Quality assurance report for academic training

Executive summary

1 Our review looks at doctors in training who are undertaking academic training either through integrated combined academic and clinical programmes (integrated training programmes) or through out of programme research (OOPR).

2 Our review has two aims.

- To provide assurance about the quality of academic training in the UK to ourselves (as the regulator of clinical training) and to academic funding bodies and sponsors of research, the public and all stakeholders.

- To support improvement of the training experience and outcomes, share good practice and show the importance and benefits of effective integrated training programmes.

3 Our scope.

- We focused on doctors in specialty training including general practice and core training, exploring the systems, processes and experiences in England, Northern Ireland, Scotland and Wales.

4 Why focus on doctors in specialty training?

- We heard of many valuable initiatives from medical students and foundation doctors to promote interest in academic training. But we felt that by focusing on doctors in specialty training we would be able to better explore the overlap between clinical and academic training. This is also a critical stage of their career both in terms of research and achieving clinical competencies.

5 Who we met with.

- Those with responsibility for funding research - eg the National Institute for Health Research (NIHR), the Wellcome Trust.

- Organisations responsible for overseeing or delivering training - often a partnership between university, NHS trust (or equivalent) and deanery/local education and training board (LETB).
A cross section of doctors in training, their supervisors - academic, clinical and educational supervisors - involved in both integrated training programmes and OOPR. We also met with Training Programme Directors.

More detailed information on who we met can be found at Annex B.

6 What we found.

All those we spoke to acknowledged the challenges of quality managing academic training – eg how to align the quality management (QM) processes used by each of the partner organisations so that they complement each other.

We found examples of efforts to adapt established and embedded QM processes to provide more relevant and meaningful quality data on integrated programmes.

We learned that there were key individuals who were pivotal in supporting the QM processes, and that the success and failure of these processes was largely dependent on the individual.

All those we spoke to acknowledged the challenges that academic training faces or may face as a result of external factors – eg: funding, the delivery of health care nationally and general changes in the delivery of postgraduate medical training.

The majority of the doctors in training we met, both those in integrated training programmes and OOPR, held a very positive view of their training.

NHS consultants spoke of the positive contribution that academic doctors in training have on their department, not just in terms of research but also the ethos and stimulation.

Integrated training programmes are seen as a way of training the next generation of academic doctors, developing clinicians with an interest in research, who will contribute to national and international research.
Key findings

Requirements

7 We set requirements where we have found that our standards are not being met. Our requirements explain what an organisation has to address to make sure that it meets those standards.

<table>
<thead>
<tr>
<th>Number</th>
<th>Paragraph in <em>The Trainee Doctor</em></th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>There must be clear return to clinical practice processes in place for those returning to clinical training from research (para. 83).</td>
</tr>
</tbody>
</table>

Recommendations

8 We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation or partnership should address to improve in these areas, in line with best practice.

<table>
<thead>
<tr>
<th>Number</th>
<th>Paragraph in <em>The Trainee Doctor</em></th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.5, 6.1</td>
<td>Those involved in designing the training programme or clinical rotas should accommodate those doctors in training who have an academic component, and ensure that both the academic and clinical components are supported (para. 81).</td>
</tr>
<tr>
<td>2</td>
<td>2.1, 2.2</td>
<td>There should be a lead with responsibility for overseeing the quality management of both the academic and clinical components (para. 86).</td>
</tr>
<tr>
<td>3</td>
<td>5.1</td>
<td>Doctors in training should be supported to meet the clinical competencies set out in their curricula (para. 106, 101.)</td>
</tr>
<tr>
<td>4</td>
<td>5.9</td>
<td>Academic input into the ARCP should be consistent across postgraduate deaneries and LETBs (para. 104).</td>
</tr>
</tbody>
</table>
**Good Practice**

9 We note good practice where we have found exceptional or innovative examples of work or problem-solving related to our standards that should be shared with others and/or developed further. These are identified in the main body of the report.
Background to the review

10 Our established quality assurance processes, as outlined in our Quality Improvement Framework, don’t allow us as clear an insight into the quality of academic training as we have into clinical training. This is for a number of reasons.

11 Doctors in academic training are dispersed across a range of specialties and deaneries/local education and training boards (LETBs) across the UK. This means they may not appear in our standard evidence base, for example the Dean’s Reports and National Training Survey.

12 The regulation of academic training also falls largely outside our remit. We are responsible for setting the standards for clinical training, and our standards for postgraduate training (The Trainee Doctor) refer to foundation and specialty training. Instead, responsibility for regulating the academic component falls to others.

13 However, during this review we met doctors in clinical training who were also undertaking academic training with a very clear overlap. Where there is an overlap we have used the standards in The Trainee Doctor to outline our findings. If our observations fall outside our statutory remit, we have presented them for others to consider and progress as appropriate.

14 Despite the limitations of our standard evidence base, we are aware that there are challenges for doctors in training in integrating their clinical and academic training, as well as for universities, funding bodies and deaneries/LETBs quality managing the trainee experience and outcomes, and in the considerable variation in the ways academic training is conducted across the UK.

15 This review differs from other GMC quality assurance reviews as the focus is on a single area of training rather than on a region, a deanery/LETB or a medical school. It is also different from recent GMC reviews of small specialties – for example occupational medicine and medical psychotherapy – as doctors in training involved in academic training are involved in a wide range of specialties. Although there is a lead Dean with responsibility for academic affairs, there is no single Medical Royal College or Faculty with responsibility for this area.

16 We do not intend this report to be a review of the quality management processes at any of the organisations visited. Neither should it read as a comparison between the organisations which operate within different national systems. Our accounts of those we visited should be treated as examples of how academic training is set up and delivered in different settings.

17 A revised version of the Gold Guide was published in June 2014, prior to the publication of this report but after our evidence gathering activities. The guide is a reference for postgraduate specialty training in the UK. It gives guidance on academic training - indeed much of the detail from part one of this report is sourced from this guide.

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The sections in the guide on academic training – both in integrated programmes and OOPR – have been revised and many of these changes echo some of our findings from this review. We note that when we visited the academic training centres as part of this review they were not yet bound by this extended guidance.

The revised Gold Guide emphasises joint working between the academic and clinical communities, in terms of supporting the doctor in training, meeting the clinical scrutiny required by Health Education England (HEE), NHS Education for Scotland (NES) and the deaneries in Wales and Northern Ireland. There is also additional guidance on the return to clinical practice of doctors in training who have been solely in academic settings. This will be welcomed by those we met.
Part one: Academic training

Background to academic training

20 Doctors in training who wish to follow a career in academic medicine can choose to undertake a period of academic training during their clinical programme. Doctors in training can either:

- compete for opportunities to enter into integrated training programmes, or
- take time out of their specialty training programme to undertake research (OOPR)

21 Integrated training programmes combine clinical specialty training with research training and experience. These programmes were established from the mid-2000s and now account for 5-10% of all doctors in training (Medical Schools Council 2009).

Data

22 The 2013 Annual Review of Competence Progression (ARCP) returns identify 1,300 doctors in training who consider themselves ‘clinical academic trainees’ (CATs). These figures do not include those undertaking OOPR.

<table>
<thead>
<tr>
<th>Deanery/LETB</th>
<th>Number of CATs</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defence Postgraduate Medical Deanery</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>East Midlands Healthcare Workforce Deanery</td>
<td>80</td>
<td>6%</td>
</tr>
<tr>
<td>East of England Multi-Professional Deanery</td>
<td>118</td>
<td>9%</td>
</tr>
<tr>
<td>Kent, Surrey and Sussex Deanery</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>London Deanery</td>
<td>407</td>
<td>31%</td>
</tr>
<tr>
<td>Mersey Deanery</td>
<td>40</td>
<td>3%</td>
</tr>
<tr>
<td>NHS Education for Scotland (East Region)</td>
<td>16</td>
<td>1%</td>
</tr>
<tr>
<td>NHS Education for Scotland (North Region)</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>NHS Education for Scotland (South-East Region)</td>
<td>40</td>
<td>3%</td>
</tr>
<tr>
<td>NHS Education for Scotland (West Region)</td>
<td>24</td>
<td>2%</td>
</tr>
<tr>
<td>NHS West Midlands Workforce Deanery</td>
<td>110</td>
<td>8%</td>
</tr>
<tr>
<td>North Western Deanery</td>
<td>53</td>
<td>4%</td>
</tr>
<tr>
<td>Northern Deanery</td>
<td>56</td>
<td>4%</td>
</tr>
<tr>
<td>Northern Ireland Medical and Dental Training Agency</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td>Oxford Deanery</td>
<td>82</td>
<td>6%</td>
</tr>
<tr>
<td>Severn Deanery</td>
<td>52</td>
<td>4%</td>
</tr>
<tr>
<td>South West Peninsula Deanery</td>
<td>20</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown - EOE/OXD</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Wales Deanery</td>
<td>34</td>
<td>3%</td>
</tr>
<tr>
<td>Wessex Deanery</td>
<td>41</td>
<td>3%</td>
</tr>
<tr>
<td>Yorkshire and the Humber Postgraduate Deanery</td>
<td>110</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Overall number</strong></td>
<td><strong>1,298</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
23 CATs are distributed across the following specialties:

<table>
<thead>
<tr>
<th>Specialty group</th>
<th>Number of CATs</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>13</td>
<td>1%</td>
</tr>
<tr>
<td>General Practice</td>
<td>123</td>
<td>7%</td>
</tr>
<tr>
<td>Medicine</td>
<td>518</td>
<td>28%</td>
</tr>
<tr>
<td>Obstetrics and Gynaecology</td>
<td>66</td>
<td>4%</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>28</td>
<td>2%</td>
</tr>
<tr>
<td>Paediatrics and Child Health</td>
<td>114</td>
<td>6%</td>
</tr>
<tr>
<td>Pathology</td>
<td>43</td>
<td>2%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>82</td>
<td>4%</td>
</tr>
<tr>
<td>Public Health</td>
<td>40</td>
<td>2%</td>
</tr>
<tr>
<td>Radiology</td>
<td>33</td>
<td>2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>201</td>
<td>11%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>37</td>
<td>2%</td>
</tr>
<tr>
<td>F1</td>
<td>258</td>
<td>14%</td>
</tr>
<tr>
<td>F2</td>
<td>297</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1853</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Integrated training programmes - how they work**

*Recruitment*

24 Applicants to integrated training programmes need to meet the clinical as well as the academic requirements for appointment, if they are not already in specialty training. Each of the four countries in the UK has developed their own arrangements for these programmes and information on these arrangements can be found later in this section (para. 34).

*Supervision*

25 Doctors in training must have an academic supervisor in addition to their clinical and educational supervisors. The academic supervisor is responsible for drawing up an academic training programme with both the doctor in training and their educational supervisor. This is to ensure that the clinical objectives are complementary to the academic objectives. Both supervisors and the trainee should be aware of the trainee’s overall clinical and academic requirements for the competencies they need to achieve.

26 At the start of the academic placement, and annually thereafter, the academic trainee must meet with both their educational and academic supervisors to agree objectives for the coming year. This could be through a joint meeting. There should be regular meetings with the academic supervisor through the year to review progress.

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Assessment

27 All doctors in training must undertake an Annual Review of Competence Progression (ARCP). For those in academic training this is a joint academic and clinical annual assessment process as they are required to complete both the full clinical training programme and meet the requirements of the academic programme in order to progress. The outcome of this joint ARCP covers both the clinical and academic components of the integrated training programme.

28 A separate annual assessment of academic progress must be undertaken prior to the joint ARCP panel. The academic supervisor is required to complete a Report on Academic Progress form which needs to be agreed and signed by the trainee for submission to the annual joint ARCP panel.

29 Academic trainees must only meet the panel if the Training Programme Director or the academic educational supervisor indicates that Outcomes 2, 3 or 4 are a potential outcome from the panel. There should also be academic representation on the panel.

Out of Programme Research (OOPR) – how it works

30 Doctors in training may also decide to take time out of their specialty training programme to do research or an appropriate higher degree, with the agreement of the Postgraduate Dean. Normally up to three years are agreed for OOPR.

31 Doctors in training who are undertaking OOPR will also have an academic supervisor who must agree their research programme.

Annual assessment

32 All academic trainees on OOPR should have a formal assessment of academic progress as described above for joint clinical and academic programmes. Similar documentation should be presented as part of the process.

33 Those out of clinical training for more than an agreed period should complete a return to work package.

Local academic training centres

34 As part of this review we visited academic training centres across the four countries to investigate this. The paragraphs below outline the processes that support academic training in each country.
NIHR

35 There are a range of approaches to combining academic and clinical training, and there are also a number of funding sources such as the Wellcome Trust, Cancer Research UK, Arthritis Research UK and the Medical Research Council. We used The National Institute for Health Research NIHR (NIHR) framework for integrated clinical and academic training as a reference point for this review.

36 NIHR provides funding to support Academic Clinical Fellowships (ACFs) and Academic Clinical Lectureships (ACLs) across England. ACLs and ACFs are appointed through selected academic programmes; these programmes are awarded to University/NHS Trust/LETB partnerships via formula allocation and rounds of competition. Nationally, LETBs handle recruitment to both ACF and ACL posts.

37 There are approximately 250 ACF and 100 ACL posts recruited annually. Each post is subject to a service level agreement with the organisation providing the training that requires protected research time.

ACFs

38 Academic Clinical Fellowships are specialty training posts that incorporate academic training. Doctors in training spend 75% undertaking specialist clinical training and 25% undertaking research or educationalist training.

39 Posts are for a maximum of three years full-time equivalent (4 years for GP trainees). The post holder will be supported in preparing an application for funding to undertake a higher degree. Success in applying is normally seen as the endpoint of an ACF.

ACLs

40 Academic Clinical Lectureships are also specialty training posts that incorporate academic training. ACLs spend 50% of their time undertaking specialist clinical training and 50% doing research. They are designed for those who have completed a research doctorate or equivalent.

41 Posts are for a maximum of four years full-time equivalent. The ACLs are expected to complete their clinical training during this period.

42 Since 2013 there is a requirement for NIHR ACL posts to be matched locally – that is each institution should locally fund an equal number of NIHR funded posts. These can either be NIHR recognised (posts equivalent in all but funding) or unrecognised.
Newcastle

43 The Newcastle programme is a partnership between the University of Newcastle, Health Education North East and County Durham and Darlington NHS Foundation Trust - the lead employer trust. The programme was established in 2011.

44 There are a range of academic opportunities at Newcastle. The Northern Deanery was responsible for the first Academic Foundation Programme in the UK and a General Practice Academic programme was established in 2004.

45 At the time of our visit there were 35 ACF and 12 ACL posts. There are also 93 doctors in training undertaking OOPR.

46 Recruitment to posts is managed by the lead employer trust. Separate clinical and academic recruitment panels are held on the same day; however it is the academic panel who decide whether an offer is made. The clinical panel confirms whether the approved candidate is suitable to be appointed to specialty training.

47 Funding for these posts is via NIHR although there are a number of matched posts. Posts are not supernumerary although research time is protected.

Oxford

48 The Oxford University Clinical Academic Graduate School (OUCAGS) was established in 2008/9. It is a partnership between Oxford University and Health Education Thames Valley.

49 At the time of our visit, OUCAG supported 50 academic foundation doctors, 68 ACFs and 41 ACLs. There were also 200 doctors in out of programme training.

50 Funding for these integrated posts is via NIHR although there are a number of matched posts. Posts are not supernumerary although research time is protected.

University College London (UCL)

51 The largest number of doctors in training nationally is in London (12,500), and London receives 35% of NIHR awards. At the time of our visit there were 416 doctors in training in London on an integrated programme and 662 trainees undertaking OOPR.

52 Health Education South London, one of the three London LETBs work with NIHR and medical schools to manage the NIHR award bidding process, recruitment, assessment and progression across London.

53 As part of this review we visited University College London (UCL) who in partnership with Health Education North Central and East London and the NHS Trusts offers a range of research opportunities for doctors in training in London.
UCL currently has a total of 74 ACFs and 43 ACLs. Typically each year UCL offers 25 ACF and 10 ACL posts.

The Specialty schools with the largest number of trainees on integrated programmes are medicine, pathology, psychiatry and paediatrics. Specialties with the highest number of academic trainees as a percentage of total trainees are public health (15%), pathology (10%). Medicine, surgery and paediatrics have the largest volume of OOPR.

**Northern Ireland**

**Belfast**

The Clinical Academic Training Programme (CATP) is a partnership between Queen’s University Belfast (QUB), the Northern Ireland Medical & Dental Training Agency (NIMDTA) and Belfast Health and Social Care Trust. CATP is overseen by a joint committee involving all partners which meets twice yearly. It was established in 2008.

CATP offers a range of opportunities for medical students and doctors in training to become involved in research. This includes the Academic Foundation programme (AF2), ACF and ACL programmes. Recruitment to ACF and ACL programmes is independent of the AF2 programme.

The ACF programme is designed for pre-doctoral trainees. Trainees are typically ST3 and above, and they will spend 25% of their time in research. The duration of this programme is normally 2 years.

The ACL programme is designed for doctors who have already obtained a PhD/MD or equivalent, or for those who are within three months of submission. Trainees are typically ST3 and above, and they will spend 50% of their time in research. The duration of this programme is usually 2-3 years.

ACFs and ACLs, which are available in any specialty, are advertised on the QUB and NIMDTA websites. There are no difficulties with recruitment into CATP as the low number of posts (there are 4 ACF/Ls recruited per year) means there is strong competition for places. Applications come from outside Northern Ireland as well as within.

ACF and ACL posts are supernumerary and are funded by Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) via NIMDTA to QUB NIMDTA. Northern Ireland is not eligible for NIHR funding but they do receive funding from HSC Innovations.

There are approximately 40 trainees OOP at any one time undertaking research degrees, PhD, MD, and MPhil. These posts are funded from a range of sources, including the Medical Research Council, the Department of Employment & Learning, and DHSSPS Research & Development.
Wales

Cardiff

63 The Wales Clinical Academic Training (WCAT) Fellowship Programme is a partnership between the Wales Deanery, the major universities in Wales and the Welsh Government. WCAT is overseen by a joint committee involving all partners. It was established in 2009. There are currently 34 doctors in training on this programme.

64 There are a range of academic opportunities in addition to the WCAT Fellowship programme. For example there is a General Practice Specialty Academic Training Programme and an Academic Core Medical Training Programme.

65 Entry to WCAT is typically at CT1/ST1 or above and continues until completion of clinical training. Doctors in training combine 20% research time with their specialty training although there is a funded 3-year PhD Training Fellowship. Doctors in training also have the option to apply for an externally funded intermediate fellowship.

66 Recruitment into WCAT is through a combined academic and clinical process. ‘Long listing’ is based on clinical competencies whereas ‘short listing’ includes an academic element. Those candidates with the highest joint score are offered the post. Doctors in training who do not have an NTN must sit a specialty interview. WCAT is oversubscribed and there is much competition for places from both within and outside of Wales.

67 WCAT posts are supernumerary and receive ring-fenced funding from the Welsh Government. This funding is however subject to an annual review by the Government and whilst the funding for those already holding WCAT posts is secure there are concerns around the security of funding in the longer term and the Wales Deanery has raised these concerns with the Welsh Government. For August 2014 entry, the Deanery arranged for the three posts to be funded. The security of funding is a challenge for WCAT.

68 In order to grow the programme WCAT will ‘recycle’ funding into new academic posts should the doctor in training secure alternative external funding from elsewhere.

Scotland

Edinburgh

69 Clinical academic training in Scotland is led by the Scottish Clinical Research Excellence Development Scheme (SCREDS) group within NHS Education for Scotland.

70 Instead of applying for specific posts, everyone applies for NTNs in open competition. They are then able to apply for a pre-doctoral scheme such as the Edinburgh Clinical Academic Training (ECAT) Lectureship, the Scottish Translational Medicine and Therapeutics Initiative (STMTI) scheme or apply for PhD funding from the Wellcome Trust, MRC or other charitable foundations.
An expanded number of SCREDS Lectureships were created for post-doctoral career development. These are deployed flexibly according to need across the specialty.

ECAT lectureships, funded by Wellcome Trust, provide funding from entry to specialty (or subspecialty training) to CCT. They provide a clinical/academic ST year to be trained in general research skills, to select a supervisor and project and prepare for a PHD. There is also a guaranteed fully funded three year PhD research training fellowship and a post-doctoral clinical/academic Lectureship leading to CCT and/or preparation for intermediate and senior fellowship applications.

Clinical Lectureships are employed by Edinburgh University and allow for 20% research and 80% clinical. Doctors in training come to these through ECAT Lectureships or after doctoral training to PHD or MD.
Part two: Summary of findings

Findings by key theme

74 Those that we spoke with commented on the positive impact of having clinical academic trainees in their departments working alongside their clinical colleagues, for example their impact on other members of the team in areas such as the culture of improvement and learning.

75 We heard that research money is concentrated in centres with research opportunities, and it is these centres that attract academic doctors in training – this can contrast with the NHS workforce who needs to provide a service across the country. This presents a challenge to smaller centres and centres that are geographically distant from large research centres, and makes it hard to find a balance between clinical and academic components.

76 We heard that clinical training often requires moves between different locations, for example due to reconfiguration or restructures, or as rotations within the clinical training programme. In contrast, it is often beneficial in academic training for doctors in training to be attached to an academic unit throughout training and we heard it can be difficult to continue their research when the location of their clinical training changes. We found there to be a tension between the need to rotate to get their clinical training but to be in the place where the research is undertaken.

77 In England and Scotland there was good networking between centres where clinical academic trainees are based, and this allowed the sharing of good practice. There were fewer opportunities for this networking in Wales and Northern Ireland due to economies of scale.

78 England benefits from a relative security of funding, but insecurity of funding has an impact on programmes in both Wales and Northern Ireland. In both countries we heard of a wish to extend the programme but that financially this would be a challenge.

79 We heard of examples of where academic doctors in training had acted as ‘trailblazers’ in specialties, and although they had experienced some challenges which had now been resolved it was felt that future trainees would not experience these challenges.
The Trainee Doctor - does academic training meet our standards?

Domain 1: Patient safety
This domain is concerned with the essential safeguards on any action by trainees that affect the safety and wellbeing of patients.

80 We found no evidence that the doctors in training we met with were either lacking appropriate supervision or working beyond competency in their clinical roles.

81 We found evidence that when balancing their clinical and academic roles, some doctors in training had concerns about workload and working hours. This applies to those undertaking training in separate blocks of clinical work and research (they may work additional hours to retain their skills and for financial reasons) and those training with split days/weeks of clinical work or research. It was unclear who from the academic or clinical side had lead responsibility for oversight of working hours to ensure compliance with working time regulations. It is essential that those involved in designing the training programme or rotas are aware of those doctors in training with an academic component so that rotas support both the academic and clinical components.

82 Processes for recognising and supporting doctors in difficulty were not always joined up and information did not always flow across the clinical and academic components. This is particularly important when difficulties could be with either component, or sometimes both.

83 We heard some evidence that processes supporting the return to clinical practice after a prolonged period of research (e.g. OOPR or integrated blocks) were not always clear or consistent. The main concern from doctors in training and their supervisors was the potential loss of clinical skills, particularly important in the craft specialties. Some doctors in training had maintained their skills by doing locum work. It is important that there is a clear return to clinical practice processes in place.

84 We had feedback from foundation doctors whose first placement as an FY1 was in research. They felt less prepared when starting their first clinical placement in December than those whose first placement was clinical. This should be considered when designing rotas.

Domain 2: Quality management, review and evaluation
This domain deals with the governance issues and how the GMC's standards will be used for review, assurance and improvement. It refers to the quality management systems and procedures of postgraduate deaneries and equivalent, and quality control by LEPs.
We found there to be comprehensive local quality management frameworks in place for clinical training through the deaneries and LETBS, and for academic training through the universities.

We also found that in the case of integrated programmes the two quality management frameworks were not always linked and it was sometimes unclear who had chief oversight. We heard that the number of stakeholders involved in clinical academic training (the university, the funder, the deanery or LETB and the trust or board) coupled with the relatively low number of trainees in a centre meant that there was little need for integration of these frameworks (see para. 87). Where there was an identified lead we found this to vary. However we did find examples of regular meetings of the stakeholders.

For integrated programmes we heard that quality was managed informally and through word of mouth. Due to the low number of trainees it was felt that it was easy to manage as ‘everyone knows everyone’. However this presents other difficulties - doctors in training can be deterred from raising concerns they might have for fear of jeopardising their future career.

We found examples of good practice in individual specialties, although these were not always shared across other specialties in the same areas or nationally. Examples include the use of feedback forms at the end of ACF and ACLs (Belfast), tracking of those exiting (Oxford) and an external review of the programme (Cardiff) to identify areas of concerns and good practice.

We found a reliance on key individuals to support the development of integrated programmes. While we acknowledge the valuable contributions of these individuals, it is essential that there are appropriately trained personnel, infrastructure, resources and quality management processes to support them. This is to ensure the stability and sustainability of these integrated programmes.

The doctors in training we met who were doing OOPR and were not in an integrated programme fell under the university processes. They reported that they were able to focus solely on research training. They had no additional demands placed on them by trying to achieve clinical competencies at the same time as undertaking their research.

Domain 3: Equality, diversity and opportunity

This domain deals with the equality and diversity matters across the whole of postgraduate training, including widening access and participation, the provision of information, programme design and job adjustment.

We met with doctors in less than full time training (LTFT) in most of the centres we visited, and in those centres that did not have LTFT we were assured that applications would be welcome. We also heard of initiatives to support LTFT, for example Chadburn lectureships (London) and clinical lecturers with carers responsibilities fund (Oxford).
We heard from some doctors in training that there were practical difficulties in combining a LTFT position with an academic post. These include dealing with clinical service providers whose priority is service provision, the challenge of meeting their clinical competencies within the allotted time, as well as the difficulties of balancing caring responsibilities. We also heard from some trainees who were actively discouraged from undertaking research through an integrated training programme.

There were also examples from doctors in training who had a much more positive experience and benefited from the flexibility that many academic training programmes can offer. We heard that some supervisors were very good at developing flexible job plans for less than full time trainees.

Whilst we acknowledge the realities of the impact of LTFT on academic training and recognise the flexibility of many integrated programmes, there are some concerns at specialty level.

Domain 4: Recruitment, selection and appointment
The purpose of this domain is to ensure that the processes for entry into postgraduate training programmes are fair and transparent.

At each centre we visited we found examples of joint process between the clinical and academic side but with some variation as to how the two sides work together. In some centres there were separate academic and clinical interviews and in others they were combined.

We heard of the challenges of balancing local recruitment with academic programmes and national recruitment into clinical training. We heard that there is a perception that academic training was an easier route into a specialty – surgery was provided as an example in a number of centres we visited. We heard that as clinicians they wanted to recruit the best candidates but felt they had to ‘settle for’ those who had been appointed to academic posts. This perception – real or not - conflicts with the requirement that entry into postgraduate training be fair and transparent.

Domain 5: Delivery of approved curriculum, including assessment
This domain is concerned with ensuring that the requirements of the curricula set by medical Royal Colleges and Faculties are being met at the local level and that each post enables the trainee to attain the skills, knowledge and behaviours as envisaged in the curriculum.

Competencies

One of the major challenges for the doctors in training we met with was meeting both the academic and clinical components of their training programme within the allotted time. We heard a number of approaches to maintaining a balance between these components, for example carrying out work in blocks rather than days, or being ‘supernumerary’.
Although working in blocks was viewed by many of those we spoke to as one way of achieving a balance, we also heard that this approach may not be appropriate for all specialties. Those doing laboratory based work may find blocks of research time helpful whereas those in more clinically based research projects may prefer to devote one day a week to research. We also heard that where days are split, for example between clinical work in the morning and research in the afternoon, then there can be difficulties when patient safety takes precedence and time is taken away from the academic component. There were also examples of doctors in training being supernumerary (Wales and Northern Ireland) and these were appreciated by those we spoke to although there were some challenges to this.

We heard of potential tension between the doctor in training and their clinical team for example over shifts and rotas - especially if the clinical team are unaware the doctor in training is an academic trainee and has commitments in addition to their clinical duties. We heard of examples of ACLs being 'paired up' to constitute a 'full-time' clinical trainee which did ease this issue, although this would only be practical in specialties with a sufficient number of academic trainees for this to be organised.

We heard of further tensions between doctors in training who were competing for opportunities to achieve their competencies, eg in craft specialties. We also had reports of them being seen as 'extra person' who acts as a potential dilution of available cases to see/do.

The reduction of clinical time meant that not only was it was sometimes a challenge to ensure that trainees get sufficient out of hours experience (OOH) to meet their clinical competencies, but this can also put them at a financial disadvantage. We also heard that when they were able to get OOH experience, for example out of hours and emergency clinical work, they were not always paid appropriately for this. It is important that doctors in supernumerary posts do not miss out on the opportunities of OOH work, from both a training and financial perspective.

We heard of challenges to particular specialties and of successful efforts to develop clinical academic training in specialties that nationally have low numbers of clinical academic doctors in training, for example craft specialties. We spoke with doctors in training from craft specialties who felt particularly at risk of not receiving enough repetition of procedures to be fully competent. We acknowledge that repetition does not necessarily result in competency, but in reality some doctors in training and trainers were worried about volume. Because of the variety in presentations of some clinical conditions there is always, especially in craft specialties, a need to see all the different possibilities. This also extends to other specialties such as radiology e.g. where there is a need to see enough images, psychiatry who need to do enough therapy etc.

Despite these challenges, we found flexibility across all the programmes we visited for doctors in clinical academic training to develop their own research, meet many potential supervisors and determine how their training is structured and completed, and this was appreciated by those we met with. This flexibility though was dependent on a
good understanding of the role of an academic trainee by supervisors, training programme directors and other doctors in training.

**ARCP**

104  We found inconsistent approaches to measuring academic progress outside of Annual Review of Competence Progression process (ARCP), e.g. at one site there were regular reviews of academic progress outside of the ARCP process, which doctors in clinical academic training found supportive and useful.

105  Although we found that there were joint ARCPs at each of the centres we visited, and that an academic supervisor’s report fed into this review, we also found that there was sometimes a challenge providing academic representation at each review, particularly in the larger centres with a high number of doctors in training. The lack of academic representation on ARCP panels can make it more difficult for ARCP panels to take academic achievements into account. This issue was raised by a number of the doctors in training we met with.

106  We also heard of a tension between the appropriate recognition of both the clinical and academic components when selecting a single ARCP outcome, although we heard that the clinical side was dominant in determining this outcome. We received much feedback from doctors in training on ARCP outcomes and that outcome 3 (has not achieved competences required to progress) was detrimental to trainees and was associated with an unfair label, especially as they had less time to achieve their clinical competencies.

107  We found inconsistencies in the approach to extending training time (until CCT) and there needs to be a balance between allowing trainees sufficient time to achieve competencies whilst minimising their time held back to allow them to progress in their career. We understand that there is ongoing work on the setting of the CCT date for academic doctors in training, and that the GMC is producing position statements on this subject.

**Career development**

108  We heard that there was a great deal of uncertainty about future employment opportunities after completion of training. Doctors in training we met felt that this is the result of the pressures on academic institutions to ensure that they undertake the highest quality research and a lack of national workforce planning for senior clinical academic numbers within each of the different specialties. There is a high level of competition across specialties for a limited number of senior clinical academic posts.

109  Doctors in training we spoke with were also concerned as to how, if they continued as clinician academics, they would achieve and maintain excellence in both clinical medicine and research. They commented on the fact that they would be competing with both clinicians and scientists who could devote 100% of their time to their own fields.
We also heard from doctors in training in specialties which were exam heavy in their first few years and who felt that this might not be the best time to undertake an ACF. In contrast we heard from those in paediatric cardiology who felt that their first few years of training was the best time for them to undertake academic training as there was less of a risk of de-skilling. What is key is finding a balance between academic training and the different stages of specialty training which differs between specialties.

Doctors in clinical academic training knew that they would leave academic training and return to full time clinical training at any point without detriment to their future clinical careers. Some did say that they would like advice on how they can use their academic skills in a more clinical context, for example in a senior medical role within an NHS consultant post, to develop a clinical academic career outside the traditional academic pathway, e.g. as a university employee.

We heard from trainees who felt there were financial disadvantages as a result of the prolongation of training. This can put clinical academic trainees at a financial disadvantage compared to their clinical counterparts who continue along the conventional NHS training route. This means that clinical academic trainees potentially obtain a consultant salary and each of their future consultant pay increments at a later stage. However we also heard that training time does not necessarily need to be extended in integrated programmes so this may be more of a concern for those undertaking OOPR (para.107).

Domain 6: Support and development of trainees, trainers and local faculty

This domain looks at the structures and support available to doctors in training and those involved in training.

The doctors in training we spoke with felt well supported, although the level of this support sometimes varied between those on integrated training programmes and those undertaking research out of programme – those OOP appreciated the time to focus entirely on research without the often conflicting demands of clinical and academic training, although we heard some examples of those on OOP feeling isolated from other academic trainees. This contrasted to the feeling of ‘community’ that we got from those on integrated programmes.

We also heard that they benefitted from being able to access a range of training resources and support across the academic centres we visited. At each of the sites that were visited we found examples of initiatives such as weekly academic medical forums which have helped develop an academic community, the opportunity to study for a Postgraduate Diploma in Health Care Research, and the use of an academic ePortfolio.

We found examples of mentoring for doctors in clinical academic training with excellent support from both their supervisors and peers through a variety of mechanisms, and those that we spoke with appreciated having a mentor who was independent from their integrated training programme.
Some doctors in training reported that those non-academic trainees and consultant doctors engaged solely in clinical practice did not fully appreciate the additional demands placed upon them, and this could cause some misunderstanding, e.g. rota issues. This was exacerbated if there supernumerary status was not acknowledged – however this supernumerary status was appreciated by doctors in training (see para.99).

Doctors in training reported that the role of the supervisor was key to their success. We recognise the three different layers of supervision (academic, educational and clinical) but it is important that roles and responsibilities of each layer are clearly defined and that supervisors are supported, trained accordingly and there is adequate time in job plans. This is complicated when supervisors may take on overlapping roles and there is potential for conflict of interests. Roles need to be clearly defined, with systems of supervision and joint working across the clinical and academic divide.

We also heard that academic supervisors were not always aware or understood the clinical side of their supervisee’s training, and that in some specialties academic supervisors are less likely to take on people who continue to take exams. We heard that is very difficult to do exams, develop competencies and do academic work all at the same time.

We also heard that clinical and academic supervisors do not have a joint approach, either to managing programmes or to understanding the conflicting pressures trainees face. There can also be tension between clinical supervisors if only one of them is an academic. Those that we met with felt that academic supervisors/mentors need to discuss in depth with their trainees how they can achieve their aims.

Domain 7: Management of education and training
This domain covers organisational management at administrative and executive level.

At each of the academic centres that we visited we found a strong ethos of integrated clinical academic training and a strong commitment to the development of clinical academic medicine at both postgraduate and undergraduate level. We found clear evidence of collaboration among those parties involved in training – university, deanery/LETB, and trust/health board.

We found that there was an absence of workforce planning and tracking of academic doctors in training, and that the measure of success was linked to individual pieces of research, e.g. publications, higher degrees, research grant awards. Some centres had tracked progression of their trainees; however there seemed to be no country-wide approach. We also heard that CFWI do not normally consider the impact of service configuration and restructuring decisions on academic training; it is often not viewed as a priority.
Domain 8: Educational resources and capacity

This domain addresses both the physical requirements for facilities to support postgraduate training and also the service, workload, management, supervisory and educational capacity of the organisation providing the training.

122 We heard of a number of administrative difficulties experience by academic doctors in training, such as issues with ID access, and banding/contract issues. Newcastle uses a lead employer trust which employed all doctors in training, and this seemed to help reduce these issues.

Domain 9: Outcomes

This domain is concerned with the outcomes of training programmes and the achievements of trainees.

123 We do not set standards for outcomes in academic training although we do for clinical training. We found no evidence that these clinical outcomes were not being met in either integrated programmes or OOPR.

Annex A

The GMC’s role in medical education

- We are responsible for setting and maintained standards and outcomes for medical education and training in the UK. The Quality Improvement Framework (QIF) sets out how we will carry out this duty, and how we will work with other organisations working in this area such as colleges/faculties and postgraduate deaneries.

- Our Quality Assurance (QA) activity will be targeted towards areas of risk identified through the GMC’s evidence base. This will include, but is not restricted to, information gathered through National Training Surveys (NTS), Annual Specialty Reports (ASRs), Dean’s reports (DRs) and Annual Review of Competence Progression data (ARCP). Additional evidence could also be gathered from visits to deaneries/LETBs and responses to concerns.

- In order to ensure a coordinated approach, we will identify common risks across all stages of medical education and training, and ensure that risks are explored across both the small specialty review process and the regional visits process.

- You can find out more about our responsibility and quality assurance activity here:
Annex B

Visit team

<table>
<thead>
<tr>
<th>Visit Team Leader</th>
<th>Steve Heys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Team</td>
<td>Jennifer Adgey, Julie Browne, Mujtaba Husain, Anita Wale</td>
</tr>
<tr>
<td>GMC staff</td>
<td>Robin Benstead, Elspeth Buchanan</td>
</tr>
</tbody>
</table>

Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>tbc</td>
<td>Meeting with Wellcome Trust</td>
<td>Discussion with key representatives.</td>
</tr>
<tr>
<td>3 November 2012</td>
<td>BMA Academic Conference</td>
<td>Discussion with a range of academic trainees and lead dean.</td>
</tr>
<tr>
<td>21 November 2012</td>
<td>NIHR National Trainees Conference</td>
<td>Discussion with a group of ACFs</td>
</tr>
<tr>
<td>23 October 2013</td>
<td>Edinburgh University</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors.</td>
</tr>
<tr>
<td>20 November 2013</td>
<td>Queens University Belfast</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors.</td>
</tr>
<tr>
<td>6 December 2013</td>
<td>Oxford University</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors.</td>
</tr>
<tr>
<td>17 December 2013</td>
<td>Cardiff University</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors. There was also senior representation from Welsh Government at the visit.</td>
</tr>
<tr>
<td>November – December 2013</td>
<td>Questionnaire</td>
<td>Questionnaire circulated to key interest groups - 33 responses were received from a range of stakeholders including NIHR leads, deaneries and LETBs, universities.</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Event</td>
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<tr>
<td>4 February 2014</td>
<td>Meeting with NIHR leads</td>
<td>Discussion with NIHR leads on findings of the review thus far</td>
</tr>
<tr>
<td>11 March 2014</td>
<td>University College London</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors</td>
</tr>
<tr>
<td>14 March 2014</td>
<td>Meeting with BMA academic trainees subcommittee</td>
<td>Discussion with trainee representatives on findings of the review thus far.</td>
</tr>
<tr>
<td>2 April 2014</td>
<td>Newcastle University</td>
<td>Meetings with senior programme management team, doctors in training and their supervisors</td>
</tr>
</tbody>
</table>
2nd September 2014

Robin Benstead
Education QA Programme Manager
General Medical Council
Visits and Monitoring Team
Education and Standards
General Medical Council
Regents Place,
350 Euston Road,
London NW1 3JN

Dear Robin

Re: Academic Training Quality Assurance Review

I would like to provide a formal response from the Wales Deanery following the recent publication of the Quality Assurance Report for Academic Training. Firstly I would like to emphasise that we welcome the importance of an external review into a relatively small but very important aspect of postgraduate medical education and training.

In relation to the specific requirements and recommendations raised within the report I would like to make the following points:

1. The Deanery has recently established an Appeals and ARCP’s Steering Group. One of the primary aims of this piece of work is to enhance consistency around the ARCP process by ensuring that there are effective governance arrangements, clear and transparent policies and procedures, and robust monitoring processes in place. This work is relevant to all medical specialties including academic training and I am confident that this will address the concerns around ARCP consistency which were raised within the report.

2. Since the GMC’s visit to the Wales Deanery the Deanery has appointed a Dr Keir Lewis as Associate Dean for Academic Careers Support and Dr S Rice has also been appointed as a dedicated WCAT Training Programme Director. I consider these appointments to be crucial in taking forward the recommendations and requirements raised within the report.

Thank you again for providing the report and should you have any queries regarding the Wales Deanery’s response then please don’t hesitate to contact me.

Yours sincerely

Professor Derek Gallen
Postgraduate Dean
Response to GMC quality assurance report on academic training

The NIHR academic leads committee for integrated academic training welcome the opportunity to respond to the draft document produced by the GMC which has looked at quality assurance of academic training.

The committee recognises and supports the important and necessary role of the GMC to provide assurance about the quality of academic training in the UK and to support improvement in the experience and outcomes of academic training.

Requirement
1. The committee welcomes the need to support academic trainees and those who have undertaken extended research training (OOPR) with clear return to clinical practice processes. The committee hopes the GMC will ensure that the process is trainee centred and a proportionate response to the doctor’s needs with different levels of formality depending on that level of the need. The process needs to be aligned with the Gold Guide and the committee supports the guidance on return to practice produced by the Academy of Royal Medical Colleges.

Recommendations
1. The committee supports the view that those designing training programmes must ensure that both the clinical and academic components are supported. It is well recognised that trainees may find balancing clinical and academic roles challenging. Communication between academic and clinical supervisors is key to ensuring trainees achieve balance in their clinical and academic roles. Representation of clinical academic staff on the Training Committee is important to ensure understanding of the issues connected with clinical academic training. We are aware that problems have arisen due to differences in interpretation of rules and guidelines by the Medical Royal Colleges and their Specialist Advisory Committees (SACs). The committee recommends that every specialty training committee has an academic member to help ensure that both clinical and academic components are supported in the design of training programmes.

2. The committee supports the recommendation that there should be a lead with responsibility for overseeing the quality management of both the academic and clinical components. This should not be prescriptive as programmes vary in size and extent of specialty involvement. It is recognised that clear and effective communication between all stakeholders is required to ensure quality of the academic training programmes.

3. The committee applauds the recommendation that trainees should be supported to achieve their clinical competencies. Clinical progress of academic trainees is competence-based rather than time-based and setting the CCT target should be determined flexibly and tailored to the needs of the trainee. The re-assessment of the target CCT date following the first year as a clinical lecturer will aid this flexibility and is welcomed, however this must not be the only point that the
target CCT can be changed without adversely affecting the progression of the
trainee. There also remains a concern as to the process of resetting the CCT date.
The provision of “outcome 3” defined as inadequate progress at the ARCP does
not meet the need for a flexible approach tailored to the trainee needs. Currently
the only outcome available to allow extension of the CCT is outcome 3 “defined
as inadequate progress” which fails to recognise the dual academic and clinical
competencies which are required to be undertaken in a specified time and
unfairly labels trainees. This is a particular issue for those training in craft
specialties. In addition, the gold guide places an absolute limit on the duration of
additional time provided for training, 1 year (6 months for CMT or GP training)
or exceptionally 2 years (1 year for GP), when an outcome 3 is given. This limit is
not appropriate for those who may spend 50% of training time over 4 years
undertaking research as clinical lecturer or 25% research time as an academic
clinical fellow at CMT and is not consistent with the need for flexibility when
supporting academic trainees. The committee urges the GMC when producing
their position statement to support academic trainees achieve their clinical
competencies by taking a more flexible and supportive approach to the annual
review of competence progression with an alternative outcome. This must be
triangulated with the gold guide advice.

4. The committee supports the recommendation that academic input should be
consistent across postgraduate deaneries and LETBs. The recent revision of the
gold guide guidance on academic representation at ARCPs should enable this
consistency to be achieved.
Dear Robin,

Thank you for the opportunity to respond to the draft report examining the quality assurance of academic training. The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 30,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. RCP membership is drawn from over 30 medical specialties, including geriatric medicine, general internal medicine and acute medicine. Our primary interest is in building a health system that delivers high quality care for all patients.

The RCP would like to take this opportunity to formally endorse the response of the National Institute for Health Research ICAT Academic Leads Committee, which we fully support. The committee’s full response can be found below at Appendix A. We would particularly like to draw your attention to the following recommendations made by the Academic leads committee, which we believe must be addressed:

- every specialty training committee should have an academic member to ensure that both the clinical and academic elements are supported in the design of training programmes
- a lead should be assigned to oversee the quality management of both academic and clinical components
- greater flexibility is needed in the annual review of competence progression, particularly around CCT target dates extensions and alternative outcomes to facilitate this
- the academic input across postgraduate deaneries and LETBs should be consistent and informed by the latest version of the Gold Guide

I hope you find this contribution helpful. I would be delighted to meet with you discuss any future work in this area.

With very best wishes

Professor John Wass
Academic Vice President
Royal College of Physicians
Appendix A

Response of the NIHR academic leads committee to the GMC quality assurance report on academic training

The NIHR academic leads committee for integrated academic training welcome the opportunity to respond to the draft document produced by the GMC which has looked at quality assurance of academic training.

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