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Dear Ian

2015 ASR REPORT

I have pleasure in enclosing the 2015 ASR report for the 29 specialties and 3 subspecialties for which JRCPTB is responsible. The report contains detailed analyses of concerns regarding training quality and delivery which have come to the attention of our SACs. The JRCPTB recognises a number of key themes through the data provided.

National issues across the medical specialties

1. **Pressure of acute medical service on specialty training experience**.
   The contribution of ST3+ to the acute on call GIM rota was again cited by a significant number of specialities as a key issue for quality of training in medical specialities and an impediment to acquiring specialist competencies. Rota gaps are reported as common on GIM on-call rotas and impact negatively on specialty training opportunities. The total GIM workload was reflected as increased and cited as a cause for reduced trainee satisfaction.

   Action: Since the 2014 report, additional specialties, not previously involved have agreed to provide limited support to the acute take. Some LETBs have also provided protection from GIM training and service delivery for periods of training which is highly valued by trainees and deemed to be best practice by SACs. An example of the practice in Endocrinology and Diabetes Mellitus in Thames Valley has been submitted as an example of best practice.

2. **Vacancies at ST3+ level**
   The existing attrition rate amongst CMT doctors, coupled with the unattractiveness of acute medicine, continues to be of concern and has, once again resulted in a failure to fill significant numbers of ST3 posts

across the medical specialities. This has subsequently had a detrimental effect on the educational experience of existing trainees, resulting in reduced specialty exposure, higher workloads and a reduction in specific experience such as acting up in final years. The withdrawal of LAT posts in England was cited as a major concern in Cardiology, Medical Oncology, Neurology and Palliative Medicine worsening cover for vacancies especially smaller specialities and those with an expectation of significant out of programme experience for research for trainees, such as Medical Oncology and Neurology.

Action: The JRCPTB reviews the medical specialty recruitment data, and will continue to work with SAC's, HEE, GMC and colleagues in the Medical Workforce Unit (Royal College of Physicians, London) to monitor this situation.

3. **Changes to the commissioning of services**
   Seven specialties (up from two in 2014) cited concerns relating to changes in commissioning of services from new providers. This was felt to have a potential and current impact on the trainee experience. The effect in England and Wales on pathology services for Haematology, PET/CT services in Nuclear Medicine, and Dermatology and GUM training require active review.

   Action: The JRCPTB will monitor any further impacts for all seven specialities in 2016.

National specialty issues

1. Clinical Pharmacology and Therapeutic training in Cambridge: The SAC were part of the HEE East of England-led visit to investigate concerns in the training programme, interviewing trainees and trainers.

   Action: 13 requirements were made were made as part of the action plan following the visit together with a recommendation on making use of training opportunities made available by the London CPT programme.

2. Specific procedural competencies and experience – Cardiology and Paediatric Cardiology reported tensions in delivery of the specific aspects curriculum at a national level with trainees struggling to perform appropriate numbers of procedures and gain competence for independent practice before the end of training. In Core Medical Training, extensive use of Do Not Resuscitate Orders in London and the North West have impacted on CPR competency and chest aspiration and chest drain is increasingly being done in A & E which reduces CMT trainee exposure.

   Action: The JRCPTB will ask external assessors at PYA for specific feedback around the issue of competence/experience in procedural competencies in identified specialities.

We hope you find the themes we have reported on together with the further detail provided in our Annual Specialty Report useful as part of the GMC's Quality Assurance processes.

With kind regards,

Yours sincerely

Professor David Black
Medical Director

Annual specialty report (ASR) 2015

Purpose and use
The ASR provides the GMC with an overview of medical specialty education and training from the perspective of the Medical Royal Colleges or Faculties who represent the profession and have a key role in managing and improving the quality of specialty training for doctors.

The ASRs feed into the quality assurance processes and are reviewed in conjunction with annual reports provided by Dean's and Medical Schools as well as evidence from our visits, surveys and other sources. Concerns raised in the ASRs are used to inform our quality assurance activities including regional reviews, check visits, small specialty reviews and enhanced monitoring. Issues in the ASR may also inform education policy developments.

Submitting your report
The deadline for submission is **31 March 2016**. Please submit your completed ASR by uploading it into your GMC Connect ASR 2015 folder. If you do not have access to GMC Connect or you have any other questions please email quality@gmc-uk.org. If your response requires extra rows, right click on the grey bar on the left handside at the same level as the table and select 'Insert'.

Question changes for 2015
We have added questions about NTS Programme Specific Questions and progression data (exams, ARCP) in order to improve our understanding of the evidence at a programme or specialty level. We would also appreciate for you to identify where you can specific locations that your response regards. This will help us to triangulate our data sources and best respond to the item.

Requested updates
You may find that some of the tables (relating to curriculum updates and small specialty reviews) within your ASR have been pre-populated with information that you have previously raised with us. We would like an update on these points in your next ASR submission. You can also provide information on additional items as you feel necessary.

Serious concerns
If you become aware of a serious concern affecting patient safety such as doctors in training working beyond their competence or the educational environment such as undermining please report this to us as soon as possible and do not wait for your ASR submission. You can contact us on quality@gmc-uk.org.

Contact details

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1. Please detail any concerns relating to the quality of specialty education and training at a National, Deanery/LETB, Training Programme or LEP level where you don't consider improvement to be acceptable
We do not require you to report concerns which have been resolved or which you are working with the Deanery/LETB to resolve.

• **Themes:** Please identify the most relevant theme(s) to summarise the concern. You may wish to choose from one of the following themes we have identified from previous ASR submissions:

- o Training programme's coverage of the curricula
- o Inadequate training experience eg due to rota gaps
- o Educational supervision eg lack of time for training available
- o Resources to support for wider educational activity eg Exam centres & examiners
- o Assessments systems - exams / WPBAs
- o Clinical supervision
- o ePortfolio
- o Access to educational resources eg Study leave

• Specialty: Please note all affected specialties. If the issue affects all specialties managed by your college/faculty please state "College/faculty-wide".
• Location: Please provide sufficient location detail to help us target the concern, including the relevant Deanery/LETB, Training Programme Reference and LEP. If the concern relates to multiple locations please list all of them.
• Evidence: For us to investigate concerns please provide the source and an outline of the evidence supporting your concern.
• Action and outcome: Please describe what action you or another party such as the LETB, have taken or plan to take in order to address the concern and the outcomes if known.
• Suggested action: Please outline any action you suggest for your college/faculty or another body to take.

Description	Main theme	Secondary themes	Specialty	LETB/Deanery - or national / specialty wide	Evidence	Action taken and outcome, including college and LETB actions	Suggested action
Pressure on the Acute service and impacts on quality of training across medical specialties Training in some sites across the UK is being compromised by rota gaps	Inadequate training experience eg due to rota gaps	Workload	Acute Internal Medicine	National	Red flags for Workload in the NTS	Continued recruitment drive but also reviewing placement of trainees to ensure that the training opportunities are maximised	
Excessive GIM time and workload in LETB/Deaneries reducing Cardiology Training	Inadequate training experience eg due to rota gaps	Workload	Cardiology	National - outside London	Programme discussions and externality during requested reviews has continued to highlight this issue.		Support TPDs in protecting training. Advice over programme balance.
Workload of CPT trainees in Mersey	Inadequate training experience eg due to rota gaps	Workload	Clinical Pharmacology and Therapeutics	North West	Gaps are common on GIM on-call rotas nationally (with some particularly affected areas such as Mersey) meaning CPT trainees are pressurised to cover. This punishes those trainees who are actually on the rota.	This is a national issue, which has been identified by the LETB.	
Attempt to include Dermatology Trainees in general medical on call	Training		Dermatology	Yorkshire and the Humber	The SAC received information that Trusts in the Yorkshire and Humber region were attempting to include Dermatology Trainees in general medical on call which would impact negatively on specialist training and the ability to meet curricular requirements.	Dermatology will continue to support acute medicine in a specialty-specific manner and contribute to unselected acute medical on-call during ST3 year only for a maximum of 15 days.	
Trainees and trainers identify GIM workload as a cause for reduced satisfaction in training and an impediment to acquiring specialist competencies.	Inadequate training experience eg due to rota gaps	Inadequate training experience eg due to rota gaps	Endocrinology & Diabetes	National	Trainees and trainers identify GIM workload as a cause for reduced satisfaction in training and an impediment to acquiring specialist competencies. This may also be contributing to a reduced interest in the specialty for those looking into entering at the ST3 level. There may be other factors, but they have not been formally explored. The SAC is optimistic that the shape of training may shield E&D trainees from the impact of GIM and improve recruitment. There is also a national drive by the Society for Endocrinology and Association of British Clinical Diabetologists to reach out and inspire doctors to train in our specialty.	The SAC feels that there should be protection from the GIM component of training and service delivery for a period of training. Some LETBs offer this protection, and the SAC sees this as good practice.	
Reduction in time available for specialist training due to the ever increasing demands of GIM	Inadequate training experience eg due to GIM cover	Workload	Gastroenterology	National	1. Interrogation of National Database for endoscopy training (JETs) 2. Trainee survey 3. Verbal evidence given by PYA assessors at SAC meetings	All regions are trying to support their trainees to achieve protected time for endoscopy training/gastroenterology specific clinics. Local surveys of trainee experience are being carried out to identify sites which are providing less than optimal time for training in Gastroenterology. The Endoscopy accreditation body (JAG) are looking to specify a minimum number of colonoscopy procedures to be done in the 12 month period before sign off which will provide some degree of protection for endoscopy training if implemented.	
Continued concerns both from trainers and trainees over workloads, delivery of service and the impact on training and recruitment.	Inadequate training experience eg due to GIM cover	Workload	General (Internal) Medicine	National	Rota gaps in (G)IM continue to be reported in a number of deaneries especially in some more northerly deaneries where ST3 vacancies exist in dual programmes involving G(I)M.		
Guy's and St Thomas' NHS Foundation Trust started including GUM trainees on the acute medical rota from June 2015. This is additional to specialty specific on call for HIV that is required of the trainees.	Inadequate training experience eg due to GIM cover	Workload	Genito-Urinary Medicine	London	Maternity leave, OOPEs and a poor fill rate in R2 has resulted in trainees unable to fill the required number of slots on the acute medical rota. The TPD is in discussions with HR to withdraw GUM SpRs from this rota until all NTNs are recruited to and it can be adequately staffed. This experience may negatively impact on recruitment in R1 & R2 to the GSTT rotation during 2016. This will be fed back on following the outcome of National GUM recruitment in 2016.		
Impact of acute medicine on call workload & intensity on training noted in 2013 ASR. Concerns voiced by many LEPs and TPDs, also reflected in GMC survey	Inadequate training experience eg due to rota gaps	Workload	Geriatric Medicine	National	The GMC survey and feedback from TPDs along with programme-specific questions in the NTS show large proportion of time spent in acute medical takes. Our concerns are well documented in previous ASRs and continue into 2016. Geriatric trainees carry a disproportionate part of the burden of the acute GIM on call take, which thus markedly reduces Geriatric training time. EoE - Some of the trusts are heavily reliant on the geriatrics training to provide G(I)M cover, which impacts on the specialty training. When this is identified, we visit and bring in the School of Medicine for action.		Maximise recruitment opportunities to prevent rota gaps. The changes proposed in SHoT should be progressed.
Accessing Less Than Full Time Training and OOPR/E across the UK is being compromised by rota gaps	Inadequate training experience eg due to rota gaps		Haematology	National	Haematology is a predominantly female specialty (>64% trainees) with significant unpredictable gaps due to parental leave (often up to 1 year). A further significant proportion of trainees (10-12%) are in OOPR/E posts. These gaps are covered by LATs. Round 1 recruitment to LATs has been >97% in the past 3 years. The majority of haematology LATs obtains an NTN (81%). TPDs across the country report gaps in rotas to SAC. There are also poor fill rates for LAS and non-training posts.	The SACs concerns were highlighted to the JRCPTB who collated responses from all of the SACs and sent this to HEE.	
Inadequate training experience due to rota gaps resulting in imbalance of training and service provision	Inadequate training experience eg due to GIM cover	Workload	Renal Medicine	National	See analysis of GMC PSQs in section 4 below		
Failure to recruit to NTN posts. 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.	Inadequate training experience eg due to rota gaps		Respiratory Medicine	National	There has been a failure to recruit to all the available NTNs in both national recruitment rounds in 2015. The SAC is reviewing the impact of future loss of LAT appointments on trainees taking up unfilled NTNs. SAC to work with BTS to look at methods of improving recruitment into specialty. Failure to appoint to all available NTNs for the first time in national recruitment. The results of the GMC NTS on the impact of GIM on specialty training are still awaited.		
Impact of acute medicine on call workload & intensity on training	Inadequate training experience eg due to GIM cover	Workload	Rheumatology	Thames Valley but also National	Where local surveys have been undertaken they often identify GIM workload as an issue rather than specialty. This makes the differentiation raised in question 1 of paramount importance. An example of this was provided by TPD for HETV where there was one trust red flag for workload. This was highlighted in a local survey as well as GMC and was found to relate to an unreasonable expectation in number of clinics and ward cover the trainees can provide in a busy GIM post.	The issues have since been addressed and resolved with the relevant ES but demonstrate the importance of being able to define exactly where a problem lies in order to address it.	

CESR workload CESR workload for SAC members	Assessments systems - exams / WPBAs	CESR	Cardiology, General (Internal) Medicine, Geriatric Medicine, Palliative Medicine	National	There is GMC pressure to complete CESR assessments within very small timeframes. The number of applicants can vary enormously from month to month and there is difficulty in completing the assessments within the given timeframes due to the amount and complexity of paperwork required to be reviewed. 6 G(T)M applications have already been received in the first four weeks of 2016. At present, the GMC are bringing forward the dates some assessments need to be completed by, sometimes within 24 hours, thereby putting even more pressure on assessors.	The SACs have expanded the pool of available assessors, a checklist to aid the review of paperwork has been developed by the JRCPTB and the GMC have run training sessions for new assessors.	Reform of the current process is urgently needed. The GMC needs to provide more notice of applications to be submitted or more time to be allowed to complete assessments.
Educational Supervision Educational Supervision is sub-optimal and concern was 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.	Externality		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).	A "Conversation of Concern" into Immunology training at Royal Free Hospital has taken place. A new London TPD and a new STC Chair have been appointed. The SAC are liaising with the London Head of School of Pathology and the TPD regarding the actions agreed as a result of the concerns raised in the report following the "conversation of concern".	
Educational Supervision is sub-optimal	Educational Supervision		Sports and Exercise Medicine	National	The issue has been highlighted in regional specialty reports	There is increasing collaboration with adjacent deaneries to increase the pool of Educational Supervision and hence improve the level of direct supervision and formal teaching.	
Delivery of Curricula CPT training programme at Cambridge	Training programme's coverage of the curricula		Clinical Pharmacology and Therapeutics	East of England	Concerns raised in the NTS regarding the training programme coverage of the curriculum and bullying	The SAC is part of the HEE East of England-led remedial process. As part of the team, two SAC members visited to Cambridge to monitor progress over the last 6 months during which we interviewed all the current trainees and trainers. The local trust has put in place a robust plan to address our, and the trainees' concerns which we will monitor in future visits. It has been recommended in the action plan that Cambridge make use of training opportunities made available by the London CPT rotation (they have agreed with this).	Continue to review
CMR training (and service)	Training programme's coverage of the curricula		Cardiology	Wales	Currently training is poor.	An advanced module OOPT or E is available in England.	
Pericardiocentesis training	Training programme's coverage of the curricula		Cardiology	National		New simulation programmes are being embedded into training programmes but possible funding issues have been identified.	
ECHO training	Training programme's coverage of the curricula		Cardiology	National	Survey results suggest ECHO training is still sub-optimal	A SAC sub-group has been convened to update curriculum and strengthen non-BSE assessment. Staged solution proposed. The SAC is continuing to work with STCs and LEPs to prioritise ECHO training. All Deanery/LETBS now have an ECHO lead. The SAC is also working with British Society of Echocardiography (BSE) to improve WPBA options.	
Insufficient exposure to intra-operative echo	Training programme's coverage of the curricula		Paediatric Cardiology	Scotland	ARCP data indicated that trainees were having difficulty gaining competence in this procedure.	Trainees now attending theatre regularly and completing formal course in transoesophageal echo.	
Curriculum coverage of Genital Dermatology (GD)	Training programme's coverage of the curricula		Dermatology	National	The National-BASHH Genital Dermatology special interest group conducted a survey of GUM SpRs with wide coverage of all Deaneries/LETBs. 42 responses were received (approx. 1/3rd GUM trainees Nationally) 17% rated their GD training very poor/poor; 39% average; 44% good. No trainees rated their GD training excellent. The survey may have been biased by mainly dissatisfied trainees answering the survey as 2/3rds of GUM trainees did not participate.	Has been discussed at GUM SAC. GD training will be considered during curriculum revision in 2016. Suggestions for improvement include: more structure with a formalised, longer attachment. More training in practical procedures. Improved local arrangements. These can be assessed by PSQs in subsequent NTS.	
Consultant retirement and changes to working practices impacting on the delivery of clinical and laboratory training	Training programme's coverage of the curricula	Workforce planning	Immunology	North East but also national concerns	Due to changes in consultant staffing (imminent retirements) and a location move for the day case procedures changes in working practices there is SAC concern that this may lead to fewer opportunities for trainees to access the curriculum. • 9 unfilled consultant posts in UK. • Loss of Immunology training posts in several deaneries. • Loss of Hewitt Funded Immunology NTN posts. • Concerns about national recruitment being not suitable for small specialities.	1. The SAC will continue to monitor curriculum delivery with changes in working practices within both clinical and laboratory areas. 2. Outcomes to be discussed and minuted at STC. 3. Two replacement consultant posts have been advertised. 4. LETB to ensure appropriate access to laboratory training after blood sciences merger. The SAC is currently engaging with "Small Specialties Workforce Planning review for Immunology.	
The change to service delivery models in some part of the UK have resulted in some trainees gaining experience in certain areas.	Training programme's coverage of the curricula		Core Medical Training	London, North West	Trainees are finding difficulties in achieving some procedural competencies. These include: CPR - in many Trusts, CPR is becoming increasingly rare because of extensive use of DNAR orders. In addition some have argued that CPR is a composite of separate procedures and therefore is difficult to cover in a single DOPS but should require a series of them. Chest aspiration – the same regions report some difficulty in trainees gaining experience as the procedure is increasingly done in A&E. (as is chest drain insertion)		
Private providers service delivery and the impact on training The fragmentation of commissioning and increase in private providers has resulted in reduction in Educational and Clinical Supervision and loss of training posts.	Training programme's coverage of the curricula		Dermatology	East Midlands	The fragmentation of commissioning and increase in private providers has resulted in reduction in Educational and Clinical Supervision and loss of training posts. The SAC has serious concerns that the fragmentation of commissioning in E Midlands has resulted in loss of the training hub at Nottingham, though trainees continue to rotate to Nottingham on an ad hoc basis for surgical exposure. There is concern that with increased commissioning to private providers, the burden of training will be left to fewer programmes with diminishing capacity, and is not sustainable. The Nottingham hub which delivered outstanding educational and research opportunities for dermatology trainees has ceased to exist. At the neighbouring hospital, (Derby) consultants are increasing training capacity to support lost NTNs from Nottingham. There are further potential threats to other programmes in this specialty as fragmentation of commissioning continues nationally.		
The single biggest threat to the training programme is that from the tendering processes for sexual health services Nationally. Local authorities (LAs) currently commission GUM services and many are being put out to tender.	Training programme's coverage of the curricula		Genito-Urinary Medicine	National	Across London a Specialist Sexual Health commissioning group has been formed but no collective decisions have been reached yet and the fear is that with so many different LAs across London responsible for individual services, that agreement will not be reached and that a cohesive strategy for London will not be achieved. Within Manchester it is looking very likely that sexual health services will be significantly re-structured affecting three of the five training sites in the rotation. This is a threat to training nationally as many services are undergoing this process and trainee numbers may be cut as part of cost savings as their salaries are not fully funded; for example, this occurred in Leeds with two NTN posts lost as a cost saving during the tender process. The other risk as services are re-structured is that sites may be less suitable for GUM training as the curriculum is no longer covered; for example, Leicester had its trainees 'seconded' following tendering as there was no facility for some aspects of service required for training (source: BASHH Manpower planning rep's June 2015 submission to the call for evidence from HEE Workforce Planning and Strategic Framework). The TPD is very involved in the process in Manchester and is keeping the postgraduate dean and others aware of developments. It is hoped that education and training can be protected, although there will most likely need to be changes made to how this is organised in the city. As the CASH and GUM services at CMFT work towards integration there are likely to be benefits for the trainees in achieving and maintaining the contraception competencies within the curriculum.	A survey of how tendering has impacted GU trainees was undertaken during 2015 by BASHH T-CARQ (Trainees Collaborative for Audit, Research and QI). This is a new sub group of the BASHH Doctors in Training Group. The survey has a broad representation of trainees across the country and targeted those who are in services that have been through tendering. There were 83 responses (out of 116 GUM trainees nationally). 43% of trainees surveyed had worked in services which had been through tendering. Of those who had been through tendering (n=42), 57% did not think training was taken into account throughout the tendering process, 61% did not think that their individual training needs had been taken into account, 43% thought they were adequately supported through the process. A common theme that emerged in the comments section what that training was not a prime concern for commissioners and that morale was down amongst trainees due to tendering. Trainees would like to be more involved in the tendering process and would like training to be included in the specification when services go out to tender. Further analysis is on-going and results will be submitted to the BASHH 2016 conference and for publication.	
Re-configuration and centralisation of pathology services with joint ventures/private labs has raised concerns as to local delivery of haematology laboratory experience.	Training programme's coverage of the curricula		Haematology	England, Wales	Following the NICE improving outcomes guidance (IOG) on haematopathology and the Carter report reviewing pathology services (2008), the re-configuration and centralisation of pathology services with joint ventures/private labs has raised concerns as to local delivery of haematology laboratory experience. Effects on training of centralisation of malignant haematology diagnostic services as a result of IOG remains a concern.	TPDs and regional training committees have asked to monitor local curriculum delivery issues.	
PET/CT services commissioning by a private company (implemented in 2015) may have a detrimental effect on the training.	Training programme's coverage of the curricula		Nuclear Medicine	National	PET/CT services commissioning by a private company (implemented in 2015) may have a detrimental effect on the training of Nuclear Medicine trainees, as the primary goal of the private company is efficiency and patient throughput. The nature of the commissioning process may have an effect on training in non FDG PET/CT work/non-cancer activity and also work with emerging tracers. Depending on the centre, there may be restrictions on trainee attendance and work in privately run facilities.	There is an acceptance by the provider that training of clinical and non-clinical staff should be integral to service, but the extent of the training component is yet to be firmly established.	

The SAC has on-going concerns regarding funding of training in voluntary sector hospices.	Training programme's coverage of the curricula		Palliative Medicine	National	Voluntary sector hospices provide a significant proportion of training in palliative medicine. Since the changes in commissioning, exceptions have been made each year for palliative medicine but a longer term sustainable decision is desirable in order to maintain the confidence of all providers.	No posts have been lost yet but the SAC are aware that the option of retaining or removing posts in several voluntary sector hospices remains in discussion.	
Across England, a number of services associated with rehabilitation, such as wheelchair services, have been privatised.	Training programme's coverage of the curricula		Rehabilitation Medicine	England	Whilst not part of the core delivery of rehabilitation services, it limits the opportunities for trainees to access placements in some of these more specialised services.	Discussions around specialist commissioning for rehabilitation services in England are on-going. At present we have not identified a major impact on training.	
Concerns regarding training in soft tissue MSK and a plan to move Rheumatology in NW Thames into the community	Training programme's coverage of the curricula		Rheumatology	National	There have been concerns regarding this discussed at SAC – and it has affected training in soft tissue MSK and individual LETB/trusts are looking at ways of addressing this. **Training doesn't generally seem to be considered in the commissioning of these services.** As far as external commissioning of rheumatology services – there have been issues regarding proposed changes to commissioning and the lack of inclusion of training in the service specification. As far as we are aware either these have not come to fruition due to challenges and the rheumatology service has not, in the end, been decommissioned or has continued to provide training.	TPDs have been asked to monitor delivery of curriculum locally and if an issue is identified then to identify specific training opportunities for trainees within their programme. Nottingham has had a transfer of service to Circle but the service is being delivered by the same consultants (and so same clinical and educational supervisors) so it has just required transfer of recognised training sites to the Circle service. A plan to move rheumatology to the community was in hand for NW Thames but this was rejected locally.	
Concerns regarding out of programme opportunities Challenges in maintaining a fair and balanced training programme when trainees want to go OOPR	Inadequate training experience eg due to rota gaps		Neurology	Scotland	The working environment has been looked in to in detail by the TPD using a confidential survey focused on the behaviour of colleagues in the workplace. The trainees were able to respond anonymously. There was an excellent response. It is clear from the comprehensive information received from the TPD, that he continues to face challenges maintaining a fair and balanced training programme at a time when so many of the trainees want to go out of programme to do some research. This experience is common to a number of TPDs.	Following discussion with the Associate Dean, a plan has been devised to respond to this information. The new Associate Postgraduate Dean has written to all trainees to emphasise the importance of arranging OOP to start in August, and to discuss plans for OOP, before applying for research posts, with their Local Programme Lead and the TPD. One MTI has been recruited and starts at the beginning of March 2016 in Glasgow. One LAS has been recruited and starts at the end of February 2016 in Glasgow. The Scotland Deanery has assured the TPD of a greater flexibility regarding the adding of posts to national recruitment right up to the time of the interviews (as is the case in other Deaneries)	
ST3 Recruitment (particularly those involved in G(I)M) Recruitment to AIM is affected by the intensity of work and the role of the medical registrar	Inadequate training experience eg due to rota gaps		Acute Internal Medicine	National	The overall % of A(I)M NTN posts recruited in 2015 after rounds 1 and 2 was 58% (64/110 posts). The regions worst affected were: WAL 0% (0/3 NTNs recruited) SCO 14% (3/21 NTNs recruited) EoE 40% (2/5 NTNs recruited) PEN 50% (1/2 NTNs recruited) TVA 50% (3/6 NTNs recruited) WES 50% (5/10 NTNs recruited) YOR 54% (7/13 NTNs recruited)	We have implemented the take AIM campaign to measure whether recruitment to AIM can be improved over the next two years.	
The male/female ratio of trainees entering the specialty and access to Less Than Full time Training. (LTFT)	Inadequate training experience eg due to rota gaps		Cardiology	National	Female Applications 2015: 25% 2014: 23% 2013: 24% 2012: 20% 2011: 17% Female Accepted offers 2015: 29% 2014: 23% 2013: 26% 2012: 29% 2011: 21% Accepted offers include both NTN and LATs.	The GIM workload may be deterring female applicants from applying for entry into this specialty. The SAC are investigating the possible reasons for this.	
Nationally, recruitment to those specialities offering GIM is falling compared with those which do not. This is an extremely serious issue that has been identified already.	Inadequate training experience eg due to rota gaps		Clinical Pharmacology and Therapeutics	National	The overall % of CPT NTN posts recruited in 2015 after rounds 1 and 2 was 50% (6/12 posts). The regions worst affected were: EMD 0% (0/2 NTNs recruited) NOR 0% (0/2 NTNs recruited) WMD 0% (0/1 NTNs recruited)		
The inability to recruit new consultants after a number of retirements, combined with relatively few NTNs in the region, threatens the future of secondary care services.	Recruitment	Inadequate training experience eg due to rota gaps	Dermatology	Wessex	Written and email correspondence has taken place between the SAC Postgraduate Dean and HEE on this issue.	The SAC is working with Prof Jacky Hayden, Lead Dean for the specialty, the Postgraduate Dean and HEE on ways to increase Dermatology recruitment in the region.	
Nationally, recruitment has been sub-optimal. Round one of interviews has a significantly better fill rate than round 2.	Inadequate training experience eg due to rota gaps		Endocrinology & Diabetes	National	The overall % of CPT NTN posts recruited in 2015 after rounds 1 and 2 was 85% (6/12 posts). The regions worst affected were: EoE 40% (2/5 NTNs recruited) YOR 55% (6/11 NTNs recruited) WES 57% (4/7 NTNs recruited) It is widely believed within the specialty that GIM has an adverse effect on specialty training and possibly recruitment. This is supported by the trainee surveys and also informal feedback from trainees. Trainees and trainers identify GIM workload as a cause for reduced satisfaction in training and an impediment to acquiring specialist competencies. This may also be contributing to a reduced interest in the specialty for those looking into entering at the ST3 level. There may be other factors, but they have not been formally explored.	The SAC feels that there should be protection from the GIM component of training and service delivery for a period of training. Some LETBs offer this protection, and the SAC sees this as good practice. The SAC is optimistic that the shape of training may shield E&D trainees from the impact of GIM and improve recruitment. There is also a national drive by the Society for Endocrinology and Association of British Clinical Diabetologists to reach out and inspire doctors to train in our specialty.	
All NTN posts were filled in the 2015 recruitment round but once again with a reduced ratio of applicants to posts. The fill rate for LAT posts was predictably poor due to the inadequate numbers of juniors exiting the CMT programme (29/39 74% in round 1, and 0/24 0% in round 2). The effect of a reduced number of LATs is likely to affect the 2016 Trainee survey results significantly. With the withdrawal of all LAT's in 2016 there will be a further negative impact on training experience which will be evident in the 2016/7 survey.	Inadequate training experience eg due to rota gaps		Gastroenterology	National	The reduced competition ratio for NTN's in gastroenterology suggests that the specialty is becoming less popular. This observation appears to be reflected across all physicianly specialties where training in acute medicine is also undertaken. The onerous nature of acute medicine cover appears to be a major disincentive to young doctors pursuing a career in hospital medicine. It is hoped that the outcome of SoT will improve the work/training balance for trainees in the future. The incomplete fill rates for LAT's will jeopardise all aspects of training for NTN's in post due to incressing pressure for acute medical cover.		
Nationally, recruitment has been sub-optimal. The overall fill rate for R1 was 41% (59% NTNs) and 4% for R2 (5% NTNs). This compares to fill rates R1 2014 68%, 2013 100% and R2 2014 42%, 2013 44%. The year- on-year fall in applications since 2012 (by 57% for R1 and by 78% for R2) has resulted in a fall in fill rates which impacts on the specialty nationally, and has lowered the candidate to post ratio. 41% NTNs and 93% available LATs remained unfilled after Round 1, and 95% available NTNs and 100% LATs after round 2. No other specialty has shown a similar percentage decline since 2012 in application numbers or fill rates, GIJM had the lowest R1 fill rate of all 22 JRCPTB co-ordinated medical specialties in 2015.	Inadequate training experience eg due to rota gaps		Genito-Urinary Medicine	National	The issues arising from this crisis include: 1. Training gaps – which impact on existing trainees; 2. Service gaps; 3. Implications for the future workforce; 4. Implications for future STI management and control. It is very difficult to re-assure trainees if the availability and nature of future Consultant posts is not clear. Although fewer in number, the quality of candidates does not appear to be diminished for Round 1. The current venue remains successful, and engagement with the national process by the recruiting leads and administrative staff remains high. The viability and cost-effectiveness of running a second round of National recruitment must be questioned. The resources required (9 Consultant days for one panel, travel and in some cases accommodation, a 4 man LETB team, a lay representative and a suitable commercial venue) may not justify a small number of successful appointments. A request to include all vacancies from August 16 up until March 2017 in Round 1 has been communicated to the JRCPTB recruitment team but the outcome has not been favourable with preference to keep to the agreed timelines and continue with R1 & R2 recruitment. Selectors at R2 were asked for suggestions and views on the recruitment crisis. • All showed a continued enthusiasm to maintain training in the specialty, and a recommendation for this to stay as a national process for NTNs. The panel voiced the dichotomy between trying to increase awareness and attractiveness of the specialty to improve applicant numbers when there may not be future posts for trainees coming out with current CCTs.		
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. It is increasingly difficult to arrange 'Acting Up' opportunities for final year StRs because of effects on already compromised rotas.	Inadequate training experience eg due to rota gaps		Geriatric Medicine	National (outside London) but particularly East of England, Scotland, Wales	The overall % of Geriatric Medicine NTN posts recruited in 2015 after rounds 1 and 2 was 85% (149/176 posts). The regions worst affected were: SCO 48% (11/23 NTNs recruited) PEN 75% (3/4 NTNs recruited) WAL 76% (13/17 NTNs recruited) NOR 77% (10/13 NTNs recruited) YOR 77% (10/13 NTNs recruited)		Appointment of trainees to inevitable future vacancies, known as 'mortgaging', is practiced in some LETBs. This should be universal and would mitigate against some of the restrictions of the once yearly appointment system.
Medical Oncology has focused in developing 'Acute Oncology' as described in the ASR 2013 and 2014. We see this as the opportunity to support GIM and the acute take. The concern will be if programmes are involved in the latter which will mean a relative reduction in specialty training (only 4 years for Medical Oncology)	Inadequate training experience eg due to rota gaps		Medical Oncology	National	Currently we are training StRs and subsequently recruiting to Medical Oncology Consultant posts which have 'Acute Oncology' in the job plan. Further involvement in GIM and acute take at St3-6 level will detract from specialty training. We predict that if additional acute take is part of the training programme that we will lose trainees to different specialties or to different countries to specialise in Medical Oncology.		

Difficulty in recruitment of trainees to specialty	Recruitment		Nuclear Medicine	National	There are low number of applicants for available posts. Also some posts are remaining vacant long-term. The most important action has been the revision of the specialty training curriculum. The new curriculum enables nuclear medicine trainees to complete core radiology training and FRCR within an extended 6 year Nuclear Medicine training programme.	Multiple efforts have been made to publicise the new curriculum – RCP specialty of the month, articles offered to Nuclear Medicine Communications, European Journal of Nuclear Medicine and BMJ careers, link made from RCR website to RCP/JRCPTB websites etc. Results of recent HEE Small Specialty Workforce Review is awaited. Joint national recruitment with Clinical Radiology instigated in 2015 and will continue in 2016 and thereafter. This has many advantages but the option to apply to both specialties via a unified application process means that some good applicants to the specialty may ultimately select Clinical Radiology instead.	Numbers of applicants for SpR posts in the specialty have increased in 2016 round 1 recruitment compared to 2015 round 1 recruitment which was held soon after curriculum approval.
Renal Medicine has always been a dual accrediting specialty, however there have been some concerns regarding GIM workload and the delivery of the acute take in our specialty which may have had a negative impact on recruitment.	Inadequate training experience eg due to rota gaps		Renal Medicine	National	Evidence from the ST3 National Recruitment figures show that in 2015, the fill rate for Renal Medicine in Round 1 was 71% for NTNs and 4% LATs compared with 93% and 19% respectively in 2014. These gaps inevitably have an impact on workload and quality of training experience which is reflected in the number of increased red flags in the GMC trainee survey (20 in 2015 compared with 17 in 2014). The red flags were particularly for workload (6) and also for local teaching (5), the latter as a consequence of trainees not being able to attend due to the workload issues. As previously noted Renal Programme Directors report some outpatient clinic experience being sacrificed to maintain adequate ward cover and commitment to G(I)M rotas. This is particularly true of renal units operating a mixed economy of G(I)M and Renal Medicine where numbers of general medicine patients regularly outnumber renal patients (East of England).		
Failure to recruit to NTN posts	Recruitment	Inadequate training experience eg due to rota gaps	Respiratory Medicine	National	There has been a failure to recruit to all the available NTNs in both national recruitment rounds in 2015. For Round 1 the recruitment rate was 94% and for round 2 it was 57% with the overall NTN recruitment rate being 88%.	The SAC to review the impact of the future loss of LAT appointments on trainees taking up unfilled NTNs. The SAC is working with the BTS to look at methods of improving recruitment into specialty.	
We have been unable to fill all our posts at the last 2 rounds of interview and it is likely that the loss of pure rheumatology training posts has had an impact on recruitment. We do not currently have any data or information to confirm or quantify the impact of making all posts dual training.	Inadequate training experience eg due to rota gaps		Rheumatology	National	We have been unable to fill all our posts at the last 2 rounds of interview and it is likely that the loss of pure rheumatology training posts has had an impact on recruitment. We do not currently have any data or information to confirm or quantify the impact of making all posts dual training. We have at least one anecdotal case of evidence of impact of dual training with GIM within the national training programme where a senior trainee moved to General Practice training as they couldn't face the need to continue acute take in all training years. I have not been able to collate other examples for the purpose of this report.		
Withdrawal of LAT posts in England Loss of LATs from August 2016	Recruitment	Inadequate training experience eg due to rota gaps	Cardiology	England	OOP access is threatened by the removal of LATs. The UK LAT fill rate in 2015 was 94% (47/50) and in 2014 was 90% (52/58)	The SAC are encouraging continued OOP support with LAS appointments.	
Loss of LATs from August 2016	Recruitment	Inadequate training experience eg due to rota gaps	Medical Oncology	England	There are considerable concerns regarding the dissolution of the LAT posts. The majority of trainees in Medical Oncology are out of programme for 3-4 years to pursue a PHD or MD as Medical Oncology is a research-driven specialty. Furthermore the percentage of female trainees in the speciality is now greater than male and this has an impact in terms of time out for maternity leave. We will only be realising the impact of this on our specialty now as this has only come into force from the last National recruitment in April 2015. We are expecting significant gaps in the training programmes, with the effect of increasing work load and less satisfaction with training programmes as a result. The current very high quality of trainees that we recruit to this speciality will decrease. We hope not to see this happen.		Reinstatement of Locum for Training posts for Medical Oncology.
Loss of LATs from August 2016	Recruitment	Inadequate training experience eg due to rota gaps	Neurology	England	It has been made clear at every opportunity that the withdrawal of LATs will have a detrimental effect on neurology training programmes across the UK. Traditionally LATs have not been employed in neurology for extended periods and as a way of filling gaps in training programmes and in service rotas, and to allow core medical trainees to try their hand at neurology, they have been very useful. It is particularly damaging in areas where the slots on training programmes vacated by trainees going out of programme to do research are not "mortgaged" and filled by another, new, trainee. This practice is routine in some areas (e.g. Wales Deanery) ensuring that the rate of production of accredited trainees remains constant, regardless of how many go out of programme during their training. Deaneries that do not do this are typically the smaller deaneries that are less confident about being able to accommodate the trainee at exactly the time they return. This is understandable but the smaller deaneries are also the deaneries where gaps in the rotation are more likely to have a very obvious detrimental effect on other trainees. In the West Midlands two posts have been decommissioned as a result of long term vacancies related directly to trainees going out of programme. An increase in the total number of NTNs within neurology to help deal with the loss of LATs is unlikely in the current climate.	It has been suggested that other health care professionals could be recruited to deal with the effect of withdrawing LATS. The follow up required for patients receiving new treatments (e.g. immune modulating treatments in Multiple Sclerosis, many of which are complicated by unusual and complex conditions) and the emphasis on our roles as diagnosticians, means that only the routine follow up of patients with stable and predictable conditions can be passed on to other health care professionals. These issues are of great relevance to the quality of the training experience and the quality of the trainees emerging from the training programmes. Feedback from Wales and Northern Ireland suggests that their training programmes will be at an advantage because LATs are not being discontinued. The Neurology SAC will continue to point out to LETBs and Health Education England that slots on neurology training programmes are wasted unnecessarily when they are left vacant by trainees going out of programme, and that to put a new trainee in to the slot, and so maintain the output of the training programme, can be cost neutral.	Reinstatement of Locum for Training posts for Neurology.
Loss of LATs from August 2016	Recruitment	Inadequate training experience eg due to rota gaps	Palliative Medicine	England	The decision by Health Education England to cease appointment of LAT posts in England is a major concern to the speciality. Health Education Thames Valley's annual report evidences that their small training programme will have significant rota gaps in 2016. Historically, there has been a high conversion rate to full time NTNs and difficulty in recruitment to LAS posts. Agency or ad hoc locums are not usually employed due to difficulties in ensuring the doctors have the appropriate skills to work in this sensitive area. LAT or LAS post holders are required to cover maternity leave, out of programme for research, leadership, education, management development etc. Many of our training programmes have small numbers of trainees and the impact of a few trainees away for statutory or educational reasons can destabilise the programme without adequate backfill. This is a particular issue for hospices which are hosting a significant part of training rotations.		Reinstatement of Locum for Training posts for Palliative Medicine.
Equality and access to Less than Full Time Training Concerns have been raised regarding equality and diversity and access to Less Than Full Time training in Cardiology	Recruitment	Inadequate training experience eg due to rota gaps	Cardiology	National	LTFTT / Equality issues have been identified with evidence from recruitment statistics and trainee feedback.	SAC discussions are continuing and are including the trainee committee (BJCA). The SAC have introduced a new PSQ on LTFT training in the 2016 NTS. The results will be analysed when they become available.	
Other National Trainee Survey concerns not reported elsewhere Red flags for Clinical Supervsion in a number of regions	Education and Training		Rheumatology	Scotland but also other LETBs	2 red flags for clinical supervision in Scotland this year and also at several Trust sites nationally, but as the survey does not distinguish between GIM or Rheumatology supervision it is not possible to explore this theme further at present.	To discuss at next SAC if it is possible for Scotland to adopt a Deanery hosted local survey such as the Bristol on line tool which is now being used in several LTEB's by Rheumatology TPDs. When these have been undertaken it is not usually rheumatology workload which is identified as the concern.	Recommendation for GMC survey to distinguish specialty from General medicine.
No GMC survey data available for Infectious Diseases/Medical Microbiology trainees	Lack of GMC Survey data		Infectious Diseases	National	GMC survey data is not available to the SAC as joint ID/microbiology trainees are not being coded to our specialty. This may get worse when core infection training is introduced if this is coded as a separate specialty.		Ideally we would like ID/microbiology programme trainees to be coded on the NTS to us as well as microbiology if possible.
Regional teaching is a red flag outlier in 5 regions	Training programme's coverage of the curricula		Infectious Diseases	East Midlands, North East, North West, Scotland Yorkshire and Humber	Red flags in the NTS	All TPDs across the country have been asked at the SAC to ensure they have an adequate programme of regional teaching. The 5 regions with red flags: East Midlands, the North East, the North West, Hull and East Yorks and Scotland have all produced a plan and shared with the SAC Quality lead. These plans adequately address the issue but we need to monitor this.	
Repeated Red Flag on GMC Trainees' Survey for years 2014 and 2015 for Handover	Handover		Neurology	Kent, Surrey and Sussex	It will not be possible to always have a face to face handover; trainees are often in peripheral clinics or off site at the time a handover is required.		A change to the question in the survey may allow the replies to focus on the quality of the handover more than its form.

Repeated Red Flag on GMC Trainees' Survey for years 2014 and 2015 for Workload	Training programme's coverage of the curricula	Workload	Neurology	Northern Ireland	A number of UK training programmes in neurology are adversely affected by rising expectations related to acute neurology and stroke, and the need for patients receiving complex treatments to be followed up in a way that was not necessary in the past e.g. the disease modifying drugs used in Multiple Sclerosis, Chronic Inflammatory Neuropathies, and acute stroke. The resulting increase in workload coupled with unfilled slots in training programmes has inevitably had a detrimental effect on the workload of the remaining trainees. It is also worth mentioning that seven trainees on the Northern Ireland training programme completed the survey, making the results particularly vulnerable to the effects of outliers.	In Northern Ireland over the past 15 months changes have been made. Colleagues in elderly care now look after stroke 9am-noon Mon-Sun, and midnight-9am on non-Bank Holiday weekend nights. There is also greater consultant support for the work in MAU. Rapid Access Neurology Clinics (RANCs) have been established to divert some of the patients to clinics instead of referral to on-call registrars. The TPD is aware that with increasing calls on the registrars to attend the acutely unwell and patients with strokes some further changes to the on-call may be required, but as in other areas it is acknowledged that partial shift rotas may have a detrimental effect on the overall training experience.	
Repeated Red Flag on GMC Trainees' Survey for years 2014 and 2015 for access to educational resources	Training programme's coverage of the curricula		Neurology	East Midlands	The TPD in East Midlands is very aware of concerns raised about access to educational resources. Trainees all have access to "Up-to-Date" and to extensive medical libraries; many admitted that they have not used these resources.	Trainees will continue to be encouraged to make the most of all educational resources, many of which are easily accessed on smart phones.	

2. Externality

Please comment on your college's / faculty's involvement in the LETB/Deanery externality processes including an assessment of any issues around the delivery of the process itself or any concerns which have been identified in the quality of training through your external advisors (if not covered above)

Description	Specialty	Outcome	LETB/Deanery - or national / specialty wide
The JRCPTB provide LETBs/Deaneries with a list of External Advisors for 29 medical specialties. External Advisors provide impartial advice and scrutiny into all processes of delivery, assessment and evaluation of specialty training including as part of a panel considering ARCP and Penultimate Year Assessments and also when required as part of LETB/Deanery or GMC-led teams to specialty training programmes or Local Education Providers. External Advisor reports are completed following each attendance covering the following areas: - Numbers of trainees assessed and ARCP/RITA outcomes given - Process • Ensuring trainees are not present during the panel decision-making process for the outcome? (although they may be present to meet with the panel after the outcome has been determined) • Did ALL trainees awarded with outcomes 2, 3 or 4 meet with the panel? • Ensuring ALL trainees awarded with outcomes 2, 3 or 4 are given time to read the Educational Supervisor and/or TPD reports and to submit a response before the meeting? • Ensuring Educational Supervisor Reports: o Reflect the learning agreement and agreed objectives o Are supported by evidence such as WPBA o Outline any changes to the learning agreement or remedial action taken during the training period for whatever reason • Ensuring other relevant evidence, particularly the e-Portfolio and PDP has been reviewed? • Ensuring the reason for any unsatisfactory outcomes are recorded and communicated clearly? (Was/were the trainee(s) made aware of the specific competences to be achieved and a timescale agreed for achieving outstanding competences?) • Ensuring the principles of equality and diversity are upheld? • Ensuring a panel member is present to present all of the specialties / curricula under review? (eg. for GIM and the specialty) - Decision-making • Were the outcome decisions satisfactory and appropriate based on the evidence available? • Were recommendations and timescales for actions clearly communicated to the trainee? • Were mitigating circumstances taken into account? - Quality of evidence • Is the trainee making appropriate use of their portfolio to record progress: o Maintaining an up to date log book or other agreed record of experience? o Maintaining an up-to-date PDP and recorded reflection where appropriate? o Using appropriate evidence (eg. WPBAs, reflection, log book evidence etc) to link competences? • Is the Educational Supervisor providing a sufficiently detailed report which reflects accurately the training progress? • Are the supervisors providing quality feedback (WPBAs, appraisals) in sufficient quantity?	Acute (Internal) Medicine Cardiology Clinical Genetics Clinical Neurophysiology Clinical Pharmacology and Therapeutics Core Medical Training Dermatology Endocrinology and Diabetes Mellitus Gastroenterology General (Internal) Medicine Genitourinary Medicine Geriatric Medicine Haematology Immunology Infectious Diseases Medical Oncology Medical Ophthalmology Metabolic Medicine Neurology Nuclear Medicine Paediatric Cardiology Palliative Medicine Rehabilitation Medicine Renal Medicine Respiratory Medicine Rheumatology Sports and Exercise Medicine	19 panel requests for externality. 130 trainees ARCP and or PYA outcomes were reviewed. 13 EA reports received. 19 panel requests for externality. 130 trainees ARCP and or PYA outcomes were reviewed. 13 EA reports received. 26 panel requests for externality. 183 trainees ARCP and or PYA outcomes were reviewed. 19 EA reports received. 8 panel requests for externality. 34 trainees ARCP and or PYA outcomes were reviewed. 5 EA reports received. 3 panel requests for externality. 6 trainees ARCP and or PYA outcomes were reviewed. 1 EA report received. 4 panel requests for externality. 10 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received. 15 panel requests for externality. 698 trainees ARCP outcomes were reviewed. 14 EA reports received. 20 panel requests for externality. 127 trainees ARCP and or PYA outcomes were reviewed. 12 EA reports received. 29 panel requests for externality. 129 trainees ARCP and or PYA outcomes were reviewed. 21 EA reports received. 66 panel requests for externality. 486 trainees ARCP and or PYA outcomes were reviewed. 38 EA reports received. 17 panel requests for externality. 41 trainees ARCP and or PYA outcomes were reviewed. 13 EA reports received. 17 panel requests for externality. 41 trainees ARCP and or PYA outcomes were reviewed. 13 EA reports received. 23 panel requests for externality. 130 trainees ARCP and or PYA outcomes were reviewed. 15 EA reports received. 7 panel requests for externality. 14 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received. 16 panel requests for externality. 62 trainees ARCP and or PYA outcomes were reviewed. 10 EA reports received. 13 panel requests for externality. 87 trainees ARCP and or PYA outcomes were reviewed. 11 EA reports received. 1 panel request for externality. 7 trainees ARCP and or PYA outcomes were reviewed. 1 EA report received. 2 panel requests for externality. 4 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received. 22 panel requests for externality. 118 trainees ARCP and or PYA outcomes were reviewed. 18 EA reports received. 1 panel request for externality. 2 trainees ARCP and or PYA outcomes were reviewed. 1 EA report received. 5 panel requests for externality. 22 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received. 14 panel requests for externality. 76 trainees ARCP and or PYA outcomes were reviewed. 11 EA reports received. 5 panel requests for externality. 14 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received. 25 panel requests for externality. 85 trainees ARCP and or PYA outcomes were reviewed. 12 EA reports received. 25 panel requests for externality. 140 trainees ARCP and or PYA outcomes were reviewed. 17 EA reports received. 21 panel requests for externality. 92 trainees ARCP and or PYA outcomes were reviewed. 13 EA reports received. 2 panel requests for externality. 5 trainees ARCP and or PYA outcomes were reviewed. 2 EA reports received.	
Curriculum delivery • Are there any gaps in specialty and sub specialty / modular experience? If so, what are they and why? • Is there any difficulty in providing experience and training in practical procedures, operating sessions etc? (If so please list the procedures affected and training locations in the Comments section below) • Is the Educational Supervisor engaging appropriately with training eg. undertaking appraisals and assessments as required? • Are clinical supervisors assisting sufficiently with curriculum delivery as evidenced by the provision of WPBAs? - Penultimate Year Assessment • Did the panel set any mandatory targets at this stage of training that concerned you eg. competences that should have already been achieved? • Were any of these procedural competences? • Please list the procedures (if applicable) - Overall rating • Overall, taking account of all of the above areas, how would you rate the ARCP / PYA process you observed at this Deanery / LETB? (please circle) Outstanding / Good / Borderline / Unacceptable	Stroke Medicine	6 panel requests for externality. 26 trainees ARCP and or PYA outcomes were reviewed. 1 EA report received. External Advisors are being actively encouraged to complete and return reports following attendance at ARCP/PYA panels. 284 reports were received, an increase of 36% in 2015 compared to 2014 but work is continuing to ensure reports are received from all EAs attending ARCP/PYA panels. Additional External Advisors were also recruited with total EAs now exceeding 400. Deaneries/LETBs are provided with a list of designated EAs they are able to liaise with when organising externality for ARCP/PYA panels.	
External Advisor reports are collated and copies sent to SAC QM Leads, PG Deans and local TPDs for review and comments where required if concerns raised. The SAC sign-off the report and an annual report is also provided to SACs highlighting all concerns raised, actions taken and examples of good practice that were highlighted.			
A small number of specific concerns were reported:	Acute Internal Medicine	Identification of all outstanding training requirements needed to complete training at PYA. All external advisors have now been made aware of this issue with prolongation of training if this occurs to ensure that the curricular objectives have been met.	National
	Cardiology	SAC Chair supported HEWM in responding to bullying allegations at a West Midlands Trust. A revisit is planned.	West Midlands
	Core Medical Training	Issues of inconsistent interpretation of the Decision Aid were identified. Some areas of difficulty in delivering part of the curriculum relating to procedures were identified. All CT1 trainees are now required to have at least simulation level ability in the curriculum required procedures.	National
	Clinical Pharmacology and Therapeutics	East of England's CPT training programme at Cambridge. Concerns raised regarding the training programme coverage of the curriculum and bullying . The SAC is part of the GMC-led remedial process. We have conducted a visit to Cambridge to monitor progress over the last 6 months during which we interviewed all the current trainees and trainers. The local trust has put in place a robust plan to address our, and the trainees' concerns which we will monitor in future visits. We have made concrete suggestions that Cambridge make use of training opportunities made available by the London CPT rotation (they have agreed with this).	East of England
	Gastroenterology	Sign off by ES's has been found to be inaccurate in isolated cases where completion of WBA's has been below the standard set out within the curriculum (number of responders in MSF's, and numbers of WBA's undertaken). This issue has not impacted on the quality of training but all TPD's have been reminded of the need for Educational Supervisors to scrutinise trainees e-portfolios to ensure that MSF's are complete before confirming that all WBA's are up to date.	National
	Genito-Urinary Medicine	The External Adviser for Mersey reported that The Mersey GUM rotation is not delivering the following areas of the curriculum adequately: a. STIs in children; (The trainees travel to Manchester for teaching session on this) b. Adequate HIV experience; as demonstrated by all those taking the Dip HIV failing it this year. (The panel have asked if trainees can attend Manchester for a secondment for this. Manchester have agreed they can facilitate this)	Mersey

3. Please provide any comments on the results of assessment of the Progression Reports published by the GMC

The GMC publish reports showing ARCP outcomes and examination results for different groups of doctors across the UK. We would be interested in any observations or analysis you have on this data and any insight into the root cause of regional variations within your specialties. Please highlight any actions you are undertaking to understand or address any concerns you may have identified about the quality of training being delivered. You can view the reports here:
Postgraduate progression reports

Report name	Comment	Action
ARCP results are reviewed and analysed by each SAC. Comments were received from a small number of SACs as follows:		
Cardiology	Nationally, Cardiology has a lower proportion of unsatisfactory ARCP outcomes but some LETB/Deaneries have higher proportions. The SAC are concerned that there is a reluctance to give and receive an ARCP3 to improve training and learning which needs effort to change. Externality suggests processes are fair.	
Core Medical Training	Some concerns were raised regarding the Outcomes awarded in the Peninsula LETB. This was raised with the Postgraduate Dean who undertook a full investigation and was able to give satisfactory assurance that the correct outcomes had been awarded.	
Gastroenterology	A trainee from The KSS deanery was missed from an administrative perspective and undertook a year of training with no Educational Supervisor identified. As a result no entries were made in the e-portfolio, and no WBAs undertaken. The trainee's training period was extended by 8 months. This is an isolated occurrence but is significant. The ES report was forwarded to David Black (JRCPTB) and he has informed the LETB that an investigation should be undertaken to prevent a future occurrence.	

General (Internal) Medicine	There remains some discrepancy in outcome decisions between panels in different deaneries. The SAC has requested External Advisors to input into the assessment of consistent quality assurance.
Geriatric Medicine	A few less able trainees were getting outcome 2s (4) as a result of poor trainer training. Two trainees have since had Interim reviews this December and both on track to improve. The TPD is planning a visit to the Trusts.
Neurology	Concerns have been expressed about eportfolio literacy, amongst the trainees and the trainers. Some trainees tend to fill their eportfolio in the week or two their ARCP despite this being discouraged. In some instances the ARCP panels have agreed that more information is required. It has been suggested that a programme of education is developed for both trainees and trainers. This will be piloted in London and the outcome will be discussed at SAC meetings.
Nuclear Medicine	Trainees sometimes attend for ARCP without an Educational Supervisor report which means an automatic outcome 5 (insufficient evidence) despite all training programmes nationally having a representative on Specialty TPMC. The SAC have reiterated the importance of the Educational Supervisor report to the ARCP process.

4. Programme Specific Questions (National Training Survey)

Please comment on the outcome of any analysis you have undertaken of your Programme Specific Questions in the National Training Survey highlighting any areas of concern or requiring further investigation which have been identified particularly around your curricula or assessment systems.

NTS Questions	Analysis	Outcome
The JRCPTB provides its SACs with NTS results on programme specific questions, including trend analysis of up to 3 years data if available. Each SAC reviews the results and initiate discussions where results are sub-optimal or unexpected. PSQs are reviewed annually to ensure they are relevant and up to date and a number of the JRCPTB's SACs have engaged the GMC's survey and question writing team in workshops to review and agree changes to existing PSQs. Analysis by specific SACs included the following:		
Cardiology	Echo training (Q1) continues to be delivered poorly in some areas and there are two assessment structures.	The basic curriculum structure is not robust enough and improvement is being prepared for submission to the GMC. MDT attendance.
Cardiology	How often do you attend joint cardiology/cardiothoracic multidisciplinary or 'Heart team' meetings? (Q3)This is insufficient in some LEPs.	The SAC is working with TPDs on this.
Clinical Genetics	Since Clinical Genetics recruits trainees from both Adult and Paediatric care training programmes, two of our PSQs were designed to determine whether there were any advantages or disadvantages in coming from either speciality. There is a perception that Paediatric trainees may, on coming into Clinical Genetics, have an advantage in their interactions with children. An analysis of the returns showed that some of our Adult core trainees initially felt at a disadvantage when dealing with children, but their concerns rapidly diminished within the first year of training.	It was decided no further action would be required by the SAC but trainers should be made aware of this and actively address it.
Clinical Genetics	There are some concerns about regional variation in consultant supervision of trainees' clinic letters. There was a PSQ to determine how long into their training consultant review was considered necessary. Unfortunately the PSQ on supervision of clinic letters was not sufficiently discriminating to get a clear view of the extent of the concern.	The trainees are now conducting a survey to obtain a clearer picture and will report back to the SAC once it is concluded.
Dermatology	Clarification of Handover and development of specialty specific handover questions for the training survey. Identification of why generic Handover question is not relevant to dermatology (no free text allowed).	Generic Handover question to be removed and specialty-specific Handover questions developed for more accurate data collection.
Dermatology	The Dermatology SAC have identified some weaknesses in the specialty-specific trainee questionnaire and tried to correlate these with ARCP feedback and outcomes. The discrepancy may be due to unrealistic trainee expectations.	The SAC have identified the areas of perceived weakness and developed an action plan to address these, ie increased communication about actual curriculum requirements vs trainees expectations, development of national courses to cover areas of perceived weakness.
Gastroenterology	A full review of our specialty questions has been undertaken by a sub-group of SAC members in conjunction with The GMC.	The balance of questions is being adjusted in order that the breadth of the specialty is better covered for future surveys with less of a focus on endoscopy training.
General (Internal) Medicine	2015 was the first time that trainee's dual training in Gastroenterology/GIM, Geriatric Medicine/GIM, Renal Medicine/GIM and Respiratory Medicine/GIM were able to be asked specific questions relating to their G(I)M training with results available by grade, main specialty and LETB. There was huge variation across LETBs/Deaneries and across the four pilot specialties. Concerns were particularly highlighted over Hospital-at-night supervision and educational feedback. 50% (821/1655) of trainees agreed or strongly agreed that their training had benefitted from working on the 'hospital at night' rota. The percentage was highest in Gastroenterology (62%) and lowest in Respiratory Medicine (48%). 12% (202/1655) of trainees said that they did not take part in the 'hospital at night' rota. This was highest in Renal Medicine (22%) and lowest in Gastroenterology (7%). 31% (516/1655) of trainees agreed they had a designated supervisor with whom they can discuss cases from their 'hospital at night' rota. The percentage was highest in Geriatric Medicine (33%) and lowest in Renal Medicine (28%). 36% (594/1655) of trainees agreed that the feedback they receive from their educational and or clinical supervisor if they lead post-take ward rounds was very good or good. The percentage was highest in Gastroenterology (58%) and lowest in Renal Medicine (44%).	Further refinement of the Specialty-specific questions to address levels of overall trainee supervision and satisfaction.
Genito-Urinary Medicine	1.How do you gain HIV in-patient experience in your current training programme 2.How do you gain contraception competencies during the training programme 3.Do you think the current arrangements within your deanery will allow you to achieve the HIV curriculum competencies as stated in the most recent curriculum? 4.Do you think you will gain sufficient contraceptive experience in your current training programme, in order to meet the GUM curriculum competencies? 5. Do you have opportunity to gain experience of contraception implant insertion/coil fit within current training programme? 6. What public health training is delivered within your current training programme to support delivery of curriculum competencies? 7. What management/leadership opportunities are available in your current training programme? 8. What exposure to, or training in, caring for individuals who have been sexually assaulted, is available in your current training programme?	Of all GUM trainees by Deanery, LETB & grade of training. N=106. One ST6 trainee responded 'no' to Q 3 & 4. Two ST6 trainees responded 'no' to Q5. From the analysis it is not clear to which training programme this trainee belonged. This will be investigated further in the 2016 NTS.
Geriatric Medicine	It can be difficult to get useful data out, with few trainees at ST3+ in each trust, so when drilled down to individual trust at ST3+, numbers aren't large enough to give a meaningful report. There are trainees who filled that were doing a stint in GER at the time of the survey, but many are not in the GER training programme as such. The other issue is separating G(I)M work from specialty work. Colchester and Watford evaluated poorly, with many red flags.	Both Trusts were visited, it seems the G(I)M component is the main issue, that the commitment to this is reducing the actual time in specialty. For instance, Watford trainees found what they did of GER to be high quality, but they spent >50% time doing G(I)M which was onerous and not educational. A Bristol Online survey is proposed for more detailed results around April/May 2016.
Haematology	Further analysis of haematology laboratory and liaison experience (Q8 & 9). Detailed analysis of trainee's daily activity through a diary exercise in 5 areas of the UK – showed in–patient work 29% time with 22% out-patient work and 20% laboratory/liaison work. During lab liaison work gave clinical advice to a wide range of hospital services and to GPs. This highlights the support given by haematologists to primary and secondary care, including the acute take.	
Infectious Diseases	At the SAC we have looked at the responses for all 10 of our questions. These questions all explore whether the curriculum is being covered adequately. Although we still have limited data we are currently satisfied that each training programme can provide adequate experience to meet the curriculum requirements.	No concerns identified but we will continue to review annually.
Medical Oncology	Ten specialty-specific questions were submitted for the 2015 GMC National Trainee Survey. In general, the rates of strongly agree/agree were either improved or stable. The analysis included a comparison between 2014 and 2015 for each question. For each question the analysis was also subdivided by training grade ST3-ST6. Finally, the analysis was divided by Deanery. The analysis was discussed at the Medical Oncology SAC meeting on 7th October 2015.	Each deanery was tasked with ensuring that they analysed their trainee's responses to look for areas for improvement. It was decided that the speciality-specific questions would be unchanged for the 2016 GMC survey.

Neurology	At the Neurology SAC meeting in September 2015 the specialty specific questions were reviewed and members agreed it was very Stroke weighted. The questions about stroke were discussed and it was appreciated that they were included in order to highlight the importance of stroke and to provide information about neurology trainee involvement in stroke.	These questions are being reviewed with a view to including more questions about acute neurology.
Paediatric Cardiology	What impact does your on call duty have to your overall training? What proportion of the echocardiograms you perform are reviewed critically to your level of competence by senior staff? In your experience, how difficult or otherwise was it for you to achieve the competencies set out in the 2010 curriculum? In a typical working month, how much time (in sessions) do you have for research and publications? Analysis of results showed an increase in reported difficulty of achieving competencies set out in 2010 curriculum. In 2014 25% of trainees reported this to be either very or fairly difficult and this increased to 50% in 2015. In addition, trainees are reporting less time for research and publications.	
Rehabilitation Medicine	Issues of handover were identified in one training location. This was investigated locally and was not found to be related to Rehabilitation Medicine.	
Renal Medicine	Review of the Programme Specific Questions was undertaken by the Renal SAC quality team in conjunction with representatives from the GMC on the 1st October 2015. All the questions were reviewed and some were revised to make them clearer and minimise any ambiguity. Questions related to Renal Biopsy were removed (procedure is not a mandatory curriculum competency in the 2010 curriculum). Analysis of questions related haemodialysis training, renal transplant recipient assessment and live donor work-up are discussed above, and these questions were further refined to capture more specific data for forthcoming year.	There were concerns around ambiguity of some of the questions. This has been addressed by revising the questions and making them clearer for trainees to respond to. No further investigation required at this stage.
Renal Medicine	In the last 12 months, 44% trainees have not attended a haemodialysis MDT meeting; 69% trainees not attended a live donor transplant work up clinic; 54% not been involved in care of adolescent patients). Many programme directors report some outpatient clinic experience being sacrificed to maintain adequate ward cover and commitment to GI/JM rotas.	
Respiratory Medicine	SSQ data shows that overall 50% of trainees have completed level 1training. 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 NTS continues to highlight an issue with level 1 pleural US sign off.	TPDs have been asked to keep a register of those in region who are able to effect sign off.
Rheumatology	Analysis of each question on basis of all trainee results, year of training and by LETB, with comparison with 2014 results (although change in LETB in Scotland meant no direct comparison available for there). Results discussed at SAC. Overall results are very good with no national areas of concern and overall improvement when compared with 2014. Individual LETB local training committees discuss results at their training committee meetings identifying any areas of concern and putting action plans in place to address these. Input was also requested through SAC trainee representative who sought the views of the local STC reps. It was felt that, on the whole, the current set of questions do capture the breadth of the different aspects of rheum training within a post but that they are quite broad in their current phrasing It was proposed by trainee reps that questions may be more discriminatory if, instead of a general question such as "I have had adequate opportunity to discuss with my consultant the management of outpatients I have seen" there is a list of some 'time frame' options ie daily, weekly, monthly, occasionally. This may be more discriminatory than the current answer options of 'strongly agree', 'disagree', 'neither agree nor disagree' etc. If trainees only have an opportunity to discuss cases on a monthly or less frequent basis then there is an issue.	One point not reflected in the survey which was felt to be important by the trainee representatives was regarding exposure to paediatric rheumatology. This has been discussed within the SAC on numerous occasions and remains an area of future interest.
Sports and Exercise Medicine	None of the 10 programmes specific questions received >30% red/disagree responses. The areas that received a >20% red response were knowledge and skills in physical activity, exercise physiology, disability sport and elite sport. Responses varied between regions according to specific strengths and weakness locally. A considerable advance over the last year has been an improvement of the clinical indemnity cover available to trainees who undertake placements in elite and disability sport. Previously a lack of suitable indemnity cover has precluded trainees from taking up suitable placements and the new arrangements will limit the impact that this has on SEM training. There has been minuted discussions at SAC meetings and two-way feedback via the SAC trainee representative.	The SEM curriculum is currently under review and it is likely that a detailed trainee survey will be conducted when the educational content is finalised.

Quality assurance

5. Good practice

We have developed an enhanced programme to promote, identify and share areas of good practice. We have published areas of good practice identified through our quality assurance activities on a new webpage.
www.gmc-uk.org/education/good_practice.asp

Please let us know about initiatives that you have successfully implemented since your last ASR submission; providing evidence to demonstrate the positive outcomes. Good practice is defined in our Quality Improvement Framework as 'areas of strength, good ideas and innovation in medical education and training'. This includes new approaches to dealing with a problem from which others might learn. This could be an initiative implemented across the college as a whole eg the validation of educational supervisors training in a bid to identify a benchmark for trainer standards, or within one deanery or LETB eg consultant residency posts in Health Education North West.

- Specialty: Please note all affected specialties. If the issue affects all specialties managed by your college/faculty please state "College/faculty-wide".
- Location: Please provide sufficient location detail to help us further identify the good practice, including the relevant Deanery/LETB and LEP. If the good practice relates to multiple locations please list all of them.

Description	Specialty or sub-specialty	LETB/Deanery - or national / specialty wide	Development of actions	Other potential use
Monitoring access to OOP opportunities. The SAC were concerned that trainees may have been applying for but been unsuccessful in applications for OOPR, OOPT or OOPE.	Cardiology	National	A Programme Specific Question (PSQ) was developed for the National trainee Survey (NTS). Have you unsuccessfully applied for any of OOPR, OOPT or OOPE in the last 12 months? No trainees reported any difficulties when answering this question in the 2015 National Trainee Survey.	The same question could be asked by other specialties as part of their PSQs.
The GMC National Trainee Survey indicated that there was poor curriculum delivery in ACHD training nationally.	Cardiology	National	The NTS confirmed poor curriculum delivery in ACHD. The SAC initiated several responses including access to an e-learning package www.achdlearningcenter.org led by Dr Kate English. This is an international venture with a European 'feel' to it, but the content is good, its free to access, follows good educational theory and it maps well to the UK curriculum. It is not though, a UK based project, being led by clinicians in the States and Holland with input from Dr English and a colleague in Canada. The site is recommended by our ACHD leads and this has the agreement of the SAC in Cardiology.	
Development of 4 week induction package. The 2014 NTS suggested there were significant variations between regional centres in the quality of the induction programme for new trainees starting out in the specialty. We therefore commissioned our SAC trainee representatives to survey all UK trainees on their experiences of induction to determine the most useful components of this process and to make recommendations. We also sought views from training centres who had received excellent feedback for their induction period. These measures have resulted in a recommended 4-week induction package which covers all the initiatives identified above which will be added to our curriculum as an appendix.	Clinical Genetics	National		The induction programme could be reviewed, standardised by other medical specialties and added as an appendix to curriculums.
We have developed a list of genetic conditions which trainees are likely to encounter during the course of their training. This is a guide to the range of conditions seen in our service rather than an exhaustive list, which will aid understanding of the broad scope of genetics.	Clinical Genetics	National		A guide to the range of disorders encountered could be helpful for other specialties that interact with nearly all others, such as Medical Oncology.

Institutional links to augment research training have been made with Astra Zeneca	Clinical Pharmacology and Therapeutics	East of England, North West	Successful PhD fellowship application (London), trainees planning careers in industry (Cambridge), development of a highly successful clinical trials unit (Liverpool)	CPT could curate nationally the relationship between the medical profession and the pharmaceutical industry, by liaising with industry leaders to identify unmet industrial need for contact with medical specialties. We have piloted a post CCT-fellowship in experimental medicine. In the future training environment, this could be open to all specialties.
RCP London Chief Registrar Project pilot The chief registrar is a new role for trainee physicians, inspired by recommendations in the Future Hospital Commission report. The focus is on acquiring skills in clinical leadership and management. Patient safety, clinical outcomes and quality of the patient experience will be at the forefront of the chief registrars' work. The new role will equip physicians in training with the values, skills and attributes that will be essential throughout their future medical careers. Part of the aim is to nurture and develop future medical directors, clinical directors and chief executives.	College-wide	National	The RCP London is running a pilot to identify the skills, time and training needed to support the role, and will formally evaluate the implications for professional development, patient experience and outcomes, and organisational outcomes.	Other Colleges could look at developing a similar pilot for their trainees.
A quality audit involving key internal and external stakeholders and reviewing all JRCPTB Quality Management activities is being undertaken.	College-wide	National	Draft recommendations include: - Development of a QM strategy - Development of a data strategy - Development of quality criteria for all higher specialties - Standardisation of deanery/LETB data collection - Increased collection of EA reports - Publication of a policy for conducting surveys - Development of routine horizon scanning for future data sets	
External Advisor reporting. More detailed external advisor reports on standards of education and training in order to highlight discrepancies between Deaneries and LEPs especially in the area of quality of educational supervisor reports.	College-wide	National	All External Advisor reports highlighting concerns and examples of good practice were collated for each specialty and reported as an annual report to the SAC. Any issues of concern were fed back to postgraduate deans with a response required on the actions taken to address the concerns raised by the EA with responses fed back to the SAC. A report on good practice will be produced subsequently and before the next ARCP round.	
CMT destination survey undertaken on CT trainees at around the time of their final ARCP to determine their subsequent career plans	Core Medical Training	National	Only approximately 60% on trainees able to progress to ST3 indicated that they came directly from CMT. This will be repeated in 2016 with the data being collected by TPDs at the time of ARCP. The CMT SAC will be developing this further to include reasons for career choice.	
CMT Quality Criteria for trainees and trainers. Survey of both trainees and trainers about aspects of the programme and progress against quality initiatives supported by the JRCPTB. Results were available region by region for comparison and dissemination to all regional programmes via TPDs and Heads of School. The results were also discussed at CMT AC and regional CMT Committees.	Core Medical Training	National	Regions were grouped into quartiles based on trainee and trainer responses to each of the criteria. The results highlighted a variation between trainers who were more likely to agree the criteria were being met and trainees who were more likely to disagree. The survey will be repeated annually to determine progress towards meeting the criteria.	

Detailed report on MRCP outcome data	Core Medical Training	National	The level of attainment of trainees entering the programme by region demonstrates marked disparities which will need to be considered when interpreting final MRCP attainment at the end of the programme by region. Areas of specific weakness in trainee attaining part of the MRCP were identified together with regional differences in specific subject areas. This will be repeated yearly to determine progress.	
Improved induction with comprehensive booklets and "buddy system" support	Dermatology	East Midlands, North West	Following poor NTS feedback from trainees, actions were developed at local level, which included comprehensive induction booklets and a "buddy system" implementing areas of successful induction programmes from other Dermatology sites. This has received favourable feedback at local level.	
Assessing the Assessors Training Day. Annual one-day course with scenario videos for WBA benchmarking, doctors in difficulty, ePortfolio and other relevant topics for Clinical and Educational Supervisors	Dermatology	National		
Regional training programme website has been established. Resources available include an induction pack with details of the training programme, guidelines, quality improvement projects and research opportunities. There is a regional newsletter which is incorporated into the website. There is an active Northern endocrine network, which also incorporates two trainee representatives and is chaired by the TPD. Four prizes are awarded within the specialty for best publication by a trainee in a peer reviewed journal, best publication by a trainee when in clinical training, best poster by a trainee in a national or international conference/meeting and best quality improvement project led by a trainee.	Endocrinology & Diabetes Mellitus	North East		Other specialties could consider this as part of their regional training programme packages.
ST5 Trainees receive exclusive specialty training at Churchill Hospital for 18-24 months including specialty on call. During this period, they have GIM commitments of 14 night shifts per 12 months, split into two weekends and two sets of weekdays. They are RMO at night, working with two CMTs to cover Endocrine, Respiratory, Renal, ID, Haematology and Oncology. They also review surgical patients with medical problems and lead the crash team. They are also point of contact for any medical specialty (except Haematology and Oncology) queries after 9.00PM.	Endocrinology & Diabetes Mellitus	Thames Valley	This is highly valued by trainees and deemed to be best practice for training by the SAC.	
Monthly central programme, which allows trainees to attend for a day and receive clinical and management training	Endocrinology & Diabetes Mellitus	Wessex	This is fully supported by educational supervisors who facilitate attendance and also teach. The curriculum is repeated every two years.	
SPRINT programme to provide accelerated training in upper GI endoscopy. Colleagues in Wales developed a programme to offer a defined programme of training with fixed induction dates and regional training days with monthly targets for exposure to endoscopy training underpinned by enhanced local mentorship. A pilot has demonstrated an improvement in acquisition of skills with earlier achievement of competency in gastroscopy.	Gastroenterology	Wales	The process has been disseminated to all TPD's through the BSG training committee to consider a future national roll-out depending on demonstration of deliverability in an extended pilot.	
Pan London SpR training day in sexual assault. This was organised by Kings College Hospital and will be hosted by HES London in September 2016 to cater for all 65 GUM trainees in London & KSS. Trainee surveys have previously identified a need for standardised adult sexual assault training due to variable provision of this training between London & KSS training centres. A similar training day organised in 2013 by KCH received excellent feedback from trainees on quality of speakers & content of training.	Genito-Urinary Medicine	London		

An additional HIV clinic produced as a "Training and teaching clinic" with longer appointments to allow for discussion before and after the consultation for more junior trainees. The trainee is seen as supernumerary with both consultant and trainee timetabled to attend the clinic. This allows for trainee to see the patient with consultant supervising in the same room. This enables the trainee then to have 2 HIV clinics per week – one in Infectious Diseases in Newcastle and one in GUM. A similar sort of clinic was introduced in Newcastle GUM for the other trainee in the Newcastle/ Sunderland rotation. In addition new MDT arrangements were recommended by commissioners and trainees are required to attend the HIV MDT meetings in GUM in Sunderland and Newcastle. Overall as the North East has one of the lowest prevalence of HIV in the UK this has increased the trainee's exposure to HIV training in preparation for the now mandatory Diploma of HIV Medicine. Trainees were concerned that as Dip HIV was now mandatory only one HIV clinic per week may not be sufficient training.	Genito-Urinary Medicine	North East	A mock OSCE for Dip GUM has been developed as part of the training. Two trainees who did the OSCE passed Dip GUM on their first sitting but further evidence is awaited on the value of the OSCE.	
Grampian - Top 5 Trusts/ Boards by numbers of green flags in 2015 NTS – Grampian – 1st equal – 5/14 green flags. Key changes made that may have contributed to this: 1. The Geriatric Medicine Dept has introduced a quality improvement programme where the StRs have taken a lead role in driving the improvement of geriatric medical services. 2. There has also been an increasing focus on community work with active inclusion of the StRs in this development. 3. StRs have also been involved in the weekly departmental consultant meetings.	Geriatric Medicine	Scotland	The introduction of clinical quality improvement programmes that actively include StRs	
Trainee feedback at trainee meetings and through the GMC survey indicated that trainees were wanting to broaden their experience. Haematology rotations now include four DGHs in the region. With a trainee full time at each of these sites a higher proportion of each trainee's time is spent at DGH level.	Haematology	Northern Ireland		Dissemination to other TPDs as an example of good practice.
Increased protected laboratory time with two specialty trainees rotating simultaneously to the lab for 3 month blocks. This has led to improved experience in flow cytometry, molecular diagnostics, and haemoglobinopathy investigation, as well as enhanced morphology experience.	Haematology	Northern Ireland	The FRCPath exam success rate at first attempt has increased.	Dissemination to other TPDs as an example of good practice.
Introduction of Core Infection Training programme. There has been a long process of development of the core infection training curriculum. This has been a complex piece of work because it has involved specialties in two different colleges (physicians and pathologists) and because it has required cooperation on a common assessment system, a common e-portfolio and a common national recruitment system and significant changes to training programmes. Transition arrangements for trainees have also been required.	Infectious Diseases	National	Trainee outcomes are not yet available. However the specialties involved have developed and agreed the curriculum and common ways of working and training programmes are being implemented.	
A survey by the Care of the Elderly and the Medical Oncologists indicated that training in decision-making in elderly patients with cancer was an issue for trainees in Medical Oncology. Following this the ACP study day was held in October 2014, which was very well attended and evaluated. Problem solving in Older Cancer Patients' 2015 Eds: A. Ring, D. Harari, T. Kalsi, J. Mansi and P. Selby was written following the ACP study day.. Section 2 of the book is a series of 32 case studies which highlights particular complex problems/issues in the older person. Authors of each case study included a Medical Oncology trainee as first author, supported by a trainee in Care of the Elderly, and Consultants in Care of the Elderly and Medical Oncology. This represented a unique opportunity for these specialties to work together. The trainees were from the London LEP (Guy's and St Thomas' NHS Foundation Trust, Royal Marsden Hospital NHS Foundation Trust) and Leeds LEP (St James' University Hospital). The book has been distributed widely across the country.	Medical Oncology	National		The philosophy of the ACP study day (reported as an example of good practice in the 2014 ASR) and then a book published on specific subjects and in particular case histories to illustrate complex problems is a theme which can be used in different disciplines (multidisciplinary) and also within medical oncology.
Development of an SAC working group on Onco-Genetics. The Onco-Genetics working group is a specialty-wide group.	Medical Oncology	National	This is to address the increasing recognition of personalised medicine and the decision-making associated with this. Outcomes will be formally assessed through the SCE.	The geneticists may wish to form a similar working group in their specialty for oncology. Precision medicine applies to many specialties.

An ACP Study Day was held on 16th October 2015 on Precision Oncology. The ACP Study Day was attended by Consultants and Medical Oncology trainees across the country and included the relationship between identification of genetic markers, targeted treatments for different types of cancer, which has increased markedly over the last few years. All attendees rated the study day extremely useful or useful with particular emphasis on the value of clinical cases and discussion. There will also be a book published in 2016 which will reflect the study day and again a series of case histories to highlight different complex scenarios written by the trainees with a Consultant Medical Oncologist/Geneticist.	Medical Oncology	National		The philosophy of the ACP study day and then a book published on specific subjects and in particular case histories to illustrate complex problems is a theme which can be used in different disciplines (multidisciplinary) and also within medical oncology.
Comprehensive chemotherapy competency tool, with a pilot in August/September 2015 to assess its use and incorporate changes before it is accepted as part of the curriculum, and made available through the eportfolio. The initial impetus for the development of the chemotherapy competency guidelines was in response to a speciality specific medical oncology question in relation to training in chemotherapy prescribing. The development of this initiative will ensure that all trainees will be formally assessed appropriately.	Medical Oncology	National	The comments from the respondents and the patient representative have been incorporated in the latest document to be submitted to the curriculum committee of the GMC.	As chemotherapy in given in disciplines other than Medical Oncology, this competency document can be used for other clinicians involved in the prescribing of systemic anti-cancer therapy.
Survey of ACLs / ACFs in Medical Oncology to determine whether those trainees with an ACF were progressing satisfactorily (this is with the knowledge that over 95% of our trainees pursue a higher degree in training outside the ACF/ACL scheme) through the process and obtaining PhDs, were able to progress to ACL, and the number of trainees in ACL posts who have gone onto become either a senior lecturer or clinician scientist. From September 2009 to January 2015, there were 57 ACFs of whom 36 had completed a PhD and 5 had progressed to ACLs. Of the 30 ACL posts, 9 had become senior lecturers or clinical scientists.	Medical Oncology	National	The survey represents baseline data and will enable the speciality to track progress and identify areas where additional input is required and identify areas of good practice. This survey can be used by other specialties that have support ACFs/ACLs.	
There has been concern that training posts in Neurology are not being filled and coupled with the continuing problems recruiting to Stroke Medicine. Neurology trainees are being appointed to 5 year programmes that lead to a CCT in Neurology and Stroke Medicine. Using stroke training posts in this way (rather than as stand-alone years done as an out of programme experience) has given the director of the training programme greater flexibility. Feedback from the training programme director has been positive, regarding not only the greater engagement of trainees in stroke but also the reduction in gaps in the training programme.	Neurology	London, Severn		The clinical disciplines of stroke medicine and neurology lend themselves to being closely coordinated for training purposes and for service delivery.
Trainees are keen to acquire experience in a number of different areas of clinical practice and As a result of having a full cohort of trainees in the regional centre in the Severn Deanery timetables are reorganised to allow trainees to take a three-month elective period to attend subspecialty clinics and pursue subspecialty training.	Neurology	Severn		If there is sufficient engagement by trainees and consultants, training programmes can be adjusted to allow trainees to pursue areas of practice outside the core curriculum, including subspecialty training and training in leadership and management.
The number of clinics attended was monitored and compared with the curriculum requirements. Feedback was sought from trainees about the number and variety of clinics attended. A flexible approach to 'attaching' trainees to specific clinical supervisors was adopted, so that they would be able to go to supervised clinics of any neurology consultant if, for any reason, their assigned supervisor was not in clinic. The number of clinics was carefully monitored over the year to ensure that enough experience and training opportunities were offered. The GMC survey of trainees rated Plymouth 6th for adequate experience and clinical supervision and 10th for workload out of the neurology programmes.	Neurology	SW Peninsula		A 'forward look' spread sheet of clinics for the upcoming month that is available to trainees ahead of the month and can allow them to ensure that their clinic training needs are met each month could be used elsewhere.
Neurology liaison consultant of the week to improve handover and consultant supervision of trainees. All Wessex consultant neurologists take part in the on call rota but only a few are based at the Neurological Centre every day. These few provide a consultant of the week service which includes a morning board round for all neurology inpatients and a clinical review of any new admissions or unwell neurology patients. There is a clear mechanism to handover patients from on call and the trainees report that they feel better supervised. The consultant of the week has no other fixed clinical commitments and so there is plenty of opportunity for training and reviewing acute neurology referrals. Since introduction, there has been improved satisfaction scores for supervision and handover in the GMC survey.	Neurology	Wessex		This requires a review of consultant job plans and sufficient neurology consultant numbers.

It was recognised that trainees were not being observed in real life clinical consultations very often in the course of their day to day work. The need for 'live' assessments of the performance of trainees was prioritised and training in common Neurological scenarios with simulation protocols developed with simulation leads in the trust and deanery. Status epilepticus and stroke thrombolysis simulation protocols have been used with groups of Neurology trainees and nurses. Other scenarios covering basic communication skills, live letter dictating using video consultations, the use of translators and breaking bad news have also been simulated. Work place based assessment tools were completed for all team members by multiple consultant assessors.	Neurology	Yorkshire and Humber	There is on the job evidence of improved performance of the trainees in practice.	Simulation scenarios could be shared. Live acute care simulation protocols and facilities could be utilised by a wider audience of trainees.
Trainee satisfaction improved A simple re-organisation of the training rotations in West, North Yorkshire and Humberside has improved trainee happiness. Trainees were previously allocated to 2 centres in a 5 year rotation and could be allocated to multiple regions. Trainees were sometimes missing out on high quality training opportunities in small DGH settings dependent on their rotation or requesting transfers. This reorganisation will allow all trainees to experience 3 different training centres but with a reduction in the total travelling required. Recruitment to the programme has also recently been more successful.	Neurology	Yorkshire and Humber		Unpopular parts of rotations are often unpopular because of the effects on family life. Looking closely at the rotation to ensure a good mix but geographically sensible locations improves trainees' happiness.
The implementation of the new curriculum (GMC approval August 2014, implementation August 2015) with the inclusion of core radiology training and FRCR within the Nuclear Medicine training programme will have a positive effect on training of NM specialty across the UK. Trainees will be better equipped with the skills to confidently interpret hybrid imaging studies, present complex imaging data at MDTs and review correlative diagnostic imaging studies in patients having radionuclide studies. The first trainees on this new curriculum will complete training in 2021 and it is hoped that employing Consultant Nuclear Medicine Physicians may become a more attractive option for Trusts than currently and that job opportunities for Consultant Nuclear Medicine Physicians may increase. Also that the improved training programme will stimulate recruitment to the specialty. Transition arrangements for trainees transferring to the new curriculum and arrangements for new trainees appear to have gone well.	Nuclear Medicine	National	Numbers of applicants for SpR posts in the specialty have increased in 2016 round 1 recruitment compared to 2015 round 1 recruitment which was held soon after curriculum approval. We will be monitoring the results of future rounds of national SpR recruitment closely and also the number of consultant posts in the specialty being advertised. Also the results of trainee feedback informally at ARCP/Informal review and via the GMC National Trainee survey.	The unique aspect of this curriculum change has been successful liaison between the Royal Colleges of Physicians and Radiologists. Dialogue has been generally very positive between the two colleges with benefits to trainees.
Formalised teaching in transthoracic echocardiography with consultant review of images taken by trainees has reduced the number of NTS red flags from 8 to 2 over a 2 year period.	Paediatric Cardiology	Severn		Formal introduction of consultant led echocardiography teaching and review with feedback should be standard across the specialty.
Development of simulation training in palliative medicine. The use of simulation in training of palliative medicine trainees is being driven by local education providers and is under development in those areas. Feedback from trainees and trainers in Yorkshire and Humber evidence enhancement of training and an ability to assess trainee's performance in emergency situations which is currently hard to do.	Palliative Medicine	Mersey, Yorkshire and Humber		Scenarios developed in Mersey and in Yorkshire and Humber could be shared with other LETB providers to develop a national portfolio which could be used in any part of the country which has simulation facilities.
Speciality Specific Handover Guidance has been developed. GMC surveys have consistently identified difficulties in handover in palliative medicine. Issues in palliative medicine are different to general internal medicine. In some areas, trainees cover more than one unit when on call and sometimes trainees are on call in a unit where they do not do daytime work. A subgroup of the SAC has worked on guidance for handover for palliative medicine which has been shared nationally.	Palliative Medicine	National	The guidance has been shared nationally and the GMC survey has demonstrated an improvement in handover for palliative medicine.	The guidance has been shared within palliative medicine nationally.
HEEM have developed the first 'Integrated care fellowship' at Lakeside Surgery [Vanguard site] and Kettering General Hospital. The fellow is working with Primary care renal leads to develop a series of quality improvement projects related to interactions between primary care and secondary care renal medicine. This is the first integrated care fellowship in Renal Medicine in England and is supported by HEEM and JRCPTB.	Renal Medicine	East Midlands	Recent innovation and outcome data is awaited.	This could be considered by other LETBs.

ESR are pivotal to the ARCP process as it provides evidence of trainee engagement with the curriculum and triangulates information from WPBA and other sources of evidence. However, ESR by their nature vary in quality and in order to improve this, we adopted and used a standardised framework to assess the quality of ESR and SLEs with targeted feedback to individuals. Successive ESRs from North West LETB has shown significant improvement in quality in ESRs with a significant increase in the "excellent" grading of the reports (13.3% to 50%) and a significant fall in the reports which "needed improvement" (33.3% to 7.1%) (P<0.0001). Qualitative feedback from ES is overwhelmingly positive.	Renal Medicine	North East, North West	ESR are pivotal to the ARCP process as it provides evidence of trainee engagement with the curriculum and triangulates information from WPBA and other sources of evidence. This could be adopted by all specialties and LETBs.
Recruitment to medical specialties has been a recent significant issue. Gaps in the rotas consequently affect the workload and quality of training of existing trainees. Northern Ireland have developed local initiatives which have resulted in excellent recruitment to renal specialty posts. These include: - Medical students encouraged to spend clinical electives in nephrology. - F2 doctors have opportunities to do "taster modules" spending one week in specialty to "see what it is like. Local nephrologists actively teach on the F2 teaching programme so all Foundation trainees get exposed to Renal Medicine. Core trainees in renal medicine e.g. F2, CT1 or CT2 are also invited to come to renal StR educational seminars (to see what is involved in renal medicine training).	Renal Medicine	Northern Ireland	These measures are maintaining a high interest in renal medicine as reflected in the number of good applicants for ST3 posts and no gaps in the rotation. This could be adopted by all specialties and LETBs.
The delivery of quarterly national training days has directly led to improved quality of teaching matched to the SEM training curriculum. Attendance at a minimum of 3 out of 4 training days is now one of the objective criteria used for satisfactory ARCP progression. East and West Midlands have combined fortnightly teaching alternating between regions has increased the quality of teaching and improved trainee attendance. Yorkshire, North East and North West combine to meet twice annually to directly address issues created by a lack of suitable trainers and familiarity with the SEM curriculum in any one region.	Sports and Exercise Medicine		It is an approach that may benefit similarly sized specialties with problems created by lack of trainers and a relatively small number of trainees.

Additional comments

Annual specialty report 2015
Curriculum approvals updates

6. Please provide an update for actions in curriculum approval decision letters from August 2014 to September 2015
If your college/faculty have submitted a change to a curriculum and received a decision letter requesting further action or follow up, please provide a summary of all actions that are still outstanding/in progress.

Curriculum approval decision	Update
Nuclear Medicine 2015 curriculum approved. Extension of training to 6 years with first three years spent in core radiology training.	New curriculum, ARCP decision aid and Implementation guidance published on JRCPTB website and trainees contacted directly to arrange transfer or advised to remain on current curriculum according to transfer arrangements. Liaison with RCR to manage enrolments and eportfolio provision during core radiology training
Palliative Medicine - 2014 amendments to allow entry to the specialty from trainees completing early years of emergency medicine (ACCS route) approved	Revised curriculum published on JRCPTB website and trainers informed. ST3 person specification updated.
Respiratory medicine - minor amendments to 2010 curriculum	Revised curriculum published on JRCPTB website. Minimum training requirements circulated to SAC, trainers and external advisers.

Additional comments

7. Please provide details of the quality management processes used to manage exams and/or other qualifications that form part of the CCT (eg MSc, Diplomas, Certificates) that are not directly delivered by the college/faculty itself (ie delivered by third parties such as universities and societies)
The GMC are responsible for the approval and quality assurance of all medical postgraduate UK curricula. To help us identify the quality management processes used to manage curricula, and more specifically any college exams or other qualifications that are delivered by an external provider, we are requesting information to understand this framework. A suggested list of the exams/courses is provided below. Please correct, add or remove any information and provide details of the quality management framework used to manage third party providers.

Exam/qualification	Delivered by	Quality management processes
Diploma in Audio vestibular Medicine	University College, London	There are close links between SAC and UCL with a faculty member as academic representative and several SAC members are examiners. Other providers have been put forward for amended taught modular requirement in current curriculum submission and the specialty is exploring running its own KBA in collaboration with the RCP London.

Diploma of GU Medicine and Diploma HIV Medicine	The Worshipful Society of the Apothecaries	GUM SAC representatives oversee both of the Diploma examinations and provide an annual report to the SAC covering the examination blueprinting, the examination concept of utility, examination standard setting, candidate feedback and appeal, and review procedures. In addition the representatives will have access to all stages of the examination process and may attend as observers to any or all examinations. The SAC representatives will audit and confirm the training of examiners. SAC representatives will be invited to all SAC meetings. This arrangement will be reviewed annually. The Worshipful Society of Apothecaries has complaints procedures and appeals regulations published on its website.
Diploma FSRH	The Faculty of Sexual and Reproductive Health	The Dip FSRH is a recognised assessment of basic competence in contraceptive service provision and builds on a Department of Health supported 'E-learning for Health' module. Assessment is competency based and conducted by trained supervisors within clinics. The Dip FSRH meets the curriculum and assessment requirements for GUM and also for General Practice, Reproductive and Sexual Health and Obstetrics and Gynaecology. There are close links with the GUM SAC which oversees the links between the curriculum and the diploma.
Diploma in Tropical Medicine and Hygiene	Royal College of Physicians of London provide the examination, the London School of Hygiene and Tropical Medicine and the Liverpool School of Tropical Medicine provide the taught course	The RCP London is responsible for the governance of the DTMH examination and commissions MRCPUK to run the exam to the same quality standard as SCEs. There are strong links between the SAC and the diploma course and examination providers with regular academic updates and involvement in quality assurance and standard setting for the examination. The Diploma of Tropical Medicine and Hygiene is strongly recommended, but is not a mandatory requirement of training in infectious diseases.
Postgraduate Diploma in Nuclear Medicine	King's College, London	The Director of the Kings College Diploma is a member of the Nuclear Medicine SAC and ensures that it meets the needs of trainees in Nuclear Medicine with regard to content and standard and ensures the SAC of the quality assurance and standard setting arrangements. There is regular dialogue with committee and several members are Module Leads and Examiners.

Additional comments

8. Please provide an update on progress for moving doctors to the current curriculum and sign-off process

We also request an update on the transfer of doctors to the current curriculum. Please provide numbers of trainees following each curriculum if this is known. As you will be aware, any specialty trainees who started before 1 August 2007 were covered by A Guide to Specialist Registrar Training ('The Orange Book') which used the RITA assessment system. As of 31 December 2015, all trainees must have transferred and be managed by A Guide to Postgraduate Specialty Training in the UK ('The Gold Guide'), which uses the ARCP process and follow the current approved curriculum.

Please provide numbers of trainees following 'The Orange Book' and confirm their transfer will take place by 31 December 2015.

Specialty	Number of doctors	Update
Acute Internal Medicine		All trainees transferred
Allergy		All trainees transferred
Audio vestibular Medicine		All trainees transferred
Cardiology		All trainees transferred
Clinical Genetics		All trainees transferred
Clinical Neurophysiology		All trainees transferred
Clinical Pharmacology and Therapeutics		All trainees transferred
Dermatology		All trainees transferred
Endocrinology and Diabetes Mellitus		All trainees transferred
Gastroenterology		All trainees transferred
General Internal Medicine		All trainees transferred
Genitourinary Medicine		All trainees transferred
Geriatric Medicine		All trainees transferred
Haematology		All trainees transferred
Immunology		All trainees transferred to 2010 curriculum. Transitional arrangements in place for 2015 curriculum
Infectious Diseases		All trainees transferred
Medical Oncology		All trainees transferred
Medical Ophthalmology		All trainees transferred to 2010 curriculum. Transitional arrangements in place for 2015 curriculum
Neurology		All trainees transferred
Nuclear Medicine		All trainees transferred to 2010 curriculum. Transitional arrangements in place for 2014 curriculum
Paediatric Cardiology		All trainees transferred
Palliative Medicine		All trainees transferred
Rehabilitation Medicine		All trainees transferred
Renal Medicine		All trainees transferred
Respiratory Medicine		All trainees transferred
Rheumatology		All trainees transferred
Sports and Exercise Medicine		All trainees transferred

Additional comments

9. Small specialty review updates

This section is only applicable to colleges/faculties with actions outstanding from small specialty reviews. We will pre-populate any actions on which we would like an update. A copy of the small specialty review report will be added to GMC Connect for your reference.

ONLY complete this section if it has been pre-populated with actions by the GMC.

Specialty: Paediatric cardiology				
Report ref	**Description**	**Update provided by College in 2014 ASR**	**GMC comments**	**Update from College in 2015 ASR**
Req 2	Postgraduate deaneries must provide doctors in training with comprehensive information about allocation to special interest areas (SIAs). Selection into the special interest areas must be more open and explicit so that all doctors in training have an equal chance in competing for a particular area.	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.	Opportunities to go into SIAs are only advertised if more than one doctor in training applies. Shouldn't an advert be placed for all SIAs? How do doctors in training know the SIA is available in the first place?	Currently all trainees are expected to complete 5 years and there is no requirement to reapply for the last 2 years during which SIA training takes place. If 2 trainees apply for one SIA in a particular deanery then interviews will be held. There are 2 separate SIAs in foetal cardiology in London which are nationally funded and pre-existed the 2010 curriculum. These SIAs are always openly advertised. Doctors in training are informed before making an application for training in Paediatric Cardiology which SIAs are available in each Deanery. The SAC Chair has recently asked training centres to specify which SIAs they are able provide to ensure that applicants are fully informed at the time of initial application. We have considered a separate appointment process for SIAs across the specialty but believe it will be disruptive and difficult to administer in a specialty with so few trainees.
Rec 2	The JRCPTB, the SAC and the deaneries should work together to reconcile and ensure their data on the number of doctors in training within paediatric cardiology training programmes is accurate. This should include information on which special interest areas are being followed by doctors in training to benefit workforce planning.	Quarterly Deanery data sets are being received from the following deaneries: • East Midlands • London • Mersey • Northern Ireland • 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.	Thank you for the comprehensive update. There is good progress reported. Please provide an update on any further activity on this recommendation.	No further activity on this recommendation.
Rec 3	Postgraduate deaneries should consider routine and scheduled visits to quality manage training in paediatric cardiology.	Formal feedback is received by the SAC from training days. Externality will include both the ARCP and 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.	There is good progress reported. Please provide further details. Are the different methods of gathering feedback cross referenced to find out whether these mechanisms are effective? What happens with the feedback gathered by the SAC? What do deaneries and LETBs do with the feedback. Is it addressed and shared with the College?	The different methods of gathering feedback are informally cross referenced and shared with the SAC. The SAC chair strongly encourages members to respond to areas of concern for the ASR. As the NTS returns from some deaneries often have 3 or fewer responses we intend to commence our own survey administered by trainee representatives to inform the SAC. With the new arrangement for ARCPs and externality (see below) we believe that feedback will be more objective
Rec 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 paediatric cardiology trainees and paediatric trainees with an interest in cardiology.	The link has been established and an RCPCH representative	There are two routes of entry into the specialty, one managed by JRCPTB and one managed by RCPCH. How is change managed across the two Colleges? For example, how are changes to the curriculum communicated? How do the Colleges make sure there is an equivalent level of knowledge between the trainees from each route?	A representative from RCPCH now sits on the paediatric cardiology SAC. Applicants from paediatrics enter after 3 years of paediatric training. Applicants from core medicine must complete 1 year in paediatrics including 6 months of level 3 neonates before entry. Paediatric trainees who wish to develop special interest training (SPIN module) in paediatric cardiology follow a 1 year curriculum written and approved by members of both colleges. Applications for this training module are signed off by RCPCH and the Chair of paediatric cardiology SAC.
Rec 5	National training days should be scheduled sufficiently in advance to enable doctors in training to arrange their attendance.	This is in place.	Recommendation is being addressed sufficiently and can be closed.	No update required
Rec 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 curriculum is being taught in local training areas.	Please provide further details in your next update.	The 3 year rolling program of national training days is now designed to enhance locally provided knowledge. Feedback from national training days is collected and analysed with good outcomes but we need to obtain feedback on locally provided knowledge through EA reports.

Rec 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.	Thank you for the comprehensive update. There is good progress reported. Please provide an update on any further activity on this recommendation.	ARCPs are now combined into 5 regions (SW, London, Midlands, Northern and Scotland together with NI) each having designated EAs. The EAs will rotate every 2-3 years.

Specialty: Audio vestibular medicine

Report ref	Description	Update provided by College in 2014 ASR	GMC comments	Update from College in 2015 ASR
Rec 2	A mapping exercise to the curriculum should be undertaken for every post in the country, particularly the secondments in Derby and Cardiff under HENW, to justify the rotations and collection of posts that make up the training programme. It would then be evident where doctors in training need to go for training and why. It would also ensure that TPDs and trainers had information about coverage nationally and could take action to ensure doctors in training were able to fill in experience and training gaps. (paragraph 32).	Recommendations for AVM not included in previous ASR		A mapping exercise has been performed. Placements, rather than secondments, in Derby and Cardiff are important for adult audio vestibular training. HENW Trainees and trainers are aware of the training opportunities at each training site and, for those few training needs not met within the programme, are aware of training opportunities available in London. This is discussed at appraisal meetings.
Rec 3	Greater clarity and guidance should be given to doctors in training on what evidence is required at ARCP and the Penultimate Year Assessment (paragraph 33).	Recommendations for AVM not included in previous ASR		The updated ARCP decision aid is available to all trainees and trainers and gives clear guidance on the required evidence.
Rec 4	The form that doctors in training complete when applying for secondments should be reviewed to reduce variation in how information is recorded and to integrate the form into the e-portfolio system more easily (paragraph 30).	Recommendations for AVM not included in previous ASR		Forms, based on curriculum competencies for the secondment, have been circulated. The e-portfolio system, however, does not lend itself to integrating such forms within it – the personal library area remains the most user friendly area to use.
Rec 5	The specialty should pursue and roll out its plans to build knowledge based assessment into the curriculum so that it is no longer dependent on University College London to deliver the assessment system (paragraphs 45 and 46).	Recommendations for AVM not included in previous ASR	Some of the exam questions used for the MSc in AVM clinical modules could be tailored towards a KBA.	The SAC are developing a Knowledge Based Assessment as a formative assessment to be delivered annually. A pilot KBA was successfully performed and a further pilot will be arranged for 2016 after modifications put in place.
Rec 6	The specialty should continue to review the Masters and explore alternative ways of assessing the knowledge and competence of AVM doctors in training (paragraph 47).	Recommendations for AVM not included in previous ASR		The SAC is in the process of validating with the GMC the delivery of Postgraduate Certificate courses by other university sites to provide some of the knowledge base.
Rec 7	The specialty should review some of the workplace based assessments currently in place to reduce the assessments in length and reduce administrative burden (paragraph 48).	Recommendations for AVM not included in previous ASR	There is a wider evaluation on WPBAs taking place across the College. The JRCPTB issued a pilot on WPBAs and produced guidance for trainers and doctors in training for implementation in August 2014, for which the outcomes are yet to be evaluated.	The current workplace based assessments will remain in place as the range is already less than other specialties, however, the quality of these is being reviewed.
Rec 8	The current requirement of the curriculum to undertake one MSF exercise every year and to obtain feedback from 12 people is proving difficult for doctors in training and this should be reviewed (paragraph 50)	Recommendations for AVM not included in previous ASR		This target is achievable and remains a recommendation. Trainees are encouraged to request feedback from non-AVM staff in addition to AVM staff in recognition of the multidisciplinary nature of our working.
Rec 9	The specialty should ensure trainers fulfil their responsibility for building the confidence and competence of doctors in training in management and leadership, by promoting available courses and learning in the workplace (paragraph 51).	Recommendations for AVM not included in previous ASR	Development of leadership and management capability is included in the AVM specialty curriculum. The specialty may wish to explore the introduction of structured assessments in this area into the curriculum (paragraph 51).	This is an area which the SAC agrees is extremely important and particularly promotes the need for this to be embedded in training, and practice, for trainees at all stages beyond just courses.
Rec 10	The specialty should pursue its plans to introduce patient feedback forms into the specialty to raise awareness amongst consultants and doctors in training of what patients expect from them (paragraph 52).	Recommendations for AVM not included in previous ASR	A patient survey is already part of the assessment framework under the JRCPTB, a generic form and guidance is available on the website. The JRCPTB is looking into reviewing requirements for a patient survey. The specialty may wish to look into the forms being included in the curriculum so that feedback from patients features in training (paragraph 52)	Regular patient surveys are expected of all trainees.

Additional comments