Applications to the GP and Specialist Registers

2015

General Medical Council

Introduction

This is our third annual report, which gives an overview of decisions we made on applications for specialist or GP registration in 2015.

It covers decisions about:

- Certificates of Completion of Training (CCT)
- Certificates of Eligibility for Specialist Registration (CESR)
- Certificates of Eligibility for GP Registration (CEGPR)
- CESR Combined Programme (CESR (CP))
- CEGPR Combined Programme (CEGPR (CP))

This report may be particularly useful for potential applicants for specialist or GP registration, medical royal colleges and faculties, and NHS employers.

What this report shows:

- How a doctor's name is added to the specialist or GP Register
- What happened in 2015
- Where applicants have worked prior to their application
- Where applicants gained their primary medical qualification
- What we've learnt from previous applications
- Some experiences and tips from successful CESR applicants
- An update on our review of the routes to the Specialist and GP Registers

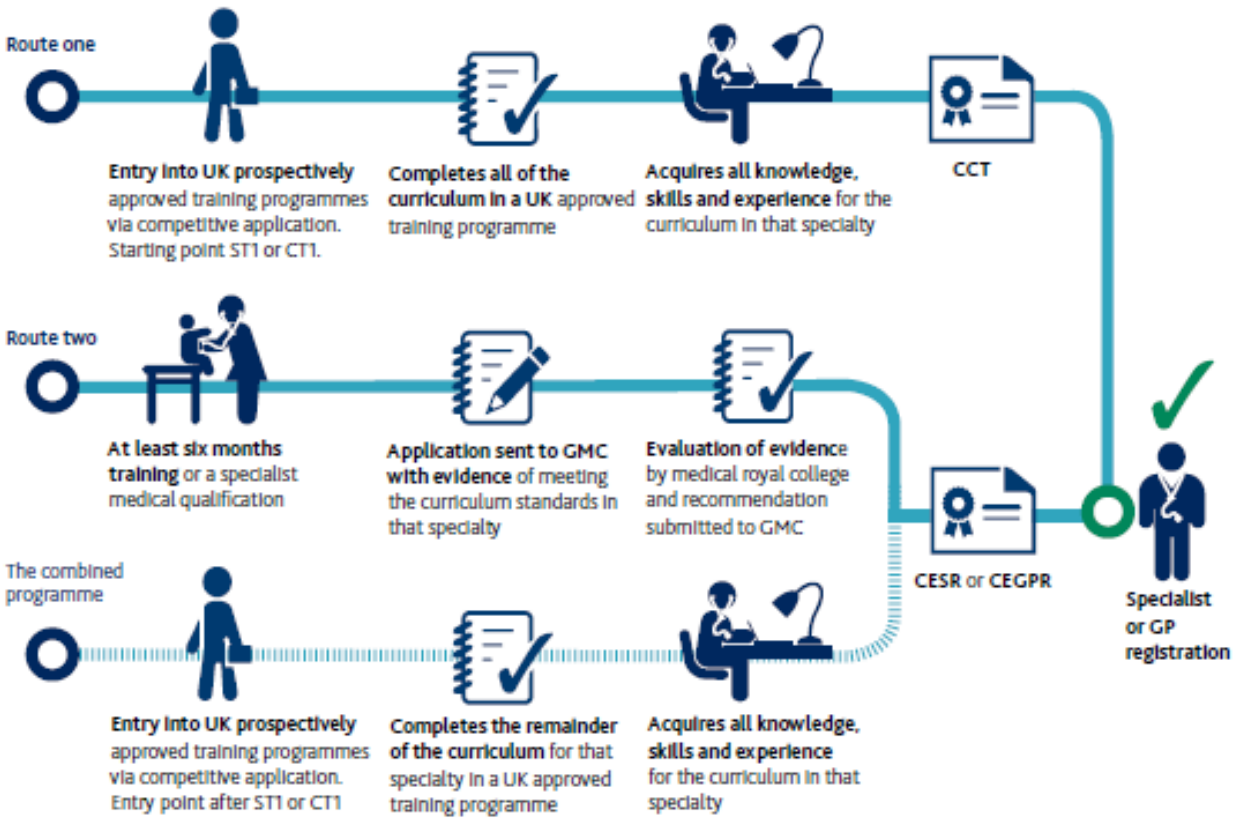
How a doctor's name is added to the GP or Specialist Register

Before a doctor can have their name added to the Specialist or GP Register, we check they have the knowledge, skills and experience required for their specialty.

This report focuses on the following ways of qualifying for entry to the Specialist or GP Registers:

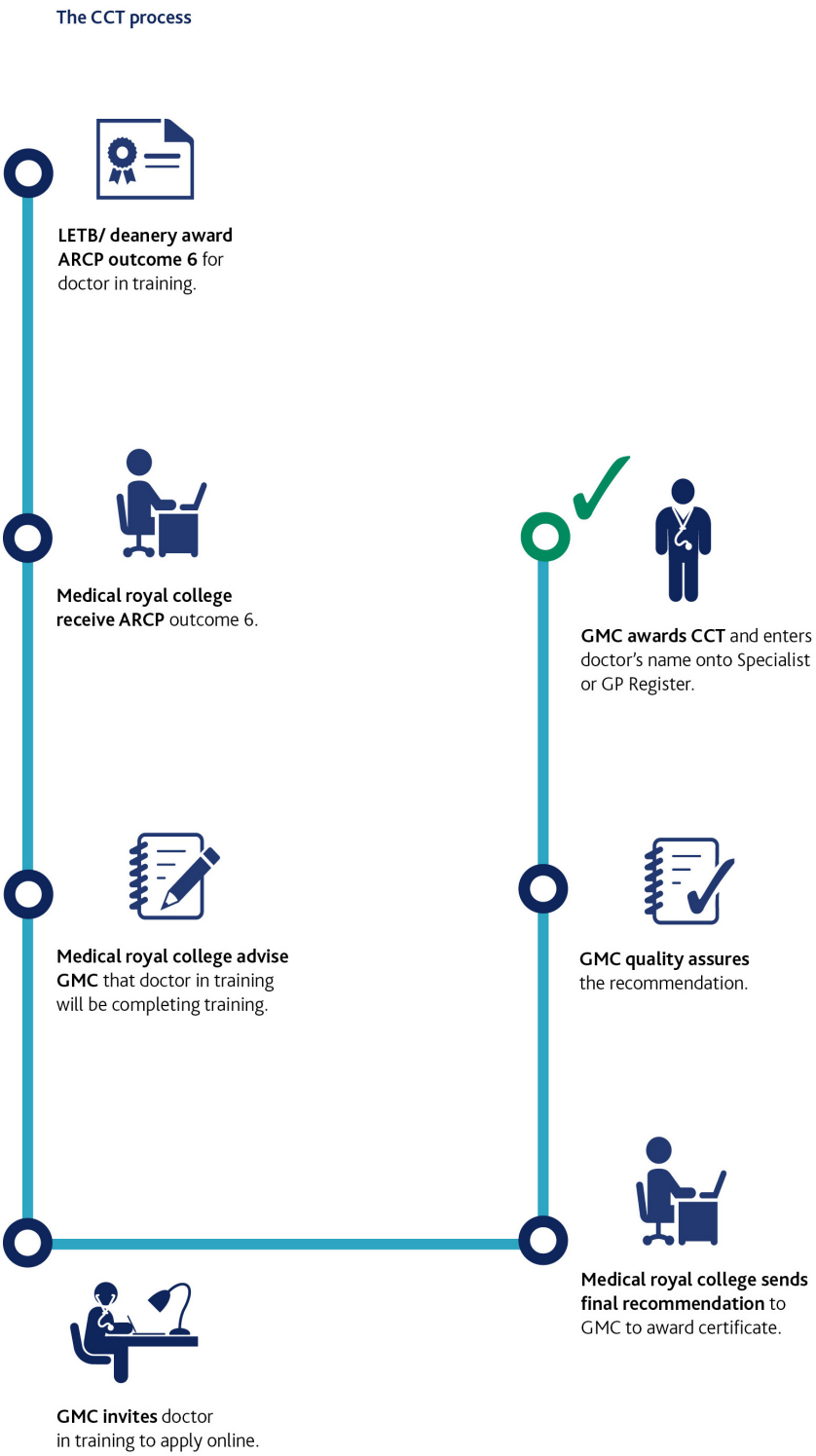
- Certificates of Completion of Training (CCT)
- Certificates of Eligibility for Specialist Registration (CESR)
- Certificates of Eligibility for GP Registration (CEGPR)
- CESR Combined Programme (CESR (CP))
- CEGPR Combined Programme (CEGPR (CP))

Routes to specialist or GP registration



Getting specialist or GP registration with a CCT

Most doctors that enter the Specialist or GP Register demonstrate that they meet the requirements by completing a full UK training programme – from competitive entry through to completing specialty curricula designed by the relevant medical royal college and approved by the GMC. We issue these doctors with a CCT, which entitles them to specialist or GP registration.



Getting specialist or GP registration with a CESR or CEGPR

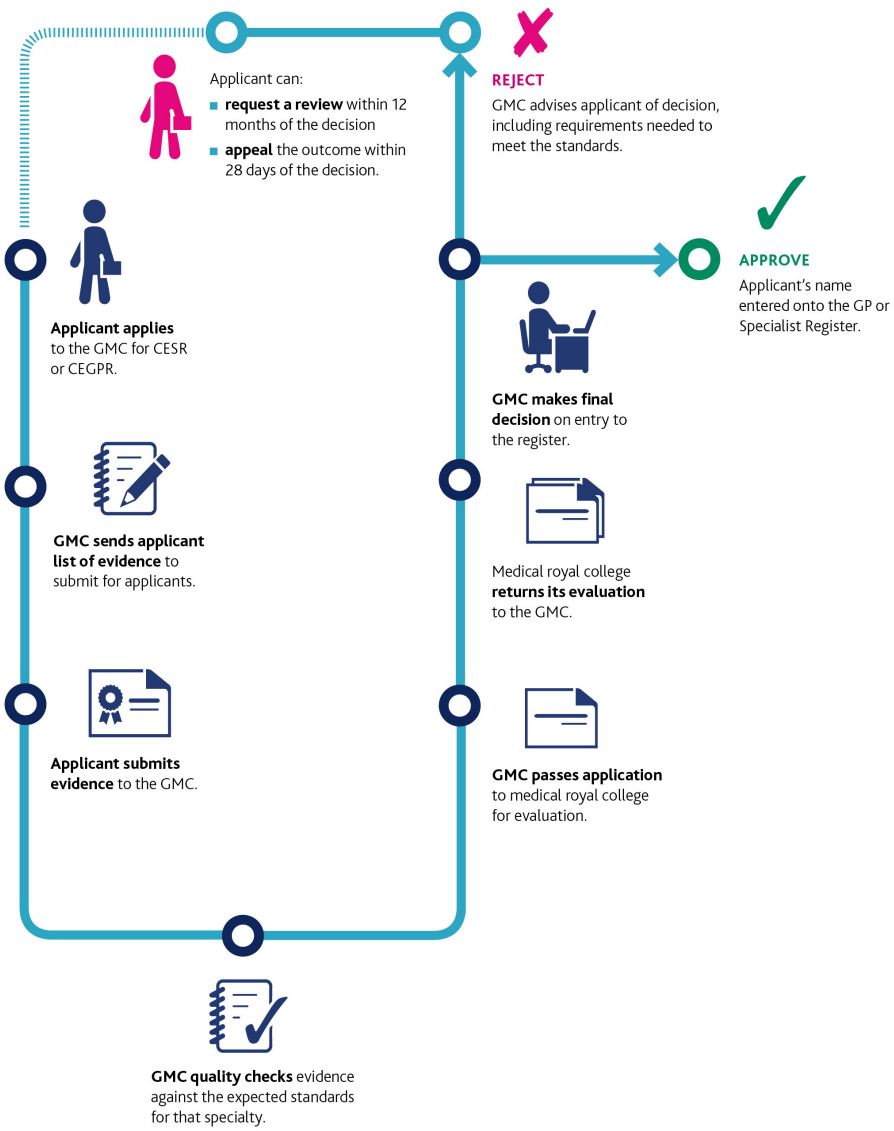
For doctors who gained their skills through training or experience outside an approved UK training programme, there are two ways to get a CESR or CEGPR certificate:

- full application to the GMC for specialist registration through CESR or GP registration through CEGPR
- through combined programme application - CESR (CP) or CEGPR (CP).

Full application to the GMC for CESR or CEGPR

If a doctor hasn't completed a UK approved training programme, they can show that they have the full skills, knowledge, qualifications and experience required by the relevant curriculum by getting a CESR or CEGPR certificate. The diagram below shows the CESR/CEGPR process.

The CESR/CEGPR process



Combined programme – CESR (CP) and CEGPR (CP)

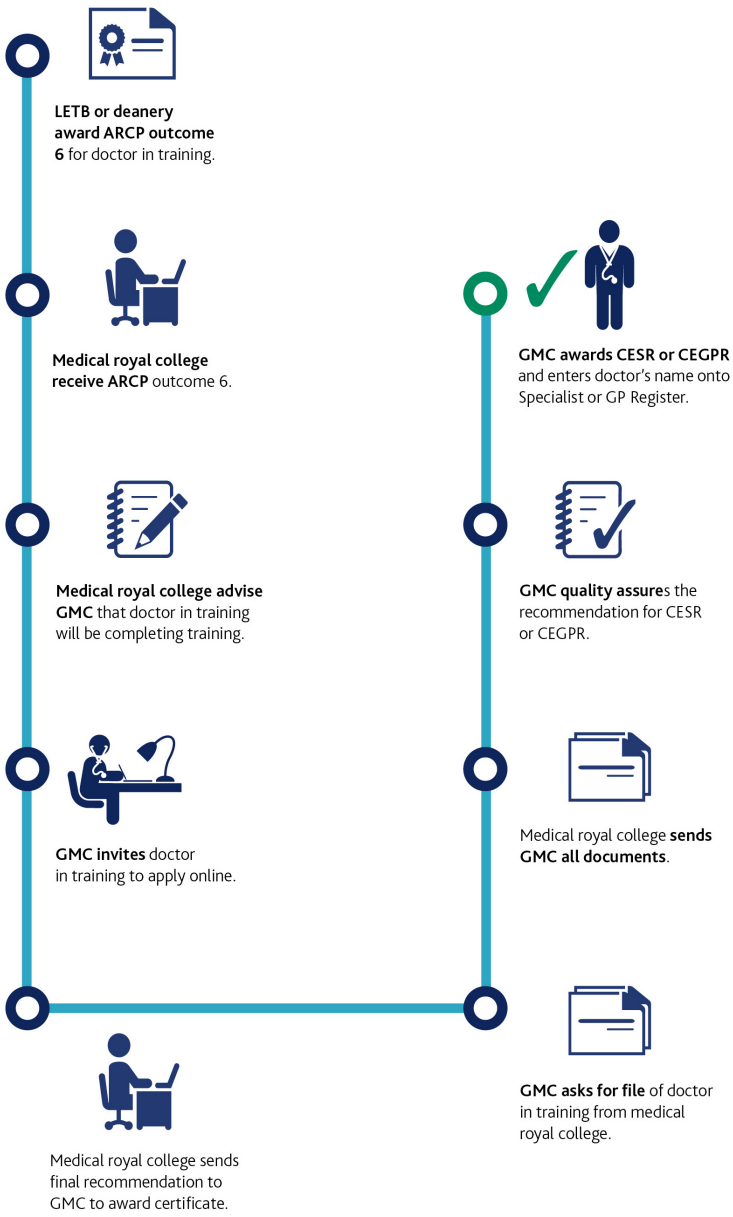
Some doctors already have skills and knowledge gained in non-approved training or experience before they apply to enter a UK training programme. This means they can demonstrate they have already acquired some of the curriculum competencies, and so will need less time to complete the relevant curriculum. This means that they can start their training programmes at a higher level than is usual. Trainees can only take this option with the agreement of their Local Education and Training Board (LETB)/ deanery and royal college.

When these doctors complete the remainder of the curriculum we issue them with a CESR or CEGPR, which entitles them to specialist or GP registration.

All applications for specialist / GP registration

When determining who is eligible for specialist or GP registration, we work with the relevant medical royal college and training programme providers. We review all the evidence a doctor submits to make sure the entry requirements for Specialist or GP Registers have been met.

The combined programme process



What happened in 2015

How many applications for CCT were approved?

In 2015, we granted 6,112 CCT applications based on recommendations from medical royal colleges and faculties across all specialties. This is fewer than 2014 when we granted 6,418 certificates. A full breakdown of applications by specialty for 2015 is shown in appendix 1, and by the royal college or faculty that issued the recommendation in appendix 5.

The table below shows the numbers of CCT applications received since 2013. This shows that overall, the numbers of applications have remained fairly consistent:

2013	2014	2015
6,280	6,418	6,112

How many combined programme applications were granted?

In 2015, we granted 109 combined programme applications in 120 specialties- some applications are made in dual specialties. This is more than the 92 applications granted in 2014.

A full breakdown of applications by specialty for 2015 is shown in appendix 2, and by the royal college or faculty that issued the recommendation in appendix 4.

The table below shows the numbers of combined programme applications received since 2013.

2013	2014	2015
92	92	109

The figures we report for CCT and combined programme applications are those that were successful. But just because we only report successful outcomes, it doesn't mean that all doctors appointed to training programmes necessarily complete their training programme. UK training programmes and standards are robust and there is an attrition rate for doctors in training for various reasons.

If a doctor in training is performing below the expected standard, they are offered remedial support at their Annual Review of Competence Progression (ARCP). This is known as an unsatisfactory ARCP outcome.

If a doctor in training continues to perform below the expected standard, they can be removed from the training programme. This is known as an ARCP outcome 4.

How many decisions were made on CESR and CEGPR applications?

In 2015, we made decisions on 537 CESR applications and 31 CEGPR applications. This is an overall decrease compared with 2014, when we made decisions on 551 CESR and 43 CEGPR applications. The table below shows the numbers of applications that were granted and rejected during 2015.

2015 – total 568

Granted	Rejected
281	287

The full breakdown of numbers of decisions by organisation and specialty in 2015 is shown in appendix 3.

We made decisions on applications in 66 specialties.

The ten most common specialties we made decisions on were:

Trauma and Orthopaedic surgery	50
General surgery	49
Anaesthetics	38
Obstetrics and gynaecology	36
General psychiatry	30
Paediatrics	29
Clinical radiology	24
Ophthalmology	23
General (internal) medicine	21
Cardiology	17
Emergency medicine	15

This includes both applications that were successful and applications that were refused.

Parallels with training programmes and CESR and CEGPR processes

As mentioned above, if doctors in UK training programmes perform below the expected standard, they are offered remedial support. This echoes our CESR and CEGPR processes, where we give unsuccessful applicants specific recommendations on how they should demonstrate the standards for specialist or GP registration if they wish to apply again in future.

Where applicants worked and where they gained their primary medical qualification

Where did our 2015 applicants get their most recent experience before they applied for CESR and CEGPR?*

All doctors who obtain specialist or GP registration through CCT and combined programme routes will be in a UK training programme, so their most recent experience will have been in the UK.

Where applicants were based for majority of time during 12 months before applying for CESR or CEGPR

	CESR	CEGPR	Total
UK	81.27%	70%	80.41%
EEA	2.48%	3.33%	2.54%
Rest of the world	16.25%	26.67%	17.05%

The majority of CESR and CEGPR applicants have already worked in the UK for most of the time during the 12 months before they made their applications. Many applicants will have cared for UK patients in non-consultant grade roles while preparing their application.

Where did our 2015 applicants get their primary medical qualification?

The table below shows the number of CCT and CESR / CEGPR (CP) applications, compared with region of primary medical qualification.

Where doctors who completed UK postgraduate training programmes gained their primary medical qualification

	CCT	CP
UK	75.34%	16.51%
EEA	3.94%	13.7%
Rest of the world	20.71%	69.72%
Total number of doctors	**6112**	**109**

* Based on place of employment at the time of application.

This shows that the region where the primary medical qualification is awarded is not a barrier to entering and successfully completing a UK training programme. More detailed breakdowns are available in appendices 5 and 6.

The following table shows the region where applicants gained their primary medical qualification, and the success rates within those regions of primary medical qualification.

Where doctors issued with a decision for CESR and CEGPR gained their primary medical qualification

	Proportion of region by primary medical qualification	Success rate by primary medical qualification region
UK	14.76%	61.90%
EEA	6.15%	45.71%
Rest of the world	79.09%	47.33%

While we can see that most applications through CESR and CEGPR are from international medical graduates, a majority of applicants have recent UK experience prior to applying. A more detailed breakdown is in appendix 7.

What we've learnt from previous applications

With the help of our partners at the medical royal colleges, we've identified some reasons why applications are often rejected in common specialties. For each of the specialties below, the percentage figure is based on the total number of applications assessed in that specialty.

General surgery

In 2015, we rejected 38 applications (78%)

While applicants tend to supply records of what they have done through logbooks and consolidation sheets, they don't always supply sufficient numbers of workplace based assessments (or equivalent) to demonstrate competence in procedures required by the curriculum. Logbooks can often be difficult to interpret if they aren't formatted in line with our specialty specific guidance.

Applicants also often fail to submit appropriate audit evidence. This can either be because they haven't completed sufficient numbers of audits, or occasionally the audit loop is incomplete. Applicants sometimes focus on a particular area of practice. This can mean that they are often unable to demonstrate maintaining competencies across the breadth of the curriculum. In general surgery, an area of special interest needs to be demonstrated, but not at the expense of the breadth of the curriculum. Applications are also rejected when the research requirements haven't been met. The curriculum is prescriptive about the number of publications and presentations required to demonstrate the standards, and the level of the applicants involvement.

Trauma and orthopaedic surgery

In 2015, we rejected 22 applications (44%)

Applicants often use logbooks as evidence of what they've done, but don't adequately demonstrate all the procedures to meet the curriculum requirements. The trauma and orthopaedic surgery curriculum gives information on procedure based assessment validation, showing how applicants can demonstrate the breadth of procedures in the curriculum. It can be very difficult to interpret logbooks if they aren't formatted according to our specialty specific guidance. The royal college asks that applicants provide a consolidation report filtered to show the numbers of SAC indicative procedures they've carried out over the last six years.

Applicants often submit insufficient evidence of audits that have been undertaken, particularly on closing the audit loop. Failure to demonstrate the required level of involvement in research also accounts for applicants not demonstrating the full curriculum requirements. Trauma and orthopaedic surgery applicants often fail to demonstrate the

required evidence of index procedures, such as paediatric orthopaedic surgery or spine surgery.

Emergency medicine

In 2015, we rejected 7 applications (47%)

The most common reason for an unsuccessful application is failure to provide sufficient evidence of current competences in the allied (Core) specialties of Acute Medicine, Intensive Care Medicine and Anaesthetics. In addition to submitting detailed logbooks and workplace-based assessments as specified in the curriculum, it is expected that the applicant will have spent a period of time of at least three months in each Core specialty. This experience should have been within five years of submission of the application.

Another frequent area of shortfall is expiry of one or more Advanced Life Support Courses (ALS, ATLS and APLS, or recognised equivalents). Evidence provided should include a current certificate of completion for each course.

Lack of evidence for completion of an audit cycle is often a reason for failure. Evidence for this can include audit reports, presentation slides, publications and any guidelines produced as a result of the audit.

General practice

In 2015, we rejected 14 applications (45%)

Overseas applications

Applicants for a CEGPR often provide insufficient evidence to show how their work as a general practitioner compares with our core curriculum statement, "Being a General Practitioner".

The following areas often lack detail and first hand, objective evidence to show personal participation in them:

- exposure to the full range of patients and conditions expected in general practice in the UK and coordination of care with other professionals in the community and in secondary care
- providing longitudinal, family orientated, comprehensive care
- clinical governance activities including audit and learning from significant events; using quality systems to improve care

- knowledge of how National Health Service general practice is organised in the UK.

The royal college of General Practitioners recommends that applicants submit a patient log showing the age, sex and diagnosis of patients seen consecutively in general practice over at least one month (the royal college can provide a template for this). Case studies; clinical records; correspondence with colleagues; notes of meetings; reports and management plans can also help to show exposure to the full range of patients and the general practitioner's role in the coordination of care.

Clinical governance activities can be evidenced with personal reflections or reviews of cases which have led to change and improvement in standards of care; reflection on a patient complaint; analysis of significant events and learning from error; evidence of personal contributions to practice improvements; examples of protocols and guidelines used in practice.

Applicants are not expected to have worked in National Health Service (NHS) general practice but should write about the research, reading and learning they have done in anticipation of coming to the UK and practising in a different health care system. Many successful applicants have reflected on their learning from web based resources, online modules, from a day of observing in a practice in the UK, courses and conferences. They have also considered where there may be gaps in their knowledge of NHS systems and processes.

Applicants previously released from a CCT programme

Applicants for a CEGPR who previously trained in a CCT programme, but were not successful in all parts of the MRCGP examination, often rely entirely on the evidence in their trainee eportfolio. However, much more evidence is needed to demonstrate equivalence to the CCT curriculum standard. In order to be successful, applicants must show progress has been made in the areas of weakness and deficiency identified in training and through examination. There is no set way of doing this. Applicants should consider how they can produce new, compelling evidence from recent clinical experience to show that all the curriculum competences have now been attained.

Dermatology

In 2015, we rejected 6 applications (43%)

It's essential that Core Medical Training (CMT) competencies are demonstrated. This can often be challenging for dermatologists who don't have any current responsibilities for unselected takes. Every applicant who failed in Dermatology during 2015 did not present sufficient evidence of CMT competence. If an applicant does not hold MRCP (UK), we would suggest they update their skills in the requirements of the CMT curriculum, and obtain assessments to confirm this.

Another common reason that applications aren't successful is that they don't have any evidence of completing a full audit cycle. Some applicants also don't have sufficient experience of management and leadership. It's very important for potential applicants to review the current curriculum in full and ensure they are able to present evidence to show they meet all the clinical competencies. If not, it's best to delay the application whilst additional work is undertaken to gather this evidence.

There is a Specialty Certificate Exam (SCE) in Dermatology which shows applicants have the knowledge base required by the curriculum. It's a good idea to pass the exam before applying for a CESR. If not, applicants will have to show that their knowledge from alternative means is very strong indeed, and maps to the SCE syllabus.

The British Association of Dermatologists (BAD) provide support to potential CESR applicants. Please see their website for details http://www.bad.org.uk/healthcare-professionals/sas-doctors/career-advice/cesr

General (internal) medicine

In 2015, we rejected 9 applications (41%)

Applicants who fail to meet the requirements in GIM often lack Core Medical Training (CMT) competencies. If MRCP (UK) has not been completed, there will need to be alternative evidence provided in the form of the following: A satisfactory Educational Supervisors report supported by the completion of an MCR (from 4 Consultant Clinical Supervisors), a satisfactory MSF and the minimum number of SLEs (10 in total including 6 ACATs, 2 CPDs and MiniCEXs each). Applicants sometimes fail to show evidence of the full depth and breadth of the curriculum being completed especially in regard to audit or quality improvement projects (QIP) and CPD. It is essential that applicants provide evidence of recent audits and completion of a full audit loop or QIP, together with evidence of up-to-date CPD, across the GIM curriculum.

Cardiology

In 2015, we rejected 9 applications (53%)

Cardiology applications generally are rejected for several reasons and have lots of recommendations, suggesting wide ranging deficiencies. Core Medical Training (CMT) competencies are not always demonstrated. If MRCP (UK) has not been completed, then there will need to be alternative evidence provided. The full depth & breadth of knowledge and clinical skills across the entire CCT curriculum is not always clearly demonstrated so attention to this section would be beneficial. There is often a lack of evidence of on-going appraisal/participation in the appraisal process, particularly MSF. Other issues that regularly occur in this speciality are a lack of recent evidence & completion of the audit loop and insufficient evidence of teaching & training, with a lack of teaching feedback

provided. Applicants are advised to provide a range of evidence relating to communication skills/team working.

Ophthalmology

In 2015, we rejected 14 applications (61%)

The most frequent reason applications in ophthalmology are rejected is a failure to adequately demonstrate the knowledge base that underpins an applicant's clinical skills. The curriculum requires that the applicant passes the Fellowship Exam of the royal college of Ophthalmologists (the FRCOphth exam) – this would fully demonstrate the knowledge base needed. Using alternative exams is acceptable as long as they are equivalent to the knowledge base demonstrated by the FRCOphth exam. It's also important that applicants provide evidence for each of the curriculum competencies.

Paediatrics

In 2015, we rejected 18 applications (60%)

It's crucial that applicants read the specialty specific guidance before they submit an application. Doctors in paediatrics typically specialise in one area of practice. A successful paediatrics applicant needs to demonstrate competency in acute general paediatrics, neonatal medicine and community child health. Unsuccessful applicants often demonstrate extensive experience in one of these areas, but insufficient experience in others in the previous five years. The royal college of Paediatrics and Child Health recommends applicants take a six month placement in each of their less recently experienced areas and make sure they match their evidence specifically to the curriculum requirements before they apply.

Obstetrics and gynaecology

In 2015, we rejected 15 applications (42%)

Applicants must demonstrate ongoing progression and maintenance of skill and competency through recent evidence. Specialty experience and evidence should be provided against the current curriculum, particularly from the last five years. And it's very important to include a completed and validated logbook in line with the current O&G curriculum. Progression through to independent clinical practice must be sufficiently demonstrated across both obstetrics and minor and major gynaecological surgery. This also includes completing mandatory training (such as a Female Genital Mutilation course) within the last five years, or providing evidence of equivalent knowledge and skills.

Applicants often fail due to insufficient evidence of management and leadership experience. We recommend that applicants use minutes of meetings they have chaired, submit certificates of attendance at approved management or leadership courses, or demonstrate evidence of leading projects. Applicants also sometimes fail to show evidence of their involvement in managing complaints. We suggest that applicants show evidence of responding to complaints, or submit evidence of a complaint handling course. In the event that no recent complaints have been received, applicants should demonstrate evidence of what they would do in hypothetical situations. Applicants should ensure they provide evidence of two-way communication as part of the overall management of patient care in collaboration with multidisciplinary teams, via referral letters. These are sometimes missing from applications.

Finally, applicants are required to complete a minimum of two Advanced Training Skills Modules. Without these, or equivalent evidence, applications will be unsuccessful.

Anaesthetics

In 2015, we rejected 18 applications (47%)

Anaesthetics applicants often fail to provide sufficient evidence relating to domain 1 of *Good medical practice* (our core guidance for doctors, on which all curricula are based). We often see applications where insufficient clinical evidence is given for intensive care, pain medicine and cardiothoracic competencies. Failure to provide sufficient evidence of experience in neuro-anaesthesia, paediatric anaesthesia and obstetric anaesthesia is also common, as is insufficient evidence of audit. The royal college of Anaesthetists recommends applicants demonstrate what they have done through clear summary logbooks, which show cumulative totals of higher level training and experience backed up with detailed logbooks. Most importantly, they must demonstrate competency acquisition to the curriculum standard through appropriate forms of assessments.

Clinical radiology

In 2015, we rejected 7 applications (29%)

Applicants rejected in clinical radiology most commonly fail to fully demonstrate the clinical skills required across the breadth of the curriculum in one or more areas. Examples include interventional radiology, radionuclide radiology, radiological procedures, ultrasound and mammography. The royal college of Radiologists recommends applicants have at least 40 radiology reports covering the breadth of the radiology specific areas of the curriculum. These reports should be supported by workload statistics from the hospital radiology information system, with supporting references from supervisors or trainers. Based on the rejections in 2015, applicants who don't demonstrate the curriculum's clinical requirements in one of these areas will also fail in other clinical areas. 90% of applicants that were rejected in 2015 also failed to adequately show they met audit and quality improvement

requirements. And over half of rejections showed insufficient evidence of clinical governance, teaching experience, management activity or involvement in appraisal. Often, applicants failed in multiple areas. Failed applications frequently relied too heavily on secondary evidence in areas including teaching, appraisal, clinical audit and quality improvement and clinical governance activity. The royal college of Radiologists recommends having two examples of clinical audit activity including a re-audit to complete the audit loop. Alternatively, evidence of completed quality improvement projects demonstrating a change in practice could be submitted. For other areas, applicants should show evidence of attendance at management meetings, multidisciplinary team meetings or leadership courses.

Applicants' experiences

The following doctors have been successful in their applications for specialist registration via a CESR. They've shared their experiences and also some tips for other applicants.

Dr Asim Ijaz – Emergency medicine

I decided to apply for a CESR in Emergency Medicine in late 2013. I'd been working in the specialty for about 11 years by then, including a period in Saudi Arabia. Applying felt like a natural progression in my career. I'd gradually become more involved in decision making and management in the department and wanted to continue this in a consultant role.

Preparation for my CESR application was key, and took me about two years. I consulted my supervisors and checked they were happy to support me in gathering evidence to submit an application. I read the Emergency medicine speciality specific guidance and curriculum, as well as the GMC's guidance on applying. I also went to a training event and spoke to the GMC on the phone. I looked for gaps in my experience, and undertook some additional courses and training to ensure I had the right evidence.

This meant that by the time I applied, my evidence portfolio was already very well organised. The GMC case officer provided excellent support, but I didn't need to do much additional work on my documents aside from obtaining some extra validation and correcting some data protection issues.

I was very happy and relieved when I received the decision. I read the evaluation form in full and felt it was very fair and thorough. I started a substantive consultant position two weeks after my specialist registration was granted.

I'd advise anyone thinking about applying for a CESR to read the speciality specific guidance thoroughly, and check you have the essential requirements. Talk to your referees and ensure you and they feel confident you're ready for consultant practice. You should provide robust evidence for each competency – this might be WBAs, e-modules, case review, courses with reflection, audits and teaching. It's vital for Emergency Medicine that you have confirmed paediatric, acute medicine, anaesthesia and ICU competencies. I'd also suggest ensuring you have a management portfolio, thorough annual appraisals, and evidence of a complete audit cycle. Some research experience is also important.

Most importantly, stay focused and don't give up!

Dr Gabriela Fillon – Paediatrics

I've been working in Paediatrics ever since I qualified as a doctor in Argentina in 1991. My career aim was to secure a consultant role in the UK, so I decided to apply for specialist registration.

I started to prepare about three years before I submitted my application. I gathered evidence both retrospectively and as I gained more experience. Before I applied, I had several conversations with both my royal college and the GMC, but the best preparation was attendance at a CESR training event for SAS doctors, which included a GMC presentation. That helped a lot with my application and gave me a clearer idea about the process.

Once I'd applied to the GMC, my adviser reviewed my evidence and sent a checklist setting out the evidence that had been accepted. A significant number of documents were sent back, and this was a little disappointing, because I'd put a lot of effort into making the initial application as good as possible. However, the comments that had been made were valid, and the majority of the papers needed additional verification or redaction.

Being granted specialist registration in Paediatrics was one of the happiest days of my life! I re-read the evaluation several times. I'll consider applying for consultant roles once I've finished my specialty contract.

I'd tell anyone considering applying for a CESR that the process can be quite time-consuming and requires the collection and review of a lot of paperwork, so it's really important to gather all of this evidence in advance. In future, I'd like to see the GMC assess capability for specialist registration by assessing doctors in the workplace – that would be much more straightforward!

Dr Ahsan Imtiaz – Renal medicine

I started training in renal medicine in Pakistan in 2006. I was attracted to the specialty for its mix of hands on and critical work. In 2010, I came to the UK. The next year, when I'd taken up a locum training role, I started considering a CESR application.

My first step was to look on the GMC website, and review all the guidance for applicants. I sat and passed the MRCP (UK) and the Specialty Certificate Exam in Renal medicine. In 2014, I started gathering my documents for an application. For me, the most challenging part was obtaining and verifying documents from Pakistan, where I'd completed much of my training. The CESR process isn't well known there, and many of the people I asked to verify documents weren't sure why it was necessary, particularly when they were available in electronic format. I had to make several trips to Pakistan to make sure I got all the right evidence.

There were some similar challenges in the UK too. Gathering information in an eportfolio was very helpful, but getting it signed off was sometimes difficult, especially if I'd been

working with locum consultants who had subsequently moved on. It took me about 16 months to prepare the documents, and I had to travel to hospitals all around the UK.

Once I'd applied, my GMC case adviser provided some very helpful advice. I submitted some additional logbooks and audits. When I received my successful outcome, I was very relieved. I also now have over 1100 pages of objective evidence I can include in my CPD and revalidation portfolios.

I'd like to see more guidance on creating an electronic logbook of procedures for CESR applicants. I collected evidence of procedures in my elogbook, but I created the format myself and wasn't sure if I should include particular data. I think a template for physicians would be very helpful.

I'd advise a doctor thinking of applying for a CESR to make sure they obtain evidence as they progress through each post. It's much easier to collect and verify documents when you complete the relevant work, than it is to gather them retrospectively. It can also be really helpful to speak to administrative colleagues to ask if they can provide statistical data and summaries of patients and procedures. I also made sure I spoke to my referees before I nominated them, and provided them with a copy of my CV. Most of all, make sure you get involved and take opportunities. Get involved in teaching, departmental meetings, and complete audits. Make sure you think about gathering evidence and plan ahead.

Trauma and orthopaedic surgery applicant

I started working in trauma and orthopaedics in 2006, first as a SHO then as a registrar. I wasn't able to secure a National Training Number, but I was fortunate to secure a locum appointment for training in 2010. My main motivation in applying for CESR was a desire to progress in my career; my goal is to become a consultant orthopaedic surgeon.

Preparing to apply was a long process. I started completing online assessments on my ISCP e-portfolio around five years ago. I've ensured I keep up to date across all the procedures in the curriculum. This meant that by the time I was ready to apply, all I had to do was to take printouts of from my portfolio and get them validated. Along with getting various other documents verified, like my logbook and evidence of teaching, the process of gathering documents took about a year. Before I started doing this, I read the guidance on the GMC's website and also talked to my colleagues who'd already been successful in applying for CESR.

I submitted my application at the end of August 2015, and my adviser suggested I submit an anonymised logbook for each job I'd had. This this took me three months, and looking back, I think this could have been avoided if I had read the guidelines in full.

When my decision was issued I felt elated, and very proud that I'd been successful. I read the full evaluation and it showed that the evaluators had thoroughly assessed my application form. I was particularly pleased to pass on my first attempt, as a reapplication

incurs further costs and time. I'm currently working as a BOA fellow, and now I have specialist registration, I hope to secure a consultant role within the next 12 months.

My advice to potential CESR applicants in Orthopaedics is to look at the CCT guidelines and ensure that you have evidence to show you've ticked all the boxes. Research and audits are very important - they take time and planning, so make sure you've considered this. Ensure that you get adequate numbers for all index procedures; if necessary arrange theatre sessions to fulfil these criteria. You might have to negotiate with your colleagues to attend their session, especially if you are lacking in numbers. Overall, preparation is the key.

Dr Susana Gillibrand – Occupational medicine

I've been working in occupational medicine since 1997, and had built up significant experience by the time I decided to apply for specialist registration. I currently have a portfolio career, including work in heavy and light manufacturing, shipbuilding and ship support, and HSE appointed doctor work.

I took my AFOM in 2009, and once I thought I'd reached the stage where I was working at consultant level and I was keen to achieve recognition of this. There can be a sense that if you work as an associate that you are different to consultant colleagues, and after many years of accruing experience I hoped that my knowledge and training was equivalent to consultant colleagues. Also, I thought that being on the specialist register was important in relation to my work as an independent occupational physician.

It took me around six months to prepare my application documents for submission, and I was able to gather some evidence from my appraisal folders. I attended a CESR day at the Faculty of Occupational Medicine which was invaluable as several advisers from the GMC were there as well as a colleague who had successfully completed CESR. This was an essential day to gain advice on how to go about compiling evidence and ensuring it was validated correctly.

I also spoke with the GMC, often on a weekly basis, whilst I was preparing my application. I found that it was very important to speak with an adviser from the Specialist Applications Team, as they have the expertise to deal with in depth queries. I made detailed notes of their advice so I had something to refer back to. I also emailed the GMC regarding my choice of referees. The GMC requests confirmation of all employment since qualification as a doctor, and tracking down some of these documents was a little problematic. I found the NHS Pensions service to be a useful resource in locating this evidence, and it would have saved some time if I'd known about this sooner. In addition, the GMC were able to provide details of my training posts undertaken as part of my GP vocational training scheme.

I ensured that my evidence showed the full breadth of my practice. As well as some complex cases I also selected some that showed evidence of more everyday situations.

You need at least 2 workplace assessments and at least one ill health retirement case, and to submit at least 2 audits. For each case I did a bullet point summary of the documents I was submitting, and then provided a summary. I discussed how I thought the case demonstrated compliance with the GMC's four domains of Good Medical Practice. I also stated how the evidence I submitted met the current curriculum. I was conscious that the assessors were going to have a considerable amount of documentation to read and so ensured my documents were really well organised and easy to follow.

I submitted 25 cases in all, which included the workplace visits. Each case had an ID number, and I included just the relevant correspondence for each referral: my report, and any correspondence to a GP or specialist.

This preparation meant that once I'd submitted my application, I had very little additional work to undertake. All of my documents were accepted as correctly verified, and my adviser was very good at keeping me updated during the process after submission.

Once the application was submitted for evaluation, it took around two months to receive a decision. I was relieved, although I had spent a lot of time preparing the best application I could, and I hoped I had done enough. I did feel a great sense of achievement though. I read the evaluation form in full and will include this in my next appraisal portfolio.

I'd advise doctors thinking about applying for a CESR in Occupational Medicine to review the current curriculum, and ensure you have evidence to demonstrate competence in all areas. It's important to make sure that you clearly set out the skills you think each piece of evidence demonstrates. On a practical level, the most important tip is to purchase very good redaction software to anonymise your documents. Using a pen is very difficult and there is a high risk that information will still be visible. It also means if you want to highlight something, you can do so by underlining or making a box around the paragraph. The assessors will then find it easier to see why you have submitted that particular piece of evidence.

The review of the routes to the specialist and GP register

In March 2010, Lord Naren Patel published a series of recommendations* for how the GMC should regulate medical education and training in the future. One of the recommendations was that we should review how doctors can be granted GP or specialist registration when they have not completed GP or specialist training in the UK.

We undertook a consultation on the 'Routes to the GP and Specialist Registers'† from March 2012 to June 2012. From the 402 responses, 13 proposed recommendations were submitted to GMC Council and approved in October 2012. For a full list of the recommendations, go to www.gmc-uk.org/routereview.

Progress

Some of the 13 recommendations were short-term and medium-term adjustments in order to improve transparency of our processes.

Recommendations 8-12 focus specifically on the role of college evaluators, use of specialist applications panels, and making sure decisions are fully supported by evidence. We have published approved terms of reference for applications panels on our website www.gmc-uk.org/doctors/24630.asp in response to these recommendations.

Recommendation 13 asked for an annual report to be published. We have published two reports since 2013 and this is the third report.

Meeting recommendations

We established an Equivalence Advisory Group (EAG) to help us implement the rest of the recommendations and in particular those that would need legislative change. This group consists of representatives from the Academy of Medical Royal Colleges, LETB and deaneries from each of the four UK countries, NHS employers and the BMA's Staff Grade and Associate Specialists Committee.

* Outcome of Consultation on the Review of the Future Regulation of Medical Education and Training – Annex B http://www.gmc-uk.org/4___Annex_B___Outcome_of_Consultation_on_the_Review_of_the_Future_Regulation_of_Medical_Education_and_Training.pdf_31275463.pdf

† Report of the Consultation on the Routes to the GP and Specialist Registers http://www.gmc-uk.org/07___Report_on_the_Consultation_on_the_Routes_to_GP.pdf_49969059.pdf

Our proposals the EAG have given advice on include the following.

1 Requiring CESR and CEGPR applicants to have a licence to practise and a minimum of 12 months' experience of working in the UK over the past three years.

2 Testing the applicant's knowledge in the relevant specialty.

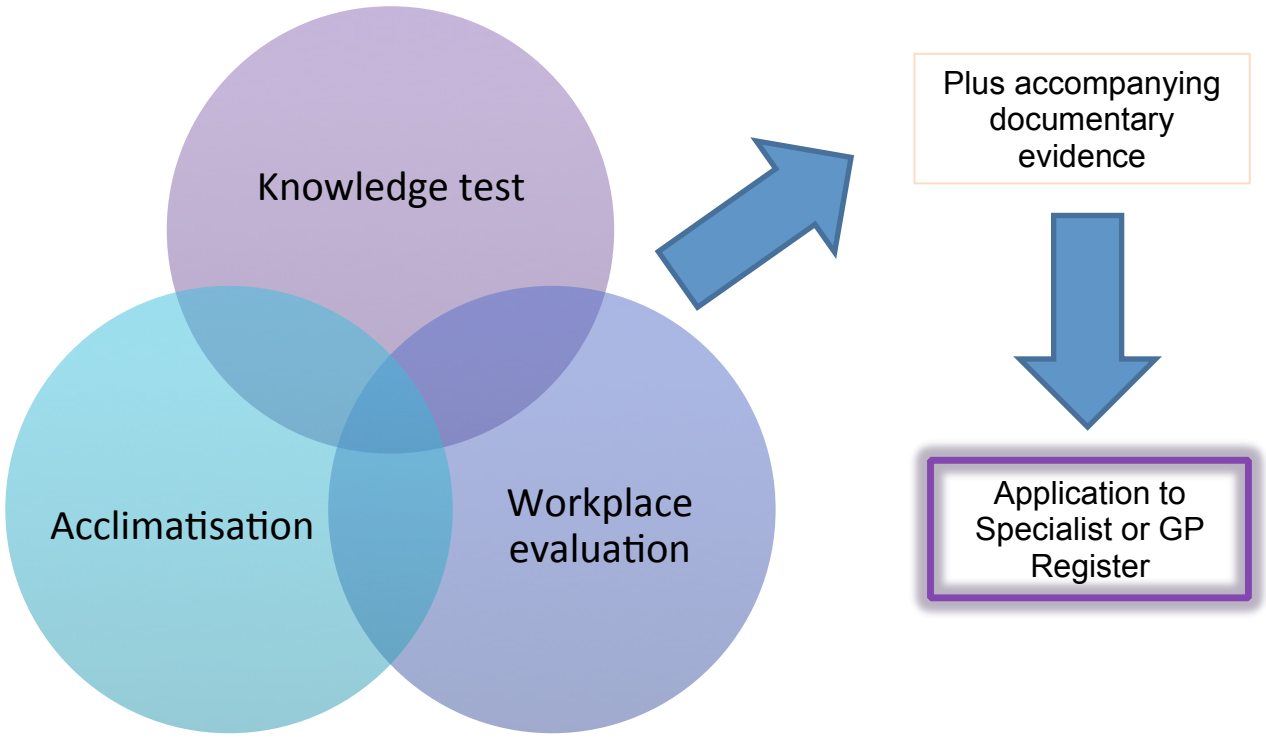
3 Evaluating the applicant's performance in the relevant specialty in a workplace based evaluation in the UK.

4 Amending legislation to allow CEGPR applicants to spend time working in GP practices in the UK.

5 How we include individuals of high international renown in the process without the need for acclimatisation or evaluation of performance.

Proposals so far

The diagram below shows the proposed model to implement recommendations.



Acclimatisation

We identified in last year's report (www.gmc-uk.org/Applications_to_the_GP_and_Specialist_Registers___DC7493.pdf_60763291.pdf page 15) that over 80% of applicants are already based in the UK before they apply. Our proposal will ensure all applicants have already worked for a minimum of 12 months in the last three years in the UK as a registered and licensed medical practitioner. For clarity, applicants will not necessarily need to be working in the specialty in which they intend to

apply for specialist registration – the recommendation merely asks for experience of working in the UK.

Knowledge test

Our proposal will require applicants to have passed the same exam as that required by the CCT curriculum in order to underpin the specialty knowledge.

Workplace evaluation

To evaluate the applicant's performance in the relevant specialty, we have asked curriculum writers in the medical royal colleges to identify a set of competencies that will be assessed in the workplace. These competencies will demonstrate an applicant's skills at the highest end of the curriculum.

Doctors of high international renown

To meet our eligibility criteria and apply through this route, the evidence an applicant will need to present is likely to include:

- a job offer from an organisation in the UK
- confirmation from the employer that the applicant needs specialist or GP registration for the post.

Estimates from the original working group suggest there will only be one or two doctors per year that fit our criteria for doctor of high international renown.

Appendices

Appendix 1 – CCT

CCT awarded 2015 by specialty

Some doctors undertake training in more than one specialty which means that there are more CCTs award than number of individual doctors applying. In 2015, 6,112 CCTs were awarded covering 6,772 specialist and GP register entries.

Acute Internal Medicine	51
Anaesthetics	447
Cardiology	91
Cardio-thoracic surgery	6
Chemical pathology	8
Child and adolescent psychiatry	57
Clinical genetics	8
Clinical neurophysiology	9
Clinical oncology	55
Clinical radiology	179
Dermatology	45
Emergency medicine	90
Endocrinology and diabetes mellitus	68
Forensic psychiatry	34
Gastroenterology	108
General (internal) medicine	546
General Practice	2,751
General psychiatry	172
General surgery	159
Genito-urinary medicine	22
Geriatric medicine	107
Haematology	59
Histopathology	56
Immunology	6

Infectious diseases	24
Intensive care medicine	101
Medical microbiology	23
Medical microbiology and virology	24
Medical oncology	29
Medical psychotherapy	14
Neurology	42
Neurosurgery	23
Obstetrics and gynaecology	162
Occupational medicine	15
Old age psychiatry	58
Ophthalmology	97
Oral and maxillo-facial surgery	18
Otolaryngology	42
Paediatric surgery	12
Paediatrics	329
Palliative medicine	48
Pharmaceutical medicine	21
Plastic surgery	37
Psychiatry of learning disability	22
Public health medicine	34
Rehabilitation medicine	10
Renal medicine	69
Respiratory medicine	110
Rheumatology	56
Trauma and orthopaedic surgery	155
Urology	48

Specialties numbering fewer than five applications – total number of applications across these specialties: 15

Allergy
Audio vestibular medicine
Clinical pharmacology and therapeutics
Medical Virology
Paediatric cardiology
Sport and Exercise Medicine

Total number of CCTs awarded in 2015: 6,112

Appendix 2 – CP

Some doctors undertake training in more than one specialty, which means that there are more CESRs awarded than number of individual doctors applying. In 2015, 109 doctors were awarded a CESR through a combined programme with 120 specialist register entries. Specialties with two or fewer applications have been grouped to minimise risk of identification.

Acute Internal Medicine	4
Anaesthetics	12
Community Sexual and Reproductive Health	4
Emergency medicine	4
General (internal) medicine	12
Geriatric medicine	5
Obstetrics and gynaecology	18
Paediatric cardiology	3
Paediatrics	18
Pharmaceutical medicine	3
Rheumatology	5
Sport and Exercise Medicine	4
Urology	3

List of specialities with two or fewer applications. Total number of applications across these specialties: **25**

Child and adolescent psychiatry
Clinical radiology
Dermatology
Endocrinology and diabetes mellitus
Forensic psychiatry
Gastroenterology
General surgery
Haematology
Neurosurgery
Nuclear medicine
Occupational medicine
Old age psychiatry
Ophthalmology
Psychiatry of learning disability
Rehabilitation medicine
Renal medicine
Trauma and orthopaedic surgery

Total number of doctors awarded a CESR through combined programme: **109**

Appendix 3 – CESR / CEGPR

Breakdown of CESR and CEGPR decisions by organisation and specialty 2015

Specialties of application with low numbers have been grouped to minimise risk of identifying applicant.

Organisation	Specialty	Registration Granted	Application Rejected	Total
Faculty of Occupational Medicine	Occupational medicine	4	2	6
Faculty of Public Health	Public health medicine	2	1	3
Faculty of Sexual and Reproductive Healthcare	Community Sexual and Reproductive Health		3	3
Joint Committee on Surgical Training		**66**	**95**	**161**
	Breast Surgery	1	4	5
	Cardio-thoracic surgery	8	5	13
	General surgery	11	38	49
	Neurosurgery	4	5	9
	Otolaryngology	4	8	12
	Plastic surgery	2	4	6
	Trauma and orthopaedic surgery	28	22	50
	Urology	4	5	9
	Vascular surgery	2	2	4
	Paediatric surgery Paediatric orthopaedic surgery Renal transplantation and vascular access Transplant Surgery	2	2	4
Joint Royal Colleges of Physicians Training Board		**63**	**44**	**107**
	Cardiology	8	9	17
	Dermatology	8	6	14
	Endocrinology and diabetes mellitus		3	3
	Gastroenterology	6		6
	General (internal) medicine	13	9	22
	Medical oncology	2	4	6
	Neurology	2	3	5

	Palliative medicine	3		3
	Rehabilitation medicine	2	1	3
	Respiratory medicine	2	2	4
	Rheumatology	2	2	4
	Sport and Exercise Medicine	5	1	6
	Acute internal medicine Allergy Clinical neurophysiology Geriatric medicine Haematology Infectious diseases Medical ophthalmology Paediatric cardiology Renal medicine Vascular Complications of Diabetes	10	4	14
Royal College of Anaesthetists		**22**	**24**	**46**
	Anaesthetics	20	18	38
	Cardio-thoracic Anaesthesia	1		1
	Intensive care medicine	1	6	7
Royal College of Emergency Medicine	Emergency medicine	8	7	15
Royal College of General Practitioners	General Practice	17	14	31
Royal College of Obstetricians and Gynaecologists	Obstetrics and gynaecology	21	15	36
Royal College of Ophthalmologists	Ophthalmology	9	14	23
Royal College of Paediatrics and Child Health		**18**	**27**	**45**
	Neonatal Medicine	3	4	7
	Paediatrics	12	18	30
	Paediatric Allergy Paediatric Allergy, Immunology and Infectious Diseases Paediatric Gastroenterology, Hepatology and Nutrition Paediatric Neurology Paediatric Respiratory Medicine	3	5	8
Royal College of Pathologists		**10**	**5**	**15**

	Histopathology	7	2	9
	Medical microbiology	2	2	4
	Chemical pathology Medical microbiology and virology	1	1	2
Royal College of Psychiatrists		**21**	**28**	**49**
	Child and adolescent psychiatry	5	3	8
	Forensic psychiatry	2	1	3
	General adult psychiatry	2	1	3
	General psychiatry	10	16	26
	Medical psychotherapy		1	1
	Old age psychiatry		4	4
	Psychiatry of learning disability	2	2	4
Royal College of Radiologists		**20**	**8**	**28**
	Clinical radiology	17	7	24
	Clinical oncology Diagnostic radiology Neuroradiology	3	1	4

Appendix 4 – all SR / GPR

All granted specialist and GP registration applications by organisation 2015

Organisation	CCT	CESR (CP)	CESR /CEGPR	TOTAL
Faculty of Occupational Medicine	15	1	4	20
Faculty of Public Health	34		2	36
Faculty of Sexual and Reproductive Healthcare		4		4
Joint Committee on Surgical Training	500	8	66	574
Joint Royal Colleges of Physicians Training Board	1541	48	63	1652
Royal College of Anaesthetists	548	12	22	582
Royal College of Emergency Medicine	90	4	8	102
Royal College of General Practitioners	2751		17	2768
Royal College of Obstetricians and Gynaecologists	162	17	21	200
Royal College of Ophthalmologists	97	1	9	107
Royal College of Paediatrics and Child Health	329	18	18	365
Royal College of Pathologists	114		10	124
Royal College of Psychiatrists	357	5	21	383
Royal College of Radiologists	234	2	20	256

Appendix 5 – PMQ and CCT

Country of primary medical qualification for CCT in 2015. All countries with fewer than ten total applications have been grouped to avoid identification.

Primary medical qualification country	Number of CCTs awarded	% total
UK	**4605**	75.34%
EEA	**241**	3.94%
Czech Republic	29	0.47%
Germany	36	0.59%
Greece	20	0.33%
Ireland	50	0.82%
Poland	25	0.41%
Romania	15	0.25%
Spain	10	0.16%
All other EEA	**56**	0.92%
ROW	**1266**	20.71%
Egypt	21	0.34%
India	634	10.37%
Iran, Islamic Republic Of	16	0.26%
Iraq	40	0.65%
Myanmar	10	0.16%
Nigeria	124	2.03%
Pakistan	202	3.30%
Russian Federation	16	0.26%
South Africa	25	0.41%
Sri Lanka	26	0.43%
Sudan	11	0.18%
Syrian Arab Republic	14	0.23%
All other ROW	**127**	2.08%

Appendix 6 – PMQ and CP

Country of primary medical qualification for combined programme in 2015. All countries with fewer than five total applications have been grouped to avoid identification.

Primary medical qualification country	Number of CESRs awarded through the combined programme	% total
UK	**18**	16.51%
EEA	**15**	13.7%
Ireland	7	6.42%
All other EEA	**8**	7.34%
ROW	**76**	69.72%
India	44	40.37%
Pakistan	6	5.5%
All other ROW	**26**	23.85%

Appendix 7 – PMQ and CESR / CEGPR

Country of primary medical qualification for CESR and CEGPR decisions in 2015. All countries with fewer than five total applications have been grouped to avoid identification

Primary medical qualification country	CESR / CEGPR approved	CESR / CEGPR rejected	Total	% Success
UK	**52**	**32**	**84**	**61.90%**
EEA	**16**	**19**	**35**	**45.71%**
Czech Republic	1	2	3	33.33%
Ireland	3	2	5	60%
Italy	4	3	7	57.14%
All other EEA	8	12	20	40%
ROW	**213**	**237**	**450**	**47.33%**
Australia	5	10	15	33.33%
Bangladesh	2	4	6	33.33%
Egypt	17	21	38	44.74%
India	78	75	153	50.98%
Iraq	11	5	16	68.75%
Jordan	2	3	5	40.00%
Libya	7	3	10	70.00%
New Zealand	3	2	5	60.00%
Nigeria	12	9	21	57.14%
Pakistan	32	48	80	40.00%
South Africa	4	9	13	30.77%
Sri Lanka	9	11	20	45.00%
Sudan	6	5	11	54.55%
Syrian Arab Republic	7	4	11	63.64%
United States	2	5	7	28.57%
All other ROW	16	23	39	41.03%

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