General Medical Council

ANNUAL SPECIALTY REPORT 2014

Section 1. Details of the college/faculty
Name of college/faculty: Royal Colleges of Physicians
Specialty: Acute Internal Medicine, Allergy, Audio vestibular Medicine, Cardiology, Clinical Genetics, Clinical Neurophysiology, Core Medical Training, Clinical Pharmacology & Therapeutics, Dermatology, Endocrinology & Diabetes Mellitus, Gastroenterology, General (Internal) Medicine, Geriatric Medicine, Genito-urinary Medicine, Haematology, Immunology, Infectious Diseases, Medical Oncology, Medical Ophthalmology, Neurology, Nuclear Medicine, Paediatric Cardiology, Palliative Medicine, Rehabilitation Medicine, Renal Medicine, Respiratory Medicine, Rheumatology, Sport & Exercise Medicine

Section 2. Contact details
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*****Please read the guidance prior to completing the questions*****

Quality Assurance

1. **Please provide specific information about concerns at National, Deanery/LETB or LEP level where you don't consider improvement to be acceptable.**

Description	Specialty	Location	Evidence	Action & Outcome
Pressure on the Acute service and impacts on quality of training across medical specialties	**Cardiology, Dermatology Endocrinology and Diabetes Gastroenterology Geriatric Medicine Respiratory Medicine**			
Excessive G(I)M workload partly due to balance in favour of district general rather than tertiary centre placements. At present many trainees only commence essential tertiary centre training in ST6.	**Cardiology**	LETBs outside London	Surveys & recent Externality	Working with STC Chairs and LETB/Deaneries to ensure the full curriculum of cardiology is delivered and the G(I)M component of posts is constantly assessed. New guidance on dual CCT training in Cardiology and G(I)M was agreed with the GMC and published on the JRCPTB website in February 2015.
There are ongoing challenges to Dermatology Training by attempts to include Dermatology Trainees in general medical on call.	**Dermatology**	Yorkshire and Humber	Legal challenges supported by the British Association of Dermatology on each occasion have stopped this from progressing.	The SAC supports the concept providing that there is no disruption to training. This means limited participation during the St3 year with only 15 days lost of Dermatology on call.

Impact of acute medicine on call workload & intensity on training	**Geriatric Medicine**	Mersey North West Wales	SSQs in GMC survey show large proportion of time spent in acute medical takes.	There has been some improvement in Mersey since the last survey, particularly at Aintree, with more regular input from Gastro trainees and the ability to fill all post there from December 2014.Wales are looking at ways at reducing GIM in certain placements but this is difficult as service pressures are high and there is no slack in the system. If other specialties re-engage with GIM (eg Rheumatology, Cardiology) this would reduce the burden.
Respiratory trainees are increasingly asked to fill gaps on the acute GIM rota as other specialties pull trainees off and to compensate for rota gaps in those specialties that do contribute to acute unselected take which leads to reduced time in specialty	**Respiratory Medicine**	National	GMC questionnaire SAC meetings BTS workforce Respiratory Medicine has high fill rates at ST3 so is left to make significant contribution to acute take rotas	Plans to ensure that all medical specialties commit to acute unselected GIM take rotas. SAC will monitor effect on respiratory training through SAC meetings and TPD reports. Concerns over patient safety have been raised but no evidence to date as Consultants fill gaps left by registrar absences.
CMT recruitment **Initial numbers of CMT recruitment posts (excluding ACCS) are currently substantially less than the HEE investment plan.**	**Core Medical Training**	National	A minimum of 1305 CMT posts should be available, however there are currently only 1229 as follows: East Midlands 84 East of England 103	The Specialty Recruitment Office has been raising this with each region as they confirm the offers.

ST3 Recruitment			Kent, Surrey & Sussex 100 North East 75 North West/Mersey 80 North West/North West 112 South West / Peninsula 33 South West / Severn 46 Thames Valley 50 Wessex 62 West Midlands 95 Yorkshire 129 London 260 **TOTAL 1229**	
Vacancies on STR rotation continue to impact on Registrar rotas. Inability to advertise to known vacancies (achieving CCT or OOP) due to national recruitment requirements. Concerns voiced by many LEPs and TPDs. National round 2 appointments do not fill northern posts adequately, candidates preferring London area.	**Geriatric Medicine**	Wales, Northern	Recruitment statistics, vacancy rates. It is increasingly difficult to arrange "Acting Up" opportunities for final year StRs because of effects on already compromised rotas.	Northern OOP policy devised to limit number of trainees out of programme. G4J conference held locally. Significant improvement seen in round 1 but still concerns about difficulty recruiting in round 2. Problem in England replicated in Wales. Numbers from CMT in Wales low and insufficient to fill ST3 posts across medical specialties. Within Wales, North Wales is proving the greater challenge in terms of recruitment. South Wales continues to attract a good field of candidates.
In some localities, LTFT trainees are placed in substantive posts resulting in fewer trainees on the programme	**Palliative Medicine**	National	In some localities, LTFT trainees are placed in substantive posts resulting in fewer trainees on the	Data is being collected on the numbers of LTFT trainees and this will be compared with the 2015 NTS survey results and other data sources to provide more precise information

			programme. Hospices have less manpower and have no control over this happening. In acute hospitals, the on-call rota and clinics are invariably affected	on the localities under most pressure. The SAC will work with the affected deaneries/LETBs to see how this issue can be progressed.
Under-filling of training programs due to an inability to recruit to specialty at StR grade.	**Renal Medicine**	National but variations	Under-filling is potentially leading to an increasing number of gaps in training programme and imbalance of training and service provision, which in some deaneries is potentially critical, e.g. East Midlands. 2014 GMC survey –high workload red flags	Ongoing discussion with Deaneries and Trusts regarding the need for consultant expansion (progress is slow so far). Flexible timing of appointments to LAT/LAS posts and the development of post-CCT training fellowships to augment middle grade cover. Potential solutions will be discussed at a special session devoted to this whole issue at the annual meeting for Renal Medicine clinical directors to be held in March 2015 called 'Filling the Gap', where solutions and good practice to support the training grade will be discussed. Withdrawal of LAT posts although a painful short-term decision, may force the issue in terms of persuading Trusts to support consultant expansion. NTN posts are under-filled in some deaneries due to the decision not to advertise being made because Renal Medicine is a reducing speciality, even when the national plan for reducing numbers states that the deanery is within target for reductions.

Withdrawal of LAT posts	**Gastroenterology** **Neurology** **Palliative Medicine**	National		**There is a general concern that the phasing out of LAT appointments will have an impact on:** • **Research opportunities** • **Trusts needing to employ locums through agencies**
Variability in out of programme experience opportunities	**Neurology**	National	Approximately 70% of neurology trainees undertake a period OOP for a designated period of research. This is only possible by careful management of the rotations by TPDs, but the SAC fear that OOP opportunities may be denied in some regions (those with relatively fewer trainees as above) but still be freely available in other regions (notably North/South Thames with greater numbers of trainees) because of greater flexibility afforded to TPDs. .	**The inequality in training numbers has been raised in previous neurology ASRs in 2012 & 2013 and the SAC are concerned that this is not being addressed centrally**. This has the potential of creating two tier training schemes where OOP opportunities are available in some parts of the country but that the same opportunity is denied in others. This needs highlighting by the GMC and the disparity in training numbers across the UK is not in any way unique to neurology. Wessex has been hit by a large percentage of trainees OOP in 2013-14. It is hoped the introduction of a neurology consultant of the week at the regional neuroscience centre in Southampton will improve the direct supervision of trainees and help with workload issues.

Red flags in the GMC Trainee survey where there are vacant posts or trainees on OOP		Severn, KSS and East Midlands	All 3 regions have had vacant posts or a large number of trainees OOP during 2013-14 (e.g. Severn region had 5 out of 11 neurology trainees OOP and had already lost 2 posts with the removal of Hewitt-Johnson posts in 2013). Gaps in training programmes understandably put greater pressure on the remaining trainees in programme and this is reflected by poor Survey outcomes.	I have liaised with the SAC representatives for each of these 3 regions, all of whom have already had discussions with their respective local HEE region. Equally all have been asked to put together an action plan to address the red flags in the survey.
	Palliative Medicine	National	TPD feedback suggests there is a variation around the country as to whether or not LATs can be appointed.	

Private providers service delivery and the impact on training **Fragmentation in the commissioning process for Dermatology services at Nottingham Treatment Centre, coupled with loss of most of the Consultant Dermatologists due to TUPE has resulted in serious disruption and loss of training opportunities**	**Dermatology**	Nottingham	External Assessors report Letter from the Dermatology Registrars to the British Association of Dermatology and the SAC	Since the external report there have been even more substantive consultants who have left Nottingham. The current training programme, director, who has just been appointed to a post in Liverpool, has met with Head of The School of Medicine, Jonathan Corne on a couple of occasions including recently with the trainees. The existing training programme for East Midlands North, has been re-configured to accommodate the needs of the three trainees who are still in programme. There is one rotation predominately involving Derby, one Kings Mill and another at Nottingham Treatment Centre. Nottingham University Teaching Hospitals has effectively lost its Adult Dermatology Department but for the present is still able to provide training in paediatric dermatology. The loss of Consultant Dermatologists from Nottingham is such that specialist Dermatology on call will effectively be lost from February 2015. The solution currently on offer is for training for the region now to be co-ordinated from East Midlands South planning to engage all

				Dermatology Consultants from both the North and South to provide the necessary on call cover and deliver the training programme, mapped to the current curriculum. The overall training capacity may be reduced but it will be better than the current situation which has effectively frozen recruitment in the spring 2015 recruitment round.
Commissioning of sexual health services on Genitourinary Medicine training	**Genitourinary Medicine**	National	Feedback to SAC and GMC trainee survey Increasing numbers of sexual health services have been put out to tender, including several training centres. In East Midlands, there has been the requirement to have extended clinic hours in 2 hubs and several spokes meaning that consultants are less accessible during clinic hours to provide supervision and training. The case mix of clinics has often undergone a dramatic change. Managing complex GU	All sexual health services in England are to be commissioned by local authorities, tendered for separately and therefore will no longer fall within NHS governance mechanisms. HIV services are becoming the responsibility of a National Commissioning Board raising the potential for disintegration of HIV/GUM services, and hence all aspects of training and supervision. Even when Local Authorities have fully engaged with HEE to try to ensure that the commissioning of service includes education and training in the procurement process and is part of the provision of services, there can still be a significant impact on training because of the service changes. Splitting up services can result in a restriction in the range of clinical training opportunities available in any one site. Training to meet the curriculum

			cases has become a rarity so it becomes difficult for SpRs to achieve the required WPBA for consideration at ARCP. In one location this led to a trainee receiving a non-standard outcome and remedial training which required them to transfer to another teaching site for targeted training to achieve these competencies. Additionally trainees for some centres have identified that under the new commissioning specification they are required to refer all chronic cases to the GP with loss of further training opportunities to manage these cases.	requirements has often evolved in centres where there were multiple training opportunities across specific services and trainees were easily able to access different opportunities. Splitting services makes this difficult and it is therefore much more challenging for TPDs to ensure curriculum coverage.

Externality	**Cardiology, Core Medical Training**			
Education and training at Milton Keynes Hospital	**Cardiology**	Milton Keynes	Survey data, ARCP externality feedback and local intelligence	Local LEP reviews have so far been ineffective. **SAC externality has been offered to the Thames Valley.** A LEP visit is taking place in April 2015 and the SAC have been invited to provide externality.
ARCP outcomes being awarded without sufficient ePortfolio evidence to substantiate them	**Core Medical Training**	London	Of the 30 eportfolios reviewed 14 were satisfactory and fulfilled the curriculum requirements for their stage of training. Thus the award of an "outcome 1" or "outcome 6" was appropriate in 47%. Thus, of trainees who had been given a successful outcome at their ARCP, 53% appeared to fail to comply with the curriculum requirements. Of the 16 CT1s, 7 were non-compliant with the decision-aid	An action plan was requested and the following is taking place: 1. Central sampling of both CT1 & CT2 ARCP outcomes across all LEPs to take place by senior school leads within 2 weeks of local ARCP panels. 2. Feedback to local TPDs, Sector Leads and Lead Providers identifying areas for immediate improvement. 3. HoS and Deputy HoS to sign-off LP action plans to address local anomalies. 4. Central ARCP panels continue to see all trainees identified as potentially requiring an unsatisfactory outcome.

			requirements. 6 of these were due to lack of achievement of the required number of competencies. In 2, there appeared to be a lack of audit/QIP project. Of the 14 CT2s, 9 were non-compliant with the decision-aid requirements. All had lack of evidence for achievement of essential procedural competencies and educational supervisors or TPDs had signed these trainees off as competent when there was a lack of DOPs evidence to demonstrate independence. In one instance, it appeared that the TPD had signed off two procedural competencies, for one trainee at her ARCP, when the only evidence presented was that the trainee herself did not feel she had sufficient experience. In addition, 2 trainees did not	

			appear to have undertaken audit/QIP, and 2 lacked completion of curriculum competency sign-off.	
Concerns regarding the quality of advice given by one ES and by the quality of reports from Bath.		Severn	The panel reviewed a trainee's portfolio and felt that the decision by the educational supervisor was incorrect (A satisfactory outcome had been recommended). Although the trainee had been informed of the preliminary decision the panel issued a further ARCP and arranged for the trainee to be informed. This was less of an issue with CT1 however there was concern about CT2 postholders as this would affect their potential receipt of completion of programme. The gaps were clearly documented and it was agreed that the trainee would be able to provide additional evidence (WBPA or ES report),	All of the affected trainees have been contacted individually and supported to provide the evidence required and all have done or are doing this, so that appropriate and fair ARCP outcomes can be assigned. No trainee has been disadvantaged by this failure. The CMT TPD has written a report on this matter and actions arising which has been circulated to Dr Stirling Pugh, CMT Associate Postgraduate Dean, Jon Francis our Quality Associate Postgraduate Dean, and to Prof Martyn Beaman.

			which the RPD could approve and take chairman's action in signing off. As a consequence all trainees under the ES were reviewed.	
Concerns regarding the delivery of Educational Supervision requirements, quality of ES reports and delivery of the Immunology curriculum at the Royal Free Hospital	**Immunology**	London	The External Advisor had serious concerns regarding the delivery of the core requirements of an ES (including weekly supervisions, implementation of ARCP-directed trainee timetable, accurate educational supervisor report utilising clinical supervisor input from the MCR). Concern was also expressed on the award of an ARCP outcome 1 despite a lack of evidence of lab training manual and record, completion of MSF and Patient Survey	One of the two trainees received an ARCP outcome 3; as 5 out of 6 objectives stipulated at the 2013 ARCP were not met and training time was extended for a further 3 months until 31/07/16. The other trainee received an ARCP outcome 5 and had a further PYA and ARCP on 15/02/15 where all evidence was presented and an ARCP outcome 1 was awarded.

Delivery of Curricula				
Core training in ACHD	**Cardiology**	National	Surveys and trainee feedback	Curriculum changes have been submitted to the GMC introducing dedicated weeks of intensive experience during core training. The effect will be monitored.
Echocardiography training	**Cardiology**	National	Surveys and specialty intelligence	Continuing to work with STCs and LEPs to prioritise ECHO training. All Deanery/LETBS now have an ECHO lead. SAC working with British Society of Echocardiography to improve WPBA options.
Simulation training	**Cardiology**	National	Surveys and trainee feedback	The SAC has a lead to co-ordinate this. All STCs now have a simulation lead. Many have started structured programmes bur UK-wide access needs to be improved.
Training at and exposure to Heart Team / MDTs	**Cardiology**	National	Surveys indicate that many trainees are only attending occasional MDTs	STC Chairs, LEPs and trainees have been reminded of the importance of MDT attendance.
Poor training in basic programming of simple pacing devices	**Cardiology**	National	Surveys and specialty intelligence	A specific question has been added to the 2015 SSQs. Pacing WPBAs have been changed to reflect programming as well as implanting skills.
Poor access to PCI training	**Cardiology**	Milton Keynes & Thames Valley	Survey data and local intelligence. International Fellows not contributing to service	A LEP visit is taking place in April 2015 and the SAC have been invited to provide externality.

Endoscopy training	**Gastroenterology**	National	Re-audit of national database of endoscopic procedures undertaken by trainees	The results of re-audit suggest there has been little change since 2012. Numbers of procedures performed remain below target levels and are only just compatible with achieving endoscopic competence.
Restructuring of haematopathology services on laboratory based training	**Haematology**	National	Poor pass rates still in FRCPath part 2 examinations which reflects inadequate experience in laboratory training	Service changes are still in progress. Trainee surveys re lab training are planned. Need to review impact and ensure curriculum delivery of lab competencies.
Trainees being trained to level 1 ultrasound competence	**Respiratory Medicine**	National	TPD reports and specialty specific questions. SSQ data shows that overall 50% of trainees have completed Level I training. Of those who had not achieved competence to date, 63% had met the required number of US examinations but had not been signed off. There was a moderately high satisfaction with training rate with 60% rating training as good/very good and 16.8% rating training as poor.	The SAC members have been asked to review arrangements for sign off of level 1 competence within their LETBs and to keep a register of those who are able to sign off trainees. The GMC specialty specific questions will be used for the next 2 years to assess the trend.

Training in integrated care, experience in pulmonary hypertension, lung transplantation and cystic fibrosis	**Respiratory Medicine**	National	SAC have updated the curriculum to specify the minimum requirements to ensure all trainees meet at least the minimum standards. The SAC will monitor progress via SAC meetings and TPD reports.	The curriculum requirements have been made and the SAC will continue to monitor the progress via the SAC meetings and TPD reports.
Training in Basic Pulmonary Function testing	**Respiratory Medicine**	National	GMC SSQ showed 47% rated training as good/very good but 24% rated training as poor with 33% having no training.	TPDs have been written to and asked to provide formal training in supervised PFT interpretation. Further monitoring will take place through GMC questionnaire over next 2 years to identify improvement.
Training in Cardio-Pulmonary Exercise Testing (CPET)	**Respiratory Medicine**	National	GMC SSQ showed 65% of trainees had no formal training	TPDs have been written to and asked to provide formal training. Further monitoring will take place through GMC questionnaire over next 2 years to identify improvement.
Induction of trainees	**Clinical Genetics**	East Midlands, Northern, West of Scotland	A common concern was identified in several deaneries with regards to the induction programme that trainees were experiencing.	The SAC Chair has: 1. Tasked our trainee representatives to obtain feedback from other trainees on their experience of induction in each region to establish the national picture. 2. Requested information on procedure and process from deaneries which had green flags for their induction in the survey (Oxford and West Midlands deaneries).

	Geriatric Medicine	Northern	Induction concerns were raised in the 2014 National Trainee Survey.	3. Drafted an induction proforma which includes the key elements for a 4 week induction. Our SAC will modify this in the light of the feedback above and then incorporate it into our programme delivery guidance. It will provide a template for individual units to follow for their induction programme to ensure a high quality and standardised introduction for trainees to our specialty. The STC is currently investigating induction concerns to identify what the specific problems are. Local survey of trainees planned Jan/Feb 2015 to further look at this.
Funding of Educational Initiatives	**Palliative Medicine**	London and KSS	Process for applying for funding for the four London LETBs and the KSS now requires multiple applications at different times. There is no co-ordination and this has resulted in unsatisfactory and piecemeal funding of a number of educational initiatives.	The London TPD is trying to progress this with the local LETBs.
National Trainee Survey results **The survey data is unable to be obtained where the**	**Cardiology**	National	In spite of significant effort to get almost 100% completion of the NTS, LEP based data for specialties is poor	STCs are being reminded to look at additional sources of data to seek out evidence on smaller LEPs.

number of trainees completing the survey is 3 or less			where the number of trainees is 3 or less. The 'aggregated' data covering 3 years of trainees in the LEP is not useful.	
	Immunology	National	The survey is not ideally suited to a small specialty such as Immunology: 1) Training programmes with few trainees do not appear: In centres with 3-4 trainees, single trainee's views skew the data. 2) Immunology replaces regional training with national training days. Thus 'Regional Teaching' can receive low scores on the national survey (East Midlands, London and East of England).	The SAC is supplementing the GMC Survey with other sources of trainee data. Trainees will carry out their own survey, focusing particularly on the national training days. The SAC is considering using other validated feedback resources such as the JEST tool.
Trainee survey data is currently not available to the Infectious Diseases SAC for joint ID/Medical Microbiology trainees	**Infectious Diseases**	National	GMC survey data is not available to the SAC as joint ID/microbiology trainees are not being coded to our specialty	The SAC will need the GMC's help in providing GMC survey data for ID/Medical Microbiology trainees training under specialty code 075.
Red flag for Educational Supervision	**Immunology**	East Midlands	Believed to be a consequence of granularity by both	The SAC are to ask all TPDs to ensure all current Educational Supervisors have completed deanery

			Educational Supervisor and Training Programme Director	/RCP ES training in line with educational appraisal requirements.
Red flag for Local Teaching	**Immunology**	East of England	The GMC survey shows a red flag for Local Teaching. Believed by ES to be a consequence of a single trainee not recognising teaching content in local seminars (University and Trust), grand round, or formal MSc course. No problems highlighted by EA at ARCP or HoS report.	1) ES to clarify locally available teaching opportunities and how these may map to curriculum items. 2) ES to ensure trainees complete WBPAs and reflective learning to document experiences and competencies when participating in local teaching events.
Handover in Genitourinary Medicine	**Genitourinary Medicine**	National	Most GUM trainees do not take part in regular out of hours work and it is felt that there are a number of red flags for handover reflecting the trainees answering a question which does not apply to them.	Greater clarity in future National Trainee Surveys would be helpful. The West Midlands have had a third red for 'handover'. The trainee rep has emailed all the trainees in the region to identify any issues and none specifically came up. The TPD and SAC suspect that this is the same problem identified previously in that the ward and clinic at UHB are at different sites therefore handover is done over the phone and not in person (our understanding is that this automatically results in a red flag). Due to the logistics of trainees working at different sites,

				unfortunately not a lot that can be done about it, however it is felt by trainees and supervisors that effective handover does take place.
	Paediatric Cardiology	Severn	Red flags in 8/12 domains (clinical supervision, induction, workload, educational supervision, access to educational resources, feedback, local and regional teaching) with pink flags in a further 2 domains (overall satisfaction and adequate experience).	1. Change in training programme directorship 2. Engagement and financial support from local management team to address the majority of the outliers 3. Compiling a comprehensive induction booklet for paediatric cardiology 4. Introducing a compulsory induction day in paediatric cardiology for new trainees which included orientation to cardiac ward, operating theatre, cath lab, training in basic echo skills and use of cardiac database. The induction requires sign off by Trust and TPD 5. Dissociation between TPD and educational supervisor with the TPD taking on a strategic and visionary role, thus avoiding conflict of interest. 6. Alternate monthly meetings between trainees and trainees with TPD in order to discuss training issues. TPD to discuss matters arising with the rest of consultant body. 7. One trainee attends consultants' meeting every other month to feed back any concerns from trainees 8. Setting up local teaching programme with internal and external

				lecturers. Focused echo teaching 9. New hybrid rota introduced in March 2014 to ensure compliance with EWTD Quality panel review was organized in January 2014 which was attended by the trainees, SAC chair, external QP representative and consultants. The trainees were asked to provide individual feedback reports which demonstrated improvement in clinical and educational supervision, local teaching but that there were concerns about EWTD compliance, ease of organizing WPBA and departmental induction.
Postgraduate examination pass rates	**Haematology**	National	FRCPath exam pass rates still poor in morphology. The pass rates for the summative exam are still low Nationally – Autumn 2014 – 43%. Due to inadequate experience in laboratory training And variability nationally as service changes are still in process.	The RCPath examination committee is currently reviewing the exam and structure.

Training **SPAs in job plans**	**Clinical Neurophysiology**	Scotland	There is concern in Scotland that new job plans have 1 SPA in total. This would be detrimental as no time has been allocated to the delivery of training.	There have been specialty submissions to the Scottish government through the annual Scottish Medical And Scientific Advisory committee (SMASAC) reports highlighting these issues. There has recently been a letter from the Scottish Executive in response saying that the Scottish Government are happy for Health Boards to appoint consultants on contracts which the Boards feel are appropriate for the service needs i.e no imposition from Government for 9:1 contracts. However the reality is that all new consultants in Clinical Neurophysiology in the biggest Scottish Health Board (Greater Glasgow and Clyde) and the only one currently training for Clinical Neurophysiology in Scotland continues to employ consultants on 9:1 contracts**.**

2. Quality improvement and areas of good practice

Specialty: Acute Internal Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
The recognition of specialty skills within the AIM curriculum has been streamlined and we have now been able to accept new qualifications for trainees to undertake.
How did you identify and develop actions that were taken?
Increased awareness of trainees to pursue possible specialty skills and presentation of each new qualification by the TPD or relevant expert to the SAC for consensus approval.
What evidence do you have regarding the outcomes?
List of new qualifications that are now recognised by the SAC
How could this be used by others?
In adopting new areas that may be relevant to training other specialties could review mechanisms by which acceptable qualifications are identified

Specialty: Allergy
Describe any programmes or initiatives you have implemented to improve the quality of training
The use of a Knowledge based assessment as a formative component of training, as it is not possible to implement a national exit exam, with the required question and validation base in such a small speciality.
How did you identify and develop actions that were taken?
More questions have been sought from members, immunologists and the trainees themselves, and active discussions with the trainees concerning the practicalities of using this as an aid to training are on-going.
What evidence do you have regarding the outcomes?
Uptake of the opportunity for this assessment remains very low, but the trainees and trainers are in active discussion and the allergy training community has renewed its support for this approach in discussions with the college.
How could this be used by others?

Specialty: Cardiology
Describe any programmes or initiatives you have implemented to improve the quality of training
Provision of externality to assist the Peninsula Deanery with red outliers in the GMC survey
How did you identify and develop actions that were taken?
Peninsula Deanery invited SAC externality to assist in improving training in Derriford Hospital following repeated multiple red flags. The Severn Programme had a triple red flag and invited the SAC to provide externality to a full programme review.
What evidence do you have regarding the outcomes?
Derriford Hospital now has green flags. Many suggestions for improvement have been made for Bristol and surrounding centres but the outcome is awaited.
How could this be used by others?
This is an example where involving SAC/JRCPTB externality in Deanery/LETB led reviews can positively improve training programmes with benefits to trainees and patients.

Specialty: Clinical Genetics
Describe any programmes or initiatives you have implemented to improve the quality of training
The introduction of a National Educational Portfolio which is in progress
How did you identify and develop actions that were taken?
This has been entirely developed by the trainees. The idea stemmed from our supra-regional ARCP panels which comprise TPDs and educational supervisors from several training centres coming together on the same day twice a year. As part of the process at the Northern ARCP panel grouping, a training morning has been included. Following this, the trainees were keen to know what the neighbouring training regions had covered on their equivalent training programmes and established access to them. This gave rise to a network of supra-regional training programmes and is now leading to a National Portfolio.
What evidence do you have regarding the outcomes?
The ability to access teaching at a supra-regional programme was well received and the trainees felt that this could be extended to a National Education.
How could this be used by others?
This would be a useful model for any small specialty, where providing a comprehensive teaching programme in each centre is difficult. An additional bonus is that the trainees themselves maintain the portfolio which is useful experience and enhances their professional network.

Specialty: Clinical Genetics
Describe any programmes or initiatives you have implemented to improve the quality of training
The Fundamentals of Clinical Genomics Course
How did you identify and develop actions that were taken?
This course has been running every two years since 2008 and is endorsed by the Clinical Genetics Society and our Specialist Advisory Committee at the Royal College of Physicians, London. It has been instigated and run by Dr Helen Firth and hosted at the Wellcome Sanger Centre in Cambridge and has a distinguished Faculty of scientific staff at the Sanger, practising clinicians and academics in Clinical Genetics. The course is open to specialty trainees in Clinical Genetics in the UK. It was developed in recognition of the need for clinicians to keep abreast of fundamental scientific advances in human genetics and genomics that underpin clinical practice, focusing on the latest scientific, technological and bioinformatics developments in this fast-moving area.
What evidence do you have regarding the outcomes?
The course has received very good feedback and is over subscribed. It is regarded as a key course to attend for trainees attempting the specialty exam.
How could this be used by others?
The course has been extended to include consultants who wish to ensure they are up to date with advances in the field.

Specialty: Clinical Genetics
Describe any programmes or initiatives you have implemented to improve the quality of training
The Cardiff Specialty Certificate Exam Revision Course
How did you identify and develop actions that were taken?
The course was set up by a practising Clinical Geneticist when the specialty exam was introduced. As part of her Masters in Medical Education, she looked at trainees educational needs in relation to the exam and established that they required an exam-specific course.
What evidence do you have regarding the outcomes?
The course had excellent feedback in the 2 years that it ran. It has now become a 2 day course and is fully subscribed.
How could this be used by others?
It is possible that in the future trainees from other specialties who need genetic skills could attend this course.

Specialty: Core Medical Training
Describe any programmes or initiatives you have implemented to improve the quality of training
The Learning to Make a Difference project
How did you identify and develop actions that were taken?
The Learning to Make a Difference project is now replacing the need for trainees to undertake an audit and is embedded with appropriate forms in the JRCPTB e-portfolio for Core Medical Trainees.
What evidence do you have regarding the outcomes?
How could this be used by others?
Dr Emma Vaux the chair of the CMT SAC is now Chairing the Academy of Royal Colleges Working Party on this to disseminate the practice to other Royal Colleges.

Specialty: Core Medical Training
Describe any programmes or initiatives you have implemented to improve the quality of training
Core Medical Training Quality Criteria
How did you identify and develop actions that were taken?
A 2013 JRCPTB survey of CMT trainees found that heavy service demands were leading to a loss of training opportunities and a wide variability in the quality of supervision. Some trainees were even put off pursuing a career in the acute medical specialties by their experiences in CMT. In response to this, consultation involving clinical educators, doctors in training and other key stakeholders took place with criteria developed and published in January 2015 covering the structure of the programme, its delivery and flexibility, what supervision and other levels of support is available to trainees and the standards of communications that should be met.
What evidence do you have regarding the outcomes?
There is evidence from TPDs that many of the criteria have been implemented in various locations across the UK. Programme specific questions based on the criteria have been developed and included in the 2015 GMC National Trainee Survey and will also be included in the JRCPTB's survey of Core Medical Trainees in late 2015.
How could this be used by others?
Other specialties could look to develop a set of quality criteria based on their training programmes

Specialty: Gastroenterology
Describe any programmes or initiatives you have implemented to improve the quality of training
The implementation of national nutrition modules
How did you identify and develop actions that were taken?
The modules were developed to allow the completion of sub specialty training in nutrition
What evidence do you have regarding the outcomes?
There are four posts now in place
How could this be used by others?
Small sub-specialty modules can be run on a national basis

Specialty: Gastroenterology
Describe any programmes or initiatives you have implemented to improve the quality of training
National recruitment process for Hepatology
How did you identify and develop actions that were taken?
Due to low fill rates in less popular posts and trainees waiting for popular ones some hepatology posts had never been filled. It was agreed that a national process may be able to address this issue.
What evidence do you have regarding the outcomes?
For the first time all Hepatology posts nationally have been filled due to a co-ordinated national recruitment process
How could this be used by others?
The benefits of a national recruitment process to better fill posts, particularly where some of these have been unpopular in the past

Specialty: Geriatric Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
Development of a curriculum induction session at regional training day early in ST3 year in Severn
How did you identify and develop actions that were taken?
It became apparent that some of the new registrars were unfamiliar with curriculum requirements and how best to source subspecialty training.
What evidence do you have regarding the outcomes?
Formal feedback from the training day has been very positive. ST3 ARCP outcomes in Severn to be monitored in 2015 to look for improvement.
How could this be used by others?
The Severn model of good practice are transferable to other programmes

Specialty: Geriatric Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
Introduction of a research mentor (a local academic consultant) and research methodology training as a regular feature of Severn STR training days
How did you identify and develop actions that were taken?
Low numbers of geriatric registrars were completing formal research projects in Severn and this was noted at ARCP.
What evidence do you have regarding the outcomes?
Monitoring of research activity via Severn ARCP process
How could this be used by others?
The model of good practice is transferable to other programmes

Specialty: Haematology
Describe any programmes or initiatives you have implemented to improve the quality of training
The development of a virtual learning environment for morphology training in London
How did you identify and develop actions that were taken?
Development over 3 years of an e-learning platform mapped to the curriculum for basic morphology teaching in haematology and histopathology
What evidence do you have regarding the outcomes?
Presentations and abstracts – showing excellent feedback from trainees for self-directed learning, small group teaching and large group teaching
How could this be used by others?
The platform should be available at all haematology trainees and funding to be secured to enable this to occur.

Specialty: Medical Oncology
Describe any programmes or initiatives you have implemented to improve the quality of training
The first annual joint trainee conference for Medical Oncology, Clinical Oncology and Palliative Medicine trainees was held in London on 15th October 2014.The event itself was organised, promoted and run by 5 StRs from the combined specialties under the supervision of Dr Karen Le Ball (Head of School, KSS Shared Services) and Dr Gill Sadler (Head of Clinical Oncology KSS Shared Services). The conference title ‘Survival’ was chosen to reflect the emerging themes of the programme: cancer survival and getting the most from postgraduate education. The event included seminars, workshops and a poster session.
How did you identify and develop actions that were taken?

There was a perceived gap in educational opportunities to improve joint working, collaboration, learning and networking in affiliated specialties: Medical Oncology, Clinical Oncology and Palliative Medicine.
What evidence do you have regarding the outcomes?
The conference was attended by 144 trainees from CMT and higher specialty training from the three disciplines. In view of the success of the inaugural event there are already plans to run the conference next year. Approximately one third of the Medical Oncology trainees attended and they all reported finding it useful. The most useful sections were the small group workshops, some of which were oversubscribed. It was also considered to be a great opportunity to meet people from allied specialties as a networking and support initiative. In addition with the involvement of CMT trainees, this was an opportunity for them to ask questions regarding the individual specialities.
How could this be used by others?
The format of the day can be used for other specialties where there is cross-over in terms of the disciplines and management of patients.

Specialty: Medical Oncology
Describe any programmes or initiatives you have implemented to improve the quality of training
A study day under the auspices of the Association of Cancer Physicians (ACP) was held on 17th October 2014 in Manchester immediately prior to the annual Medical Oncology Trainees weekend. The programme was organised by Professor Peter Selby (President of the ACP) and Dr Janine Mansi (Honorary Secretary of the ACP) in conjunction with a steering group made up of the presenters at the study day. The programme included a wide variety of multidisciplinary talks and also case presentations to highlight issues commonly found in elderly patients with cancer. The cases were presented by four of the trainees in conjunction with an oncologist, care of the elderly physician and general practitioner.
How did you identify and develop actions that were taken?
The incidence of elderly patients with cancer continues to increase and forms a significant proportion of new diagnoses. The cancer mortality rates for older people in the UK are improving at a slower rate than in younger patients, and patients face inequalities in terms of experience of care, their assessment and management. A survey instigated by the Care of the Elderly in conjunction with Medical Oncology identified that training in decision-making in elderly patients with cancer was an issue for trainees in Medical Oncology.
What evidence do you have regarding the outcomes?
The meeting was formally evaluated by 38 of the 130 attendees. All respondents found the meeting extremely useful (61%) or useful (39%) with an excellent programme (61%). Many considered the meeting was thought-provoking in terms of how we train our trainees and how we organise our services for an increasingly older population with cancer. All the attendees who completed their CPD evaluation rated it as an excellent event.
How could this be used by others?

The format of the day was truly multidisciplinary and can be used as a template for other educational meetings. The organisers are now in the process of writing a book called 'Problem-solving for Elderly Cancer Patients'. This will involve a number of trainees throughout the country, which will form part of the educational roll-out process.

Specialty: Nuclear Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
The 2010 nuclear medicine training curriculum did not optimally equip nuclear medicine trainees with the structural imaging skills they require to interpret hybrid imaging studies such as SPECT/CT and PET/CT, there was no way in which radiology experience obtained by our trainees in the course of nuclear medicine training could be recognised and some consultant posts requiring nuclear medicine experience were being advertised for FRCR candidates only.
How did you identify and develop actions that were taken?
A revised curriculum for nuclear medicine was written by members of the SAC nuclear medicine and approved by the GMC 13 August 2014. This incorporates core radiology training and a requirement to complete FRCR within an extended (6-year long) training programme. Core Radiology training will be provided to nuclear medicine trainees using already approved radiology training programmes/training locations. The revised curriculum will better equip nuclear medicine trainees of the future with the skills required to confidently interpret hybrid imaging studies, review and interpret diagnostic imaging studies such as CT and MRI in patients undergoing radionuclide studies, and present and discuss a broad range of imaging studies within multidisciplinary meetings. The implementation date for the revised curriculum is August 2015.
What evidence do you have regarding the outcomes?
The revised specialty curriculum is yet to be implemented so evidence regarding outcomes is not yet available. Arrangements to provide core radiology training to existing nuclear medicine training programmes have progressed sufficiently to enable 9 posts nationally to be entered into the ongoing recruitment round. This round of national recruitment, performed jointly with The Royal College of Radiologists for the first time, yielded more applicants than previous recent recruitment rounds suggesting the specialty may be perceived as more attractive by potential applicants since curriculum revision. Transition arrangements for all existing trainees are in hand and it has been possible to offer all current trainees (not just those mandated to transition to the revised curriculum) the opportunity to move to the new curriculum.
How could this be used by others?
This piece of work is not really transferable to other specialties save that collaboration and co-operation with another Royal College has been key to progressing curriculum revision and subsequent national curriculum implementation.

Specialty: Palliative Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
Training in Palliative and end-of-life care. Guidance for trainees (and their trainers) in non-palliative medicine training posts August 2014 (revised 17.11.14)
How did you identify and develop actions that were taken?
Palliative Medicine was receiving requests from several other specialties that have palliative care in their curricula about the kind of training needed to deliver their palliative and end-of-life competencies. Dr Fiona Hicks, Palliative Medicine Consultant, developed the guidance on how the required competences can be gained at training programme level in response to these requests.
What evidence do you have regarding the outcomes?
Feedback has so far been positive and well received and continues to be monitored by the JRCPTB. The guidance has been disseminated widely by the JRCPTB as an example of good practice.
How could this be used by others?
The guidance provides trainees and trainers in specialties commonly managing illness in patients who may be in the last phase of their lives with a list of the key competences expected and provides guidance on how the required competences can be gained at training programme level.

Specialty: Renal Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
Monthly trainee communication meetings in all 3 main training sites with quarterly discussion at local consultant and STSC level of trainee performance and any issues particularly of trainees in difficulty. This allows any specific training issues to be identified early so that steps can be put in place to address and resolve the issue.
How did you identify and develop actions that were taken?
Limited ability to react quickly to individuals' training needs in a large regional training programme involving several different hospitals. Identified at ARCP by TPD and actioned by Northwest Deanery.
What evidence do you have regarding the outcomes?
A high level of satisfaction from trainees in their local annual report.
How could this be used by others?
Adoption of similar meetings when several LEPs involved.

Specialty: Renal Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
The introduction of bimonthly study days with a three year cycle of “themed days” so that all aspects of the Renal curriculum are covered and any trainee who misses one day through on-call, annual leave etc can attend the same topic another time within their training period. All Trusts have embraced it and it has received universally good feedback from trainees.
How did you identify and develop actions that were taken?
Relatively infrequent study days and lack of predictable time based repetition of curriculum topics meant that individual trainees could miss significant topics when attending 75-80% of study days. Identified by TPD Southwest and Peninsula.
What evidence do you have regarding the outcomes?
Report from TPD Southwest.
How could this be used by others?
Adoption of this in a similar format for other specialties.

Specialty: Sport and Exercise Medicine
Describe any programmes or initiatives you have implemented to improve the quality of training
Sports and Exercise Medicine National Teaching Days
How did you identify and develop actions that were taken?
Sport and Exercise Medicine specialty trainees are widespread in geographical location across the country and can be isolated with reduced access to didactic teaching. To manage this issue, a national teaching programme has been developed. This has been organised to comprise 4 teaching days per year. Each teaching day is hosted by a different Deanery/LETB, who each have the responsibility for organising the educational programme for the respective day. All SEM trainees are asked to attend a minimum of 3 out of 4 teaching days per year. The teaching days provide education based on specialty training curriculum competencies and facilitate peer networking.
What evidence do you have regarding the outcomes?
Registers are taken to document attendance at teaching days and fed back to the Specialist Advisory Committee.
How could this be used by others?
Similar national programmes of teaching can be used by other specialties, particularly those with a smaller number of trainees spread amongst multiple geographical locations across the country.

3. Please provide an update for actions in curricula approval decision letters from August 2013 to September 2014.

Description of request	Update
Infectious Diseases and Tropical Medicine: delivery of management of patients requiring palliative and end of life care	A number of specialties requested support in organising training to deliver the competencies for management of patients requiring palliative and end of life care. In response, the Palliative Medicine SAC produced guidance which was welcomed by the SACs, including ID/TM, and has been widely circulated and published on the JRCPTB website in August 2014. We plan to survey the SACs for feedback on how palliative and end of life care training is being delivered in light of the guidance later this year.
Neurology: Further detail of number of responses required for a patient survey and feedback on whether the number is achievable.	The minimum number of patient responses needed for a valid patient survey is 20. The Neurology SAC has confirmed that trainees undertake a minimum of 2.5 outpatient clinics per week throughout the training programme and are able to obtain a minimum of 20 respondents to complete the patient survey. The requirement for a patient survey has only affected a relatively small number of trainees to date as it is required in ST6 only. The JRCPTB and SAC will continue to monitor this mandatory requirement through the training programme directors in Neurology. The JRCPTB will review the use of the patient survey in light of recent discussions at the Academy Assessment Committee (AAC)

4. **Please provide an update on progress for moving doctors to the current curriculum**

Specialty	Update	Number of doctors on each curriculum (If known)
Cardiology Clinical Pharmacology & Therapeutics Endocrinology & Diabetes Gastroenterology Haematology Medical Oncology Neurology Respiratory Medicine	London – 2 to transfer London – 1 to transfer London – 2 to transfer London – 1 to transfer London – 10 to transfer London - 2 to transfer East of England – 1 to transfer London – 2 to transfer London - 5 to transfer East Midlands – 1 to transfer West of Scotland – 1 to transfer	
Infectious Diseases	New curricula are being implemented from August 2015 (under 2015 Infectious Diseases curriculum) and it has been agreed that there would be a 2 year period in which to transfer to the new curriculum.	The SAC are in the process of identifying which trainees will need to transfer to the new 2015 curriculum.
Nuclear Medicine	New curricula are being implemented from August 2015 under 2010(2014) and it has been agreed that there would be a 2 year period in which to transfer to the new curriculum.	4 trainees are expected to need to transfer and they have been contacted and advised accordingly.

Small Specialty Review – Progress Update ***(Only complete if pre-populated by GMC with items requiring an update)***

5. Please provide a progress update on outstanding actions from any Small Specialty Reviews

Report ref	Description	Further action planned	Timeline for action	Progress update
Requirement 2.	Postgraduate deaneries must provide trainees with comprehensive information about allocation to special interest areas. Selection into the special interest areas must be more open and explicit so that all trainees have an equal chance in competing for a particular area.	SAC to map SIAs and feed into workforce planning. Guidance to be sought from cardiology SAC on their approach to SIAs.	**End 2015**	All trainees have been given advice from SAC chair. SIA opportunities are now explicit at time of recruitment. SIAs to be chosen at ST5 ARCP and open competition will take place if more than one trainee applies.
Recommendation 2.	The JRCPTB, the SAC and the deaneries should work together to reconcile and ensure their data on the number of trainees within	JRCPTB to continue data exercise: The JRCPTB briefed us on improvements since the visit, and how there is now an agreement with the deaneries to provide quarterly data sets of	Ongoing	Quarterly Deanery data sets are being received from the following deaneries: • East Midlands • London • Mersey • Northern Ireland

	paediatric cardiology training programmes is accurate. This should include information on which special interest areas being followed by trainees to benefit workforce planning.	doctors in training in post, those who have resigned, ARCP data etc. The ePortfolio can also be used to flag up trainees not known to the JRCPTB.		• Severn • West Midlands • Wessex • Yorkshire and Humber Annual data is received from Scotland and the Northern Deanery is being actively encouraged to submit quarterly data returns but has not yet submitted any. An ePortfolio mapping exercise was also undertaken to identify any Paediatric Cardiology trainees who have a post on Eportfolio but were not known on the JRCPTB's trainee database. No Paediatric Cardiology trainees were identified.
Recommendation 3.	Postgraduate deaneries should consider routine and scheduled visits to quality manage training in	SAC to look at suggested methods of gathering feedback. There was discussion over how ARCP or SAC training	Ongoing	Formal feedback is received by the SAC from training days. Externality will include both the ARCP and

	paediatric cardiology.	days might enable SAC members to talk to doctors in training face to face to gain quality feedback on training. It was also suggested that SAC trainees reps attending training days might be used to collect information on the quality of programmes in other deaneries. It was suggested that trainee reps be used to gather feedback from doctors in training on these days and report back.		PYA processes. The SAC chair is now meeting all trainees at the final training day of the year. All deaneries/LETBs with Paediatric Cardiology trainees are collecting feedback to formerly evaluate the quality of the training provided.
Recommendation 4.	The JRCPTB should establish and develop formal links with the Royal College of Paediatrics and Child Health to ensure continuity of training between core and specialty training and to promote interaction between		Ongoing	The link has been established and an RCPCH representative has been invited to join the Paediatric Cardiology SAC.

	paediatric cardiology trainees and paediatric trainees with an interest in cardiology.			
Recommendation 5.	National training days should be scheduled sufficiently in advance to enable trainees to arrange their attendance		Immediate	This is in place.
Recommendation 6.	The curriculum should be taught within the local training areas, and national training days should not be used for basic training but for amplification of knowledge already provided and the introduction of new approaches and methods	The SAC to ensure that prior to the approval of future programmes they ask what is the structure for delivering teaching, rather than in service teaching.	Immediate	The curriculum is being taught in local training areas.

Recommendation 8.	Externality in the ARCP process should be formalised to ensure that the process is as transparent and fair as practical.	JRCPTB to explore a formal rotation or regional approach (for ARCP in all specialties) once future focus of externality & the role of the College has been agreed. SAC to consider viewing the ePortfolio and checking education supervisor's report. Attendees acknowledged the challenges of securing externality for ARCP processes within a small specialty. The PYA, which has formalised externality, fulfils a similar function and covers all doctors in training in their final year. JRCPTB keen to do this with all specialties but propose waiting until the future of externality has been determined following the GMC quality review.	Ongoing	Agreed externality arrangements will be in place by April 2015. PYA panels were convened for 6 trainees in 2014 in the following deaneries: • London (3) • Wessex (1) • West Midlands (1) • Yorks & Humber (1)