaluations and resulting recommendations must acknowledge the very different circumstances of different LETBs/deaneries and that a one size fits all approach to support for trainees at risk is neither feasible nor sensible.</p> <p>For the RCGP’s part, the College has focused, this year, on working with key stakeholders and on implementing an MRCGP</p>

\* Support for Struggling GP Trainees Discussion Paper (RCGP, April 2015).

<p>experience of domestic violence; Goggle-box: Channel 4: exploring English language, reactions of “ordinary viewers” to current/topical television programmes;</p> <ul style="list-style-type: none"> <li>• The development of a tool that is able, with a fair degree of accuracy, to identify trainees at risk of failing before they fail. A detailed quantitative analysis was carried out on data on trainees who began training in 2010 and 2011 the aim being to see if it was possible to predict, at the end of ST1, which trainees might need additional support. Two WPBAs (MSF and PSQ), an educational supervisor competency assessment and scores from stage 2 recruitment, in combination, were found to identify trainees likely to struggle. A self-administered questionnaire will be developed to allow trainees and educators to identify where specific problems lie;</li> <li>• The provision of an enhanced induction programme for both IMGs and those receiving a score of 2 in the national recruitment Situational Judgement Test; this ran as a pilot last year and is being evaluated;</li> <li>• 20 trained GP mentors, part of local training support networks, aligned geographically to GP training programmes to support struggling trainees;</li> <li>• Self-declaration of trainees with low recruitment scores to help them access support early.</li> </ul>	<p>action plan. Collaborative work will now focus on evaluating current training interventions to establish what works best in terms of identifying and supporting trainees who might struggle with the MRCGP.</p> <p>Finally, the recommendations of the Steering Group are applicable, not only to those in training for general practice, but also to struggling trainees in other specialities and should be shared widely.</p>
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## MRCGP

The development and monitoring of MRCGP assessments to ensure they meet GMC standards, are fair, embrace best practice in assessment methodology and fully test the competences required of GPs practising in the NHS, continues. MRCGP Annual Reports are published on the RCGP web site\* and go into greater detail on outcomes than we do here. The reports break candidate outcomes in the AKT and CSA down by protected characteristics including sex, race (ethnicity and place of primary medical qualification) and, more recently, disability.

Exam monitoring and development is now overseen by a new RCGP committee - The Assessment and Curriculum Development Committee - that met for the first time during the reporting period and should help to ensure coherency in the development of both the GP curriculum and assessments. Membership includes COGPED, patient, lay, trainee and First5 representatives.

A formal equality assessment of the MRCGP and the development of a new MRCGP Equality and Diversity policy, ensuring congruence with best practice and with the College's recently published *Membership Equality and Diversity Statement*, were completed during the reporting period and the MRCGP team and examiners received training in the PSED. E&D training is delivered at every MRCGP examiner conference with a focus, each year, on a different protected characteristic.

The RCGP continues to work with key stakeholders including the GMC, AoMRC, COGPED, BAPIO, BIDA, BMA and trainee representatives to address differential attainment. Recent examples include:

- With COGPED, the publication of joint guidance on local support for CSA preparation<sup>†</sup>;
- Providing MRCGP data for the GMC research project '*Exploring the Relationship between General Practice Selection Scores and MRCGP Examination*', in order to help develop an effective tool for the early identification of trainees who might struggle to progress with their training;
- Participation in the BMA symposia on differential attainment and contributing to the subsequent document '*Ensuring fairness in clinical training and assessment: Principles and examples of good practice*';
- Running joint educational events with BAPIO and BIDA: including a session with COGPED and BAPIO at the RCGP Conference on cultural sensitivities in GP education; and a joint session with the GMC on differential attainment at the

Given the wide variety in practices, within schools in relation to testing for dyslexia, there may be merit in good practice guidance in this area, possibly across all specialties.

\* <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports.aspx>

<sup>†</sup>[rcgp.org.uk/training-exams/~/media/Files/GP-training-and-exams/CSA-page/Joint%20RCGP%20COGPED%20guidance%20on%20CSA%20preparation%20October%202014.ashx](http://rcgp.org.uk/training-exams/~/media/Files/GP-training-and-exams/CSA-page/Joint%20RCGP%20COGPED%20guidance%20on%20CSA%20preparation%20October%202014.ashx)

BIDA conference;

- Working with the GMC on a review of progress with the recommendations in the Esmail and Roberts review of the MRCGP;
- Continued publication of papers on fairness in the MRCGP. A summary of this research is available at <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/~/media/Files/GP-training-and-exams/Annual-reports/MRCGP-Fairness-Report-v010215.ashx>

As part of a commitment to ensuring fairness in the MRCGP, the RCGP reviewed the experience of disabled candidates in the AKT and CSA. This work was described in the 13-14 ASR. As part of the RCGP's commitment to equality and diversity, GP schools were asked to comment on aspects of the review for the purposes of this report. All schools report that they are familiar with RCGP guidance on the process for declaring a disability when applying to take the AKT and CSA. All schools were also satisfied that the process was effective and fair; one commenting that it '*erred on the generous side*'. There were, as is often the case, some examples of schools asking for changes to process or regulation where they already exist (for example, the College has already appointed a lead to consider adjustments for trainees whose disabilities fall outside the normal parameters; and it is already standard practice to allow an additional attempt at the AKT/CSA where dyslexia has been diagnosed after an unsuccessful attempt). So, it is important that the RCGP continues to need to ensure that it updates and promotes existing guidance to educators locally.

Schools also reported on their own policies in respect of AKT failures and dyslexia assessments. A number of schools have automatic screening thresholds; for six that threshold was after one AKT fail, and for some of that group, only if the fail was sufficiently serious (between more than 5% and 8% below the cut score); for four the threshold was after two fails (in one case, however, only if the fail was by more than 8%). For some the decision making was more nuanced with a number reporting that dyslexia screening could be offered very early in training following a review by clinical and educational supervisors and TPDs. Three report that trainees who fail are interviewed by a senior educator and that this may lead to dyslexia screening. The majority of schools offer free dyslexia screening, and in five of those the trainee undertakes the screening themselves using an online package. All but four schools report that, following screening, the school pays for a full dyslexia assessment.

### Quality assurance of the MRCGP

A formal review of the QA of the MRCGP was commissioned in 2014-15. The final report contains 14 recommendations focusing primarily on the selection and training of new examiners, their contractual arrangements and a system for examiner performance review. These recommendations are currently being implemented. The new examiner recruitment process should encourage applications from underrepresented groups on the panel, to further enhance diversity.

### Supporting the training community

The main focus of the work of the RCGP's exams team this year was on supporting the training community and individual trainees with exam preparation. A number of resources/initiatives were developed in this regard, including:

- CSA preparation resources, for example, an eLearning course and RCGP book based on sociolinguistic research carried out on the CSA, that specifically aims to improve performance in the interpersonal skills domain<sup>\*</sup>;
- AKT preparation resources, for example, '*Preparing to take the MRCGP AKT*' a concise guide for trainees, and an InnovAiT AKT Podcast produced jointly with the AiT Committee<sup>†</sup>;
- Educational sessions for trainers and TPDs on MRCGP preparation, for example, a session on the CSA at the 2015 Medical Educators Conference;
- To help dispel CSA 'myths', continuation of the programme inviting educators from LETBs/academies to observe the CSA.

The RCGP will continue to work on supporting the training community with MRCGP preparation, the focus moving to providing more benchmarking resources for WPBA.

### AKT and CSA

Changes to the AKT and CSA during the reporting period include the following:

- From August 2016, candidates to be allowed an exceptional fifth attempt at the CSA if they meet a series of educational criteria (approved by the GMC in late 2015);
- The introduction of a seven-year limit on passes in the AKT and CSA, in line with AoMRC and GMC guidance;
- An increase in the duration of the AKT by 10 minutes and the provision, for all candidates, of an on line calculator that

<sup>\*</sup>[rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-clinical-skills-assessment-csa.aspx](http://rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-clinical-skills-assessment-csa.aspx)

<sup>†</sup> <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-applied-knowledge-test-akt.aspx>

may particularly assist candidates with dyscalculia. The extra time means that very few candidates now fail to complete the AKT. Use of the calculator also appears to have improved performance on the drug calculation questions but there is some evidence that it has also led to some unpredicted answers;

- Alteration to the pattern of CSA diets so they are shorter but more frequent (eight rather than three times a year). Informal candidate feedback on the change was generally positive, with candidates appreciating the greater scope for re-sits and increased promptness in the receipt of results. For the purposes of this Report, feedback was also sought from GP schools the majority of which welcome the increased flexibility, reporting that it benefits LTFT and out of synch trainees and means that shorter extensions to training can be offered. A number, however, point to the attendant increase in administration, in particular the need for additional ARCP panels. Schools also report, however, some unintended consequences: trainees retaking too early rather than spending time preparing and shorter booking windows creating anxieties and meaning that some trainees book to take the assessment earlier than they should; the potential for fragmentation of the half day release course. Schools refer to the '*scramble to get booked*' and trainees being unable to sit when they wish to. A significant minority express concern at the lack of diets between June and October, noting that the majority of adverse ARCP outcomes are awarded in June. The contention is that this arrangement is particularly problematic for LTFT and out of synch trainees; the latter group often includes those who are struggling and on training extensions. One school predicts that this problem will worsen as the number of part-timers increases and following HEE's decision to introduce two recruitment rounds each year. The new pattern of diets was modelled on previous booking patterns and the most popular diets remain those in January, February and March. The College needs to continue to ensure that, as far as possible, supply matches demand. It will consider educator and trainee feedback in detail and continue to review frequency and timing of diets and notes that COGPED may be willing to help with modelling of anticipated demand.

#### AKT and CSA Research and development

The MRCGP Leads group is currently looking at ways of enhancing the assessment of prescribing across all three components.

The RCGP hosted a cross specialty seminar on '*Assessing Interpersonal Skills in the MRCGP*'. Future assessment developments in this area will be informed by its final recommendations.

Papers published in peer referenced journals include:

- Russell, D., Simpson, R., Eden, M. and Foreman, P., 2015. The use of child actors to simulate paediatric patients in the MRCGP Clinical Skills Assessment (CSA): developing an effective model. *Education for Primary Care*, 26(4), pp.242-247.
- Dixon, H., Blow, C., Milne, P., Siriwardena, N., Milne, H. and Elfes, C., 2015. Quality assurance of the Applied Knowledge Test (AKT) of the MRCGP examination—an immediate post-test questionnaire evaluation of the candidates' views. *Education for Primary Care*, 26(4), pp.223-232.
- Denney, M. and Wakeford, R., 2015. Do role-players affect the outcome of a high-stakes postgraduate OSCE, in terms of candidate sex or ethnicity? Results from an analysis of the 52,702 anonymised case scores from one year of the MRCGP clinical skills assessment. *Education for Primary Care*, pp.1-5.

Internally published/circulated research and papers include:

- A summary of AKT and CSA research and development '*Making assessment fair in the MRCGP*'\* published on the RCGP web site<sup>†</sup>.
- The 'fairness in the CSA' project (R Simpson & D Russell) completed and the results presented to the panel of examiners.
- A CSA Candidate Questionnaire analysis; findings circulated to deaneries/ LETBs.

#### WPBA

The RCGP WBPA group is reviewing the format of WBPA with the aim of maximising its assessment potential, filling the gaps

<sup>†</sup> <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/~/media/Files/GP-training-and-exams/Annual-reports/MRCGP-Fairness-Report-v010215.ashx>

where aspects of the curriculum are not currently assessed and reducing the overall burden of assessment. Changes may be fairly significant and stakeholders will be consulted with a view to introducing a new WPBA programme in August 2017.

Developments in WPBA during the reporting period were as follows:

#### *Audio Consultation Observation Tool (Audio COT)*

The AudioCOT has been developed to reflect the increasing importance of telephone consultations in general practice. It will support the trainee in readiness for independent practice and for the CSA when s/he may be assessed on a telephone case. An equality analysis of the impact of introducing this new assessment tool, particularly in respect of candidates with disabilities, such as hearing impairments, and candidates for whom English is not their first language, was completed during the reporting period. It will be incorporated into the TeP from Summer 2016. This work was included as an example of good practice in GMC guidance on approving changes to curricula, examinations and assessments.

#### *Clinical Examination and Procedural Skills (CEPS)*

Plans to integrate DOPS from its current isolated assessment form into a CEPS assessment received GMC approval. CEPS were released in the TeP in January 2015 initially as a dual system alongside DOPS. Since October 2015 only CEPS have been required. The new tool will continue to be evaluated to with GMC requirements. Schools report that the introduction of CEPS has not posed any particular challenges for trainees with disabilities.

#### *MSF in Leadership (MSF)*

An MSF tool, mapped to the leadership competencies in the GP curriculum, was piloted during the reporting period. It was developed for ST4 trainees but could be included as an optional assessment in ST3 in place of the current MSF tool and used in a formative, educational planning meeting with the trainee's educational supervisor to determine the priorities for the development of leadership and management skills after qualification. Those providing feedback must include at least five clinicians and five non-clinicians. As the response rate within the pilot sites was low, further evaluation of the tool will be needed before it is developed further.

#### *Word Pictures for WPBA Competencies*

Following the design of a word picture for the new competency on Organisation, Management and Leadership the word pictures for all the WPBA competencies were rewritten, with the input of the RCGP Disability lead and linguist They are likely

to replace the existing word pictures in the TeP sometime in 2016.

### Disability and WPBA

For this Report, schools were asked to report on any reasonable adjustments made specifically to assist trainees with disabilities when attempting WPBAs. The question yielded little in the way of information on specific adjustments. One school noted, explicitly, that rises in trainees declaring disabilities when sitting AKT or CSA did not correlate with increased numbers requesting reasonable adjustments in the workplace. It may be reasonable to conclude that WPBA-specific adjustments, over and above the more general ones described below, are rarely made or needed. Only one school described a WPBA-specific request *“..trainees with perception disorders claim it takes them longer to complete the e-portfolio and the reasonable adjustment they want is a lower assessment burden (which is not reasonable)’.*

Many schools report that requests for adjustments across the programme are on the rise, though we do not know what percentage of requests are granted. Requested adjustments include: part time working; placements close to home; altered hours of attendance (particularly for OOH training); IT support (for example voice recognition software); rest periods; accessibility (for example the provision of first floor consulting rooms); increased patient consultation times and increased time to complete practice administration tasks; specially adapted equipment (for example a specialised stethoscope for a profoundly deaf trainee, tinted glasses for a trainee with sight problems, specially adapted chairs).

In the vast majority of LETBs/deaneries consideration of requests for reasonable adjustments is undertaken at employer/LEP level with the support of Occupational Health Services. It is the responsibility of employing organisations, including GP practices, to provide funding for adjustments in the workplace. It is common for GP Schools to work with host employers to ensure that any necessary adjustments allow trainees to access educational resources appropriately and get the full benefit from them. This is particularly relevant if modifications are required to enable trainees to access the TeP. It is also common for GP educators to participate in LETB/deanery-wide groups considering the most complex cases. In many areas, a lead-LEP system is now in place for the totality of the three/four-year programme, thus streamlining and making more equitable the process for considering and agreeing adjustments. It may be, therefore, that schools are not aware of some of the adjustments being made in the workplace for WPBAs. However, given what schools have told us, we think this is unlikely.

### Guidance on good practice in WPBA

We reported last year on a review of the purpose and the content of good practice guidance for WPBA and ARCP Panels developed by the RCGP and a GP Deanery Assessment Leads Group (the DALs Group) that was formerly published on the RCGP web site.

There are obvious benefits in having a forum for WPBA experts to share their experiences and in developing and sharing guidance on best practice in WPBA. However, the interpretation and application of the guidance, by deaneries/LETBs and EAs alike, was inconsistent across the UK resulting in inequities for trainees. For instance, some ARCP panels were using the level of “best practice” as the minimum level required for CCT. The web-based guidance document has been removed from the RCGP web site and the formation of the SAC and closer cooperation between COGPED and the RCGP is providing an opportunity to review the guidance and the role of the DALs Group. A new modus operandi for the Group, now renamed the Deanery Assessment Reference Group (DARG), should ensure that it can continue to provide guidance on educational development and best practice and act as a forum for calibrating decision making between LETBs/deaneries, whilst not cutting across WPBA implementation locally. Any guidance from the group that merits formal adoption, nationally, will be first considered by the SAC. The DARG is drawing up guidance on what how to evaluate satisfactory trainee progression during the early years of training. An update will be provided in next year’s ASR.

## **Curriculum approvals updates**

**6** Please provide an update for actions in curriculum approval decision letters from August 2014 to September 2015

If your college/faculty have submitted a change to a curriculum and received a decision letter requesting further action or follow up, please provide a summary of all actions that are still outstanding/in progress.

Curriculum approval decision	Update
<p>Pending approval of a four-year GP training programme major changes to the GP Curriculum are on hold. However, the RCGP continues to adapt and improve the current three-year curriculum in response to feedback from stakeholders. In January 2015 a version with a simplified layout and improved content presentation was submitted to the GMC. The changes, described in the 2013-14 ASR, received GMC approval in January 2015.</p>	<p><u>Feedback on changes</u></p> <p>A variety of methods were used to communicate the changes to trainees, educators and examiners. The Curriculum/MRCGP blueprint document was revised to map to the new curriculum structure. Initial feedback from trainers and trainees was that the new layout is simpler to navigate and easier to relate to MRCGP assessments. These initial responses are strongly borne out by comments from GP schools submitted for this ASR many of which comment on the new version's clarity and conciseness. We note, in particular, support for the link to <i>Good Medical Practice</i>, the emphasis on capability rather than competency and the increased emphasis on leadership, organisational skills and health promotion. The focus on life-long learning is also welcomed. Some examples of comments from schools are as follows:</p> <p><i>'Emphasis on capability rather than competency is helpful in enabling trainees and trainers to discuss observed variations in performance level and articulate what development needs to take place and makes clearer the consistency of performance required for independent practice'</i></p> <p><i>'the 5 areas align with our experience of the core skills needed for GP. They are clearer in their meaning with good descriptors'.</i></p> <p>A couple of GP schools refer to the core curriculum statement <i>Being a GP</i> as a useful means of focusing learning at the outset of training as it '.... "walks them" through the training journey linking posts, identifying learning opportunities linked to the relevant sections of the community'. One school suggests that all GP schools should present the curriculum in this way to trainees as part of their induction into GP training.</p> <p><u>Online Curriculum</u></p> <p>As part of the process of writing this Report, the RCGP also asked schools to comment on the new Online Curriculum. Feedback was positive. Suggestions for further improvements focus on improvements to visual presentation – more use of graphics, infographics, diagrams and web casts to break up the dense text, and more use of colour and different font styles to help trainees with differing learning styles and those with cognitive processing difficulties. There are also requests for greater use</p>

of social media technologies and one school asks the RCGP to consider developing an app version. Two schools complain that the search facility produces illogical and irrelevant results. A request for an additional change to the Curriculum - a requirement that trainees attain level 3 competencies in safeguarding\* - was submitted during the reporting period, approved by the GMC and rolled out in August 2015.

#### Curriculum Review 2016

The Curriculum Editors have begun work on the 2016 review of the Curriculum. The areas to be considered will include:

- an equality and diversity review of the Curriculum as a whole and the production of a statement bringing together equality and diversity content
- the development of a gender health statement to replace the men's and women's health statements
- how to include 'missing' topics such as renal health
- a review of the knowledge base

#### Future changes

In their reports to the RCGP GP schools were also asked to suggest further improvements or changes to the curriculum. This feedback will be considered as part of further changes. Suggestions relate to curriculum areas not covered in sufficient detail (genomics, renal medicine/urology and haematology, occupational health, the UK health system and the place of primary care within it, including clinical commissioning). One school expresses concern that the current fitness to practise competency is inappropriately named; failure to demonstrate not equating with evidence that the trainee is unfit to be revalidated.

One school commends the RCGP "Bright Ideas" initiative and suggests that the RCGP's Curriculum Development Group could monitor this and changes within the New Care Models programme (Vanguards) and other initiatives to ensure that the curriculum remains fit for purpose.

\* Intercollegiate Guidelines 'Safeguarding children and young people: roles and competences for health care staff' (March 2014)

## **Confidential section**

One of our core organisational values is transparency. With this in mind we would like to ensure that you are content that the information you submit to us is publishable. We understand that in order for you to fully respond to the questions within the ASR you may need to provide sensitive information that you wish to remain confidential. Please provide this information below.