



The state of physicianly training in the UK

Appendices

Report 1 2017

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Appendix A: Data analysis

This section details the results from the data analysis of the key datasets, mapped against the General Medical Council (GMC) themes for standards of medical education and training.¹

1.0 Global theme

The data sources used to inform this theme include: the GMC national training survey (NTS) (generic and specialty-specific data); annual review of competence progression (ARCP) and Membership of the Royal Colleges of Physicians of the United Kingdom (MRCP(UK)) outcomes; higher specialty training workforce census data / new consultants (post-CCT) survey; and penultimate year assessment (PYA) reports.

1.1 GMC NTS – generic data

The total number of higher specialist trainees (HSTs) who completed the GMC NTS survey in 2016 was 9,600. The breakdown by specialty is shown in Table 1.

Table 1. Numbers of trainees who completed the GMC survey, by specialty

Specialty	2015	2016	Contribution to the acute take
Acute internal medicine	339	315	Yes
Allergy	9	9	No
Audiovestibular medicine	14	15	No
Cardiology	572	561	Yes
Clinical genetics	47	53	No
Clinical neurophysiology	30	28	No
Clinical pharm and therapeutics	25	25	Yes
Core medical training	2,947	2,912	Yes
Dermatology	199	193	No
Diabetes and endocrinology	339	350	Yes
Gastroenterology	476	465	Yes
General internal medicine	1,655	1,650	Yes
Genitourinary medicine	106	90	Yes
Geriatrics	619	660	Yes
Haematology	389	392	Some
Immunology	21	24	No
Infectious diseases	97	85	Yes
Medical oncology	154	148	Some
Medical ophthalmology	<3	<3	No
Neurology	237	232	Some

Nuclear medicine	8	9	No
Paediatric cardiology	27	39	No
Palliative medicine	185	183	Some
Pharmaceutical medicine	101	110	No
Rehabilitation medicine	55	65	No
Renal medicine	259	242	Yes
Respiratory medicine	495	489	Yes
Rheumatology	223	226	Yes
Sports and exercise medicine	30	30	No
Total	9,658	9,600	

Table 2. Overall satisfaction (mean scores by deanery / local education training board (LETB) in 2016)

	Specialty	2015	2016	Difference
1	Allergy*	80.80	99.00	18.20
2	Audiovestibular medicine*	90.75	92.67	1.92
3	Nuclear medicine*	85.50	90.67	5.17
4	Clinical neurophysiology*	86.09	88.40	2.31
5	Clinical genetics*	86.49	87.26	0.77
6	Paediatric cardiology*	82.73	86.88	4.15
7	Rehabilitation medicine*	90.08	86.86	-3.22
8	Palliative medicine	89.48	86.66	-2.82
9	Dermatology	85.99	85.92	-0.07
10	Combined infection training*	N/A	85.78	
11	Medical oncology*	85.56	85.66	0.10
12	Genitourinary medicine*	85.42	84.67	-0.75
13	Immunology*	83.78	84.50	0.72
14	Neurology	83.01	84.47	1.46
15	Pharmaceutical medicine	83.13	84.18	1.05
16	Haematology	83.87	84.09	0.22
17	Sports and exercise medicine*	80.89	83.67	2.78
18	Cardiology	82.60	82.79	0.19
19	Infectious diseases*	84.66	82.77	-1.89
20	Diabetes and endocrinology	82.72	82.68	-0.04
21	Rheumatology	84.87	82.31	-2.56
22	Gastroenterology	81.19	81.74	0.55
23	Respiratory medicine	81.74	81.50	-0.24
24	Geriatric medicine	81.29	80.96	-0.33
25	Renal medicine	81.93	79.90	-2.03
26	General internal medicine*	80.00	79.67	-0.33
27	Acute internal medicine	77.13	79.60	2.47
28	Clinical pharmacology and therapeutics*	78.73	76.83	-1.90
29	Medical ophthalmology*	N/A	N/A	18.20
	Total	9,658	9,600	

*Not all deaneries / LETBs that hosted the speciality programme had three or more trainees completing the NTS, so a complete set of mean scores was not possible from all regions. Calculations have been made based on the data available.

Table 3. Overall satisfaction by core training programme

Specialty	2013	2014	2015	2016	2015/16
Core anaesthetics training	83.28	83.65	87.68	87.67	-0.01
Core psychiatry training	82.59	83.01	83.43	85.00	1.57
Core surgical training	76.86	75.96	77.71	76.58	-1.13
Core medical training	74.42	75.72	76.85	75.34	-1.51

In total, 2,912 core medical trainees (CMT) (1,440 CMT1 and 1,472 CMT2 trainees) completed the GMC NTS in 2016. This was an overall decrease of 6% compared with 2015.

Table 4. Top five indicators for core medical training showing the highest percentage of trusts with red or green flags compared with 2015

Specialty (red flags)	% (2015)	Specialty (green flags)	% (2015)
Supportive environment	7 (+5)	Adequate experience	12 (+11)
Reporting systems	7 (new)	Handover	11 (+2)
Overall satisfaction	6 (+3)	Reporting systems	9 (new)
Clinical supervision (out of hours)	6 (+1)	Regional teaching	8 (+2)
Handover	6 (+4)	Local teaching	7 (+1)

The ‘supportive environment’, ‘handover’ and ‘overall satisfaction’ indicators showed the biggest increase in 2016 in the percentage of trusts with red flags compared with 2015; however ‘handover’ was also one of the highest indicators with green flags. ‘Reporting systems’ also recorded high numbers of both red and green flags.

1.2 GMC NTS – specialty-specific data

The cumulative analysis of the specialty-specific questions (SSQs) for all specialties that had data available is shown in Table 5. There is a lot of variability both in the number of questions and the content, and this makes comparisons between specialties difficult. Smaller specialties that have fewer than three trainees in one site are not represented by the GMC survey. There is also a lack of consistency in terms of which GMC themes have been covered by each specialty, but an attempt has been made to identify the issues raised and to map them to the GMC themes. This is not an exhaustive list of all the results but it is a summary of some of the issues that are raised, mapped to the GMC themes.

One of the recommendations from this report is to work with the SACs to re-write the SSQs and map them to the GMC themes, to allow more meaningful comparisons in the future.

Table 5. Cumulative analysis of the GMC SSQs (2016)

Specialty	Number of trainees	Qs	Main findings	Mapped to GMC themes
Acute medicine	315	18	Disproportionate amount of service provision to acute take (39% increasing trend); managing take supervised by AMU consultant 71% (downward trend); educational supervisor (ES) is an acute medical physician (75%); study leave to attend specialist meeting (58%)	1,2,3,5
Allergy	9	5	Able to manage urticaria, angioedema and asthma (100% agree); chronic rhinitis (only 50% agree – downward trend); BASCI training days cover topics mapped to curriculum (89%) (better than 2014)	1, 5
Audiovestibular medicine	12	9	Overall satisfaction in training in: Adult – audiology (80% satisfied); vestibular medicine (60% satisfied) Paediatric – audiology (66% satisfied); vestibular (40% satisfied) Practical procedures (60% satisfied to achieve competencies)	1, 5
Cardiology	561	14	63% of trainees in G(I)M reported that none of their time was spent in delivered curriculum-based teaching; there were issues around: pericardiocentesis (only 34% were confident to perform the procedure unsupervised); temporary pacing wire in emergency (59% confident); variable rates of practical simulation training were being received; 56% reported that the deanery was supportive of LTFT and 71% reported that the ES was supportive	1,2,3,5
Clinical genetics	48	10	Good access to formal teaching (>80%); good training opportunities and support within departments	1,2,5
Clinical neurophysiology	21	7	Evidence of good training in specific competencies	1,5
Diabetes and endocrinology	350	5	54% of trainees reported that G(I)M commitments impact on specialty experience; 44% were unable to attend specialty clinics (>25% of time); only 29% experienced diabetes care in the community	1,2,3,5
Gastroenterology	465	17	46% reported access to endoscopy was limited by G(I)M commitments; effectiveness of training towards independent practice was: gastroenterology >90%, endoscopy 80%, hepatology 83% and nutrition 72%; quality of supervision was >80%; overall satisfaction with training was 81%	1,2,3,5
Geriatric medicine	660	15	Curriculum coverage/training opportunities were lowest in tissue viability, continence, community geriatrics, old age psychiatry	1,2,3, 5
Genitourinary medicine (GUM)	81	8	Over 80% were gaining HIV competencies in the local deanery; public health delivery to achieve curriculum competencies were: 32% e-learning, 35% don't know, 13% local unit and 5% course	1,2, 3, 5
Haematology	392	11	97% do not do medical on calls; 75% do haematology out of hours – on call; 18% do full shifts; 3.5% do partial; specialty-specific experience was low for paediatric haematology and haemoglobinopathy and lab time in the last 12 months (0–10% highest time, then 11–20% (30%))	1, 2, 5
Immunology	7	15	Trainees are meeting some curricular competencies for ST stage; only 59% of trainees feel they have sufficient lab training to achieve competencies	1,2, 5
Infectious diseases (ID)	72	10	There are questions mainly around curriculum coverage (most requirements >67%); pre-travel advice was lowest at 47%	1, 5

Medical oncology	148	10	>90% trainees reported an appropriate level of supervision; 82% had completed audit projects; 86% had the opportunity to be involved in research	1, 2, 3, 5
Neurology	232	10	Curriculum requirements were achieved in >90%; acting up in the past 3 months was achieved in 72%; there was good clinic exposure; 65% were involved in the national stroke strategy; 52% were involved in full 24-hour cover	1,2, 3, 5
Paediatric cardiology	39	7	43.7% of trainees relocated to another deanery to get training; the proportion of ECHOS reviewed by senior staff was 33% in 75–100% of the time; 15% were able to achieve curriculum competencies fairly difficult; in 1 month, 56% of trainees have no time for research/publications	1, 2, 3, 5
Renal medicine	242	9	Overall workload and G(I)M are compromising specialty training: there was poor attendance at haemodialysis MDT (35% none); live donor assessment (54.5% none); and adolescent care (45% none)	1, 2, 3, 5
Respiratory medicine	489	11	Issues in pulmonary physiology training (52% rated as poor, 30% receive no training and 46% receive limited training); there are issues in cardiopulmonary exercise training (36% rate as poor and 33% not available)	1, 5
Rheumatology	226	10	Good clinical supervision (outpatients clinics 91%, wards 90%); good educational opportunities (X-ray meetings 80%) and training (safe prescribing 91% and joint injections 80%)	1, 2, 3, 5
Sports and exercise medicine	30	10	Able to gain training: >70% most competencies but 60% in exercise physiology, 63% in disability sport and 62% in care of elite athletes; systems used to assess skills and knowledge adequate in 60%	1, 5

1.3 ARCP outcomes

Overall, 10,579 ARCP outcomes that were recorded for 8,571 HSTs (1.2 outcomes per trainee) were reported to the GMC in 2014–15. A further 70 outcomes were unsatisfactory due to exam failure and these are not included.

- Of the outcomes reported, 96.42% were ARCP outcomes.
- Of the outcomes reported, 3.58% were record of in-training assessments (RITAs).

Table 6. Proportion of ARCP outcomes in each category for HSTs

Outcome	1	2	3	4	5	6	7.1	7.2	7.3	7.4	8	Total
Overall	55%	4%	2%	0%	13%	10%	2%	0%*	0%*	1%	13%	100%

Satisfactory (1, 6 and 7.1)	Unsatisfactory (2,3,4,5,7.2,7.3 and 7.4)	Out of programme (8)
67%	20%	13%

In total, 3,503 ARCP outcomes for 3,006 CMT trainees (1.2 outcomes per trainee) were reported to the GMC (excluding exam failure) in 2014–15.

Table 7. Proportion of ARCP outcomes in each category for CMT

Outcome	1	2	3	4	5	6	7.1	7.2	7.3	7.4	8	Total
Overall	31%	4%	1%	0%*	30%	33%	2%	0%*	0%	0%*	0%*	99%

* <0.5% of the total number of trainees, so number rounded down to 0%.

Satisfactory (1, 6 and 7.1)	Unsatisfactory (2,3,4,5,7.2,7.3 and 7.4)	Out of programme (8)
64%	35%	0%

* <0.5% of the total number of trainees, so number rounded down to 0%.

Note. The different outcomes are explained in Appendix C, Table 1.

The satisfactory outcomes were similar in HST and CMT. However, the unsatisfactory outcomes were greater in CMT (35%) compared with HST (20%). There was a greater proportion of Outcome 5s in CMT (30%) compared with HST (13%). There were 13% of trainees out of programme (OOP) in HST, but none were OOP from CMT.

Fig 1. Proportion of ARCP outcomes by deanery/LETB (excluding RITA) for HST

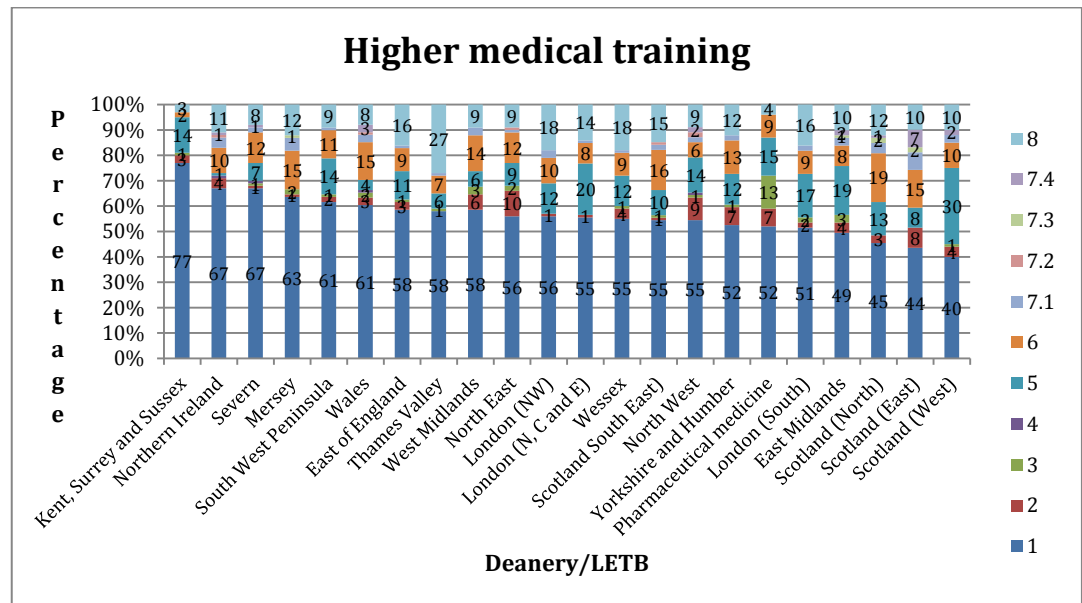
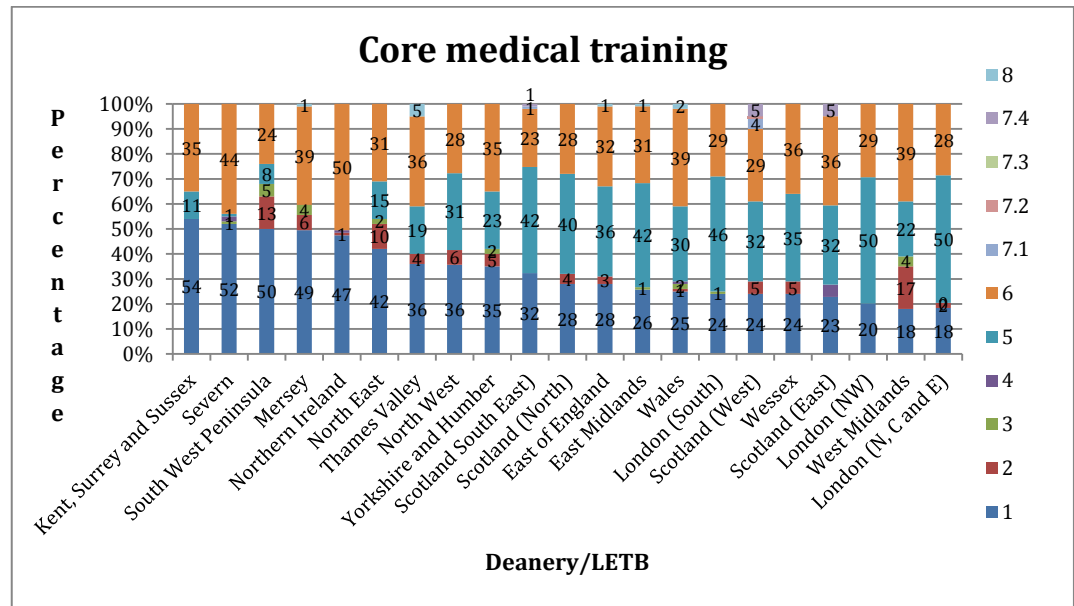
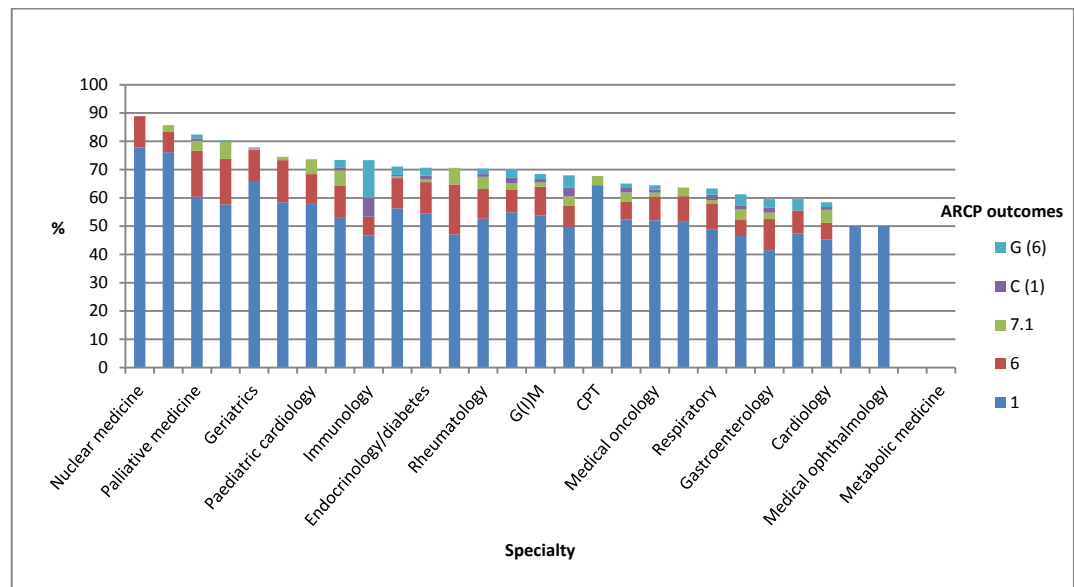


Fig 2. Proportion of ARCP outcomes by deanery/LETB for CMT



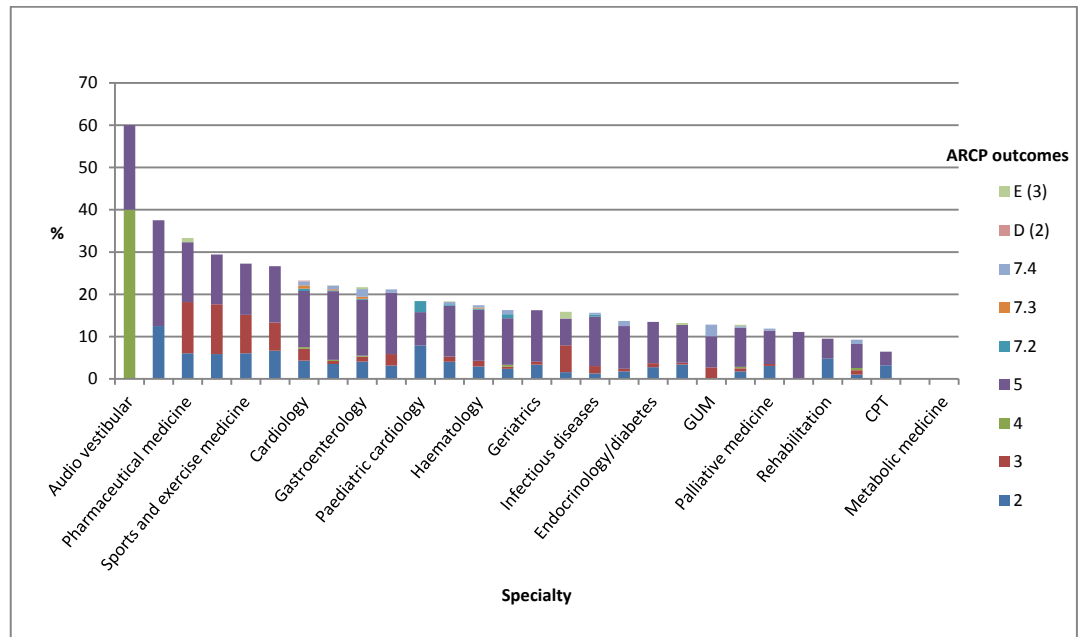
Significant variability was noted in the proportion of ARCP outcomes both in HST and CMT across the deaneries/LETBs. This is explored further under GMC theme 2.

Fig 3. Satisfactory ARCP outcomes by speciality (excluding RITAs)



Some variability was noted in satisfactory outcomes by speciality (89% in nuclear medicine to 50% in medical ophthalmology) (Fig 3). Some of the differences may be due to the smaller numbers in certain specialties.

Fig 4. Unsatisfactory ARCP outcomes by specialty (excluding RITAs)

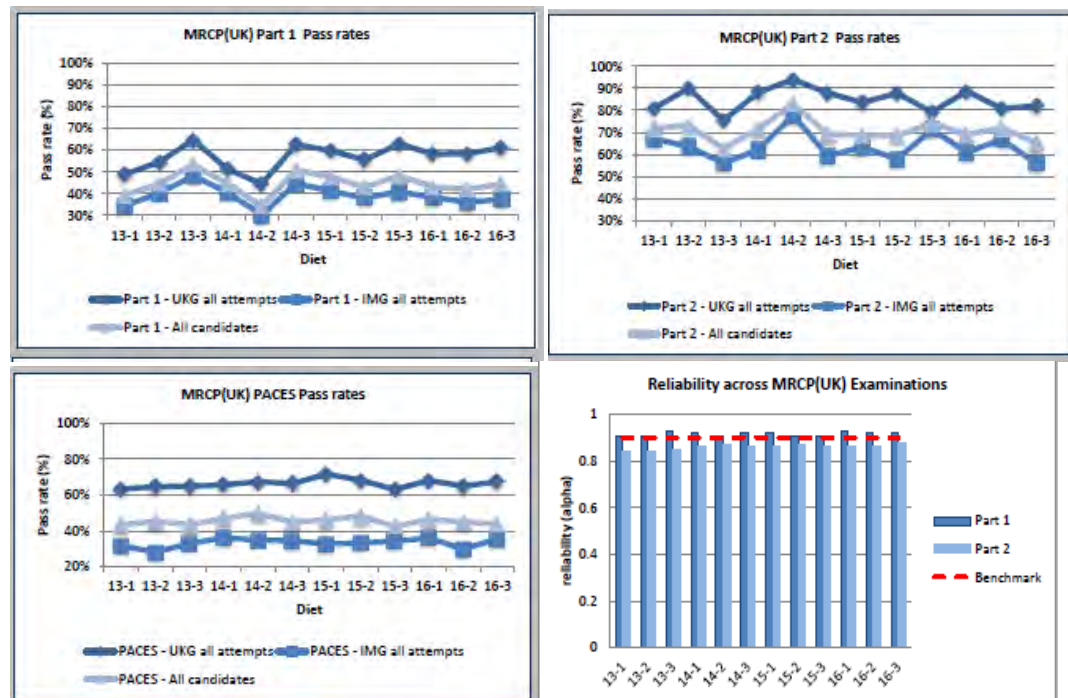


Significant variability was noted in unsatisfactory outcomes by specialty; audiovestibular medicine was at the top with a high proportion of Outcome 4s. The proportion of Outcome 5s was still very high and this is explored under GMC themes 2 and 5.

1.4 MRCP outcomes

The MRCP(UK) dashboard data show that overall pass rates for the MRCP(UK) exams have been consistent for the past 5 years (Fig 5). The overall reliability and standard error of the mean (SEM) is consistent, with good values across all examinations. Examiner concordance remains at a similar level to 2015.

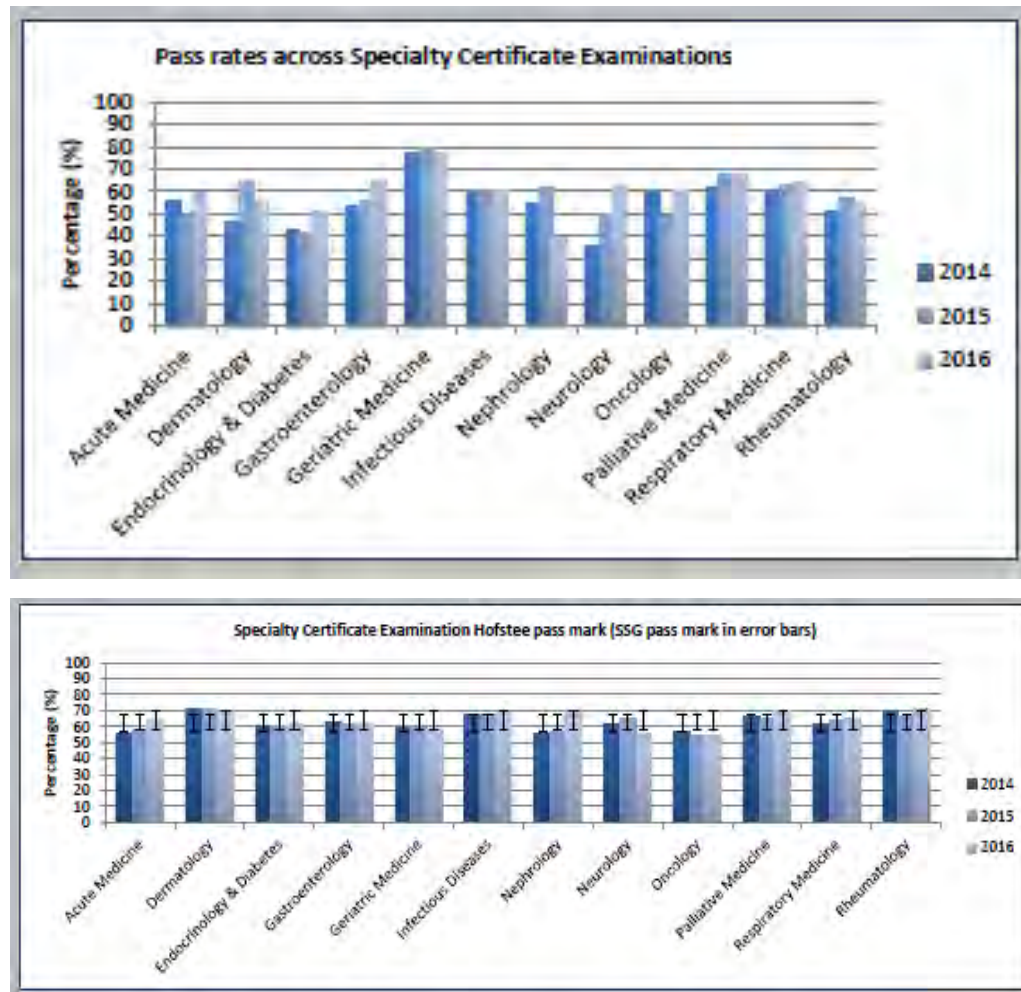
Fig 5. Pass rates and reliability across all MRCP(UK) exams



Data from twelve specialty certificate examinations (SCEs) were available and the trend analysis of pass rates and pass marks over the past 3 years (2014–16) is shown in Fig 6 and Table 8. There was some variability in the pass rates for some specialties. Increasing pass rates were seen in gastroenterology and neurology (with pass marks remaining similar). Variable trends were seen in acute medicine, dermatology and nephrology. There was a significant fall in pass rates in nephrology (2015–16), with a higher pass mark in 2016.

Data were also analysed by deanery/LETB and also by ethnicity and primary medical qualification, and these are discussed under GMC themes 2 and 5.

Fig 6. Pass rates and pass marks for SCEs



The MRCP(UK) core trainee (CT) progression data are shown in Fig 7. Trainee progression has been consistent in Part 1 and 2 of the MRCP(UK) exam over the past 5 years but is slightly down in PACES. Overall, 75% of those at CT2 achieve full MRCP (Parts 1, 2 and PACES) before the end of their training. This is down 3% from 2015–16 but the overall number of trainees who are achieving this has gone up by 4.6% in 5 years.

There is a trend for a greater number of trainees to enter CT1 with Part 1 and for a greater number proportionately to then enter CT2 with Part 2 and PACES. This is due to the trend of trainees entering core medical training in subsequent years after completing foundation training (Fig 8).²

Table 8. Pass rates, pass marks for all MRCP (UK) examinations

KEY:	Colour	Highlights difference between 2015 and 2014 of:
	Red	values > 5
	Orange	values between 3 and 5
	Green	values between -2.99 and 2.99
	Yellow	values between -3 and -5
	Pink	values < 5

Please note that the colours highlight differences, rather than show a change as positive or negative.

Pass rates	2012	2013	2014	2015	2016	Difference
Part 1	41.8	46.4	43.9	46.5	43.6	-2.90
Part 2	60.5	67.9	73.4	70.9	68.3	-2.60
PACES	45.2	43.4	47.0	45.5	45.2	-0.30
Acute Medicine	67.6	66.3	55.5	49.1	59.2	10.10
Dermatology	87.9	54.1	45.7	63.8	55.8	-8.00
Endocrinology & Diabetes	66.8	54.3	42.6	41.8	51.3	9.50
Gastroenterology	65.1	66.9	53.5	55.7	65.0	9.30
Geriatric Medicine	89.0	78.6	77.0	79.7	77.2	-2.50
Infectious Diseases	66.7	56.1	59.3	60.7	60.9	0.20
Nephrology	74.7	73.8	54.1	61.7	38.5	-23.20
Neurology	79.3	63.9	35.8	49.3	63.2	13.90
Oncology	74.7	69.0	59.0	48.7	60.8	12.10
Palliative Medicine	75.4	70.8	61.8	67.1	67.1	0.00
Respiratory Medicine	67.9	70.2	60.0	62.4	64.0	1.60
Rheumatology	79.8	70.5	50.5	56.6	54.6	-2.00

Pass mark	2012	2013	2014	2015	2016	Difference
Acute Medicine	56.8	53.5	56.0	58.3	55.7	-2.60
Dermatology	68.8	69.4	71.4	70.5	67.3	-3.20
Endocrinology & Diabetes	54.6	52.8	59.8	59.8	57.8	-2.00
Gastroenterology	57.4	61.7	62.2	62.0	60.8	-1.20
Geriatric Medicine	57.7	56.8	59.6	58.8	58.2	-0.60
Infectious Diseases	63.0	63.5	67.3	67.3	67.8	0.50
Nephrology	60.0	49.5	55.5	56.8	62.0	5.20
Neurology	52.5	62.0	62.0	65.5	55.8	-9.70
Oncology	51.5	50.0	56.5	54.5	53.3	-1.20
Palliative Medicine	62.5	67.8	65.8	65.0	66.5	1.50
Respiratory Medicine	59.5	61.5	61.5	63.5	64.5	1.00

Fig 7. Core trainee progression data (2012–16)

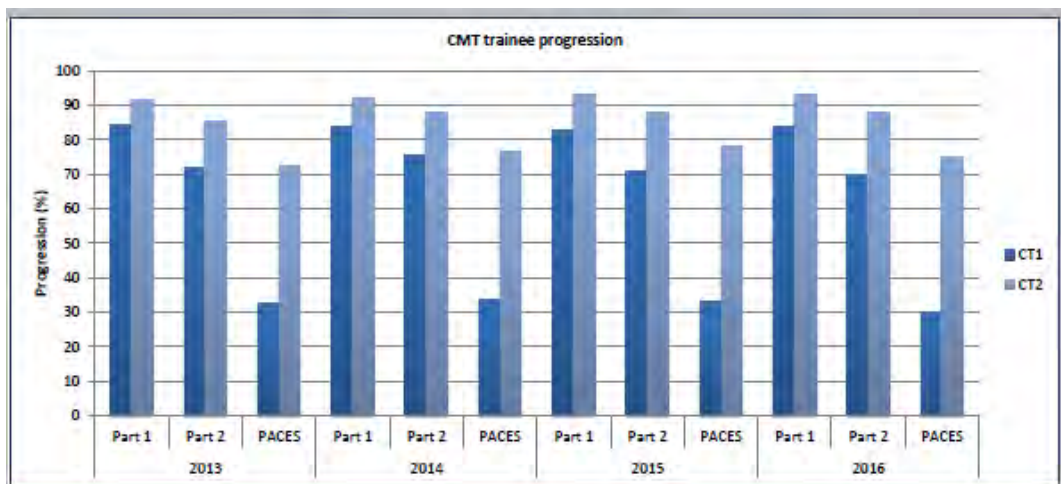
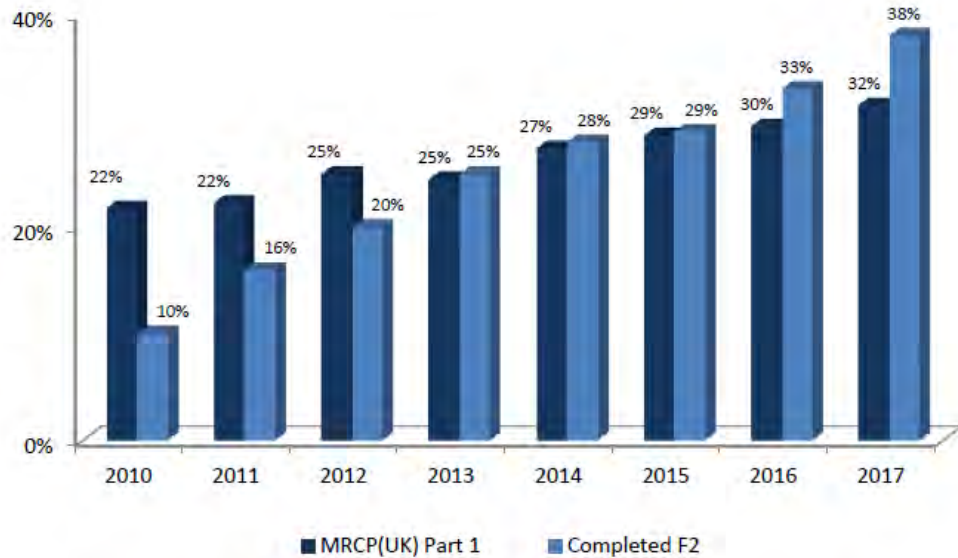


Fig 8. Percentage completing MRCP(UK) Part 1 at the time of their application, compared with the percentage applying after completing foundation training



1.5 HST census and new consultants (post-CCT) survey data

Data from the annual HST workforce census survey from 2015–16 were analysed.³ This included 1,592 respondents, of which the majority were HSTs at ST5 stage and above. Overall, 52.4% were female and 78.2% were aged between 31 and 40. In total, 60.8% were on full-time contracts and 11.3% were on less-than-full-time contracts, of which 90.4% were female.

There was an interesting gender split in specialties and this is shown in Fig 9. There was a higher proportion of women training in allergy, metabolic medicine, nuclear medicine and clinical genetics, although these are smaller specialities and the proportions may be easily skewed by the small numbers of survey respondents. GUM and palliative medicine had the highest proportion of women in the medium- to larger-sized specialties. Conversely, there were a higher proportion of men training in stroke, intensive care medicine, hepatology, clinical neurophysiology, clinical pharmacology and therapeutics and cardiology.

The acute take and specialties' participation in G(I)M is shown in Fig 10, and specialties that accredit in G(I)M are shown in Fig 11. The non-specialty general medical inpatient workload is highest in geriatric and respiratory medicine.

Fig 9. HST census data: gender versus speciality

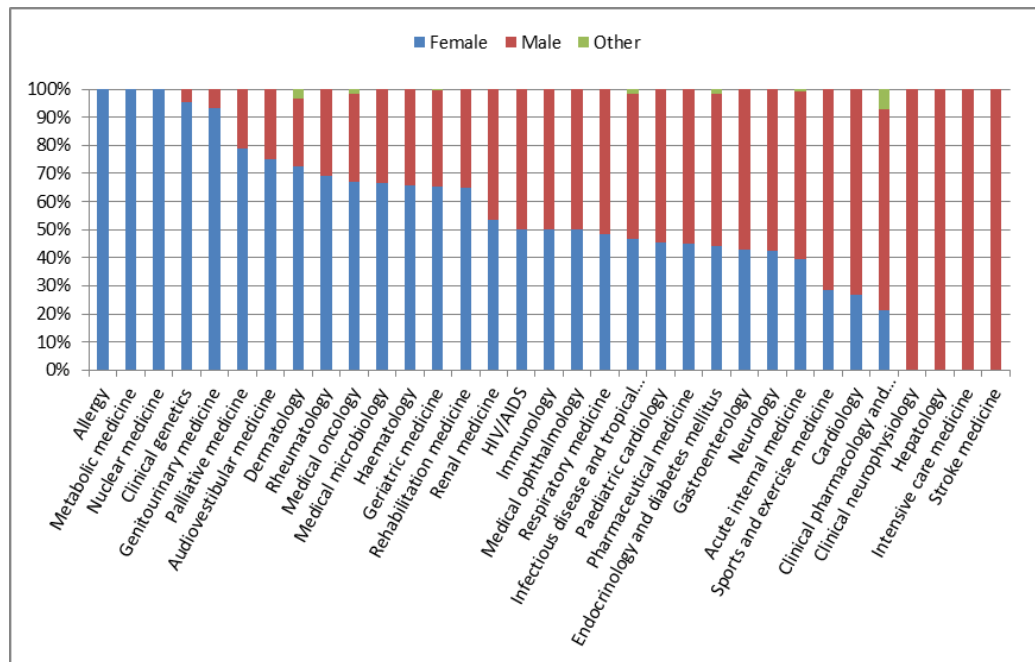
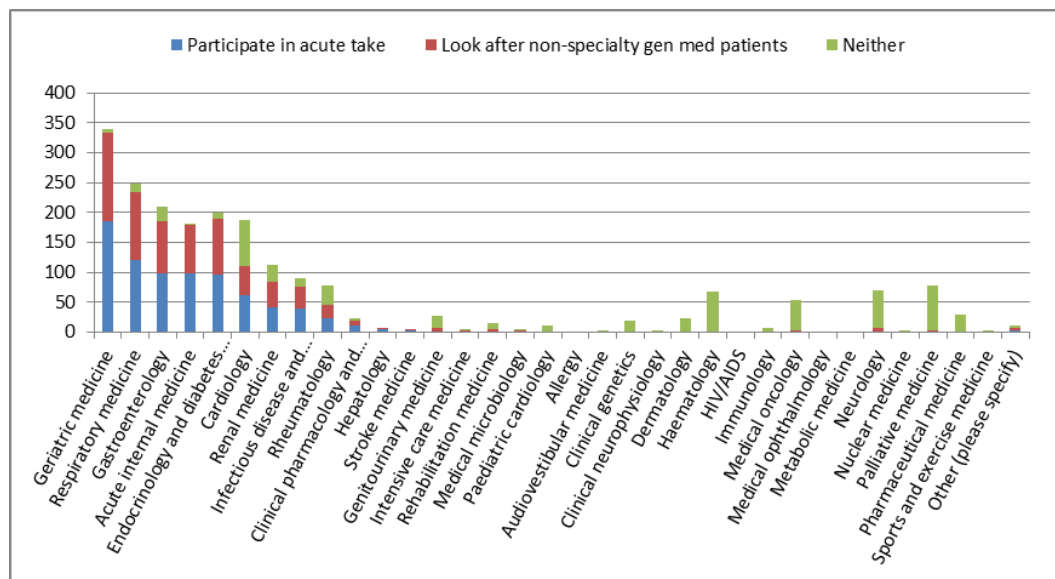


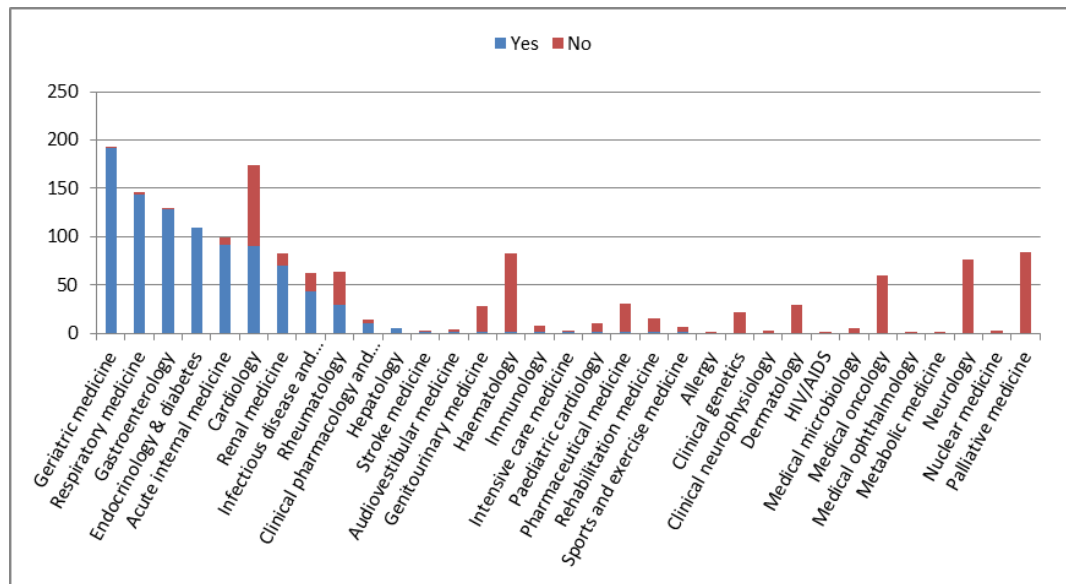
Fig 10. The acute take and specialties' participation in G(I)M



The overall trend of participation in G(I)M is down compared with previous years (2014–15).

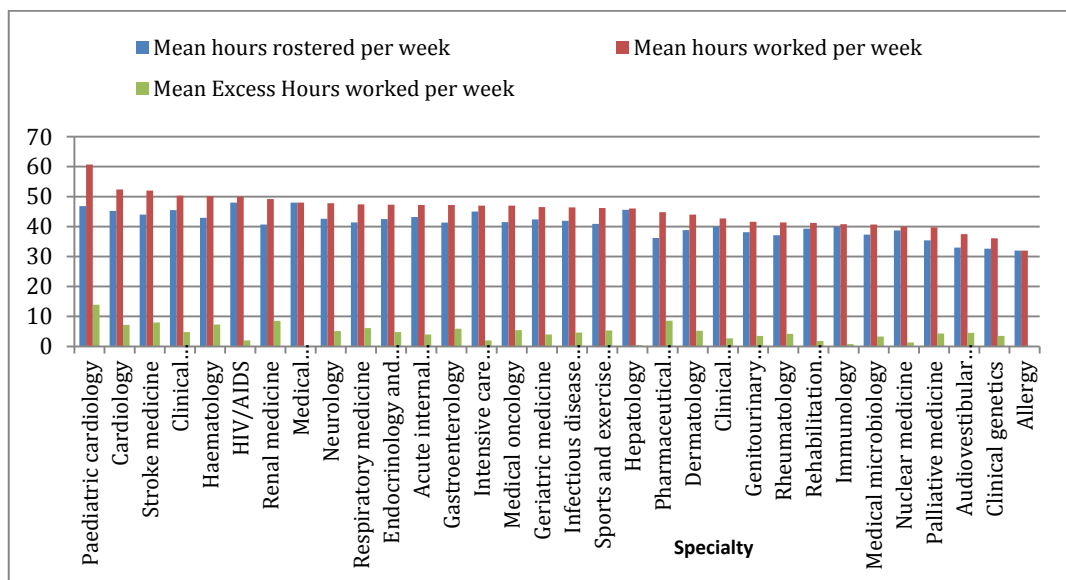
The specialties with the highest (>90%) number of trainees accrediting in G(I)M are geriatric, respiratory, gastroenterology, diabetes and endocrinology and acute internal medicine. Less than 50% of trainees dual accredit in cardiology, infectious diseases and rheumatology.

Fig 11. Specialties that accredit in G(I)M



The mean hours worked per week is highest for mainly the acute medical specialties and also paediatric cardiology (Fig 12). The sessional split between inpatient, outpatient and procedural lists varies depending on the specialty. Very little administration time is noted in a number of specialties.

Fig 12. Time worked by specialty

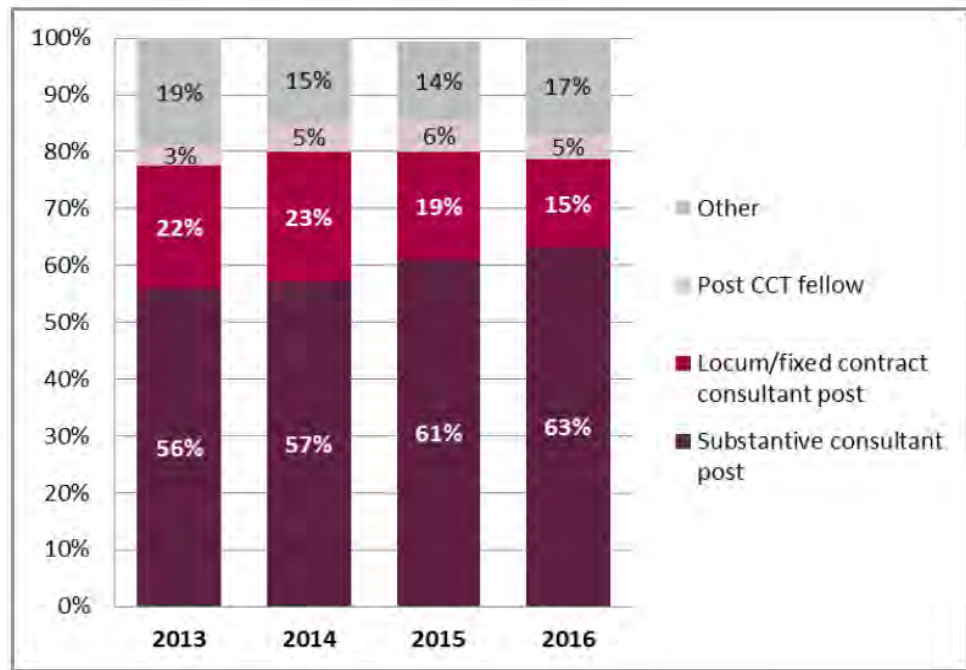


The new consultants (post-CCT) survey included data from medical consultants who had obtained their CCT in the past 12 months.⁴ In 2016, 855 CCT holders were contacted to complete the survey and 386 responses were received (45.1%), which

is slightly lower than the response rate in 2015 (49.6%). Overall, 53% of respondents were male and 18% of respondents were training less than full time. There was an ethnic mix: 53% of respondents were white British, 20% were Indian, 6% were white other than British, 5% were Pakistani and all other ethnic groups each accounted for less than 5% of respondents.

The trend analysis of the employment status over the last 4 years is shown in Fig 13. Interestingly, the percentage who obtained substantive posts has increased steadily, and those doing locum posts has decreased. This may reflect the vacancies in the consultant posts, particularly in the acute medical specialties.

Fig 13. Current employment status of CCT holders (2013–16)



The success rate of being shortlisted for interview and being successful in obtaining a consultant post by gender is shown in Fig 14. Women are more likely to be shortlisted and offered a post, and there is a similar trend for less-than-full-time trainees, reflecting the higher proportion of women in this cohort.

The overall perceived quality of training in G(I)M is generally poorer than specialty training, and the perceived quality of specialty training seems to be generally falling (Fig 15).

Fig 14. Success rate in being shortlisted and being offered the post

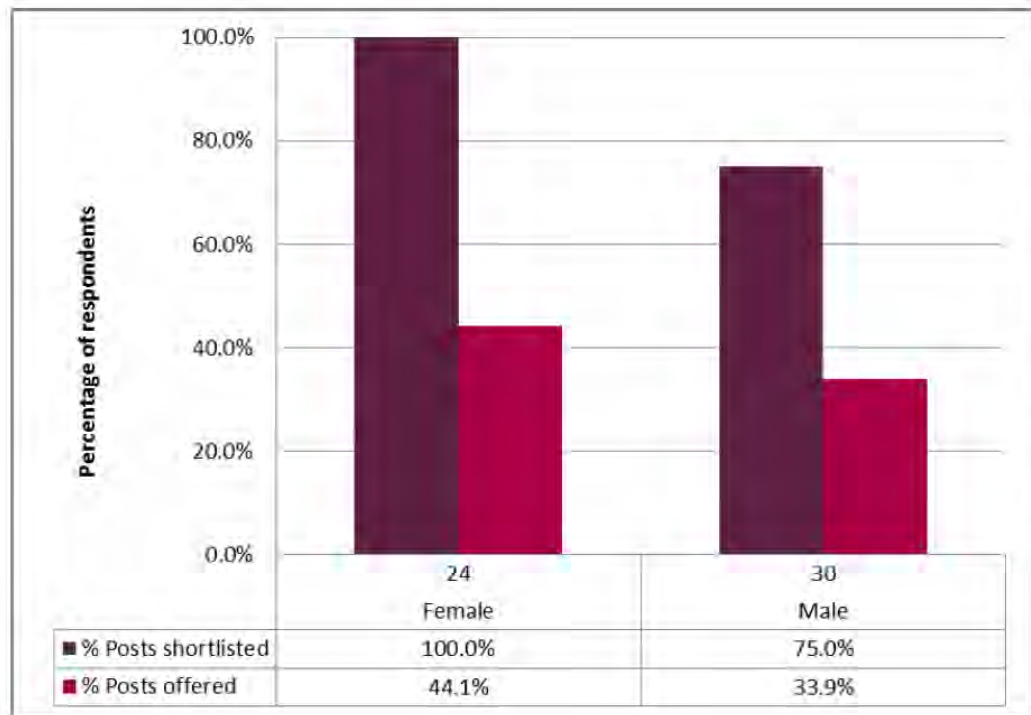
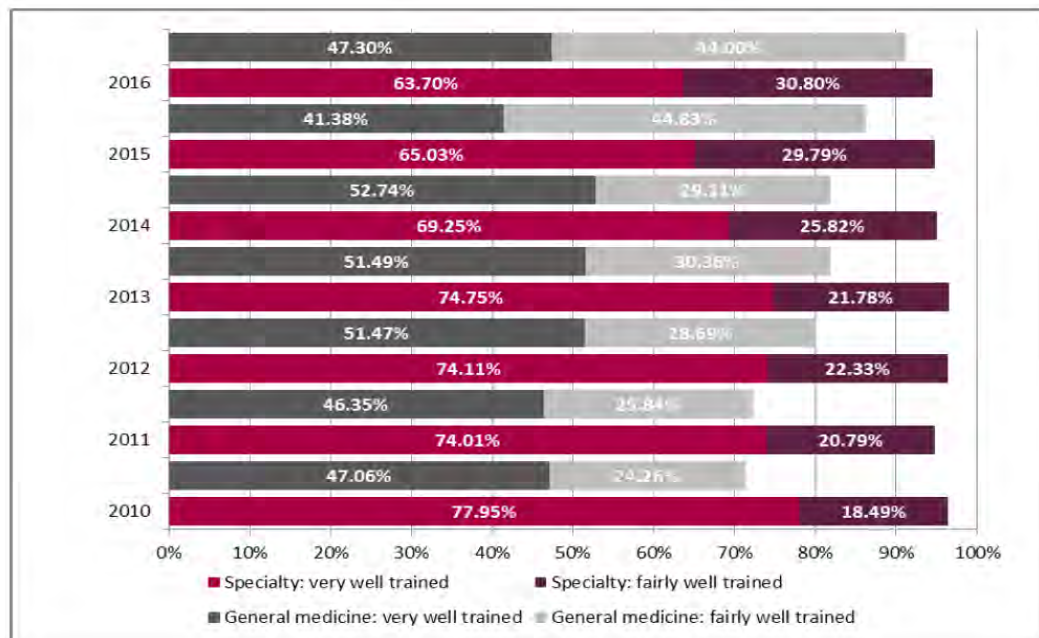


Fig 15. The overall perceived quality of training in G(I)M and specialty

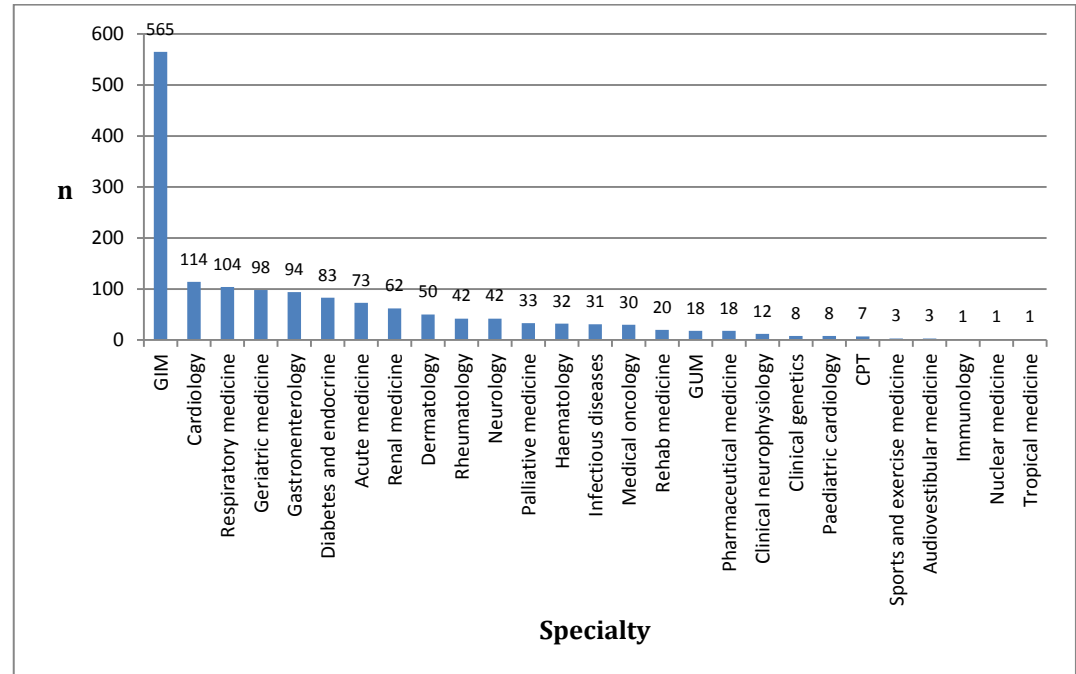


1.6 Penultimate year assessments

In total, 1,553 trainees from 27 medical specialties undertook penultimate year assessments (PYAs) between 5 August 2015 and 3 August 2016 (Fig 16). There were

no PYAs recorded as taking place during this period for trainees in allergy or medical ophthalmology.

Fig 16. Number of trainees who undertook PYAs by specialty in 2015–16



Seven trainees were in specialist trainee (ST) year 4, 192 were ST5, 863 were ST6 and 388 were at ST7 level. Overall, 96 trainees were out of programme (OOP).

Table 9 shows the percentage of trainees in the above specialties who were rated as satisfactory against the ARCP decision aid requirements at the time of their PYAs.

Table 10 shows the average mandatory and recommended PYA targets that are set per trainee for all specialties.

The variability between different specialties, and some of the more specific issues, are discussed in the relevant GMC themed sections later in these appendices.

Table 9. Percentage of trainees who were rated as satisfactory against the ARCP decision aid requirement at the time of their PYA

ARCP decision aid requirements	Trainees rated as satisfactory (%)
Quality of educational supervisor's reports	86.88%
Quality of training portfolios	79.24%
Workplace-based assessments	80.59%
Specialty-specific examination pass	76.26%
Valid ALS certification	75.43%
Research and audit	
- Adequate research skills	93.08%
- Active in audit / quality improvement project	92.12%
Course completion	
- Formal teaching	62.60%
- Management training	47.12%
Teaching	
- Undergraduates	94.71%
- Postgraduates	92.58%
- Other clinical staff	91.63%
Communication	
- With patients	71.58%
- With staff	87.21%
- With colleagues	89.67%
Legal / ethical knowledge	94.43%
CPD diary registration	37.64%
Timekeeping	
- Leave/absence (sickness or maternity)	19.92%
- Effective timekeeping	93.09%

Table 10. Average PYA targets per trainee

PYA targets set in 2016	Average per trainee
Mandatory	4.92
Recommended	1.82

2.0 Theme 1: Learning environment and culture

The data sources used to inform this theme include the GMC NTS (generic and SSQ), ARCP outcomes, HST census data, PYA reports and monitoring visit reports.

2.1 GMC NTS – generic data

Table 11: Deanery/LETB red flags by specialty in 2015 and 2016

	Specialty	2015	2016	Difference
1	Geriatric medicine	30	50	+20
2	Acute (internal) medicine	35	42	+7
3	Gastroenterology	28	33	+5
4	Respiratory medicine	19	27	+8
5	Diabetes and endocrinology	22	25	+3
6	Cardiology	14	21	+7
7	Renal medicine	20	16	-4
8	Core medical training	12	15	+3
9=	Clinical pharmacology and therapeutics	9	11	+2
9=	Infectious diseases	10	11	+1
11=	Haematology	12	9	-3
11=	Rheumatology	6	9	+3
13	Neurology	8	8	No change
14	Paediatric cardiology	10	7	-3
15=	Immunology	0	5	+5
15=	Medical oncology	6	5	-1
17	Rehabilitation medicine	3	4	+1
18	Combined infection training	New	3	
19=	Palliative medicine	5	2	-3
19=	Sports and exercise medicine	2	2	No change
21	General (internal) medicine	2	1	-1
22=	Allergy	0	0	No change
22=	Audiovestibular medicine	0	0	No change
22=	Clinical genetics	2	0	-2
22=	Clinical neurophysiology	1	0	-1
22=	Dermatology	15	0	-15
22=	Genitourinary medicine	4	0	-4
22=	Medical ophthalmology	0	0	No change
22=	Nuclear medicine	0	0	No change
22=	Pharmaceutical medicine	0	0	No change

Nine of the ten specialties that had the highest number of deanery/LETB red flags recorded an increase in the number of indicator red flags compared with 2015.

Renal medicine was the only specialty in the top ten that recorded a decrease in red

flags (down by four) compared with 2015. Dermatology recorded the highest overall decrease in deanery/LETB red flags (down by 15) compared with 2015.

Table 12: Deanery/LETB green flags by specialty in 2015 and 2016

	Specialty	2015	2016	Difference
1	Palliative medicine	22	32	+10
2 =	Clinical genetics	14	22	+8
2 =	Dermatology	22	22	No change
2 =	Rehabilitation medicine	13	22	+9
5	Genitourinary medicine	14	21	+7
6	Clinical neurophysiology	13	13	No change
7=	Rheumatology	4	11	+7
7=	Sports and exercise medicine	8	11	+3
9	Medical oncology	9	10	+1
10	Paediatric cardiology	0	9	+9
11	Haematology	6	8	+2
12	Combined infection training	N/A	7	
13=	Nuclear medicine	3	6	+3
13=	Renal medicine	4	6	+2
15=	Diabetes and endocrinology	1	4	+3
15=	Neurology	0	4	+4
17=	Allergy	1	2	+1
17=	Audiovestibular medicine	7	2	-5
17=	Gastroenterology	1	2	+1
17=	Immunology	2	2	No change
21=	Acute (internal) medicine	1	1	No change
21=	Clinical pharmacology and therapeutics	0	1	+1
21=	Infectious diseases	2	1	-1
21=	Respiratory medicine	3	1	-2
25=	Cardiology	1	0	-1
25=	Core medical training	1	0	-1
25=	General (internal) medicine	0	0	No change
25=	Geriatric medicine	0	0	No change
25=	Medical ophthalmology	0	0	No change
25=	Pharmaceutical medicine	0	0	No change

Eight of the ten specialties that had the highest number of deanery/LETB green flags recorded an increase in the number of indicator green flags compared with 2015. Dermatology and clinical neurophysiology had the same number of green flags compared with 2015. Palliative medicine recorded the highest increase in deanery/LETB green flags (up by 10) compared with 2015.

Table 13: Red flags by indicators for acute medical specialties, showing the number of trusts with red flags compared with 2015

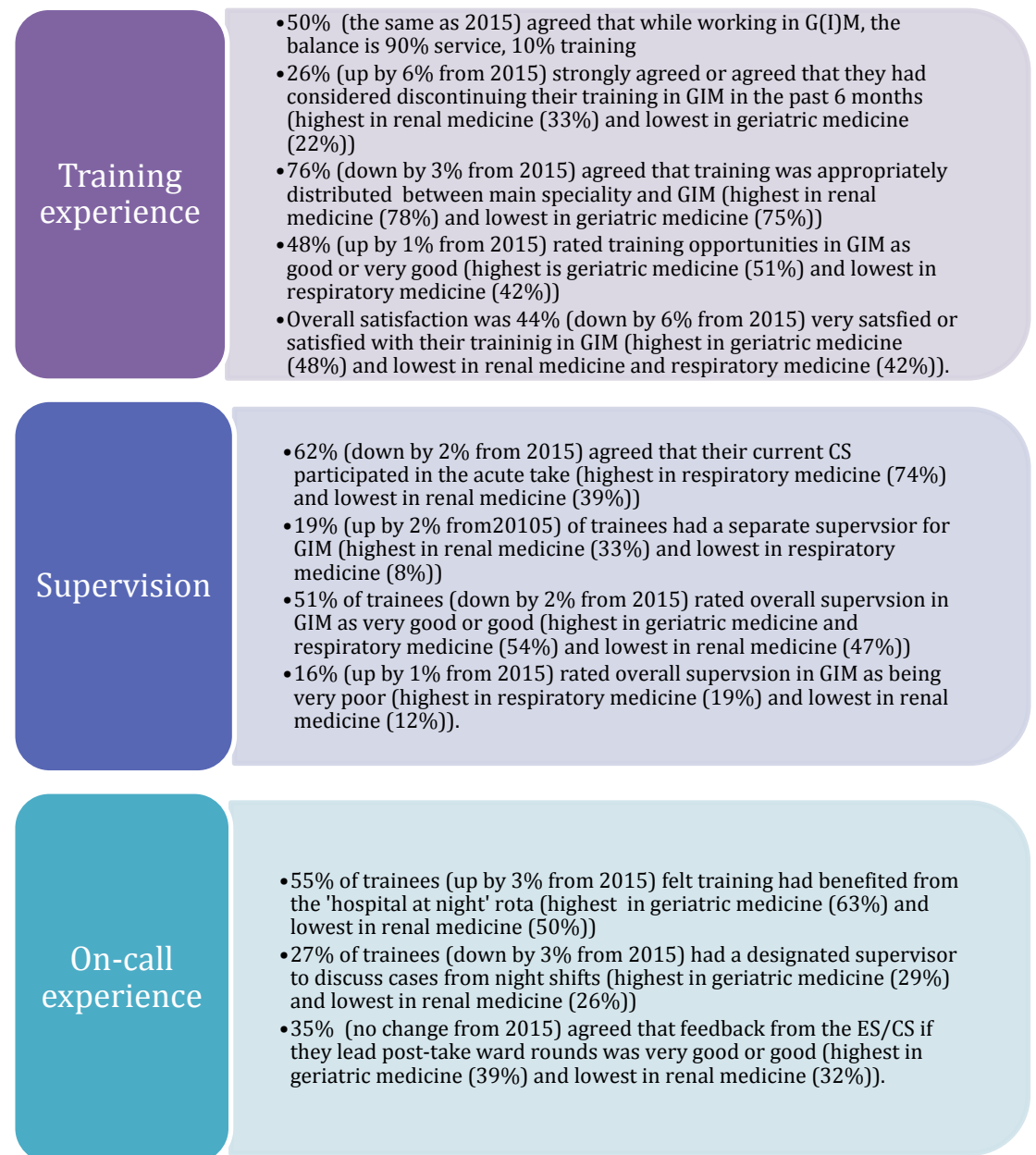
Specialty	Overall satisfaction	Work load	Adequate experience	Clinical supervision in hours	Clinical supervision out of hours	Local teaching	Regional teaching	Study leave	Access to educational resources
Acute (internal) medicine	7 (0)	4 (+2)	8 (+4)	4 (-3)	4 (-3)	10 (+6)	5 (-4)	2 (-4)	4 (0)
Cardiology	3 (-4)	7 (-2)	3 (-4)	0 (-1)	2 (0)	6 (-1)	8 (-1)	7 (-1)	4 (-1)
CMT	11 (+0)	9 (-3)	4 (-1)	7 (-1)	11 (+2)	6 (-3)	5 (-4)	9 (+2)	8 (+2)
CPT	2 (+1)	1 (0)	1 (-1)	0 (-1)	1 (0)	0 (-2)	1 (0)	0 (0)	3 (+1)
Diabetes and endocrinology	3 (-3)	5 (-1)	4 (0)	2 (-4)	5 (-1)	0 (-2)	2 (-1)	5 (-1)	3 (+2)
Gastroenterology	9 (+1)	11 (0)	5 (-4)	3 (+1)	6 (-4)	14 (+4)	10 (+1)	11 (+3)	5 (-2)
Geriatric medicine	13 (+3)	7 (+5)	17 (+3)	10 (+1)	19 (+4)	8 (-6)	12 (+2)	10 (+3)	7 (0)
Haematology	4 (-3)	9 (+2)	2 (+2)	1 (0)	0 (0)	5 (+3)	6 (-7)	2 (+1)	4 (0)
Infectious diseases	0 (-1)	2 (+1)	0 (-2)	0 (0)	2 (+2)	1 (+1)	4 (-2)	0 (0)	2 (+2)
Renal medicine	6 (+2)	6 (0)	0 (-1)	1 (0)	1 (0)	8 (0)	10 (+6)	3 (0)	6 (+3)
Respiratory medicine	9 (-2)	11 (-6)	6 (-4)	1 (-1)	4 (-3)	14 (-6)	5 (-3)	7 (-1)	7 (0)
Rheumatology	1 (+1)	3 (+2)	3 (+2)	1 (-3)	2 (+1)	2 (+1)	3 (-2)	4 (+2)	0 (0)

2.2 GMC NTS – specialty-specific data

In 2015, a pilot survey was undertaken as part of the GMC’s NTS, whereby trainees who declared that they were dual training in one of the following specialties were asked 12 additional questions relating to their training in G(I)M: gastroenterology, geriatric medicine, renal medicine or respiratory medicine together with general (internal) medicine (G(I)M).

Data from 2015–16 were analysed and the main findings are summarised in Fig 17. In total, 92% were training in G(I)M as their second specialty (up by 1% since 2015) and this was highest in geriatric medicine at 98% (down by 1% since 2015) and lowest in renal medicine at 81% (up by 3% since 2015).

Fig 17. Summary of GIM SSQs data for 2015–16



2.3 ARCP outcomes

Satisfactory outcomes by specialty are shown in Figs 18 and 19. Outcome 1s (satisfactory progress, competencies achieved as expected) were reported in 93% (27/29) of higher medical specialties. This was highest in nuclear medicine (77.8%) and lowest in gastroenterology (41.5%). Outcome 6s were reported in 83% (24/29) of higher specialties. Some variability is expected year on year, due to trainees' stage of training. The number of reported Outcome 6s was highest in clinical neurophysiology (17.6%) and lowest in infectious diseases (5.6%).

Fig 18. ARCP Outcome 1s by specialty

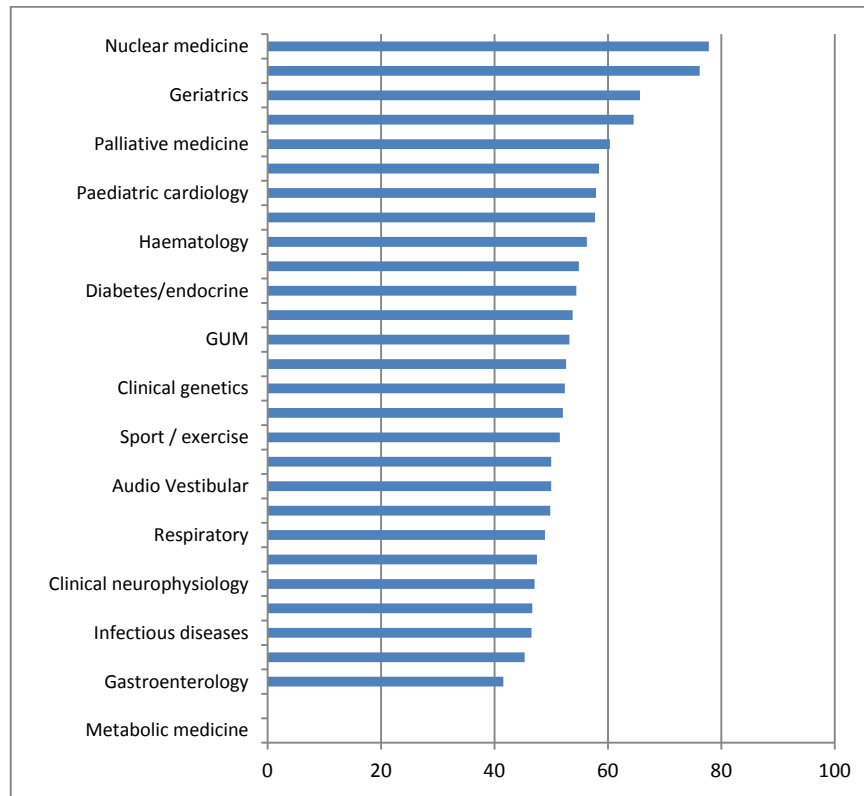
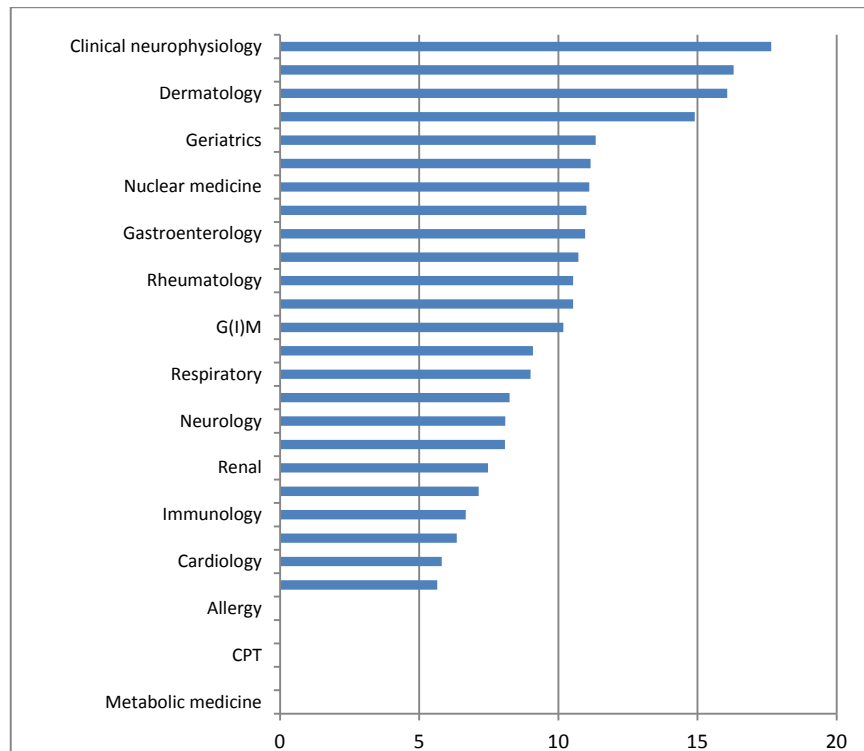


Fig 19. ARCP Outcome 6s by specialty



2.4 HST workforce census data

The overall quality of training and the balance between service versus training and speciality versus G(I)M obtained from the HST census data are shown in Figs 20–22.

Fig 20. Balance of service versus training in main speciality

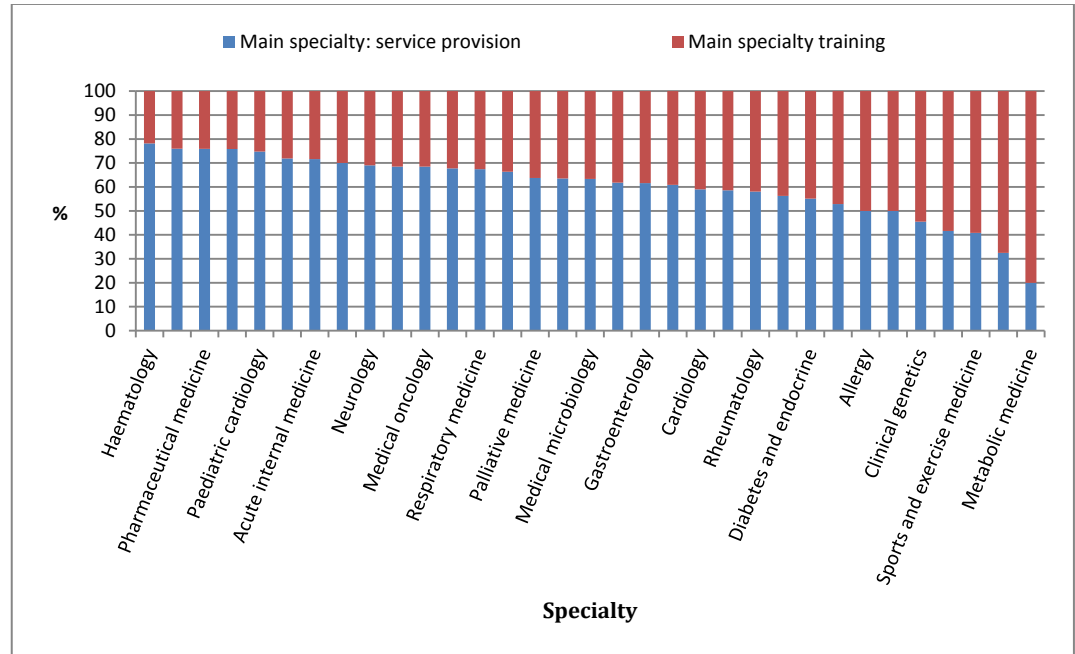
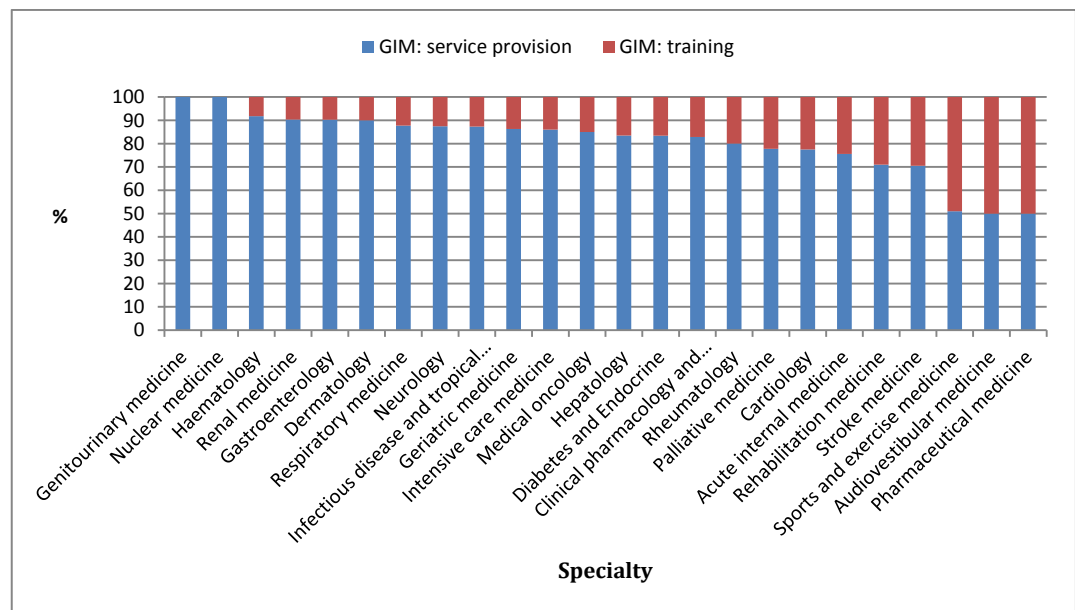
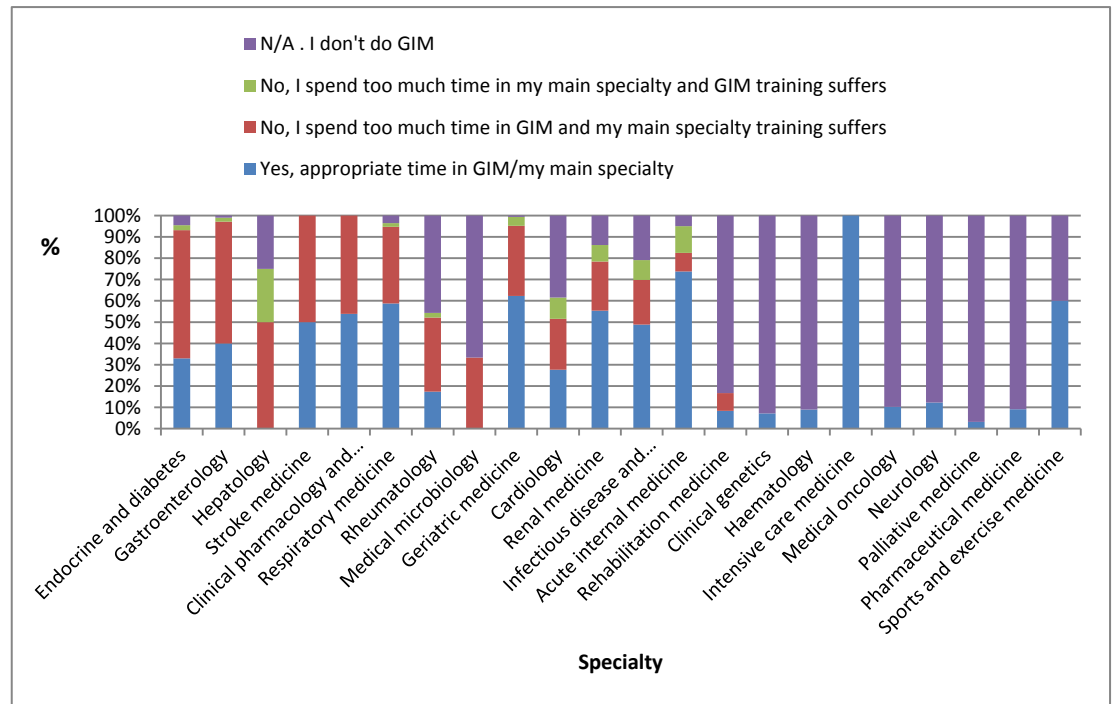


Fig 21. Balance of service versus training in G(I)M



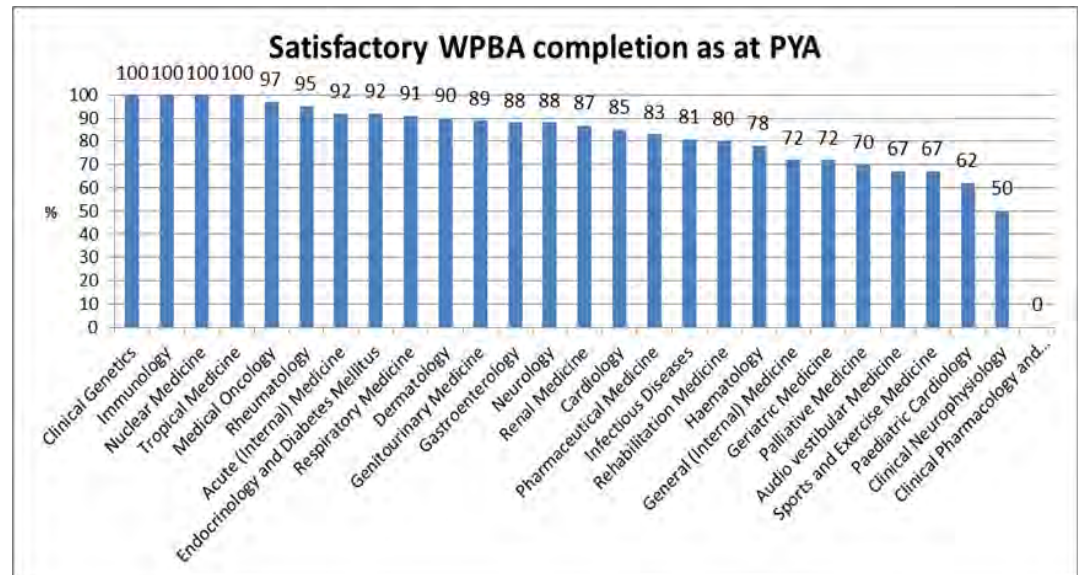
*Specialties where 100% of trainees responded that they were not doing any GIM were excluded from the analysis

Fig 22. Speciality versus G(I)M experience



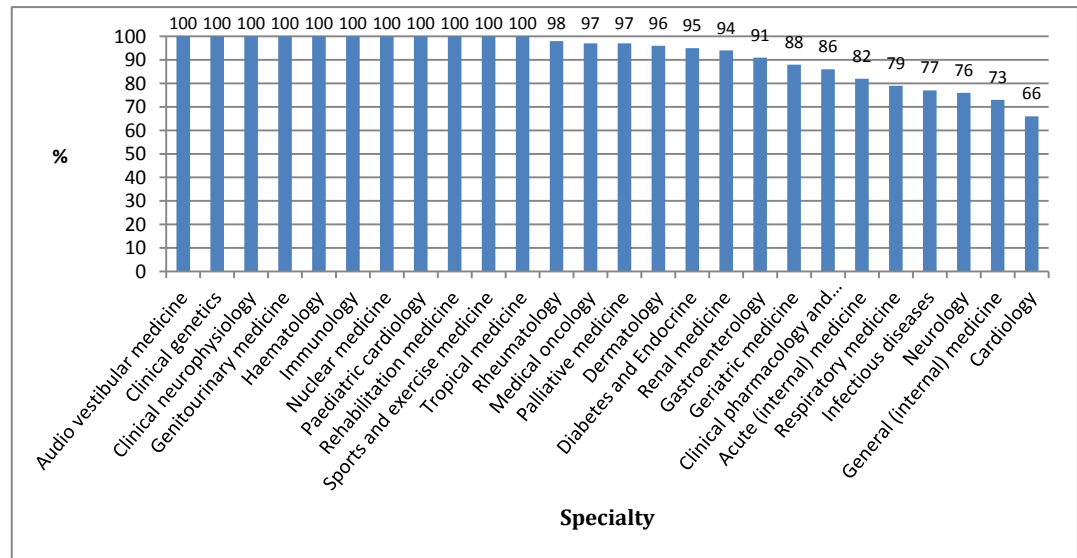
2.5 Penultimate year assessments

Fig 23: Satisfactory workplace-based assessment (WPBA) completion as at PYA



Across the 27 specialties, the average percentage of trainees who had satisfactorily completed their WPBA at the time of their PYA was 80.6%. There was some variation between the specialties, with clinical pharmacology and therapeutics, neurophysiology and paediatric cardiology being at the lower end.

Fig 24. Active in audit / quality improvement project (QiP)



The average percentage of trainees presenting for PYA who had demonstrated satisfactory activity in audit / quality improvement projects (QiP) was 92.1%. In total, eight of the ten specialties that had the lowest percentage of PYA trainees being active in audit or QiPs were in the acute specialties. Data for pharmaceutical medicine were not available for this indicator.

2.6 Monitoring visit reports

A summary of the reports from the monitoring visits with the JRCPTB representation from the training year 2015–16 are shown below. Some direct quotes are used from the individual reports.

Belfast – clinical genetics

This was a cyclical review and, overall, the report was graded B2 using the outcomes template shown in Fig 25. A few areas of improvement were identified around practical experience and educational resources, but otherwise there were no major concerns. Specialty induction was highlighted as an area of good practice. The report was mapped to the GMC domains and standards and it stated clear recommendations: ‘The conclusions were categorised into educational governance (training) and clinical governance and patient safety issues.’

Fig 25. Monitoring visit outcomes template

	Grading Outcome	Description	Deanery Action
A1	Excellent	Exceeds expectations for a significant number of GMC domains.	Cyclical.
A2	Good	Meets expectations under all GMC domains.	Cyclical.
B1	Satisfactory	Areas for improvement identified, but no significant areas of concern.	No automatic re-visit / Cyclical.
B2	Satisfactory (with conditions)	Areas for improvement identified. Amber concern(s) to be addressed.	No automatic re-visit / Cyclical / Follow Up report required.
C	Borderline	Areas of concern to be addressed (may include one red or multiple amber RAG ratings).	A Deanery review within 12 months (unless all concerns adequately addressed by Trust within 6 months of rated action plan being issued). The review may include a re-visit.
D	Unsatisfactory – Not able to assess	Unable to assess due to lack of trainee and/or trainer engagement with visit.	
E	Unsatisfactory - Urgent action	Urgent action required on significant areas of concern (multiple red RAG ratings).	Deanery review within 6 months of rated action plan being issued. This is expected to include a re-visit unless all areas have been adequately addressed within 6 months.
F	Unsatisfactory-Unsafe Training Environment – Immediate Action	Will apply if a red* RAG rating is identified or may occur if multiple red RAG ratings. Immediate action to be taken by notification to nominated Trust representative. Possible withdrawal of trainees (single or multiple red*).	Automatic review within 3 months. If no improvement is apparent within 3 months, the GMC Withdrawal of Approval process may be initiated.

Glenfield – cardiology

This was a targeted visit to address concerns related in particular to the working patterns of HSTs and the clinical supervision of more junior trainees. ‘A key barrier to training had been identified as the excessive number of out-patient clinics covered by HSTs with poor clinical supervision. Another barrier to training identified previously was the level of input the HSTs were providing to the clinical decision unit (CDU) with minimal support.’ There was a ‘high reliance on trust employed doctors and this was not sustainable to support trainees and service. The long hours exceeding EWTD and medical staffing and rotas were a huge issue. The visiting team were impressed with the progress made to improve the education and training environment.’ However, there remains some work to do around further strengthening clinical supervision arrangements for HSTs who are covering consultant clinics, those who are on the CDU at nights and for the more junior doctors on the wards. The trust executive team supported changes to the rotas and to increase the level of clinical support provided to trainees and also to reinstate education time in consultant job plans.

South-East Scotland – cardiology

‘Issues were raised regarding the lack of specialty teaching programme, safety in the context of heavy workload, handovers and lack of informed feedback’ on the Scottish training survey. ‘There were signals of concern around a culture of undermining of confidence.’ Repeated pink flags were also noted on the NTS around

induction, educational supervision and workload. ‘The training programme director (TPD) had indicated awareness that vacancies at trainee and trainer level had placed additional pressure on the existing trainees in the reduced satisfaction.’ The following points were noted and recommended for development: competition for sub-specialty experience as well as issues around the unsupervised clinics, lack of formal regional teaching, study leave not being equitable and no formal return to work programme especially around procedures. Areas of good practice and concerns were highlighted, and the findings were presented with clear actions and recommendations mapped to the GMC standards and themes.

West of Scotland – cardiology

This was a targeted visit to address issues around induction, adequate experience and poor regional teaching. Training was compromised ‘at the expense of international clinical fellows’. Trainees were also not being released for training opportunities to tertiary centres. ‘For example, catheter lab experience due to overall workload at base hospital.’ There was a lack of consultant supervision in clinic. Off-site protocols were not readily available, which compromised patient safety. Some of the recommendations included to stop/minimise trainees covering off site without consultant/adequate supervision being in place, and ‘TPDs to assist trainees in identifying competencies which need to be achieved and barriers in achieving this ahead of ARCPs and improving consultant supervision in clinics with named consultant clinic lists’.

East of England – clinical pharmacology and therapeutics

This was a GMC-enhanced visit due to previously reported ‘serious concerns around training, patient safety and undermining’. A number of recommendations were put into place after the initial visit but ongoing concerns were raised, with red flags noted in overall satisfaction, experience, clinical supervision, supportive environment and local teaching, and therefore a re-visit was arranged. The visiting team noted that, ‘the department has made significant progress with addressing many of the concerns identified in the previous visit’. Areas of ongoing concern with further recommendations included: ‘developing a structured training programme mapped against the curriculum’; dual programmes to be approved prospectively by the GMC/RCP; developing scheduled departmental induction; allocating accredited

educational and clinical supervisors in a timely fashion; developing the consultant rota for supervision of trainees; ensuring there are no unsupervised clinics and no trainees requesting investigations for patients they have not seen; and stopping any undermining behaviour.

In summary, monitoring visits were done in a cyclical or targeted fashion. There were variable methods of conducting reviews, and reporting and standardising the method of reporting mapped to the GMC themes and/or the Health Education England (HEE) quality framework would allow better comparisons between training programmes and regions.⁵

3.0 Theme 2: Educational governance and leadership

The data sources used to inform this theme include the GMC NTS (generic and SSQ data), ARCP outcomes, MRCP outcomes, HST census data / new consultants (post-CCT) survey results, PYA reports and monitoring visit reports. The National Specialist Recruitment Office provided some of the equality and diversity data.

3.1 GMC NTS – generic data

Table 14. GMC NTS red flags by indicators for all medical specialties

No	Indicator	2015	2016	Difference
1	Clinical supervision out of hours	40	54	+14
2=	Adequate experience	24	31	+7
2=	Reporting systems (new in 2016)	N/A	31	N/C
4	Local teaching	32	30	-2
5=	Clinical supervision	26	27	+1
5=	Regional teaching	24	27	+3
7	Feedback	12	20	+8
8	Induction	12	19	+7
9	Supportive environment	16	14	-2
10	Study leave	19	13	-6
11	Handover	17	11	-6
12=	Work load	36	10	-26
12=	Access to educational resources	7	10	+3
13=	Overall satisfaction	9	8	-1
15=	Educational supervision	1	0	-1

N/C = non-comparable

Table 15. Repeated red flags (2015 and 2016) by indicators for all medical specialties

No	Indicator	2015/16	%
1	Clinical supervision out of hours	32/40	80%
2	Clinical supervision	10/26	38%
3=	Adequate experience	9/24	37%
3=	Study leave	7/19	37%
5	Local teaching	11/32	34%
6	Induction	4/12	33%
7	Regional teaching	7/24	29%
8	Feedback	3/12	25%
9=	Overall satisfaction	2/09	22%
9=	Work load	8/36	22%
11	Supportive environment	3/16	19%
12=	Access to educational resources	0/07	0%
12=	Educational supervision	0/01	0%
12=	Handover	0/17	0%
12=	Reporting systems (new in 2016)	0/00	0%

Table 16.Green flags by indicator for all medical specialties

No	Indicator	2015	2016	Difference
1	Work load	29	54	+25
2	Induction	26	30	+4
3	Access to educational resources	23	29	+6
4	Regional teaching	29	26	-3
5	Clinical supervision out of hours	14	23	+9
6	Handover	5	16	+11
7	Reporting systems (new for 2016)	N/A	13	N/C
8	Local teaching	6	11	+5
9	Study leave	7	8	+1
10	Supportive environment	10	4	-6
11=	Overall satisfaction	0	3	+3
11=	Feedback	3	3	N/C
13=	Adequate experience	0	0	N/C
13=	Clinical supervision	0	0	N/C
13=	Educational supervision	0	0	N/C
13=	Supportive environment	0	0	N/C

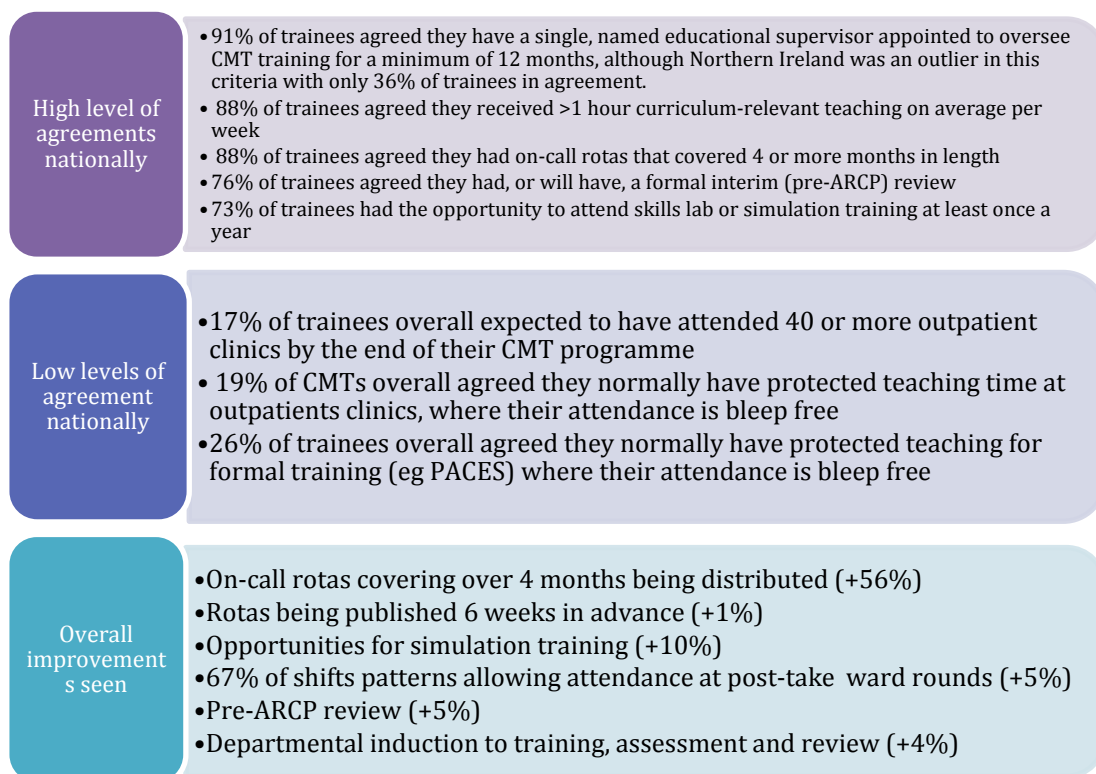
Table 17. Repeated red flags (2015 and 2016) by indicators for all medical specialties

No	Indicator	2015/2016	%
1	Work load	20/29	69%
2	Clinical supervision out of hours	8/14	57%
7	Regional teaching	13/29	45%
12	Access to educational resources	10/23	43%
3	Study leave	3/07	43%
9=	Induction	10/26	38%
11	Feedback	1/03	33%
4=	Local teaching	2/06	33%
9=	Supportive environment	1/10	10%
6	Adequate experience	0/00	0%
4=	Clinical supervision	0/00	0%
13	Educational supervision	0/00	0%
14	Handover	0/05	0%
8	Overall satisfaction	0/00	0%
15	Reporting systems (new in 2016)	0/00	0%

3.2 GMC NTS – SSQ data

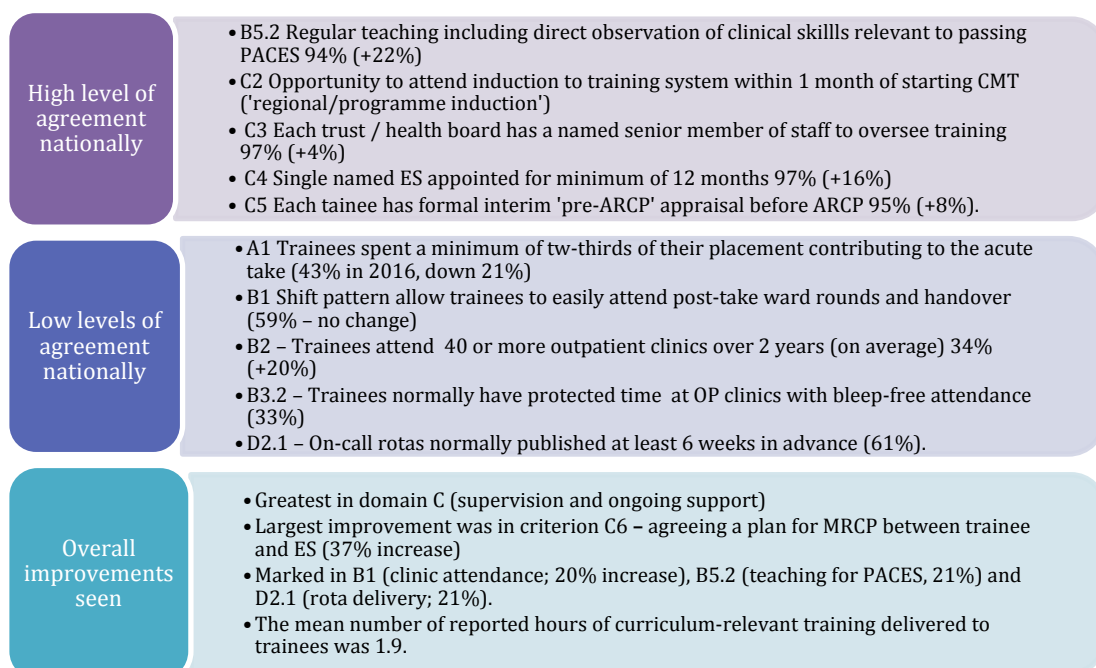
The CMT quality criteria were launched in 2015 in an attempt to drive quality of training and enhance the educational experience. The criteria have been grouped into four domains, and questions related to each of the domains were developed and included in the 2016 GMC NTS as programme-specific questions. The data analysis from 2,912 trainees (1,400 CMT1 and 1,472 CMT2) is summarised in Fig 26. A wide degree of regional variation was noted across the breadth of the criteria.⁶

Fig 26. CMT quality criteria – trainee survey results 2016 (compared with 2015)



Trainers were also asked similar questions regarding the CMT quality criteria, and the survey results are summarised in Fig 27. In total, 112 trainers (mainly TPDs) responded in 2016 (+13% compared with 2015).

Fig 27. CMT quality criteria – trainer survey results 2016 (compared with 2015)



3.3 ARCP outcomes

Fig 28. Proportion of satisfactory/unsatisfactory/OOP ARCP outcomes by deanery/LETB (excluding RITAs) – HST

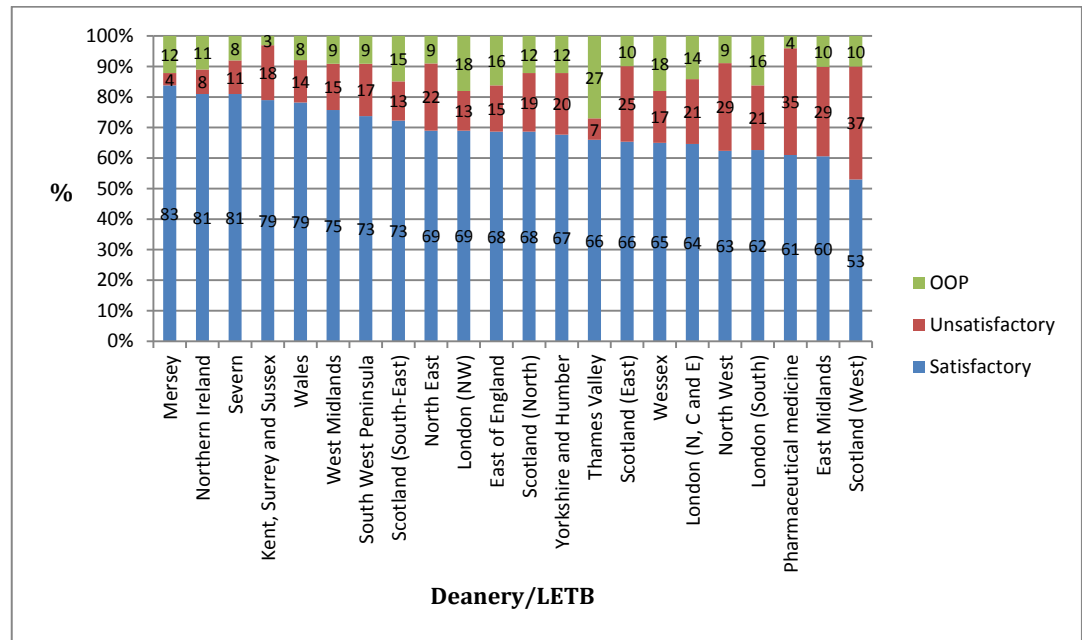


Fig 29. Proportion of satisfactory/unsatisfactory/OOP ARCP outcomes by Deanery/LETB (excluding RITAs) – core medical trainees

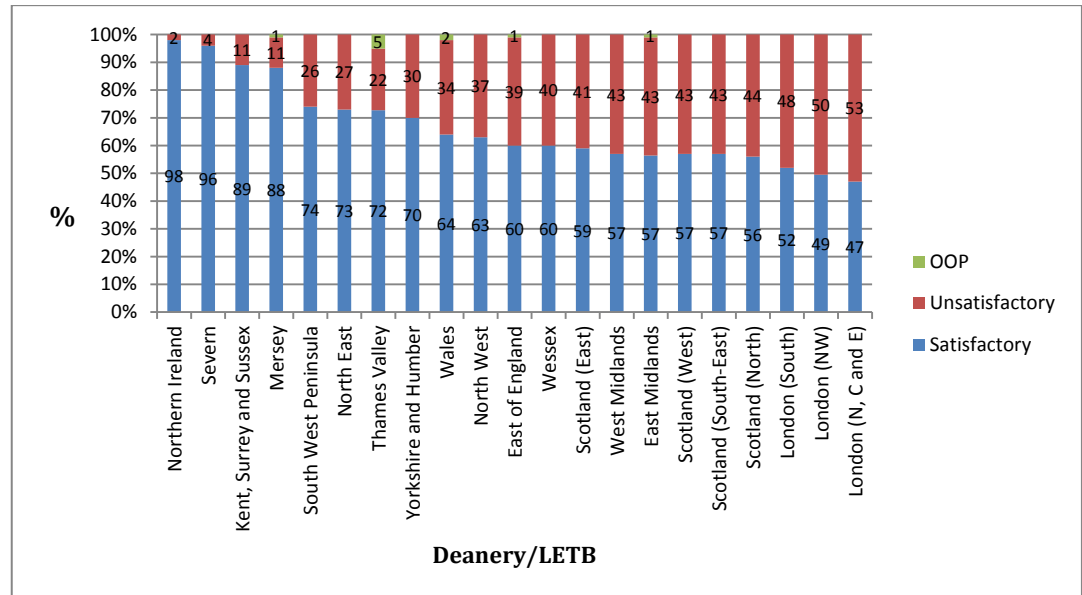


Fig 30. Proportion of Outcome 5s by deanery/LETB proportion – CMT

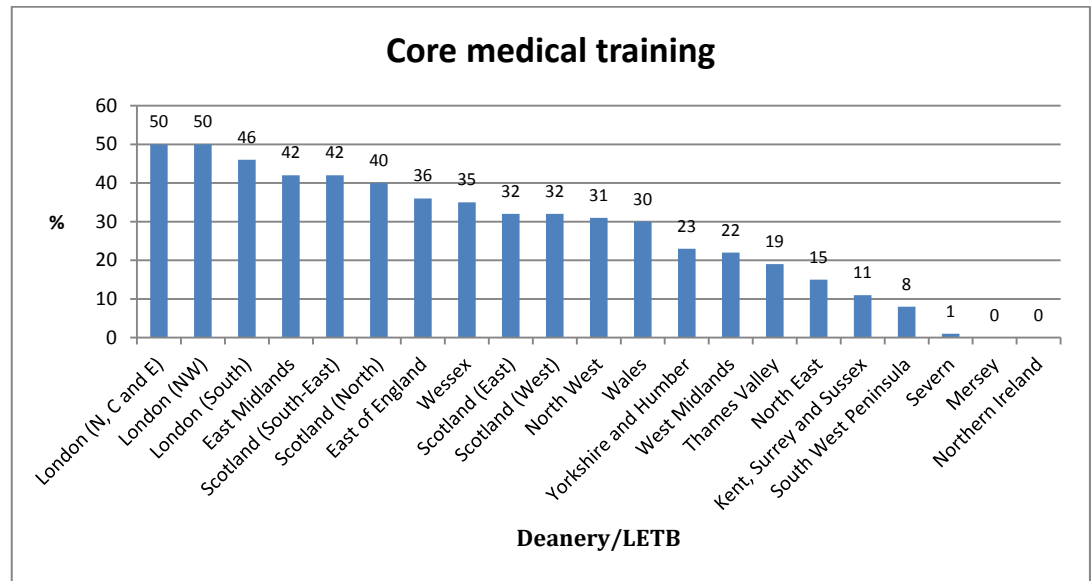
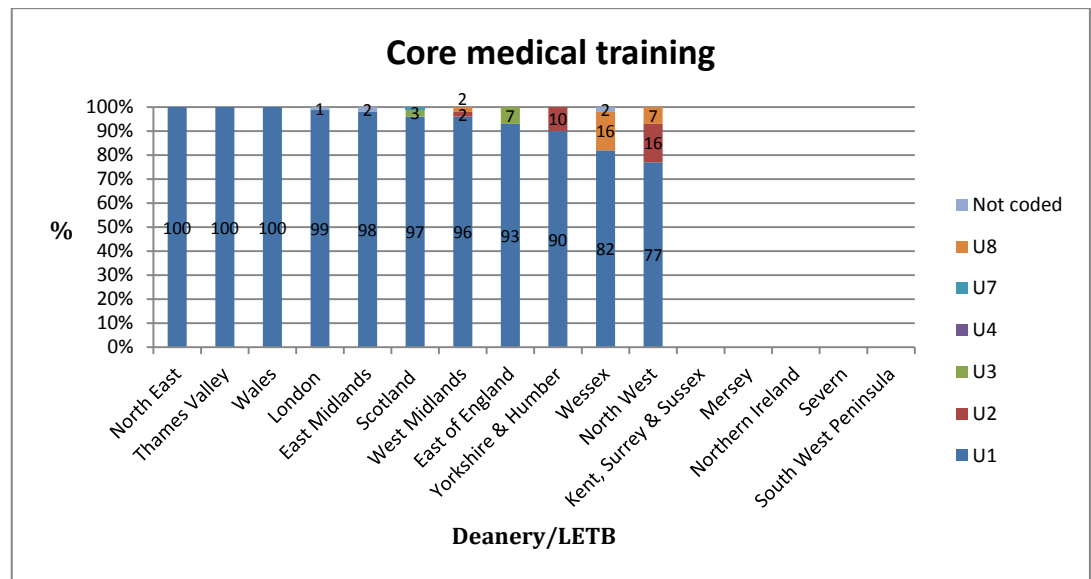


Fig 31. Reasons for reported Outcome 5s by deanery/LETB – CMT



The reasons for Outcome 5s are not reported by the GMC, so e-Portfolio data were reviewed. Although the numbers of outcomes do not correlate directly between the two datasets, in the majority of cases the outcome was due to unsatisfactory record keeping / evidence (U1) on trainees’ e-Portfolios. In a small number of cases, inadequate experience (U2) was cited as the reason, notably in the North West and Yorkshire and the Humber. Non-engagement with supervisors (U3) was also cited as a reason for 7% of trainees in the East of England and 3% in Scotland.

Fig 32. Proportion of Outcome 5s by deanery/LETB proportion – HST

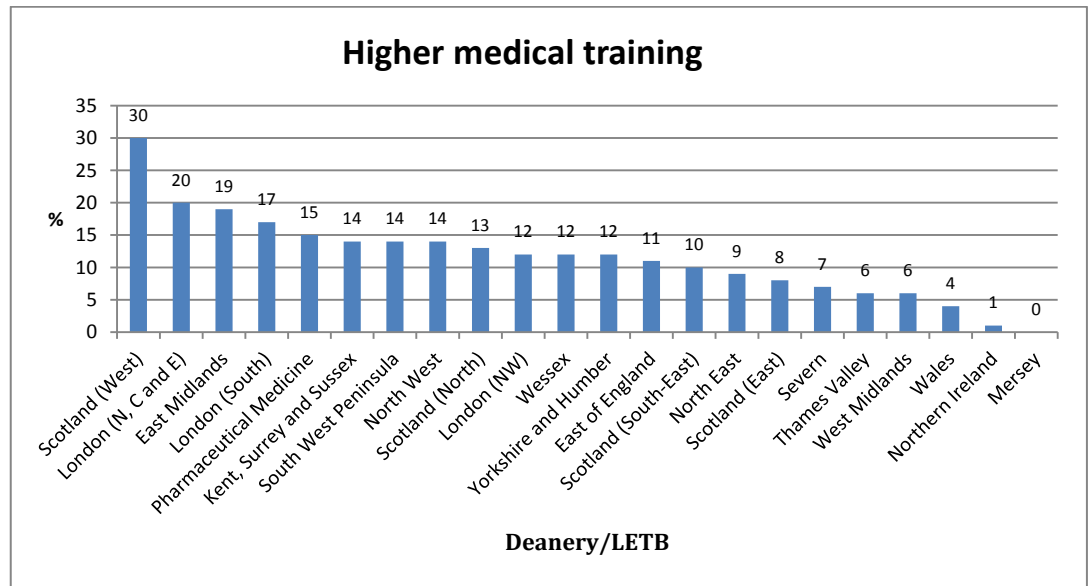
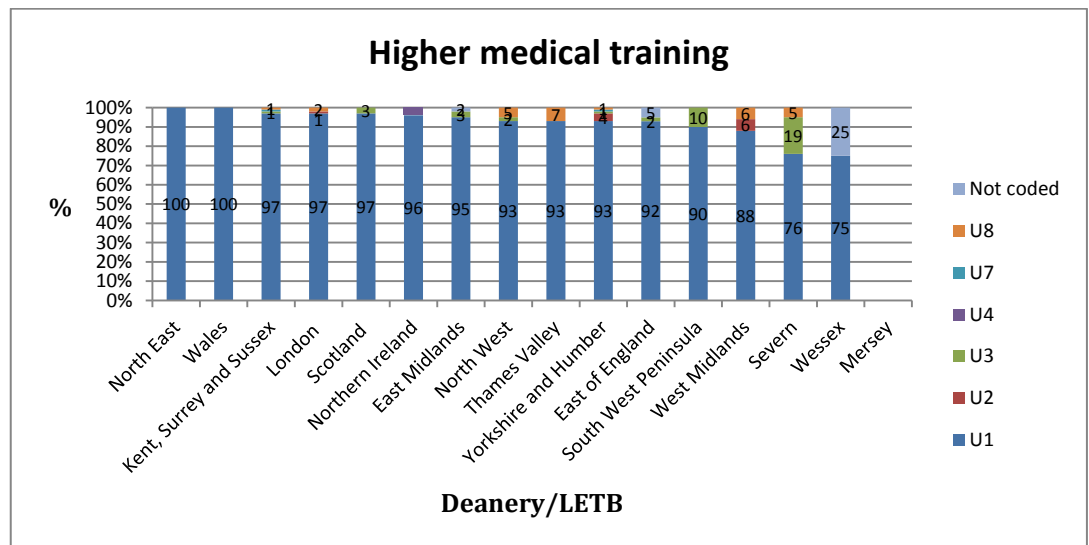


Fig 33. Reasons for reported Outcome 5s by LETBs – HST



The majority of the Outcome 5s results from unsatisfactory record keeping / evidence on trainees' e-Portfolios.

3.4 MRCP outcomes

Table 18. CMT progression (2012–16)

CT1 trainee progression	2012	2013	2014	2015	2016	Difference
Part 1	82.7	84.5	83.9	83.0	84.0	↔ 1.00
Part 2	68.5	71.9	75.6	71.0	70.0	↔ -1.00
PACES	30.2	32.6	33.7	33.0	30.0	↓ -3.00
CT2 trainee progression	2012	2013	2014	2015	2016	Difference
Part 1	89.8	91.9	92.1	93.0	93.0	↔ 0.00
Part 2	83.4	85.2	88.0	88.0	88.0	↔ 0.00
PACES	70.4	72.7	76.8	78.0	75.0	↓ -3.00

Fig 34. CT1 and CT2 MRCP(UK) pass rates by deanery – 2016

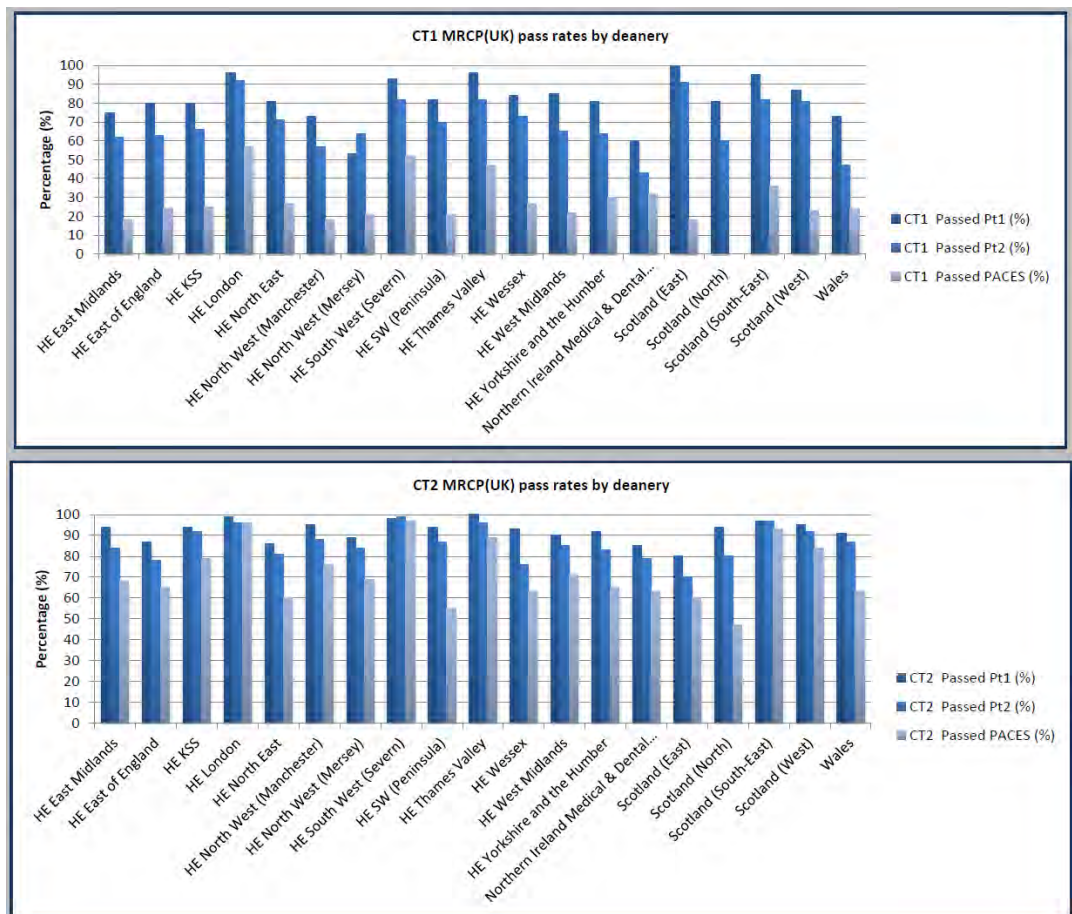


Table 19. MRCP(UK) outcomes – pass rates by ethnicity (2012–16)

Pass rates by Ethnicity UKG	2012	2013	2014	2015	2016	Difference
Part 1-White	58.2	59.6	58.9	64.0	63.0	→ -1.00
Part 1-Non-White	46.9	52.3	49.2	42.5	55.2	↑ 12.70
Part 1-Undeclared	50.6	52.8	46.1	50.4	48.4	→ -2.00
Part 2-White	80.0	86.4	93.6	88.6	87.1	→ -1.50
Part 2-Non-White	66.2	72.3	83.8	74.1	78.4	↑ 4.30
Part 2-Undeclared	67.3	75.7	84.3	79.0	75.0	↓ -4.00
PACES-White	69.5	68.3	70.2	71.6	71.6	→ 0.00
PACES-Non-White	60.3	58.1	59.7	64.4	60.8	↓ -3.60
PACES-Undeclared	58.3	67.1	64.3	60.6	62.5	→ 1.90

Pass rates by Ethnicity IMG	2012	2013	2014	2015	2016	Difference
Part 1-White	35.4	40.3	40.5	41.3	38.0	↓ -3.30
Part 1-Non-White	40.2	41.7	36.9	38.6	28.8	↓ -9.80
Part 1-Undeclared	39.5	42.3	48.6	48.1	46.7	→ -1.40
Part 2-White	59.7	68.4	73.8	75.7	48.4	↓ -27.30
Part 2-Non-White	51.2	60.1	63.6	63.3	59.6	↓ -3.70
Part 2-Undeclared	59.4	65.1	72.0	71.7	63.3	↓ -8.40
PACES-White	36.5	36.7	36.4	50.7	43.2	↓ -7.50
PACES-Non-White	31.7	30.2	34.3	31.8	34.3	→ 2.50
PACES-Undeclared	38.5	31.0	41.2	37.5	29.5	↓ -8.00

Ethnicity UKG	2012	2013	2014	2015	2016	Difference
Asian	15.5	15	12.3	13	9.7	↓ -3.30
Black	2	1.8	2.3	2.1	2.1	→ 0.00
Chinese/SE Asian	6.7	7	7.1	7	6.4	→ -0.60
White	60.4	58.1	57	57	56.5	→ -0.50
Other	5.9	7.5	7.4	7.1	12.2	↑ 5.10
Unknown	9.6	10.6	13.9	13.9	13.1	→ -0.80

Ethnicity IMG	2012	2013	2014	2015	2016	Difference
Asian	43.2	37.3	53.1	54.1	44	↓ -10.10
Black	8.5	6.4	8.3	7.6	6.3	→ -1.30
Chinese/SE Asian	7.7	8.4	7.4	7.2	7.3	→ 0.10
White	11.2	6.8	5.7	5	4.9	→ -0.10
Other	18.3	28.7	12	12.4	26.1	↑ 13.70
Unknown	11.2	12.4	13.5	13.7	11.4	→ -2.30

Ethnicity Examiners	2012	2013	2014	2015	2016	Difference
Asian	15.9	15	28.1	37.8	20.5	↓ -17.30
Black	1.5	1.3	2.4	2.9	1.7	→ -1.20
Chinese/SE Asian	2	1.9	5.2	4.7	2.6	→ -2.10
White	57.3	48	52.9	50.1	34.7	↓ -15.40
Other	18.5	11.2	5.4	3	22.2	↑ 19.20
Unknown	4.9	22.6	6	1.5	18.3	↑ 16.80

Table 20. MRCP(UK) outcomes – pass rates by gender (2012–16)

Pass rates by Gender UK	2012	2013	2014	2015	2016	Difference
Part 1 - Male	70.5	60.0	58.2	65.1	62.1	→ -3.00
Part 1 - Female	62.5	54.1	51.3	56.3	57.9	→ 1.60
Part 2 - Male	85.3	82.0	88.3	84.5	85.8	→ 1.30
Part 2 - Female	85.8	80.0	90.3	83.0	80.9	→ -2.10
PACES - Male	61.0	61.4	64.0	65.5	62.9	→ -2.60
PACES - Female	68.7	67.3	68.5	70.4	69.8	→ -0.60
Pass rates by Gender IMG						
Pass rates by Gender IMG	2012	2013	2014	2015	2016	Difference
Part 1 - Male	47.7	43.3	40.4	41.6	37.5	↓ -4.10
Part 1 - Female	46.9	38.7	36.5	38.1	35.6	→ -2.50
Part 2 - Male	64.3	61.0	65.8	66.9	62.4	↓ -4.50
Part 2 - Female	65.7	61.3	64.2	62.6	57.9	↓ -4.70
PACES - Male	28.3	27.7	31.2	28.9	30.2	→ 1.30
PACES - Female	42.8	37.3	43.0	43.9	41.3	→ -2.60

3.5 HST workforce census data

Fig 35. Overall quality of training in main specialty

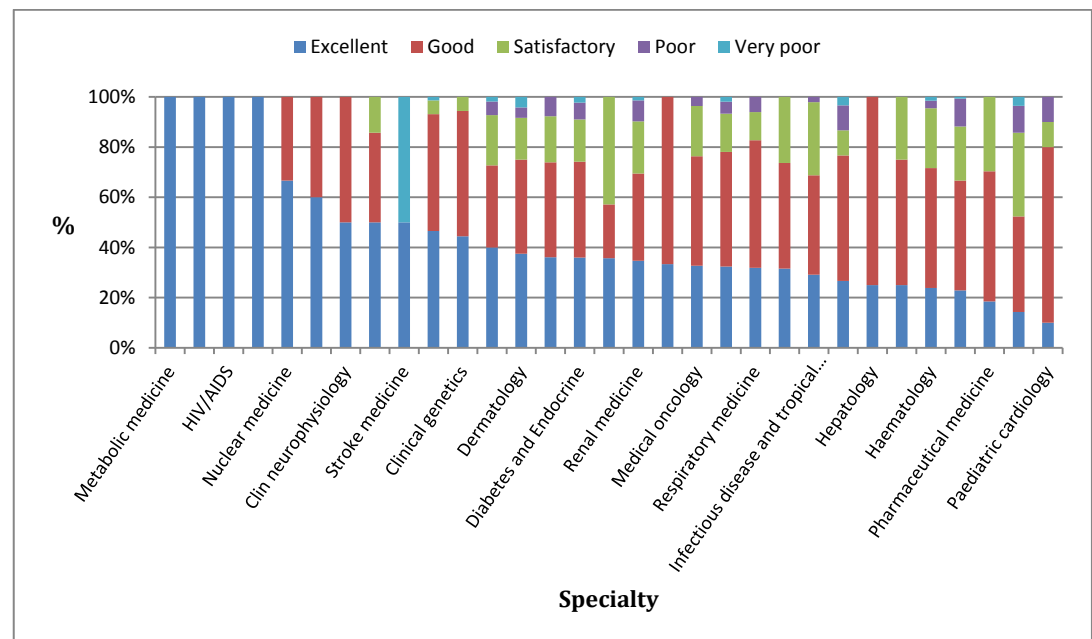
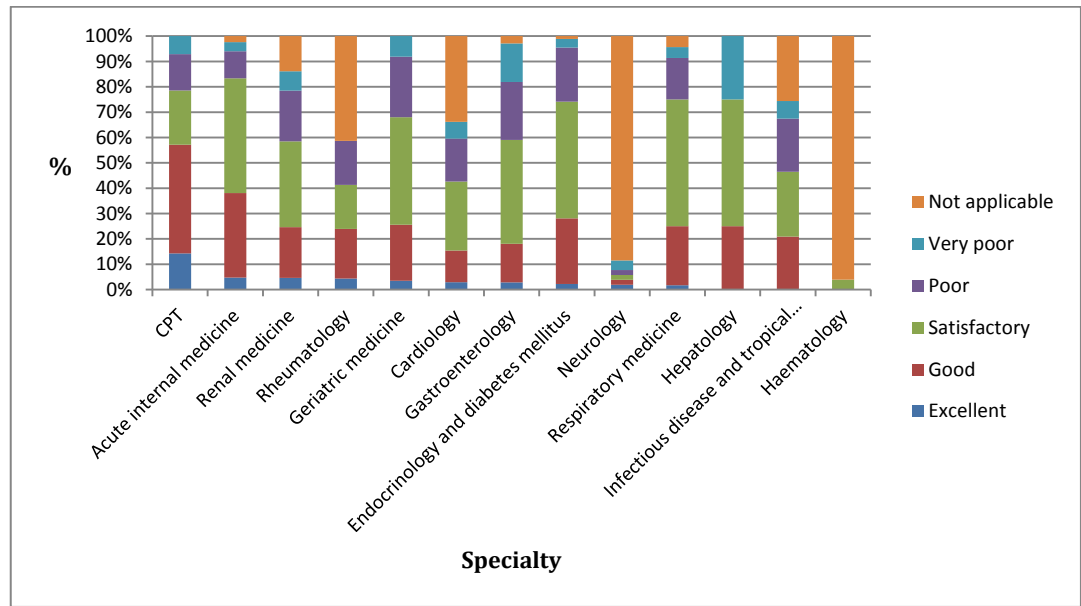
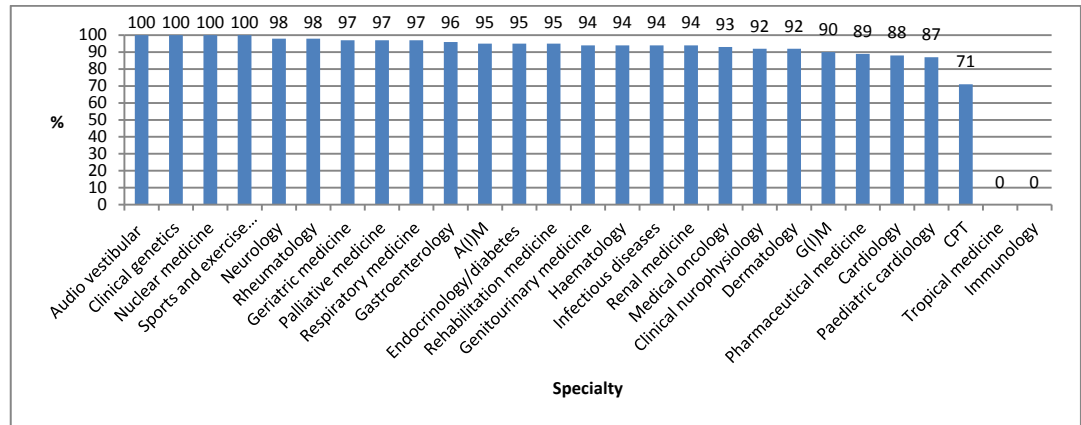


Fig 36. Overall quality of training in GIM component



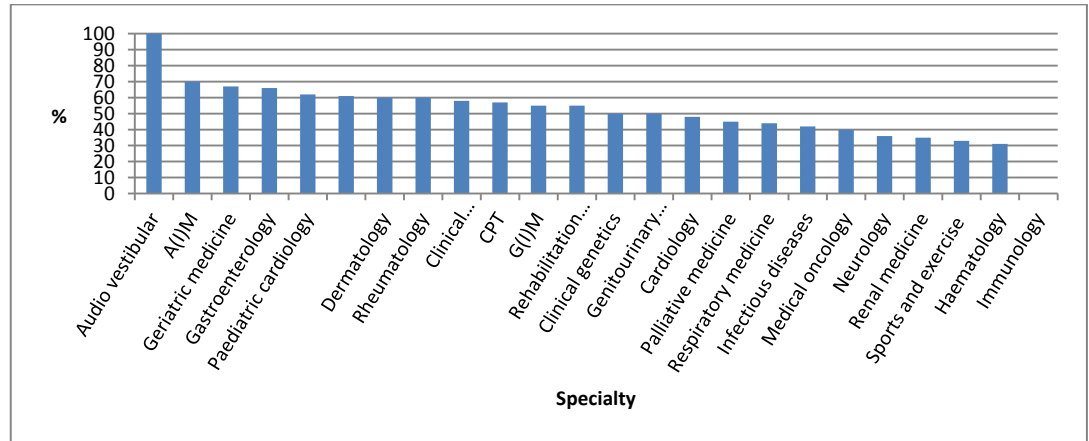
3.6 Penultimate year assessments

Fig 37. Satisfactory educational supervisor report at PYA



The average percentage of trainees across the 27 specialties who had satisfactory educational supervisor reports at the time of PYA was 86.9%.

Fig 38. Attendance at a management course at the time of the PYA



The average percentage of trainees who presented for a PYA who had evidence of having attended a management course was 51.04%. Significant variability is noted, with 100% attendance in audiovestibular medicine and 70% in acute medicine and 31% (the lowest) in haematology.

3.7 Equality and diversity data

Trainees are recruited into core medical training and higher medical training annually, and the majority of this recruitment is carried out by the specialty recruitment office (SRO) at the JRCPTB. Applicants are required to provide personal information, which includes the nine protected equality and diversity (E&D) characteristics that are required to be requested and monitored as part of the provisions of the Equality Act 2010.

Data from 2,490 applications in 2015 and 2,684 applications in 2016 to core and higher medical training were analysed for the purpose of this report.

The average age of applicants in 2015 and 2016 was:

- core medical training: 2015: 27 years 2016: 28 years
- higher medical training: 2015: 29 years 2016: 29 years

Fig 39. Ratio of male:female applicants (2015–16)

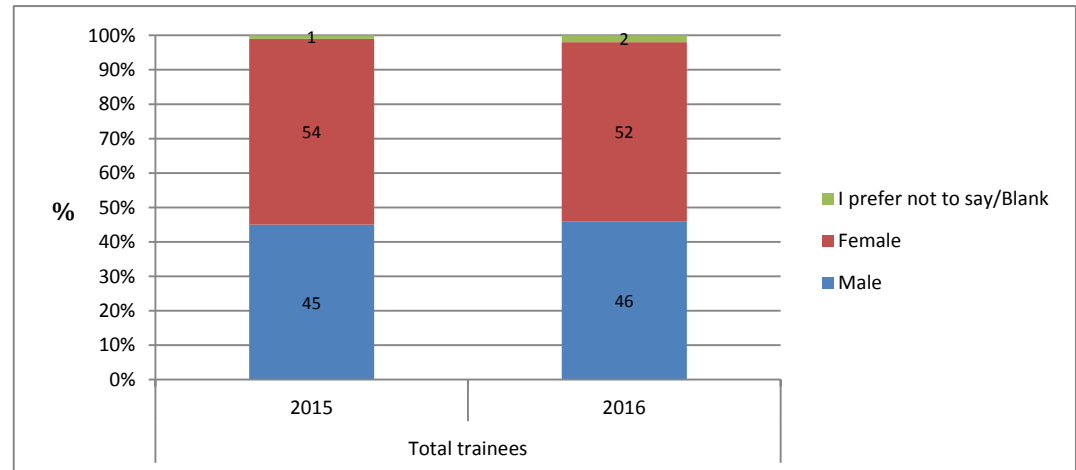
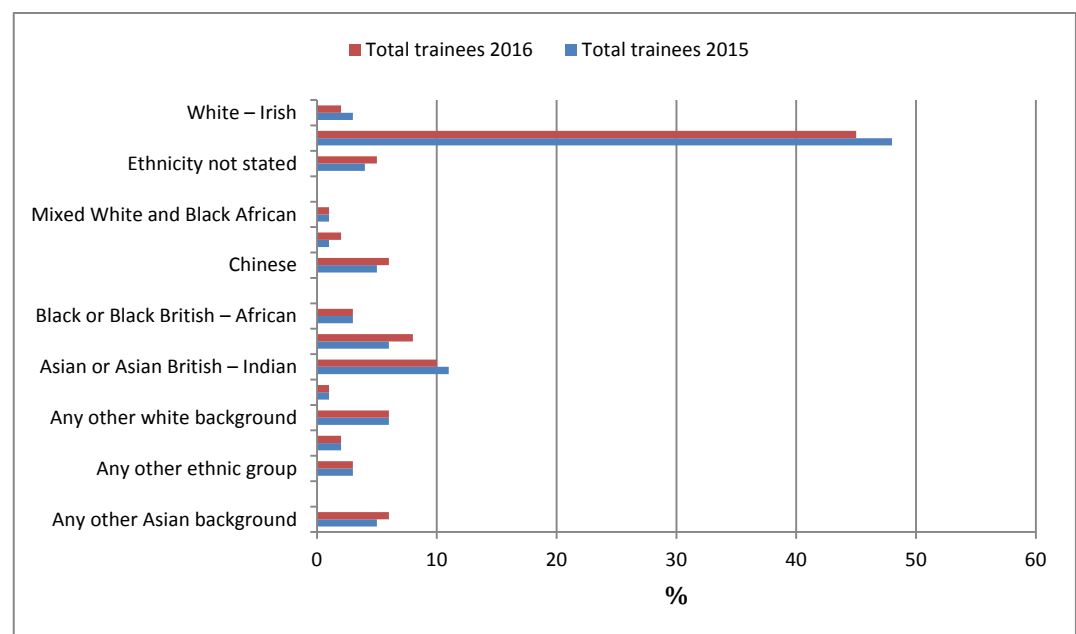


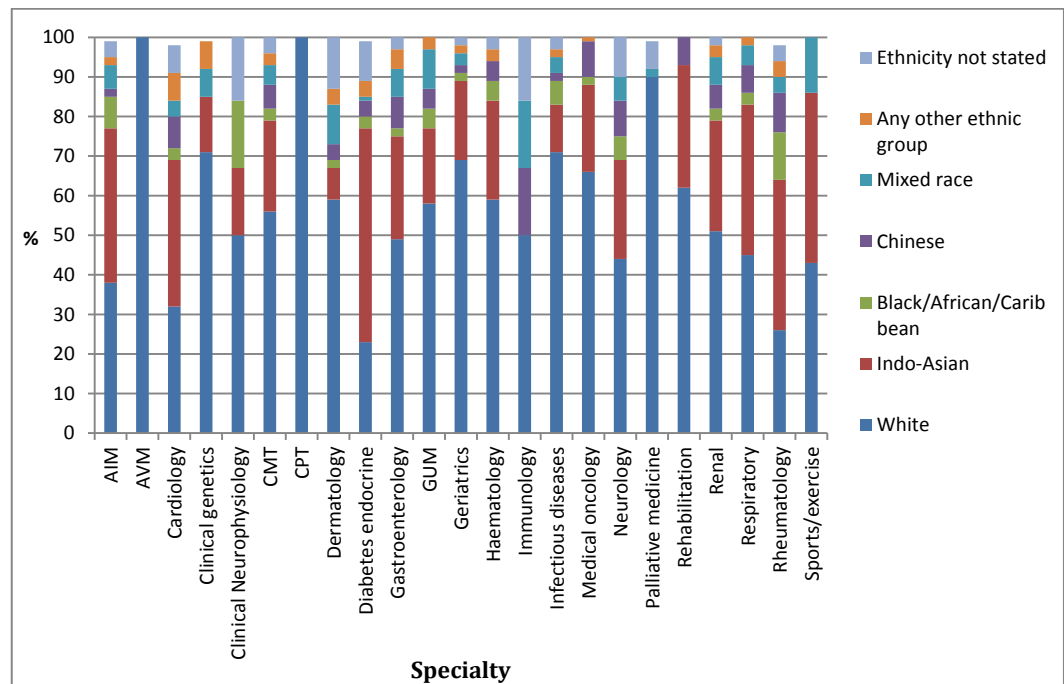
Fig 40. Ethnicity of CMT/HST applicants (2015–16)



Of the total applicants in 2016, the top three ethnic groups were white British (45%) followed by Asian British Indian (10%) and then Asian British Pakistani (8%).

For the analysis of ethnicity by specialty, some of the ethnic groups were merged. This comprised: white (white Irish and British); Indo-Asian (Asian or Asian British, Indian or Pakistani, Bangladeshi, any other Asian); Chinese; Black, African/Caribbean (Black, Black British, African, Caribbean, any other Black); mixed (mixed white and Asian, Black African, Black Caribbean, any other mixed); any other; and not stated.

Fig 41. Ethnicity of applicants in 2016 by specialty



*Smaller specialties that had no applicants in 2016 were excluded from the analysis

Fig 42. Less-than-full-time (LTFT) applicants by specialty

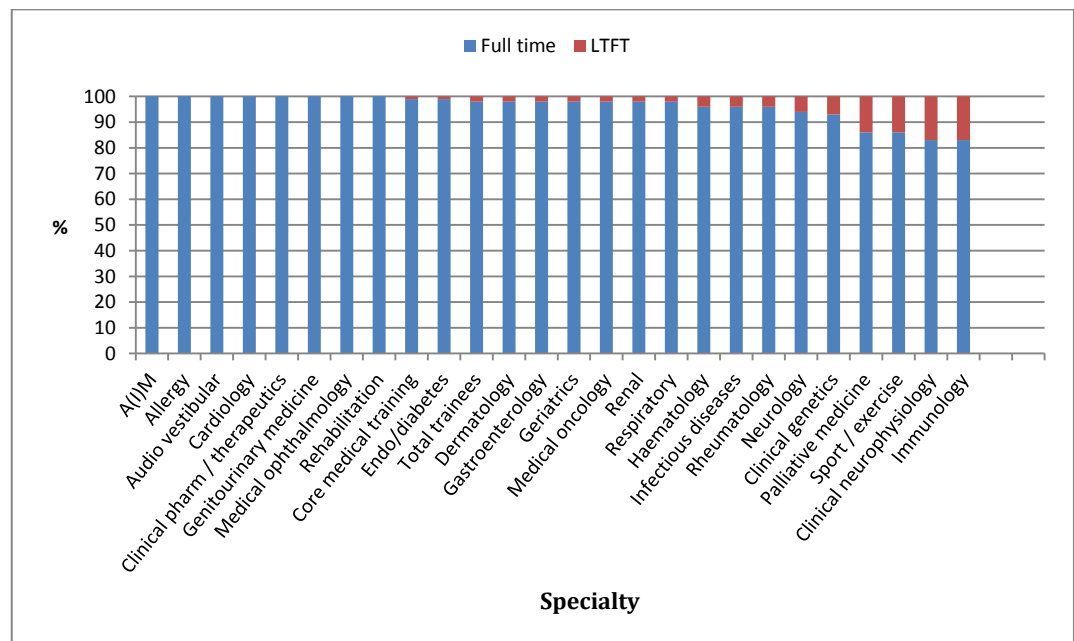
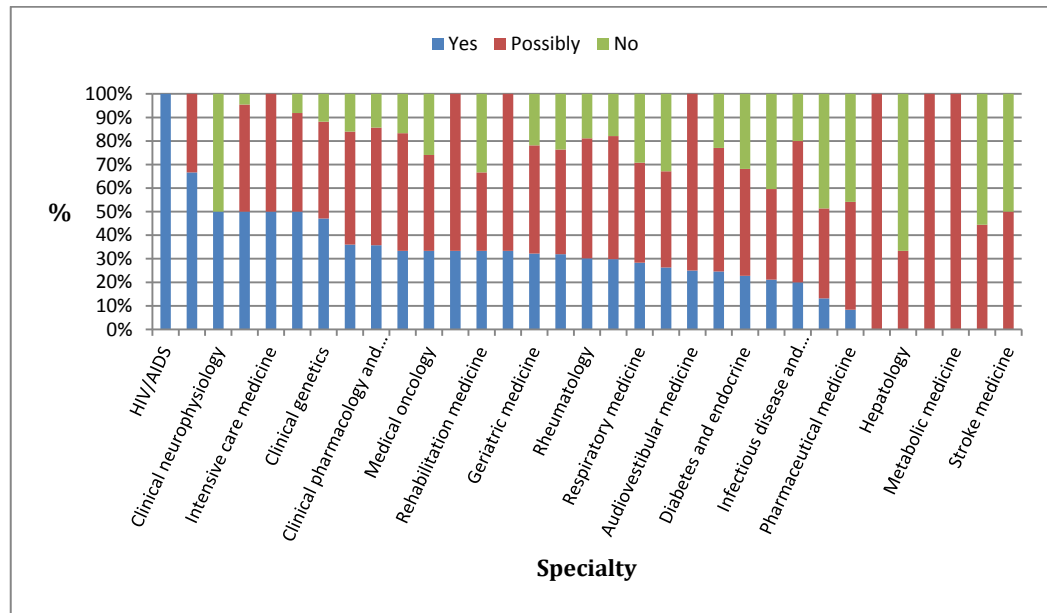


Fig 43. HST census data – would you like an LTFT consultant post?



Significant variability between specialties was noted. The number of trainees in LTFT training was:

- high in HIV/AIDS, medical microbiology, clinical neurophysiology, GUM and palliative medicine
- low in stroke medicine, paediatric cardiology and hepatology.

Fig 44. Applicants with a disability

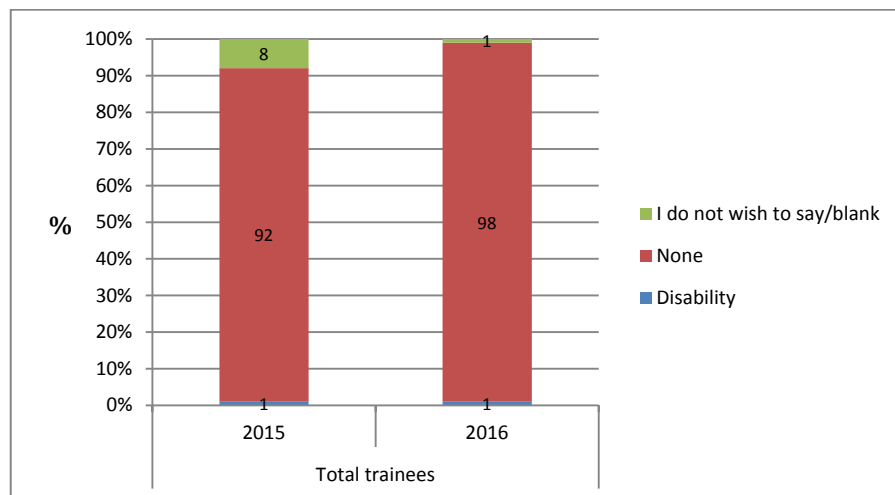


Fig 45. Applicants' sexual orientation

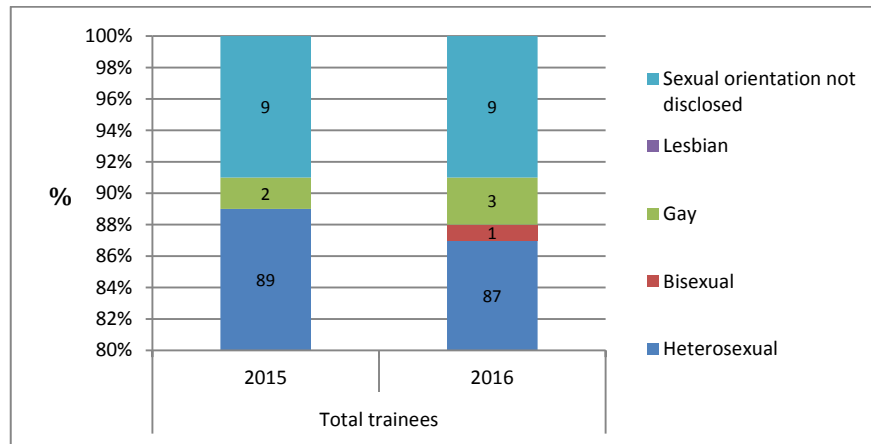


Fig 46. Applicants' marital status

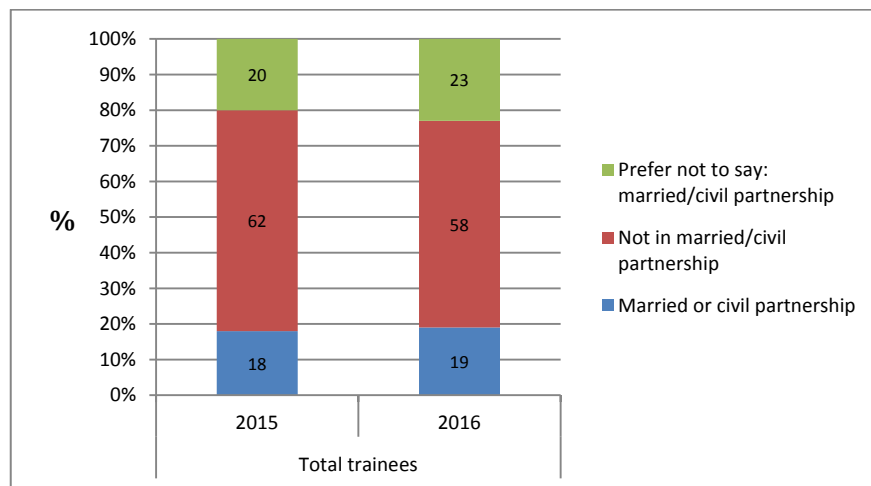
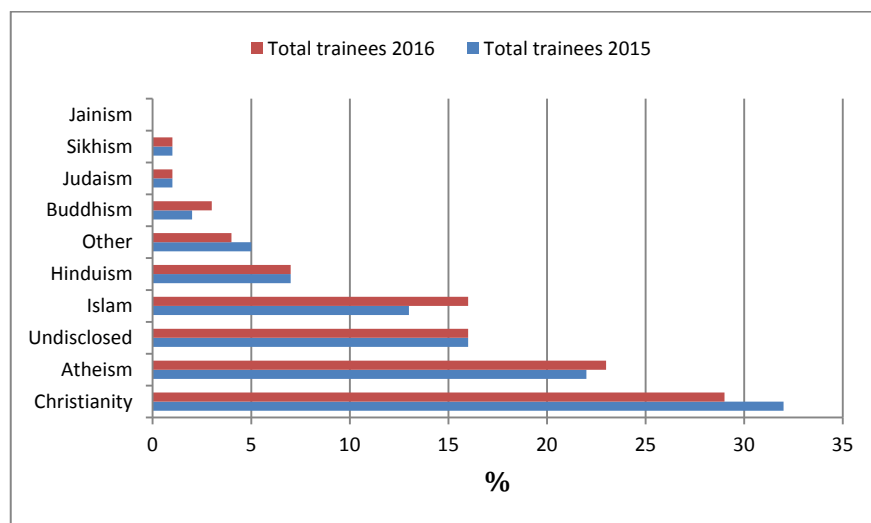


Fig 47. Applicants' religious beliefs

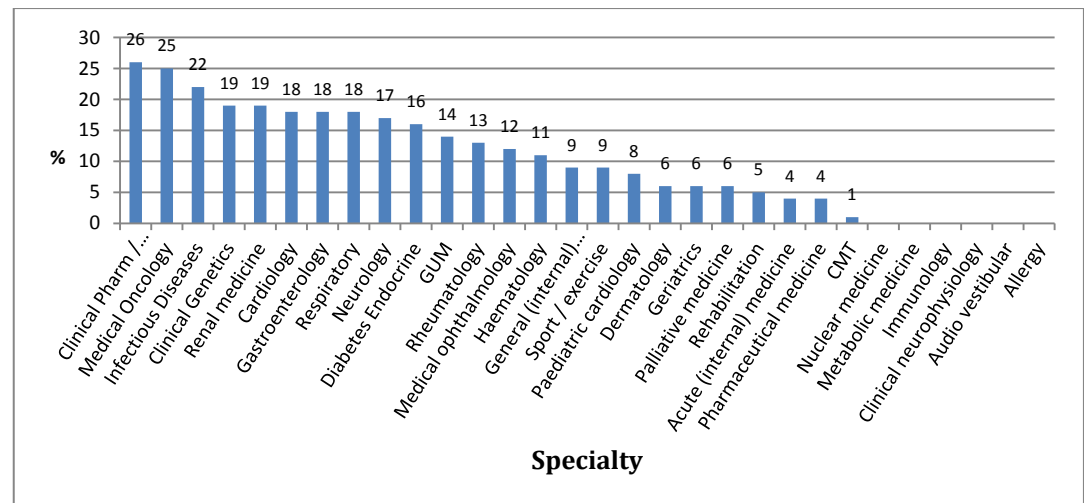


4.0 Theme 3: Supporting learners

The data sources used to inform this theme include the GMC NTS (generic and SSQ data), ARCP outcomes, HST census data and PYA reports. The data analysis from the GMC NTS and SSQs has been presented earlier in the report and will be referred to where it is appropriate for this theme.

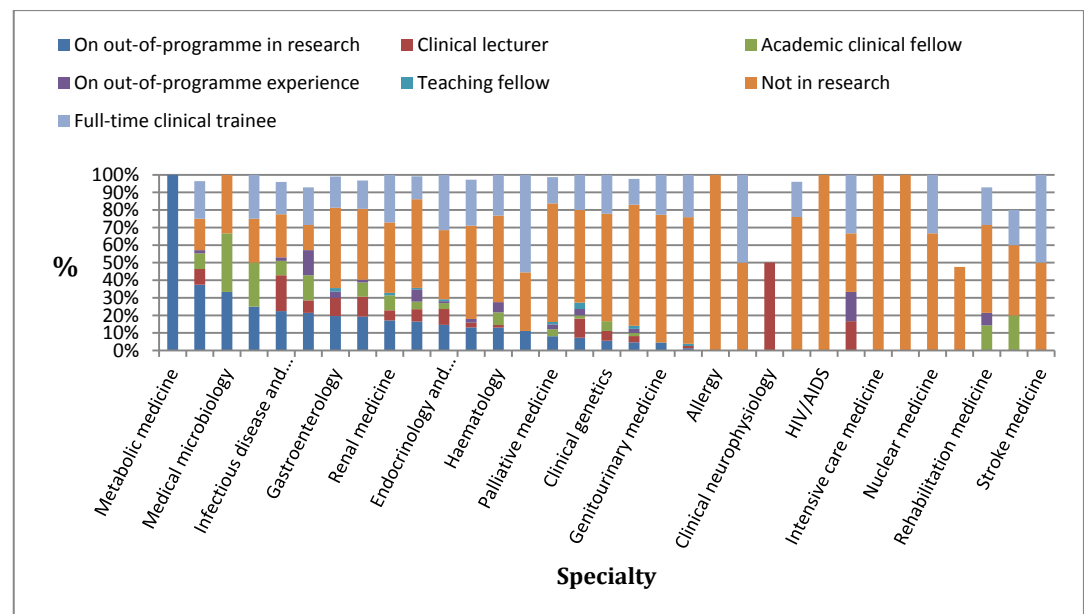
4.1 ARCP outcomes

Fig 48. Out-of-programme ARCP outcomes by speciality



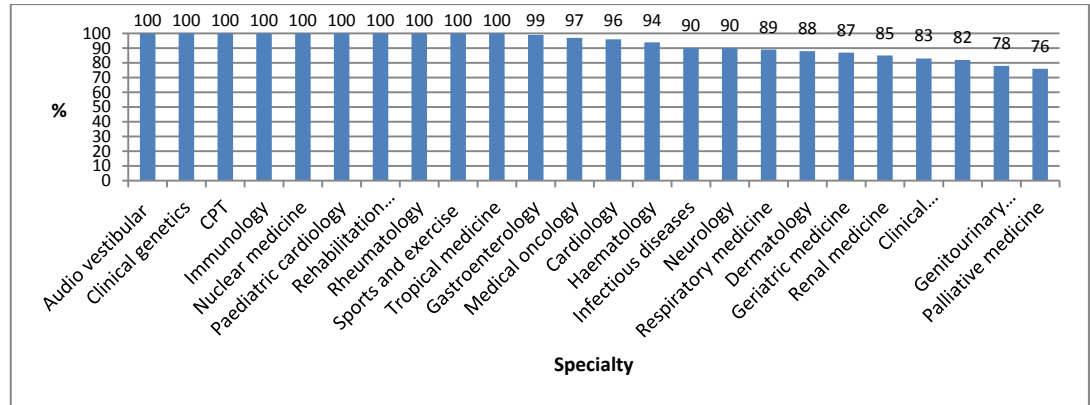
4.2 HST census data

Fig 49. Research/academic training posts



4.3 Penultimate year assessments

Fig 50. Adequate research skills at PYA



5.0 Theme 4: Supporting educators

The data sources used to inform this theme include the GMC NTS (generic and SSQ data), HST census data / new consultants (post-CCT) survey, PYA reports and monitoring visit reports. The analysis from many of the datasets has been presented earlier in the report and will be referred to where it is appropriate for this theme.

Data from the GMC trainer survey have also been analysed, to augment the evidence for this theme.

5.1 Census data and new consultant (post-CCT) survey

Data for the new consultant appointments in 2016 are shown in Fig 51.³

Fig 51. Consultant appointments in 2016

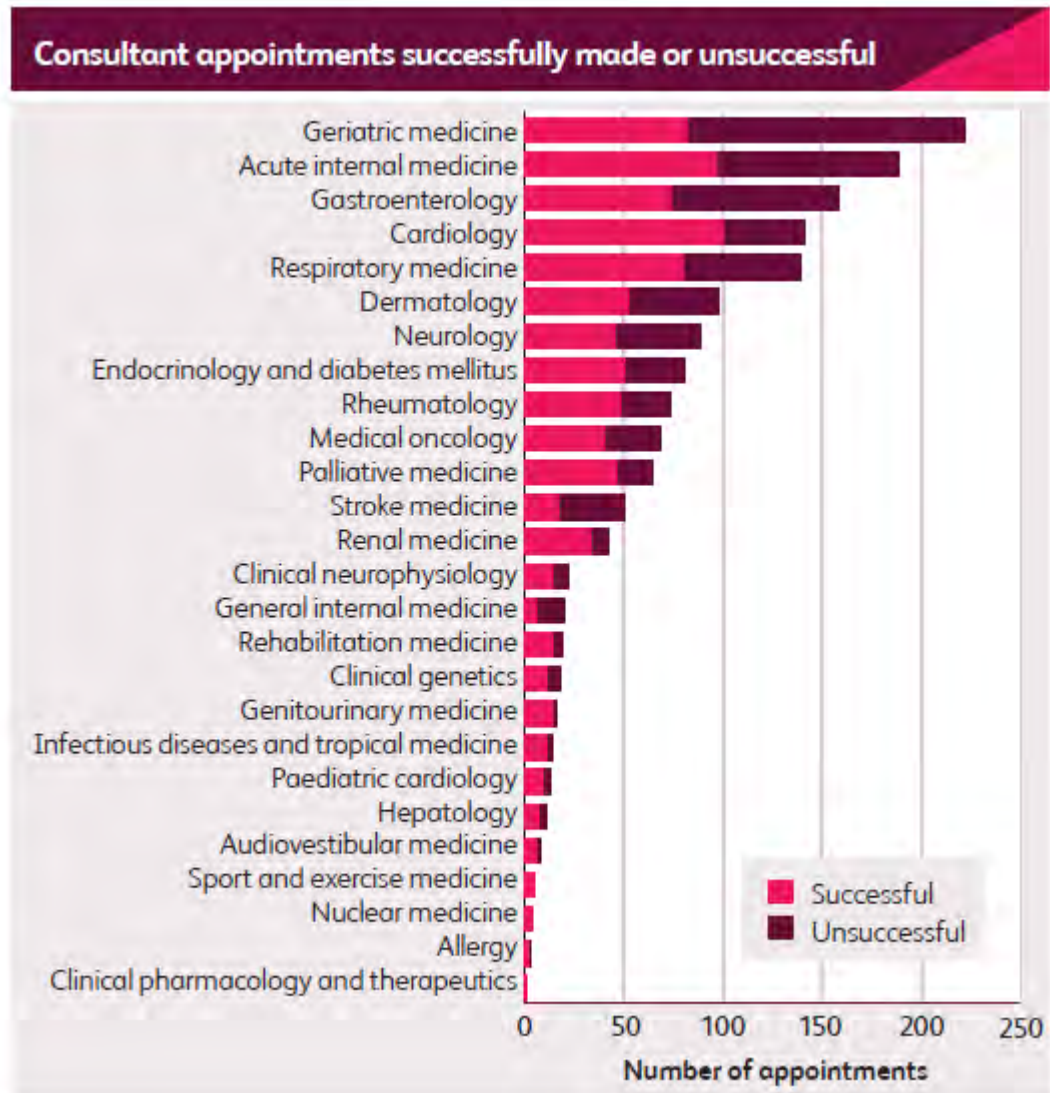


Fig 52. Work pressures due to inadequate numbers of consultants in posts

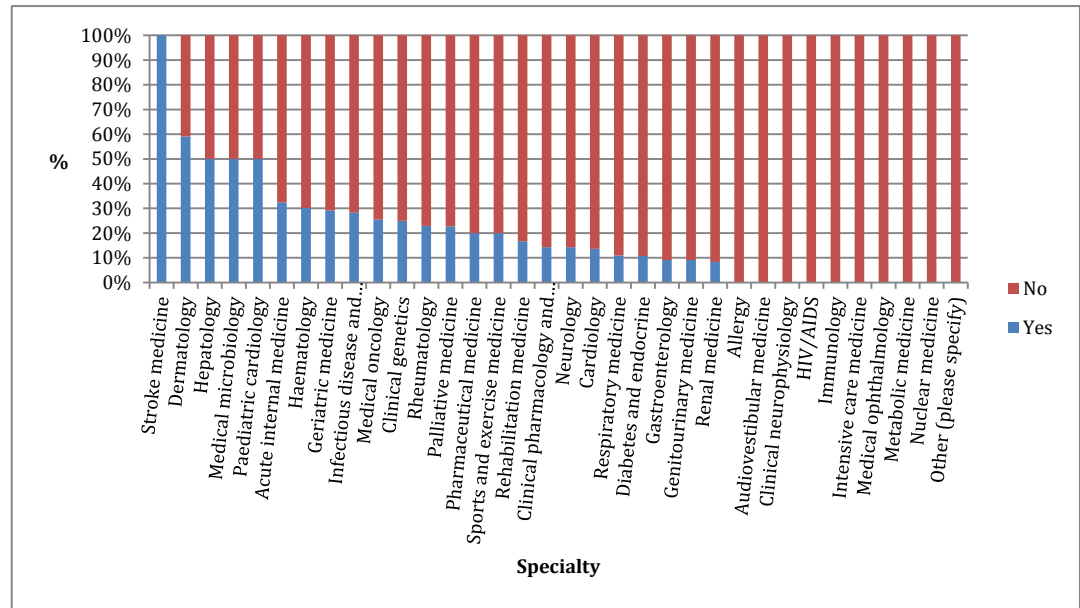


Fig 53. Work pressures due to inadequate numbers of HSTs in posts

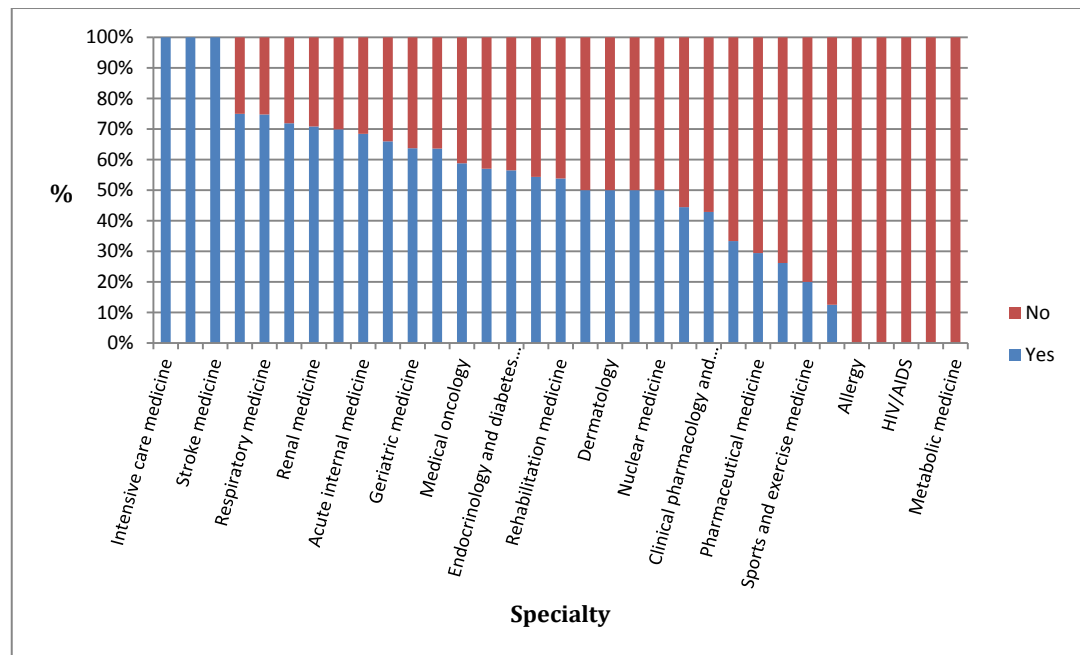


Fig 54. Overall satisfied in post – specialty

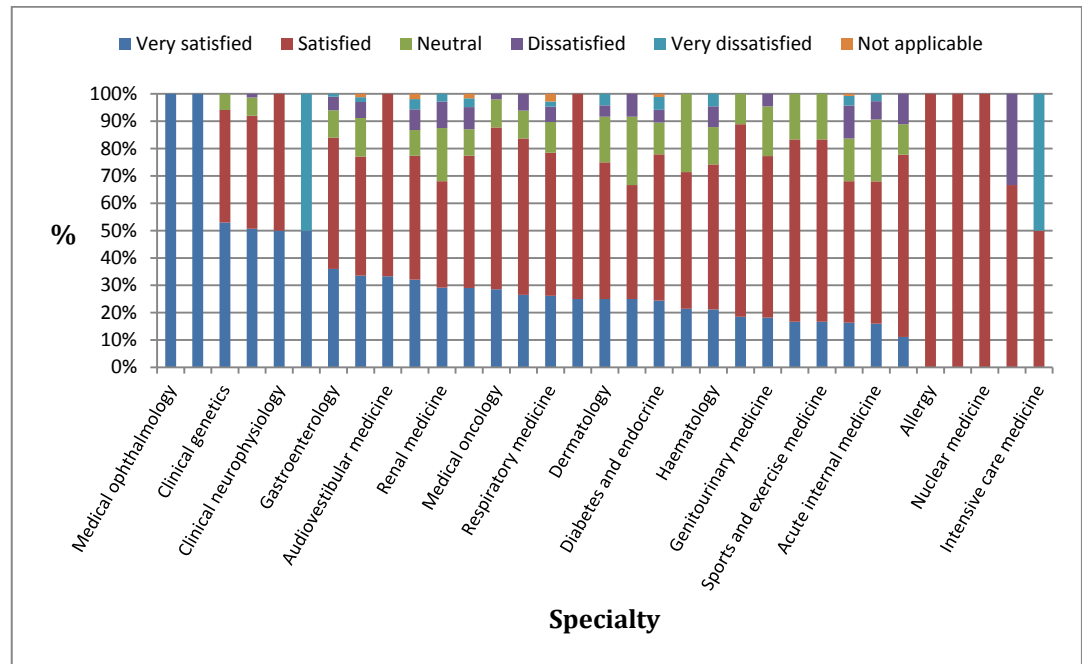


Fig 55. Overall satisfied in post – GIM

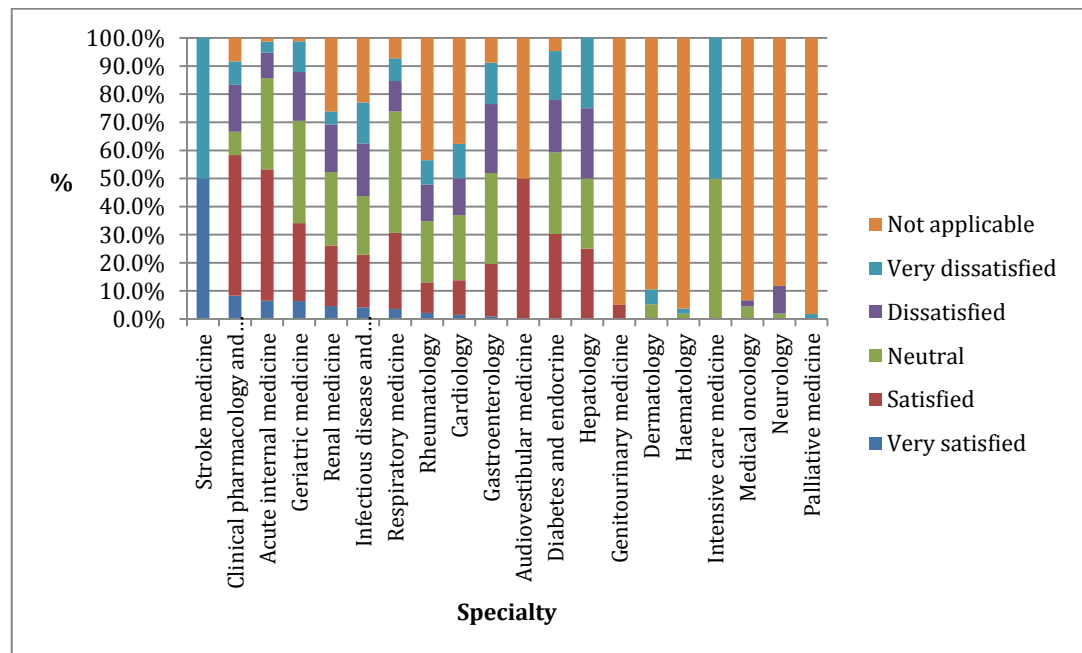
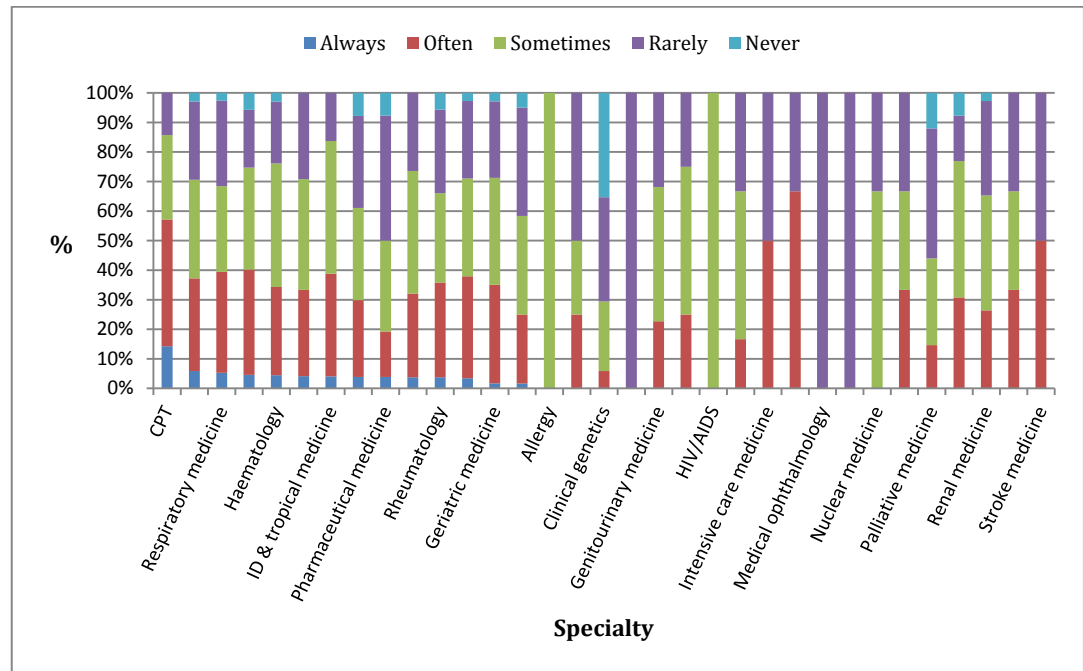


Fig 56. Felt down in their post



5.2 GMC NTS

The NTS was introduced in 2016. The overall national response rate for all specialties was 53.3%. In total, 5,158 physicians completed the survey. Six domains were assessed: organisational culture, supportive environment, handover, time for trainers, support for trainers and supervisor training.

Trainers from 29 higher medical training specialties participated in the 2016 survey. The average response rate across all 29 medical specialties was 72%, with a range of 45% (55–100%).

Specialties that contribute substantially to the acute take showed the largest number of red flags in 2016 across a mixture of specialties. Those specialties that contribute to the acute take and those with little or no contribution to the acute take recorded the greatest number of green flags. The distribution of red and green flags by domain in the top five specialties is shown in Figs 57 and 58.

Table 21. Top five specialties showing the highest number of specialty red or green flags

Specialty (red flags)	Number	Specialty (green flags)	Number
Cardiology	57	Geriatric medicine	41
Respiratory medicine	44	Rheumatology	27
Geriatric medicine	38	Dermatology	23
Gastroenterology	32	Respiratory medicine	21
Acute (internal) medicine	20	Diabetes and endocrine	21

Fig 57. Red flags by domain in the top five specialties

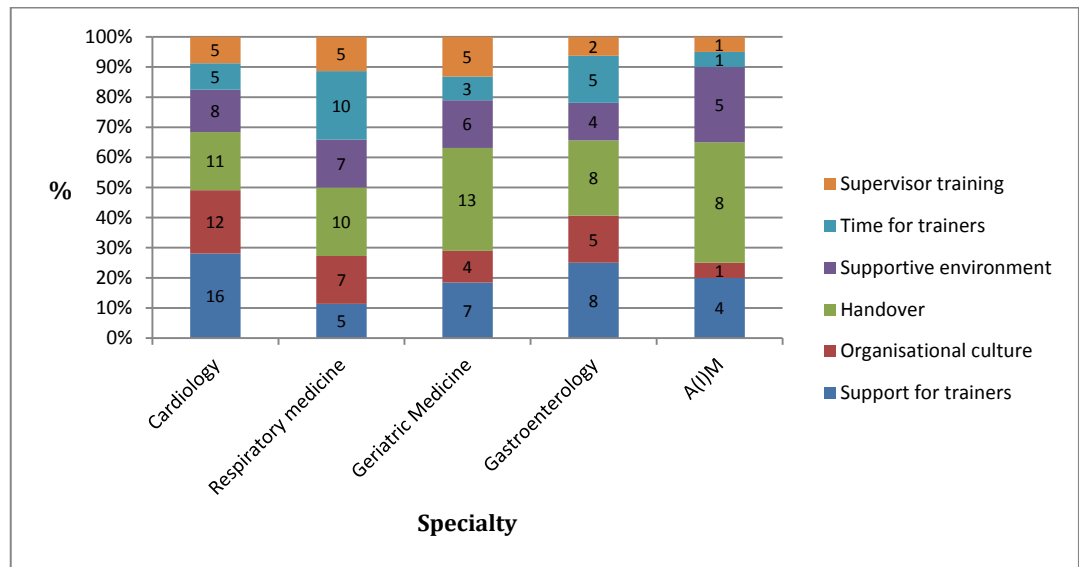


Fig 58. Green flags by domain in the top five specialties

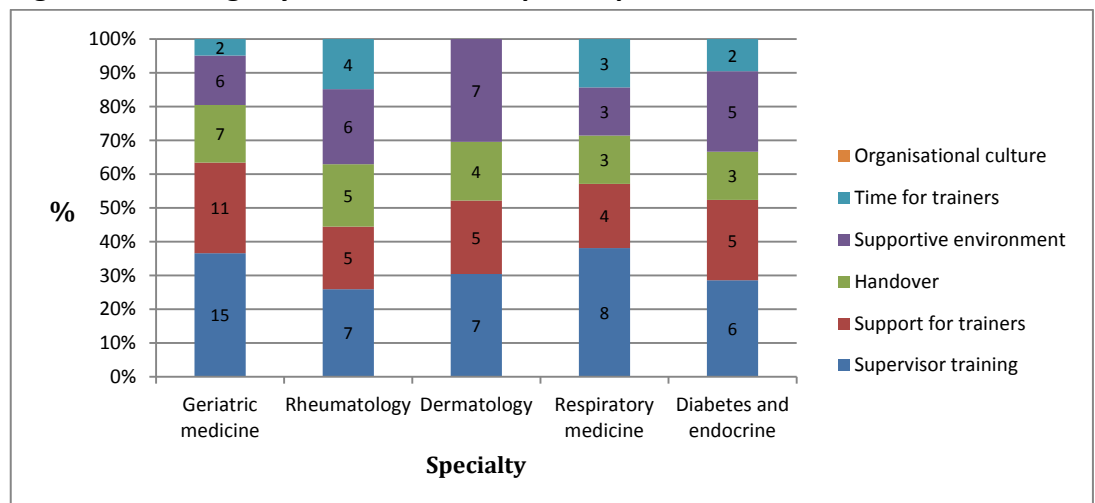


Fig 59. Red flags by specialty

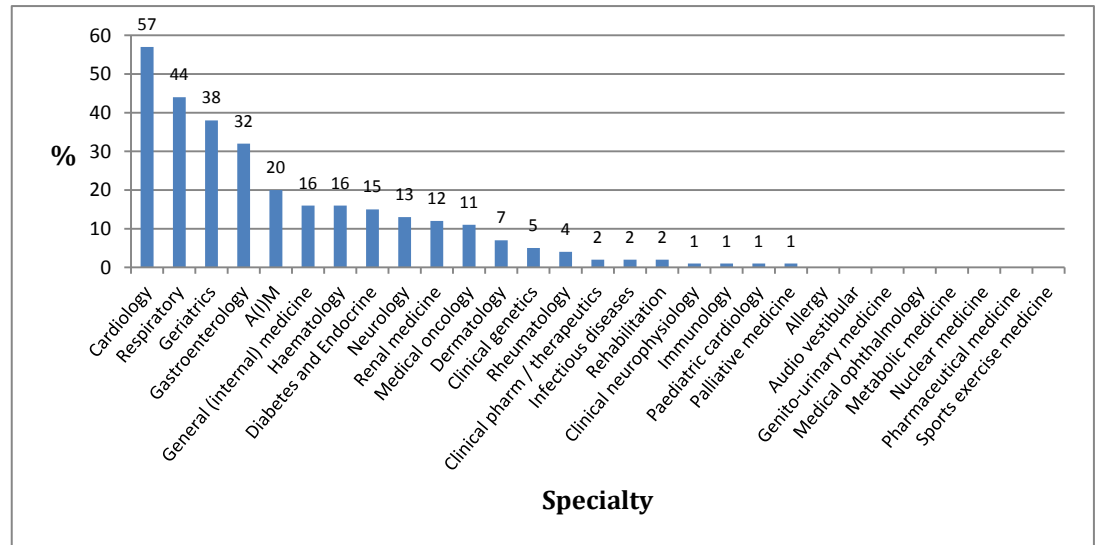


Fig 60. Number of trust red flags by domain

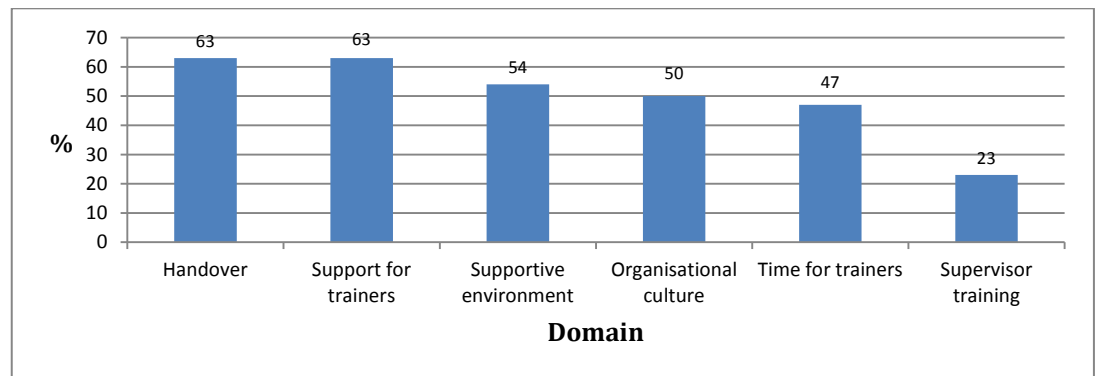


Fig 61. Distribution of red flags by specialty and domain

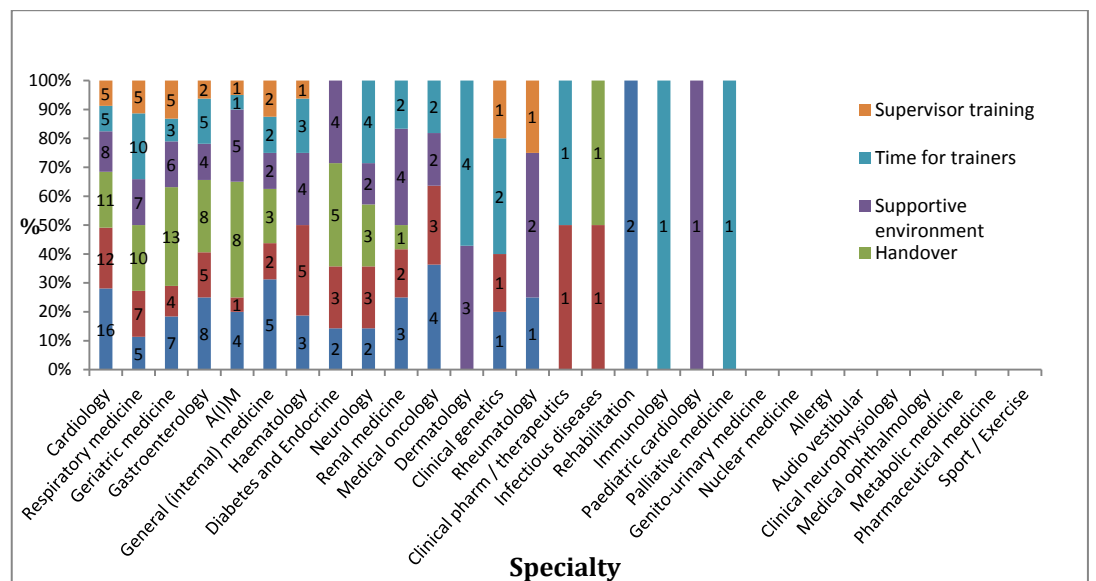


Fig 62. Number of red flags by deanery/LETB

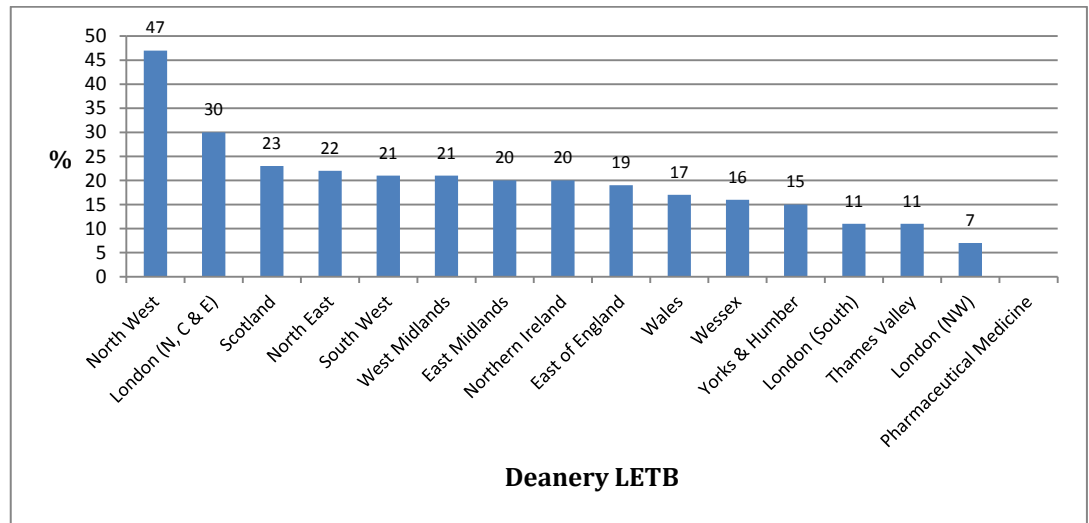


Fig 63. Proportion of red flags by deanery/LETB and domain

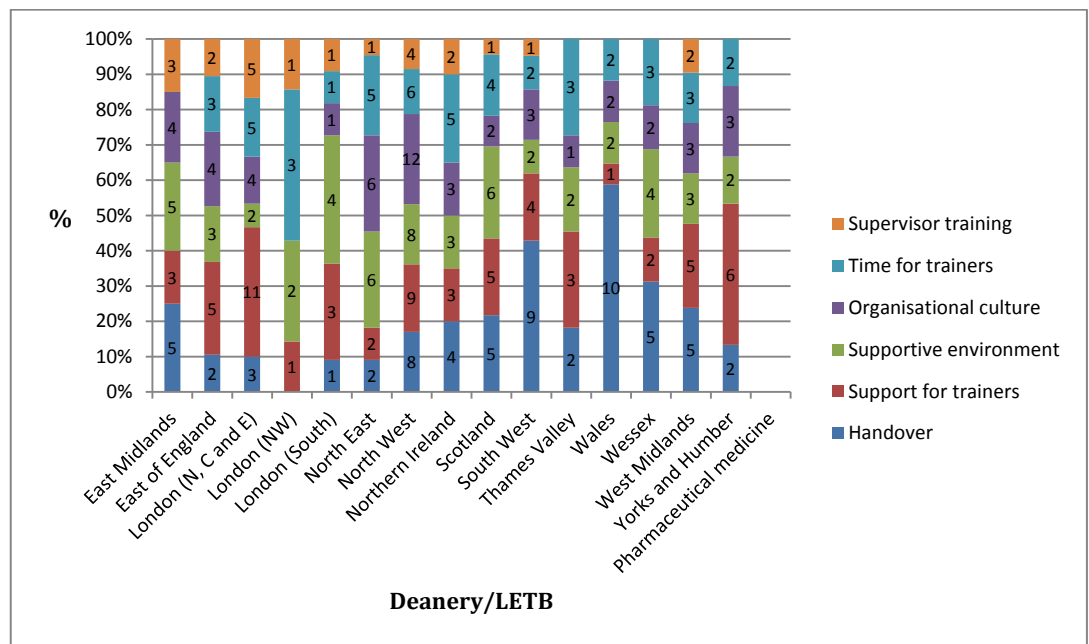


Fig 64. Green flags by specialty

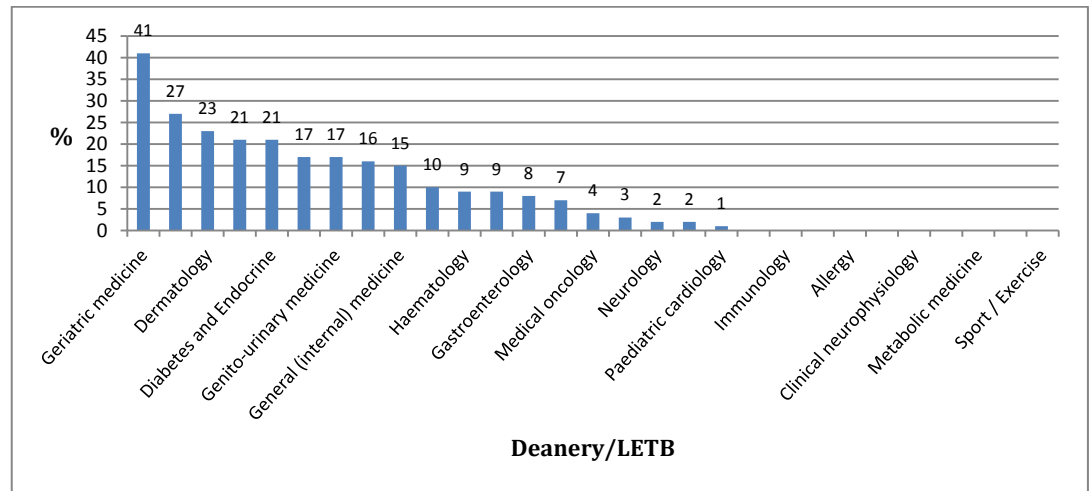


Fig 65. Green flags by domain

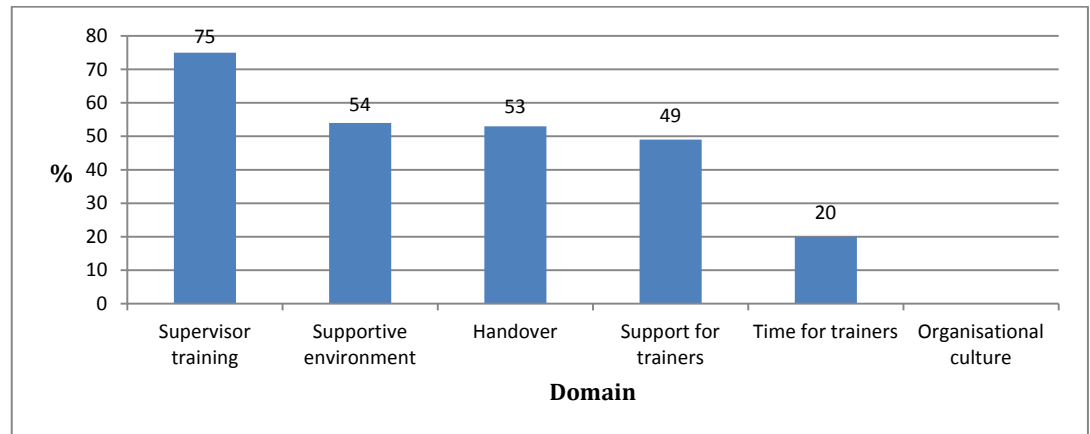


Fig 66. Green flags by specialty and domain

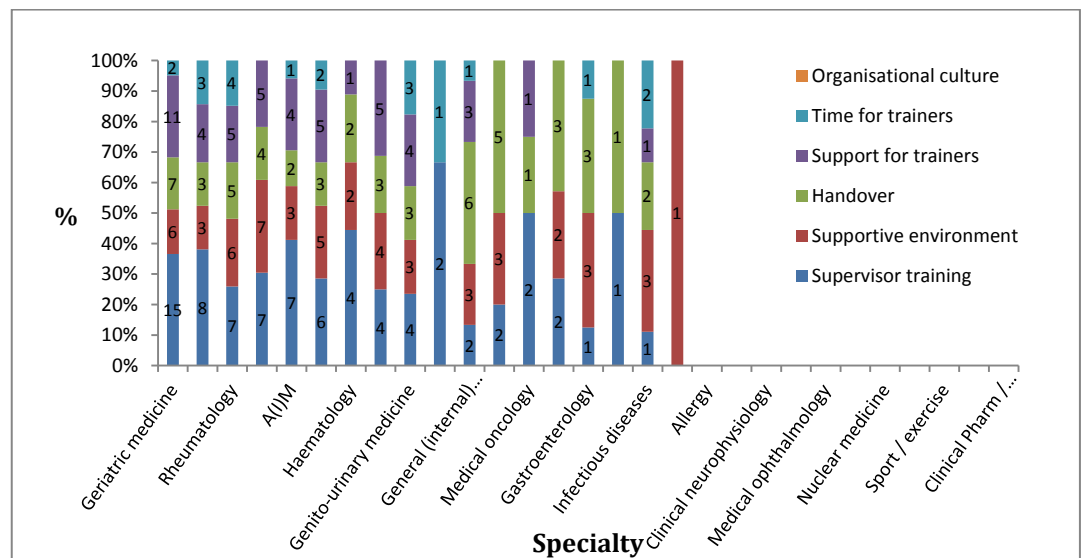


Fig 67. Green flags by deanery/LETB

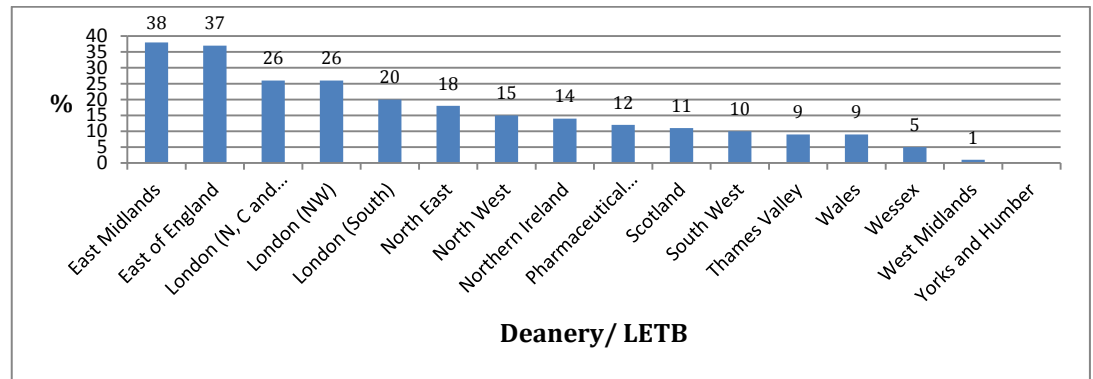


Fig 68. Proportion of green flags by deanery/LETB and domain

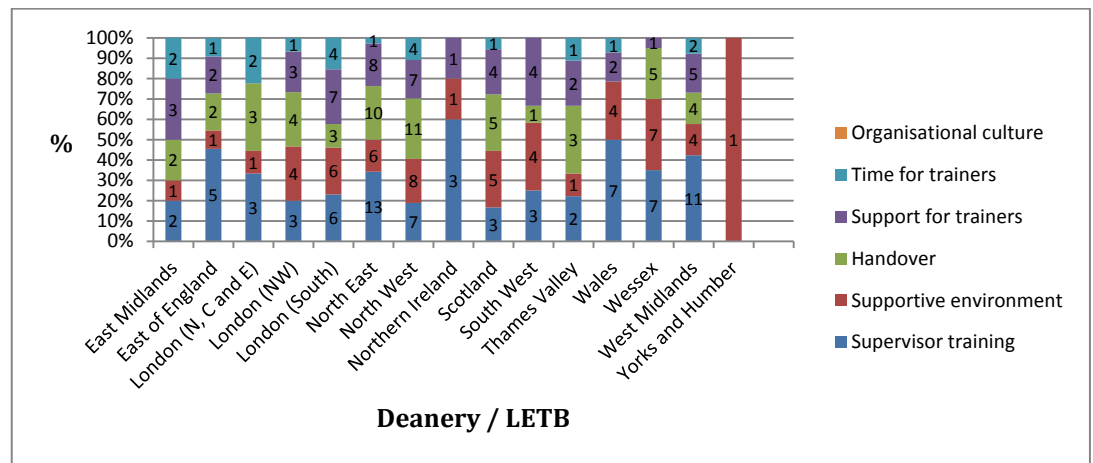
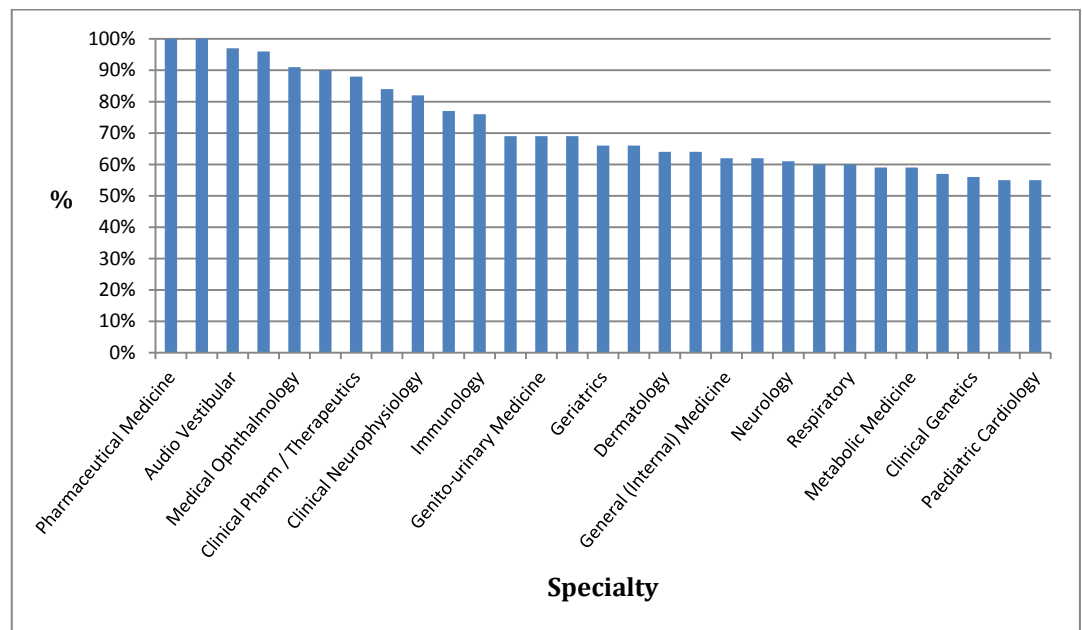


Fig 69. Response rate by speciality



6.0 Theme 5: Developing and implementing curricula and assessments

The data sources used to inform this theme include the GMC NTS (generic and SSQ data), ARCP outcomes, MRCP outcomes and PYA reports. The data analysis from the GMC NTS and SSQs has already been presented earlier in the report and will be referred to where it is appropriate for this theme.

6.1 ARCP outcomes

Fig 70. Proportion of satisfactory/unsatisfactory/OOP ARCP outcomes by specialty (excluding RITAs)

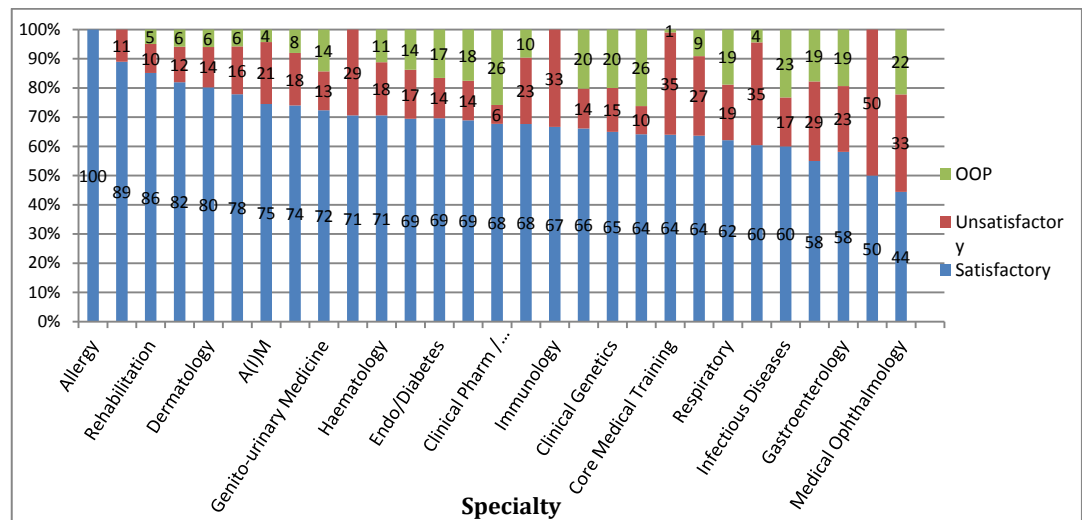


Fig 71. Outcome 5s by specialty (excluding RITAs)

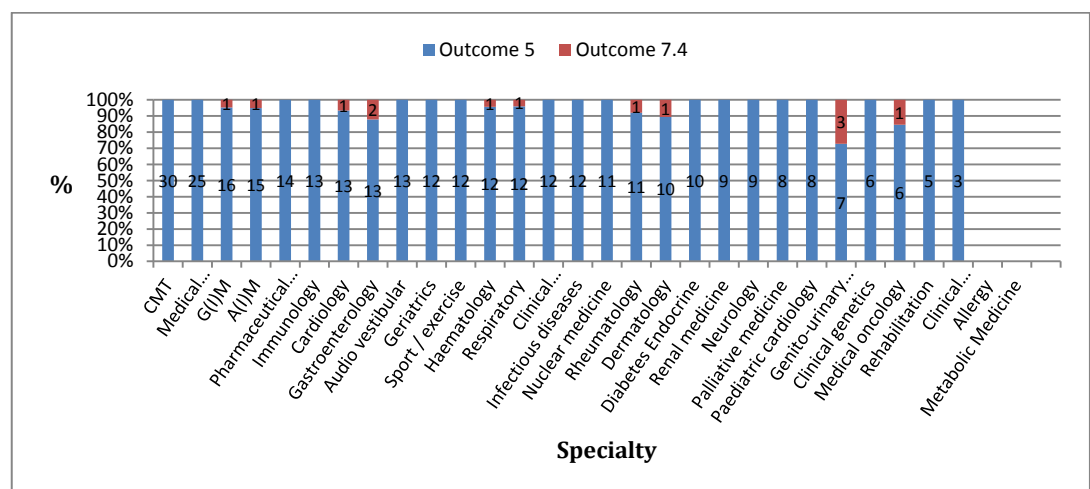


Fig 72. Proportion of ARCP Outcome 2 and Outcome 7.2 by specialty

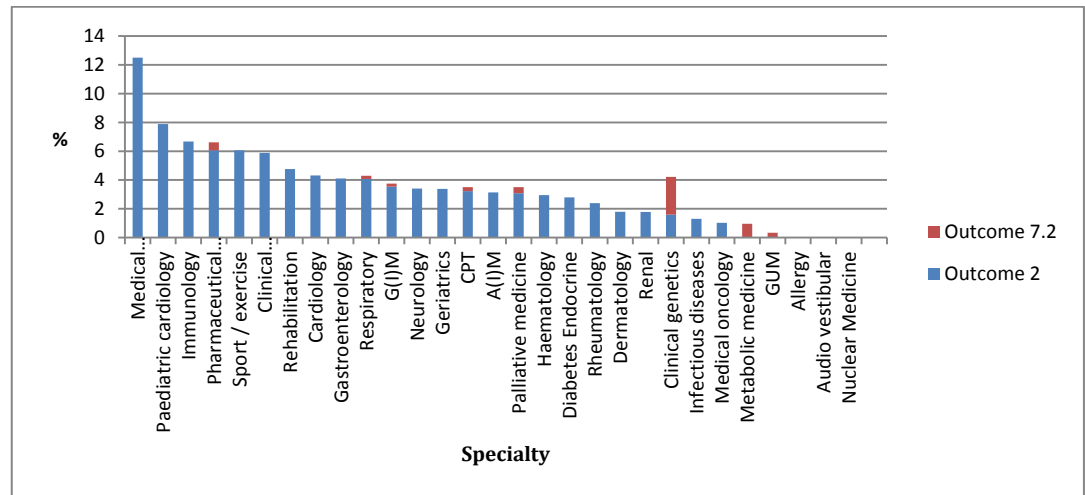


Fig 73. Proportion of ARCP Outcome 3 and Outcome 7.3 by specialty

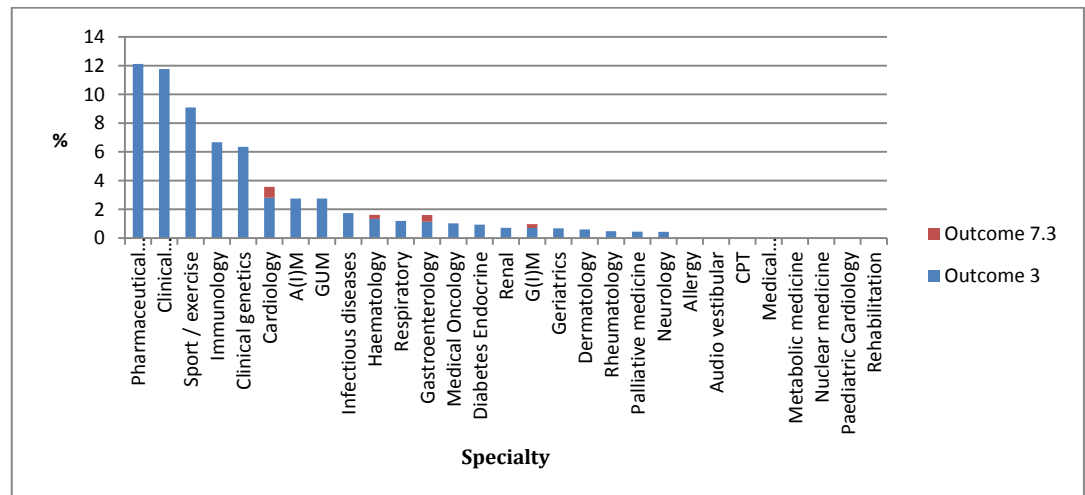
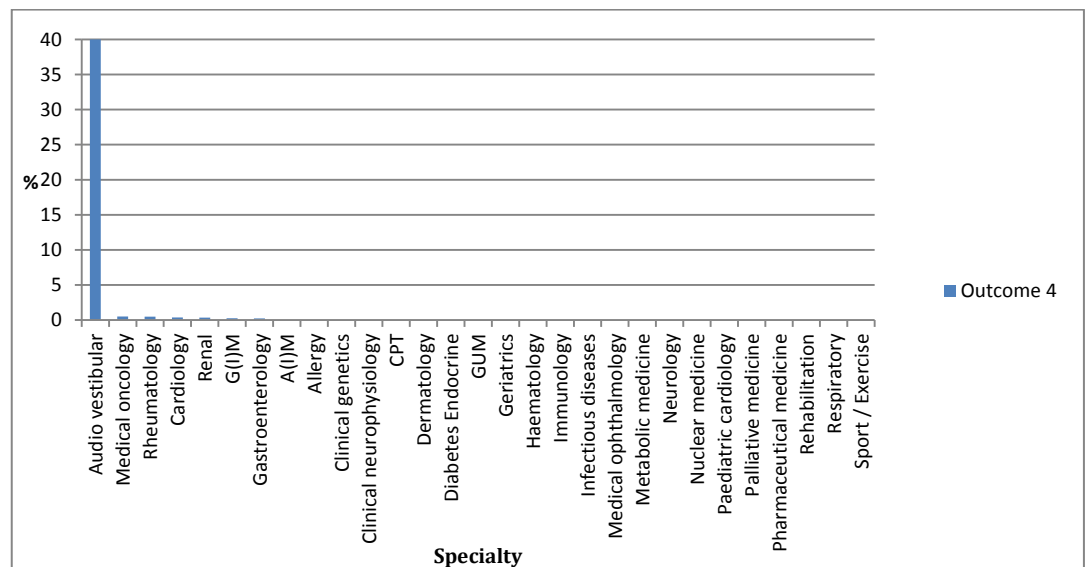


Fig 74. Proportion of ARCP Outcome 4s by specialty



ARCP outcomes in general internal medicine

In total, 2,948 ARCP outcomes for 2,392 G(I)M trainees (1.2 outcomes per trainee) were reported to the GMC (excluding exam failure) in 2014/15:

- 96.75% of the outcomes reported were ARCP outcomes.
- 3.26% of the outcomes reported were RITAs.

Table 22. Proportion of ARCP outcomes in each category for G(I)M

Outcome	1	2	3	4	5	6	7.1	7.2	7.3	7.4	8	Total
Overall	56%	4%	1%	0%*	17%	1%	2%	0%*	0%*	1%	9%	101%

Satisfactory (1, 6 and 7.1)	Unsatisfactory (2,3,4,5,7.2,7.3 and 7.4)	Out of programme (8)
69%	23%	9%

* <0.5% of the total number of trainees so number rounded down to 0%.

Fig 75. Proportion of satisfactory/unsatisfactory/OOP ARCP outcomes by Deanery/LETB (excluding RITAs)

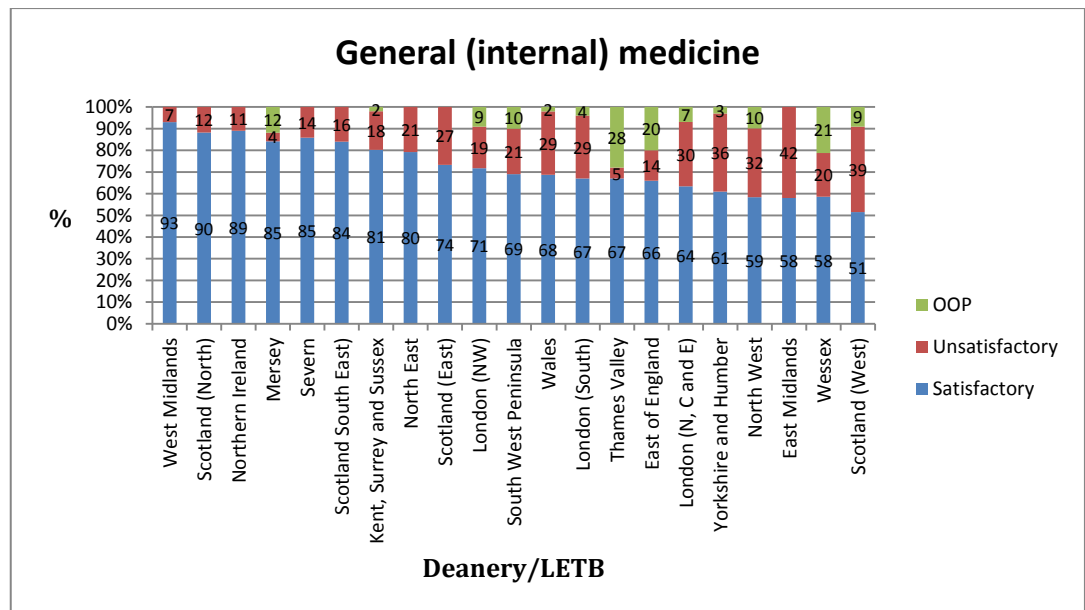


Fig 76. Outcome 5s for G(I)M

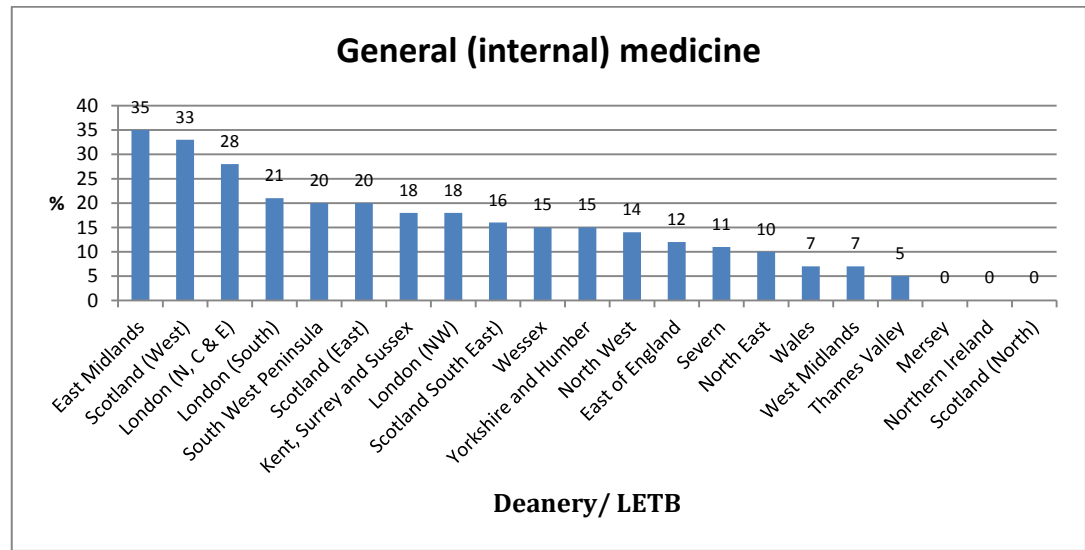
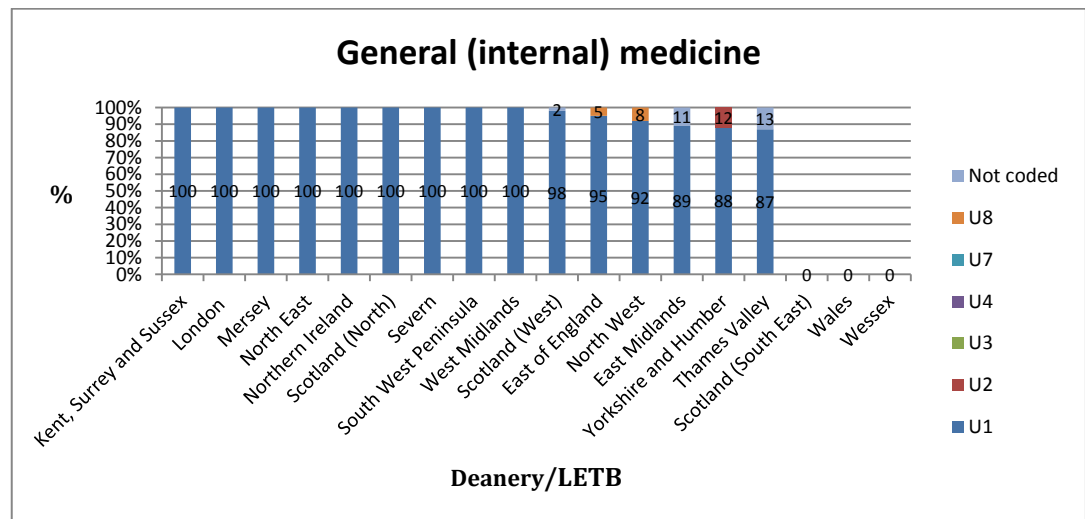


Fig 77. Reasons for Outcome 5s for G(I)M by deanery/LETB



The reasons for Outcome 5s are not reported by the GMC, so e-Portfolio data were reviewed. Although the numbers of outcomes do not correlate directly between the two datasets, in the majority of cases the outcome was due to unsatisfactory record keeping / evidence on trainees’ e-Portfolios. Outcome 5s were reported to the GMC from Scotland (South-East), Wales and Wessex, however no Outcome 5s were reported on the e-Portfolio for these regions. Outcome 5s were reported on e-Portfolio for Mersey, Northern Ireland and Scotland (North), but these were not reported to the GMC.

6.2 MRCP outcomes

Table 23. CMT progression (2015–16)

		Completed at Start	Completed During	Total
CT1	Part 1	62%	22%	84%
	Part 2	34%	37%	70%
	PACES	2%	28%	30%
		Completed at Start	Completed During	Total
CT2	Part 1	85%	8%	93%
	Part 2	72%	16%	88%
	PACES	34%	41%	75%
		Completed at Start	Completed During	Total
ST	Part 1	96%	0%	96%
	Part 2	96%	0%	96%
	PACES	95%	1%	96%

Fig 78. Specialty certificate examination (SCE) in acute medicine

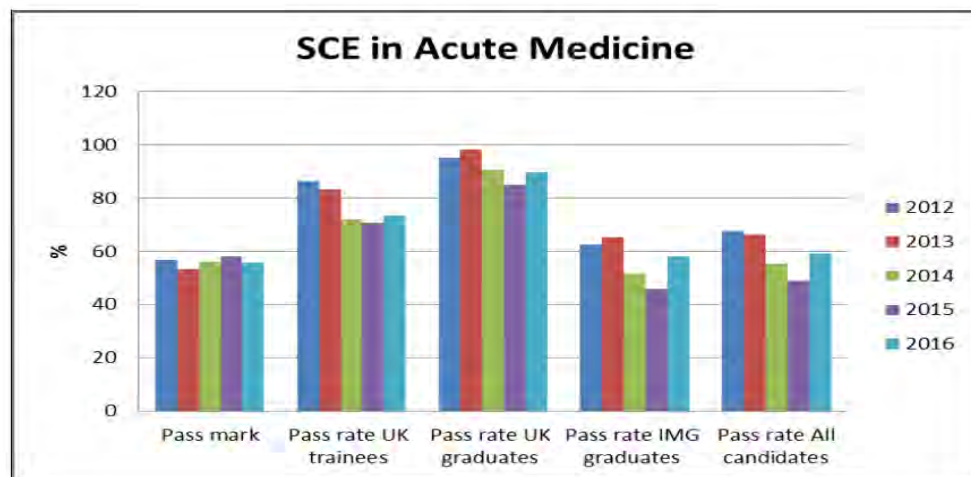


Fig 79. SCE in dermatology

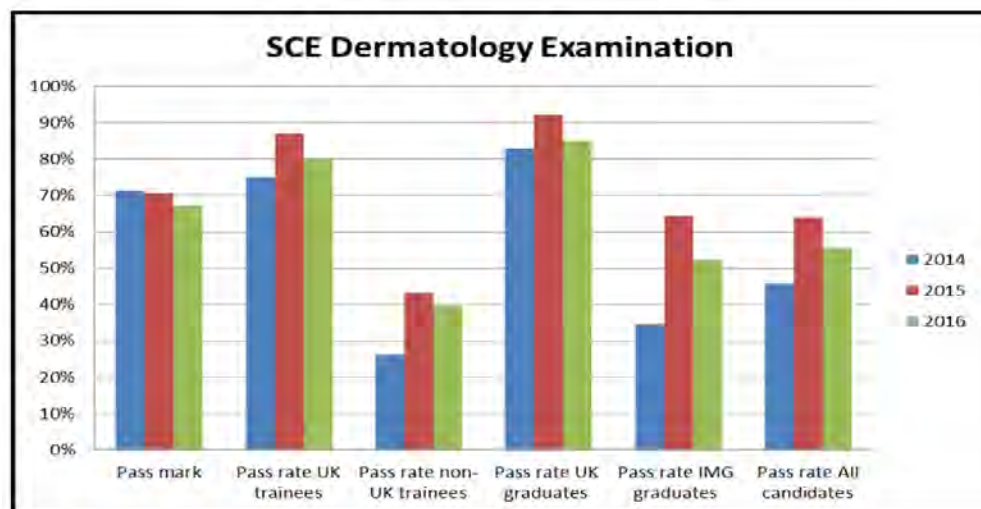


Fig 80. SCE in endocrinology and diabetes

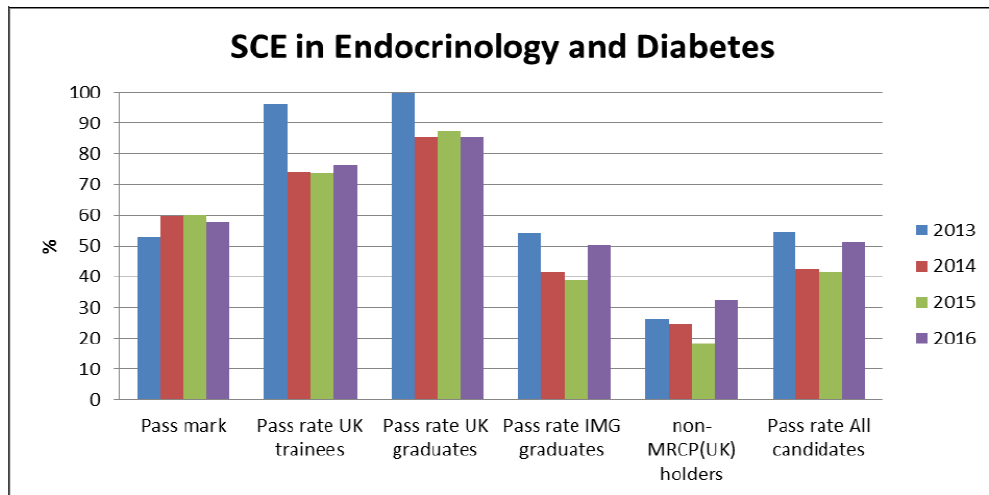


Fig 81. SCE in gastroenterology

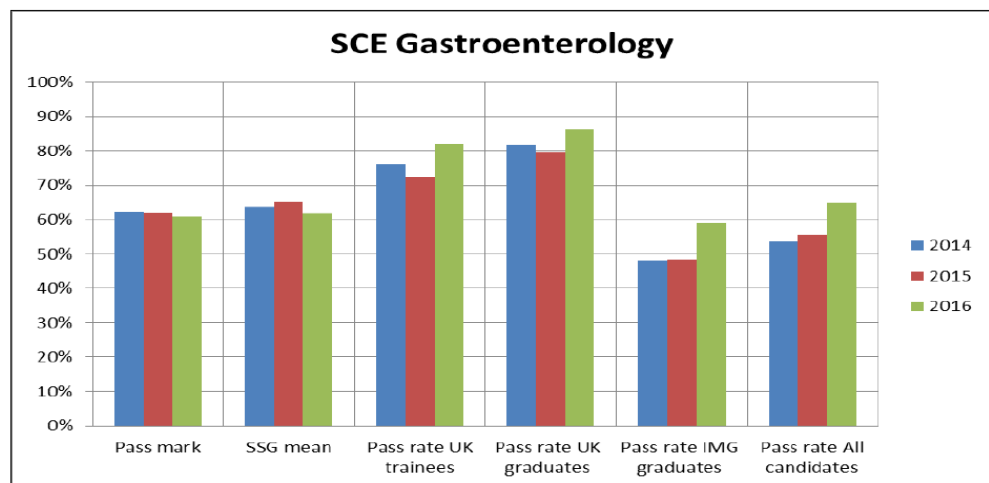
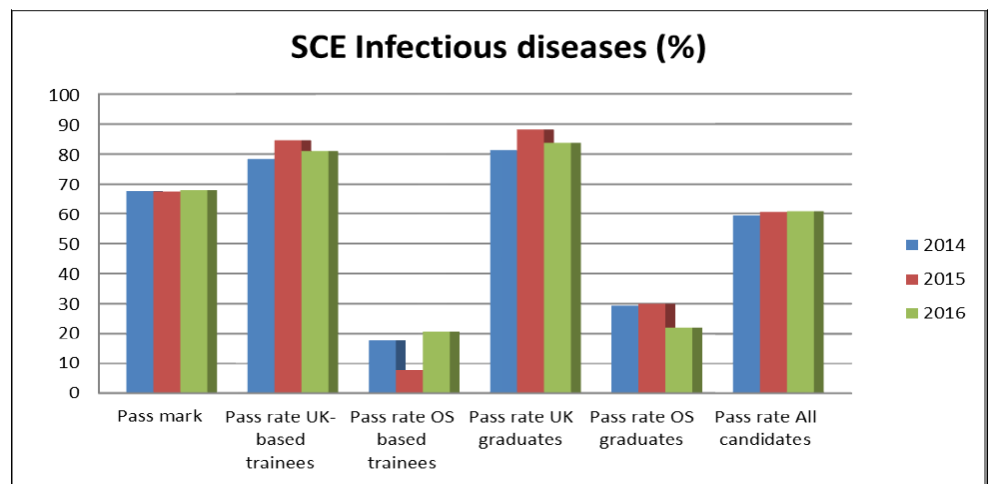


Fig 82. SCE in infectious diseases



OS = overseas

Fig 83. SCE in medical oncology

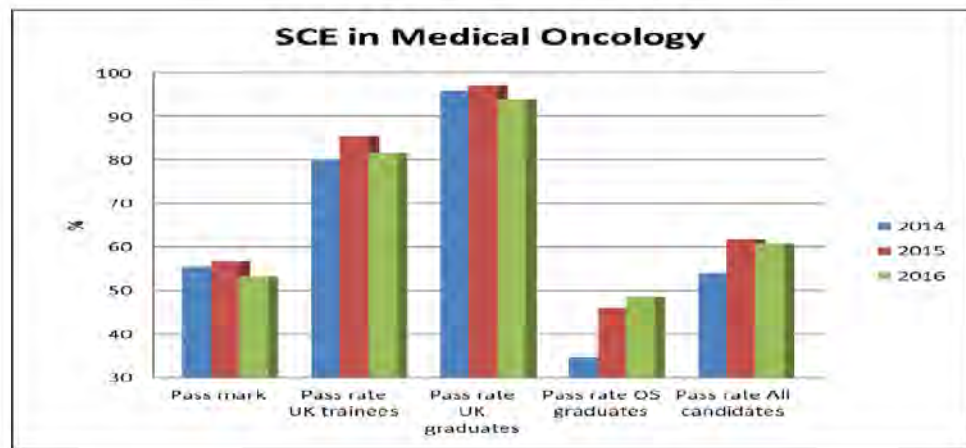


Fig 84. SCE in respiratory medicine

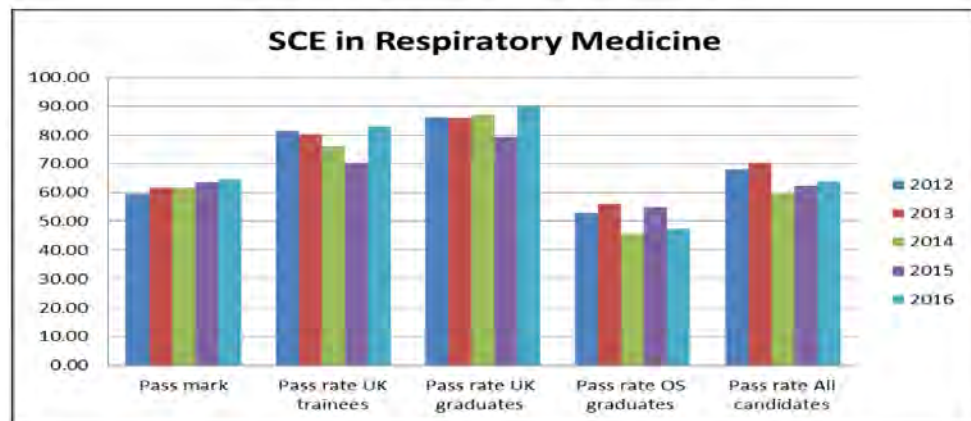
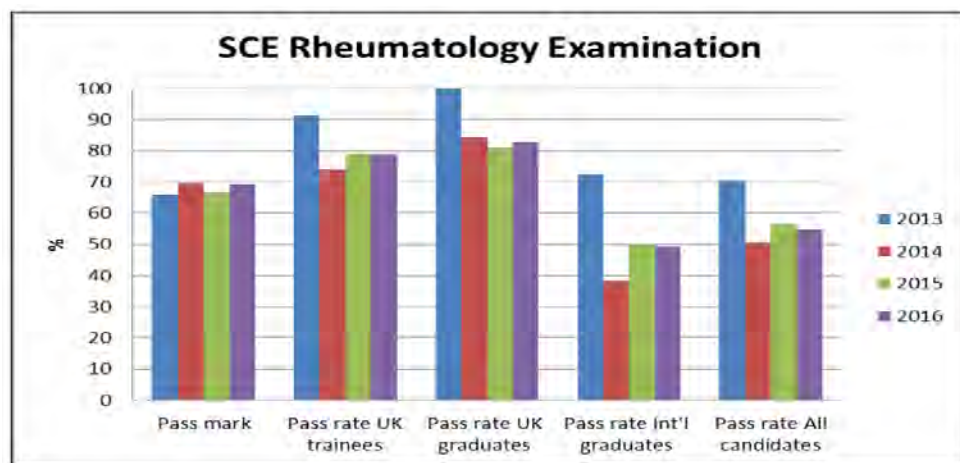


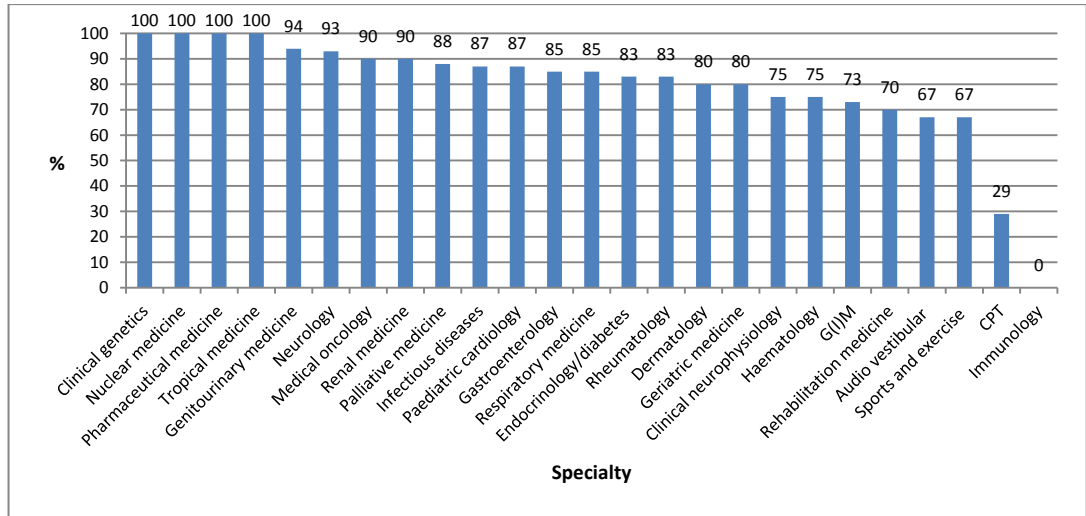
Fig 85. SCE in rheumatology



Int'l = international

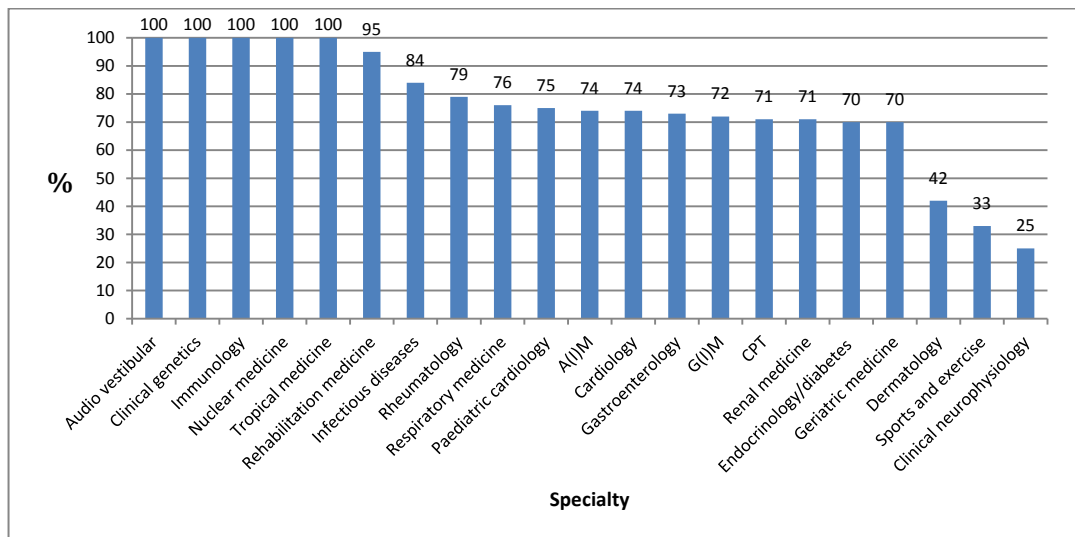
6.3 Penultimate year assessments

Fig 86. Satisfactory e-Portfolio at PYA



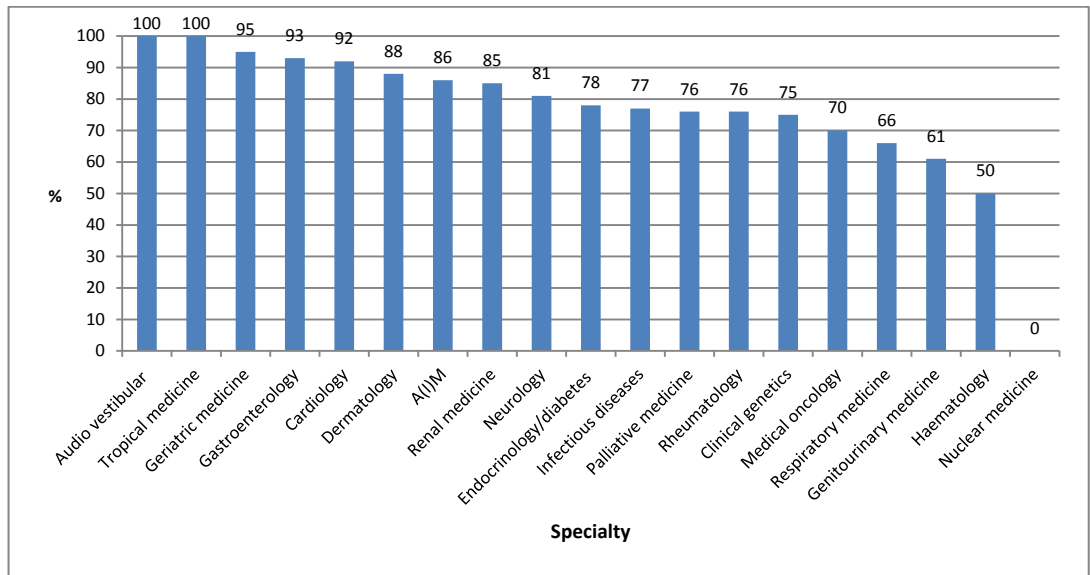
Across 25 specialties, the average percentage of trainees who had this indicator as part of their PYA and had a satisfactory e-Portfolio at the time of their PYA was 79.2%.

Fig 87. Valid advanced life support (ALS) certificate to CCT (by specialty)



Across the 21 specialties, the average percentage of trainees presenting for PYA who require a valid advanced life support (ALS) certificate and who had evidence of a valid certificate up to their anticipated CCT date was 75.4%.

Fig 88. SCE pass at the time of their PYA



The average percentage of trainees across the 19 specialties who has passed their SCE by the time of their PYA was 76.2%.

Appendix B: Datasets

This section gives some background information and explains the six key datasets that have been analysed to inform the *The state of physicianly training* report.

1.0 GMC national training survey

Generic data

The national training survey (NTS) is an annual survey that is commissioned and administered by the General Medical Council (GMC). The NTS has been in place since 2010. Its purpose is to gather feedback from trainees to help local education providers such as hospitals and general practices improve their training practice. It also helps postgraduate deaneries / local education and training boards (LETBs) to manage training programmes, which are usually delivered across a number of different local education providers (LEPs). The GMC uses red and green colour coding to highlight results that are significantly above or below average, to help identify areas for investigation.

The NTS is composed of a set of generic questions (that test trainees' perceptions of training providers' compliance with the GMC standards), and specialty specific questions set by royal colleges and faculties (that test trainees' perceptions of the quality of delivery of the curricula). It is a unique opportunity for managers of training programmes to hear the views of their trainees.

The generic questions test trainees' perceptions of the following areas:

- overall satisfaction
- clinical supervision
- clinical supervision (out of hours)
- reporting systems (new in 2016)
- handover
- induction
- adequate experience
- supportive environment
- workload

- educational supervision
- access to educational resources
- feedback
- local teaching
- regional teaching
- study leave.

Responses are colour coded as follows.

	Below outlier
	Within the lower quartile (Q1) but not below outlier
	Within the middle quartile (Q2/IQR)
	Within the upper quartile (Q3), but not an above outlier
	Above outlier
	Three or fewer trainees, results not published
	Zero trainees completed the survey, no result

Red – the score for the indicator is significantly below the national score in the benchmark group. A score is defined as being a ‘below outlier’ if it meets both of the following criteria: the upper 95% confidence limit associated with the indicator score must be below the lower 95% confidence limit of the benchmark indicator mean score; and the mean of the indicator score must be below the lower quartile (Q1) score of the benchmark group.

Green – the score for the indicator is significantly above the national score in the benchmark group. A score is defined as being an ‘above outlier’ if it meets both of the following criteria: the percentage confidence limit associated with the indicator score must be above the upper 95% confidence limit of the benchmark indicator mean score; and the mean of the indicator score must be above the upper quartile (Q3) score of the benchmark group.

Light green – the confidence interval overlaps with the interquartile range, which could indicate that trainees’ perceptions are positive. The result is in the third quartile, but is not an above outlier for the indicator result.

Pink – the confidence interval overlaps with the interquartile range, which could indicate that trainees' perceptions are negative. The result is in the first quartile, but is not a below outlier for the indicator result.

White – the result is within the interquartile range, suggesting that the result for this indicator is average.

Grey – insufficient number of respondents for the indicator result ($n < 3$).

Yellow – there are no respondents for the indicator result.

GMC NTS specialty-specific questions

The specialty-specific questions (SSQs) have been developed to test trainees' access to, participation in or confidence in the attainment of specific aspects of the specialty training curriculum.

The questions have been included as programme-specific questions in the annual GMC NTS. The details of these questions and the trainee responses (nationally, by deanery/LETB and by grade) can be found within this report.

Each specialty has its own set of questions related to their curriculum, and these vary in number and content, which makes comparisons difficult.

For this report, data from the 2016 GMC NTS were analysed for all physicianly specialties and core medical training, and the trend analysis was undertaken for 2014–16.

2.0 Annual record of competence progression outcomes

The annual record of competence progression (ARCP) is a defined and approved process that supports the curriculum. Trainees' progress in their training programme is assessed using a range of defined and validated formative and summative assessment tools, along with professional and triangulated judgements about their progress.

Following evaluation of the written evidence of progress, a review results in an outcome that determines the next steps for a trainee. A satisfactory outcome confirms that the required competences have been achieved.

The possible ARCP outcomes and supplementary U and N code descriptors are listed in Table 1.

Table 1. ARCP outcomes

Outcome type	Classification	Description
0	No outcome	Trainee did not have an ARCP review.
1	Satisfactory	Satisfactory progress. Achieving progress and the development of competences at the expected rate.
2	Unsatisfactory	Development of specific competences required. Additional training time not required.
3	Unsatisfactory	Inadequate progress – additional training time (up to 6 months) required.
4	Unsatisfactory	Released from training programme – with or without specified competences.
5	Unsatisfactory	Incomplete evidence presented – additional training time may be required.
6	Satisfactory	Gained all required competences – will be recommended as having completed the training programme (core or specialty) and if the trainee is in a run-through training programme or higher training programme they will be recommended for award of a certificate of completion of training (CCT) or certificate of eligibility for specialist registration (CESR) / combined programme (CP) gained all required competences.
7.1	Satisfactory	Satisfactory progress in or completion of the locum appointment for training (LAT) / fixed-term specialty training appointment (FTSTA) post.
7.2	Unsatisfactory	Development of specific competences required – additional training time not required LAT/FTSTA placement.
7.3	Unsatisfactory	Inadequate progress by the trainee – LAT/FTSTA placement.
7.4	Unsatisfactory	Incomplete evidence presented – LAT/FTSTA placement.
8	Out of programme	OOP (Not specified)
8.1	Out of programme	OOPE (Experience)
8.2	Out of programme	OOPR (Research)
8.3	Out of programme	OOPC (Career break)
9	Unsatisfactory	Top-up training

The supplementary information for trainees who have had an unsatisfactory review outcome is shown in Table 2.

ARCP outcome data from 2015–16 for core and higher specialty trainees were analysed for this report.

Table 2. Reasons for unsatisfactory outcomes

Outcome type	Reason	Description
U1	Record keeping and evidence	Trainee failed to satisfactorily maintain their royal college / faculty ePortfolio including completing the recommended number of workplace-based reviews, audits, research and structured educational supervisors report, in accordance with recommendations for that particular year of training in line with the royal college / faculty curriculum requirements.
U2	Inadequate experience	Training post(s) did not provide the appropriate experience for the year of training being assessed in order to progress. As a result, the trainee was unable to satisfy the royal college / faculty curriculum requirements for the year of training.
U3	No engagement with supervisor	Trainee failed to engage with the assigned educational supervisor or the training curriculum in accordance with the royal college / faculty requirements for that particular year.
U4	Trainer absence	Nominated educational supervisor or trainer did not provide the appropriate training and support to the trainee because of their absence on a sabbatical, through illness or other reasons, and no nominated educational supervisor deputy took over to ensure that an appropriate level of training was maintained. As a result, the trainee was unable to satisfy the royal college / faculty curriculum requirements for the year of training.
U5	Single exam failure	The trainee failed to satisfy the respective royal college / faculty examination requirements to progress to the next year of training.
U6	Continual exam failure	The trainee failed to pass the respective royal college /

		faculty examination within the allowable number of examination attempts following a number of re-sits and is therefore unable to progress any further in this specialty.
U6a	Repeated exam failure – other competences satisfactory	U6a or U6b activated where U6 above has been selected.
U6b	Repeated exam failure – combined with other training concerns	U6a or U6b activated where U6 above has been selected.
U7	Trainee requires deanery support	The trainee has issues to do with their professional personal skills; for example behaviour / conduct / attitude / confidence / time keeping / communications skills etc, and requires the support of the deanery performance team.
U8	Other reason (please specify)	

3.0 MRCP(UK) outcomes

The MRCP(UK) Diploma and specialty certificate examinations (SCEs) are designed to test the skills, knowledge and behaviour of doctors in training. The MRCP(UK) Diploma is the knowledge-based assessment for core medical training in the UK. It has three parts:

- MRCP(UK) Part 1
- MRCP(UK) Part 2 Written
- MRCP(UK) Part 2 Clinical (PACES).

Successful completion of the whole three-part examination is required before a trainee can start specialist internal medicine training in the UK. Internationally, the MRCP(UK) Diploma is also a valued professional distinction.

All parts of the MRCP(UK) and SCE are approved by the GMC as part of the UK postgraduate medical training programme, they follow the UK curricula and guidelines.

MRCP(UK) exams outcome data were obtained from MRCP(UK). Annual data from 2012–16 were examined for both MRCP(UK) and SCE, and trends are reported in the main *The state of physicianly training* report.

4.0 Higher specialty trainee census and new consultants (post-CCT) survey

The census of consultants and higher specialty trainees (HST) is coordinated by the Medical Workforce Unit of the Royal College of Physicians of London (RCP) on behalf of the Federation of the Royal Colleges of Physicians. Census forms are sent out electronically to all UK consultants who are in post on 30 September of each year. The RCP verifies consultant numbers by checking with each specialty representative and it then telephones each trust, so that headcount data are accurate. HST data are obtained from an electronic census that is sent to all registrars on the Joint Royal Colleges of Physicians Training Board (JRCPTB) database. For this report, the HST census data from 2015–16 were examined and analysed in detail.

The new consultants (post-CCT) survey is undertaken annually by the Medical Workforce Unit at the RCP. Contact details and CCT dates of all HSTs are obtained from the JRCPTB, and trainees who have obtained their CCT in the preceding 12 months are contacted by email and invited to participate in the survey.

5.0 PYA reports

The penultimate year assessment (PYA) is unique to physicianly training. It is an arrangement that involves a meeting between the trainee and a representative of the specialist advisory committee (SAC) for the specialty who is external to the trainee's region. It should take place 12–18 months prior to completion of training. In the PYA, a trainee's progress so far is reviewed against the curriculum. The PYA will then identify outstanding targets, to ensure the trainee meets the requirements of the curriculum in full. PYAs are completed for all trainees who are training in a medical specialty.

This report provides an analysis of the following areas:

- the number of trainees who were assessed in this period, by deanery
- the number of trainees who were assessed, by grade
- the quality of educational supervisors reports
- the quality of the training portfolio
- the percentage of trainees who completed the required number of workplace-based assessments
- the percentage of trainees who have valid 4-year advanced life support (ALS) certificates
- the percentage of trainees who have adequate research skills
- the percentage of trainees who are active in audit / quality improvement projects
- the percentage of trainees who completed the required formal teaching and management courses
- the percentage of trainees who had satisfactory reports on communication with patients, staff and colleagues
- the percentage of trainees who demonstrated appropriate knowledge of legal and ethical issues, including GMC requirements and regulations
- the percentage of trainees who registered with the CPD online diary
- the percentage of trainees who demonstrated effective timekeeping
- the percentage of trainees who had mandatory and recommended targets and the number of these targets per trainee
- the percentage of targets that were set based on the specialty-specific curriculum requirements
- details of the required competencies that were not completed by more than 80% of the trainees.

External adviser reports

The GMC's quality improvement framework (QIF) requires HEE/LETBs/NHS Education for Scotland (NES)/Wales deanery/Northern Ireland Medical and Dental Training Agency (NIMDTA) to ensure external scrutiny of the quality management (QM) process. At specialty levels, such advice will normally come from the medical

royal colleges and faculties. The role of the external adviser (EA) is to provide expert impartial advice and scrutiny of all processes of delivery, assessment and evaluation of specialty training, according to the GMC quality framework (QF). It is a Gold Guide requirement⁷ that an EA reviews 10% of all ARCP outcomes and the evidence supporting these and any recommendations from the panel about concerns over progress (ARCP outcomes 2, 3 and 4).

The EA report for each specialty and core medical training covers the period from 1 August 2015 to 31 July 2016 inclusive, and includes the following areas:

- total numbers of ARCP dates convened by deaneries/LETBs
- total reports received from EAs
- total number of trainees included in EA reports
- reported areas of concern
- reported examples of good practice.

For the *The state of physicianly training* report, all the specialty and core medical training EA reports were reviewed and analysed, and key themes are reported in the main report.

6.0 Monitoring visits

Monitoring visits to trusts or regions that were undertaken with the JRCPTB's involvement have been reviewed for the purpose of this report. Some of these visits were cyclical and others were targeted due to issues in particular programmes or specialties. Comparisons were difficult, due to the variable methods of conducting the reviews as well as reporting. However, some areas of good practice

7.0 GMC national trainer survey

In addition to the six key datasets, the GMC national trainer survey was also analysed to provide evidence for Theme 4 (supporting educators) of the GMC's standards for medical education and training.¹

The national trainer survey is an annual survey that is commissioned and administered by the GMC. The survey has been in place since 2016.

Similarly to the national training survey (NTS), the purpose of the national trainer survey is to gather feedback from trainers in order to help local education providers such as hospitals and general practices improve their training practice. It also helps postgraduate deaneries/LETBs to manage training programmes, which are usually delivered across a number of different local education providers (LEPs). The GMC uses red and green colour coding to highlight results that are significantly above or below the average, to help identify areas for investigation.

The national trainer survey is composed of a set of generic questions that test trainers’ perceptions of training providers’ compliance with the GMC standards. It is a unique opportunity for managers of training programmes to hear the views of their trainers.

The generic questions test trainers’ perceptions of the following areas:

- organisational culture
- supportive environment
- handover
- time for trainers
- support for trainers
- supervisor training.

Responses are colour coded as follows:

	Below outlier
	Within the lower quartile (Q1) but not below outlier
	Within the middle quartile (Q2/IQR)
	Within the upper quartile (Q3), but not an above outlier
	Above outlier
	Three or fewer trainees, results not published
	Zero trainees completed the survey, no result

Appendix C: Glossary

ACF	academic clinical fellow
A(I)M	acute (internal) medicine
ALS	advanced life support
ARCP	annual review of competence progression
ASR	annual specialty report
AVM	audiovestibular medicine
CCT	completion of certificate of training
CESR	certificate of eligibility for specialist registration
CIT	core infection training
CMT	core medical trainee
CPD	continuous professional development
CPT	clinical pharmacology and therapeutics
CS	clinical supervisor
EA	external adviser
EAR	external adviser report
ES	educational supervisor
ESR	educational supervisor report
E&D	equality and diversity
EWTD	European Working Time Directive
FTSA	fixed-term service appointment
G(I)M	general (internal) medicine
GMC	General Medical Council
GUM	genitourinary medicine
HEE	Health Education England
HMT	higher medical trainee
HST	higher specialist trainee
ICM	intensive care medicine
ID	infectious diseases
JRCPTB	Joint Royal Colleges of Physicians Training Board
KBA	knowledge-based assessment

LAS	locum appointment for service
LAT	locum appointment trainee
LETB	local education and training board
LTFT	less than full time
MDT	multidisciplinary team
MRCP	Membership of the Royal Colleges of Physicians
NES	NHS Education for Scotland
NHS	National Health Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
NTN	national training number
NTS	national training survey
OOP	out of programme
OP	outpatient
PYA	penultimate year assessment
QA	quality assurance
QF	quality framework
QM	quality management
QIP	quality improvement projects
RCP	Royal College of Physicians
RITA	record of in-training assessments
SAC	specialist advisory committee
SEM	sports and exercise medicine
SCE	specialty certificate examination
SLE	supervised learning events
SSQ	specialty-specific questions
ST	specialist trainee
STR	specialist trainee registrar
TPD	training programme director
WPBA	workplace-based assessments

References

- 1 General Medical Council. *Promoting excellence: standards for medical education and training*. London: GMC, 2015. www.gmc-uk.org/Promoting_excellence_standards_for_medical_education_and_training_0715.pdf 61939165.pdf
- 2 Specialty Recruitment Office, Royal College of Physicians, London. *For further information regarding recruitment data, please email your request to: st3recruitment@rcplondon.ac.uk*.
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