Applications to the GP and Specialist Registers

2016

General Medical Council

Introduction

This is our annual report, which gives an overview of decisions we made on applications for specialist or general practitioner (GP) registration in 2016.

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 2016
- 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/CEGPR applicants
- An update on our review of the routes to the Specialist and GP Registers

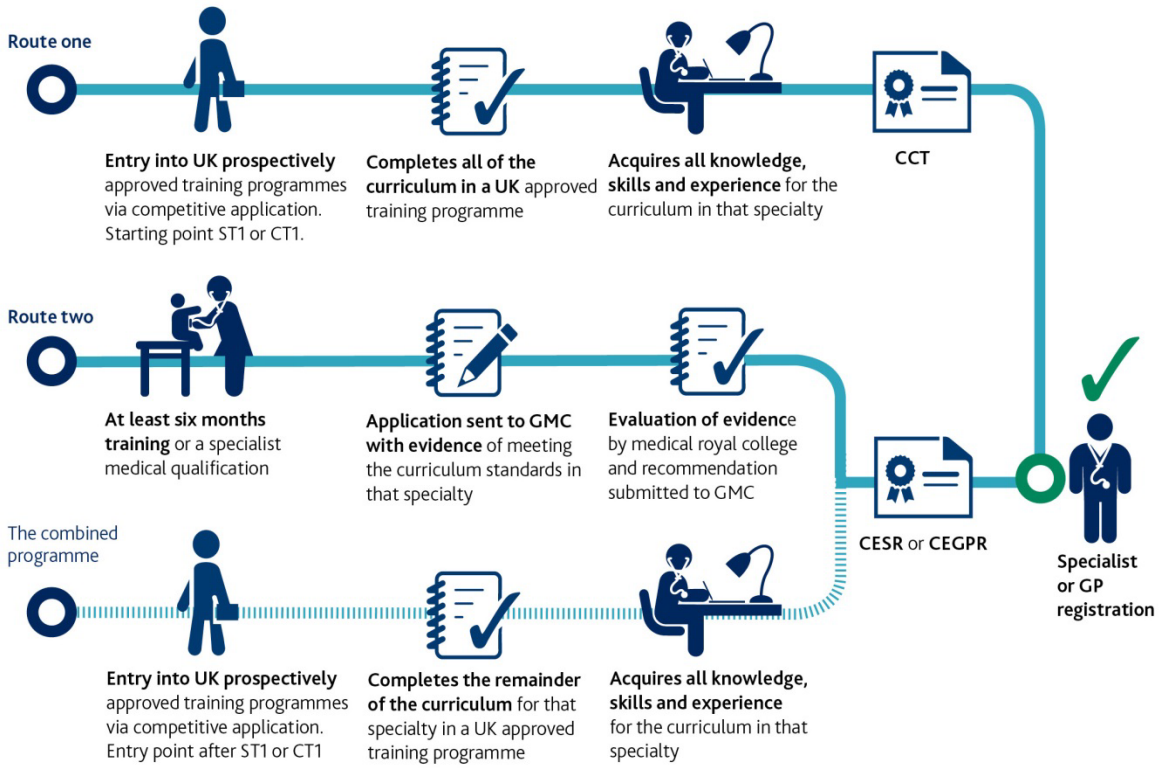
How a doctor's name is added to the GP or Specialist Register

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.

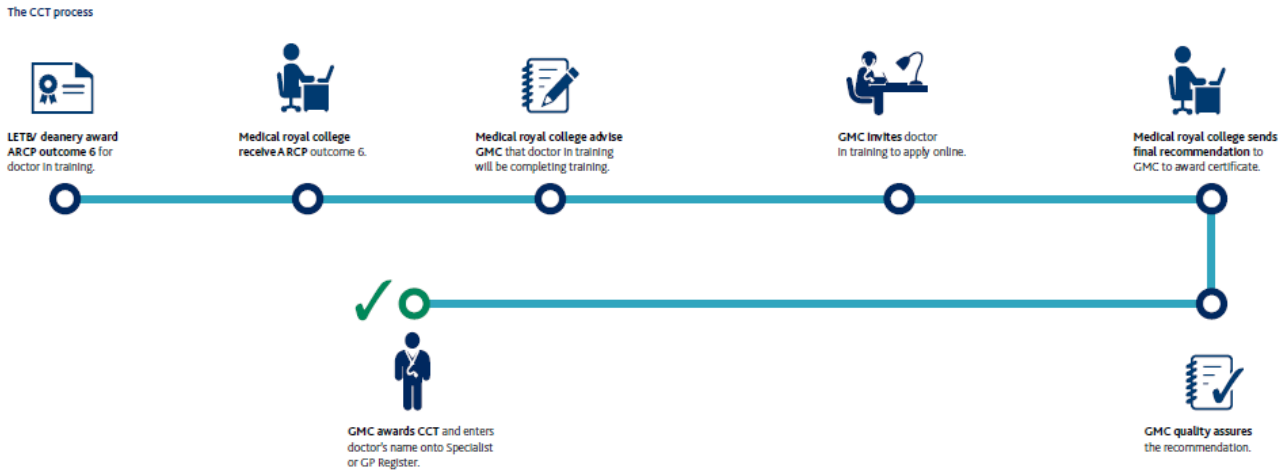
- Certificates of Completion of Training
- Certificates of Eligibility for Specialist Registration
- Certificates of Eligibility for GP Registration
- CESR Combined Programme
- CEGPR Combined Programme

Routes to specialist or GP registration



Getting specialist or GP registration with a CCT

Most doctors who 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 us. We issue these doctors with a CCT, which entitles them to specialist or GP registration.



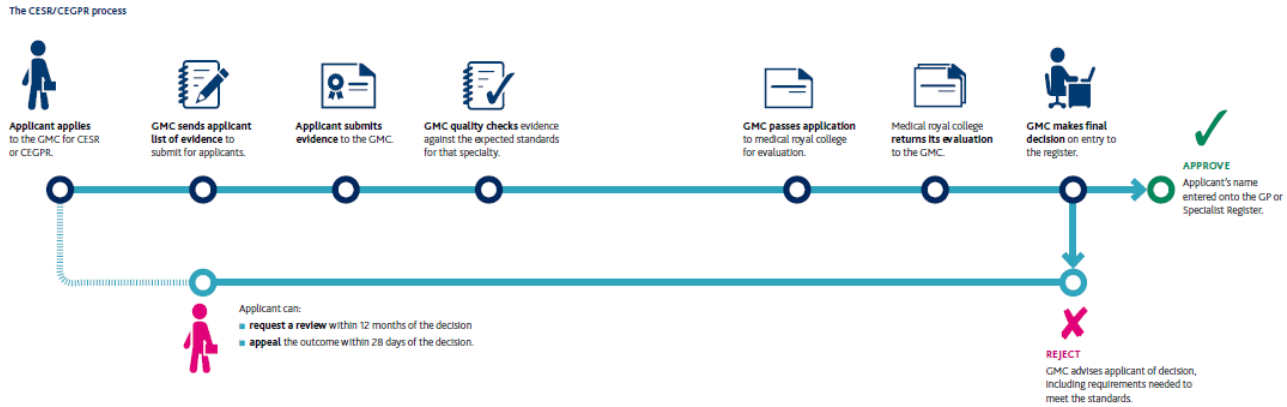
Getting specialist or GP registration with a CESR or CEGPR

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

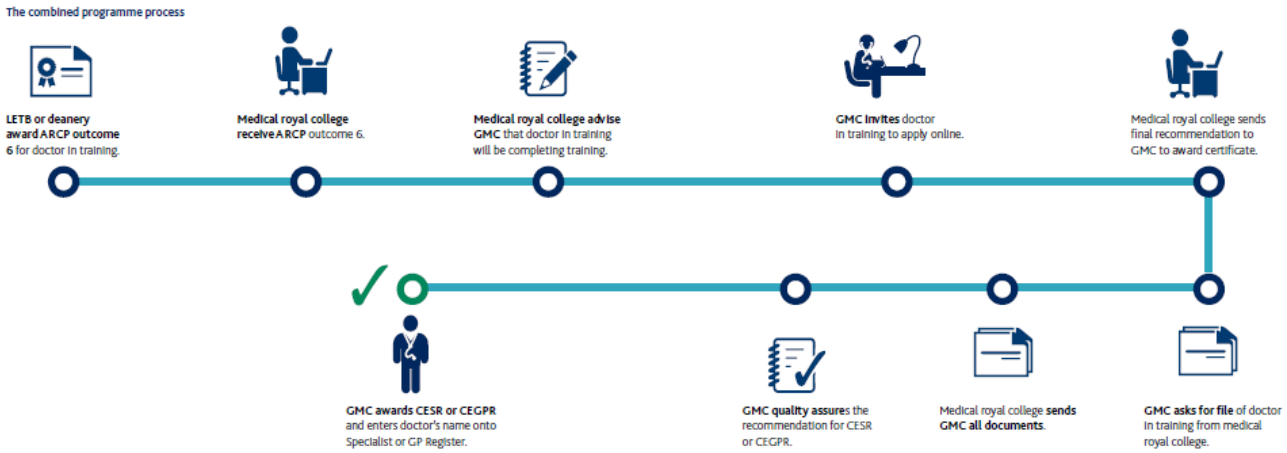
If a doctor hasn't completed a UK approved training programme, they can show they have the full skills, knowledge, qualifications and experience required by the relevant curriculum by getting a CESR or CEGPR certificate. The diagram below shows the CESR/CEGPR process.



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

Some doctors already have skills and knowledge gained in non-UK 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 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 or 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.

What happened in 2016

How many applications for CCT did we approve?

In 2016, we granted 6,145 CCT applications based on recommendations from medical royal colleges and faculties across all specialties. This is slightly higher than in 2015 when we granted 6,112 certificates. A full breakdown of applications by specialty for 2016 is shown in appendix 1, and by the royal college or faculty that issued the recommendation in appendix 5. Some applications are made in dual specialties, therefore the breakdown of specialties is higher in number than the number of CCT applications we approved.

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	2016
6,280	6,418	6,112	6,145

How many combined programme applications did we grant?

In 2016, we granted 124 combined programme applications in 35 specialties. This is more than the 109 applications granted in 2015.

A full breakdown of applications by specialty for 2016 is shown in appendix 2, and by the royal college or faculty that issued the recommendation in appendix 4. Some applications are made in dual specialties, therefore the breakdown of specialties is higher in number than the number of combined programme applications we approved.

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

2013	2014	2015	2016
92	92	109	124

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 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.

How many decisions did we make on CESR and CEGPR applications?

In 2016, we made decisions on 593 CESR applications and 23 CEGPR applications. This is an overall increase compared with 2015, when we made decisions on 537 CESR and 31 CEGPR applications. The table below shows the numbers of applications we granted and rejected in 2016.

2016 – Total 616

Granted	Rejected
333	283

The full breakdown of numbers of decisions by organisation and specialty in 2016 is shown in appendix 3.

We made decisions on applications in 70 specialties.

The ten most common specialties we made decisions on were:

Specialty	Number of applications
Trauma and orthopaedic surgery	58
General surgery	48
Paediatrics	37
Anaesthetics	34
Clinical radiology	34
Obstetrics and gynaecology	32
General (internal) medicine	31
Ophthalmology	26
General psychiatry	24
General practice	23
Emergency medicine	23

This includes applications that were successful and applications we 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 2016 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	88.19%	73.91%	87.66%
EEA	2.36%	0%	2.27%
Rest of the world	9.44%	26.08%	10.06%

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 2016 applicants get their primary medical qualification?

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

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

	CCT	CESR(CP) /CEGPR (CP)
UK	78.20%	24.19%
EEA	3.62%	11.29%
Rest of the world	18.16%	64.51%
Total number of doctors	**6,145**	**124**

* 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 CESR/CEGPR applicants gained their primary medical qualification, and the success rates for applicants by region.

Where CESR and CEGPR applicants gained their primary medical qualification

	Proportion of doctors by region of primary medical qualification	**Success rate by primary medical qualification region**
UK	15.63%	58.33%
EEA	7.81%	47.91%
Rest of the world	76.54%	53.82%

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. We also include this information in our Specialty Specific Guidance on our website. For each of the specialties below, the percentage figure is based on the total number of applications assessed in that specialty.

General surgery

In 2016, we rejected 21 applications (44%)

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 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. We also reject applications 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 applicant's involvement.

Trauma and orthopaedic surgery

In 2016, we rejected 33 applications (57%)

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 is most helpful if these are grouped by type and accompanied by a summary sheet. 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 overall case numbers and the numbers of Specialist Advisory Committee (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 2016, we rejected nine applications (39%)

A common reason for an unsuccessful application is failure to provide sufficient evidence of current competencies 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, we expect the applicant to have spent at least three months (whole time equivalent) in both anaesthetics and intensive care medicine. A period in acute medicine is desirable although these competencies may be achieved in the Emergency Department. Experience in a Paediatric Emergency Department is recommended but paediatric emergency medicine competencies may be achieved in a General Emergency Department with sufficient exposure to paediatric patients. Primary evidence of all competencies should have been within five years of submission of the application.

Another frequent area of shortfall is expiry of certificates in one or more Advanced Life Support Courses (ALS), Advanced Trauma Life Support (ATLS) and Advanced Paediatric Life Support (APLS), or recognised equivalents. Evidence should include a current (ie within the four year expiry date of the certificate) 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 2016, we rejected four applications (19%)

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.

- Exposure to the full range of patients and conditions expected in general practice in the UK and coordination of care with other professionals within the workplace, in the community and in secondary care.

- Providing ongoing, 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 e-Portfolio. However, much more evidence is needed to demonstrate equivalence to the CCT curriculum standard. 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 other recent clinical experience to show that all the curriculum competences have now been attained.

Dermatology

In 2016, we rejected five applications (42%)

It's essential that core medical training competencies are demonstrated. This can often be challenging for dermatologists who don't have any current responsibilities for unselected takes (ie admission through A&E or GP referral). Every applicant who failed in Dermatology during 2015 did not present sufficient evidence of core medical training competence. If an applicant does not hold Membership of the Royal College of Physicians (UK) (MRCP (UK)), we would suggest they update their skills in the requirements of the core medical training 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 curriculum in full and make sure they can present evidence to show they meet all the clinical competencies. If not, it's best to delay your application so you can carry out additional work to gather this evidence.

There is a Specialty Certificate Exam 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 Specialty Certificate Exam syllabus.

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

General (internal) medicine

In 2016, we rejected 15 applications (48%)

Applicants who fail to meet the requirements in general (internal) medicine often lack core medical training competencies. If MRCP (UK) has not been completed, applicants will need to give alternative evidence in the form of:

- a satisfactory educational supervisors' report supported by the completion of a multiple consultant report (from four consultant clinical supervisors)
- a satisfactory multi-source feedback

  and
- the minimum number of supervised learning events (ten in total including six acute care assessment tools, two case based discussions, and two mini-clinical evaluation exercises).

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 and

continuing professional development. It is essential that applicants provide evidence of recent audits and completion of a full audit loop or quality improvement project, together with evidence of up-to-date continuing professional development, across the general (internal) medicine curriculum.

Cardiology

In 2016, we rejected five applications (38%)

Cardiology applications generally are rejected for several reasons and have lots of recommendations, suggesting wide ranging deficiencies. Core Medical Training competencies are not always demonstrated. If MRCP (UK) has not been completed, applicants will need to provide alternative evidence. The full depth and breadth of knowledge and clinical skills across the entire CCT curriculum is not always clearly demonstrated. There is often a lack of evidence of ongoing appraisal/participation in the appraisal process, particularly multi-source feedback. Other issues that regularly occur are a lack of recent evidence, no evidence of completion of the audit loop and insufficient evidence of teaching and training, with a lack of teaching feedback provided. We advise applicants to provide a range of evidence relating to communication skills and team working.

Ophthalmology

In 2016, we rejected 16 applications (62%)

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 2016, we rejected 16 applications (43%)

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. It's crucial that applicants read the specialty specific guidance before they submit an application.

Obstetrics and gynaecology

In 2016, we rejected 13 applications (41%)

Applicants must demonstrate ongoing progression and maintenance of skill and competency through recent evidence. They should provide evidence of specialty experience 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 obstetrics and gynaecology 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 make sure 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 2016, we rejected ten applications (29%)

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). This year, the main areas where insufficient clinical evidence was provided was in intensive care medicine, paediatric anaesthesia, obstetric anaesthesia and cardiothoracic anaesthesia. Failure to provide sufficient evidence of experience in teaching and training is relatively common, as is insufficient evidence of audit.

The Royal College of Anaesthetists recommends applicants demonstrate evidence of competence through clear summary logbooks, which show cumulative totals of higher

level training and experience backed up with detailed logbooks and triangulated with other supporting evidence. Most importantly, they must demonstrate competency acquisition to the curriculum standard through appropriate forms of assessments.

Clinical radiology

In 2016, we rejected ten 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, and a training curriculum. Many unsuccessful applicants also failed to adequately show they met audit and quality improvement requirements.

The Royal College of Radiologists recommends having at least 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. Many unsuccessful applications showed insufficient evidence of clinical governance, teaching expertise, management activity or involvement in appraisal.

Often, applicants failed in multiple areas. Unsuccessful applications frequently relied too heavily on secondary evidence in areas including teaching, appraisal, clinical audit and quality improvement and clinical governance activity. For other areas, applicants should show evidence of attendance at management meetings, multidisciplinary team meetings and leadership courses.

Clinical oncology

In 2016, we rejected one application (100%)

Applicants must demonstrate equivalence to the CCT curricula requirements in clinical oncology which covers both systematic therapies and radiotherapy. Applications can fail if they submit inadequate evidence of either of these areas. Applicants should submit a wide range of cases in terms of tumour sites, treatment intent and complexity.

Among other things, applicants should give a concise summary of each case containing the history, the relevant investigation results and their recommended treatment, explaining the reasons for the recommendations and evidence to support these. If there was a variation from standard clinical practice, applicants must give a reason to justify the

decision – the Royal College of Radiologists provides guidance on the submission of clinical cases in the specialty-specific guidance, which is available on our website.

The plans and prescriptions should be supported by workload statistics and/or logbooks, with supporting references from supervisors or trainers, and a training curriculum. It is essential that information about communication with colleagues and patients is submitted, such as formal multisource feedback and patient questionnaires.

Unsuccessful applications showed insufficient evidence of clinical governance, teaching expertise, management activity, research or involvement in appraisal. These applications frequently relied too heavily on secondary evidence in areas including teaching, appraisal, clinical audit and quality improvement and clinical governance activity. For other areas, applicants should show evidence of attendance at management meetings, multidisciplinary team meetings and leadership courses.

The review of the routes to the Specialist and GP Register

In March 2010, Lord Naren Patel published a series of recommendations[*] for how we 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 carried out 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 our Council and approved in October 2012. For a full list of the recommendations, go to www.gmc-uk.org/routereview.

Completed recommendations

Some of the 13 recommendations were short-term and medium-term adjustments 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.

[*] Outcome of Consultation on the Review of the Future Regulation of Medical Education and Training – Annex B 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 www.gmc-uk.org/07___Report_on_the_Consultation_on_the_Routes_to_GP.pdf_49969059.pdf.

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. We have not needed to convene a panel since 2012, due to increased engagement with colleges and faculties.

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

Outstanding recommendations

We established an Equivalence Advisory Group 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, LETBs and deaneries from each of the four UK countries, NHS employers and the BMA's Staff Grade and Associate Specialists Committee.

Proposals the Equivalence Advisory Group have given advice on include:

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

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

3 Evaluating the applicant's performance in a workplace based evaluation in the UK, against a set of 'pinnacle competencies' for the relevant specialty.

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.

Progress

Implementing the proposals will require amendments to legislation. We continue to lobby Government to make these, and other, changes to the legislative framework within which we are required to work. At present, it's not clear when such changes are likely to be made and we cannot implement the outstanding recommendations until this happens.

Other work to improve the equivalence process

In the interim, we intend to take forward a number of other actions to improve the CESR and CEGPR process for applicants and assessors. These include:

- Reviewing how applicants can submit and verify evidence of their knowledge and skills.
- Improving guidance for applicants. We recently introduced expanded and more detailed specialty-specific guidance for applicants in a small number of specialties. We developed this with input from royal colleges and faculties to draw on their experience of assessing CESR applications. The improved guidance allows applicants to target their evidence to the requirements of the specialty, and makes the requirements for a successful application clearer. We will expand this enhanced guidance to other specialties.
- Continuing training with potential applicants and assessors. Practical exercised-based training, delivered by our staff, has received consistently excellent feedback and allows applicants to submit applications that are more likely to be 'right first time'. We will consider how we can make training accessible to more applicants.

During 2017, we will develop a new set of standards for postgraduate medical curricula.[*] In addition, plans for improving the flexibility of postgraduate training have recently been published.[†]

[*] www.gmc-uk.org/education/29569.asp.

[†] www.gmc-uk.org/Adapting_for_the_future___a_plan_for_improving_the_flexibility_of_UK_postgraduate_medical_training_FINAL.pdf_69842348.pdf.

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 Workplace Based Assessments (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 Intensive Care Unit (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 e-portfolio 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 1,100 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 e-logbook, 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 Senior House Officer (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 Intercollegiate Surgical Curriculum Programme (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 British Orthopaedic Association 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 Health and Safety Executive (HSE) appointed doctor work.

I took my Associates of the Faculty of Occupational Medicine (AFOM) exam 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 two workplace assessments and at least one ill health retirement case, and to submit at least two 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.

Dr Nada Al-Shammari – obstetrics and gynaecology

I've been working in this speciality since 2000 and have worked as a consultant in the United Arab Emirates for a few years. When I moved to the UK, I had to work as a registrar which I thought I was overqualified for so decided to apply for specialist registration.

To prepare for my application I did everything I could – I spoke to my supervisor, contacted my royal college and the GMC, read the GMC's guidance and attended a CESR training event run by the GMC. Because of my family commitments, it took me three years

to prepare all of my documents. However, more than 50% of my documents for this application were from overseas.

My Specialist Applications team adviser was very helpful throughout my application to the GMC and the format of the application process was very clear and organised. The only thing I regret is not submitting my documents a few months earlier as I had everything ready but I was doing my research and contacting people for advice. When I received my decision from the GMC I was very happy – I couldn't believe that it was accepted!

For those thinking about making a CESR application, my advice is to keep good records of every day practices based on the GMC guidance and focus on completing the Advance Training Module within the specialty which might take most of the preparation time. Also, having the presence of a supportive educational supervisor is essential.

Since gaining my specialist registration I have been appointed as a consultant in the same hospital I was working. Applying for CESR is a good opportunity for doctors who have had overseas experiences to progress.

Dr Clodagh Dugdale – sport and exercise medicine

I have been working in sport and exercise medicine (SEM) for the military and in various sporting jobs since 2010. Additionally, I have held an academic post in SEM. Once I had the experience I felt that if I did not apply for specialist registration I would be left in quite a vulnerable position in terms of employment.

In order to prepare for my CESR application my first port of call was the Faculty of Sport and Exercise Medicine, and the specialty advisers were able to provide me with information and advice. I was lucky enough to know a previous CESR evaluator, who was able to identify areas of the curriculum in which it may have appeared that I was lacking experience. The GMC referred me to their excellent online guidance, which I reviewed in detail. I referred back to the guidance many times as I found myself doing things in the wrong order at first with significant duplication. Once I had discovered the dividers on the GMC's website, these provided clear structure for my evidence. I would recommend that downloading the dividers is the first thing any prospective applicant do.

I made sure that I collected evidence to demonstrate all the areas of the curriculum. In the areas in which I felt I was deficient I went and did some extra training. I ensured that all my qualifications – eg ALS were up to date. I was careful to signpost the areas in which I felt could have been overlooked to ensure that the assessors were aware of all my expertise. It is essential that the evidence is easy and accessible to the evaluators – and this comes with organisation. I cannot stress this strongly enough.

It took about three months to actually physically collect and prepare the evidence for the initial submission and this was with me dedicating a huge amount of time and effort in to doing so. After the initial submission the GMC advisor reports back with areas that they feel need addressing and it took a further two months to prepare this additional evidence.

My adviser was extremely helpful and it was clear she wanted the best submission possible for me, and I was willing to do additional work to make my application as strong as it could be. I cannot speak highly enough of the help that I received from my GMC advisor.

When I received an email from the GMC with the news that I had been successful I couldn't believe it at first – I even rang my adviser to check that it was correct! I have read my evaluation form in full and it was clear that the evaluators had thoroughly assessed all of my evidence and I was impressed by how detailed the assessment was.

I would really recommend that applicants attend a GMC supported CESR training event before making an application and would advise any prospective applicant not to underestimate the time and effort involved in submitting a CESR application. A good relationship with the GMC adviser is essential – they are there to help, not to judge. Also it is so worthwhile keeping a logbook as you go, rather than trying to compile this at a later date, when it is very difficult and time consuming. But the best price of advice I can give is to download the dividers first and work from there. This is the basis for a well organised submission.

Dr Sally O'Shea – dermatology

I have been working in dermatology for over seven years and chose to apply for specialist registration because I wanted to apply for a consultant post in the UK. Having worked in the UK for the past few years I was keen to have some of this work recognized.

The first step I took was to discuss my prospective application with my supervisor. I also contacted the royal college, the GMC and the local training programme director. This gave me a better understanding of what the UK training requirements were and how to go about applying. I read the GMC's online guidance about CESR applications and the Specialty Specific Guidance and referred back to this guidance several times. I also read the specialty curriculum in place at the time in detail.

It took me several months to prepare the documents before I submitted my application. This was partly because the documents had to be signed by the original supervisors for each part of my training, which had spanned several years and the supervisors lived in other countries. In addition, I had to ensure that my name was on the documents and that the documents were validated appropriately. It was also necessary to ensure that no identifiable details of patients were on the documents. It took time to gather the documents and to cross check these to ensure they were correct. Making a CESR application is a serious undertaking; the nature and the volume of evidence and its validation takes time. In addition, the amount of evidence required is substantial and it's demanding of all involved.

I was not aware of the timelines between submitting the application, the review of documentation and submission of further supporting evidence but my adviser made very helpful suggestions regarding the evidence I provided. I clarified these to make sure I

understood them fully before submitting additional evidence. It was necessary to gather and validate several more pieces of evidence at that point, although the bulk of my evidence had been submitted.

One area to ensure you cover is audit – make sure that you include evidence of the full audit cycle, including Powerpoint slide handouts from previous teaching and presentations. Also, I would really recommend listening to your specialist applications adviser's feedback and recommendations to strengthen your evidence. To be successful in CESR be highly motivated from the outset, willing to dedicate your time to the application and pay attention to detail.

I was delighted when I received my decision from the GMC and read the evaluation in full a few times – it was very nice to receive the feedback after the effort I had put in to my application. I would recommend making a spreadsheet (including your name at the top of each page) listing each heading of the curriculum. Under each heading you can summarise briefly how you have met each criterion of the curriculum and where the evidence for that criterion can be found. This can then be submitted with your evidence so that it is really clear. Where possible, organise the evidence in reverse date order.

Dr Ezzat Chohda – general surgery

Having worked in my specialty for ten years, I wanted to be assessed and gain the necessary accreditation recognising my experience. I also wanted to be able to work independently. To prepare for my application I read the GMC's guidance, general surgery curriculum and the BMA's guidance. Additionally, I spoke with colleagues who had applied for CESR and my clinical supervisor, clinical lead and college representative.

Before beginning to prepare my documents, I attended a CESR workshop. I had been planning to apply for CESR since 2007 and so started collecting the required evidence as I went, ensuring that I had regular assessments during each job. It took me about 12 months to fully compile my documents for submission. Once I had submitted my evidence as part of my application, I read the advice given to me by my specialist applications adviser in full twice. My adviser gave some valid points that strengthened and improved my application. My adviser was available for discussion and further advice over the phone and this helped me to obtain most of the additional evidence she recommended within the two month timeframe to provide additional evidence.

Upon receiving my decision from the GMC I read the evaluation in full. I felt that my hard work for the last few years had finally paid off and this reinforced my trust in the system. My advice to any potential CESR application is to read the curriculum carefully, fulfil any gaps in your training and have regular assessments. It is important to listen and act on feedback from colleagues and your application adviser – don't rush to submit your application if you feel it doesn't cover the curriculum. And finally, don't give up!

Appendices

Appendix 1 – CCT

CCT awarded 2016 by specialty

Some applications are made in dual specialties, therefore the breakdown of specialties is higher in number than the number of CCT applications we approved. Specialties included in fewer than five applications have been grouped to minimise risk of identification.

Acute internal medicine	62
Anaesthetics	400
Cardiology	130
Cardiothoracic surgery	16
Chemical pathology	9
Child and adolescent psychiatry	51
Clinical genetics	14
Clinical neurophysiology	5
Clinical oncology	44
Clinical radiology	176
Dermatology	44
Emergency medicine	122
Endocrinology and diabetes mellitus	75
Forensic psychiatry	37
Gastroenterology	85
General (internal) medicine	494
General practice	2,897
General psychiatry	152
General surgery	185
Genitourinary medicine	22
Geriatric medicine	87
Haematology	70
Histopathology	59
Infectious diseases	26
Intensive care medicine	117
Medical microbiology	18
Medical microbiology and virology	25
Medical oncology	28
Neurology	46
Neurosurgery	22
Obstetrics and gynaecology	175
Occupational medicine	8
Old age psychiatry	62

Ophthalmology	67
Oral and maxillofacial surgery	29
Otolaryngology	50
Paediatric cardiology	5
Paediatric surgery	10
Paediatrics	265
Palliative medicine	34
Pharmaceutical medicine	19
Plastic surgery	58
Psychiatry of learning disability	22
Public health medicine	27
Rehabilitation medicine	5
Renal medicine	48
Respiratory medicine	96
Rheumatology	48
Trauma and orthopaedic surgery	149
Urology	54

Specialties numbering fewer than five applications – total number of applications across these specialties: 25

Allergy
Clinical pharmacology and therapeutics
Forensic histopathology
Immunology
Medical Virology
Medical ophthalmology
Medical psychotherapy
Nuclear medicine
Sport and exercise medicine
Tropical medicine

Total number of CCTs awarded in 2016: 6,145

Appendix 2 – CESR (CP) / CEGPR (CP)

In 2016, 124 doctors were awarded a CESR through a combined programme. Some applications are made in dual specialties, therefore the breakdown of specialties is higher in number than the number of combined programme applications we approved. Specialties included in two or fewer applications have been grouped to minimise risk of identification.

Anaesthetics	30
Community sexual and reproductive health	3
Emergency medicine	7
Gastroenterology	3
General (internal) medicine	19
General psychiatry	9
Geriatric medicine	5
Haematology	3
Medical oncology	3
Obstetrics and gynaecology	9
Paediatrics	14
Pharmaceutical medicine	3
Renal medicine	3
Respiratory medicine	5

List of specialities with two or fewer applications. Total number of applications across these specialties: **28**

Acute internal medicine	Neurology
Cardiothoracic surgery	Neurosurgery
Cardiology	Occupational medicine
Child and adolescent psychiatry	Old age psychiatry
Clinical neurophysiology	Ophthalmology
Clinical oncology	Oral and maxillofacial surgery
Diagnostic neuropathology	Paediatric and perinatal pathology
Endocrinology and diabetes mellitus	Palliative medicine
General practice	Rheumatology
Immunology	Trauma and orthopaedic surgery
Intensive care medicine	

Total number of doctors awarded a CESR through combined programme: **124**

Appendix 3 – CESR/CEGPR

Breakdown of CESR and CEGPR decisions by organisation and specialty 2016

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	3	0	3
Faculty of Public Health	Public health medicine	4	1	5
Faculty of Sexual and Reproductive Healthcare	Community sexual and reproductive health	3	2	5
Joint Committee on Surgical Training		**81**	**91**	**172**
	Breast Surgery	1	2	3
	Cardiothoracic surgery	5	3	8
	General surgery	27	21	48
	Neurosurgery	6	5	11
	Otolaryngology	7	8	15
	Paediatric surgery	0	4	4
	Plastic surgery	2	4	6
	Trauma and orthopaedic surgery	25	33	58
	Transplant Surgery	1	2	3
	Urology	3	6	9
	Vascular surgery	2	2	4
	Breast and oncoplastic surgery Oral and maxillofacial surgery Paediatric urology	2	1	3
Joint Royal Colleges of Physicians Training Board		**71**	**72**	**143**
	Cardiology	8	5	13
	Dermatology	7	5	12
	Endocrinology and diabetes mellitus	2	2	4
	Gastroenterology	5	6	11
	General (internal) medicine	16	15	31
	Geriatric medicine	1	4	5
	Haematology	2	4	6
	Medical oncology	4	4	8
	Neurology	2	5	7
	Palliative medicine	2	6	8
	Rehabilitation medicine	1	2	3
	Renal medicine	3	1	4
	Respiratory medicine	5	2	7
	Sport and exercise medicine	5	3	8
	Acute internal medicine Allergy Clinical pharmacology and therapeutics Food allergy and immunotherapy Genitourinary medicine Infectious diseases Nuclear medicine Paediatric cardiology Pain medicine Pharmaceutical medicine Rheumatology Transfusion medicine	8	8	16
Royal College of Anaesthetists		**32**	**11**	**43**
	Anaesthetics	24	10	34
	Cardiothoracic anaesthesia	1	0	1

	Intensive care medicine	7	1	8
Royal College of Emergency Medicine	Emergency medicine	14	9	23
Royal College of General Practitioners	General practice	19	4	23
Royal College of Obstetricians and Gynaecologists	Obstetrics and gynaecology	19	13	32
Royal College of Ophthalmologists		**10**	**17**	**27**
	Ophthalmology	10	16	26
	Inflammatory eye diseases, medical retina and immunosuppression	0	1	1
Royal College of Paediatrics and Child Health		**30**	**22**	**52**
	Community child health	2	1	3
	Paediatric neurology	2	1	3
	Paediatrics	21	16	37
	Neonatal medicine Neonatology Paediatric allergy, immunology and infectious diseases Paediatric endocrinology Paediatric infectious diseases Paediatric oncology	5	4	9
Royal College of Pathologists		**4**	**4**	**8**
	Histopathology	3	3	6
	Diagnostic neuropathology Medical microbiology	1	1	2
Royal College of Psychiatrists		**19**	**26**	**45**
	Child and adolescent psychiatry	3	6	9
	General psychiatry	12	12	24
	Medical psychotherapy	2	0	2
	Old age psychiatry	2	8	10
Royal College of Radiologists		**25**	**11**	**36**
	Clinical radiology	24	10	34
	Clinical oncology Neuroradiology	1	1	2

Appendix 4 – all Specialist Registration / GP Registration

All granted specialist and GP registration applications by organisation 2016

Organisation	CCT	CESR (CP)	CESR / CEGPR	TOTAL
Faculty of Occupational Medicine	8	1	3	12
Faculty of Public Health	27	0	4	31
Faculty of Sexual and Reproductive Healthcare	0	3	3	6
Joint Committee on Surgical Training	573	5	81	659
Joint Royal Colleges of Physicians Training Board	1,477	55	71	1,603
Royal College of Anaesthetists	517	31	32	580
Royal College of Emergency Medicine	112	7	14	133
Royal College of General Practitioners	2,897	1	19	2,917
Royal College of Obstetricians and Gynaecologists	175	9	19	203
Royal College of Ophthalmologists	67	1	10	78
Royal College of Paediatrics and Child Health	265	14	30	309
Royal College of Pathologists	70	2	4	76
Royal College of Psychiatrists	328	12	19	359
Royal College of Radiologists	220	2	25	247

Appendix 5 – primary medical qualification and CCT

Country of primary medical qualification for CCT in 2016. All countries with fewer than ten total applications have been grouped to avoid identification.

Primary medical qualification country	Number of CCTs awarded	% total
UK	**4,806**	78.2%
EEA	**223**	**3.62%**
Czech Republic	23	0.37%
Germany	23	0.37%
Greece	29	0.47%
Ireland	38	0.61%
Italy	10	0.16%
Malta	11	0.17%
Poland	25	0.40%
Romania	15	0.24%
All other EEA	**49**	0.79%
Rest of world (ROW)	**1,116**	**18.16%**
Bangladesh	15	0.24%
Egypt	28	0.45%
India	475	7.72%
Iran	21	0.34%
Iraq	37	0.60%
Jamaica	13	0.21%

Myanmar	11	0.17%
Nigeria	100	1.62%
applicationPakistan	209	3.40%
South Africa	24	0.39%
Sri Lanka	18	0.29%
Sudan	30	0.48%
Syria	14	0.22%
Ukraine	10	0.16%
All other ROW	**111**	1.80%

Appendix 6 – primary medical qualification and CESR (CP) / CEGPR (CP)

Country of primary medical qualification for combined programme in 2016. 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	**30**	**24.19%**
EEA	**14**	**11.29%**
Ireland	5	4.03%
All other EEA	**9**	7.25%
ROW	**80**	**64.51%**
Egypt	5	4.03%
India	39	31.45%
Pakistan	11	8.87%
South Africa	5	4.03%
All other ROW	**20**	16.12%

Appendix 7 – primary medical qualification and CESR/CEGPR

Country of primary medical qualification for CESR and CEGPR decisions in 2016. All countries with fewer than five total applications have been grouped to avoid identification.

Primary medical qualification country	CESR/CEGPR approved	CESR/CEGP rejected	Total	% success
UK	**56**	**40**	**96**	**58.33%**
EEA	**23**	**25**	**48**	**47.91%**
Ireland	5	5	10	50%
Italy	3	3	6	50%
Spain	4	6	10	40%
All other EEA	11	11	22	50%
ROW	**253**	**217**	**470**	**53.82%**
Australia	10	5	15	66.66%
Bangladesh	4	1	5	80%
Egypt	26	25	51	50.98%
India	88	84	172	51.16%
Iraq	7	3	10	70%
Libya	5	3	8	62.5%
New Zealand	2	4	6	33.33%
Nigeria	8	6	14	57.14%
Pakistan	52	36	88	59.09%

South Africa	11	7	18	61.11%
Sri Lanka	9	10	19	47.36%
Sudan	4	8	12	33.33%
Syria	4	8	12	33.33%
United States	5	1	6	83.33%
All other ROW	21	14	35	60%

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