

# GMC Quality Framework

Learning points from the second year of annual reporting  
and the major review of all specialty and subspecialty  
curricula and assessment systems

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General  
Medical  
Council

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This report provides a summary of the main learning points from the second year of implementing annual deanery reports (ADRs) and annual specialty reports (ASRs) as part of the PMETB and now GMC Quality Framework (QF). The report also includes outcomes, evaluation and reflections on the major review of all specialty (61) and subspecialty (35) curricula and assessment systems.

The report sets out the background to annual reporting and the curriculum and assessment system review process. The 2008-09 reporting cycle is discussed, identifying good practice and learning points in terms of content and process.

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# Background

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The QF was published in the autumn of 2007. It was relaunched as the GMC Quality Framework in April 2010 following the merger of PMETB and the GMC. The QF sets out the expectations of the regulator for the annual reporting processes. In addition, the *Quality Framework Operational Guide* has set out the dates for submission and requirements, including templates and headings, since January 2008, normally working three years ahead.

Initially, the emphasis for medical Royal Colleges (RCs) was to provide information to PMETB on national examination data and provide to each deanery the examination data for the deanery's trainees. The process and requirements for the national examination data were agreed at a meeting between the Academy of Medical Royal Colleges (AoMRC) and Conference of Postgraduate Medical Deans (COPMeD) with PMETB in autumn 2007. As work progressed, it became clear that RCs could and should provide a more formal narrative on each specialty to inform the quality assurance (QA) work of the UK regulator and to enable the deaneries to set their training within the national perspective for each specialty, in essence to 'benchmark' their provision. ASRs were discussed extensively at the Academy Specialty Training Committee after the experiences of the first year, and headings and further guidance were provided to help structure the ASRs in a more consistent manner.

For deaneries, the QF affirms that ongoing approval is based on the satisfactory receipt and content of the annual report. The original template agreed in spring 2008 was revised based on experience and feedback from deaneries. The template must be completed as set out and includes a dataset on trainee progression, achievement and, where applicable, attrition. The template and guidance are available in the *Quality Framework Operational Guide* on the website. The GMC therefore receives a report per specialty (61 UK specialties presently) from a national perspective from the College or faculty and a report per deanery (20 deaneries in the UK plus a 'virtual' deanery in pharmaceutical medicine) which sets out exceptions across all specialty training within that deanery.

The principles for both sets of annual reports include that exception reporting is to be used. This is not an easy task, and determining what is an exception and when an exception should be included is a difficult process. The QF is based on three levels of responsibility:

- QA by the GMC
- quality management by deaneries
- quality control by local education providers (LEPs).

The RCs interact with the relevant bodies at all three levels to ensure a focus on the implementation and development of specialty training.

(See GMC QF for details and GMC Operational Guide for definitions and glossary of terms.)

The GMC does not require the detail that is necessary and appropriate at quality management and control levels. The GMC does need the local managers to inform it of those training issues that either potentially fail to meet or exceed the regulator's standards and requirements.

CoPMED and the AoMRC agreed with PMETB to report on the same timelines, and this was agreed in 2008 as August to July.

# The 2008-09 Annual Deanery Reports

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## Background

PMETB had determined that ongoing approval for deaneries was based on the satisfactory receipt and content of the ADR. The PMETB Training Committee agreed an original template in spring 2008. After some consultation with the deaneries this was adjusted slightly. It was also agreed that there would be a set reporting period for all annual reports, from August through to the following July. The agreed template included three sections:

- self-assessment against the *Generic Standards for Training and Standards for Deaneries* for the defined reporting period (in which the deaneries self-assessed against each requirement within the standards documents)
- action plan for the subsequent reporting period
- dataset for each approved programme, including outcomes such as trainee progression, achievement and, where applicable, attrition.

Deaneries were advised to use the principles of exception reporting, outlined within the QF and expanded within the 2009 PMETB *Annual Reporting Learning Points* document.

The 2007-08 ADRs were collected in late 2008 and scrutinised by Post and Programme Approval Panels in early 2009. Decision letters regarding approval status were disseminated in the first quarter of that year, after which the action plans were published on the PMETB website. This was the first time this type of activity had been undertaken, and it was clear that the quality of these reports and the level of detail included by deaneries were variable. However, it was the first time that such a baseline had been collected. Detail and analysis of this first cycle of ADRs is included within the 2009 *Annual Reporting Learning Points* document. This paper also contained advice and instruction for deaneries in preparation for their second ADR for 2008-09.

### Changes for the 2008-09 ADR cycle

Decision letters to deaneries from the previous cycle had included suggestions on cross-referencing domains and actions, as well as guidance about reporting detail. In preparing for the second cycle of ADRs, deaneries also had the advantage of access to the entire set of deanery action plans from the PMETB website, thus being able to consider a variety of approaches.

The self-assessment and action planning templates remained essentially the same for the second cycle of ADRs. However, the new dataset template had several additions. In 2008-09, deaneries were now asked to report on academic trainees: headcount, annual review of competence progression (ARCP)/review of in-training assessment (RITA) outcomes and attrition rates. It was also agreed that the ADR would be used for an annual update to GP trainer approvals. Deaneries were instructed to submit all changes to their GP trainer lists (for example, retirements, extensions of approval periods, and new trainers) through the ADR dataset template.

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### **2008-09 ADR submissions**

Twenty one deaneries (20 geographical and 1 virtual) submitted their ADRs during the period October 2009–January 2010, according to the deadlines published in the *Quality Framework Operational Guide*. Those deaneries with an October 2009 deadline were granted the option of a one month extension. While each deanery was reporting for the same period, the deadlines were staggered so that the approval process was manageable.

The approvals and evidence teams undertook extensive work to assess the ADRs before they were presented to the panel. All dataset discrepancies were followed up with the deaneries. These discrepancies were mostly related to missing programmes, unexplained high failure/attrition rates and large gaps between headcount and approved maximum training capacity. Deaneries were asked to clarify these gaps, and provide missing programme information prior to the scheduled panels. All deaneries complied with the requests, and this exercise resulted in several deaneries submitting applications for an increase in trainee capacity in some programmes.

A more detailed analysis of the self-assessments and action plans was undertaken by the Head of Monitoring and Review, who summarised key points in preparation for panels. This internal scrutiny also resulted in two requests for complete resubmissions (from West Midlands and South West Peninsula) where the detail in the report was not appropriate.

Brief panel consultation confirmed these decisions, and these ADRs were deferred to later panels.

The overall quality of submissions was much improved from the previous year, which had been the first time deaneries or PMETB had dealt with ADRs. The 2007-08 ADR scrutiny resulted in detailed feedback and suggestions for deaneries, and the 2009 *Annual Reporting Learning Points* document also included evaluation of that year's submissions.

It was apparent that deaneries were taking on board PMETB advice regarding exception reporting and the construction of ADRs. The majority of reports adhered appropriately to exception reporting, and clearly cross-referenced the self-assessment to the action plan. The East Midlands Deanery report was considered to be an exemplar for other deaneries to follow. Panels also praised Wessex Deanery, KSS Deanery, Defence Deanery and North Western Deanery on the organisation and clarity of presentation within their reports. London Deanery submitted a very complete and detailed report, a particular success considering it is the largest deanery in terms of trainee numbers. Less successful reports came from South West Peninsula Deanery and West Midlands, as well as Wales Deanery, Yorkshire & the Humber Deanery, and Mersey Deanery, although these deaneries all submitted revisions which raised the reports to a good standard.

The length of the submissions also varied. Some reports were very lengthy and had appendices, but the content was not always focused or relevant. In contrast, KSS submitted one of the briefer reports but the content was considered to be suitable and straightforward. Panel and staff feedback indicated that it continued to be appropriate not to set a page minimum or limit, as the more successful reports did not follow one model.

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Every dataset received as part of the ADR required some clarification/correction prior to panel scrutiny. In most cases, there were straightforward errors or omissions and deaneries were quick to address the discrepancies brought to their attention. It is anticipated that the future submission of ADRs through a portal to the GMC will eliminate these kinds of errors, as deaneries will be using the GMC lists of approved posts and programmes.

This year's ADR dataset template asked specifically for justification of any discrepancies or clarification of issues such as high attrition rates. Most deaneries utilised this column appropriately, although some needed to be reminded. Examples of issues which required explanation were particularly high ARCP failure or attrition rates and cases where headcount greatly exceeded approved numbers. The data were also used to provide additional evidence when there was a known issue. For example, there were documented issues with trauma and orthopaedics (T&O) in West Midlands, where the ARCP failure rates for core surgery and T&O were particularly high. This is an example of how the ADR will initiate an investigation as part of the responses to concerns process. It is also worth noting that the ASR for surgery (T&O) also raised this issue, an example of triangulated evidence leading to a specific response by the regulator.

There will be more extensive longitudinal analysis of the data after the 2010 annual reporting cycle as there will be three years' worth of data to consider.

#### **ADR panels – decision outcomes**

For each ADR, the panel was given an accompanying summary of evidence held by PMETB in relation to that deanery. This was to help the panel gain a broad picture of what was happening within the deanery and to highlight key issues or areas of notable practice. It was also used to draw the panel's attention to gaps in the content of the ADR. In addition, the panel received a detailed brief, outlining how the ADR fits within the QF and giving instructions on how the discussions and decision-making should proceed. Every panel reported that these documents were helpful and assisted in setting the context for each ADR discussion.

Each panel was asked to make a decision on every ADR, choosing one of these options:

- there is insufficient information to make a decision and further submissions are required
- continuation of approval for training
- continuation of approval for training subject to meeting conditions

and considering whether there are new areas of concern that warrant investigation.

Table 1 indicates how many decisions were taken for each outcome (South West Peninsula and West Midlands are counted twice as their resubmissions were considered by separate panels).

**Table 1**

OUTCOME	NUMBER OF DECISIONS MADE	DEANERY NAME
Insufficient information to make decision, resubmission	2	South West Peninsula, West Midlands
Continuation of approval, no conditions/recommendations	1	East Midlands
Continuation of approval with recommendations	14	London, KSS, East of England, North of Scotland, East of Scotland, West of Scotland, Northern Ireland, North Western, Northern, Wessex, Severn, Defence, Oxford, SW Peninsula
Continuation of approval with conditions	5	Wales, Yorkshire & Humber, South East Scotland, Mersey, West Midlands, Pharmaceutical Medicine
Areas of concern warranting further investigation	1	West Midlands – (ongoing monitoring of an existing concern regarding Mid-Staffordshire NHS Trust) - trauma and orthopaedics

Table 2 sets out the number of recommendations and conditions that were set during the ADR scrutiny process.

**Table 2**

Total number of conditions set	25
Total number of recommendations set	67

Table 3 is a summary of the content of these conditions.

**Table 3**

CONDITION	TOTAL NUMBER
Action plan not fit for publication and/or not constructed using 'SMART' approach, resubmission of action plan	1
Dataset indicates issues which are not justified or explained, for example, high attrition rates, high failure rates in specific specialties	4
Specific points within self-assessment are unclear and do not give enough information in context	12
Specific deanery actions are vague or do not have appropriate timescales	3
Conditions from a recent Visit to Deanery still apply (Pharmaceutical Medicine only)	5

It is important to note that, where deaneries were set conditions or required to resubmit part or all of their ADR, this was usually in relation to the clarity of the report rather than concerns about the provision. Where resubmission of action plans was requested, it was largely where further objectives were required or there needed to be more specificity regarding timescales and persons responsible.

As of the date of this report, all conditions have been met. All deaneries swiftly sent PMETB (and, as of 1 April, GMC) the required information. And, once this was received, a recommendation was sent to the original ADR panel chair for a final decision. The one outstanding condition relates to the West Midlands Deanery. As part of the West Midlands ADR resubmission, an update was provided regarding the situation in Mid-Staffordshire NHS Trust, which is the subject of ongoing monitoring as a concern. The Deanery is required to provide the GMC with an update following a deanery review of the situation in summer 2010.

### Monitoring visit to deanery and other conditions

The QF states that ADRs are used to monitor ongoing issues previously identified within deaneries. This is the formal mechanism for deaneries to report on conditions set during scheduled and triggered visits (unless another timeframe is made explicit), and it is the responsibility of the ADR panel to decide whether conditions have been met or require further action, reporting, or monitoring. At the time the ADR panels met, PMETB was more than halfway through the 2007-10 visit cycle.

Seven deaneries were obligated to report formally on their conditions resulting in a decision by the panel on whether the conditions had been met (one deanery visited early in the cycle had no conditions, only recommendations). An additional four deaneries reported on progress. These deaneries and the remaining eight to be visited will report again on their conditions in next year's ADR. Deaneries which reported on conditions approached this within the ADR in a variety of ways. Some included detail within the context of the self-assessment and action plan, while others included a separate document. As long as the content was clear, panels did not prefer one method of addressing the conditions over the other.

Table 4 addresses the Visit to Deanery (VTD) conditions considered during the ADR process, and the current status.

**Table 4**

DECISION OUTCOME	NUMBER OF CONDITIONS	DEANERIES
Condition met (monitoring in next ADR)	29	London, Mersey, KSS, Oxford, SW Peninsula, Wessex, Yorkshire & the Humber
Further information is needed to make decision	2	SW Peninsula (now fully met)
Condition not yet met; further report needed prior to next ADR	0	Not applicable

All deaneries which had been visited and had recommendations made as a result of the visit addressed these in a detailed way. Deaneries were commended by ADR panels for this.

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### **Notable practice**

Deaneries were asked to exception report within their self-assessment on areas they considered to be notable practice. Most deaneries did this, while some (for example, Wales and Northern Ireland) gave undue attention to positive areas which may not necessarily be notable. However, because of the nature of exception reporting and the format of the ADR, it was difficult for panels to differentiate between what was truly notable, potentially notable (for example, there was only brief detail provided), and what was working well in the context of that particularly deanery. Panels were able to highlight several instances of innovative and particularly good practice but, overall, were reluctant to identify these as 'notable' due to the lack of detail and ability to triangulate. Notable practice was acknowledged in a general way by some panels, and more specifically by other panels, making it difficult to consolidate notable practice data. The 2009 PMETB *Notable Practice Report* (published March 2010) should assist deaneries in reporting notable practice. Some positive areas which were fed back to the deaneries included:

- innovative and proactive approach to dealing with undermining of trainees and delivery of assertiveness training (Northern Ireland)
- an Associate Postgraduate Dean assigned to each school with trainees in difficulty (Yorkshire & the Humber)
- the induction programmes for Tri-Services trainees (Defence)
- use of an algorithm for modelling likely recruitment gaps supported by extensive recruitment activity (Northern)
- curriculum mapping pilot (KSS).

Wessex Deanery also reported further on developments made on areas of notable practice identified in the VTD report. The panel noted that this was an exemplar of quality improvement.

### **Feedback on the ADR processes**

Informal deanery feedback indicates that, overall, deaneries were much happier with the ADR process, which is evidently bedding down within quality management systems. The detailed letters sent by PMETB this year, indicating specific points within ADRs including what was good and what could be improved, seemed to be appreciated and considered helpful. However, it should be noted that positive feedback from deaneries on the process was largely from deaneries which had good outcomes and feedback on their ADRs. Deaneries which submitted ADRs later in the process were the last to be scrutinised by a panel and may not have received decision letters until late March/early April. Some of these deaneries were required to submit supplementary information on the content of the ADR. This means that information about the 2008-09 period was still being exchanged through April/May 2010. Some deaneries have questioned the value of continuing work on this when they are already looking towards the next ADR.

Most deaneries were satisfied with the guidance provided in preparation for the 2008-09 ADR, and several referenced specifically the 2009 Annual Reporting Learning Points document as being particularly helpful in defining exception reporting. However, there were still challenges identified in benchmarking against other deanery activities, particularly with notable practice. It is anticipated that the PMETB *Notable Practice Report* document, published in March 2010, will also be helpful to deaneries.

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Most deaneries also reported that the ADR was a helpful platform for reporting progress against conditions set by visits and response to concerns, and provided a focus for the work. It was also regarded as an efficient way of monitoring, although one deanery did express a preference for a separate action plan feedback mechanism following a visit. This may be developed further as part of a revised visit process.

Feedback regarding the PMETB/GMC responses to ADR was varied. Some deaneries were surprised by the amount of additional information which was required by panels and regarded some of this to be unnecessary, but most felt that the responses were reasonable and helpful. The feedback to deaneries seemed to be greatly appreciated, and one deanery noted that 'while the feedback did not add to the deanery's information, it was valuable to realise that the regulator understands the ongoing issues'. There were also several notes regarding the time lapse between the submission and the original PMETB response; this was several months in some cases because of panel dates.

Overall, the deaneries valued the ADRs and recognised them as a valid and appropriate mechanism for reporting to the regulator. Further guidance for the 2009-10 ADRs will be disseminated by the end of July, and GMC aims to tighten timescales for feeding back outcomes to the deaneries.

Panel feedback was varied. Most panellists were new to the activity and reported some apprehension about how the discussion and decision-making would take place. Those who had already participated in similar panels indicated that they were more comfortable with the process. Four of the five panels considered that the panel ran smoothly, PMETB guidance was appropriate, and that the discussions during the day were reasonable and fit for purpose. One panel fed back that it was difficult to make an approval decision based on the ADR. This panel, which had a larger agenda than the others, also felt that the workload was too extensive. All panels considered the evidence summary and guidance document to be fit for purpose and key to the process, and one panel also wished to have an executive summary of each ADR. During the process, panels made practical suggestions as to how to present the evidence summaries and the datasets, and improvements were subsequently made for later panels. Several panels also asked for thresholds to be set which, if met, meant that further investigation was required into high attrition and failure rates for specific programmes.

# Annual Specialty Reports

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An ASR is a concise report of the education and training towards UK certificate of completion of training (CCT) and certificate of eligibility for specialist registration combined programme (CESR CP) in a particular specialty provided by the relevant Royal College, College or Faculty to GMC on an annual basis. The reports need to contain information, identified either nationally or at a specified deanery, which helps GMC to understand (1) notable practice in the specialty, (2) key issues and concerns facing the specialty, and (3) any recommendations to GMC. Each specialty covered by the report should include fully analysed trainee examination data with a supporting explanatory narrative.

Presently, the ASR should discuss subspecialties under the lead 'parent' specialty but only where the report identifies an area of notable practice or concern.

The national examination/s is/are a significant part of the approved assessment system for each specialty curriculum. The RC holds this information and undertakes evaluation and analysis of the occurrences and outcomes of these examinations. The data for each specialty (where applicable) should be annexed to the ASR weblink.

As holders of the expertise, history and innovation in the specialty, the RC or faculty produce a report that analyses both quantitative and qualitative information that will result in:

- verification by the GMC of the deaneries' self-assessments within the ADRs, that is, accuracy of the exceptions
- an indicator of actual or potential problems in one or more parts of the specialty including GP training delivery
- an activation of a concern to the GMC where appropriate
- a way of recommending changes for consideration by the GMC
- a way of sharing notable practice
- a way to promote improvement across deaneries and across specialties.

# The 2008-09 Annual Specialty Reports

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PMETB received ASRs pertaining to 59 specialties submitted by all the Colleges/faculties, including the Joint Royal Colleges of Physicians Training Board (JRCPTB) and the Joint Committee on Surgical Training (JCST); Tropical Medicine was incorporated into the report on infectious diseases. One specialty is new and therefore will not report until 2010.

GMC provided feedback to each College/faculty by June 2010.

The ASR provides an opportunity for Colleges and faculties to raise concerns and/or offer feedback to the regulator; most of the 13 Colleges/faculties took advantage of this.

ASRs generally contained recommendations relating to specialty concerns and were often accompanied by action points identified by the College/faculty.

## Examples of good practice in the completion of the ASRs 2008-09

The structure of the ASRs varied between specialties but, again, each ASR contained examples of good practice. Some examples are listed below.

- The Royal College of General Practitioners (RCGP) had an outstanding dataset and narrative which should act as an exemplar to other RCs. The RCGP explained the data very well and the narrative enabled the regulator to understand the particular issues in training and assessment that they are addressing.
- The Royal College of Anaesthetists provided a clear concise structure for their report, and provided a precise summary of the examination data in relation to pass rates.
- The JRCPTB used a generic template for all 28 specialties, which enabled a greater understanding of those issues that were found across all specialties. Some Specialty Advisory Committees set out the challenges and strengths clearly and succinctly and included clear actions for the following year. However, a few of the specialties were so minimalist and lacking in information that the regulator was unable to glean any insights into the specific issues and strengths. The MRCP data is still a work in progress but it was considerably improved this year. However, it did also raise questions when a few doctors had been allowed to take the Part 1 up to and including 17 times, and some doctors had taken the Practical Assessment of Clinical Examination Skills (PACES) nine times.
- The Royal College of Pathologists made good use of the school reports and reported a high level of trainee satisfaction.
- The Royal College of Psychiatrists provided a global narrative on the specialties and set out a narrative description of the examination statistics but, like some other RCs, was not yet able to provide the data by deanery.
- The JCST used a generic template for all nine specialties. The reports were very clear on the concerns, in particular the impact of European Working Time Regulations (EWTR) and the lack of breadth and depth of surgical experience for core and higher specialty trainees.

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- The JCST, the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Pathologists were able to identify particular deaneries in more cases this year; this makes it easier for PMETB (and now the GMC) to cross-check against the ADRs.
  - The College of Emergency Medicine clearly signposted the improvements made during the previous year, including an e-learning project, and they made effective use of the regional schools' information.
  - The JRCPTB provided commentary for the core curricular elements and this provided additional insights. It is recommended that all RCs with core elements consider whether they will present a joint core report or make sure they present core results for their specific specialty. As long as it is clear which of these two options is being undertaken, the GMC will be content to receive the information that is most useful/accessible for the RC.
  - The RCPCH provided a comprehensive report supported by a clear presentation of the data with bar graphs. The RCPCH has repeated the high standard of its action plan which is commended to the other RCs.
  - The Royal College of Radiologists provided a traffic light system to identify the level of risk for clinical radiology, which worked very well, while clinical oncology set out the work streams that had been put in place.
  - The Faculty of Public Health used links to key documents effectively and provided a concise but clear analysis of the data.
  - The Royal College of Obstetrics and Gynaecology provided a particularly helpful commentary in relation to workplace-based assessments (WPBAs) and was very clear about its priorities and concerns – EWTR and the time for trainers to undertake their role.
  - The Royal College of Ophthalmologists had a clear and helpful ASR. The analysis of the data was clear and explained important issues such as the rules between compensation between various parts. This RC set out definitions that explained what they meant by trainees (for example, including Locum Appointed Training posts) and discussed pass rates and ethnic mix and gender mix. The RC also explored the examination data by deaneries and explained that numbers in each deanery can vary from 0 up to 9 so that one cannot analyse by deanery. The challenge of small numbers of trainees, either nationally or even more when it is at deanery level, is a common challenge for many specialties.

This second tranche of ASRs provided a significantly improved standard of useful information on the current state of specialty training in the UK from the college or faculty perspective. A detailed record of the information contained in the reports is mapped against the ADR outputs and will inform the evidence used by GMC to track deanery, LEP and/or specialty issues over future reporting cycles and QF activities. All concerns that were raised with the regulator have been followed up; some matters have been resolved and some are being monitored.

## ASR process evaluation

Questionnaires were sent to all Colleges and faculties involved. (Feedback had previously been sought on the questionnaire format and content.) There were 36 replies. The respondents' replies to the specific questions are summarised below in Table 5.

**Table 5**

QUESTION	YES	NO	OTHER
Did you consider that the guidance provided in 2009 from PMETB was sufficient to formulate the report?	6	30	0
Was the information provided in the 2009 Learning Points Report helpful?	35	1	0
Was the information provided in the QF Operational Guide helpful?	35	1	0
Would further guidance would be helpful?	6	0	30
Did you understand the definition of exception reporting, for example, what to include and what not to include?	36	0	0
Do you understand how the ASR is used by the regulator?	34	2	0
Do you understand how the ASR it fits into the QF and informs other QA activity?	35	1	0
Was the ASR a useful way to update the regulator on concerns or issues being discussed/actioned in the previous report?	36	0	0
Did the College/faculty find the feedback given by PMETB/GMC to be clearly outlined in the letter?	35	0	1
Will the College/faculty be able to use this feedback to inform next year's ASR?	35	1	0
Has the College/faculty already started work on the 2009-10 ASR?	32	4	0
Does the College/faculty currently ask for external advisers' reports?	4	32	0
Does the College/faculty see an improvement in information flow between it and the deaneries?	32	4	0

The feedback from RCs is generally positive. One wishes for a template but most find the enhanced guidance and headings provided in 2009 sufficient. The main area of concern appears to be the examination data and what exactly the regulator expects. Structural problems exist in that RCs collect national examination data which includes many doctors who are not on training programmes, and several RCs do not know the relevant deanery for those who are in training. In addition, the request for narrative to support the data has tended to be interpreted as description of the data categories. While this is essential and helpful, the regulator needs to have the benefit of the RCs considering the implications and issues arising from the examination results.

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One example would be narrative explaining why some occurrences or diets have a higher fail rate; another would be narrative to explain the actions taken by the RC where fail rates are more than 50% or where pass rates are 100%. An explanation of why these rates are seen as acceptable or indeed desirable would be helpful. There has so far been little to show the link between evaluation of the delivery of the curriculum and changes to the assessment system. The regulator is aware that RCs are reflective and reflexive in many cases and are making these links, but this is not evident from many of the ASRs.

Written feedback to each College/faculty from PMETB was delayed due to personnel changes/merger impact, but the results of the questionnaire show that RCs consider that they will be able to use this feedback in the 2010 ASRs. The delays caused understandable frustration but were period specific and will not be repeated next year.

# Key issues related to specialty including GP training across all annual reports

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There were several issues consistently reported across the reports. These largely reflect the issues addressed in 2007-08, but there are some changes. The repetition may not mean that issues have not been addressed during the past year by deaneries and/or RCs, but rather that they are endemic issues which deaneries and RCs are addressing with a variety of approaches. The following issues were consistently reported for many specialties (but not all):

- rotas that may be EWTR compliant but the methods used to achieve compliance have introduced problems in terms of workload, inappropriate specialty experience, or work intensity
- persistent unfilled posts at both junior and senior level, particularly in rural settings (for example, reported particularly in Northern Ireland, Scotland, Wales, Northern, and SW Peninsula). This situation is deteriorating in these areas and is directly impacting on some services
- difficulties in maintaining adequate supervision of trainees, linked with a lack of time and lack of recognition of the trainer role in acute settings
- service pressures interfering with educational activity (reported particularly in paediatrics, exacerbated by gaps in rotas)
- concerns with non-compliance with 48-hour working week (ADRs)
- induction to LEPs was still patchy, sometimes ineffective and sometimes comprehensive.

There were fewer issues reported this year around WPBAs. Training and successful implementation of WPBAs is expanding; this has been reported in other areas and triangulated through the ADRs. This is a very positive development to note.

There were also many fewer specific issues reported by deaneries around bullying. This may be because issues are being addressed successfully, and is an example of an improving situation. It is unlikely that deaneries are not reporting this, as they have demonstrated a willingness to be open and address such problems. The national surveys would also demonstrate directly to the regulator if this was not the case (the 2010 results were not yet available at time of writing).

# Formal review 2009-10

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The third phase of the curriculum approval process, the formal review of all specialty and sub-specialty curricula and their associated assessment systems against all the Standards for curricula and assessment systems (July 2008), had been set for the period October 2009 to February 2010. This staggered approach was agreed between PMETB and the Academy of Medical Royal Colleges (at the RCs' request) in early 2006.

Each specialty is considered in its totality against the Standards for curricula and assessment systems. The outcomes of each panel scrutiny can be either that the curriculum and blueprinted assessment system for the specialty are approved, approved with conditions or not approved. In the last case, a resubmission is planned following further guidance and advice on the gaps and problems. Six specialties required resubmission, all successfully. Of the 59 specialties reviewed, 13 had one condition, seven had no conditions and the remainder had a range of two to eight conditions. All RCs were successful in meeting the requirements and all are approved by the GMC.

Notable practice was identified in all but two specialties and several subspecialties. The notable practice tended to be based around the RC approach or joint RCs (JRCPTB and JCST) and a few specific specialty issues. The following are examples and not meant to be a comprehensive description of every notable practice, but the RC is identified so that access to the expertise is possible.

- The College of Emergency Medicine has an annual survey of new consultants to inform curriculum development.
- The Royal College of Ophthalmologists undertakes training of named assessors; they were also commended on the active use of lay colleagues.
- The Royal College of General Practitioners has a robust process for selecting examiners.
- The Royal College of Psychiatrists has a structured network involving college tutors, supervisors and programme directors; it was also commended for a very active and inclusive involvement of trainees.
- The Royal College of Radiologists made very effective use of anchor statements in the assessments; the layout of the curriculum was particularly easy to read and user friendly.
- The Faculty of Public Health had very clear and easy to use learning portfolios; it also had ensured extensive involvement of trainees.
- The Royal College of Pathologists had been particularly successful in the full use and integration of the Medical Leadership Competency Framework.
- The JCST had made great strides in relation to WPBAs and the emphasis on assessment for learning throughout the surgical curricula.
- The JRCPTB has a very successful ARCP decision aid and grid; combined with clarity of learning outcomes, this means that trainee progression and achievement should be consistent and equitable.
- The Royal College of Obstetrics and Gynaecology was commended for its very accessible website and the two guidance documents: *Tips for Trainees and Tips for Trainers*.

The conditions were also very varied as to focus and content. However, trends were identifiable; in decoupled specialties there was a lack of integration of core with higher specialty training. In essence, applications dealt with higher specialty years as though the core was 'a given'. However, the regulator wished to be assured that the whole specialty (core and higher) made a coherent whole for the trainees. This was particularly evidenced in the articulation of learning outcomes at each stage and showing progression.

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Learning outcomes were meant to be clearly articulated at each stage in the curriculum and this is quite a challenging process, as previous emphasis had been solely on the outcomes expected of the trainee to be awarded a CCT. Not surprisingly, the run-through curricula found this aspect easier to handle and could demonstrate an increasing depth and complexity in the knowledge and skills of the trainees.

The third consistent aspect identified was a lack of statistical or evidenced support for the assessment methods put forward; debates were particularly lively in relation to oral examinations, including vivas. A few RCs were convinced of the desirability of the oral examination but had further work to do to justify it.

The remaining conditions were specific to the specialty or group of specialties and so varied, but the vast majority with conditions had them in relation to

**Standard 1:**

*The purpose of the curriculum must be stated, including linkages to previous and subsequent stages of the trainees' training and education. The appropriateness of the stated curriculum to the stage of learning and to the specialty in question must be described.*

Many had them against **Standard 2:**

*The overall purpose of the assessment system must be documented and in the public domain.*

and **Standard 3:**

*The curriculum must set out the general, professional, and specialty-specific content to be mastered, including:*

- (a) the acquisition of knowledge, skills, and attitudes demonstrated through behaviours, and expertise;*
- (b) the recommendations on the sequencing of learning and experience should be provided, if appropriate;*
- (c) the general professional content should include a statement about how Good Medical Practice is to be addressed.*

Often the RCs had undertaken the work and were clear when questioned, but the initial curriculum and assessment system documentation did not always reflect that clarity. The RCs had been specifically required to articulate more clearly the key outcomes required for each year of training; it was expected that the level of detail would vary according to the particular specialty.

It is not thought that there are particular problems with postgraduate medical curricula but that any organisation would find it a challenge to justify their assessment regime with robust evidence. The RCs generally had put an immense amount of work into demonstrating the utility of their assessments.

Areas for recommendations were widespread and most are about ongoing work that the RCs are following up and reporting on in the next ASR. The trends were further work on utility of specific examinations or assessments, involvement of lay members, and WPBAs, all of which could be expected. Interestingly, the RCs' efforts to articulate the different roles of those involved in the development and delivery of curricula and assessments led to several with recommendations to continue that good work. There is a multiplicity of roles and any clarification at a national level is to be welcomed; however, it remains a very specialty-specific interpretation.

## Formal review evaluation

There were 41 responses to a brief questionnaire which RCs had an opportunity to comment upon. The responses from RCs and Joint Royal Colleges were supplemented by specialty specific responses.

A summary is presented below in Table 6, and a more detailed description of the comments is set out in Annex.

**Table 6**

QUESTIONS	YES	NO	OTHER
Did you consider that the guidance provided in 2009 from PMETB was sufficient to formulate the report?	29	11	1
Was the information provided in the QF Operational Guide helpful?	31	8	2
Did you read and refer to the letter (April 2009) sent to the Royal Colleges from the two Chairs of the PMETB Statutory Committees?	32	4	5
Were the Templates provided clear and easy to understand?	24	14	3
Were you clear about how the submitted documentation would be scrutinised by the regulator?	14	26	1
Was the information on the practical arrangements for the panel meetings clear and easy to understand?	35	6	0
Did the Chair of the panel introduce the members and explain the activities for the meeting?	41	0	0
Did the panel meeting give you opportunity to discuss your submission in an open and constructive way?	20	10	11
Did the College find the feedback given by PMETB/GMC to be			
a) provided in the agreed timescales?	7	33	1
b) clearly outlined in the letter?	30	10	1
Did you understand what you were required to do in order to meet the conditions?	26	15	0
Will the College be able to use the recommendations to inform next year's ASR?	27	8	6

There remains a fundamental communication issue that Colleges still do not grasp the regulator's emphasis on the Standards of curricula and assessment systems. Comments about lack of guidance did acknowledge that the template was designed to ensure the regulator could ascertain that the Standards had been met, rather than structure the actual documentation around the Standards (done in the first phase). A letter from the two Chairs of the PMETB statutory committees was sent to all RCs in April 2010 setting out the specific issues that would be explored. Some RCs had made good use of that, others did not. The other main point of contention was the requirement to look at each specialty in totality, including core elements; feedback confirmed that the 'decoupled' specialties found this time consuming and repetitious. However, this approach reflects the actual experience of trainees and there were significant gaps in awareness for some specialties in relation to the core experiences of trainees. As many specialties have more than one core route into higher specialty training, a complete and comprehensive description of the whole routes to CCT is not an unreasonable expectation of the regulator.

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Feedback to the GMC did not include many suggestions for additional information or guidance that would have helped. However, JCST suggested that a more collaborative and informal discussion would aid the process in future. A consensus did appear to be that the specific questions/areas for discussion that a panel identified should be sent to the RC before the panel meeting so that the discussion could be more fruitful. The GMC will look to incorporating this into future scrutiny work.

The panels and the resulting conditions and recommendations were felt to be variable by several RCs. In addition, the RCs considered that some panellists did not keep to the Standards specifically. It is recognised that ensuring a consistent approach across many panels and panellists is extremely difficult and that it was not achieved throughout. Having completed this major review, this aspect of scrutiny and the use of panels are to be considered by the GMC, alongside the feedback received.

In process terms, those panels that went earlier in the period of review received the outcomes on time; later in 2009 and into 2010 there were unfortunate delays by PMETB in sending out the letters due to personnel changes. However, this time lag was significantly exacerbated by many (more than 37) of the specialties seeking an extended time period for core training. While that was being discussed with the funding and commissioning bodies, PMETB could not finalise approval of the curricula. Once that situation was clarified – that extensions to core training times were not being sought - approval letters were then processed to reflect the agreed length of core training.

GMC is incorporating the specialty information into the QF evidence base; all issues will continue to be followed up carefully and robustly through the QF.

# All annual reports to the GMC

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The following points are a reminder of the key points to address:

- all reports address the previous year August to July
- all reports use exception reporting. Reports should identify concerns or problems and all reports should identify notable practice
- all reports need to make it clear when they are raising an issue or concern that they wish GMC to investigate specifically
- all reports should provide narrative supporting and explaining the trainee/assessment data provided. This does not mean just a detailed description of the categories used but the implications and impact on training of the figures presented
- all reports should consider equality and diversity issues. Deaneries need to provide the analysis on ethnicity and gender within the relevant Domain and Standard, but this is also important in relation to examination data and RCs
- all reports should consider the academic programmes and trainees (please note in the annual report when not applicable)
- all reports should consider the less-than-full-time trainees (please note in the annual report when not applicable)
- all annual deanery reports must show how the actions taken have resolved or ameliorated the problems identified, not just identify more actions
- evidence of improvement is needed, rather than just the actions taken.

# Conclusion

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The standard of documentation and information provided by both deaneries and RCs was significantly improved in 2009. The feedback provided by PMETB, the additional guidance and the first learning points report all contributed to this. However, each organisation has demonstrated a willingness to improve on the systems used to gather information on training and to be accountable for reporting on their work to deliver and enhance postgraduate medical training. Where the reports in totality were considered and signed off by a senior person within that organisation, there was a notable positive difference in the standard of report.

In four years, the regulator has gained a significant and considerable evidence base for determining that standards are being met and the quality of training achieved. The ADRs and ASRs are vital parts of that quality assurance framework. There remains a considerable amount of work and a number of challenges for GMC, the deaneries, the Colleges and faculties, the specialty committees and groups, and the LEPs. The emphasis now needs to be less on the documentation of actions taken and more on improvement and enhancement of training; there also need to be more ways to disseminate notable practice (PMETB published the first *Notable Practice Report* in March 2010). There are plans to incorporate the Foundation programme into the reporting mechanisms from 2010. However, there will be further discussions with the UK Foundation Programme Office regarding a coordinated approach to data collection.

The reports have confirmed that there are persistent problems with ensuring sufficient and supportive supervision for trainees, time for supervision and recognition for the role of the trainer and the negative impact of service pressures on training. However, these are not applicable to all specialties nor are they applicable to all providers for any specialty; there are many cases of an excellent standard of training with highly satisfied trainees. There has been an improvement in the reported 'bullying' behaviours and there have been fewer concerns about delivering WPBAs. The challenge is to ensure that the information is sufficiently robust and specific so that more specific outcomes can be measured, successes shared and problems targeted.

The GMC will need a further year of comprehensive and clear information and trainee data to be able to start identifying positive and negative trends. The GMC has already undertaken to provide easier access for partners to provide and share data and reports with the regulator.

RCs, the GMC and deaneries need to look again at the examination data categories having had two years experience of reporting on these, including work on shared definitions of terms. Deaneries and Colleges will need to continue to improve data sharing, particularly considering the changes planned for the health services and medical education. The importance of the active involvement of LEPs in this cannot be underestimated; the providers need to have feedback and understand their role and responsibilities. Presently, the action plans only from the ADRs are published. Further discussion will be needed on how best to inform patients, trainees and the public about the outcomes of the scrutiny of training.

Now that all specialties have identified and published curricula and blueprinted assessment systems that have demonstrated compliance with national standards, discussions on effective, proportionate scrutiny in the future will be essential.

Sincere thanks are given to all deaneries, programme managers, heads of school, directors of medical education, specialty tutors and RCs, Colleges and faculties' staff and committees for their hard work and willingness to engage in improving specialty, including GP, training.

# Annex

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## Formal review summary of comments to GMC

### 1 Documentation

#### 1.1 Agendas

For some RCs the initial agenda and briefing given regarding the format of the panel meeting had little resemblance to the actual panel. Some RCs considered that they had not been clearly informed of how the meetings were to be carried out. It had initially been agreed that the RCs were to discuss how they had worked towards meeting all 17 Standards:

**Part 1** - *Formal Review of General Practice: RCGP to highlight any changes that they have made to Standards 1-7, 9, 11, 14 and 17 (reference SCAS) to the curriculum and associated assessment system.*

**Part 2** – *Formal Review of General Practice: RCGP to demonstrate how the remaining assessment Standards 8, 10, 12, 13, 15 and 16 (reference SCAS) have been met.*

(taken from the agenda)

Panel discussions were centred on the 17 Standards for curricula and assessment systems. Panel members had been asked to formulate questions around certain Standards which some specialties were unprepared for.

It was also agreed within initial agendas that the College would be given a period of time to explain the major changes that the 2007 curricula had undertaken.

#### 1.2 Chairs' letter

Some Colleges/specialties did not receive the April 2009 letter from both chairs to all Presidents and college QA leads.

Even if it had been read, many felt it was not the greatest help with regards to preparing for the review process.

#### 1.3 Decision letters

There was inconsistency between panels when a condition was set and when a recommendation.

Many letters were late and some found them inconsistent. However, the majority of conditions that were set seemed appropriate and attainable to meet in the timescale given.

Most Colleges were pleased with the feedback given and appreciated the recognition of notable practice.

### 2 Process

#### 2.1 Panel meeting

There has been a diverse response to the conduct of panel discussion. There has been positive feedback regarding the nature of the panel meetings; many specialties felt discussion was positive, welcoming and conducive to the decision letters. At the same time, others felt the experience was more like an 'interview', 'cross-examination' and, in one instance, it was felt that the panel had already made their decisions before the panel meeting.

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## 2.2 Guidance

The RCGP: The documentation relating to the assessment system was generally sufficient. However, the RC were also advised that they should make a submission of the revised curriculum and there was no helpful guidance in relation to this, neither was there a template to follow. The RCGP decided to submit a track changed version of the curriculum in addition to the assessment review template.

The JRCPTB: One specialty found the documentation extremely difficult, in particular the Standards for curricula. The content was considered difficult to decipher. They felt that simple, precise English would be better. The actual guidance document was deemed to be simpler and relatively straightforward in describing the dates and how things would happen, but they felt it did not indicate the complexity of the work they were expected to undertake. Quite a few specialties commented that the guidance had to be deciphered by JRCPTB and the education dept of RCP, London, and felt this assistance was absolutely essential in ensuring that the process was successfully completed.

The RCPCH: The guidance was sufficient in that a pro-forma was provided, with a letter from the Chairs of the committees. So, at the time of preparation, the guidance seemed clear. Reflecting back, the guidance did not seem to match the actual process.

The JCST: The PMETB *Quality Framework Operational Guide* and 17 Standards for curricula and assessment systems were the only guides provided. While these were helpful for understanding the overall process, they felt that there should have been specific guidance for completing the template and the submission as a whole. As a result, the SACs and Colleges were left to determine for themselves how best to complete the submissions. They believe that a statement of purpose and an explanation as to how the purpose would be achieved would also have been helpful.

## 2.3 Panel discussion

Some Colleges and specialties were unaware how the submitted documentation would be scrutinised by the regulator.

Many specialties felt that the questions asked were not relevant to the work they had produced.

A considerable number of specialties felt that panel members had their own agenda and were asking questions for their own benefit rather than for assessing the quality of the curriculum. Many panel members concentrated on the clinical parts of the curriculum with which they were most familiar (for example, the urologist asked about haematuria and the psychiatrist about the psychiatric aspects of care).

Many Colleges felt that time was wasted covering generic areas that had been dealt with by previous panels.

## 2.4 Outcomes

Generally speaking, specialties were very pleased with the outcomes to the formal review, which provided constructive and clear requirements.

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## 2.5 Process

Many Colleges/specialties felt that it would be beneficial if at least one panel member came from their own specialty.

## 3 Organisation/timing

### 3.1 Panel/decision turnaround

The turnaround time was a disappointment. Some specialties waited over three months for a panel decision letter. The nature of the feedback received was considered overdue, formulaic, and less than helpful.

### 3.2 Review guidance

In one instance a College was unaware until the QA College Leads meeting that there had to be any college representatives at the scrutiny.

## 4 Panel/chair

### 4.1 Panel member scrutiny

General consensus that the panel process itself was not what was expected and underappreciated the considerable amount of work that had gone into producing and remastering the curricula.

Many specialties requested consistency in panels for the future; while it was recognised that having the same partners was unlikely, the use of the same chair was strongly requested.

### 4.2 Chairs

There was a unanimous opinion that chairs conducted the panels in an appropriate manner.

## 5 Key evaluation

The most constructive criticism was that the formal review process and the ASR should not be the only forms of feedback between the regulator and RCs. The evaluation indicates that there is a clear desire to improve communications between the two bodies and that a more informal feedback system would be appreciated.

Among both negative and positive reviews, there was a general consensus that Colleges would prefer the regulator to be more prescriptive, concise and straightforward in the information requests. Many people found the *Quality Framework Operational Guide* helpful as a broad outline with reference to dates and administration; however, many specialties relied on their college educationalists and project managers to decipher 'jargon' and ensure that submissions had met the regulator's requests in an appropriate way.

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