

Annual specialty report (ASR) 2016

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 May 2017**. Please submit your completed ASR by uploading it into your GMC Connect ASR 2016 folder. If you do not have access to GMC Connect or you have any other questions please email 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'. If you are using specialty-specific abbreviation or initialisation, please initially write the term out in full.

Question changes for 2016

Some questions have been altered to be clearer in intent following feedback from last year's ASR process.

We have added one question on fair training pathways.

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.

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 Local Education Provider level where local action has been insufficient to address the concern. 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 e.g. due to rota gaps
 - Educational supervision e.g. lack of time for training available
 - Resources to support for wider educational activity e.g. exam centres & examiners
 - Assessments systems - exams / WPBAs
 - Clinical supervision
 - ePortfolio
 - Access to educational resources e.g. 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	Action taken and outcome, including college and LETB actions	Suggested action
CUTS TO GP EDUCATOR WORKFORCE AND ADMINISTRATIVE INFRASTRUCTURE – COMPREHENSIVE SPENDING REVIEW IN ENGLAND		
<p>Following the Comprehensive Spending Review GP Schools in England have been asked by HEE to reduce running costs. This is likely to mean large cuts to GP educator and administrative workforces, posing a substantial challenge to the delivery of GP Training. Support for trainees in difficulty (TiDs) and activities that require significant administrative input, such as the ARCP process and GP recruitment, will be at risk. The cuts are being made against a background of continuing difficulties recruiting into GP training – a subject examined in detail in previous ASRs.</p>	<p>In letters to the Secretary of State for Health and the Chief Executive of NHS England, the Chair of RCGP Council argues that the cuts will exacerbate the concerns and unhappiness that junior doctors have already been expressing and send a message to trainees, and to the profession that the task of training the next generation of clinicians is not valued. The Chair of the College's Associates in Training Committee has written in a similar vein.</p>	<p>We know this will be of concern to the GMC which has been working with the RCGP to respond to the recommendations arising from the Judicial Review of the MRCGP CSA and we urge the GMC to express these concerns directly to HEE in strong terms.</p>
ACCREDITATION OF TRANSFERABLE COMPETENCES (ATC) PROGRAMME		
<p>The ATC programme was approved by the GMC for the training intake of August 2015 and is in its third year of operation.</p> <p>It was devised to attract trainees from popular specialties into less popular ones and could contribute to GP workforce</p>	<p>This year we collected information from GP schools on recruitment to the programme and sought feedback on how its governance and administration could be improved. Schools told us the following:</p> <ul style="list-style-type: none"> • changes in policy and guidance from HEE compromise the ability of those managing the application process to work effectively and efficiently; • a multiplicity of sources of information, inconsistencies between 	<p>This is the first year the RCGP has collected data on the ATC programme. We will consult with the GMC to improve the questions in future GP school templates, to enable the collection of more precise</p>

<p>expansion, facilitate movement into general practice from other specialities, result in better concordance of generalist skills in participating specialities and achieve modest cost savings from reductions in programme duration. This sort of flexibility is also congruent with Shape of Training objectives.</p> <p>Entry via the programme, into general practice was extended during the reporting period to include Acute Care Common Stem (ACCS) and Emergency Medicine. Trainees from seven specialities, meeting certain criteria, can now transfer into GP training. The specialty has been asked to add Ophthalmology and Public Health to the programme and the curricula for both specialities are being reviewed by GP Curriculum editors.</p>	<p>those sources of information, out of date information and ignorance of the application criteria and process amongst specialty school staff cause confusion for applicants;</p> <ul style="list-style-type: none"> • significant numbers of applications are received from trainees who are not in eligible specialities or not in recognised UK training programmes; two schools urge greater flexibility in the system to enable the exercising of discretion in unusual cases; • applicants for transfer do not always have the necessary competences and require a three-year GP training programme; • there is no telephone or online support for queries and no centralised office to deal with complaints and disputes; • unrealistic application deadlines mean trainees are unable to provide the required paperwork, particularly, confirmation of ARCP outcome; this has a knock-on effect on programme planning; • the online application form permits trainees to pick specialities they are not eligible to apply for and does not ask for key pieces of information (NTN, start date of training, last ARCP date and outcome) that would enable ineligible applicants to be sifted out. <p>Schools were also asked to summarise their reasons for rejecting applications. Most reported receiving applications from trainees from ineligible specialities and a significant minority from F2s or doctors in non-training grade posts. Other reasons were: failure at ARCP, out of training for too long, insufficient evidence provided with the application form/errors on the application form. Several schools also reported that some eligible applicants were offered a place but did not start, deferred entry, or opted to do a full three-year programme.</p> <p>Figures for applications and entrants into GP training for the last two years are given below, as are figures for originating specialities. Neither set of figures is completely accurate as one school has not been collecting the</p>	<p>information on the numbers of trainees coming from each incoming specialty, the numbers exiting GP training using the ATC route and the number of trainees against each of the criterion for rejection.</p> <p>A simplified, well thought through application process should be capable of being administered, in its entirety by administrative staff, without the need for input from clinicians. We hope the feedback in this report and any feedback we provide in the future will help those administering the programme to decide where to focus their energies, both in relation to advertising and recruitment, and in streamlining and improving process.</p>
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data (it will do so from now on) and one was not able to supply a detailed breakdown by “originating” specialty. Most schools report that 100% of entrants to the programme in 2015 were successful at their first GP ARCP and so have been permitted to continue on a shortened programme. Schools do not have precise figures on the numbers exiting GP training using the ATC framework, but report that there is a small outward drift.

	2015 entry	2016 entry
Applications received	328	389
Applications accepted	119	139

Figure 1: number of applicants accepted into GP training (data supplied by 16 of 17 deaneries/LETBs)

	2016 entry
ACCS	7%
Anaesthetics	17%
Medicine	47%
Emergency medicine	3%
O&G	9%

Paediatrics	12%
Psychiatry	5%

Figure 2: Percentage of accepted applications by “originating” specialty (data supplied by 16 of 17 deaneries/LETBs).

QUALITY ASSURANCE OF SECONDARY CARE CLINICAL SUPERVISORS

We have reported often in ASRs on variability in coverage of the GP Curriculum and poor contextualisation in secondary care as well as a lack of familiarity with the GP Curriculum and WPBAs on the part of secondary care clinical supervisors (SC CSs). The GMC in its own QA reviews has identified the same problem.

We have also reported on the involvement of GP schools in the training and approval of SC CSs.

Given the GMC now requires all named SC CSs to be trained and formally approved, we invited GP schools to update us by telling us if this new requirement had improved consultant engagement in the supervision of GP trainees.

Just over 50% of schools reported some improvement, a welcome and surprising development in the context of severe service pressures in much of the NHS. We also asked about consultant engagement with the GP CSR. While RCGP ARCP QA/QM data (see below) shows that GP CSRs continue to be better quality than those written by consultants, there are improvements across the board and, overall, the quality of SC CS CSRs is high. Some schools complain, though, that CSRs remain wholly generic and non-discriminatory, containing no formative feedback. There are also reports that many GP trainees continue to be supervised, for much of the time, by middle grade doctors, not the person completing the CSR, and that service reconfigurations are creating huge departments with a consultant body even less familiar than previously with their trainees.

A plethora of GP school initiatives aimed at engaging the consultant workforce has been met with varying levels of interest and the message from schools in this regard is, as in previous years, downbeat: Six schools continue to report that they play no part in training SC CSs and others that they provide educational opportunities for SC CSs but take up is poor. As in previous years, the activities that seem to be most successful in achieving SC CS engagement in the GP curriculum and WPBAs are those that already form part of routine deanery/LETB QM: joint visiting and joint primary/secondary care educator training days and networks; formal

As the RCGP is developing a new CSR with 7, rather than 17, questions, and focusing on the 12 GP curriculum competences/ capabilities it is hoped that we will continue to see improvements in the quality of SC CS CSRs. Indeed, feedback on the new format has been positive. The new CSR will also have an Assessment of Performance question which asks about the level of supervision needed in the post. It is hoped that the new form will be introduced in the summer of 2017.

GMC evaluation of the success of its new requirement for the formal approval and training

	<p>meetings involving all specialty schools.</p> <p>Schools told us about some initiatives, not previously reported on:</p> <ul style="list-style-type: none"> • a Charter for GP Training in which SC CS engagement with the GP CSR is a success criterion; • hospital departments with consultants with specific responsibility for GP trainees (reported to be particularly helpful in identifying and supporting struggling trainees); • a booklet for SC CSs on how to complete CSRs, given to all CSs at the start of a trainee placement; • monthly drop in sessions for SC CSs run by local GP educators; • GP training champions to promote GP training in hospitals. 	<p>of all named clinical supervisors should include scrutiny of consultants' role in supervising and assessing GP trainees as well as trainees in other specialities.</p>
<p>POST AND PROGRAMME APPROVAL</p>		
<p>All applications for GMC-approval of new posts and programmes require the written support of the College. The RCGP has worked with the GMC to improve the approval process: revise application forms, put time limits on approvals and move College involvement to post-approval QA. The intention was to trial a new approach with a small panel of colleges, including the RCGP, and deaneries/LETBs from early 2016. The trial did not take place and the process is being re-thought.</p> <p>It continues to be the College view that the process is overly bureaucratic. Further, while the RCGP welcomes school support</p>	<p>GP schools were invited to comment on the risks and benefits were the RCGP role in post and programme approval to change to one of post hoc QA, rather than pre-approval/recommendation. 14 of 17 schools responded but responses were too varied to enable us to conclude that schools' have a preferred model. Many criticised the bureaucratic nature of the process and would like GMC forms to be redesigned to be more appropriate to primary care. A minority expressed concern that removing the RCGP risked the process becoming ever more generic and inappropriately focused on secondary care. One asserted that leaving the GMC to manage the process without College input risked judgments that <i>'fail to balance regulatory imperatives with operational realities'</i>. Just over 50% of respondents said the College did not need to be involved because sophisticated local QM, with GMC scrutiny, is now the norm. Two commented that the College role appears simply to be a tick box exercise; another that College input did not add value as the College has no mechanism for gaining a detailed knowledge of the training environment it</p>	<p>The College would like the GMC to rethink the process of prospective post and programme approval. We believe it may be grounded in an over legalistic approach and a continued lack of understanding of the differences between the governance of GP training and that of other specialities. For reasons explained in previous ASRs, the RCGP does not have local networks of training provider-based educators meaning it does not have</p>

<p>for our specialist input, it believes it is being required to make important decisions, and put a formal imprimatur on individual approvals in the absence of robust information to support decision making, putting the College at risk if a post or programme falls below the required standards.</p>	<p>is approving.</p> <p>So, very few schools are concerned that there is a risk in the College not being involved. A number want the process to be reviewed to better reflect the nature of primary care training, and a number see the benefits of a high-level role for the College in setting standards and assisting the GMC in drawing up, and regularly reviewing, approval guidance and paperwork</p>	<p>ready access to independent sources of information on the likely quality of a new post or programme and so is unable to triangulate effectively, the information supplied by deaneries/LETBs. It is our view that the other mechanisms that make up the GMC's QA process should be sufficient to meet regulatory requirements.</p>
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TRAINING IN OUT OF HOURS (OOH) GENERAL PRACTICE

<p>GP OOH training continues to be an area of risk with variations persisting in the way in which GP schools QM OOH placements and clinical supervisors, and in the methods for assessing trainees in OOH work.</p> <p>Achieving consistency UK-wide is hampered by differences in the way OOH care is delivered around the UK and by frequent changes in OOH providers. Training is expensive and training needs often ignored when GP OOH contracts are put out to tender. Repeated attempts to impose</p>	<p>COGPED is undertaking a major review of its guidance on GP OOH training, looking afresh at how OOH competences are attained in the context of changes to OOH work. New guidance will need to encompass GMC generic professional capabilities and must also consider any recommendations from the GMC's 2016 review of GP training.</p> <p>Also, driving the review are changes to the Junior Doctors' contract in England, which are making the planning and provision of OOH training more complex: time spent training in OOH is now deducted from the normal working week, thus reducing the hours spent training, overall, and in OOH settings. This, in turn, is adding urgency to discussions on the settings in which OOH competences can and should be obtained.</p>	<p>A fundamental review of guidance on OOH training – its delivery and QA/QM is timely. There are opportunities and threats for OOH training in the new Junior Doctors' contract. In England aspects of the GP Curriculum related to OOH competences may also need review.</p> <p>The GMC is scrutinising the delivery of OOH care as part</p>
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<p>consistency and engage Government in England in securing adequate and stable OOH training provision have been unsuccessful.</p> <p>The GMC's view that because OOH training is done on a session by session basis it does not require the same level of scrutiny as other aspects of training, compounds the difficulties described.</p> <p>RCGP QM finds marked differences both between, and within, schools in the quantity and quality of evidence detailing a trainee's competence in OOH. This year RCGP review of ARCP Panels found examples where OOH evidence was lacking and it was unclear how the decision that a trainee was competent for OOH practice had been reached.</p>	<p>There are pockets of good practice and the GMC has, for example, recently reviewed and commented favourably on the QM of OOH training in Northern Ireland.</p>	<p>of its 2016/17 review of GP training and we hope for constructive and helpful recommendations on how this area of GP training should be quality managed and GMC quality assured in the future.</p> <p>In acknowledgement of concerns about OOH training and assessment and, as part of the wide scale review of WPBA described below, the RCGP will consider developing a WPBA focused on OOH competences. The RCGP and COGPED are also developing a proposal to create an ePortfolio form for recording OOH sessions.</p>
<p>GMC ENHANCED MONITORING</p>		
<p>The most recent set of GMC enhanced monitoring data includes only posts/programmes in secondary care and none of them are classified as being GP-relevant.</p>	<p>The absence of reference to GP trainees in the enhanced monitoring data is an error: particularly in some of the small and remote training providers, it may be that most, if not all, trainees are in a GP programme.</p>	<p>The GMC has regulatory responsibility for approving, as fit for training, posts and programmes for all trainees. It should ensure that, where GP trainees are training in posts/programmes under</p>

		scrutiny, the classification of the problem includes general practice and GPs are involved in monitoring arrangements.
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2. External advice provided to LETB / Deanery processes

Please describe your involvement in the LETB/Deanery ARCP or Visit processes since the ASR submission in March 2016 including any changes in your externality process, and a summary of the number of ARCP panels and/or proportion of trainees whose ARCP has been observed by a college or faculty external advisor.

- Please list any training programmes which have not been provided with the minimum external advisor input required to ARCP panels and outline the reason why, e.g. not requested or too late notice.
- Please describe any issues your external advisor has identified around the delivery of the ARCP process for the training programme under review
- Please describe any concerns your external advisor has identified in the delivery of the curricula and assessment systems in the training programme under review and describe what action which has been agreed as a result and when the issue is expected to be resolved.

External Advisor processes are described in the following documents:

- Academy of Medical Royal Colleges: 2010 statement on external advice from medical specialists: <http://www.aomrc.org.uk/publications/reports-guidance/jactag-external-advice-from-medical-specialists-0310/>
- COPMeD: Gold Guide 2016 – page 70 <http://www.copmed.org.uk/publications/the-gold-guide>

Description	Outcome
QUALITY MANAGEMENT OF THE ARCP PROCESS	

The RCGP continues to QA/QM GP school ARCP panel reviews. A sample of ARCP Panel reports and associated ESRs and CSRs are reviewed. Evidence in the 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):

1. observes a sample of ARCP panels across the UK; EAs complete a feedback report describing what went well and areas for development. 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

The quality of GP ESRs, CSRs and ARCPs remains high and continues to improve year on year. The percentage of ESRs of acceptable quality increased to its highest point since the College introduced its QA/QM processes. Problems generally relate to a lack of written suggestions for a trainee's further professional development in the year after award of the CCT. For the first time, over 80% of CSRs were found to be of acceptable quality. In most schools, GPs produce better CSRs than secondary care consultants but both GP and consultant CSRs are improving.

The highest ever percentage of ARCP outcomes with sufficient TeP evidence was also recorded this year. The number of ARCP panel reports without recent ESR reports decreased during 2016 and where there was insufficient evidence it was usually because the trainee had failed to engage in the completion of the PDP. There were some examples of missing CEPs or a CEP assessed by someone not qualified for this task. This data is tabulated below.

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%
2016	3171	66.9%	76.7%	7.4%	94.8%	80.06%

Figure 3: Summary of RCGP QA/QM statistics for all GP schools: 2010-2016

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

ARCP panel reviews lead to an unsatisfactory outcome in 19.36% of cases with more unsatisfactory outcomes in ST1 and 3 than in ST2. It is possible that this is because many trainees do a placement in general practice in ST1 and it is generally easier to identify performance issues in the WPBAs done in primary care. An analysis of what placements/specialties are

comment on the data;

2. participates in the central checking of a sample of ESRs, CSRs and ARCP panel reports. In line with Gold Guide requirements, 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). All OOP Outcomes (Outcomes 7, 8 and 9) are excluded.

Here 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. It includes the data requested by the GMC: 3171 ARCPs were reviewed during Central Checking sessions, which was 26.1% of the total ARCPs

more likely to lead to an unsatisfactory outcome would provide evidence to support this supposition. Further, there are no absolute definitions of the competence levels required at the end of ST1 and ST2 and reaching a decision that progress has been unsatisfactory in the early stages of GP training, may be difficult or inappropriate, except in the most extreme cases. It is important to understand that the development of competence is often simply stalled or developing more gradually than expected. ARCP outcomes by training year are given in the graph below.

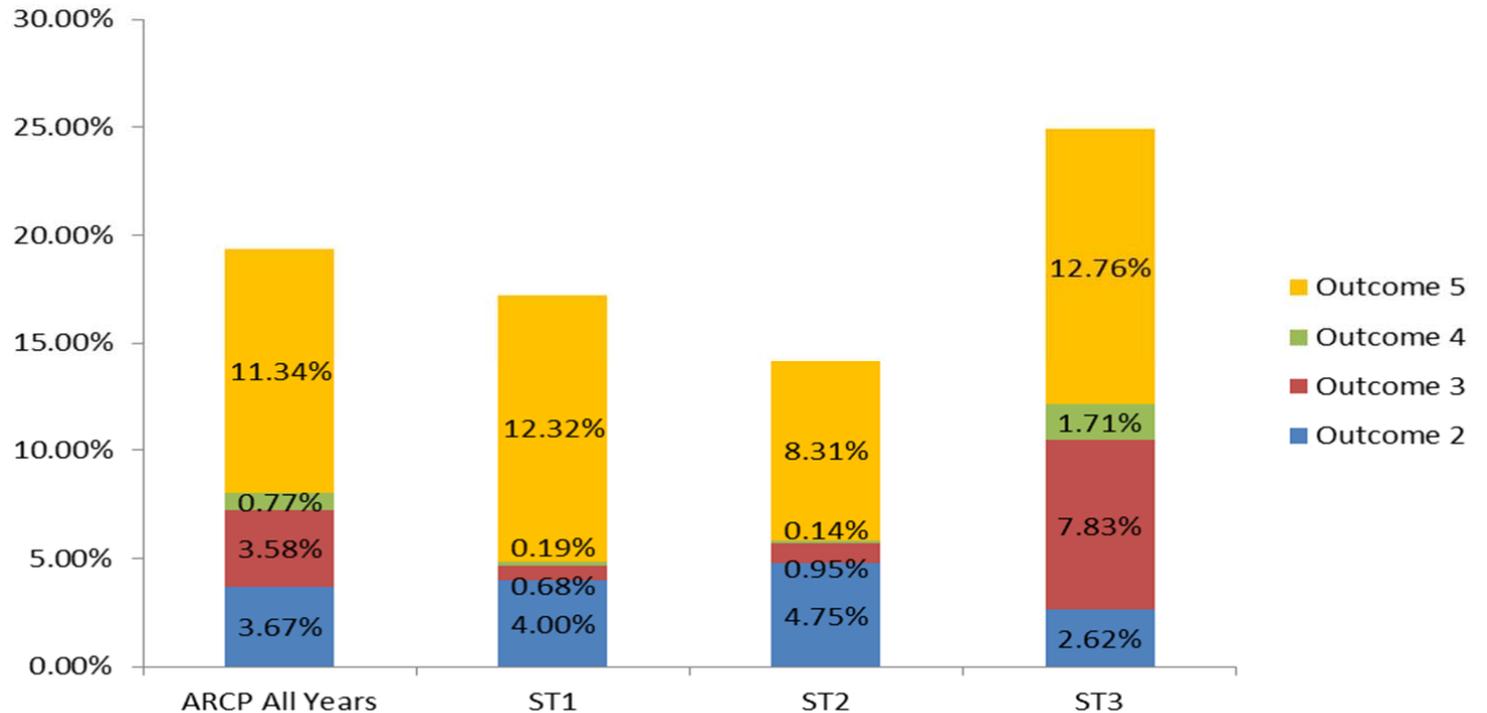


Figure 4: Unsatisfactory ARCP panel review outcomes % per trainee year: 2016

The number of Outcome 5s, as a proportion of all outcomes awarded, decreased a little but remained relatively high. This is because large numbers of Outcome 5s continue to be awarded when trainees fail to submit correctly completed Form Rs (or equivalents in devolved nations), fail to complete the GMC NTS, or fail to comply with deanery/LETB-specific, local standards. We think it likely that in other specialties ARCP outcomes are also affected by changes in local and/or national requirements year on year, but, as other medical royal colleges do not operate QM processes at the level of scrutiny of

awarded during the review period. We can also confirm that all GP training programmes have been provided with the EA input required by the Gold Guide. Concerns identified by RCGP EAs are summarised here, and described in more detail in the appended report.

Changes being made to the RCGP's QM of ARCPs are described in the Good Practice section in this report.

general practice, this data is not available. In our 2014-15 ASR, we alerted the GMC to our concerns that the imposition of additional professional requirements at ARCP was resulting in inequity for GP trainees and a skewing of our ARCP QM data. We urged the GMC to provide guidance, arguing that, at the very least, considered and careful consultation should be required before further changes are made to professional requirements.

Many schools continue to experience time pressures managing ARCP panels simply because of volume and/or because administrators have been unable to complete basic checks pre-panel. One suggests that an agreement, nationally, on what these checks might include would be helpful. Panels also waste time trying to find mandatory evidence uploaded into the wrong section of the TeP. Schools often struggle to undertake calibration exercises and provide comprehensive feedback to ESs on their ESRs. Most schools continue to screen TePs before panel, but the methods used vary from a simple check on the presence of mandatory evidence, to a process, in one, where the Panel Chair or panel members undertake a much more time consuming and detailed exercise than the norm – presenting the panel with an excel spreadsheet covering mandatory evidence, CEPS and DOPS, the PDP, AKT and CSA scores, feedback scores, SEA, audit and comments on the quality and quantity of log entries and the quality of the ESR.

There are marked variations, both between schools and between programmes within a school, in the quantity and quality of evidence detailing a trainee's competence in OOH activity. Where OOH evidence is absent it is not clear how the ARCP panel has reassured itself that a trainee is ready for safe post-CCT OOH work.

While, in this report, we provide only a summary of some aspects of national ARCP QM data, the full QM report goes into detail about individual deaneries/LETBs and shows discrepancies between them, for example in relation to the number of ARCP O1s and O4s. The explanations for these differences are multifactorial: for example, deaneries/LETBs take different approaches to awarding O5s; the proportion of trainees in difficulty (TiDs) varies significantly by geography and a wide variety of support arrangements are deployed for trainees in difficulty. There are several sets of data (on recruitment, progression and outcomes, including RCGP ARCP data) that, analysed together, could produce useful data on differential attainment and the effectiveness of support arrangements. We urge the GMC to think again about undertaking research looking at the factors lying behind differential attainment and at how, it can be mitigated and in so doing to consider the benefits and risks of making recruitment data – which currently has restricted circulation - more widely available.

3. Variation in attainment between training programmes

Please provide an update on the actions you described in your March 2016 annual report which arose from your identification of variation in attainment between training programmes based on the progression reports published by the GMC.

Please also outline any further actions you plan to undertake to understand or address any new concerns you have identified since the data was updated in summer 2016. You can view the reports here: <http://www.gmc-uk.org/education/25495.asp>

Comment	Action
These reports provide additional information relevant to our comments on the MRCGP (see below) and work we have been doing and reporting on for several years to support trainees in difficulty.	Rather than providing new information, these reports support our understanding of issues we are already exploring. However, we recognise that these are a potentially valuable initiative and will continue to keep them, and our use of them, under review.

4. Fair training pathways for all

Please provide a summary of your work to understand the factors contributing to differences in attainment at training milestones between cohorts of doctors who share protected characteristics. Please describe any actions you are taking to attempt to address the issues you have identified across training milestones such as ARCP and specialty exams and how the impact will be monitored over time:

- Our research Fair training pathways for all: Understanding experiences of progression <http://www.gmc-uk.org/about/research/29485.asp> identified that key challenges for BME doctors is access to learning or support and the relationship between education supervisors and doctors in training
- We would be particularly interested to hear about your activity in the following areas:
 - whether you train examiners in unconscious bias

- how you monitor examiner performance
- how you support both trainers and trainees to understand what is required from your programme of assessments
- whether you cover issues around differential attainment in training you provide for educational or supervisors or those undertaking workplace based assessments

Activity area	Comment	Action
RCGP SUPPORT FOR TRAINEES IN DIFFICULTY		
<p>The College continues to consider and act on the recommendations in the Judgment of Mitting J in <i>Bapio v RCGP and GMC</i> [2014] (the JR judgement) on the MRCGP CSA. It also continues to scrutinise and refine its policies and processes to ensure they comply with the requirements of the Equality Act more generally.</p> <p>It is important that a focus on inclusion is retained and that work in this area continues to be carefully recorded. The ASR is one of the mechanisms for doing this.</p> <p>The work being done by deaneries/LETBs to support TiDs is described below.</p>	<p>The GMC already has a great deal of information on the RCGP's approach to understanding the factors contributing to differences in attainment in GP training:</p> <ul style="list-style-type: none"> • We have reported in detail in all ASRs on how MRCGP assessments are scrutinised and developed to ensure they meet GMC standards, are fair, embrace best practice in assessment methodology and test the competences required of GPs practising in the NHS; • MRCGP Annual Reports, published on our web site and shared with the GMC, include commentary on outcomes broken down by deanery/LETB, primary medical qualification and protected characteristics. The most recent report is appended to this ASR and shows, as in previous years, patterns of differential attainment akin to those found in all UK postgraduate assessments, but also a reduction in the differences in attainment, in the CSA, between UKGs and IMGs; • The GMC commissioned a review of the MRCGP in 2013 and has subsequently worked with the 	<p>In summary, during the reporting period, a College-wide review of equality and diversity led by RCGP chair delivered the following:</p> <ul style="list-style-type: none"> • Monitoring all protected characteristics for all members, including Associates in Training and examiners; • A review of committee membership • Public Sector Equality Duty training (either face to face or via a specifically designed e-module) for all those involved in decision making, including clinical leads and committee members; • The implementation of a process for the equality analysis of decision making (a form of Equality Impact Assessment). <p>More information is contained in the assessment and curriculum sections of this report.</p>

	<p>College to review the recommendations in the review report;</p> <ul style="list-style-type: none"> • Latterly we have also reported, in ASRs, on how the GP Curriculum has been developed to ensure that it complies with the Equality Act and reflects the needs of all patient populations. 	
DEANERY/LETB SUPPORT FOR TRAINEES IN DIFFICULTY		
<p>The JR judgement, as well as RCGP and GMC reviews of the AKT and CSA which reported around the same time, concluded that the CSA was legal and fair and that interventions to help TiDs should focus on training arrangements locally.</p> <p>Providing support for TiDs continues to be a resource-intense activity for deaneries/LETBs. GP schools are under pressure to show that the range of interventions they have developed and implemented to support TiDs are effective.</p> <p>Appended to this report are the RCGP's 2015 and 2017 discussion</p>	<p>Pass rates in both the AKT and CSA have improved in recent years and the number of ARCP outcome 4s is going down: as a percentage of total trainee numbers, from 1.6%: in 2012-13, 1.29% in 2013-14, 1.06% in 2014-15 to 0.77% in 2015-16. We do not know for sure what lies behind these improvements. It is likely that the support mechanisms in place in schools, and the guidance and support developed by the RCGP for trainees and educators, and described in MRCGP Annual Reports and ASRs are contributing to improving standards. It is also possible that the appointment of more able trainees, more rigorous selection with higher standards and/or better exam preparation are also contributing to improved outcomes. Improvements in outcomes do not mean, however, that the specialty should become complacent.</p> <p>During 2015 a COGPED-led Task & Finish Group reviewed the implications of the JR judgement for deaneries/LETBs and made recommendations for best</p>	<p>Themes emerging from the 2015-16 school data are as follows;</p> <ul style="list-style-type: none"> • In most schools support for TiDs is in a steady state. This may be because outcomes are improving, memories of the JR are fading and GP schools are under, not only increasing financial pressure, but pressure to come into line with other specialty schools, thus compromising the will and ability to innovate; cuts to the GP educator workforce above the level of trainer and to the administrative infrastructure would put considerable pressure on schools' capacity to provide support; • There continues to be relatively little in the way of published research into the effectiveness of the interventions; the explanation being that evaluations are

<p>papers describing deanery/LETB support for TiDs¹.</p>	<p>practice in key aspects of training body activity. To demonstrate continued scrutiny of support arrangements and to inform the 2015-16 ASR, GP schools were asked to report to the RCGP on progress against those recommendations and to answer some additional questions on trainee outcomes. What deaneries/LETBs have told us is described in an RCGP discussion paper which updates a similar paper published in 2015. Both will be considered at an RCGP seminar on support for TiDs that will take place in later in 2017.</p> <p>Accepting that evaluating the effectiveness of deanery/LETB interventions to support TiDs is complex, some sort of scrutiny is important, not least for reasons of equality and diversity but also to avoid data from uninformed sources being used inappropriately to make bad decisions. A paper published in <i>Medical Teacher</i> in late 2016² describes a methodology for working out which deaneries might offer better “value-added”, overall. The data lying behind the research relates to one year’s GP training intake (2007/output 2010), from just over half of all UK GP schools. It reviews AKT, but not CSA, outcomes. The researchers stress that the research is not intended to identify individual schools as</p>	<p>extremely difficult given the number of interventions in place for any one trainee at any one time; other confounding factors, such as trainee personal circumstances further complicate. In January 2014 the RCGP made an outline proposal to the GMC and HEE for a research project that would seek to improve outcomes for those at greater risk of failing the MRCGP, taking into account the range of interventions in UK deaneries to improve candidate performance, and known differential candidate examination performance according to candidate subgroups. This proposal was overtaken by GMC plans for a cross speciality evaluation, which was then not taken forward</p> <ul style="list-style-type: none"> • Examples of good practice sharing <i>between</i> GP schools nationally or between specialties within a deanery/LETB are few in number; there are many reports of good practice sharing between GP programmes in the same deanery/LETB. To a certain extent COGPED acts as a forum for good practice sharing and there have been COGPED
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¹ [Support for Struggling GP Trainees, Discussion Paper](#). RCGP, April 2015 and [Identifying and supporting at risk and struggling GP Trainees Discussion Paper 2](#). RCGP April 2017 (appended to this report)

² [Exploring the value-added of postgraduate medical education: A preliminary evaluation](#). Med Teach. 2016 Oct;38(10):1003-1010. Gregory S, Patterson F,3, Baron H, Knight A,4, Walsh K, Irish B, Thomas S.

	<p>low or high performers but is an attempt to find a methodology that could be used in the future, saying '<i>value-added evaluations [could be used] as confidential quality improvement tools rather than as summative judgements</i>'. However, the researchers also note '<i>... significant differences in the value-added score between regional training providers</i>', the data showing that one deanery falls way below expected vs. actual performance. The power of such data to influence Government and those responsible for funding GP training should not be underestimated.</p>	<p>workshops on TiD support, but there is unhappiness about the demise of the UKCEA and reductions in funding, more generally for conferences and seminars which provide a better forum for good practice to be considered. The Developing Excellence in Medical Education Conference is reported to be a less effective forum for sharing good practice in GP education;</p> <ul style="list-style-type: none">• While trainees come to deaneries/LETBs with a ranking and SJT score, there is a lack of clarity about whether LETBs (England only) are permitted to use this data to allocate trainees at risk to appropriate programmes and trainers in order both to offer the trainee a high level of support and avoid over burdening particular geographical areas with high levels of at risk trainees. An HEE initiative to increase the number of trainees placed in their first or second choice of locality, thus favouring more popular programmes, is a complicating factor. There is a dilemma between doing what is best for the trainee and the patient and doing what increases numbers.
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5. Programme Specific Questions (National Training Survey)

Please provide an update on any actions you identified in your March submission to address issues identified through your Programme Specific Questions in the NTS or other data you collect. Please also highlight any new areas of concern which have been identified around the implementation of your curricula or assessment systems.

Activity area	Comment	Action
No new issues identified		

6. Good practice

Please let us know about initiatives that you have successfully implemented or identified with individual Deanery/LETBs since your last ASR submission. Initiatives should have been completed or piloted and evidence available to demonstrate a positive impact.

Good practice is defined in our Quality Assurance 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 e.g. the validation of educational supervisors training in a bid to identify a benchmark for trainer standards, or within one deanery or LETB e.g. 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.

Description	Development of actions	Other potential use
REVIEW OF THE RCGP ROLE IN THE QA/QM OF TRAINING		

<p>As reported last year, the College's bi-annual quality check of a sample of ARCP outcomes, ESRs and CSRs, has helped to produce consistent national standards and provided stimulus to promote change locally. It has, however, also been administratively burdensome and resulted in some duplication of activity. In the context of GMC and Gold Guide guidance, the RCGP and COGPED have reviewed the process and the RCGP's QA/QM role more generally</p>	<p>The review concluded that:</p> <ol style="list-style-type: none"> 1. the scope of the detailed checking of ESRs and CSRs should be reduced and the RCGP's team of EAs should focus on the WPBA tools that merit closer scrutiny, providing enhanced formative feedback on those areas. During 2016-17 CEPs, introduced into the trainee ePortfolio (TeP) in January 2015, will be scrutinised. 2. the RCGP should, from time to time, invite schools to describe how they undertake a QM/QC activity. Where the information received causes concern or describes what may be good practice, a sample of schools may be scrutinised further either by seeking additional written information and/or by an EA visit. <p>The decision to scale back the detailed checks on ESRs and CSRs has not been universally welcomed with some arguing that standards will fall. These changes will be kept under review; one of the agreements on the new processes being that RCGP QA/QM should be flexible enough to change as need dictates.</p> <p><u>Schools' quality management of ESRs and CSRs</u></p> <p>As part of this year's ASR process GP schools were asked to describe how they QM ESRs and CSRs and about their use of feedback from the RCGP's central checking process.</p> <p>As anticipated, a wide variety of QM mechanisms were reported, some clearly dictated by size of deanery/LETB and by pan-deanery/LETB structures. ESRs are reviewed by ARCP panels, in most areas against a set of criteria. In at least five schools criteria are the same as those used in RCGP central checking. Two schools report on the development and piloting of new criteria/checklists and one that a score is given against each criterion and an overall mark for ESR quality. Four schools report that, in advance of ARCP panels, TPDs review all ESRs and provide comments to inform the ARCP panel. It would be useful to know whether all schools use set criteria/a checklist and undertake pre-checking. For reasons of fairness,</p>	<p>Our model is transferrable to other specialties and the RCGP has, at the GMC's request, presented on the model to other colleges.</p>
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introducing some consistency nationwide could be considered.

There is also significant variation in schools' approaches to providing individualised feedback to educational supervisors (ESs) on ESR quality with some citing resource pressures as a barrier. In most, ESs receive feedback every year. However, in one feedback is given only once every three years and in another only to ESs supervising ST1 and ST3 trainees. Three schools report giving individualised feedback only to the ESs who produce poor quality ESRs. There are also variations in how schools deliver negative feedback, though we did not receive enough information in this area to reach any conclusions about what is common practice. In one school, negative feedback is reviewed centrally by the school beforehand. In another it is delivered on a one to one basis by the TPD. In three schools the ES is contacted by an associate GP director and asked to seek guidance from their trainers' group. Again, the RCGP and/or COGPED could consider what might be best practice in this area with a view to achieving greater consistency nationwide. What schools told us is consistent with the observations of RCGP EAs, as described in the RCGP's ARCP QA/QM report, appended.

Other school QM mechanisms, that may be examples of good practice and merit further investigation, are as follows:

- Trainer workshops used as fora for reviewing ESRs and for trainers to engage in benchmarking;
- Programmes receiving feedback on ESR quality benchmarked against the school;
- Data on the overall standards of ESRs and CSRs collated and used in general feedback and trainer training;
- Trainees asked on programme visits about the quality of CSRs and ESRs and feedback given to TPDs;
- Scrutiny of ESRs being built into the ES/practice re-approval cycle.

GP school involvement in the QM of CSRs is, unsurprisingly, more limited. Only three report providing individual feedback to secondary care clinical supervisors (SC CSs). However, other

	<p>mechanisms are described: poor CSRs discussed with the local training provider; poor CSRs referred to the TPD to investigate; where the CSR is particularly good, feedback given to try to encourage the sharing of good practice between SC CSs. One school would like a UK-wide framework for providing CSR feedback. This may be something the RCGP and COGPED could consider. As described below, a new and simpler CSR, developed by the RCGP, is being piloted which, it is hoped, will improve SC CS engagement.</p> <p>Schools were also asked how they use the feedback from RCGP central checking and how it might be improved. All schools review the feedback and most appear to find it useful, though two report that they don't always agree with it, one saying it is not forwarded to local educators as it is '<i>badly worded and contentious</i>'. It is common for RCGP feedback to be used as part of the training programme for ARCP panel chairs and members. In many schools, it is also presented at annual trainers' conferences and/or local educator workshops. In most schools the feedback is also considered more formally by school boards and specialty training committees. The following suggestions for improvements will be reviewed by the College QMTS team:</p> <ul style="list-style-type: none"> • The feedback needs to be communicated to schools more quickly; • Link feedback to written policy or additional further reading; • Focus on developmental comments not adequate/inadequate decisions; • Delegate to local teams feeding-back to ESs; • Review the ESR quality criteria in line with recent changes to the ESR; • Target specific areas each year e.g. OOH, safeguarding; • Collate a summary of themes emerging across the UK. 	
<p>GP TRAINING STANDARDS/<i>PROMOTING EXCELLENCE</i></p>		
<p>We reported last year that the RCGP and COGPED would develop new, GP-</p>	<p>Current guidance contains standards for the three key categories of educator responsible for supervising GP trainees (GP CSs, ESs and TPDs) and, in common with the GMC's framework for trainer approval, uses the Academy of Medical Educators <i>Framework for the Professional</i></p>	<p>The RCGP and COGPED will set up a short life working</p>

<p>specific training standards that would be less detailed than current guidance³ and structured to be read "beside" <i>Promoting Excellence</i> with clarification/amplification of individual standards where necessary.</p>	<p><i>Development of Postgraduate Medical Supervisors</i> of 2012.⁴⁵ It is not, therefore, envisaged, that major changes will be made to GP educator standards as part of the review of GP-specific guidance.</p> <p>To inform this review all GP schools were asked whether <i>Promoting Excellence</i> was a useful framework for their own QM/QC processes and if they had developed new standards/criteria following its publication. Almost all reported that it is and that, unlike <i>The Trainee Doctor</i>, is sufficiently relevant to general practice to enable GP schools to extract the relevant elements and apply them to the GP training practice. Only one school complains that it is too secondary care focused; another that it is too long and repetitive, requiring significant distillation to be used as part of GP QM.</p> <p>Schools have taken a variety of approaches to embracing the new standards: they have drawn up completely new GP standards in line with <i>Promoting Excellence</i>, adjusted the terminology and phraseology of existing guidance to mirror <i>Promoting Excellence</i> or mapped existing criteria to the requirements in <i>Promoting Excellence</i>. One school reports that the criteria in <i>Promoting Excellence</i> have also been used to draw up an accreditation process for GP out of hours training placements.</p>	<p>group to develop the new guidance.</p>
<p>QM OF APPLICATIONS FOR A GP CCT</p>		

³ <http://www.rcgp.org.uk/training-exams/mrcgp-information-for-deaneries-supervisors-and-trainers.aspx>

⁴ <http://www.medicaleducators.org/index.cfm/linkservid/C575BBE4-F39B-4267-31A42C8B64F0D3DE/showMeta/0/>

⁵ The GMC has adopted the same framework for the approval of trainers. It has said that it will not be altering its trainer requirements in line with new AoME guidance, which has superseded the Framework: *Professional Standards for medical, dental and veterinary educators, October 2014*

<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>For now, the RCGP continues to check all CCT applications but the process has been, and will continue to be, rationalised. This year GP schools were asked for feedback on the peak application period and, in response, further process refinements were introduced. Although a number of applications have to be returned to deaneries/LETBs as they contain errors, it is our view that these refinements are both appropriate and safe in the context, overall, of the maturing of processes at the College and in deaneries/LETBs whose completion of ARCP forms improves year on year. In themselves these refinements are not intended to contribute towards a more rapid turnaround in CCT applications – turnaround is already very swift and confounding factors such as the concentration of ARCP panels across the country into shorter time periods have a more significant effect on turnaround times than a streamlined checking process could ever hope to have.</p>	<p>In the context of improvements locally in both the ARCP process and CCT applications we continue to question whether undertaking these detailed checks is an appropriate role for a royal college and, if at some point in the future, the RCGP should assume a QM/QA role more akin to its ARCP QM activities.</p>
<p>MRCGP</p>		
<p>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. An annual report on the MRCGP⁶ includes</p>	<p><u>General</u> Joint working between the RCGP and the Academy of Medical Royal Colleges to produce guidance for trainers and assessors including:</p> <ul style="list-style-type: none"> • Guidance for trainers on giving feedback including advice on cultural sensitivity aimed at optimising a supportive training environment (working group in progress); • Guidance on reasonable adjustments for disabled candidates in high stakes assessments (working group in progress); • Guidance on unconscious bias for assessors (planned working group). <p>Joint working between the RCGP and BAPIO, BIDA to support IMG trainees:</p> <ul style="list-style-type: none"> • RCGP and BIDA joint working to develop the BIDA Trainee Support Programme and BME leaders; • The Chief Examiner took part in a session on women leaders at the BAPIO conference in 	<p>It is essential that the RCGP continues to work with key stakeholders, including BAPIO and BIDA, to prioritise research and development in all aspects of differential attainment in the MRCGP. Work to date has largely focused on differential attainment on the basis of PMQ and ethnicity. It is important, also, to consider the performance of candidates in relation to</p>

⁶ <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports/mrcgp-annual-reports-2015-2016.aspx> (appended to this report)

<p>assessment outcomes broken down by deanery/LETB, place of primary medical qualification and protected characteristics.</p> <p>Here we provide an update on actions taken by the RCGP during the reporting period to ensure continued compliance with the PSED in the delivery of the MRCGP. We also report on MRCGP developments more generally.</p>	<p>November 2016.</p> <p>Work with the GMC to review progress meeting the recommendations in the Esmail and Roberts review of the MRCGP⁷.</p> <p>A new examiner recruitment process to encourage applications from underrepresented groups.</p> <p>Further exam preparation resources for trainees, ESs and TPDs have been published.</p> <p>A joint RCPsych and RCGP event for educators on supporting IMG trainees was held in December 2016.</p> <p>Work being done to analyse data on complaint outcomes based on protected characteristics is at an early stage and will continue.</p> <p>The MRCGP examiner conference in September 2015 included sessions on both disability and unconscious bias.</p> <p>Two recent publications (appended to this report) - <i>Making Assessment Fair in the MRCGP</i> and <i>Promoting High Quality Research on the College's Assessments - A Summary of Research on the MRCGP</i>⁸ - summarise research and development related to the CSA and AKT and record the RCGP's commitment both to developing its exams to ensure they embrace best practice and to continuing to investigate the reasons for differential performance between British trained doctors and those who qualified elsewhere.</p> <p>Late in 2015, the RCGP hosted a cross specialty/patient/lay seminar on assessing</p>	<p>other protected characteristics such as sex and disability and in other assessments including WPBA and at ARCP.</p> <p>The causes of differential attainment are complex, multifactorial and poorly understood (see above), but there is increasing evidence that a supportive training environment, peer and family support and an appropriate work life balance are key to performance. It is also essential that all those involved in making judgements about trainees' progress in the workplace or in high stakes assessments receive training about cultural issues and unconscious bias.</p> <p>The GMC is asked to consider, in any new generic guidance on WPBA, the views of GP schools summarised here on:</p>
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⁷ http://www.gmc-uk.org/MRCGP_Final_Report__18th_September_2013.pdf_53516840.pdf

⁸ <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports.aspx> (both papers are appended to this report)

interpersonal skills in the MRCGP. An internal paper - Foreman P, Denney ML. *Assessing Interpersonal Skills in the Examination for Membership of the Royal College of General Practitioners (MRCGP)* was published January 2016.

AKT

The structure and delivery of NHS general practice in the four nations is diverging, making the development of AKT health informatics and administrative questions increasingly problematic. The AKT team is developing items to test practice finance/business skills.

The terms of reference of a reconstituted AKT Adjudication Committee has allowed more stakeholder engagement and externality between formal standard setting processes.

The impact of dyslexia on AKT pass rates is being reviewed and a paper is currently in peer review.

Adjustments for candidates directly affected by pregnancy and maternity may be considered by the AoMRC working group on disability.

CSA

GP trainers and others continue to observe the CSA.

COGPED and the RCGP held a joint session on CSA preparation at the RCGP Medical Educators Conference.

The format and level of detail in CSA candidate feedback has been enhanced. The CSA is summative, not formative - designed to differentiate between those who have and have not demonstrated competence. Nevertheless, candidates and supervisors value feedback to help them understand a pass/fail result and guide future learning. Candidates can now view the marks for each domain (data gathering and interpretation; clinical management; interpersonal skills) within every case as well as generic feedback statements. Guidance on interpreting feedback and suggested learning strategies are also provided.

- the effectiveness of GP WPBAs;
- the use of met and not met criteria;
- increasing the number of WPBA assessors.

Prescribing is an area currently under assessed in the MRCGP and associated with significant, avoidable morbidity and mortality. A 14th CSA case, focusing on polypharmacy and multi-morbidity, was piloted in May 2016. The pilot questions were generally well received by candidates, but not well answered. Refinement of the questions continues. 10 cases have been developed for a fuller pilot.

Increasing lay input into the CSA is under consideration, in anticipation of the outcome of the GMC's review of its Standards for Curricula and Assessment.

A new process for reviewing CSA examiner performance is working well. Every 12 to 18 months, examiners undertake a benchmarking exercise on videoed cases and discuss their performance statistics (number of candidates examined, average case score, range of case scores and concordance with peers). Any unprofessional behaviours are reviewed. If performance statistics fall short of accepted norms, a learning needs assessment, remedial intervention and reassessment take place.

Based on feedback from GP school views on the spacing and frequency of CSA diets, an additional diet was offered in October 2016 intended to benefit less than full time trainees and those applying for accreditation of transferable competencies. Additional dates have also been added to the March diet.

Clinical examination and procedural skills (CEPs) were introduced into the TeP in January 2015 as a dual system alongside DOPS. Since October 2015 only CEPS have been required of trainees, although DOPS remain in the TeP as evidence for trainees who completed this form of WPBA early in training and have yet to finish training. Five mandatory CEPS are recorded within the evidence section of the TeP and confirmed within the ESR. In addition, the trainee is encouraged to document, within the learning log, the breadth of clinical and procedural skills carried out in the GP practice posts.

In response to requests from GP schools, the RCGP published more guidance on WPBA and,

for the first time, produced a WPBA Annual Report.

The status and format of WPBA within the tripos are being reviewed to reflect GMC generic professional capabilities and to ensure that WPBA can better identify trainees who are failing to progress. The review is also looking at ways of reducing the overall assessment burden and at aligning WPBA with the type of evidence required for post-CCT revalidation. There is a tension, which is not new, between responding to the GMC's wish, and the wish of some in the GP training community, to reduce the assessment burden and the need continually to assess more competences as the role of the GP expands and becomes more complex.

The RCGP has published a research paper on Case Based Discussion (CbD). It concludes that hospital based CbDs, particularly those assessed by junior doctors or associate specialists, produce over optimistic results which are frequently in conflict with the overall assessment of a trainee

GP schools' views on changes to WPBA were sought to inform the WPBA review and this Report and were, in summary, as follows:

- The mid-year ESR should be made less burdensome, unless there are training concerns; the focus should be on the end of year ESR;
- The current PSQ tool should be rewritten to match that for GMC post CCT requirements and carried out only once in training as, though important, it has not contributed a great deal to assessment processes.;
- Overall, the number of assessments in the early stages of training should be reduced to help, in particular, those trainees new to the NHS;
- There should be more flexibility, based on trainee progress, in the number of assessments required, with more successful trainees requiring fewer assessments as training progresses;
- A greater range of negative indicators should be available to assessors; currently there is just one – 'needs further development';
- More detailed assessor feedback, of the type currently included in the 'educator notes'

section of the ePortfolio, should be required with WPBAs;

- A standardised method of recording OOH activity and assessment of OOH competences should be introduced into WPBA;

The College is responding to feedback from the training community and improving WPBA as follows:

- An interim ESR is being designed for trainees who are progressing satisfactorily;
- The PSQ tool is being rewritten with support from lay advisors and a new version will be piloted shortly;
- Overall, the number of WPBAs (CBDs, miniCEXs and COTs) will be reduced;
- New CSR and SLEs are being designed to include assessor feedback;
- There has been a reduction in the number of action plans required from both the trainee and ES;
- The process for producing a PDP now mirrors that for post-CCT GPs;
- Word descriptors describing each capability are being updated

GMC proposals for changes to WPBA

GP Schools were also asked to comment on GMC concerns that WPBA is not a reliable way of assessing progress. Responses are explored and summarised below for the information of the GMC as it develops further guidance on WPBA:

WPBA as a tool for assessing progress and identifying failing trainees

It is accepted that there is variability in the consistency and reliability of WPBA judgments, with significant variation between assessors of different status and seniority, and those in primary and secondary care. Trainees can “hide” in large secondary care environments and may persuade their junior colleagues, rather than their SC CS to judge WPBAs.

It is also accepted that WPBA is generally more specific and predictive in the GP practice in ST3 than at any other point in training. There continues, however, to be a reluctance on the part of some ESs to fail trainees based on WPBA alone (just seven ARCP Outcome 4s were

awarded in 2015-16 for WPBA failure only) and substantial WPBA issues may only be identified in a training extension following failure in the AKT and/or CSA.

However, all GP schools agree that WPBA, undertaken in general practice, and particularly where the ES is experienced, confident and supported by triangulation from other ESs, does identify performance issues. Schools also point to evidence of a strong correlation between difficulties with WPBA and negative comment in the ESR, and the likelihood of failure in the AKT and CSA. Research being undertaken by a group of GP schools has identified markers in WPBA that predict problems with AKT and CSA and, as the amount of data collected increases, the validity of those markers in predicting difficulties will increase. Schools also argue that, while any one WPBA tool may have weak predictive value, when analysed together at ARCP, WPBAs are a good way of assessing progression and identifying TiDs. One school describes WPBA as a useful tool for making decisions about competence at the margin and, specifically, where there is concern, and that there is merit in using additional WPBAs to assess the progress of struggling trainees.

WPBA as a summative tool with met and not met criteria

All schools but one have anxieties about using “met” and “not met” criteria in GP WPBA, arguing that GP training does not progress in clear stages as it does in more technical specialties. GPs in training undertake different posts/specialties in different orders and the focus is on progress overall and not the attainment of specific competences at particular points. Schools stress the formative value of WPBA, its use in developing reflective practice and the damage that might, therefore, be done if being found not to have a competence at an early stage of training is defined as a failure. Further, several of the existing MRCGP WPBA tools do not lend themselves to pass marks and the challenge to define what “met” and “not met” mean, particularly early in training, and to train supervisors to assess consistently, would be significant. One school writes “... *the calibration required for GP trainers [would be] daunting and for hospital trainers impossible*”. Our observations above in relation to SC CS engagement in GP WPBA add weight to these concerns. Though, as the

GMC's requirements vis a vis supervisor training and approval gain more traction, there may be more opportunity for achieving consistency and robustness in assessor judgments across primary and secondary care

Increasing the range of assessors who are involved in WPBA

Most schools support triangulation in WPBA judgments and it is acknowledged, as stated above, that with a close ES/trainee relationship there may be reluctance on the part of the ES to fail the trainee. However, most schools also argue that GMC concerns may be misplaced in relation to primary care where there is already triangulation: the TiD is always assessed by a range of assessors when undergoing extended training in a different practice and is monitored by senior GP educators, specifically trained for that purpose. Trainees often train in more than one GP practice, and in a range of primary and secondary care settings, or in large practices where other trainers do some assessing. GP trainees in the GP practice are assessed by means of a MSF tool, involving nurse practitioners, amongst others. Patient assessment is a feature of WPBA. Further triangulation comes from the ARCP panel which reviews WPBA judgments and may disagree with ES recommendations.

There is, however, potential for improving triangulation and schools suggest that small practices could "buddy up" with neighbouring training practices or that WPBA assessments could be shared between ESs in the same local trainers group. One school suggests that the RCGP should mandate that a specified number of COTs and CbDs are signed off by someone other than the named ES – a fellow ES in a nearby practice or in the same practice. These methodologies would require planning and resources.

Enhancing the assessment of leadership, quality improvement and prescribing

Schools are generally supportive of RCGP plans to enhance assessment in these areas but concerned about adding new hurdles early in training when trainees develop at different rates, in different settings. Many say the addition of new tools should be offset by the removal of others, the PSQ.

	<p>Most anxieties were focused on the assessment of leadership with schools arguing that a trainee can do leadership training but assessing whether they are a good leader is complex and it is important to acknowledge the range of leadership skills required of qualified GPs – both within and outside the clinical environment. Some believe leadership is not doable or assessable in ST1 and 2 or that it is sometimes not possible to provide trainees with the opportunity to display leadership qualities.</p>	
<p><u>Major review of the MRCGP</u></p>	<p>As part of its commitment to ensuring that the MRCGP continues to be fit for purpose, proposals for a major review of all three components are in development. The MRCGP has been the licensing examination for general practice for ten years and the GMC will shortly report on the review of its own Standards for Curricula and Assessment, which will drive reviews of all medical training curricula. This major review is, therefore, timely. The College is in the process of tendering for the review work and will report in more detail next year.</p>	

7. Curriculum approvals updates

Please provide an update for actions in curriculum approval decision letters from August 2015 to September 2016

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>No curriculum or assessment changes were submitted to the GMC's Curriculum Advisory Group during the reporting period. Some minor changes were submitted through the GMC's 'administrative change process' and were approved, published, and, in February 2016, implemented. Information on the changes was communicated to deaneries/LETBs and trainees.</p>	

Additional comments

The RCGP is making major revisions to the GP Curriculum in the context of the GMC's review of its Standards for Curricula and Assessment and the publication of the Generic Professional Capabilities Framework. The review will also include the following:

- an equality and diversity review;
- the development of an Equality, Diversity and Inclusion module; E&D will also be considered by Curriculum Editors as part of their review of each clinical module;
- The completion of work to slim down curriculum topic modules and re-integrate the AKT knowledge base and CSA skills, with new/redeveloped curriculum modules covering the longstanding high profile content gaps (renal problems, haematological & immune problems, infectious disease & travel health, and care of people with long-term conditions (including cancer));
- The inclusion of guidance on how stakeholders can feed back on E&D.

In their reports to the RCGP, GP schools were asked for feedback on the curriculum and to suggest improvements. Responses were rich and detailed and will be considered as part of the major review. A flavour of what schools said is given below.

What changes are needed to the GP curriculum and assessments to enable future GPs to manage an increasingly complex general practice workload and deliver the new models of primary care set out in the Five Year Forward View (and the similar policies in the devolved nations)?

The Curriculum should embrace multi professional working, acknowledging that GPs need to take a leadership role in multi-professional teams. It should prepare trainees to undertake care planning, protocol development, critical thinking, shared decision making, resilience and quality improvement and to manage complex co-morbidity and polypharmacy. Competences in telephone triage and telephone consultation should be enhanced. The Curriculum needs to describe better the knowledge and skills needed to serve harder to reach populations.

To enable GPs in training to acquire the competences described, more blended learning placements and multi professional learning activities will be necessary. One deanery/LETB describes 'learning together clinics' where trainees see patients in primary care with secondary care colleagues, for example joint care of the elderly/GP clinics in care homes.

A significant minority caution against significant change at this stage, arguing that changes should not be made in response to a single policy document such as GP Forward View, that Governments change their minds, and that the RCGP should wait until new models of care have become established.

In the absence of 4-year GP specialty training, there is increasing pressure from internal and external stakeholders for more emphasis to be placed on their area of interest within the 3-year programme. What areas of current training and assessment could be de-emphasised or reduced to allow time and opportunity for this?

Schools reacted strongly to this question, saying that de-emphasising areas of the curriculum is not the solution; the only realistic way to deliver more

in the form of additional skills in the new models of primary care being to extend training beyond the current three years. The arguments for extending training and for basing more of the programme in general practice have been extensively rehearsed elsewhere. However, it is worth quoting the following from schools' responses to this question to give a flavour of the prevailing view:

- *'With primary care becoming increasingly diverse, with blurring of role boundaries (support workforce, registered workforce, advanced practice beyond traditional role boundaries, new roles), blurring of organisation boundaries (e.g. federation), and blurring of sector boundaries (e.g. integration such as PAC, MCP models) it is increasingly difficult to experience the full range of General Practice with only 18 months of training placement in the specialty out of the already short three year training journey.'*
- *'Rather than ask GP directors and Heads of School what to drop, we believe that the RCGP could use the e-portfolio to identify parts of the curriculum that cannot be covered in General Practice. We further believe that "fully innovative training" where a trainee is placed in General Practice for the entire three years and seconded to out-patients and community settings where the case mix and case density allows exposure to appropriate learning is a better model than rotation through defined posts.'*

How should the increasing divergence in healthcare policy between the four nations be managed within a UK-wide training and assessment programme? Should the curriculum and assessments be made more flexible, to cater for home nation-specific elements?

Again, this question received a forthright response with most schools asserting that CCT training should remain generic and that nation specific training would reduce career opportunities and should be delivered post-CCT. The RCGP will, however, continue to review whether some guidance to trainees to enable them to move between the four nations without needing additional training and guidance is necessary.

GP Specialty Training in Paediatrics

The RCGP believes that all GP trainees should have specialist-led training in child health. This training could take place in primary care, community or secondary care settings and does not need to be, and often is not best delivered by, a paediatric placement. The RCGP and RCPCH are developing proposals on improving training in paediatrics. A position paper *Learning Together to Improve Child Health*, produced by the education teams of the RCGP and RCPCH describes a more integrated approach to training and reviews joint GP/paediatrics training pilots going on around the UK. It envisages outreach services run jointly by paediatricians and GPs, and other primary care colleagues within GP practices. Exposing trainee paediatricians and GPs to increased numbers of children outside traditional healthcare settings, should enable them to learn from one another, improve health outcomes for children and reduce costs to the wider healthcare system. The paper recommends:

- Paediatricians should spend time working side by side with GPs and other primary care professionals in general practice settings

- Trainee GPs should spend time in specialist settings such as hospitals alongside paediatricians, to expose them to large numbers of sick children in safe, supervised environments
- Extending GP training to four years to include specialist child health training
- After training, GPs and Consultant Paediatricians should continue to spend time working side by side in general practice and specialist settings