Agenda item: M6

Report title: New standards for curricula, new assessment guidance and a refined approvals process

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Action: To consider

Executive summary
Since March 2016, we have been redefining our approach to postgraduate training. We have carried out an extensive review of the standards for curricula, guidance on assessment in postgraduate training, and our regulatory approach to the approvals process. We have engaged with key stakeholders from the four UK countries.

The new standards and assessment guidance, through an outcomes-based approach and a focus on critical progression points will improve the safety and quality of medical education and training. Good medical practice and the Generic professional capabilities framework will be embedded into every postgraduate curriculum. Combined, these changes will result in improved flexibility for trainees to move between specialties and help us deliver a large part of our commitments outlined our report, Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training. The standards will also, eventually, set out the principles for approving regulated credentials.

Alongside the standards and assessment guidance, we are revising our approvals process to reduce unnecessary regulatory burden and ensure the standards are implemented effectively. Most of the current curricula will meet these standards by December 2020.

Recommendations
Council is asked to:

a To approve the document Excellence by design: standards for postgraduate curricula at Annex A and the assessment guidance, Designing and maintaining postgraduate assessment programmes at Annex B.

b To note the consultation outcomes at Annex C.

c To note that we will launch the standards, guidance and approvals process as a package in early May 2017, subject to approval.
Background

1 Currently, there are 66 medical specialties and 32 subspecialties recognised for postgraduate medical training in the UK. Each discipline has its own curriculum and assessment framework which are developed largely in isolation by the individual medical colleges/faculties and approved by the GMC. We use the *Standards for curriculum and assessment systems* to approve submitted curricula.

2 We inherited these standards from the Postgraduate Medical Education and Training Board (PMETB) when it was merged with the GMC in April 2010. Although rebranded, these standards have not been reviewed or significantly updated since 2007.

The purpose of the review

3 The new standards and assessment guidance will improve how postgraduate training is developed and approved. It will help rationalise the ever-increasing assessment burden. It will create more flexibility for trainees to move between specialties.

4 Updated standards for curricula will ensure that *Good medical practice* and the *Generic professional capabilities* (GPC) framework is embedded in every postgraduate curriculum, which in turn will help reduce risks to patients and simplify our approvals process.

5 We have committed to reducing the regulatory burden where possible, while maintaining professional standards. In order to achieve this we are refining our approvals process. This will improve the safety and quality of curricula over time, particularly in relation to data collection, monitoring impact and ensuring externality.

The outcomes of the review

6 We propose to launch the standards, guidance and new approvals process as a package in May 2017.

*Excellence by design: standards for postgraduate curricula*

7 *Excellence by design* sets out explicit standards and requirements for colleges and faculties in terms of what we expect a curriculum to demonstrate – available in Annex A.

8 These standards complement our widely respected standards – *Promoting excellence: standards for medical education and training* – which we use to check that training is implemented properly at the local level.
Curricula will be driven by learner, patient and service needs. Firstly, the purpose of a curriculum will be endorsed by a strategic workforce group with representation from the four UK countries. Secondly, we are introducing an outcomes-based approach that embeds Good medical practice and the GPC framework as core requirements of postgraduate training. This will move curricula away from time-based, ‘tick-box’ and process-based training and focus on doctors in training demonstrating the capabilities required for safe professional practice.

This more flexible approach will allow trainees, employers and patients to understand what can and should be expected of their doctor at different points in their career. It will provide a clearer and more transparent way of recognising previous learning, particularly if doctors want to demonstrate equivalence or move between specialties. More service input from the four UK countries will ensure the medical workforce is capable of meeting future service demand.

We sought feedback through a number of engagement events and a formal public consultation. The consultation asked about whether these standards should apply to credentials. While there was support for the principles, it was felt some standards and requirements would be too onerous. Given credentials have yet to be introduced, we concluded standards for regulated credentials should be developed separately. However, they will follow the same principles and fundamental approach as outlined in the new standards for postgraduate curricula.

We have revised extensively the postgraduate assessment guidance developed by PMETB. The full guidance document is available in Annex B. Based on a modern view of validity theory, the guidance focuses on emphasising the purpose and strategic development of programmes of assessment and explains key assessment principles, such as validity and reliability. It aligns with the operational guidance that will inform the approvals process.

We have worked with our Assessment Advisory Board and the AoMRC’s Academy Assessment Committee (AAC) in developing these standards. We built consensus on the guidance with colleges and faculties and have taken advice from UK experts in assessment. An international expert group in assessment, Health Professional Assessment Consultancy led by Professor Katharine Boursicot, reviewed the final draft of the guidance.

We are reviewing the approvals process, in order to reduce unnecessary regulatory burden on our stakeholders. We have met with all colleges and faculties to explore
their challenges with the current system and to discuss how we could improve the approvals process.

15 As a result, we have developed transitional arrangements for curricula to move onto the new standards over the next three years. We are also reviewing the role of the Curriculum Advisory Group (CAG) to ensure it has the right expertise and focus in the future. We have developed new operational guidance and templates to accompany the launch of the standards and assessment guidance. These were developed with input from the colleges and faculties and with advice from CAG. We have already introduced a more bespoke way of managing relationships with colleges and faculties in order to better facilitate the approvals submissions, including providing more support on equality and diversity issues, GMC expectations and data management.

16 As well as the approvals process, we will begin to quality assure curricula as part of our quality assurance framework over the next five years. The GMC quality assurance framework will be reviewed in 2017 and will be updated in light of the new standards for curricula.

Flexibility review

17 These standards and the GPC framework are instrumental to delivering the actions in our report, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training*.

18 The standards require curricula to identify common or shared areas of training and so will require colleges and faculties to coordinate any interdependencies between related specialties and other professions. This will help considerably with workforce planning, role development and role substitution.

19 Curricula will also describe fewer, high-level generic and specialty outcomes, which will support all doctors better in understanding what is expected of them in their training programme. Training will have a greater focus on developing the generic professional capabilities common to all doctors. It will also help those doctors not in regulated training to demonstrate equivalence in specialty registration.

20 Using these standards, we will ask medical colleges and faculties to work together to identify aspects of their training that are common or shared across related areas of practice. We will also improve how we approve postgraduate training with the aim of introducing greater flexibility in curricula through our approval arrangements. We will use our Quality assurance framework and National training surveys to monitor the progress of our reforms and other developments in the four countries designed to promote flexibility.
Engagement and consultation

21 Starting in March 2016, we began a period of extensive engagement, meeting all 22 medical colleges and faculties as well as other key stakeholders. In June 2016, we facilitated a stakeholder forum to consider the first draft of the standards and a new approach to approvals.

22 We convened an external expert advisory group, with representatives from colleges, employers, patients, and postgraduate deans as well as representation from the four UK countries. This group tested our thinking about the fundamental principles that should inform the development and approval of postgraduate curricula and advised us on the draft standards and consultation document.

23 We particularly sought input from employers throughout the process. NHS Employers were a member of the expert advisory board. We also spoke to, and received feedback from, the Medical Workforce Forum in May 2016. We also spoke twice in 2016 to the UK Medical Reference Group – a four country strategic oversight group on medical education and training in the UK – about the standards. Subsequently, we have written to NHS England and the other employer organisations in the devolved administrations to explore how we can better engage employers in our education and training functions.

24 Based on these discussions, we revised the standards and publicly consulted on them from 5 September to 28 October 2016. We received 69 responses; 36 from individuals, and 33 from organisations. The full consultation report is in Annex C. An audit review of our consultation is available in Annex D.

25 At the same time, we organised a task and finish group with UK experts to advise us on the draft assessment guidance, including equality and diversity aspects. We have undertaken a consensus-building exercise, seeking feedback from all colleges and faculties and assessment experts on emerging drafts of the guidance.

26 This programme of reforms aligns closely to our work on differential attainment and will provide one of the key mechanisms for realising some of our commitments to improving equality and fairness in medical education and training. We are working closely with our Equality and Diversity colleagues for advice on this, particularly in relation to the assessment guidance. We have produced an equality assessment for the project.

27 Our review of flexibility occurred concurrently to this work on our postgraduate standards. In order to ensure a more transparent mechanism for doctors to transfer between specialties, the new standards require curricula to identify and develop more common generic and shared outcomes as well as consolidate the established
specialty outcomes. Following on from this review, we will work with the Academy of Medical Royal Colleges and others to identify and develop shared training components across related specialties.

28 We have sought legal advice on the standards for postgraduate curricula. They comply with the *Medical Act 1983* and do not need any legislative change to take forward.

**Next steps**

29 We aim to publish the new curriculum standards, assessment guidance and information about the new approvals approach, including operational guides and templates in early May 2017, subject to Council approval.

30 We anticipate that the new curriculum standards will be used in the approvals process from September 2017 onwards. We will have transitional arrangements in place until 2020 to allow for the revision of all 103* curricula.

* There are 66 specialties and 32 subspecialties. But the total number of curricula is currently 103, as there are multiple curricula for some specialties, such as core medical training curriculum, the core surgical training curriculum and the broad based training curriculum. These are not specialties in their own right.
M6 - New standards for curricula, new assessment guidance and a refined approvals process

M6 - Annex A

Excellence by design: standards for postgraduate curricula
About these standards

This document sets out our standards and requirements that all postgraduate curricula* must meet to be approved by the GMC. They also apply to any changes or revisions made to such curricula. They may also be applied to other learning and assessment frameworks or tests of competence, curricula and educational or training approval processes where appropriate.

GMC-approved postgraduate curricula must be applicable and relevant to the UK as a whole and have outcomes that receive the full support of the four countries in the UK.

There must be sufficient flexibility to enable organisations to manage training locally, to better reflect their educational and service capacity and capability, provided curricular outcomes are met.

These standards are to be used in conjunction with our Promoting excellence: standards for medical education and training.† Together they provide an integrated standards framework for the development, approval and provision of postgraduate medical education and training in the UK.

These new standards require curricula to describe fewer, high-level generic, shared and specialty outcomes, which will support all doctors better in understanding what is expected of them in their training programme. They require curricula to identify common areas of training and to have a greater focus on the generic professional capabilities common to all doctors. These requirements for approval will enable delivery of improvements to the flexibility of postgraduate medical training as described in our flexibility review in March 2017.‡

* The standards and requirements apply to both general practice and specialty curricula. In this document, references to specialty curricula or requirements include general practice.
‡ Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training available at http://www.gmc-uk.org/Adapting_for_the_future___a_plan_for_improving_the_flexibility_of_UK_postgraduate_medical_training_FINAL.pdf_69842348.pdf
Applying these standards

During GMC approval processes, organisations* will be required to describe and evidence how the standards and requirements set out in this document have been addressed in the design and development of the proposed curriculum.

For a curriculum to be meaningful, it must address many interdependent factors such as clinical safety, expected levels of performance, maintenance of standards, patient expectations, equality and diversity requirements, strategic workforce issues and system coherence, as well as operational and professional perspectives.

Our curriculum approval process will ensure that all of these different dimensions have been appropriately considered and addressed effectively during the development process.

* Organisations are broadly defined in this document to make sure it is as flexible as possible for future changes in medical education and training. It is most likely the organisations that will develop postgraduate curricula will be medical colleges and faculties.
Details of the GMC curriculum approval process are available on our website.*

* Approval of specialty training curricula – see www.gmc-uk.org/education/approval_curricula_and_assessment_system.asp
Principles

Patient safety
Patient safety is the first priority and is at the core of these education standards. Just as all doctors must make the care of patients their first concern, so must the organisations that design and develop postgraduate curricula.

To be approved, curricula must identify and explain how key areas of patient/population needs, patient safety and relevant risk are identified, defined and addressed. This should include a focus on safety-critical content, clarity on expected levels of performance and the necessary breadth of experience required for safe professional practice. The learning experience itself should not affect patient safety unnecessarily. The curriculum, therefore, should also include other relevant guidance, expectations and requirements for the provision of safe and effective learning, such as mandatory training required to address safety themes.

Upon satisfactory completion of training programmes, we expect learners to be able to work safely and competently in the defined area of practice and be able to manage or mitigate relevant risks effectively.

The safety of patients is a key theme in our Generic professional capabilities (GPC)\(^*\) framework and covers core capabilities aimed at keeping patients safe. The framework outlines generic professional capabilities and expectations related to clinical responsibility and governance systems, individual roles and responsibilities in relation to safety, team interactions and the importance of raising concerns.

Learning outcomes allow local education providers to use courses, techniques and approaches that best meet their local arrangements and resources. But where serious patient safety concerns have been identified related to specific training requirements, these risks must be mitigated through explicit mandatory curricular requirements. These must be proportionate and limited to where there are no other appropriate or acceptable ways to protect patients. Examples might include specific resuscitation courses, specific kinds of simulation interventions or requirements for enhanced clinical supervision.

Maintaining standards across the UK
To protect the public and maintain trust in the medical profession, GMC regulated training must ensure standards are maintained consistently across the UK. Curricula need to set

\(^*\) Generic professional capabilities – see www.gmc-uk.org/education/23581.asp
out the expected levels of performance of doctors achieving a Certificate of Completion of Training (CCT).

**Excellence**

Patient safety and competent practice are both essential, but we expect curricula and training to also promote and encourage excellence in postgraduate education, training and professional practice.

To support this endeavour we require *Good medical practice* and the GPC framework to be embedded in all GMC approved curricula. We also expect all curricula to describe the expected levels of performance in terms of high-level generic, shared and specialty-specific learning outcomes or professional capabilities.

Learners should be encouraged and given opportunities to aspire to excellence. Organisations should provide guidance about how higher levels of performance and achievement might be recognised.

**Fairness**

The principles of fairness, equality and diversity must be embedded in the development processes and learning outcomes of the curriculum.

Organisations developing postgraduate curricula must demonstrate that they have met their statutory obligations under equality legislation, including providing reasonable adjustments. Organisations must also consider the impact of the learning outcomes the progression of learners, including how this impact might differ for groups of people who share different protected characteristics.

Particular consideration must be given to ensuring that entry-to-training requirements at all transition points, assessments and progression decisions are fair and robust.

Key to meeting these standards will be taking account of our equality and diversity guidance.

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† General Medical Council (2015) *Approving changes to curricula, examinations and assessments: equality and diversity requirements* available at [www.gmc-uk.org/education/postgraduate/EandD_college.asp](http://www.gmc-uk.org/education/postgraduate/EandD_college.asp) – describes the responsibilities of organisation designing curricula. It defines terms like protected characteristics and reasonable adjustments.
In order to ensure progression is fair and transparent, data on the impact and outcomes of the training will be monitored, analysed and published where appropriate. We will require such information to be provided to us for our quality assurance processes.

Current and future workforce and service needs

There has to be a balance between curricula designed for the learner and the profession and the expectation that it can evolve to meet current and future advances, service needs and opportunities. Curricula must support and align with strategic workforce needs and meet the needs of the service and its patients. The GPC framework is a key approach that will ensure common, universal content across all curricula. The GMC is committed to reviewing the GPC framework periodically to ensure it is kept up to date.

Regular review of curricula allows redundant content to be removed and new content to be introduced consistently across the medical workforce. These changes will need to be approved by us. This more responsive approach means postgraduate training will be able to adapt to current and emerging patient and population needs.
Theme 1: Purpose

Purpose of this theme
This theme is about making sure the curriculum is based on patient and population needs as well as strategic service needs and is formally endorsed by the four countries of the UK.

The purpose statement must clearly address patient and service needs. It must set out specialty-specific capabilities, including scope of practice and the levels of performance expected of those completing training.

It must identify generic and shared content and allow flexibility and transferability of outcomes. It should support recognition of capabilities between and across specialties.

The purpose statement should also include any notable exclusions or limitations to the training or scope of practice.

Standards
CS1.1 The curriculum has a stated and clear purpose based on scope of practice, service and patient/population needs.

CS1.2 The curriculum considers interdependencies across related specialties and disciplines. It demonstrates that it has addressed the expectations of the service and healthcare system.

CS1.3 The curriculum supports flexibility and transferability of learning.

Requirements
The purpose statement must meet the following requirements.

CR1.1 Explain the need for the curriculum based on an analysis of patient/population, professional, workforce and/or service needs.

CR1.2 State the purpose and objective of the curriculum, including how it links to each stage of critical progression.

CR1.3 Describe the scope of practice of those completing the curriculum including notable exclusions where appropriate.
**CR1.4** Specify the high level generic, shared and specialty-specific learning outcomes so that it is clear what capabilities must be demonstrated, and to what level, in order to complete training.

**CR1.5** Demonstrate the curriculum has four-country endorsement of the purpose statement.

**CR1.6** Demonstrate how the key interdependencies between the curriculum and other training programmes, professions or areas of practice have been identified and addressed.

**CR1.7** Explain how the curriculum supports flexibility and transferability of learning outcomes and levels of performance across related specialties and disciplines.
Theme 2: Governance and strategic support

Purpose of this theme
This theme is about making sure curricula are developed through demonstrable and robust processes that are informed by relevant stakeholders.

Standards

CS2.1 The curriculum is developed and regularly reviewed through clear governance processes.

CS2.2 The curriculum results in feasible, practical and sustainable training programmes that can be implemented by those organisations responsible for training and service provision.

CS2.3 The curriculum and development process makes sure that education and training is fair and is based on principles of equality and diversity.

Requirements

Development processes
Organisations developing curricula must meet the following requirements.

CR2.1 Explain how the curriculum and its learning outcomes were developed, including input from key groups.

CR2.2 Explain the rationale for the learning outcomes.

CR2.3 Explain how the curriculum is feasible, practical and sustainable.

CR2.4 Describe how the curriculum and its programme of assessment will be communicated to learners, the public, and to those providing the education and training.

Input and feedback
Organisations developing curricula must meet the following requirements.

CR2.5 Describe how input and involvement was sought from relevant stakeholders including patients, employers and learners. Engagement and consultation should
be proportionate to the change being made and tailored to the relevant group. It must include input from all the following groups:

- **a** employers, service providers and organisations responsible for planning learning and development
- **b** patients, relevant patient groups, carers and lay people
- **c** education or training providers and statutory education bodies
- **d** learners, including specific input from doctors who share protected characteristics
- **e** professionals and professional bodies, including those involved in relevant research and policy areas, where appropriate
- **f** those with expertise in curricular design and assessment.

**Equality and diversity**

**CR2.6** Organisations must demonstrate that they meet their legal obligations under equality legislation and that they have considered equality, diversity and fairness in the development of the curricula and programme of assessment.
Theme 3: Programme of learning

Purpose of this theme
This theme is about making sure the curriculum must clearly describe the expected learning outcomes for the area of practice and appropriate learning methods and approaches.

There must be clear guidance about the appropriate breadth of experience and expected level of performance, for satisfactory completion and at critical progression points during the training programme, particularly focusing on safe transitions where patient or training risk may increase.

Taken together, these describe a programme of learning.

Standards

CS3.1 The curriculum describes the generic, shared and specialty-specific outcomes, as capabilities, expected levels of performance and the breadth of experience that learners must demonstrate in order to progress or complete training.

CS3.2 Good medical practice and the Generic professional capabilities framework are mapped in the curriculum.

CS3.3 The curriculum must indicate what is needed for learners to show competence but it should also recognise proficiency or excellence in relevant areas of practice.

Requirements
The curriculum must meet the following requirements.

CR3.1 Identify the learning outcomes that learners must demonstrate to complete training and to move through critical progression points.

CR3.2 Match the learning outcomes, educational approaches, breadth of experience and expected levels of performance to the stated purpose of the curriculum.

CR3.3 Include Good medical practice and the content of the Generic professional capabilities framework.

CR3.4 Provide guidance on the appropriate educational methods and approaches, breadth of experience and learning opportunities necessary to ensure safe training and to meet the learning outcomes.
CR3.5 Provide guidance that describes the responsibilities, capabilities and expected levels of performance of medical educators in order to ensure they are professionally credible and competent.

CR3.6 Explain how learners will receive meaningful and timely feedback.
Theme 4: Programme of assessment

Purpose of this theme

This theme is about making sure the organised set of assessments planned for the curriculum – the programme of assessment – and its individual components are based on fair and robust assessment principles and processes. However the way they are demonstrated may vary depending on the training context or on the type of individual assessment or assessment approach being deployed.

Key to meeting these standards will be our assessment guidance that describes good practice in developing programmes of assessment.*

Standards

CS4.1 The programme of assessment is valid, fair, acceptable, feasible and effective. It permits reliable judgements to be made and is blueprinted to the curriculum, including the generic, shared and specialty-specific learning outcomes.

CS4.2 It has a positive educational impact and the assessment burden is proportionate.

CS4.3 The programme of assessment discriminates effectively between different levels of performance, and includes critical progression points including completion of training.

CS4.4 The programme of assessment incorporates summative assessments which allow learners to demonstrate they have met the learning outcomes in the curriculum, including generic, shared and specialty-specific outcomes.

CS4.5 The programme of assessment provides principles to inform the management of learners who have not met the required learning outcomes at critical progression points.

CS4.6 The programme of assessment offers opportunities for formative assessment and feedback to support learning, linked to learning outcomes.

* General Medical Council (2017) Designing and maintaining postgraduate assessment programmes available at [insert web link when ready]
Requirements

Developing the programme of assessment

The programme of assessment must meet the following requirements.

CR4.1 Describe clearly how assessments which contribute to decisions about a learner’s progress (summative assessments) have been:

a selected and integrated to produce valid and reliable judgements

b produced so that the purpose of each individual element within the programme of assessment and its contribution to the programme of assessment as a whole is clear and the overall assessment burden is proportionate

c subject to appropriate validation/piloting

d blueprinted to the learning outcomes described in the curriculum, so that it is clear how and when learning outcomes are demonstrated

e sequenced and applied across the curriculum, particularly around critical progression points, to ensure patient and training safety

f appropriately standard set to clearly describe expected levels of performance, using a methodology that is consistent, robust and fair over time

g supported by appropriate guidance for learners, examiners and assessors so that assessments are conducted consistently and fairly

h clearly distinguished from formative or developmental assessments that promote learning and feedback or assessments which combine formative and summative functions.

CR4.2 Provide guidance on how poor performance should be managed including advice on addressing underperformance safely and fairly and ensuring concerns about performance are escalated appropriately.

CR4.3 Integrate information about the learner’s performance across the programme of assessment to evidence decisions at critical progression points and completion of the training programme.

CR4.4 Provide a rationale that explains the impact of the assessments, including the impact on doctors who share protected characteristics.
Monitoring the quality of the programme of assessment

Organisations developing curricula and programmes of assessment must meet the following requirements.

CR4.5 Monitor and continuously improve the quality of assessment.*

CR4.6 Provide data about assessments to meet regulatory requirements for quality management and quality assurance processes.

CR4.7 Publish the quality performance metrics of high-stakes summative or progression assessments to promote transparency and openness.

CR4.8 Describe how those involved in assessments should provide meaningful and timely feedback to candidates, including summative assessments.

Assessors

CR4.9 As part of the programme of assessment, guidance must be provided about the nature, role and responsibilities of assessors and examiners.

CR4.10 Organisations must set out appropriate requirements and guidance to enable assessors and examiners to make professional judgements about learners’ performance and behaviour to an agreed standard.

CR4.11 There must be clear and regular processes for calibrating and benchmarking examiners so that they assess to agreed standards, and for reviewing their performance.

CR4.12 Organisations must ensure that assessors and examiners are able to distinguish consistently between different levels of performance and behaviour.

CR4.13 Organisations must indicate where professional development is required including on the equality and diversity issues that are relevant to their role as assessors and fair decision-making.

* This does not require organisations developing curricula to take responsibility for the quality of assessments conducted in the workplace by local education providers. This falls under the standards and requirements outlined in Promoting excellence: standards for medical education and training and will be addressed locally through our quality assurance framework.
Theme 5: Quality assurance and improvement

Purpose of this theme

This theme is about making sure that the curriculum, and its programme of assessment are monitored, regularly reviewed, improved and quality assured. Information gathered through governance and monitoring processes must inform changes to the curriculum, including the programme of assessment. This includes feedback from education and service providers and others that implement training programmes. Consideration should be given to aspects of the curriculum that are redundant and should be removed or that need to be revised. Changes should also consider how new or amended curricula or programmes of assessment will be implemented.

The GMC’s quality assurance framework will determine how the curricula and programme of assessment are monitored and quality assured. We will use Promoting excellence: standards for medical education and training to quality assure how the curricula and related training programmes have been implemented locally.

Standards

CS5.1 The curriculum is regularly reviewed and there are processes in place to ensure it is monitored and improved in order to keep it up to date.

CS5.2 Redundant elements of the curricula are removed.*

Requirements

Organisations developing curricula must meet the following requirements.

CR5.1 Set out plans for how the curriculum or changes will be introduced, including a clear plan for the transition of learners.†

CR5.2 Demonstrate how the curriculum will be evaluated and monitored over time through quality management and quality improvement processes, include information about:

a the arrangements that will be used to gather data and how it will be used to inform improvements to the curriculum

* Changes to the curriculum, including removing redundant elements, is subject to our approval.
b the mechanisms that will be used to keep the curriculum up to date and current, including how innovations in the area of practice or training will be incorporated over time and out-of-date elements will be removed.

CR5.3 Set out how the impact of the learning outcomes on the progression of different groups of doctors will be evaluated, including those who share protected characteristics.
Responsibilities and relationships

Roles, responsibilities and interdependencies

The diagram below shows the two sets of standards for postgraduate medical training, and the roles, responsibilities and interdependencies among organisations.

[This diagram is being updated to remove credentials / redesigned for publication]

The quality assurance framework (QAF)* shows how the quality assurance, quality management, and quality control functions work together for quality improvement.

Promoting excellence: standards for medical education and training applies to both undergraduate and postgraduate medical education and training.

* Details about the QAF and how we monitor the quality of education and training are on our website – http://www.gmc-uk.org/education/qaf.asp and http://www.gmc-uk.org/education/27080.asp.
Our role in medical education and training

The General Medical Council (GMC) is required by law to set educational standards for all doctors in undergraduate and postgraduate education and training in the UK. We do this, in part, by approving postgraduate medical education and training – this includes approving curricula and associated training posts, programmes and assessments.

We assure the quality of medical education and training by carrying out rigorous reviews and regular monitoring activities to ensure our Promoting excellence standards are being met by local education providers. These GMC quality assurance processes help us to identify and deal quickly with any concerns and so make sure that trainees receive safe and effective training and appropriate clinical supervision in settings that provide safe patient care.

Responsibilities in designing curricula

The General Medical Council

Alongside our functions described above about our role in medical education and training, the GMC has the specific responsibilities listed below.

- Sets the professional standards for all UK doctors through Good medical practice and other professional guidance.
- Oversees and maintains the generic outcomes of the Generic professional capabilities framework. This is done in partnership with the Academy of Medical Royal Colleges (AoMRC).
- Approves posts and programmes of learning for postgraduate training programmes.
- Quality assures regulated and approved curricula by monitoring and checking to make sure that our educational standards are maintained.
- Provides system leadership in determining critical interdependences across, between and within programmes of learning.

The four UK governments and their related organisations

- Identify and prioritise strategic, system, service or workforce needs including, through their related organisations, the funding, planning, commissioning and quality management of training programmes.
Funders/commissioners and employers

- Identify and prioritise service and workforce needs, and work with colleges to help predict future workforce needs.

- Support and provide sponsorship, funding and opportunities for education, training and professional development including the quality management of local programmes of learning.

Colleges/faculties or other credible professional bodies

- Design and develop a curriculum and associated programmes of assessment.

- Maintain and monitor a curriculum and associated programmes of assessment.

- Ensure the curriculum and associated programmes of assessment meet obligations under equality legislation on fairness, equality and diversity.

- Contribute to and support the GMC in its quality assurance and statutory responsibilities.

- Work with deaneries/HEE local teams on quality management issues

Deaneries/HEE local teams

- Implement GPC framework in training.

- Provide quality management of locally implemented education and training.

Local educational providers

- Implement elements or complete programmes of learning at the local level.

- Provide local quality control and participate in local quality management of education and training.

Statutory education bodies

- Responsible for commissioning and/or management of postgraduate training.

- May hold some of the responsibilities of government related organisations, funders/commissioners and employers, or professional bodies, as described above.
Glossary

Assessor
An assessor provides an assessment and is responsible for interpreting the learner’s performance in that assessment. Assessors should be appropriately trained and should normally be competent (preferably expert) in the area that is being assessed, and capable of making appropriate professional judgements. This includes examiners as a specific type of assessor.

Assessors also include the day-to-day trainer, who may conduct assessments on a daily basis in the workplace.

Blueprint
A blueprint is a template used to define the content of a test that may be designed as a matrix or a series of matrices. This can help to ensure that the assessments used in the assessment system cover all the outcomes required by the curriculum.

Clinical governance
Clinical governance is the system through which National Health Service (NHS) organisations are accountable for continuously monitoring and improving the quality of their care and services, and for safeguarding the high standard of care and services.

Critical progression point
A critical progression point is a point in a curriculum where a learner transitions to higher levels of professional responsibility or enters a new or specialist area of practice, including successful completion of training. These transitions are often associated with an increase in potential risk to patients or those in training, so they need to be carefully managed and decisions to progress need to be based on robust evidence of satisfactory performance.

Curriculum
A curriculum is a statement of the intended aims and objectives, content, experiences, learning outcomes and processes of a programme or course of learning, including a description of the structure and expected methods of learning, teaching, assessment, feedback and supervision. The curriculum should set out in a programme of learning and specify what learning outcomes the learner will achieve. How these outcomes will be assessed through a coherent programme of assessment and how learners will be determined as having successfully completed a programme of learning must also be described.
Doctor in training / trainee

A doctor in training is a doctor participating in an approved postgraduate medical training programme (Foundation Programme or specialty including general practice training).

Education organisers

Education organisers are postgraduate deans and medical schools who are responsible for recognising trainers in four specific roles, in accordance with our requirements for recognising and approving trainers. Education organisers work together to recognise trainers where there is overlap between the groups of trainers.

Educators

Educators are individuals with a role in teaching, training, assessing and supervising learners. This includes:

- individuals in a recognised and approved trainer role
- other doctors or healthcare professionals involved in education and training in the course of their daily clinical or medical practice
- academic staff from a range of disciplines with a role in education and training.

Educators may also include patients and members of the public who have roles in medical teaching or training, and other people whose knowledge, experience or expertise is used in teaching or training.

Experience

We refer to the necessary or appropriate breadth of experience to describe when a doctor in training has had enough experience to be able to practise safely and competently at an expected level of performance, eg with a particular procedure, simulation, or patients. This is not intended to indicate experience measured in specific numbers or time, but sufficient practice to have acquired and consolidated the learning outcomes described.

Generic professional capabilities framework

The Generic professional capabilities (GPC) framework is a matrix of educational outcomes and descriptors that states common core content required in all postgraduate curricula. The GPC framework describes minimum GMC regulatory requirements and are essential and critical capabilities underpinning core professional practice in the UK. Along with Good medical practice they must be included in all postgraduate curricula to achieve GMC approval.
Learners
Learners are medical students receiving education leading to a primary medical qualification and doctors in postgraduate training leading to a certificate of completion of training (CCT).

Learning outcomes
Learning outcomes are the knowledge, skills, capabilities, behaviours and expected levels of performance that a learner must acquire and demonstrate by the end of a period of education or training. They may be generic, shared, or specialty specific.

Medical college or faculty
A medical college or faculty is a professional body responsible for the development of the professional standards and expectations for one or more medical specialties.

The medical colleges and faculties develop curricula and assessment systems for specialty training, professional examinations and also provide continuing professional development support and advice for their members.

Medical trainer
A medical trainer is an appropriately trained and experienced doctor who is responsible for educating, training and assessing medical students or trainees within an environment of medical practice.

Four medical trainer roles are performed only by recognised or approved trainers who are registered doctors holding a licence to practise. The arrangements do not cover other doctors whose practice contributes to teaching, training, assessing or supervising medical students or trainees, but whose role does not need to be formally recognised.

Organisations developing curricula
Most likely the organisations that will develop postgraduate curricula will be medical colleges and faculties but there is nothing to prevent other credible organisations developing a curriculum for approval by the GMC.

Postgraduate dean
In England, the roles of the postgraduate dean and management of postgraduate training sit within Health Education England. In Northern Ireland, these roles are held by the Northern Ireland Medical and Dental Training Agency. In Scotland, the postgraduate deans and the Scotland Deanery are part of NHS Education for Scotland. In Wales, the
postgraduate dean is part of the Wales Deanery (School of Postgraduate Medical and Dental Education), Cardiff University.

These are the UK bodies that the GMC has authorised to manage approved training programmes and the training posts.

**Programme of assessment**

A programme of assessment is the organised set of assessments planned for the curriculum, which demonstrates how the learning outcomes must be achieved, articulating clearly the professional standards and specific levels of performance expected at critical progression points and for successful completion.

**Programme of learning**

A programme of learning is the organised experiences, methods and educational approaches used to create appropriate learning opportunities for those in training so they can achieve the stated learning outcomes of the approved postgraduate curricula. The purpose of a programme of learning is to allow those in training to develop and acquire the necessary experience, learning outcomes and capabilities as outlined in the approved postgraduate curricula.

**Quality assurance (QA)**

The QA of medical education and training in the UK includes all the policies, standards, systems and processes in place to maintain and enhance quality. The GMC carries out systematic activities to assure the public and patients that medical education and training meets the required regulatory standards.

**Quality control and management (QC and QM)**

In the context of the GMC’s quality assurance framework, QC covers the arrangements through which Local Education Providers (LEPs) ensure that medical students and trainees receive education and training that meets local educational and professional standards. Medical colleges and faculties also have a role in QC in terms of ensuring that the national examinations they run are in line with assessment best practice.

Medical schools and postgraduate deaneries are responsible for managing undergraduate and postgraduate training programmes and the progress of students and trainees according to the GMC’s education standards. Medical schools and postgraduate deaneries will have QM systems to satisfy themselves that the LEPs delivering their local programmes are meeting the GMC’s standards. These systems normally involve reporting and monitoring mechanisms.
Training programme

A training programme is a formal alignment or rotation of posts that together comprise a programme of postgraduate training in a given specialty or subspecialty. A programme may deliver the full curriculum through linked stages to a CCT, or the programme may deliver different component elements of the approved curriculum.
M6 - New standards for curricula, new assessment guidance and a refined approvals process

M6 - Annex B

Designing and maintaining postgraduate assessment programmes

(Draft document under final review)
Contents

What’s the purpose of this guidance? ........................................................................................................... 3

Part 1: Designing programmes of assessment ............................................................................................ 10

Setting out the purpose of the programme of assessment (CR4.1a, CR4.1b, CR4.2) ........................................ 10


Content decisions: formative and summative (CR4.1h, CR4.2, CR4.7) Error! Bookmark not defined.

Evidencing format decisions: acceptability, feasibility, cost effectiveness (CR2.5a-f, CR4.1b-c, CR4.4) Error! Bookmark not defined.

Part 2: Managing programmes of assessment Error! Bookmark not defined.

Evidencing content quality: setting up structures to ensure the quality of assessment (CR2.4a-f, CR4.1g, CR4.6) ................................................................................................................................... 26

Setting out expectations: examiners and assessors (CR4.1g, CR4.4, CR4.10-12) ........................................ 34


Evidence about assessment structure: validity, reliability and small cohorts (CR4.1a) Error! Bookmark not defined.

Part 3: The impact of a decision Error! Bookmark not defined.

Evidencing decisions are appropriate: standard setting (CR4.1f, CR4.5, CR4.11) ........................................ 44

Evidencing the impact of assessments (CR4.2, CR4.3, CR4.4, CR4.5) .................................................... 47

Appendix 1: Annual publication of exam data Error! Bookmark not defined.

Key terms used in this document Error! Bookmark not defined.

Bibliography Error! Bookmark not defined.
What’s the purpose of this guidance?

1. This guidance is supplementary to our standards for curricula. It gives advice for those making decisions in organisations (typically colleges and faculties) about how programmes of assessment are designed and maintained.

2. Our standards for curricula emphasise five principles.
   - Safety – assessments assure the profession, patients and the public that doctors are safe
   - The maintenance of professional standards
   - Excellence – enables learners to develop the skills, knowledge and performance for excellent patient care
   - Fairness – affords all learners opportunities to demonstrate outcomes and considers their performance consistently in line with clear and transparent criteria
   - Meeting patient and population needs – current and future

3. The standards require curricula to describe fewer, high-level generic, shared and specialty outcomes, which will support all doctors better in understanding what is expected of them in their training programme. They require curricula to identify common areas of training and to have a greater focus on the generic professional capabilities common to all doctors. These requirements for approval will enable delivery of improvements to the flexibility of postgraduate medical training.

4. Our standards also require that assessment should also impose a reasonable burden on learners and their trainers.

5. The guidance sets out the steps and principles that you should follow when:
   - planning and designing a programme of assessment
   - determining expected levels of performance for critical progression points and completion of training
   - maintaining its quality and validity in practice.

6. It also suggests approaches that you could use, but these are not prescriptive.

7. This is not a guide addressing the technical requirements for GMC curricular approval; this will be subject to separate GMC operational approval processes.
This guidance is intended to offer organisations further detail, examples and information in support of the ambition and expectations set out in the new GMC curriculum standards *Excellence by design*. Much of this detailed guidance concerns the design, development, conduct and management of programmes of assessment and their quality management systems. By focusing further on the fundamental principles and practical considerations outlined in *Excellence by design* it is hoped this guidance will support organisations as they develop their assessment philosophy, strategy and programme of assessment.

The guidance explores how organisations might evidence how they:

- meet the standards and requirements outlined in the new GMC curriculum standards *Excellence by design*
- clarify and communicate these expectations to others charged with implementing approved curricula
- establish a flexible but robust approach to the quality management of the programme of assessment and will meet GMC quality assurance requirements.

Who is this guidance for?

This guidance gives advice and information for colleges and faculties to support those making decisions about the programme of assessment in their curricula. It is written with the intention of assisting in the design, development and management of the programme of assessment, and the applicable section of the standards and evidence to form the approvals process is highlighted in each section.

Information and guidance on making submissions to our curricular approvals process is contained in (dedicated guidance/the submission form). While this guidance does not describe or advise on the approvals process, the principles contained in this document are the same as those underpinning our approvals process.

This guidance may also be relevant to other organisations involved in medical education in the UK. Local training bodies conducting assessments in the workplace are subject to the standards in *Promoting excellence* (see especially R1.18 and S1.2).

What we mean by assessment

We define assessment as all activity aimed at judging a learner’s attainment of curriculum outcomes, whether for summative purposes (determining progress) or formative purposes (giving feedback). An ‘examination’ is an example of an individual assessment test.

Assessments need to:
- give opportunities for learners to develop and demonstrate the learning outcomes set out in the approved curriculum
- identify learners who have not, demonstrated the expected level of performance, attainment or achievement needed to progress in or complete training
- give learners appropriate opportunities to receive timely feedback that provides a basis for action, so that they can understand what is expected at their level of practice and provide them with evidence and guidance as to how they can act to improve their performance and continue to develop.

What's new in this guidance?

Programme of assessment

15 A ‘programme of assessment’ refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the approved curriculum.

16 The programme of assessment is likely to be comprised of several different individual types of assessment. These may include national examinations, summative assessments, assessments in practice and formative or developmental assessments. The choice of methods relates to what learning is being assessed and why, and the consequences of the assessment. For example, assessments that result in feedback will require different choices to those that result in decisions about progression to be defensible. A range of assessments may be needed to generate the necessary evidence needed for judgements about performance and decisions about progression in, and completion of, training. All assessments, including those conducted in the workplace, must be linked to the relevant learning outcomes (eg through the blueprinting of assessments).

Safe management of critical progression points in training

17 There are critical progression points in all training programmes which may represent significant risk to patients, the service and those in training. These must be identified and safely managed through the requirements and guidance set out in the approved curricula and programme of assessment.

18 These critical progression points may include: when transitioning to higher levels of professional responsibility or entering a new or specialist area of practice; when a doctor in training is being considered or deemed to have satisfactorily completed the
programme of training. In each case, the risks to patients, the service and doctors must be safely and appropriately managed.
Greater emphasis on validity

19 ‘Validity’ is seen as the key consideration in current assessment theory (HPAC 2016). We define validity as ‘interpretations and uses of tests that make sense and are supported by appropriate evidence’ (adapted from Kane 2013:3).

Space reserved for visual description of validity evidence sources

20 Validity is demonstrated by:

- setting out of the explicit purpose of particular assessments, clearly communicating their contribution to the wider programme of assessment and decision making process particularly in relation to progression and satisfactory completion of training (what is being tested and why)

- collecting evidence about:
  - the choice, content and format of assessments – are the assessment methods that have been chosen appropriate for the declared outcome being assessed?
  - the practical conduct of the assessment, eg whether those assessing and being assessed understand what they are required to do or demonstrate, or whether exams are scored or conducted correctly and effectively
  - ‘internal structure’ – the psychometric performance of a test – eg is an examination sufficiently reliable, for example?
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

- the relationships between different assessments within the programme of assessment – do assessments that intend to test similar things do so in practice? Are they all necessary, what particular value do they add and why?

- describing the consequences of the assessment, and how decisions made using assessments are defensible. Decisions should be consistent, defensible and fair to doctors in training and provide appropriate assurance about the safety and quality of their practice (HPAC 2016). The consequences of a decision will affect the evidence needed to support it; more impactful decisions will need more robust evidence (Kane 2013).

Outcomes-based curricula

21 The new Excellence by design GMC standards for curricula require all postgraduate curricula to describe appropriate high level outcomes as generic, shared and specialist professional capabilities. Outcomes-based curricula focus on what kind of doctor the programme will produce rather than the process by which these capabilities are achieved (Harden et al 1999). Doctors are required to demonstrate complex knowledge and skills, but it is widely acknowledged that (good) doctors are defined by much more than this. Training programmes should ultimately aspire to assess and evidence a learner’s holistic/’global’ performance.

Incorporating Good medical practice and the Generic professional capabilities framework as generic outcomes in the programmes of assessment

22 In the standards, we require organisations to develop outcomes-based curricula containing high level generic, shared and specialist outcomes. Good medical practice (GMP) and the Generic professional capabilities (GPC) framework must be included in all postgraduate medical curricula as a minimum regulatory requirement.

23 The programme of assessment will incorporate this common content as a series of agreed generic outcomes as outlined in the guidance being developed by the AoMRC and the GMC. This approach to generic outcomes will be consistent across all specialties to support greater flexibility and transferability of learning in training.

The importance of professional judgement

24 The guidance emphasises the importance and centrality of professional judgment in ensuring learners have attained the learning outcomes as set out in the approved curricula. Assessors are required to use their professional expertise and experience and through their understanding of the expected levels of performance make accountable, professional judgements as part of a valid programme of assessment. A coherent and integrated programme of assessment will allow can be collated to support programmatic assessment and holistic decisions about learners’ progress.
College and faculty responsibilities for administration and conduct of assessments

25 The quality of administration and governance is part of an assessment’s validity. We describe colleges’ responsibilities for:

- quality managing the assessments they deliver
- supporting and enabling the quality of assessments carried out locally by issuing appropriate guidance and specialty-specific expected levels of performance.

Flexibility

26 Our curriculum standards allow for greater flexibility in the way assessments are designed. Those designing a programme of assessment will need to describe what informed their choices and how it supports the overall validity of the programme of assessment.
## Part 1: Designing programmes of assessment

### Setting out the purpose of the programme of assessment

*Excellence by design*: CR4.1a, CR4.1b, CR4.2, Theme 1

#### Key issues in this section

<table>
<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
<th>For managers and administrators</th>
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<tbody>
<tr>
<td><strong>CR4.1b</strong></td>
<td></td>
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<tr>
<td></td>
<td>What kind of doctors are you aiming to produce?</td>
<td>Where is this written down?</td>
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<td></td>
<td>How does the programme of assessment help to achieve this?</td>
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<td></td>
<td>What are the underlying principles and purpose of the programme of assessment?</td>
<td>Does each assessment within the programme of assessment have a clear purpose in relation to the curricular outcomes?</td>
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<tr>
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<td>Where are they set out?</td>
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<td></td>
<td>Are they clear and linked to the agreed purpose of the curriculum?</td>
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<td>Is it clear what methods will be used to assess and when?</td>
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<td></td>
<td>Is the choice of methods and timing supported by clear argument, research or best practice?</td>
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</table>

| **CR4.1a CR4.3** | How does the programme of assessment aim to capture the doctor’s professional development towards achieving curricular learning outcomes over time? | How is longitudinal development intended to be captured in assessment? Where and how is global judgement of a learner’s performance made? What is the format of the test (numbers/length/scoring)? How was this decided? |

| **CR4.2** | How is underperformance by learners identified, and what is the approach to its management? | Can learners who aren’t making progress be identified? What happens to them then? |

| **CR4.4** | What are the equality considerations of your choices? |  |
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

<table>
<thead>
<tr>
<th>Ref</th>
<th>Evidence for approvals or QA</th>
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<tbody>
<tr>
<td>CR4.1a</td>
<td>A1) Clear articulation of desired purpose of each element of an assessment, and indication that this has informed choice of format to ensure validity</td>
</tr>
<tr>
<td>CR1.1b</td>
<td>B Assessment strategy document clearly presenting the identified purpose of each element in relation to one another and in the context of the assessment's outcome. Identification of the role each summative assessment plays in progression decisions within the broader training</td>
</tr>
<tr>
<td>CR4.3</td>
<td>Systematic approach to:</td>
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<td>■ identifying each area required prior to progression at waypoints of the training programme (documented and highlighted in a matrix/overarching blueprint)</td>
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<td></td>
<td>■ Systematic approach to identifying discrepancies between trainees’ fulfilment of workplace-based and summative assessment requirements respectively</td>
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</table>

Guidance

Assessing outcomes using a programmatic approach (CR4.1b)

27 A programme of assessment is designed to demonstrate that a learner has met the learning outcomes of the approved curriculum. Since most outcomes are not confined to one-off assessments (Schuwirth and van der Vleuten 2011), assessments should be part of an integrated programme of assessment that gives learners multiple opportunities for feedback and development, and to demonstrate mastery of each learning outcome over the course of their training.

28 A programme of assessment must have a clearly stated overall purpose in relation to the curriculum and must clearly state the purpose of its individual assessment components, setting out the range of different assessments that can contribute different evidence to support overall judgements about performance and decisions about progression and satisfactory completion of training.

29 This means organisations will need to plan their programme of assessment (not just examinations) as an integrated, interdependent, programme to show doctors have achieved the relevant learning outcomes. Programmes of assessment should be synoptic in design. (CS4.2, CR4.1a)
30 Individual assessments within the programme may have a range of purposes, such as:

- identifying or developing an individual's strengths and weaknesses (CS4.6, CR4.3) to plan future learning, remediation and guide development
- providing opportunities for reflection
- enabling key capabilities to be developed further through formative or developmental assessments particularly when outlining expected levels of performance or in the promotion of excellence
- demonstrating (partly or wholly) the achievement of curricular outcomes at critical progression points and preventing the progression of those who have not achieved them
- demonstrating achievement of a satisfactory standard at the completion of training.

31 Failing to reflect changes in the curriculum within assessment will compromise the purpose of the assessment, and the assurance that satisfactory completion of assessment provides about the standard of learners. For this reason, changes to the format, content, rules, standard or structure of assessments should not be made without appropriate oversight, involvement and agreement of those responsible for the curricula. Organisations should be able to describe why any standalone changes to the assessment system are required and be able to describe how the programme of assessment continues to meet the needs of the curriculum.

Designing a strategy as a basis for a programme of assessment CR4.1b

32 An organisation should take a structured, coordinated approach to the design and development of its programme of assessment and communicate these in the form of a coherent assessment strategy. This will be required to demonstrate that the programme of assessment meets the standards set out in Excellence by design. The fundamental principles and practical considerations must be addressed and followed to support the eventual demonstration that judgements made from assessment can be justified. Specifically, the overall assessment strategy should set out how organisations have ensured that:

- assessments contribute to enabling safe, high quality care for patients
- all learners have opportunities to develop and improve their performance from feedback to achieve the approved learning outcomes
the assessment approaches adopted afford all groups of learners a fair opportunity to develop or demonstrate they have achieved the required learning outcomes (subject to patient safety considerations)

- learners who have not met curricular outcomes are identified and there is a clear approach as to how they should be managed and supported.

33 In adhering to these high-level principles, the assessment strategy document should clearly articulate:

- the purpose of each assessment and how this is ensured in the selection, development and validation of the format chosen
- the combination of assessment methods that are to be used to test each part of the curriculum, and why they are appropriate and proportionate to what is being tested
- standard setting principles and approaches in the context of expected levels of performance
- the way in which assessments provide, in conjunction with one another, the required information to contribute appropriately to important decisions regarding progression within, and completion of, training.

34 The assessment strategy document does not require exacting detail for each assessment, but should give an overview of the programme as a whole and where and how critical decisions should be made, highlighting key principles such as safety, expected levels of performance and scope of practice. We anticipate a wide range of approaches will be acceptable if supported by appropriate evidence, and a clear narrative.

Making decisions at critical points within the programme of assessment (CR4.3)

35 The decisions made at critical progression points and completion of training should make defensible use of evidence from a range of assessments, potentially including exams and observation of behaviour by those who have appropriate expertise/experience. They can also incorporate evidence from formal observations, such as from supervisors or assessments demonstrating progress over time in the feedback provided (see also AoMRC 2016).

36 Periodic (at least annual) review can be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progress. Assessments such as entrustable professional Activities (EPA) -type formats also involve looking across a range of different skills and behaviours to make decisions about a learner’s suitability to take on particular
responsibilities or tasks, as do decisions about the satisfactory completion of modules within curricula.

37 To put this into practice, organisations will need to:

- provide clear performance criteria at each critical progression point against which evidence can be gathered to enable summative decisions and judgements to be made. Decision aids or flow diagrams may assist this process and describe adequate and inadequate performance

- match assessments to appropriate points in the curriculum. We do not require particular assessments to be scheduled at particular points. In structuring programmes of assessment organisations should consider:
  
  - identifying how learners are expected to progress through the curriculum; we anticipate the latter stages of the programme of learning will include assessments that integrate complex evidence to make global judgements about overall performance and progression
  
  - describing what outcomes learners should have already demonstrated and to what level, and with what degree of confidence
  
  - balance the overall assessments required for learners, faculty and organisations.

38 Some examples of approaches organisations may find helpful to use, adapt or combine are:

- HPAC’s programmatic assessment case study (2016)

- the portfolio approach to a curriculum module described in Roberts et al (2014)

- the approach developed by the Association of American Medical Colleges (2014) which is concerned with a learner’s trustworthiness to complete clinical tasks that integrate different skills and knowledge independently (ten Cate 2013).

39 The choice is not limited to these approaches but choices should be set out and clearly justified in the assessment strategy.
## Linking curricula content and assessment

*Excellence by design: CS4.5, CR4.1d-e*

### Key issues in this section

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<th>For decision makers</th>
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<tbody>
<tr>
<td>CR4.1d</td>
<td>How do you ensure those completing training meet the GMC regulatory requirements in relation to the generic outcomes and include and embed GMP and the GPC framework through your curriculum/assessment programme?</td>
<td>What particular types of outcomes are you assessing (usually expressed as general learning outcomes in a curriculum)? (HPAC 1.4)</td>
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<td>CR4.1e</td>
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<td></td>
<td>Within the curricular outcomes how are the assessments of skills/knowledge and performance balanced and demonstrated at the appropriate level across the length of training?</td>
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<td></td>
<td>How do these provide a basis for developing global professional performance?</td>
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<td></td>
<td>Can the college or faculty demonstrate that the learning outcomes and assessments have been clearly linked through blueprinting to the approved curriculum, and is the blueprint used as a basis for the programme of assessment?</td>
<td>Examsbv2</td>
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<td></td>
<td>How are the expected levels of performance determined and what should they be at completion of training or critical progression points in training?</td>
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### Exams
- How do you map the programme of assessment to learning outcomes?
- How do you choose and develop items relevant to assessment blueprint domains? (HPAC 21.1-3)

### Assessments at work
- How do you map the skills required by the assessment task to learning outcomes? (HPAC 2B.1)
- How are global judgements made of the observed performance in the context of the identified standard?
- How are expected levels of performance determined?
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

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<tr>
<td>CR4.1d</td>
<td>How do you ensure that assessment continues to meet curricula needs?</td>
<td>What structures ensure that those responsible for curriculum have appropriate oversight and input into all aspects of assessment?</td>
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<tr>
<td>CR4.1e</td>
<td>How are decisions about assessment made with appropriate oversight and input from those responsible for the curriculum?</td>
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<tbody>
<tr>
<td>CR4.1d</td>
<td>• D1) Blueprinting grid for each assessment element reflecting the organisation of the relevant syllabus (informed by the organisation of the curriculum), with sample population showing the division of labour between different formats used where applicable</td>
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<td>• D2) Multi-dimensional approach to blueprinting, demonstrating how different domains within each curriculum module can be covered within a given assessment (single clinical topic assessed with regard to basic science, management, investigations, communication etc)</td>
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<td></td>
<td>• D3) Overarching assessment blueprint identifying what is assessed by which method in the context of the curriculum modules; clear identification of what is required by way of attainment in such a context for progression at waypoints within training</td>
</tr>
<tr>
<td>CR4.1e</td>
<td>• E1) Syllabus for each assessment clearly organised with reference to the organisation of the curriculum and linked to learning outcomes at each waypoint so expected content or performance and standard is clear</td>
</tr>
</tbody>
</table>

Guidance

40 Our standards require programmes of assessment to be based on the curriculum, and must include GMP and the GPCs framework. As such organisations need to make sure that:

- curricula describe the required generic, shared and specialist learning outcomes for satisfactory completion of the programme of training and at critical progression points within that training

- generic, shared and specialist learning outcomes are linked to and demonstrated through evidence gathered throughout the approved programme of assessment

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the programme of assessments, the individual items within it and the content and format are derived exclusively from the content of the approved curriculum.

41 To ensure this is the case, staff who are responsible for the curriculum should be closely involved in the development of the programme of assessment; assessment developments should not be carried out independently of those responsible for the curriculum.

42 A blueprint is a template or table that provides the evidence that learners are judged against the stated learning outcomes of the approved curriculum. The generic, shared and specialist outcomes of the curriculum provide the framework for the design, planning and evaluation of the programme of assessment.

43 Blueprinting is a key exercise for developing the evidence to support the validity of an assessment (Coderre et al 2009). A blueprint specifies which assessment method is used to assess each learning outcome. It may also show the stage of training at which outcomes are assessed, and how content may be sampled across different assessments over time. Blueprinting of assessments against the curricular learning outcomes is essential in taking a systematic approach to the design of the programme of assessment.

44 As well as this overarching blueprint for the programme of assessment, individual tests should also have a blueprint showing how curricular content will be covered and sampled in the individual assessment.

45 Organisations need to be able to show through assessment blueprints that every learning outcome is appropriately evidenced and assessed at least once, using one or more approved assessment methods. Colleges should provide a comprehensive assessment blueprint showing how all the learning outcomes in the approved curriculum are assessed over the course of training in addition to blueprinting individual exams. Blueprints must be kept up to date and reflect the approved curricular content and learning outcomes.

46 Organisations may also design systems to collate and aggregate various low stakes assessment (including assessments at work) and provide evidence of coverage of outcomes (for example, see Maastricht case study in HPAC (2016)). To do this,
organisations need to provide a range of assessments mapped to curricular outcomes which can be completed, capture and demonstrate the spread of assessments completed by the learner, and provide a process by which the spread of assessments completed is reviewed against the criteria required for progression.

**Sequencing and integrating assessments – (CR4.1d-e)**

**47** At any particular time in a programme of learning, some outcomes will be more critical to the safety and effectiveness of the work the doctor may be expected to do. Therefore the programme of assessment will need to be explicit in terms of priority of outcomes and expected levels of performance during different phases of training. This may require that the programme of assessment describes sequencing and prioritisation of learning outcomes over time and describes how the triangulation and integration of evidence and judgements from multiple assessments will be made to inform decisions around critical progression points and satisfactory completion of training.
Content decisions: formative and summative

*Excellence by design*: CR4.1h, CR4.2, CR4.7

### Key issues in this section

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<th>For decision makers</th>
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</table>
| CR4.1h| How does the programme of assessment give opportunities for learners to gain experience and receive feedback on their performance?  
Where are summative decisions made about whether learners have achieved outcomes?                                                                                     | How are the different kinds of assessment reflected in blueprints/assessment strategies?  
What are the formative/developmental assessments?  
How are they linked to curriculum outcomes?                                                                                                                                                                                      |
| CR4.2 | How are feedback, improvement and remediation incorporated into your programme of assessments?                                                                                                                                 | What are the expectations regarding feedback for those conducting assessments locally?                                                                                                                                                                                                         |
| CR4.8 |                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                |

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<th>Ref</th>
<th>Evidence for approvals or QA</th>
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| CR4.8 | - Feedback integrated into assessments at work, with sufficient prominence afforded to this in the case of formative assessments  
- Routine feedback provision with summative assessment results to enable unsuccessful candidates to identify and target specific areas of development prior to their next attempt at that examination  
- Routine feedback provision with summative assessment results to enable successful candidates to improve their performance |
| CR4.1h| - H1) Assessment clearly framed as summative by explicit contextualisation with regard to a waypoint in training and inability to progress within successful completion; role in relevant ARCP identified. Mandatory nature and relevant limit on attempts clearly identified |
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

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<tr>
<th>Ref</th>
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<tr>
<td>CR4.2</td>
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</table>
|   | 1) Routine feedback provision to enable unsuccessful candidates to identify and target specific areas of weakness prior to their next attempt at the examination  
|   | x) Routine feedback provision with summative assessment results to enable successful candidates to improve their performance  
|   | 2) Clear information for trainees regarding sources of guidance and support where difficulties are encountered in passing relevant assessments  
|   | 3) Clear information regarding rationale and detail of the relevant attempts limit and any requirement for extra attempt(s) beyond this |
| CR4.1j |  
|   | J1) Process in place for examiners to identify potentially dangerous practice betrayed by candidates within the context of an assessment  
|   | J2) Feedback sufficiently instructive to identify occasions on which an unsuccessful candidate is some way below the minimum standard required, either in specific domains/syllabus areas, or in the assessment overall to ensure appropriate remediation |
| CR2.4 |  
|   | Clear information regarding the overall assessment system and its constituent parts available in the public domain  
|   | Clear identification of formative and summative elements, along with how each part of the programme of assessment contributes to decisions regarding progression with training |

Guidance

48 Programmes of assessment combine several functions (see 26 above), and their individual components may:

- assist the learner to develop, evidence and acquire new skills, knowledge and capabilities as required by a curriculum (formative assessments which have consequences around the development of the learner)

- demonstrate and evidence the level of performance a learner has achieved for a particular purpose, such as determining eligibility for specialist registration (summative assessments, which may have direct or partial consequences for registration or progression)

- do both; another approach is one in which the feedback from numerous small formative assessments is monitored, collated and reviewed periodically to give a
rounded view of the learner’s performance and improvement over time. This can in turn enable reliable holistic judgement to be made about suitability for progression, eg at annual review (ARCP) (see HPAC 2016 case study, van der Vleuten et al 2012).

49 The purpose of an assessment in relation to both its immediate objective and the role it plays more generally within the programme of assessment must be clear to learners and assessors. A lack of clarity regarding the purpose of an assessment can serve to undermine its validity by compromising the extent to which this purpose is achieved.

50 As part of the requirement for curricula to ensure learners receive appropriate developmental feedback, organisations should provide assessments at work that are primarily formative in nature. Dedicated advice on improving the quality of feedback is given by AoMRC (forthcoming).

51 Formative assessments should:

- require and enable interaction between learners, assessors, teams and patients
- generate effective feedback, from assessors with the right expertise and/or experience, and with appropriate training where required (HPAC 2016)
- give qualitative/narrative feedback about a doctor’s performance and how it can be improved and prompt the learner to consider their own performance and development needs
- be chosen/led by the learner or a trainer to gain experience of, feedback about or insight into one or more areas of the learner’s performance
- result in the learner taking action and provide evidence of that action (eg through a further formative assessment or in the course of supervision)

52 Feedback from these formative assessments can be used to identify issues of engagement, professional development or serious underperformance, which can be communicated to those responsible for training programmes. In prioritising learning and feedback, such assessments should not require learners to demonstrate that they can progress; rather, the standard required to progress may be used as a benchmark to guide discussions and plan future learning and development.
53 Organisations should also provide summative assessments and processes which:

- demonstrate that the learner has acquired (and maintained) knowledge and skills as required by the approved curriculum (e.g. knowledge or clinical exams, logbooks, some assessments of practice)

- give information on a learner’s ability to practice safely within a defined area or aspects of it with progressive levels of supervision (multi-source feedback (MSF), supervision reports, portfolios, EPAs some assessments of practice)

- synthesises the range of assessment data at critical progression points to consider the holistic performance of the learner and to make summative decisions and judgements about whether they are performing to the level expected/whether they are making acceptable progress towards achieving curricular outcomes.

54 Organisations may also design summative decision making processes that collate and synthesise evidence from a range of assessments which may not be carried out primarily for summative purposes. Such an approach is consistent with the approach in which assessments are neither formative nor summative but have different stakes attached. (see Maastricht case study in HPAC 2016). Underpinning this should be:

- clear information on the use of assessments for learners and assessors

- a defensible process for collation and synthesis of this evidence, supported by guidance to enable synthesis and decision making.
Evidencing format decisions: acceptability, feasibility, cost effectiveness

*Excellence by design*: CR2.5a-f, CR4.1b-c, CR4.4

**Key issues in this section**

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<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
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<tbody>
<tr>
<td>CR2.5a-f</td>
<td>How have stakeholders of an assessment had a (proportionate) say in their design?</td>
<td>How were learners, supervisors, deaneries/HEE local teams and local education providers involved in the development of/change to assessments (where appropriate)?</td>
</tr>
<tr>
<td>CR4.4</td>
<td>What do you know about the experiences of different stakeholders, and especially different groups of learners? How are they included in the design process?</td>
<td>What equality and diversity considerations were identified? How did they influence the outcome?</td>
</tr>
<tr>
<td>CR4.1b</td>
<td>How are you assured that assessments will function as intended in practice?</td>
<td>Do new or modified assessments require piloting to determine their feasibility in practice?</td>
</tr>
<tr>
<td>CR4.1c</td>
<td>How are patient safety and quality of care prioritised in assessment design?</td>
<td>If so, what does piloting show?</td>
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<td>What other information do you gather about putting assessments into practice?</td>
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<td>What resources are required to implement the assessments/programme of assessments?</td>
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<td>Are these reasonable and universally available?</td>
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How do you decide that an assessment is safe to use? What rules or processes ensure safety?
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

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<tr>
<th>Ref</th>
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<tbody>
<tr>
<td>CR4.1b</td>
<td>B) Assessment strategy document clearly presenting the identified purpose of each element in relation to one another and in the context of the assessment’s outcome. Identification of the role each summative assessment plays in progression decisions within the broader training programme</td>
</tr>
<tr>
<td>CR4.1c</td>
<td>C1) Details of pilot structure and outcomes (include metrics where appropriate) for proposed new assessments</td>
</tr>
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<td>C2) Details of pilot participants (prospective candidates or past candidates of the live assessment)</td>
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<td></td>
<td>C3) Evidence of routine piloting in the inclusion of new questions (non-scored marker questions within live assessments) whilst ensuring that reliability of the assessment is not compromised</td>
</tr>
<tr>
<td>CR4.4</td>
<td>E&amp;D considerations in assessment material development</td>
</tr>
</tbody>
</table>

Guidance

Assessments should be developed with input from those responsible for carrying them out and subject to them (R2.1-3). Ensuring feasibility and acceptability to assessors and doctors in training is a priority in assessments at work (AoMRC 2009, 2016), as is ensuring the environment has the capacity to deliver the assessment. Organisations could demonstrate this in a number of ways:

- Using (or establishing) groups which involve trainers, employers, learners and patients to understand what is likely to work in practice or not. This should be proportionate, and many organisations will already have structures for this.
- Include the service in the development of the assessment to ensure feasibility in the learning and working environment is recommended.
- It is desirable to include a diverse range of stakeholders who share protected characteristics in such groups; different groups of learners are likely to have different experiences of undertaking assessments, which can affect the outcome. Taking steps to understand these experiences and include them in the process of producing these assessments may help organisations to understand and address the possible impacts of assessments.
- Identifying the resource required and the capacity of the environment to deliver them.
Planning the programme to be cost effective and efficient in sampling and evidencing the approved curricular learning outcomes, so minimising the burden of summative assessment.

Piloting/trialling new developments if feasibility is questionable or experience of delivery is required.

Organisations should gather evidence that equality and diversity issues have been properly considered and have influenced the outcome. Organisations and institutions need to be able to demonstrate that, wherever it was relevant to do so, they considered equality and diversity issues pertinent to the work they undertook (e.g., through data collection and equality analyses).
**Part 2: Managing programmes of assessment**

**Evidencing content quality: setting up structures to ensure the quality of assessment**

Excellence by design: CR2.4 a-f, CR4.1 g4, CR4.5, CR4.6

**Key issues in this section**

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<tr>
<th>Ref</th>
<th>For decision makers</th>
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<tbody>
<tr>
<td><strong>Quality structures</strong></td>
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<tr>
<td><strong>CR2.5 a-f</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>CR4.5</strong></td>
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<tr>
<td>How are stakeholders, including learners, patients and the public, involved in the oversight of assessment?</td>
<td>How do structures ensure that the review and management of assessment is carried out with appropriate input from or links to the curriculum?</td>
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<td>How is the programme of assessment reviewed?</td>
<td>How do structures ensure curricula changes are reflected in assessments?</td>
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<td></td>
<td>What are the mechanisms for involving learners, patients and the public in the oversight of assessment?</td>
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<td></td>
<td>How do you ensure the quality of assessments and items produced?</td>
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<td></td>
<td>Is there a quality strategy for assessments?</td>
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<td>What checks and review of assessments are made?</td>
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<tr>
<td><strong>CR4.6</strong></td>
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<tr>
<td>Does comparing assessments with other assessments that purport to measure similar things assure you that assessments are measuring what they intend to measure?</td>
<td>Are there assessment tasks in which learners’ performance is particular poor or good when compared to other similar tasks?</td>
<td></td>
</tr>
<tr>
<td>What does this tell you about validity and balance of assessments within the programme of assessment?</td>
<td>Is there evidence of too much or too little testing of particular areas within the assessment programme?</td>
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</table>
### Managing exams and assessments in the learning environment

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<tr>
<th>Ref</th>
<th>For decision makers</th>
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</table>
| CR4.5 | How do you quality control the production of assessments, and review and manage the quality of exams? | Exams  
- How do you check the marking/moderation of the exam for accuracy/quality?  
- What safeguards make sure responses are accurate?  
How do you systematically analyse learner responses to review and check assessment question phrasing and brief to learners? |
| CR4.5 | How do you support the local conduct of assessments/organisations carrying out assessments locally? | What training/guidance/rules/other resources do you give to support deaneries/HEE local teams and assessors to conduct assessments or make decisions?  
What information can you use to support the identification of issues and improvement of local practice?  
How do you identify where design changes and additional support/information are necessary? |

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<tr>
<th>Ref</th>
<th>Evidence for approvals or QA</th>
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<tbody>
<tr>
<td>CR4.1g</td>
<td>G1) Evidence of quality assurance infrastructure, with processes drawing on appropriate expertise to identify issues and resolve these appropriately</td>
</tr>
<tr>
<td>CR4.4</td>
<td>Conscious action to ensure that assessment design and material development is accessible to all and without bias</td>
</tr>
<tr>
<td>CR4.5</td>
<td>Systematic monitoring of assessment performance metrics including: reliability coefficients; SEMs; pass rates; examiner marking behaviour; ARCP outcomes with regard to assessment outcomes</td>
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</table>
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

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<tbody>
<tr>
<td></td>
<td>■ Periodic review of guidance material in the public domain; feedback from relevant stakeholder groups regarding need for necessary updates</td>
</tr>
<tr>
<td>CR4.6</td>
<td>■ Regular reporting through ASR</td>
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</tbody>
</table>

Guidance

Quality structures

57 Organisations must subject their programme of assessment to systems and processes that monitor and improve quality (CR4.6). Organisations must have processes to quality control all stages of assessments they deliver themselves (such as national knowledge based exams) and specific guidance and expectations to support those conducted by others. These structures should enable those with responsible for curriculum to have appropriate input into and oversight of assessment.

58 Organisations should be able to describe the structures, groups/committees and processes they use to manage, monitor and review the quality and performance of their assessments and how they assure the validity (including the reliability) of their assessments.

59 A common issue across medical education is difficulty collecting equality and diversity data about learners. Given the importance of collecting equality data as part of the management of assessment, organisations may wish to consider what information they can provide (in addition to legal notices) to explain to learners the importance of equality and diversity data in managing the programme of assessment, citing examples of its use where appropriate. These difficulties do not exempt organisations from the requirement to attempt to collect, analyse and use this data.

Managing the ongoing quality of assessment designed and delivered by organisations (usually exams)

60 The validity of assessments depends on their practical delivery and day to day management as well as their design. Assessments designed and delivered entirely by organisations, such as national exams, require appropriate quality management at all stages. Organisations:

■ are obliged to carry out quality control of the scoring and judgements of examiners

■ must make sure assessments have been scored and reported accurately
must have processes to check for and identify errors in administration.

61 Software packages to process assessment data are widely available and can help to minimise clerical/processing errors; organisations are encouraged to use technology to manage assessment data for this reason. Staff should have sufficient expertise to use this software in appropriate ways, and be able to identify where errors in the use of, or calculations made by, this software have occurred.

62 Organisations should also:

- publish information about the performance of their exams (see appendix 1 for a suggested publication scheme) (CR4.8)
- routinely analyse (and publish) them for trends related to protected (and other relevant characteristics) (see appendix 1 for suggested analysis)
- investigate anomalies and act to address risks to fairness or safety identified
- report any such concerns to the regulator.

63 Bodies within the organisations should routinely review and report on the overall patterns shown in assessment and consider what issues these raise within established internal governance systems. This should include analysis of results for equality and diversity issues (Coombes et al 2016), and the identification of performance differentials between different groups.

Managing the ongoing quality of assessment – conducted in the learning environment

64 Assessments conducted in the learning environment, particularly formative or developmental assessments, need an environment and culture that values and supports education and training. The quality and conduct of these assessments are the responsibility of organisations providing training. These organisations are subject to our Promoting excellence standards. Monitoring and maintaining the quality of these assessments, when conducted, should be an explicit consideration in their design and development (see PE S1.2). Organisations and deaneries/HEE local teams need to work together to ensure that curricular and professional standards are maintained. This may include gathering information in order to:

- take steps to provide or improve guidance for those using and providing assessments
- engage with those using and providing assessments
- improve the design of assessments conducted in the workplace
support deaneries’/HEE local teams’ quality management process, helping them in continuously improving their conduct of assessment (where appropriate and possible).

Managing the programme of assessment as a whole

Collating the results of different assessments together enables integrated judgements about a doctor in training’s overall performance. Organisations should:

- Where possible, provide evidence that assessments are valid by reference to other assessments that assess at similar things
- Optimise and minimise the assessment load by establishing the relationships between assessments and eliminating unnecessary repetition of testing, balancing this with the need to triangulate judgements
- Where possible, make this information available to learners and supervisors so that a longitudinal view of an individual’s strengths and weaknesses can be formed

A benefit of using programmes of assessment is that a balanced view can be taken of the need for testing across the length of training. Evidence of validity of individual assessments can also be collected through looking at the relationships between results of different assessments which aim to test similar things; for example showing ‘a strong positive correlation with some other measure of the same achievement or ability’ and no/negative correlation with assessments of different outcomes (Downing 2003:835). High level outcomes are likely to be demonstrated by a range of assessments over time, some degree of congruence between different assessments of similar/the same outcomes may be useful to show that the outcome has been demonstrated.
## Setting out expectations: learners

*Excellence by design* CR4.1g, CR4.2 CR4.4

### Key issues in this section

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<tbody>
<tr>
<td>CR4.1g</td>
<td>How do you ensure educators and learners have enough information about assessment to respond to it in the way intended in the design?</td>
<td>What information is given to learners about their assessments?</td>
</tr>
<tr>
<td>CR4.2</td>
<td>How are learners informed about the role of formative/developmental assessments in the programme of assessment?</td>
<td>How can communication to learners around what is expected be improved?</td>
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<td>How are learners familiarised with assessment formats?</td>
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<td>Is the grading/mark sheet (or a variation of it) or expected level of performance shared with learners prior to the completion of the assessment?</td>
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<td>If not, why not? (HPAC 2B.6)</td>
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<tr>
<td>CR4.4</td>
<td>What kind of support do you offer to different groups of learners (eg IMGs, those in need of reasonable adjustments)?</td>
<td>Do you mandate/support/suggest particular actions for those delivering assessments on your behalf?</td>
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<td>What’s the rationale for your choices?</td>
<td>How are reasonable adjustments/appeals dealt with?</td>
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<td>How is this information communicated to learners?</td>
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<tr>
<td>CR4.1g</td>
<td>G1) Evidence of quality assurance infrastructure, with processes drawing on appropriate expertise to identify issues and resolve these appropriately. Presentation of this infrastructure to all stakeholders to offer appropriate transparency of processes, including the ability to appeal outcomes</td>
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<td></td>
<td>G2) Clear identification of assessment context, content (syllabus) and standard against which candidates will be assessed, with reference to the relevant training waypoint where applicable</td>
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<td>G3) Sample questions for each format available in the public domain</td>
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<td>CR4.2</td>
<td>I2) Clear information for trainees regarding sources of guidance and support where difficulties are encountered in passing relevant assessments</td>
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<td>Clear information regarding the overall assessment system and its constituent parts available in the public domain</td>
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<td>Clear identification of formative and summative elements, along with how each part of the programme of assessment contributes to decisions regarding progression with training</td>
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<tr>
<td>CR4.4</td>
<td>Reasonable adjustments policy in the public domain</td>
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**Guidance**

**67** An effective programme of assessment depends on learners being aware of what is expected from them. Learners should have information to help them understand:

- how they can use the programme of assessment to drive and plan their own learning and development
- what feedback they can expect to receive from their assessments
- why they are being assessed
- what skills, knowledge, behaviours they are expected to develop and demonstrate and the level at which they are expected to perform
- the relationship between assessments
- what are the critical progression points and expected levels of performance at different phases of training
what assessments are summative or enable progression and which are formative/developmental, and how critical progression decisions are made

the processes for appeals in summative exams, reasonable adjustments and similar should be clear and transparent.

68 The responsibility for communicating about these issues with learners is shared with deaneries/HEE local teams, as part of their responsibility under *Promoting excellence*. Organisations will need to make resources available to communicate the purpose, format, rules and decision making process to learners depending on the individual assessment and how it impacts upon the programme of assessment. Organisations designing assessments at work should work with those putting them into practice to give all relevant information to learners.
Setting out expectations: examiners and assessors

*Excellence by design.* R4.1g, CR4.4 CR4.10-12

**Key issues in this section**

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<tbody>
<tr>
<td>CR4.1g</td>
<td>What are the organisation’s expectations for assessors and examiners?</td>
<td>What information is given to examiners/assessors about assessments they work within?</td>
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<tr>
<td>CR4.9</td>
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<td>How can communication to assessors/examiners around what is expected be improved?</td>
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<td>How is understanding of the standards required developed across all examiners/assessors involved? (HPAC 2B.5)</td>
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<td>Who can act as an assessor or examiner in what circumstances?</td>
<td>Where is this set out?</td>
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<td>Are there particular requirements (eg training) for particular roles?</td>
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<tr>
<td>CR4.4</td>
<td>How are assessors/examiners able to use their judgement and experience in decision making/feedback?</td>
<td>How are examiners selected, trained, monitored and appraised?</td>
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<tr>
<td>CR4.10</td>
<td></td>
<td>Do they understand their equality and diversity responsibilities?</td>
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<tr>
<td>CR4.10</td>
<td>How do you ensure the quality of assessors you provide (eg examiners)?</td>
<td>What feedback and support do your assessors receive?</td>
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<tr>
<td>CR4.11</td>
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<td>CR4.12</td>
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<tr>
<td>CR4.1g</td>
<td>G4 Appropriate guidance provided to examiners within assessment material in addition to provision through briefing and subsequent calibration processes</td>
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<tr>
<td>CR4.</td>
<td>E&amp;D training requirement for examiners, and, where appropriate, other assessors, outline content of training</td>
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Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

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**Ref** | **Evidence for approvals or QA**
---|---
**CR4.10** | 1) Role description and person specification for assessors and examiners respectively  
2) Selection policy available for the appointment of new examiners  
3) Outline content of examiner training programme  
4) Clear communication of annual time commitment expected of examiners

**CR4.11** | 1) Calibration of examiners integrated into routine examination schedule  
2) Calibration includes material-specific discussion where a station is marked by more than one examiner, in addition to overview of expected standard, with reference to the role played by summative assessment within the training programme, undertaken with all examiners prior to each examination diet  
3) Feedback provided to examiners in the form of peer observation and/or marking data

**CR4.12** | 1) Guidance for examiners included in marking scheme or, where global judgements are applied to generic domains, station-specific guidance included in the assessment material to inform judgements  
2) The need for initial training (and subsequent training, where applicable) stipulated and includes E&D training

**Guidance**

69 Organisations are already required to set out requirements for those who work directly for them in their exams (‘examiners’), and should take steps to support the conduct of assessment in the workplace through setting out clear requirements and providing support, guidance, training and resources as appropriate.

**Professional judgements**

70 Assessment literature sees professional judgement of appropriately trained, expert assessors as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance (HPAC 2016, Street 2015). Assessment tools are available that can capture and integrate a range of professional judgements from different groups including colleagues, supervisors and non-medical staff. HPAC (2016) advises that expert judgement can be applied to decisions about levels of supervision or entrustment and that the concept of trust can be helpful in supporting assessor decisions and feedback. Methods that can give this evidence include:
multi-source feedback

EPAs and WBAs

supervision reports.

Professional judgement requires care in its use. Research on differential attainment has found that interpersonal interactions and local context can potentially put some groups at a disadvantage (Regan de Beere et al 2015, Woolf et al 2016). Professional judgements are made in this context so it is important that assessments take place fairly and reliably. Organisations can support this by

- designing assessment programmes that collate multiple judgements and assessors when using professional judgements
- setting out clearly what criteria professionals should judge against
- using formats which require/encourage assessors to record evidence and reasons for their judgements
- providing information and training for assessors where appropriate, including their responsibilities in safeguarding patients and the public
- defining what professional expertise is needed in each assessment and when/if particular training is required. This should not unduly restrict the range of assessors that can be used, but where particular professional qualifications, experience or training is necessary, this should be clear
- providing resources and guidance to those who make such judgements (eg training or guidance) to make sure they understand their role and how to keep their judgements fair
- increasing trainers’ and assessors’ understanding of the barriers faced by specific groups of doctors: for example, Woolf et al (2016) found that, while all doctor in training faced challenges, those from UK minority backgrounds or who trained overseas were vulnerable in particular ways that could result in poorer outcomes for these groups- such as in poorer perceptions by trainers and lack of opportunities to demonstrate outcomes
- encouraging diversity amongst decision makers (Woolf et al 2016); for example attempting to recruit a diverse cohort of examiners and standard setters
- providing, where possible and appropriate, training in the consistent application of the mark criteria and standards, and providing regular calibration opportunities for high stakes tests.
For assessors they manage directly (usually their examiners), guidance on the recruitment and management of these assessors is already set out by the AoMRC.

Organisations should also produce information about their examiners’ performance (eg leniency vs harshness). Organisations should act to remediate/remove their assessors who consistently fail to assess candidates in line with assessment rules.

Assessors working within deaneries/HEE local teams/delivering assessments at work

Organisations do not have any specific obligations for the quality management or appraisal of these assessors. But they should:

- set out clear expectations for assessors, including who is an appropriate assessor in a particular task and what expertise, experience or training (if any) is required
- provide resources to support the fair and correct conduct of assessment- such as guidance or local training
- utilise local networks, where possible, to support assessors (eg college tutors)
- support local quality management of assessors. Examples of this support might include feeding the results of portfolio audits to deaneries/HEE local teams or providing targeted training to support the conduct of a particular assessment
- attempt to focus quality management activities on supervisor and assessor engagement with feedback processes
- consider providing information to support the educational aspects of appraisal by the deanery/HEE local team where possible/appropriate; eg enabling supervisors to review the feedback they have given to learners in their appraisal where possible.
Evidence about assessment structure: statistical analysis

Excellence by design: CR4.1a, CR4.1g, CR4.5 CR4.6, CR4.7

Key issues in this section

<table>
<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
<th>For managers and administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR4.1a</td>
<td>How do statistics show your exams/assessments are of good quality and set appropriately consistent standards?</td>
<td>What psychometric analyses do you perform on your test or test response data?</td>
</tr>
<tr>
<td>CR4.5</td>
<td></td>
<td>- Item level data (eg discrimination)</td>
</tr>
<tr>
<td>CR4.7</td>
<td></td>
<td>- Test level data (eg standard error of measurement (SEM), generalisability)</td>
</tr>
<tr>
<td>CR4.6</td>
<td>Which groups of learners are included when calculating assessment metrics?</td>
<td>What is your review process for checking quality of items using the data from the test?</td>
</tr>
<tr>
<td>CR4.1g</td>
<td>What does assessment data say about the performance of different groups of learners?</td>
<td>How does this show the test is valid? (HPAC 2A.6-7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How is data used to set standards for, or trigger review of, items or whole assessments?</td>
</tr>
<tr>
<td></td>
<td>Who reviews and interprets this data, and what actions are taken as a result?</td>
<td>Can you identify/quantify the main sources of error in assessments?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What can be done about them?</td>
</tr>
<tr>
<td></td>
<td>Do you look at the relationships of results from your assessments with other results from other assessments?</td>
<td>Which correlations with other relevant variables such as other in-course assessments or other summative assessment do you investigate?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is the correlation with similar tests, or dissimilar tests?</td>
</tr>
</tbody>
</table>
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

<table>
<thead>
<tr>
<th>Ref</th>
<th>Evidence for approvals or QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR4.1a</td>
<td>■ A2) Clear articulation of how the question sampling (number of questions included in each element of an assessment) fulfils requirements of content validity (appropriate syllabus coverage) and reliability (internal consistency)</td>
</tr>
<tr>
<td>CR4.1g</td>
<td>■ G1) Evidence of quality assurance infrastructure, with processes drawing on appropriate expertise to identify issues and resolve these appropriately</td>
</tr>
<tr>
<td>CR4.5</td>
<td>■ Systematic monitoring of assessment performance metrics including: reliability coefficients; SEMs; pass rates; examiner marking behaviour; ARCP outcomes with regard to assessment outcomes</td>
</tr>
<tr>
<td>CR4.6</td>
<td>■ Report of examination quality, considering and explaining key sources of validity evidence including psychometric properties of individual elements of assessments (item and test level metrics, especially reliability and SEM) and contribution to the programme as a whole including (eg through congruence with similar or related tests)</td>
</tr>
</tbody>
</table>

**Guidance**

75 An important source of evidence about the validity of an assessment (or set of assessments) is its ‘internal structure’, ie psychometric properties (Sullivan 2011:119). These properties can help to understand the quality of the pre-test planning, design and the quality of the assessment’s conduct. It can help to identify key quality concerns and provide evidence about whether decisions are fair and defensible. Psychometric evidence can help to identify and investigate questions about fairness, particularly where variations are observed between different groups.

76 This information cannot be produced or used without a critical understanding of the different measures. Organisations need to:

- ensure they have secured sufficient access to expertise to analyse and understand the data, and to act where it shows action is required

- carry out psychometric review and investigation into assessments at the level of:

  - items within exams (ie the performance and properties of individual questions, eg discrimination)

  - the properties of tests as a whole, (eg their reliability, measures of error). In particular, reliability is an important part of the demonstration of overall validity (Downing 2004)
- the programme as a whole (e.g., through the congruence of similar tests or analysis of the outcomes of those completing training)

77 Psychometric analysis should take a broad view of the quality of assessments and aim to produce information that enables the quality of all aspects of assessment to be understood and improved. In addition to routine reporting of assessment metrics, psychometric analysis should use a range of metrics to provide a holistic view of assessment as evidence of the reliability and validity of the interpretation of the assessment's results.

Assessments at work and reliability

78 The purpose of assessments at work will generally be formative supervised learning events, where feedback and engagement in the learning process is key; we do not require these assessments to meet reliability criteria and caution it may be undesirable to try and reduce the rich information these formats can give to something that can be demonstrably reliable (see HPAC 2016:37).

79 If the purpose of assessment in the workplace is summative, then judgements about knowledge, skills or performance need to be made reliably. Organisations may wish to consider:

- utilising tools or formats shown to be reliable elsewhere (provided they are transferable)

- making use of expert judgement, and doing so over multiple assessors and occasions (AoMRC 2016:4). This can be:
  - within the individual assessment (with some research supporting the psychometric reliability of an MSF (Moonen-van Loon et al 2015)) or;
  - as part of a programmatic approach in which a summative process collates and synthesises individual elements

- training assessors in their roles and declaring expected standards.

80 HPAC (2016:44) advise that attempting to create psychometrically reliable assessments at work may be undesirable. They also suggest that entrustment formats may have advantages in terms of authenticity and rigour, which may in turn have advantages for learners’ engagement with assessments at work. Furthermore, asking assessors to entrust responsibilities for patient care may link the assessor’s judgement more closely to their own duties to uphold standards. This is important because research indicates such considerations to be enable assessors, who might otherwise feel unwilling or unable, to fail underperforming or unsafe learners (Yepes-Rios et al 2016).
We do not mandate a particular approach but organisations should show that, where assessments at work are used for summative purposes, the judgement produced will be defensible, and supported by consideration of reliability issues.
Evidence about assessment structure: validity, reliability and small cohorts

Excellence by design: CR4.1a

Key issues in this section

<table>
<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
<th>For managers and administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR4.1a</td>
<td>What’s your approach to ensuring reliability in exams where cohorts are too small to calculate reliability/SEM?</td>
<td>If an assessment is too small to make reliability calculations, what steps have you followed to ensure reliability?</td>
</tr>
</tbody>
</table>

Ref Evidence for approvals or QA

- A1) Clear articulation of desired purpose of each element of an assessment, and indication that this has informed choice of format to ensure validity
- A2) Clear articulation of how the question sampling (number of questions included in each element of an assessment) fulfils requirements of content validity (appropriate syllabus coverage) and reliability (internal consistency)

Guidance

82 In the summative assessments of cohorts which are too small to produce meaningful statistics about reliability. Organisations still need to design and deliver assessments which have overall validity for their intended purpose, including appropriate reliability, even if this cannot be demonstrated as a coefficient.

83 Organisations can address some of these difficulties by:

- utilising tools or formats shown to be reliable elsewhere (provided they are transferable)
- carrying out quality checks on the design and item writing process
- training examiners and assessors in their roles and declaring expected standards
- trying to achieve reliable overall results by appropriate combinations and correlations of numerous assessments taken over time with different assessors
- comparing or correlating results with tests assessing similar things and which are known to be reliable (concurrent/predictive validity).
Approaches which use assessments at work in combination to make judgements would be acceptable, as long as a programme of assessment was appropriately designed.
### Part 3: The impact of a decision

**Evidencing decisions are appropriate: standard setting**

*Excellence by design.* CR4.1f, CR4.5, CR4.11

#### Key issues in this section

<table>
<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
<th>For managers and administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CR4.1f</strong></td>
<td>How do you use standard setting to ensure safety, fairness to learners and promote excellent patient care? How does this provide assurance to stakeholders?</td>
<td>What standard setting method do you use to determine the passing standard? Why do you use this method? (HPAC 2A.8) What do you do with the SEM? Why? How do you ensure consistency in the standard between diets? What arrangements exist for review of the standard itself and the standard setting process?</td>
</tr>
<tr>
<td><strong>CR4.11</strong></td>
<td>What experience do you need to set standards?</td>
<td>How are standard setters recruited, trained and managed?</td>
</tr>
</tbody>
</table>
Ref | Evidence for approvals or QA
---|---
**CR4.1f** | ■ F1) Clear identification of standard against which trainees are being assessment, evident in syllabus and with reference to relevant waypoint within training programme
■ F2) Criterion-referenced approach in the standard setting of assessments; compromise methods used in addition to this by way of triangulation but not as principal method to identify pass marks
■ F3) Details of standard setting approach used for each individual component of an assessment. If test equating is applied to standard set assessments, indication of review process and frequency of periodical revisiting of question material
■ F4) Details of training for standard setters and calibration measures prior to each exercise
■ F5) Details of whether a compensatory or conjunctive approach is taken for each element of the assessment to inform the overall pass/fail status
■ F6) Details of application of SEM in deciding upon the final pass mark of an assessment.

**CR4.11** | ■ Role description and person specification standard setters

**Guidance**

85 Standard setting should reference the purpose of the assessment in explicitly considering what the consequence of passing the assessment will be to provide assurance about the safety of patients and the public.

86 Decisions with significant consequences (eg GMC specialist registration) cannot use ‘norm-referenced’ standards, by which passing or failing learners are defined relative to the performance of other learners. Aside from this, organisations should select the most appropriate method to ensure professional standards and fairness to candidates are maintained. The AoMRC notes the importance of considering the purpose of an assessment in deciding the standard setting method.

87 Organisations should attempt to ensure the identified standard is maintained with each diet of a summative exam (unless there is a reason to modify the standard). This means making sure that, through a ‘criterion-referenced’ approach, the chosen standard setting technique enables the identified standard to be applied to assessment material in each examination diet. Fluctuations in pass marks or pass rates and data gathered from statistical analysis might for example prompt consideration of examiner behaviour, standard setting or item quality.
88 Organisations need to show that an appropriate standard has been set to pass a summative assessment. They also need to:

- make sure the chosen approach to standard setting is suitable for the format of the examination and put into practice in a way that follows evidence and best practice. A typology and explanation of methods is set out in guidance from the AoMRC (2015:3,11-18)

- consider whether the standard setting process should be informed by particular cohorts of learners; this is particularly applicable to examinations which are also taken as independent qualifications by learners for purposes other than progressing towards specialist registration

- consider guidance from the AoMRC (2015).

89 Where pass rates are unstable, low or otherwise of cause for concern, organisations should investigate to determine whether this is caused by defects in the assessment itself, or whether this stems from other causes (eg changes in the performance of the learners taking the test). They should take action where this analysis shows the quality of the assessment is an issue. Organisations should consider:

- comparison of each assessment diet with others

- reviewing pass rates

- reviewing assessment material

- reviewing standard setting approaches

- looking over a period of years to identify pass rate trends and investigating possible factors accordingly.

90 Organisations should periodically review both the standard and the standard setting process to ensure the standard set and methodology around it continues to be appropriate.
**Evidencing the impact of assessments**


**Key issues in this section**

<table>
<thead>
<tr>
<th>Ref</th>
<th>For decision makers</th>
<th>For managers and administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR4.3</td>
<td>How can the evidence about the design, delivery and analysis of assessment be summarised to justify why the assessment has strong validity?</td>
<td>How do you manage the impact of failing on learners and feedback to employers/training providers?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What arrangements are there for remediation/support? (HPAC 4.2-3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How are academic dishonesty and appeals managed?</td>
</tr>
<tr>
<td>CR4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR4.2</td>
<td>How do decisions ensure fairness to learners, patient safety and support learners to achieve excellence?</td>
<td>What kind of feedback (score reporting and qualitative information) is given on the assessment? (4.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How does the programme of assessment enable the identification of learners who are not (yet) safe to practice at the point of completion of training?</td>
</tr>
<tr>
<td>CR4.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CR4.5</td>
<td>What impact do the results of the assessment have on:</td>
<td>Do your monitor the % of passes and fails?</td>
</tr>
<tr>
<td></td>
<td>- curricular outcomes</td>
<td>What impact do the results of the assessment have on the curriculum and assessments and the programme in general? (HPAC 4.5-6)</td>
</tr>
<tr>
<td></td>
<td>- the delivery of learning (HPAC 4.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- the future design and conduct of assessments?</td>
<td></td>
</tr>
<tr>
<td>CR4.6</td>
<td>What external review is undertaken of the programme of assessment?</td>
<td></td>
</tr>
</tbody>
</table>
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

<table>
<thead>
<tr>
<th>Ref</th>
<th>Evidence for approvals or QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR4.2</td>
<td>Process in place for assessors to identify potentially dangerous learners</td>
</tr>
<tr>
<td>CR4.3</td>
<td>Systematic approach to identifying each area required prior to progression at waypoints of the training programme (documented and highlighted in a matrix/overarching blueprint)</td>
</tr>
<tr>
<td>CR4.4</td>
<td>Conscious action to ensure that assessment decisions and decision aids are made without bias</td>
</tr>
<tr>
<td>CR4.5</td>
<td>Systematic monitoring of assessment performance metrics including: reliability coefficients; SEMs; pass rates; examiner marking behaviour; ARCP outcomes with regard to assessment outcomes</td>
</tr>
<tr>
<td></td>
<td>Periodic review of guidance material in the public domain; feedback from relevant stakeholder groups regarding need for necessary updates</td>
</tr>
<tr>
<td>CR4.6</td>
<td>Regular reporting through ASR on assessment quality</td>
</tr>
</tbody>
</table>

Guidance

91 The successful completion of many postgraduate training programmes is linked to the ability to practise as a consultant or GP in the NHS- so concerns about validity of assessment have their roots in the concerns of the wider public (Kane 2013:2). Organisations need to ensure decisions about progression and actions in respect of learners who do not (yet) meet standards reflect this.

92 Organisations should recognise that assessments support processes in the wider healthcare and training system. Organisations/deaneries/HEE local teams should work collaboratively to ensure and provide assurance about the quality of learners completing the programme by providing evidence against the domains of validity (see above 4). Organisations should consider how deaneries/HEE local teams would need to use assessment data, eg in the planning and management of service and training. They should ensure they provide data in a sufficiently timely way to enable deaneries/HEE local teams to use the information to plan learners’ progression.

Assuring patients, learners and others

93 Groups who have an interest in assessment decisions include:

- patients and the public, employers and colleagues, all of whom can expect a certain standard of performance from a doctor; patient safety is the first priority
the doctor, who can expect to be treated fairly, assessed objectively and to have reasonable opportunities to remediate and develop in areas of weakness

the organisation, along with relevant local training organisation, who are accountable for conducting assessments and making key decisions in the form of critical progression and satisfactory completion. They are also responsible for deciding what is taught and, to some extent, how. Organisations should:

- use data to continuously improve the quality of their assessments
- use data to support curricula/outcomes review.

Organisations should report on how the programme of assessment has provided appropriate assurance about those successfully completing training.

Establishing formal mechanisms with external organisations/peers to carry out periodic reviews of their programmes of assessment may help to improve quality and share practice.
## Appendix 1: Annual publication of exam data

We suggest the following as a minimum set of information/template for publication about individual major national exams which provide assessment against approved curricula.

<table>
<thead>
<tr>
<th>Exam name</th>
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</thead>
<tbody>
<tr>
<td><strong>Exam format</strong></td>
<td>Please describe the type of assessment, type and number of items</td>
</tr>
<tr>
<td><em><em>Number of candidates</em> and pass rates</em>*</td>
<td>Please state the number attempting the exam in year/each diet within year. It may be appropriate to report only a sub-cohort of those taking the test, such as those in UK training (see footnote).</td>
</tr>
<tr>
<td><strong>Breakdown of candidates and passing candidates by:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td> demographic groups/ protected characteristics</td>
</tr>
<tr>
<td></td>
<td> place of qualification</td>
</tr>
<tr>
<td></td>
<td> attempt number</td>
</tr>
<tr>
<td><strong>Standard setting method</strong></td>
<td>Please describe:</td>
</tr>
<tr>
<td></td>
<td> the standard setting method and reasons for the choice</td>
</tr>
<tr>
<td></td>
<td> additional measures to ensure the safety of the standard set, eg minimum numbers of stations to pass or adjustments for error.</td>
</tr>
</tbody>
</table>

* We would recommend colleges report data on the basis of those candidates to whom the whole programme of assessment to which a test is part of applies; for example where an exam forms part of a programme leading (eventually) to specialist registration, it might be reasonable to report only on the basis of those candidates who might be expected to eventually achieve entry to the specialist register (and not those pursing the exam as an independent qualification or for purposes overseas).
| Most recent report to oversight body | It may be helpful to provide a report describing in a comprehensive and holistic manner:
- the quality of the assessment using a range of metrics supported by appropriate explanation and interpretation
  - this should include discussion of the reliability/internal consistency of the assessment using an appropriate choice of metrics
- interpretations of this information including discussion of quality management activity which is required or desirable in respect of the assessment
- any other action appropriate action in respect of the wider functions of the organisation setting the assessment

We suggest reporting on a regular (annual) basis, to considering the diets of the assessment carried out that year. |
Key terms used in this document

Assessment
We define assessment as all activity aimed at judging a learner’s attainment of curriculum outcomes, whether for summative purposes (determining progress) or formative purposes (giving feedback). An ‘examination’ is an example of an individual assessment test.

Assessor
An assessor provides an assessment and is responsible for interpreting the learner’s performance in that assessment. Assessors should be appropriately trained and should normally be competent (preferably expert) in the area that is being assessed. It includes examiners as a specific type of assessor.

Critical progression point
A point in a curriculum where a learner transitions to higher levels of professional responsibility or enters a new or specialist area of practice, including successful completion of training.

 Examiner
An examiner is category of assessor working within the context of a formal, summative exam.

Learners
Learners are medical students receiving education leading to a primary medical qualification and doctors in postgraduate training leading to a certificate of completion of training (CCT) or doctors completing a regulated credential.

Learning outcomes
Learning outcomes are the knowledge, skills, behaviours that a learner must demonstrate by the end of a period of education or training.

Organisation
In this document, ‘organisation’ refers to a body, expected to be a college or faculty, with responsibility for design and maintenance of an approved curriculum and programme of assessment or a part of it. It does not include HEE offices (‘LETBs’) or deaneries which may have responsibilities for the quality of the conduct of some assessments locally.
Council meeting, 26 April 2017

Agenda item M6 – New standards for curricula, new assessment guidance and a refined approvals process

Bibliography


Schuwirth LWT & CPM Van der Vleuten (2011), Programmatic assessment: from assessment of learning to assessment for learning, Medical Teacher, 33:6, 478-485


Tighe, J, IC McManus, NG Dewhurst, L Chis, J Mucklow (2010) ‘The standard error of measurement is a more appropriate measure of quality for postgraduate medical assessments than is reliability: an analysis of MRCP(UK) examinations’, BMC Medical Education 10:40


Draft standards for curricula and assessment consultation report

About the consultation

1. We consulted on draft standards for postgraduate curricula and regulated credentials from 5 September to 28 October 2016.

2. Working with stakeholders, we developed draft standards for the design and development of curricula and regulated credentials, and asked those with an interest in medical education and training if we have got the standards right.

3. We also asked some questions about how we might apply these standards in order to reduce regulatory burden, where appropriate, and to better support those organisations designing and developing curricula and credentials to meet our standards.

Reviewing the standards

4. As part of our work quality assuring medical education and training, we approve postgraduate medical educational curricula and programmes of assessment to make sure they meet our statutory requirements.

5. Our standards for curricula and assessment systems hadn’t been reviewed for almost ten years, and we needed to update them to take several developments into account. These included wanting to embed generic professional capabilities (GPCs) into curricula, providing a basis for approval of regulated credentials, applying lessons from our work looking at differential attainment, and providing an integrated standards framework together with Promoting excellence: standards for medical education and training.

6. We engaged extensively with colleges and faculties in early 2016, inviting each of them to meet us and share their views on the current standards and processes, and to give feedback on our plans.
We also worked with an external advisory group (EAG) made up of representatives of the four UK countries; with curriculum and assessment experience; from college, deanery/HEE local team, and employer backgrounds; and including a patient and public representative.

In June 2016 we held a UK stakeholder day where we discussed an early draft of the standards with colleges, which helped us develop the draft standards for consultation.

**Consultation methodology**

The consultation was public and was available through our e-consultation website and on our project web pages. We emailed invitations to everyone who’d been involved in earlier engagement, four-country stakeholders, representatives of equality and diversity groups, doctors in training, and those who’d responded to the credentialing consultation in 2015.

We promoted the consultation in the GMC news e-bulletin, as a web news story, and in a blog post published on our website written by a member of the EAG, Namita Kumar, Postgraduate Dean at Health Education North East.

We asked 15 questions about the draft standards document; and 11 about our plans for revised processes for approving curricula, and developing our quality assurance activities to support the new standards.

We arranged for our consultation analysis to be audited through our internal audit and risk assessment processes.

**Summary of our findings**

**Respondents to the consultation**

We received a total of 69 responses; 36 from individuals; and 33 from organisations.

The majority of individual respondents were doctors (22) or medical educators (9), but there were also medical students (2), one member of the public, and two not categorised. Of the 31 who identified as doctors or medical educators, 16 didn’t state their roles, but the 15 who did included general practitioners (3), consultants (8), doctors in training (2), one medical manager, and one SAS doctor. Among the individual respondents there were several members of the curriculum advisory group (CAG).

Individuals gave their country of residence as England (13), Scotland (3) or not stated (20).

Ethnic group distribution was made up of half who identified as white (18), with the rest identifying as Asian or Asian British (6), mixed or multiple ethnic groups (2), with
one from another ethnic group, and nine who preferred not to say or who gave no response.

17 Gender breakdown was female (10), male (16), with ten who preferred not to say, or who didn’t respond. There was one respondent who stated that they had a disability.

18 Organisation responses came from college and faculty bodies (20), postgraduate medical institutions (3), bodies representing doctors (3), NHS or HSC organisations (3), one regulatory body, and three other organisations.

19 A large majority of organisation responses were from UK-wide organisations (24) with responses from organisations based in England (4), Scotland (4), and one from Wales.

Overall support for the standards

Structure and clarity of the standards document

20 There was strong support for the aspects of the structure of the standards document we asked about: organising the standards under the four domains (73%); the layout of purpose, standards and requirements under each domain (73%); stating the core principles of patient safety, excellence, and fairness at the beginning (69%); and outlining the responsibilities and relationships at the end (67%).

21 Where respondents disagreed or weren’t sure, most of the comments indicated that they wanted changes to details, rather than rejecting the proposed structure, and we’ve made many of the changes suggested where appropriate.

22 Support for the four domains was strong. However some responses, along with discussions with stakeholders in our EAG and our quality assurance teams, indicated it would be useful to separate the governance and quality assurance functions. So we created a fifth domain in the final standards, ‘Quality assurance and improvement’, and renamed Domain 2 as ‘Governance and strategic support’. We also replaced ‘domain’ with ‘theme’ to align with Promoting excellence, and to avoid confusion with domains in the GPC framework.

23 Minor changes were suggested for each of the three core principles of patient safety, excellence and fairness. However in response to concerns raised in comments about Domain 1 and other questions, about how to best express the need to consider future workforce needs in the standards, we have created a fourth core principle for this purpose.

24 A large majority (86%) said the standards were either very clear or fairly clear, but we have taken on numerous drafting suggestions to improve clarity, as well as some suggestions for additions to the glossary.
The standards and requirements

25 There was also solid support for the content of the standards and requirements under each of the four domains: Domain 1: Purpose (62%); Domain 2: Governance and quality assurance (65%); Domain 3: Learning outcomes, approaches and experience (63%) and Domain 4: Assessment (61%). Many of the comments were around the details of particular standards and requirements, and we’ve taken on many drafting suggestions for the final standards.

26 In general there was support for the wider concepts, such as the move from time-based training to high-level outcomes, however there were some elements that respondents were concerned about.

27 For Domain 1, several respondents made comments about the focus on workforce need and the challenge of getting four-country agreement. However most agreed these were needed and we have rewritten some of the standards and requirements to make these points more clearly and helpfully.

28 There were some concerns raised about Domain 2 around the level of stakeholder engagement being asked for, with calls that this should be proportional. There were also concerns about clarity and robustness in relation to quality improvement, which have been picked up with the development of Domain 5 in the final standards.

29 For Domain 3, the most common issue raised by respondents was the requirement for a minimum level of experience. They were concerned that it was setting out minimum expectations for ‘time-served’ and would undermine an outcomes-based approach. We have addressed these concerns by changes to wording.

30 For Domain 4, there was a clear level of uncertainty expressed in many of the college responses about their obligations in relation to the quality management of programmes and their role in relation to assessors in LETBs/deaneries. Many colleges considered postgraduate assessments to already meet high standards of quality and considered little improvement was possible, although some considered clarity and consistency would be improved by the standards.

31 Overall, the respondents agreed that the standards were flexible enough to enable organisations to carry out assessments appropriate to the needs of their area of practice. However, many answered ‘not sure’ as they felt that resource and systems implications may affect practical implementation.

32 In relation to equality and diversity, 63% agreed the new standards would help embed the principles of fairness and equality in programmes of learning and programmes of assessment. However, some wanted the requirements to be more explicit about how
organisations are expected to demonstrate the relevant aspects of fairness and equality.

33 There was 57% agreement that particular groups of doctors or other people who share protected characteristics are not likely to be adversely affected by the new standards, however, 24% weren't sure. One concern was that the impact on international medical graduates had not been properly reflected in the standards documents as a consequence of this in itself not being a protected characteristic. There were several calls for guidance or support in carrying out responsibilities under the Public Sector Equality Duty.

Issues for application of the standards

Transition and implementation

34 Only 27% of respondents said it would be straightforward to develop or review curricula based on these standards. Many were concerned about the time and resources involved. However there were comments that these standards are the way forward, and several helpful suggestions for how to ease the transition.

35 A majority of respondents (61%) said that between three and five years would be a reasonable transition period, with an even larger majority (83%) among college and faculty respondents. Exactly half of all colleges and faculty organisations said 3-4 years was a reasonable period. Many respondents acknowledged it would be demanding, but some pointed out that it would be practical to keep the transition period as short as possible.

36 While 48% agreed that these standards would be suitable for the design and development of regulated credentials, most respondents called for more clarity and guidance about how regulated credentials might be implemented. Some suggested it would be better to wait until credentialing was further developed, to see how it works first. Feedback has led us to reconsider including credentialing in these standards, and we will instead produce a separate document for credentials in due course, which will align with these standards as much as possible.

Quality assurance and quality management

37 There was clearly support for the concept (68%) that organisations that develop and design curricula should have a more formal role in our quality assurance of curricula and programmes of assessment at the local level. However many of those who responded wanted more detail about how the process would work in practice. There were also concerns about resource implications, and a number of comments stressed the need for consultation and buy-in from employers.
Some of those who responded thought organisations that develop and design curricula would bring expertise to the quality assurance process. Reference was also made to the fact that many college/faculty representatives already have input to local QA processes, and clarity was requested with regard to specific roles and responsibilities.

We asked what information and evidence we should consider, and over half of the comments received suggested making greater use of the data sources that already exist, and the sharing of data between organisations. There were a number of other sources suggested, which we will consider as we develop our processes.

Most respondents (79%) agreed that a regular review of curricula with a process for ‘retiring’ elements or the curriculum itself, is a good idea. Many colleges indicated that they already have a system for this in place. There was a strong preference towards a longer review period of at least five years. This was noted as being not only more manageable in terms of workload but less disruptive for doctors in training.

Only a small majority (53%) agreed that GPCs should be reviewed every 3-5 years. Some respondents thought the GPC review cycle should be aligned to curricula review. Some respondents challenged the need for reviewing GPCs to stay aligned with workforce needs, as most GPCs have always been and will always be relevant to practising medicine.

We asked what kinds of support, structures or bodies might be helpful in developing or revising curricula or credentials. The suggestions made by respondents were mainly for guidance or advice, including templates or examples; access to contacts or expertise; and systems or networks. Several also mentioned resources.

There was 65% agreement that it would be helpful to introduce a system that ensures that the service and patients have meaningful input into development of curricula, and that workforce needs are consistently identified and addressed. A number of responses were about the challenges involved in this, but many offered suggestions for how this might work, including suggestions for a national reference group to provide consistency in assessing and providing guidance for those developing curricula.

Suggestions for how to get four-country agreement for curricula or credentials included dialogue with relevant bodies, and a defined process with named contacts. Several colleges requested GMC support, and as with the previous question about ensuring meaningful service and patient input into curricula, there were suggestions that we set up or use an existing reference group or forum for consultation, and that we support the process.
We asked what areas we should cover in explanatory guidance, and the majority of respondents wanted more detail on how the new standards would be implemented. There were calls for guidance to cover supporting evidence, to clarify who should be consulted, and to advise on getting four-country agreement. There were a large number of suggestions, which included requests for guidance on GPCs, assessment, and equality and diversity, all of which we are in the process of developing.

Details of feedback on each consultation question are in Appendix A.

Conclusions and next steps

On the whole, there was good support for both the general direction and the detail of the standards. Apart from minor amendments, the final standards document will not differ greatly to the consultation draft. The main changes will be the removal of credentialing to be dealt with separately at a later time; adding an extra domain for quality improvement; and adding extra core principles to address the importance of considering future workforce needs when designing and developing curricula, and maintaining consistent standards across the UK.

There was mixed support for our proposals around application of the standards, with some unease due to the fact that at the time of consultation we hadn’t yet presented any firm plans. Concerns were expressed about the time and resource involved in changes to an already onerous process. We are now developing new processes for approving curricula against the new standards, and our plans include a number of mechanisms to support colleges and faculties in designing and developing curricula to meet the standards.

These standards, along with the GPC framework will provide us with the levers to introduce more flexibility in postgraduate training, and are key components of our commitments in the flexibility review we undertook in late 2016 and early 2017. Our plans for improving flexibility in postgraduate training were not yet developed when we consulted on the standards, so we’ve expanded some of the requirements to enable these to be delivered.

Subject to agreement by Council in April 2017 we intend to publish the new standards in spring 2017, alongside guidance documents and templates to support transition to a new approvals process, and assessment guidance. We will launch the new approvals process at the same time, and we’re planning engagement events to inform stakeholders about the new documents and processes.
About the respondents

51 We received a total of 69 responses to our consultation.

52 In addition to those who responded using the questionnaire on the e-consultation website or the pdf response form, we received consultation responses in the form of email or letter. We have included these in the total number of consultation responses as ‘other format’ responses.

53 We have taken the content of the ‘other format’ responses, where respondents sent us their views without directly addressing specific consultation questions, and applied the comments to the relevant questions.

Method of response

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Type of respondent

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Categories of individual respondents

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<td>Other healthcare professional</td>
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Council meeting, 26 April 2017

Agenda Item 6 - New standards for curricula, new assessment guidance and a refined approvals process

**Categories of organisation respondents**

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<td>Postgraduate medical institution</td>
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<td>Regulatory body</td>
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<td>Other organisation</td>
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**Country organisation is based in**

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**Details of individual respondents**

54 Further breakdown of individual respondent data including details of doctor roles, disability, gender, age and ethnic origin, are at Appendix B.

**Details of organisational respondents**

55 A list of all the organisations who responded is at Appendix C.
All respondents by category

- Doctor: 32%
- College/faculty organisation: 29%
- Medical educator: 13%
- Body representing doctors: 4%
- Other individual: 3%
- Member of the public: 2%
- Medical student: 3%
- Postgraduate medical institution: 4%
- Regulatory body: 2%
- Other organisation: 4%
- NHS or HSC organisation: 4%
Appendix A - Feedback on our proposals

1 Below, we set out each question, followed by a statistical breakdown of responses and a summary of themes arising from the comments, and our analysis and findings.

2 The statistical breakdown is based on the number of respondents who either answered the question by ticking yes/no/not sure or who left these boxes blank but made a comment. Where a respondent didn’t choose yes/no/not sure, but made a comment which clearly agreed or disagreed with the question, we have used our discretion in some cases to count these as ‘yes’ or ‘no’ responses. Otherwise, comments from those who left the question blank have been considered alongside those that answered ‘not sure’.

Structure of the standards

Question 1

Do you agree that the four domains are a helpful way of organising the standards?

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3 There was clear support for our proposed four-domain structure for the standards. One medical educator described it as ‘overdue, but timely’, while the Royal College of Obstetricians and Gynaecologists (RCOG) agreed that they are ‘a good way to organise the standards.’

4 A number of respondents indicated that the domains and standards are simpler and more comprehensive than the current standards document. The Federation of the Royal Colleges of Physicians (fRCP) echoed this support, suggesting they are ‘an improvement on the multiple standards in the current system.’ Similarly an individual thought there was ‘less overlap than previous standards’.

5 A few respondents welcomed the continuing requirement that professional standards and requirements must be consistent across the UK but they can be applied flexibly in local systems. The Royal College of Physicians and Surgeons of Glasgow indicated that it was ‘good to set out clearly the need to have UK wide agreement of a curriculum but
with scope to allow effective local implementation.’ Others suggested the domains will better support the different expectations for those involved in developing postgraduate curricula and assessments, with NHS Employers agreeing they will ‘help individuals to determine where their roles and responsibilities start and end.’

6 Some respondents, whist supporting the domains, suggested we need to be clearer about how they will work together. For example, the BMA cautioned that ‘significant components cross between domains such as research, which is critical to informing each’.

7 The health authorities from Scotland, Wales and England agreed that the domains were useful but NHS Education for Scotland (NES) was unsure about some of the details in the domains and in particular indicated that Domain 3 and 4 needed to be linked more closely.

8 Thirteen respondents were unsure about four-domain structure with most comments recommending that ways to structure the standards. One individual argued ‘it is useful to have a structure I am sure. Whether or not this is the right one is a matter for debate’. While a medical educator proposed ‘curriculum development, purpose and review aggregate together well and intuitively or in other words you could consider conflating Domains 1 and 2 with only minor changes.’

9 Three responses didn’t find the four domain approach helpful. The only organisation that disagreed with our proposed approach was the Joint Committee on Intercollegiate Examinations which suggested ‘specific sections on curricula and on assessment would be more helpful.’

**Question 2**

Do you agree that the structure of setting out the purpose, standards, and requirements under each domain is helpful?

<table>
<thead>
<tr>
<th>Q2</th>
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<tr>
<td>% of those who responded to this question</td>
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<table>
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10 There was strong support (73% agreement) for the structure of purpose, standards and requirements under each domain. A large number of those in agreement or ‘not sure’
commented that the structure was useful, that the purpose statements or other aspects were particularly helpful, that ‘the structure is very clear and follows the structure of Promoting excellence which is helpful.’ (Medical Schools Council) The Faculty of Surgical Trainers / The Royal College of Surgeons of Edinburgh said ‘This gives further clarity to each domain and makes it clear what will be expected of future curricula’. And the Association of the Anaesthetists of Great Britain and Ireland said the structure ‘addresses the broad aims of the standards.’

11 A few comments were general criticisms without suggesting improvements – that the document lacked simplicity or clarity; that our approach was reductive and discouraged diversity of thinking; and one simply objected to our role in setting the standards.

12 Most of the clarifications or improvements suggested – by those who agreed as well as those who weren’t sure or disagreed – were for minor changes or additions, rather than any change to the structure. These included several who wanted an explanation or definition of the terms ‘standard’, ‘requirement’, ‘particular capability’ and ‘credible body’. There were also some grammatical suggestions – to avoid repeating ‘curriculum or credential’ unnecessarily; a caution about the phrasing of ‘the curriculum will evaluate its impact’; and a couple of respondents thought the document lost focus of the fact that we’re describing what should be in a curriculum document, or that it confused what the curriculum should contain with what a submission should contain.

13 One respondent found it confusing to have ‘purpose’ as a domain heading and a section heading within the domains.

14 A couple of respondents felt that the document focused on process instead of outcomes and that the purpose should be less about aims and more focused on educational endpoints and what doctors need to be equipped to do.

Question 3
Is the section at the beginning about patient safety, excellence, and fairness clear and helpful?

<table>
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<table>
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15 Overall support was positive, with 71% agreement that the section on patient safety, excellence, and fairness was clear and helpful, and many comments elaborated on this. The Faculty of Sexual and Reproductive Healthcare ‘believes the outline of these core principles are useful anchors to underpin these education standards and welcomes that this section signposts to other relevant guidance.’ The Faculty of Public Health said it was ‘really important to emphasise goals of excellence in education and fairness’ while the Faculty of Occupational Medicine said these principles were ‘clearly appropriate’. And the Shelford Group said ‘this helps the GMC deliver its purpose as an organisation’ and CAIPE said they welcome ‘the focus upon patient safety, excellence and fairness.’

16 The comments by those who disagreed or weren’t sure, and many from respondents who agreed, were largely suggestions for expanding or amending the three subsections. Many were minor drafting suggestions. A few commenters suggested the section was vague, too wordy, or repeated details that were elsewhere in the standards. A couple noted that this section was aspirational rather than instructive, and that the challenge is in translating it into the rest of the document. One suggested referencing the complexity of the clinical environment, and highlighting the aspects of leadership and management.

17 Suggestions for the subsection on patient safety included noting the distinction between ensuring patient safety during training and the effects of training on patient safety; advising on how to identify key areas of patient safety and clinical risk in practice; expanding on systems thinking and human factors; the need to reflect the social context, and that resource pressures can compromise the safety of patients and staff; the need to consider population safety; and the necessity for appropriate supervision and support.

18 Many respondents welcomed the inclusion of excellence, but some asked how it could be included in curricula. NHS Education for Scotland thought ‘the standards mention excellence however the assessment structure seems to be less focused on this aspect’. Other comments suggested that emphasising excellence in trainers, and in the learning experience, might facilitate excellence in achievement. The RCPsych in Scotland thought that ‘to aspire to excellence is praiseworthy but having a “good enough” doctor does not imply mediocrity instead it implies a medical workforce that consistently produces a medical output of appropriate standard that can be sustained throughout a working career.’ Another said that exams are to separate the competent from the not competent, so examining for excellence would mean exams were pitched at the wrong level.

19 On fairness, there were a lot of requests for support on advice, and comments noted that there could be conflict between fairness and progress on the basis of competition; and challenges around including selection processes and training opportunities. Others raised issues around the collection, sharing, and monitoring of data.
Question 4

Is the section at the end describing responsibility and relationships clear and helpful?

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20 There was 69% agreement that the section describing responsibility and relationships was clear and helpful, with many comments expressing support. A large number of those who agreed, disagreed, and weren’t sure made drafting suggestions, to expand or clarify the details of roles and responsibilities.

21 Several respondents wanted more details included on the role of the colleges in QA/QM, as well as more explanation around quality processes generally, including QI, and explanation of the QAF and examples. The Faculty of Intensive Care Medicine and Faculty of Pain Medicine of the Royal College of Anaesthetists pointed out that the college role in QA ‘goes beyond only “contributing” to the GMC’s activities.’

22 There were a few suggestions for expanding or clarifying employer responsibilities, and a number of suggestions to include details on deanery/HEE local team responsibilities for QM, supporting implementation of GPCs, and playing a part in developing credentials.

23 There were also a couple of calls to define the role of the service, which can vary across the four countries, as well as to include NES and HEE, and organisations not linked directly to the Department of Health.

24 There were several comments on the diagram, a few in praise but a few suggesting changes, eg changing its structure from hierarchical to more collaborative, showing the colleges’ role in QM, and including relationships with HEE, COPMeD, and AoMRC.

25 And there were some broader suggestions, such as moving the section to the beginning of the document, tweaking terminology, and to note where some specific requirements apply to someone other than the curriculum developer, particularly in domains 3 and 4.
Content of the standards

Domain 1: Purpose

Question 5

Have we identified the right standards and requirements for curriculum development and design under this domain?

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Q5 comments

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26 About two-thirds of respondents agreed with the standards and requirements in Domain 1, with one organisation indicating that it ‘is simple and clear.’ Similarly, the College of Paediatricians and Child Health suggested the domain content seemed ‘sensible and clear’, but asked for further information about the level of detail needed against each requirement.

27 It was far more likely for individuals to indicate we hadn’t identified the right standards and requirements for Domain 1. With two individuals arguing that it was outside the remit of the GMC to consider the purpose of curricula. In contrast all nine respondents who were unsure about the content of the domain were organisations.

28 The majority of those who commented on this question, regardless of whether they agreed, disagreed or were unsure, raised concerns either about its focus on workforce need or the difficulty in getting four-country agreement (or both).

29 A little under half of the comments were concerned that S1.1 and R1.1 overemphasised workforce needs as the key driver for curricula development. A few respondents rejected the notion entirely with one doctor arguing that ‘the purpose given is to meet workforce needs. The purpose of education is to develop the person...grow themselves as independent learners.’ A medical educator echoed this concern, suggesting the section ‘appears to refer to workforce planning rather than educational standards.’

30 However, most comments recognised that workforce needs should be an important influence on curricular design, but felt we should instead focus on preparing doctors to meet population needs over time. As one organisation suggested ‘this domain reads
very much as though the development of a curriculum or credential will be based on a short-term view of workforce or patient need, rather than a longer-term or population-wide view.’ Some of the college and faculty and NHS organisations also raised the same concerns. For example, NHS Employers indicated ‘Employer perceptions of service need are likely to be influenced by recruitment and retention challenges, and considering curriculum standards from this perspective could lead to a creeping reduction of standards and training’, whilst the Royal College of Pathologists warned ‘At the level of a published curriculum, there can only be high level, minimal reference to workforce needs (otherwise the curriculum could easily become out of date annually)’.

31 Other responses suggested our approach didn’t put patient and population needs at the centre of curricula development. One medical education thought ‘patient need should come before workforce need, as the patient need is the driver.’ Health Education England (HEE) wanted the domain to do further and ‘articulate how the curriculum will align or contribute to or evaluate impact on patient experience and outcomes’. A few responses, such as the Royal College of Radiologists and Royal College of Obstetricians and Gynaecologists called for more prominence on learner needs or professional and technical needs.

32 A number of comments welcomed the emphasis on agreement from the four-countries, with a medical educator particularly supporting this requirement. But many respondents challenged whether this was a realistic expectation when the approach to service delivery is diverging greatly between the four countries. The RCOG explained that ‘currently it is very difficult to get any feedback from one of the countries for curriculum approvals’. The Joint Committee on Surgical Training (JCST) suggested the four-country endorsement was ‘entirely reasonable in principle’ but like other respondents was concerned about its feasibility in practice. Their response also argued that ‘in particular it is essential that there is ‘buy in’ from employers in the 4 countries.’ Most comments related to the requirement for four-country endorsement asked for more information on how this should be undertaken and suggested the GMC must have a role in facilitating this process.

33 A few respondents like the JCST and the British Thoracic Society thought this domain should only apply to new specialties or credentials or significant changes to current curricula. It would be, they argued, a disproportionate amount of work for already established curricula to provide evidence against this domain. The British Thoracic Society questioned to need for ‘well established and accepted curricula,…to 'justify' their existence and perform needs analysis and establish workforce gaps for the purpose of simply achieving these domains’. They felt ‘this would be burdensome and could impact on the goodwill of individuals involved with curriculum review.’

34 Other issues raised about this domain related to the challenges related to move curricula towards high level outcomes, the impact of these standards on specialties that
train outside of the NHS and to developing regulated credentials. There was also a
general theme for more details about how the standards should be met and clarity
about how this domain will be considered as part of the GMC approval process.

Domain 2: Governance and quality assurance

Question 6

Have we identified the right standards and requirements for curriculum development and
design under this domain?

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As with other questions about the domains, most comments in all categories raised
concerns about particular aspects in the standards and requirements. In particular,
respondents suggested the standard requiring submissions to take account of the
interdependencies with other disciplines would be difficult. With NHS Education for
Scotland asking ‘Specifically what expectations in the wider service and healthcare
system would be expected?’ while the Joint Committee for Surgical Training want more
to clarity about the extent to which interdependencies are evaluated such as
‘Presumably we only need to address interdependencies where the curriculum content
specifically crosses specialty boundaries?’ These questions are echoed by the Royal
College of Paediatrics and Child Health, which suggests further guidance about what
information will be needed to meet the standard on interdependencies. The Faculty of
Sexual and Reproductive Health indicated that the interdependencies requirement
would only work if there were ‘stronger working relationships between medical
specialties and the establishment of formal processes to facilitate intercollegiate
working and information sharing.’

Many other respondents in all categories were concerned that the level of stakeholder
engagement was more extensive than previously. For example, the Federation of the
Royal Colleges of Physicians indicated that ‘Obtaining feedback from patients, patient
groups, carers and lay people will be challenging. How will the GMC advise on the
cost/benefit for such a potentially onerous requirement, even for minor curriculum
changes?’ Similarly the Academy Assessment Committee argued that ‘Considerable
work will be required to obtain meaningful input from patients, lay people and
representatives of those with all protected characteristics.’ One college felt that engaging early on in the development process would be difficult and ‘wonder[ed] whether we would always get a response in a timely manner. However, we are happy to seek involvement.’”

37 Others called for the requirements of engagement to be proportionate. Some respondents also asked for clarity in defining some groups as well as guidance and support in stakeholder engagement, especially with doctors with protected characteristics, employers and patients. For example, the Federation of the Royal Colleges of Physicians indicated ‘We would expect this requirement to be proportionate and guidance on approach will be needed.’ As with other questions, respondents raised concerns about getting meaningful feedback from the four UK countries.

38 A number of respondents suggested amendments or additions to the stakeholder list to make sure it has more focus on doctors in training, educational experts and researchers.

39 Some respondents commented on the requirements related to quality improvement processes. In particularly, they asked for clarity on the kinds of data that will be required. A few respondents sought clarity about the different roles and responsibilities for Colleges in quality management and assurance. However, there was general support for more robust quality improvement arrangements. A number of respondents were concerned particularly about ensuring they have appropriately addressed equality and diversity requirements in the curriculum, especially how to monitor the impact of the curriculum on doctors with protected characteristics.

**Domain 3: Learning outcomes, approaches and experience**

**Question 7**

Have we identified the right standards and requirements for curriculum development and design under this domain?

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% of those who responded to this question: 63%, 12%, 25%, 0%

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The most common issue raised by respondents, regardless of their response category, was the requirement for a minimum level of experience. They were concerned that it was setting out minimum expectations for ‘time-served’ and would undermine an outcomes-based approach. One individual explained ‘Minimum levels of experience = guaranteed extension of training, impact on women doctors and depriving patients of the number of doctors they need.’ Similarly NHS Education for Scotland viewed experience was a further expectation and argued ‘It would appear that this is in addition to that relating to competency and capability with respect to the learning outcomes.’

Several respondents, again in all categories, were concerned about the requirement that set out specific expectations for trainers, managers and other. For example, the Royal College of Pathologists indicated that ‘Expectations [about trainers] don’t ensure credibility and competence.’ And the JSCT argued that ‘It is difficult to know how to address this beyond stating the requirement and ensuring that all trainers meet the GMC’s requirements for recognition.’ Some suggested that the need for the trainers to be ‘clinically competent’ would disadvantage specialties that don’t need clinical trainers such as public health. Indeed NES questioned ‘Why should a manager be clinically credible?’ And the Faculty of Pharmaceutical Medicine suggested ‘the GMC amend R3.6 by deleting the word “clinically” to state instead “…are credible and competent…” because pharmaceutical medicine is a non-clinical specialty.’ A few respondents pointed out that while the requirement for trainers and managers was laudable, it was not easy to implement. As the Royal College of Paediatrics and Child Health explained ‘it is very positive to see that expectations for educators, programme leaders and managers must be clear (R3.6), but this will be meaningless if the GMC cannot do more to ensure that protected time is guaranteed for those in these roles.’

Some respondents were particularly concerned about the requirement to include ways for doctors to achieve excellence. They recognised the value of this expectation, but were particularly concerned about how it would be implemented and measured. The Federation of the Royal Colleges of Physicians queried ‘the aspiration to recognise excellence is commendable but we are not clear on how this can be built into curricula and programmes of assessment.’ One college asked us to ‘define excellence and what this looks like.’

A number of respondents suggested there needed to be more clarity about feedback and in particular the role of colleges in determining what this should look like.

As with other questions, there were a number of comments seeking more clarity on how the standards and requirements should be implemented. The BMA indicated that ‘our main concern is how this will be implemented in practice. An emphasis upon higher level, more broadly defined capabilities must not obscure a trainee’s ability to draw actionable learning points that they need to progress.’
Domain 4: The programme of assessment

Question 8

Have we identified the right standards and requirements for curriculum development and design under this domain?

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45 While there was broad support for most of the principles outlined in this section among colleges and faculties (10 agreeing), several organisations, including colleges were unsure and two disagreed.

46 One issue raised was the parts of the standards which required colleges to take on a role in monitoring the quality of assessment. Five organisations (mostly colleges) were concerned about how the requirements would be implemented.

47 A second issue was assessors, with a further five responses questioning whether and how colleges could meet standards in relation to assessors who were largely located within LETBs and deaneries. The RCPCH linked this to concerns about the ability of college to contribute to the quality management of local assessments: ‘The same [concern] applies to some extent to R4.11 where many persons that fall under the term ‘those involved in assessments' are to a greater or lesser extent beyond the control or influence of the College.’ (RCPCH)

48 There is a clear level of uncertainty from many of the college responses about their obligations in relation to the quality management of programmes and their role in relation to assessors in LETBs/deaneries. Some responses also indicate a lack of clarity around how we see formative and summative assessments, and many respondents were concerned to have early sight of and influence in the development of supporting guidance.

49 A further issue raised by only a small number of respondents, but which has important bearing in the standards, is our treatment of validity and reliability in exams and in assessments in the workplace. It seems unlikely that our intended approach to reliability of exam type assessments is problematic, but it may require clarification that

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we continue to expect high standards of reliability from exams. The issue of workplace assessment and validity/reliability is considered more closely in our guidance but clarity is required in the standards as well.

**Question 9**

Do you think the standards and requirements under this domain are likely to help improve the quality of assessments?

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50 Many colleges considered postgraduate assessments to already meet high standards of quality and considered little improvement was possible, although some considered clarity and consistency would be improved by the standards. Some also identified specific concerns about undermining value of formative assessment.

51 Some respondents raised practical concerns, in particular, the heavy dependence on assessors and ensuring they had sufficient resources (usually time): ‘Whilst the standards themselves may help improve the quality of assessments, it is whether trainers […] actually have the time […] to properly assess their trainees that will have the biggest impact on quality.’ (FICM)

52 A widely raised issue was around formative assessment, with a number of colleges concerned that the standards as written did not make a clear distinction between assessment for learning (formative assessments) and assessments of learning (summative). Some respondents suggested that without a greater emphasis, assessment for learning would continue to be undervalued: ‘[A] Stronger tone highlighting assessments as a tool to enable learning as a means to drive patient outcomes. The risk that the guidance may move assessment away from low reliability WPBAs to exam format, as an unintended consequence.’

53 Individuals and organisations outside the colleges felt obligations around feedback, quality and assessors were likely to result in improvements (nine comments of this type); five comments wanted to see requirements around assessors, feedback or quality management strengthened. However, the recurring issue of ensuring that the colleges are not subject to unreasonable expectations was of concern to many
Council meeting, 26 April 2017

Agenda Item 6 – New standards for curricula, new assessment guidance and a refined approvals process

respondents. This refers to issues raised in Q8 that colleges are unsure they can influence the quality of assessors or assessments that they do not deliver themselves, and the relationship with the requirements set out in Promoting excellence on deaneries/LETBs.

54 Several respondents saw the helpfulness of the standards as very dependent on other things, such as practical support for assessors and assessment (especially formative assessment) in the workplace (11 respondents). However, guidance on validity, improvements to ARCP, ways to share practice and clear assessor instructions from colleges/faculties were all raised as issues on which any improvements were dependent.

Question 10

Are the standards and requirements under this domain sufficiently flexible to enable organisations to carry out assessments in a way which is most appropriate to the needs of their area of practice?

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55 Although only 45% answered yes, that the standards were sufficiently flexible to enable organisations to carry out assessments in a way most appropriate to the needs of their area of practice, comments seemed to suggest that overall the standards were sufficiently flexible. However, organisations had reservations about other issues, or felt that practical considerations were more likely to affect whether assessments could be put into practice or not. For most respondents, this question was relatively uncontroversial compared with other assessment questions.

56 Overall, the respondents indicated that the standards themselves were flexible, but remained concerned by some aspects. ‘Provided the requirement for workplace assessor training is modified or removed and the QA process is sufficiently flexible then, probably, yes.’ (Academy Assessment Committee)

57 Six respondents suggested that resourcing in the workplace, especially systems and time to support assessors and supervisors in their role was the most likely challenge to
the flexibility of the standards: ‘Potentially, but there might be political and resourcing issues around the appropriate training of assessors.’ (RCGP)

58 Many who answered ‘not sure’ felt that the standards were generally sufficiently flexible in themselves, but they noted that resource and systems implications may affect practical implementation. Several respondents also identified specific concerns (largely raised in Q8-9, concerning assessors) which they considered needed to resolved before they agreed to the statement

59 Respondents also highlighted that the flexibility of the approval/assurance process supporting the standards was also vital, and if flexibility was enshrined in the standards, it would also need to be in the supporting quality processes.

**Equality and diversity**

**Question 11**

Do you think the standards and requirements will help embed the principles of fairness and equality in programmes of learning and programmes of assessment?

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</table>

60 Of those respondents who answered ‘yes’, three identified that while it is a positive move to be explicit about the collection and analysis of data, there is a risk that this becomes burdensome for organisations and that the approach should be in line with the aims of the analysis. The Academy Assessment Committee explained that ‘A proportionate approach to the collection and analysis of this data will be required, particularly as trainees are not required to provide all such information.’

61 Two other respondents identified that trainers are key to ensuring the effective delivery of this aim, eg Faculty of Surgical Trainers / The Royal College of Surgeons of Edinburgh said: ‘we should set a high bar for the professionalisation of trainers to ensure that our future curricula are delivered with an aspiration to excellence.’

62 Five respondents were supportive and believed that it was good to ‘explicitly mention’ equality and fairness, and that if the steps identified were followed, it should lead to fair
assessments. One of these respondents did identify that a lot of work had already been undertaken on this aspect.

63 One response did suggest that, in order to meet the standards and ensure policies were suitable, training could be offered.

64 Of the respondents who answered ‘no’, the overriding theme was that the requirements need be more explicit, both about the expectations of various roles within the education system, but also about how organisations are expected to demonstrate the relevant aspects of fairness and equality.

65 One organisation stated that equality and fairness issues were already embedded within curriculum development and that the new standards would not go beyond this, while an anonymous respondent expressed concerns about bureaucracy.

Question 12

Do you think the standards and requirements are likely to adversely affect any particular groups of doctors or other people who share protected characteristics?

<table>
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66 Some respondents expressed concern that the impact on international medical graduates had not been properly reflected in the standards documents as a consequence of this in itself not being a protected characteristic. One organisation noted that non-trainees who demonstrate their outcomes via equivalence could potentially be impacted by changes to approaches in assessments in the same way.

67 Two respondents identified that an aspiration of ‘excellence’ may well have an unintended impact on differential attainment, although neither commenter expanded on this to assist in understanding the reason for this.

68 Two respondents noted the relevance of the issues to trainees in less than full-time training – one believing that curriculum reviews disproportionately impact on LTFT trainees and one suggesting that the proposals adequately reflect LTFT issues.
Three respondents also discussed how the proposals would impact on smaller and emerging specialities, potentially as a consequence of not being able to meet the stringent demands of quality assuring as implied by the standards, or because the emerging specialities may not have an NHS training pathway, or because a small available workforce impacts on training and assessment in general.

Other comments were broadly positive about the impact of the proposals, with some highlighting the importance of trainer and assessor roles, while one organisation indicated that “the stronger content on fairness and equality should hopefully improve rather than adversely affect...training experiences”.

A single organisation noted that guidance on specific and common disabilities would be helpful as it would help avoid perceived victimisation of disabled doctors and ensure reasonable adjustments did not become subject to unnecessary discussion.

The language used within the document was broadly supported, although a number of respondents identified a need to make it explicit that international medical graduates (IMGs) should feature in any consideration of fairness and equality. There appeared a common agreement that the standards are directly relevant to the GMC’s ability to fulfil the demands of the public sector equality duty (PSED), but the issue with IMGs suggests that GMC could legitimately go beyond the requirements of the legislation to make it clear how fairness is relevant across all aspects of medical education.

Three respondents commented on the need for the GMC to have conducted an equality analysis of the new standards, which will need to address the concerns about fairness.

Some organisations seemed to draw a connection between an aspiration for ‘excellence’ and the issue of differential attainment, although unfortunately it was not possible to explore this further in their responses.
The standards overall

Question 13

How clear is the draft standards document? Please tell us about anything you found unclear, and let us know if there are any terms you think should be added to the glossary.

<table>
<thead>
<tr>
<th>Q13</th>
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</table>

75 A large majority (86%) thought the standards were either very clear or fairly clear, with only three respondents finding the document not very clear, and only one organisation saying it was not clear at all.

76 Comments included some about the general clarity of the standards document, with a number offering specific corrections or glossary suggestions. And several respondents suggested clarification of some of the ideas within the standards.

77 One medical educator suggested greater clarification in our grammatical expression of what the GMC's standards are concerned with. Is it ‘the curriculum design process for which the curriculum or credential document is the ‘evidence’, as well as the 'manual' for putting the curriculum into practice’?

78 Health Education England found that ‘responsibility for the quality assurance of regulated credentials may require better clarity’. Two college/faculties asked for inclusion of further information on credentialing.

79 The Faculty of Pharmaceutical Medicine would welcome guidance on ‘how the standards and requirements should be interpreted by non-clinical specialities, particularly those that do not operate within the NHS such as pharmaceutical medicine’.

80 Others felt that the draft standards are good as a set of principles, but need more detailed work and negotiation to turn into a framework for implementation, or asked for supplementary guidance and templates.
Question 14
Is there anything missing from the draft standards document, or anything that should be removed?

<table>
<thead>
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Question 15
Do you have any other comments on the draft standards document?

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We have looked at question 14 and 15 together. The themes and issues raised in these two questions were very similar and could be considered together.

There were 49 responses to question 14 that asked if there were any gaps in the standards and requirements with just under half indicating that something was missing or should be added. 20 respondents left comments to question 15 which provided a place for any other comments.

Most comments and themes were covered in earlier questions. The main themes were:

- clarity on the details for the standards and requirements
- more information on implementation and timescales
- misunderstanding about role of Promoting excellence and the Generic professional capabilities, resulting in requests for aspects of training related to them to be covered in these standards
- wanting key performance indicators
- clarity on credentialing and moving forward with its introduction
- requirements to address complaints and appeals
- shared examples and good practice from colleges and faculties.
Applying the standards

Transition and implementation

Question 16

Will it be straightforward to develop new curricula or review current curricula based on these standards?

<table>
<thead>
<tr>
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84 Slightly more respondents (27%) said it would be straightforward to develop or review curricula based on these standards, than the number who said it wouldn’t be (24%), with approximately half answering not sure or leaving the question blank (49%).

85 A significant number were concerned about the time and resource involved, including some who said it would be straightforward as well as those who said it wouldn’t, or who weren’t sure. However, others pointed out that developing curricula is always challenging.

86 A couple of colleges said curricula were already being developed in line with the new standards, and others were supportive. ‘Whilst acknowledging that this will be a difficult task, HEE is keen to act as a facilitator and enable the system to work together to deliver an improved product.’ (Health Education England) And ‘the move proposed by these standards, towards outcomes based, robustly assessed programmes is absolutely the way forward.’ (Faculty of Surgical Trainers / The Royal College of Surgeons of Edinburgh) Others said that the standards should work effectively, and provide a robust framework.

87 In addition to general comments about the demands on time and resources, concerns expressed included: having to review internal curriculum development processes while already developing curricula for 2018; the risk that some would put off curriculum change because the requirements are demanding; dealing with major changes to an already complex and burdensome process; more work at a time when the educational system is undergoing a number of changes; vague terminology; and untrained GMC staff. Particular aspects of the standards that worried respondents were: the challenge of adapting current curricula into high level outcomes-based curricula; making
significant changes to the content and structure of curricula; the extensive consultation needed prior to developing a curriculum; the requirement for multiple stakeholder input with evidence; the work involved in including GPCs; and the challenges around getting workforce data, including that calculations would be based on current establishment rather than need. The Royal College of General Practitioners compiled a list of the most time- and resource-intensive requirements, saying ‘it will be resource intensive to review current curricula to align.’

Some respondents made suggestions for how to help transition, including: reducing impact by introducing the standards at the next major curriculum review; guidance on ‘how non-clinical specialties should interpret some of the standards such as R1.4’ (Faculty of Pharmaceutical Medicine); investment in developing faculty; ‘exemplars to work from if the aim is to ensure far greater consistency in curriculum planning processes and curriculum writing’ (medical educator); and knowing if the new format is likely to be enduring. The Joint Committee on Surgical Training (JCST) suggested ‘the GMC supports the system with appropriate resources (eg reference groups, stakeholder fora)’, offers guidance on ‘adapting current curricula into high-level outcomes-based curricula’, and ‘greater clarity about equality and diversity requirements, particularly data collection.’

Question 17
What would be a reasonable transition period for all curricula to meet the new standards and requirements?

<table>
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<th>1-2 years</th>
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<table>
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A majority of total respondents (28 out of 46, or 61%) said that between three and five years would be a reasonable transition period. Among college and faculty respondents an even larger majority thought this (15 out of 18, or 83%) with exactly half of all colleges and faculty organisations saying 3-4 years was reasonable.

Most respondents acknowledged it would be demanding. NHS Education for Scotland said ‘there is a lot of work involved and a need for a culture change.’ Several commented that the time needed depended on the college or the current stage of curricula review, with a suggestion that the timing is based on the next curriculum review.
review. One faculty suggested we workshop a transition plan with the colleges and faculties.

91 Those who favoured a shorter transition period said a lot of curricula would be able to meet the new standards already; 1-2 years would be long enough to meet with and help all the colleges and faculties; there was no value in delaying the process; and a period of intense work would allow all curricula to meet the standards.

92 Those favouring 3-4 years said it was ambitious but achievable, with advice and support. The Joint Committee on Surgical Training said ‘this is a minimum.’

93 Reasons given for a longer period included the challenges of delivering the changes in practice, for colleges and the GMC. The Royal College of Paediatrics and Child Health said it ‘will require a substantial cultural shift for those delivering and assessing training, and so to fully implement the standards “on the ground” will require more than simply rewriting the curriculum and assessment strategy, and will also be likely to take several years.’ Several responses referred to the extensive work, time, and resources involved in the current process, saying more time would be needed for the new process. NHS Employers said ‘4-5 years is a reasonable timeframe for transition of all current curricula’ as ‘there is a balance to be struck in terms of effecting change within a reasonable time scale and imposing change too quickly.’

94 The British Medical Association suggested the transition period ‘should be informed by the consultation responses from organisations currently responsible for curricula’ but that ‘the guiding principle should be to do this properly rather than quickly.’

Question 18
Do you think these standards will be suitable for the design and development of regulated credentials?

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95 Many of the comments from those who agreed with our approach were very supportive of a consistent set of standards and requirements for both postgraduate curricula and credentials. The Faculty of Sexual and Reproductive Healthcare agreed that ‘these
standards should be applied across all education and training to ensure high-quality patient care.' While the Federation of the Royal Colleges of Physicians suggested credentials should be ‘subject to the same scrutiny by the regulator.’ Others viewed this as a strong framework for credentials with the Royal College of Physicians and Surgeons of Glasgow endorsed the idea of ‘Mini-curriculum for each credential and quality assurance of training delivered.’

96 Two respondents were generally unsupportive of the GMC’s involvement in regulated credentials and viewed it as bureaucratic and overstepping our role as a regulator. Two respondents felt there was not enough information about the credentialing model to respond to the question effectively.

97 As with other questions, many comments were very similar across the three response categories. Most respondents called for more clarity and guidance about how regulated credentials might be implemented.

98 A few respondents were concerned that the approach to credentials, if too onerous, would prevent their development. One college, for example, indicated consultant are more likely to need portfolio-based evaluation ‘which maybe harder to evidence in terms of standards.’ One body representing doctors warned ‘those who already practicing in the field and want a credentialing...They cannot go through the whole curriculum training/assessment’.

99 Other respondents were concerned that it was difficult to comment on the appropriateness of the standards until regulated credentials were already developed. As the Royal College of General Practitioners explained ‘the picture with credentialing is still emerging, and until we are clear on the final format we can't be sure on their suitability.’ This was echoed by the Joint Committee on Surgical Training and the Royal College of Paediatrics and Child Health. A few respondents also sought clarity in the definition and scope of credentials – and whether or not it would address the approach described in the Shape of Training Review. NES particularly wanted further work ‘to ensure an agreed and shared understanding of credentials before consideration can be given to how they should be designed, developed and implemented.’

100 Some respondents wanted clarity on specific aspects of the credentialing model, including how we would address conflicts between credentialing bodies and how we will ensure the right credible body is involved in the process. In particular, the Royal College of Emergency Medicine was concerned about ‘the development of parallel organisations for parts of our current areas of work.’

101 A few respondents wanted more information about how credentials will be quality assured and viewed this expectation as difficult. For example, Health Education England suggested ‘quality assuring these credentials could be better defined, particularly where other ‘credible body’ holds responsibility for the credential’.
A number of comments reflected the concern that credentials might be implemented differently at local levels. The Royal College of Pathologists worried this would limit access to credentials because they would only be available in highly specialised centres. The Joint Committee on Surgical Training warned that credentials available only in one UK country would be ‘divisive’.

Quality assurance and quality management

Question 19

We think that organisations that develop and design curricula should have a more formal role in our quality assurance of curricula and programmes of assessment at the local level. Do you agree?

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There was clearly support for the concept (68% agreeing to the proposal) however many of those who responded wanted more detail about how the process would work in practice.

The other main area of concern was resource implications, with a number of people stressing the need for consultation and buy-in from employers.

Some of those who responded thought organisations that develop and design curricula would bring expertise to the quality assurance process.

Other respondents wanted to know more detail and questioned how the arrangement would work in practice and at local level.

Reference was also made to the fact that many college/faculty representatives already have input to local QA processes and clarity was requested with regard to specific roles and responsibilities.

Resources, and in particular the time available to undertake such duties was called into question.
Those who disagreed with the proposal gave as their reasons: satisfaction with the current quality assurance process, perceived additional bureaucracy ‘without clear advantage’ and the possibility of conflicts of interest.

Respondents who were unsure fell into two main categories - those who wanted more detail and those who were concerned about the resources implications.

Many asked for clarity with regard to the role and remit of those involved.

**Question 20**

What information and evidence should we consider?

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Many of the comments suggested making greater use of existing data and a number of organisations made specific reference to the sharing of GMC data. Credentialing was mentioned as a consideration as was the need to build on existing working relationships both between organisations and locally between trainers and trainees. Relevance to ‘patient and service need’ was also raised. A number of those who commented did so to say that they didn’t know what information and evidence should be considered while some didn’t fully understand the question.

Over half of the comments that were received (56%) suggested making greater use of the data sources that already exist and the sharing of data between organisations. Most commonly, reference was made to the use of ARCP outcomes and GMC NTS results. Other sources of information included visit reports and examination data. The Royal College of Obstetricians and Gynaecologists stated that ‘simple feedback from trainers and trainees would be the best kind of information and evidence’ and this was a sentiment agreed by others. Two organisations also made reference to their regional networks as a source of information.

On a precautionary note, the Royal College of General Practitioners stated ‘information and evidence will vary considerably. They may be different for almost every College, assessment and requirement.’ The Faculty of Sexual and Reproductive Healthcare questioned whether ‘there should be an assessment as to whether we can collect meaningful data that measures the impact of these applied standards’ and similarly NHS Education for Scotland felt that ‘asking those that develop curricula to provide evidence that the desired output has been achieved’ may ‘result in data that is not particularly robust or informative’.
One doctor suggested that credentialing could be a route to develop ‘niche areas’ and input from organisations involved with credentialing was also raised.

NHS Education for Scotland also said ‘it will be essential to consider how and who is able to provide the answer to ‘identify and address patient and service need’ a sentiment endorsed by another organisation.

Six respondents commented that they didn’t fully understand what the question was pertaining to, as it may have been unclear that it followed the previous question.

Question 21

We think curricula and credentials should be reviewed every 3-5 years to make sure they remain relevant. This could involve a process for ‘retiring’ elements of the curriculum, learning outcomes, or the curriculum itself, when no longer relevant. Do you agree?

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Most respondents (79%) agreed that a regular review of curricula is a good idea, and many Royal Colleges indicated that they already have a system for this in place. Only three (6%) disagreed and 57% of those who weren’t sure also agreed with the principle, but may have had other reservations.

There was a strong preference towards a longer review period of at least five years. This is not only more manageable in terms of workload but is less disruptive for doctors in training.

A shorter review cycle was identified as having the potential to be more disruptive for those training less than full time (who are disproportionately women) as they could be forced to transfer between curriculum versions multiple times during the course of their training programme.

A number of comments highlighted a lack of common understanding about the nature of the review in the question and the roles of the stakeholders involved, including the GMC.
There were concerns about the amount of work a review would require, even among those who supported the proposal. Some respondents commented that the current curricula approval process would not support a cyclical review.

Question 22

We think generic professional capabilities, in order to be responsive to workforce and service needs, should be reviewed every 3-5 years. Do you agree?

<table>
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Q22 comments

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Only a small majority (53%) agreed that GPCs should be reviewed every 3-5 years. Three respondents (all college/faculties) specified a five year cycle and four respondents (one college/faculty, one PMI and two individuals) believed it should be longer.

One respondent suggested we should wait to see how implementation of GPCs goes before planning a review cycle, and a college/faculty thought the GMC should decide the review details.

Five respondents (two college/faculties, HEE, one body representing doctors and one individual) thought the GPC review cycle should be aligned to curricula review. One college/faculty suggested including a process to compare different curricula/credentials to avoid duplication.

Three respondents didn't understand the link to workforce needs. The Academy Assessment Committee summed this feeling up: ‘Most of the GPCs have always been and will always be relevant to the practice of the profession of medicine. We do not understand the possible link between the GPCs and 'workforce and service need' and how modification of them might be necessary as a response to such demands.’

Two college/faculties said the current curriculum approvals process is too lengthy and needs to be improved. One body representing doctors suggested widening GPCs to other health professions as a way of reducing burden on doctors.
There were some comments about the GPC framework itself: that the GPC framework needs review; that ‘GPCs are not specialty specific. A spiral learning programme from student to CCT should be available to all.’ (NHS/Social Care organisation)

**Support and structures**

**Question 23**

We know that there are some requirements that some organisations might struggle with. What kind of support, structures or bodies might be helpful to you in developing or revising curricula or credentials?

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</table>

There were 32 respondents who commented on what support, structures or bodies might be helpful in developing or revising curricula or credentials. Comments came from 11 individuals and 21 organisations, of which 14 were from college or faculty organisations.

The types of support suggested could be broadly grouped as: guidance or advice, including templates or examples (11 mentions); access to contacts or expertise (12); systems or networks (15); and resources (7).

There were requests for guidance on: embedding GPCs; E&D; assessment; supporting evidence and documentation; how to interpret the standards for non-clinical specialties; and developing curricula. There were requests for examples of how to demonstrate meeting the requirements; examples of old curricula that had been rewritten to meet the new standards; and a medical educator suggested ‘exemplars to work from ... to ensure far greater consistency in curriculum planning processes and curriculum writing.’ One respondent asked for clarification of roles and responsibilities and advice on appropriate QA approaches or best practice sharing. There was also a request for updates and opportunities to comment on guidance being developed.

There were suggestions around access to contacts or expertise. Colleges wanted a closer working relationship or meaningful dialogue with the GMC, with requests for informal discussions while developing curricula; meetings with CAG; GMC attendance at specialty curriculum review meetings; and contacts within the GMC and deaneries/LETBs to go to for advice. Colleges also wanted access to expert support, asking for advice on accessing educational experts, or lists of recommended expert contacts, particularly around equality and diversity (E&D). There was a request for support/ partnering for those with subject area expertise and an interest in developing credentials but who lack experience in developing curricula with the GMC.
Council meeting, 26 April 2017

Agenda Item 6 – New standards for curricula, new assessment guidance and a refined approvals process

133 Systems or networks were suggested to help those developing curricula, particularly to meet the requirements of Domain 1. Suggestions included a system for four-country support; a collaborative approach from leadership organisations to identifying regional and national service needs; and the Joint Committee on Surgical Training (JCST) suggested ‘the GMC establish a reference group, or groups, to involve colleges alongside four-country service, lay/patient, protected characteristic and other relevant groups … [to] provide a forum for discussion and advice and potentially prevent multiple approaches to the groups concerned.’ And NHS Education for Scotland said ‘in Scotland, the Specialty Training Boards could provide advice and input’ as they have an appropriate range of representation and ‘an understanding of local, regional, and national needs.’ Others mentioned a GMC structure for independent organisations to get curricula accredited; and a non-expert advisory council which would lack conflicts of interest.

134 Suggestions for networks or collaboration included: an active regional structure providing coalface feedback; liaising with Australasian and American colleges; facilitating sharing of information and best practice among colleges; sharing between HEE offices and PGME schools; local faculty groups to bridge the divide between academia and the front line; support and empowerment from local trust management, and cooperation from employers to provide data necessary to meet the standards.

135 A few colleges said support was needed from the service and the GMC to assure clinician time would be protected for development and implementation of curricula. One suggested additional resource would be needed for credentials, and one suggested additional administrative support might be needed in colleges. Other organisations suggested dedicated generic educationalists; help for deaneries/LETBs to train enough assessors; and centralised funds for grants to support curriculum development.

136 One doctor suggested removing the link between clinical diplomas and training.
Question 24

We want to introduce a system that ensures that the service and patients have meaningful input into development of curricula, and workforce needs are consistently identified and addressed. Do you agree that this would be helpful?

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137 There was 65% agreement that it would be helpful to introduce a system that ensures that the service and patients have meaningful input into development of curricula, and that workforce needs are consistently identified and addressed. Comments were largely to do with the challenges of getting meaningful patient input; the limited views or agendas of those who might provide service input; the fact that many organisations are already doing this and don’t think a system needs to be set up for it; and how such a system might work.

138 There were a large number of comments about the difficulty of getting meaningful patient input. Several were about patients not being qualified, or not understanding workforce needs, or lacking knowledge of some specialties. Others commented that any patient representatives couldn’t represent the diversity of patient views, or that it is challenging to identify the right patients to ask. However, some organisations commented that they are already managing patient input successfully or have networks set up, and others suggested ways of doing this, including using lay panel members, specific charities, or having service groups identify focus groups. One said it would be important to feed back to patients about their input. The Federation of the Royal Colleges of Physicians (JRCPTB and MRCPUK) said ‘it is important that curricula reflect genuine workforce and patient need but getting meaningful input from patients may be challenging and there is a need for more clarity on how the GMC wants this collected, measured and reported.’

139 There were some comments about service input including several pointing out that those designing curricula or on curriculum committees were already clinicians with service experience; that there’s a risk of narrow views or political, management, or employer agendas; that input is needed from a variety of roles from those in the service; and that some organisations already do make sure they have service input.
While a couple of respondents said they already consider workforce needs, others raised some concerns: that workforce needs would be interpreted as limited to service provision; that there are problems with poor workforce data; and that it is for trusts and commissioners to plan for workforce needs, not curriculum designers. One consultant said ‘workforce planning has always been fraught with difficulty, primarily because of the lack of real communication between the trusts that employ and those that plan training numbers’ and that ‘evidence of that dialogue will be more important that a single group declaring a workforce gap.’

There were also a number of comments, largely from those who agreed with the proposal, about how a system might work. One cautioned against a too-elaborate system, and a medical educator suggested targeted guidance to support organisations in consulting with appropriate stakeholders. A few respondents said any system would need to be four-nation wide, and a couple of organisations suggested a national reference group should be set up ‘consisting of patients and service users (including those with protected characteristics) who could provide consistency in assessing and providing guidance for those developing curricula.’ (NHS Education for Scotland) Another commented on the usefulness of partnerships between academic institutions and the service in implementing innovation; and Central and North West London NHS FT said ‘there should be a role for NHS Providers and HEE ie commissioners in approving as well as developing … curricula ie a more integrated and corporate approach to the approval process.’

Question 25

How can we ensure four-country agreement for curricula or credentials?

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There were 36 responses to the question of how we can ensure four-country agreement for curricula or credentials, with 24 organisations commenting, and 12 individuals.

Most respondents agreed this was important, with some describing their current efforts to ensure four-country agreement. However, a few suggested it wasn’t necessary, while some commented on the need for flexibility for local implementation or local requirements. NHS Education for Scotland said ‘it is important that all four countries support and endorse all specialty curricula, although it should be recognised that each devolved country may wish to develop bespoke curricula relevant to how healthcare needs to be delivered locally eg Remote and Rural Healthcare in Scotland.’
Many comments were about the challenges of getting four-country agreement for curricula or credentials, particularly around getting input from employers, resources in the smaller countries, and the continuing divergence of the systems. There were a lot of comments about regional variations, such as differences in provision of service, NHS structures, clinical practice, legislation, workforce, and patient needs.

There were a large number of suggestions made about what was needed to support four-country agreement. These included the need for dialogue with relevant bodies; and the need for colleges to formally acknowledge the four-country context and provide specific guidance about different working environments, as well as respond to changes across sectors and organisations. The Federation of the Royal Colleges of Physicians (JRCPTB and MRCPUK) said ‘there should be a defined process with named contacts to guide colleges and ensure consistency.’ Others suggested workshops; and building on existing mechanisms, with a sufficient range of stakeholders represented.

Some colleges said they’d welcome GMC guidance or suggestions, with specific suggestions including facilitating introductions to key players and helping where contacts are not responsive; and cascading curriculum documents to relevant bodies. The Joint Committee on Surgical Training (JCST) said ‘the GMC should use its authority and its own devolved structure to establish a forum for consultation’ and ‘if this is to be an absolute requirement, the GMC must ensure that it is feasible and must support the process with resources of its own.’

There were suggestions that we use a reference group to sense check and cascade curricula. Health Education England suggested joint college training boards or equivalents, and said ‘it has been agreed that curricula changes arising from the Shape of Training will obtain four-country approval through the Medical Education UK Reference Group (comprising the four UK Health Departments, HEE and NES). This is a possible route to secure such approval for all curricula changes.’

Several respondents noted the importance of getting agreement and support for any processes from all four countries, with a couple of suggestions that it would be useful to get England right first. Wales Deanery said it is ‘vital that colleges formally acknowledge four-country context and are mandated to avoid any terminology / requirements which relate exclusively to one of the four countries. HEE must be required to formally acknowledge need for four-country agreement: this is the single greatest threat to successful UK-wide implementation.’
Question 26

We will be providing explanatory guidance on applying these standards and on our curricula and credential approval processes. What particular areas would you like to see addressed?

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Of the 30 consultation respondents who answered this question there was universal consensus that explanatory guidance was required. The majority of respondents wanted more detail on how the new standards would be implemented.

Suggestions for areas respondents would like to see explanatory guidance for included:

- clear information on what supporting evidence and documentation the GMC will be looking for alongside the published curriculum for approval
- clarity who we expect would be consulted during the design and development phase of each curriculum – with employers and lay involvement specified
- guidance on obtaining four-country agreement
- examples of acceptable quality assurance mechanisms
- our expectations regarding the publication of quality metrics in respect of high stakes assessments
- clear practical advice on how to incorporate the content of the generic professional capability framework into curricula that the GMC would approve
- the GMCs expectations for assessments in the workplace – both formative and summative
- ARCP decisions
- the implementation of learning and assessment around patient-centred practice
- clearer instruction for making curricula leaner and ‘SMARTer’
- strengthening the processes around the transfer of data regarding doctors in training
- clarification of how excellence should be expressed in the curriculum and assessment framework
- supporting and assessing longitudinal professional development
- how to develop feasible, practical and sustainable training programmes
Several respondents requested guidance specifically around the subject of equality and diversity:

- how to provide equality and diversity evidence proportionate to the curriculum change
- what ‘reasonable adjustments’ are required for doctors with disabilities in terms of meeting specific curricular requirements
- how assessors should manage people with protected characteristics for whom an element of the assessment is difficult or impossible
- what equality and diversity data the GMC expects organisations to collect and what we will provide to College bodies to avoid duplication.

There was some divergence of opinion on whether guidance documents should be as general or as specific as possible. The first option providing leeway for independent interpretation by a number of institutions and specialties; the second reassuring providers on how the new standards can be mapped to their speciality areas.

Some respondents also sought reassurance and greater clarity on the involvement of other agencies and how the new standards would feed strategically into issues like workforce planning.
### Appendix B - Individual respondents

**Country of residence**

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**Role of doctor respondents - doctors and medical educators**

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**Full time or part time - doctors and medical educators**

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### Council meeting, 26 April 2017

#### Agenda item 6 – New standards for curricula, new assessment guidance and a refined approvals process

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Appendix C - Organisation respondents

Academy Assessment Committee
Association for Nutrition
Association of Anaesthetists of Great Britain and Ireland
British Association of Body Sculpting
British Medical Association
British Thoracic Society
Central and North West London NHS Foundation Trust
Centre for Advancement for Interprofessional Education
Faculty of Intensive Care Medicine and Faculty of Pain Medicine of the Royal College of Anaesthetists
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine
Faculty of Public Health
Faculty of Surgical Trainers / The Royal College of Surgeons of Edinburgh
Federation of the Royal Colleges of Physicians (JRCPTB and MRCPUK)
Health Education England
Joint Committee on Intercollegiate Examinations
Joint Committee on Surgical Training (JCST)
Medical Schools Council
NHS Education for Scotland
NHS Employers
RCPsych in Scotland
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Physicians and Surgeons of Glasgow
Royal College of Psychiatrists
Shelford Group
The Faculty of Sexual and Reproductive Healthcare
The Royal College of Emergency Medicine
The Royal College of Ophthalmologists
The Royal College of Pathologists
The Royal College of Radiologists
Wales Deanery
Council meeting, 26 April 2017

**M6 – New standards for curricula, new assessment guidance and a refined approvals process**

**M6 – Annex D**

**Consultation audit review**

**Introduction**

1. The audit review was conducted at the request of the consultation manager, Rose Ward. The consultation, which covered the standards for postgraduate curricula and regulated credentials, was available to the public between 05/09/16 and 28/10/16. Sixty nine responses were received. Responses were received from individuals and organisations across Wales, Scotland and England. There was no response received from Northern Ireland and only one response from a member of the public.

**Audit analysis**

2. The audit review selection was made by the Assistant Director Audit and Risk Assurance and was chosen randomly to cover:

   - at least one question from each of the consultation six sections – structure of the standards document, content, standards overall, transition, quality assurance and quality management, support and structures
   - at least one question analyses by each report preparer to explore consistency of approach and reporting across the team
   - questions where an initial review of the responses received suggested less clear cut answers or there were a substantial number of comments received.

3. In addition the two questions relating to equality and diversity were selected reflecting the organisational priority on equality and diversity issues.

**Overall conclusion**

4. Overall, the analysis conducted reflects the responses received. A number of key themes emerge across the consultation comments relating to the current context and challenges within the system which may require further consideration in the GMC’s final response.
- the need for sufficient resources within the system to balance service requirements and educational needs
- the cultural shift needed to move to outcomes
- better sharing of data and information across the system in mutually accessible formats to support the education of individuals
- more detailed information/guidance to provide further clarification on areas, for example developing learning outcomes and assessment.

5 Finally, there was no response received from Northern Ireland and only one response from a member of the public. It is recommended that the project team consider the importance of this and whether further engagement is needed to minimise potential negative perception and impact at later stages of the work.

Management response

6 The key themes described above have been noted and expanded on in the consultation report to reflect their overall importance. Some of the points raised will be picked up in related workstreams.

a While the standards can’t address the resources issues in the system, they do include a requirement that input is sought from employers, and from education providers on feasibility of the curriculum. In terms of resources within the colleges for developing or updating curricula to meet the new standards, our approvals team will be working closely with the colleges to offer increased support during the transition.

b Our early engagement with colleges indicated that there was broad agreement for the move to outcomes, so we will be working together to support the cultural shift needed. Our approvals team are also continuing regular meetings with colleges which will allow opportunities to support them with any challenges.

c The new standards have clearer expectations for colleges to share data with us, trainees and the public, with a particular emphasis on doctors with protected characteristics. We will also facilitate better data sharing by providing colleges with our data about specialties from the annual specialty returns and the National Trainee Survey among others. We will support colleges to take action as a result of the data, particularly where it impacts on progression and retention.
d We will publish guidance on assessment and generic professional capabilities (GPCs) alongside the standards, as well as a guide to the new approvals process which will give more detail on how to meet the standards around developing learning outcomes and assessments.

7 Although there was no consultation response from Northern Ireland, two members of our external advisory group (EAG) who helped us develop the standards were from the Northern Ireland Medical and Dental Training Agency (NIMDTA). During the consultation period we offered an opportunity to meet by video conference with stakeholders in the devolved countries but this was only taken up in Scotland. We shared a post-consultation revised version of the standards with the EAG and neither of our NI members made any comments or suggestions for change. We didn’t expect many responses from members of the public as the standards for curricula and assessment are quite technical, but we did have a patient and public representative on the EAG who provided valuable input in the development of the standards.
Key findings from the consultation

Q1 - Do you agree that the four domains are a helpful way of organising the standards?

Only 4 respondents did not agree that the domains were helpful. Three of these provided comments suggesting the domains were ‘vague, overlapping and highly subjective’, that ‘specific sections on curricula and on assessment would be more helpful. The change in terminology of assessments to regulated credentials appears unnecessary’ and one suggesting the website paper was unclear.

The majority of respondents (73%) agreed that the four domains were helpful. Organisations’ responses were stronger with 90% agreeing with the statement. With the individual responses 58% agreed with the statement, 1% did not agree and 33% were unsure.

Of those individual respondents who were unsure (33%) only five offered a comment. Key points noted were that the standards map fairly well to the more usual curriculum setting of ‘aims, outcomes, Learning framework, assessment and evaluation’, and that they can be arranged in a number of ways but the challenge is to avoid duplication. There is also a comment suggesting that the framework is a mechanistic one and that more explicit consideration should be given to the ‘values, beliefs and aspirations’ of the environment in which curricula is delivered.

Conclusion

The analysis and discussion points raised by the Team properly reflect the responses received. It is notable that less individuals responded positively to the statement on the four domains than organisations. With respect to the four country input, Scotland, Wales and England agreed that the domains were useful and only Scotland provided comments, suggesting there may be scope to consider ‘conflating domains 1 and 2 with only minor changes’.

Q9 - Domain 4: The programme of assessment - Do you think the standards and requirements under this domain are likely to help improve the quality of assessments?

This question produced one of the widest variety of responses with 31% of respondents agreeing with the statement, 23% disagreeing and 42% not sure. Of the organisations who responded, 31% agreed and the remaining 65% either did not agree (23%) or were unsure (42%).
13 Of the respondents who answered ‘no’ to the question and provided comments three considered that high quality arrangements were already in place. Some commented that the new standards may lead to loss of recognition of formative assessment and that tightening requirements for assessors may make it less likely for workplace assessments to take place or to use the range of assessors needed to provide a balanced view.

14 Of those respondents who were unsure some of the ‘no’ comments were echoed. For example, the importance of trained assessors with clear roles separate from supervision.

15 Several responses also refer to the current pressures in the NHS in general and the lack of time for senior staff to carry out appropriate assessments with one commenting that unless protected time were provided for assessments and training, the impact of the standards would be very limited. Cultural change would be needed to do this approach justice and move to learning outcomes. Lack of educational roles in job plans and pressure on time available for educational training are also cited.

16 A further theme was the investment needed to ensure people have proper training and understand their role in the assessment process. Questions are also posed about how assessors themselves would be ‘calibrated and benchmarked’.

17 In an additional comment (where no response was provided to the question), there was acknowledgement of the need for better sharing of information: ‘…..For all future curricula and credentials it should be a required of all parties that they demonstrate what minimum data sets of educational progress are required, how they will be shared and possibly how those processes could be quality assured. The current arrangements of predominately manual transfer of data from College to LETB/Deanery systems is unacceptable and all involved should be encouraged to work to shared solutions.’

18 A positive comment observed that collaboration between medical schools and things like sharing best practice has had a very positive impact on undergraduate assessment.

19 Another individual comment of note is that there is no mention of underperformance in training programme and assessment and how to act in such circumstances.

Conclusion

20 The analysis and recommendations raised by the Team properly reflect the range of comments received with regard to the question of flexibility of standards and requirements in the programme of assessment, domain 4. Other factors noted in the responses to this question fit with GMC objectives around promoting the shared use of data across organisations in the wider system. This may be something the team wish

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to consider further as well as how assessments are supported and achieved against a backdrop of tightening resources in the system generally.

Management response

21 We’ve developed assessment guidance to sit alongside the standards, and we had helpful discussions with evidence team colleagues during the process. The principle of sharing assessment data appropriately to deaneries/ HEE local teams is included in this guidance. As future quality assurance processes are developed this can be picked up further.

Q10 - Domain 4: The programme of assessment - are the standards and requirements under this domain sufficiently flexible to enable organisations to carry our assessment in a way which is most appropriate to the needs of their area of practice?

22 Although the number of respondents answering yes to the question was only 45% and 43% were unsure, the majority of comments reflect general agreement that there is flexibility to enable assessments to be carried out but there are other factors which need to be taken in to account.

23 In particular there are echoes with the comments in Q9 around sufficiency of resources within the system generally to balance service requirements and educational needs, the need to share data/information across the system and that more detailed information/guidance would be helpful. It is also noted that smaller colleges and specialities may struggle more with the resourcing issue.

Conclusion

24 The analysis and recommendations raised by the Team properly reflect the responses range received with regard to the question of whether the standards and requirements are sufficiently flexible to enable organisations to carry our assessments in a way which is most appropriate to the needs of their area of practice. The issues raised under Q9 with respect to the tensions of pressure in the system between service delivery and educational needs are re-iterated.

Management response

25 Although the tensions between service delivery pressures and educational needs are a wider issue which curriculum standards can’t address, our approvals team have begun working more closely with colleges to support them in developing their curricula, which will be of particular help to the smaller colleges with resourcing issues. As mentioned in earlier responses, we are also providing supporting guidance.
Q11 - Do you think the standards and requirements will help embed the principles of fairness and equality in programmes of learning and programmes of assessment?

26 The majority of respondents (63%) agree with this statement, with the colleges being the most supportive (providing 12 out of 19 organisations’ ‘yes’ responses). There is need however for clearer practical guidance and support from the GMC. Of the 22% who were unsure, comments also include the need for clear guidance on how fairness and equality principles are embedded.

27 Of respondents who answered ‘no’ (12%), comments relate to the need for clearer links to the requirements, more explicit guidance on how it is achieved in practice (including the role of education providers and employers), and the risk of increasing bureaucracy.

28 One respondent raised the issue of trainees not being required to provide E&D data and the current hindrance with IT requirements to collect data. There was also an important comment that concern for fairness should not dilute standards and that ‘fears of inequality of access should not limit what is mandated for future generations of doctors.’

Conclusion

29 The analysis prepared by the Team properly reflects the responses range received with regard to the question of embedding the principles of fairness and equality in programmes of learning and assessment. The report does not present any reporting suggestions or recommendations. One potential recommendation may be to link with other findings regarding the need for clearer and more explicit guidance being available.

Management response

30 We had analysts helping with the consultation who hadn’t been part of the standards development so weren’t necessarily familiar enough with the background to make recommendations. However, the need for explicit guidance was noted, and our new assessment guidance will address much of this, and our approvals team and our E&D team will also be supporting colleges to help them meet the standards.

Q12 - Do you think the standards and requirements are likely to adversely affect any particular groups of doctors or other people who share protected characteristics?

31 Fifty seven percent of respondents said that they did not think the standards and requirement likely to affect particular groups who share protected characteristics.
32 Of those who responded ‘yes’ to the question, examples cited as to who might be affected included less than full time trainees, trainees who break their training programme (particularly females on maternity leave), those in emerging specialities (eg cosmetic surgery) and disciplines where there is no NHS based training pathway.

33 Some comments also suggest that the GMC needs to do separate E&D impact analysis, including consultation with those in the nine protected characteristics group and to consult with other professional groups and to be prepared to share the analysis. One respondent suggested that the GMC undertake a review of this area 1-3 years after implementation of the new standards to see what impact they are having on people who share protected characteristics. Two respondents suggest that a framework aspiring to excellence could in itself increase differential performance rather than reduce it and consequently risk reducing performance overall.

34 Three respondents noted that the impact of the standards on international medical graduates and non-trainees with protected characteristics was not properly reflected.

35 Again the issue of resources was raised in general terms and the impact on training and assessment in general where resources are limited or specialities have small numbers.

Conclusion

36 The analysis prepared by the Team properly reflects the responses received with regard to the impact of the standards and requirements adversely impacting on any groups who share protected characteristics. Appropriate recommendations are made drawn from the analysis.

Q13 - How clear is the draft standards document? Please tell us anything you found unclear, and let us know if there are any terms you think should be added to the glossary.

37 The vast majority of respondents (86%) suggest that the draft standards are very clear or fairly clear. Of those that found the review not very clear (6%) or not clear at all (2%) the two comments provided related to needing to explain the review was happening, the purpose of credentialing and the practical application of the standards.

38 A range of individual comments were provided suggesting areas for clarity and plainer writing either in the standards or in the glossary. The Team will need to consider each of these individually.
Conclusion

39 The analysis prepared by the Team properly reflects the individual responses and comments received with regard to the clarity of the document and the recommendation appropriately suggests that drafting suggestions should be considered.

Q14 - Is there anything missing from the draft standards document, or anything that should be removed?

40 Thirty one percent of respondents answered ‘no’ to this question and 20% were unsure. The majority of comments reflect the need for clarification in a number of areas, for example on developing learning outcomes and assessments, differentiating between the credentials in skills beyond the specialist register level, more on education supervision, clinical risk, patient safety and safety-critical content and one comment about recognising the role of Royal Colleges and faculties in workforce planning.

41 The issue of sharing of trainee progression and assessment information across the education system is raised again and the need to consider data systems in a mutually accessible, appropriate format for educators.

42 Three omissions are noted. The first is that ‘there is no mention of health and well-being of trainees’ which is seen as an increasing issue. The respondent considers that concepts such as resilience, emotion and physical health need to be included in the curriculum. The second key thing considered missing is any discussion about the benefits, disadvantages or decisions to have regulated credentials governed by the GMC as the respondent is not aware of any strategic setting where the concept has been discussed and agreed by key stakeholders, including employers. Finally, there is a response noting that KPIs are missing. A further respondent considers that an economic, educational and equality impact assessment is needed illustrating the ‘measuring of the problem’ and how the new standards are attempting to address it.

43 One respondent also considers that an urgent discussion is needed on what makes a ‘credible organisation’ if postgraduate curricula is developed by organisations beyond medical colleges and faculties.

44 An observation is made that the tone of the document is ‘very task focused’ and ‘mechanistic’ in contrast to Good Medical Practice which is principles driven. The respondent considers the detail lacks a holistic touch with little included on the values of education, ensuring caring and healing.

45 Finally, one respondent suggest that the GMC should consider holding workshops across the countries to address the practical issues of the revised approach to training with outcomes-based curricula.
Conclusion

46 The analysis team have taken questions 14 and 15 together in their summary. Currently, it does not appear to specifically reflect the omissions noted, i.e., health and well-being, discussion about the benefits, disadvantages or decisions to have regulated credentials (though this may have been had and the respondent not be aware of it) and the need for an impact assessment.

47 The team should consider whether specific attention to the areas noted above is needed.

Management response

48 As these two questions were specifically for picking up anything missing or that needed to be changed in the standards, we considered each suggestion while revising the standards but didn’t write up full details in the analysis report as this work was done in spreadsheets with all the suggested changes from other questions.

49 The specific omissions mentioned above have been covered elsewhere e.g., health and emotional wellbeing are included in the GPC framework, which the standards require to be embedded in all curricula. And we carried out a public consultation on credentialing in late 2015 which received 217 responses, including a number from NHS organisations and other employer bodies. We have carried out an equality analysis as part of the standards review.

Q17 – What would be a reasonable transition period for all curricula to meet the new standards and requirements?

50 There is no clear cut response to this question though the majority of respondents, 61%, fall in to the 3-5 year timeframe. Of these, 20 of the 28 respondents were from organisations and 11 of the 20 preferred 3-4 years as an implementation timeframe. The comments reflect the need for consideration of the practical implications of implementation such as the increased workload on resources and differences in specialities and well as the cultural implications.

Conclusion

51 The analysis by the team captures the key discussion points and makes a pragmatic recommendation based on the responses which is to aim for 3-4 years but work closely with all colleges and faculties as they make the transition, particularly those who favoured the 4-5 year time horizon.

Q18 - Do you think these standards will be suitable for the design and development of regulated credentials?
Forty eight percent of respondents agreed with this statement and only 12% answered ‘no’. However, 32% were unsure. The supporting comments reflect the divergence of views as to the need for credentialing at all and the opinion that they should ‘meet the same standards and requirements of post graduate curricula and are subject to the same scrutiny by the regulator’.

Some concern is expressed by respondents that credentialing is likely to be delivered by organisations unfamiliar with the rigorous requirements and structure that is a feature of postgraduate medical education and there are several comments referring to the need for further clarity.

Conclusion

The key themes are included in the team’s analysis. No recommendations are made.

Management response

Credentialing discussions have continued outside of this consultation and the curriculum standards review, both within the GMC and with stakeholders eg at the EAG. As a result of these discussions and the consultation responses, we decided that credentialing shouldn’t be included in the curriculum standards but that any future standards for credentialing would be based on, or aligned with, the curriculum standards. At the time of the consultation analysis these decisions were still being made so the recommendations weren't included in the analysis report.

Q19 – We think that organisations that develop and design curricula should have a more formal role in our quality assurance of curricula and programme of assessment at the local level. Do you agree?

The majority of respondents (61%) agreed with this statement, many noting that there is already input from across the system to the process and the value of the expertise brought in to the quality assurance process. A few respondents would like more detail and there was some concern about the resource implications of achieving it.

Only three respondents did not agree with the suggestion of organisations having a more formal role in curricula quality assurance and assessment at local level. Two appear content with the current arrangement and one noted the conflicts of interest compromising the independence of the process.

Of the 26% who responded ‘unsure’ the main comments related to needing more information and the resourcing implications of achieving this at local level. One comment notes the key role of employers, many of whom do not appear to encourage such activity:
‘Colleges have largely disestablished local networks in favour of TPDs, etc. And many employers have made it next to impossible for doctors to develop roles in Colleges through leave policies designed to prevent such, despite contractual obligations to do so. Whilst engagement with Colleges may well be helpful, there needs to be agreement with employers that this can occur – the real obstacle is any encouragement or empowerment from employers to be involved in such activity.’

Conclusion

59 The analysis prepared by the Team properly reflects the individual responses and comments received and the recommendations made are appropriate.

Q25 - How can we ensure four-country agreement for curricula or credentials?

60 Only 36 responses were received in total to this question and two thirds of these were from organisations. However, no response was received to the consultation from Northern Ireland.

61 Most respondents concur that four country agreement is important whilst acknowledging the challenges of doing so. Comments reflect the need for appropriate recognition of the language and terminology used across the four countries, with flexibility for local arrangements within a consistent UK wide framework. Several comments refer to the need for some kind of forum or reference group which can speak on behalf of all four countries for agreement and sense checking of curricula.

Conclusion

62 The analysis report provides a lengthy summary of a difficult area, recognising the political and practical challenges with four-country working. An appropriate recommendation is made to consider setting up some form of national group to provide a forum for four country discussion and understanding.

63 However, no response was received from Northern Ireland and the team should consider if further work is required to ensure there is appropriate four country representation and to minimise the risk of challenges at the next stages.

Management response

64 We had two Northern Ireland representatives on our EAG while developing the standards, and we sent them a final draft with post-consultation changes. Neither of them had any comments on the final draft, and they had provided input and been generally supportive of earlier drafts, and overall we’ve had a reasonable amount of input from all four countries.

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