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Health Education England

Enhancing training and the support for learners

Health Education England's review of competence progression for healthcare professionals

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Foreword – Professor Wendy Reid

In January 2017, we launched a programme to review and improve the mechanisms by which doctors in training are assessed, appraised and receive feedback on their progress and development, including the Annual Review of Competence Progression (ARCP). The aim was to make these processes more effective and efficient, but above all, ensure that they value doctors and enable flexible training.

Health Education England is responsible for ensuring that doctors in training have an annual review to confirm that they are progressing satisfactorily. The requirement for what and how progress should be assessed is set out by the medical Royal Colleges, based on the specialty curricula approved by the GMC. An overwhelming message from our stakeholders was the need for consistency and clarity in how assessment should be undertaken and that the current unwarranted variation across specialties and geographies undermines confidence in the ARCP process.

In a shared endeavour to improve how we collectively support our trainees the review has harnessed the enthusiasm and engagement of stakeholders across the education and training spectrum. It has revealed the high expectations trainees have of their annual appraisal and assessment process and the areas that require improvement. Trainees value constructive feedback and assessment, underpinned by high quality supervision. Although documentation is required to provide evidence that doctors are progressing as expected, many trainees have told us how stressful and unnecessarily time-consuming the ARCP process felt to them. There is so much more to being a doctor than a 'tick-box' exercise which does not support the culture of professionalism or individualism that doctors and the public expect.

The review also presented an opportunity to explore how some of the principles for appraisal and assessment of medical trainees might be applied to the benefit of other healthcare professionals. Evidence shows that high quality supervision and feedback contributes to a safety culture in which difficulties are discussed, questions are asked and honest reflective practice is necessary to help work though complex clinical problems.

The review has therefore enabled us to set out HEE's commitment to competency progression that could be applied across a range of professions, disciplines and specialties including doctors not in formal training programmes and professionals specifically engaged in advanced clinical practice.

The principles highlight the importance of consistent frameworks underpinned by outcomes-based curricula, support for appraisal and assessment; how portfolios are appreciated by the wider workforce as a tool to support their progression; the crucial role of trained and adequately supported supervisors and Mentors; and consistent assessment processes that ensure patient safety, whilst supporting employers and professionals to build multi-disciplinary skills for the future.

Given current workforce challenges and the need to support and retain high quality healthcare professionals, now is an opportune time to focus on the application of the principles set out through this review.

There is a wealth of evidence that multi-professional teams (MPT) improve safety, patient experience, productivity and the working lives of clinicians. By applying these principles HEE will seek greater opportunities for local education and training that benefit doctors not in formal training and staff stepping into advanced clinical practice roles. As the Blue Triangle below illustrates, education and training across the whole clinical workforce can support teams to meet the needs of the people we serve and improve the working lives of all healthcare professionals to improve job satisfaction and retention.

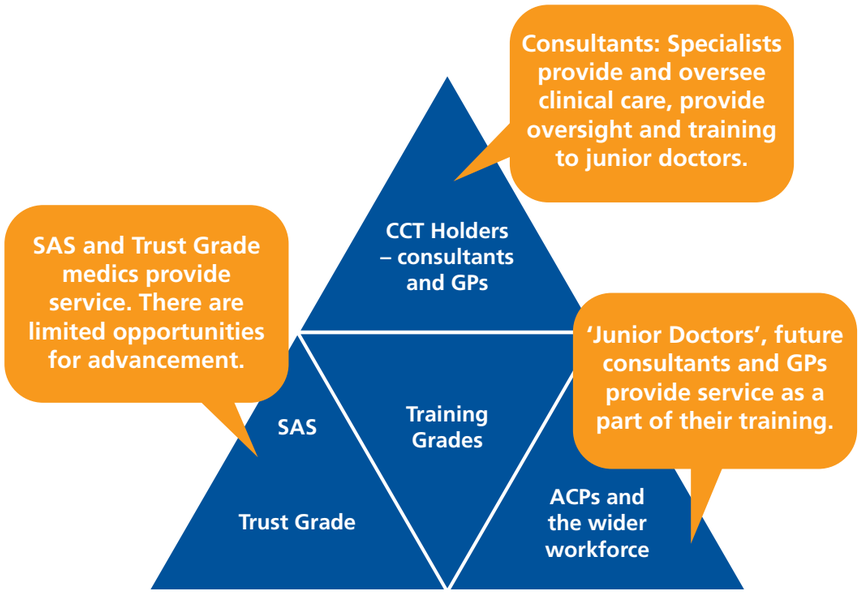

Figure 1: The Blue Triangle

The recently published consultation document, 'Facing the Facts, Shaping the Future; A draft health and care workforce strategy for England to 2027'[1], sets out our wider shared challenges and ambitions to continue to improve the training and working lives of all of our healthcare workforce. I look forward to our continued collaborations through the workforce strategy and in working together to implement the important recommendations contained in this report.

I would like to extend my thanks to all who have been involved in, and contributed to, this review. The collaborative nature of our discussions since its launch, has resulted in a set of recommendations that have been tested and refined through many lenses, not least through that of trainees.

[1] https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%252c%20Shaping%20the%20Future%20%281%29.pdf

Executive Summary

Over the last year we have engaged with many doctors in training, educators, healthcare professionals, system partners and other stakeholders to consider how competency progression for those working in a clinical environment can best support the delivery of excellent healthcare.

This report is focussed on reviewing the effectiveness of the Annual Review of Competency Progression (ARCP) process for doctors in training. Specifically, on how we can ensure the process is consistent, and reliable, safeguard patient safety and best support the development of trainees.

The review has also explored how the principles and learning from good assessment and appraisal processes for doctors in training might be applied to benefit the wider multi-professional team, including doctors not in training, in order to improve patient care and the working lives of other clinical professionals.

It has enabled us to define a set of principles in our approach to competency progression that improves patient safety and the wider quality of patient care whilst supporting and retaining healthcare professionals within the NHS. These principles could be applied across a range of professions, disciplines and specialties and form a cornerstone of Health Education England's commitment to ensure that staff delivering care to patients develop and train in a high-quality learning environment.

These principles are:

1. Healthcare professionals developing their competence or scope of practice should do so within the framework of an agreed outcome-based curriculum that sets out the knowledge, skills, values and behaviours that are required. The curriculum should specify appraisal and assessment requirements.

2. Learners should have access to a portfolio that allows collection and presentation of evidence that demonstrates competency progression.

3. Learners should be supported by trained supervisors and/or Mentors with available time, resources and access to professional support where necessary.

4. There should be a widely recognised, valid and reliable assessment process to review progression against the curriculum that provides a consistent standard to protect patient safety and supports transferability of competences.

5. Once a defined level of competence has been achieved this should be documented so it is recognised by learners, faculty, employers and the wider public.

Across the review several key themes emerged, for which we propose a set of recommendations:

Delivery of educational supervision

The quality and availability of educational supervision is not consistent, partly because of system constraints and service pressures, resulting in variation in quality, professional development, trainee motivation, support and educational outcomes.

In the clinical environment, doctors in training should receive high-quality formative feedback throughout their training year which includes preparation for and provides timely feedback after the ARCP panel, including career discussions at appropriate points.

The supervision process should ensure that ARCP decisions do not come as a surprise to trainees, and trainees who are not progressing as expected should be identified and supported in a timely way. To deliver this, it is essential that Educational Supervisors are appropriately supported, trained, and given adequate time in their job plans to fulfil the role.

In addition, greater clarity is needed about the many roles in education that support trainees, including those of Clinical Supervisors, Training Programme Directors, Heads of School and Mentors to maximise the effectiveness of this crucial support infrastructure.

In response to what we have heard in this crucial area of support to doctors in training, HEE will work with partners to review the role of the Educational Supervisor to maximise the effectiveness and support required to deliver this key role and seek views on how to maximise the effectiveness of wider supervision and educational support to trainees.

Consistency of ARCP panels

The review heard from trainees and from HEE local teams, that The Gold Guide (A Reference Guide for Postgraduate Specialty Training in the UK[2]) is not interpreted and applied consistently across different regions and specialties, leading to significant variation in the way ARCP panels conduct assessments, recruit and train panel members and feedback outcomes to trainees. Following this review, we will ensure that, as per the Gold Guide, all ARCP panel decisions will be made in absentia to improve the validity of outcomes. Aligned to this, we will also emphasise that detailed formative feedback should be made available to all doctors in training following the ARCP panel.

We will work with the Academy of Medical Royal Colleges (AoMRC) to aid consistent decision making by panels through the provision of decision-aids that are applicable nationally and are consistent in quality across specialties. We will also will work with the AoMRC and the National Association of Clinical Tutors (NACT) to enhance the quality and consistency of Educational Supervisor reports which are of vital importance to panels.

[2] https://www.copmed.org.uk/images/docs/publications/Gold-Guide-6th-Edition-February-2016.pdf

Professional and personal support for trainees

We have heard from trainees and educators that postgraduate training, including the ARCP process needs to be an agile system characterised by differentiated and tailored approaches in supporting trainees with varying abilities to succeed. To enable this HEE will ensure that Educational Supervisors, ARCP panels and trainees are provided with high quality information about the professional and personal support available to all trainees to provide equitable access across England.

Standardisation of quality assurance and quality management processes

Standardisation of the methods for quality assurance and quality management regarding the ARCP process is required to monitor standards and ensure consistent credible, valid, reliable and relevant assessment decisions are made across specialty training programmes. Assessment requirements are set by the medical Royal Colleges, based on the specialty curricula approved by the GMC. Standardisation and clear guidance to ARCP panels, such as decision aids, will reduce unwarranted variation across geographies and specialties. HEE will work with the AoMRC and the medical Royal Colleges to enhance and standardise approaches to assuring the quality of ARCP processes.

Defining and communicating purpose and responsibilities within the ARCP process

Throughout the review we have heard from doctors in training that there is no common understanding of how the components parts within the ARCP process interconnect to produce a coherent evidence-based outcome. The Gold Guide provides the framework, but it is essential that roles are effectively communicated and understood to empower trainees, including defining their own responsibilities. Following this review, HEE will develop and implement a communication strategy for England, working with the devolved nations to standardise communications across the UK. We will also work with the General Medical Council (GMC) to develop a guide to revalidation which will help clarify the responsibilities of doctors in training and identify key individuals within the process, including where doctors step out of training programmes for a period of time.

Trainees should also know the competencies they need to achieve at the start of a training year and the criteria against which these will be assessed should be understood upfront and free from unexpected changes during a training year.

Promoting Flexibility in Postgraduate Training

As well as looking to improve ARCP processes for doctors in training, we have explored how the principles may facilitate increased flexibility throughout training pathways through assessing competence of those leaving and re-joining programmes. ARCP assessment of competencies at different stages in the training pathway should facilitate trainees to exit and re-enter training, enabling progression at their own pace and proficiency and appropriately recognising the competencies that may be gained when out of training programmes. Following this review, we will therefore look to adapt Out of Programme (OOP) arrangements to allow a 'Step-on Step-off' approach that allows greater flexibility. HEE is supporting trainees return to training programmes through the SuppoRTT (Supported Return to Training) programme[3], which will be an important enabler in creating greater flexibility.

We will also look to fully evaluate the work undertaken in GP training, to inform options for deferred entry to training more widely in the future, and ensure there are equitable principles applied to requests to train less than full time (LTFT).

Utilising the ARCP model for developing and supporting SAS Grade and Trust Grade Doctors

We have heard from these two groups of doctors and their employers that the ARCP process could be broadened to allow recognition for skills and competencies gained, provide potential to re-enter training or enable progression to more senior roles within the profession. We will therefore explore whether support through an ARCP style process could be beneficial to engage, develop and value this workforce.

Applying the principals established through this review to the wider workforce

Throughout this review we have heard consensus that all healthcare professionals are supported in their career development. This review has enabled us to identify the principles and processes that can be applied to support those engaged in advanced clinical practice. Following this review, HEE will work with stakeholders to further explore and pilot a structured, consistent national clinical competency assessment process to support ACP development across several specialties.

[3] https://www.hee.nhs.uk/sites/default/files/documents/Supported%20Return%20to%20Training%20-%20FINAL%20report.pdf

Section 1: Introduction

Background

Health Education England (HEE) exists for one reason only, to support the delivery of excellent healthcare to the patients and public of England by ensuring that the workforce of today and tomorrow has the right skills, values and behaviours, and is in the right numbers, at the right time and in the right place. A fundamental part of this commitment is to support healthcare professionals to develop and progress their level of competence.

The review is rooted in our commitment to support and enhance the working lives of trainee doctors and improve their experience of training. We have identified how the Annual Review of Competency Progression (ARCP) process can be improved to ensure it enables trainees to achieve their full potential whilst continuously providing excellent, safe care to patients. A major component of this review was a focus on the progression of doctors through postgraduate training and is part of a programme of work to help address wider issues relating to morale and wellbeing.

A significant driver for undertaking this review was feedback from doctors in training about their experiences of the ARCP, including how it could feel like an impersonal tick-box approach, distant from their personal career aspirations and lacking in flexibility to recognise excellence. Specifically, the ARCP process was identified as adversely affecting trainee morale and significantly contributing to dissatisfaction with training with reports that for some 'it felt like a viva examination'. Further exploration demonstrated that ARCP processes are being inconsistently applied within specialties and across HEE's local offices.

Reviewing the ARCP process was one of the commitments HEE made in its report 'Enhancing Junior Doctors' Working Lives'[4].

We are already seeing workforce innovations to advance the clinical practice of a range of registered professions. As the review progressed, our engagement revealed an appetite for structured competency progression across a range of healthcare professionals, and the potential to apply the principles set out in the review to benefit groups such as SAS grade doctors, trust grade doctors and staff engaged in advanced clinical practice. As a result, the review considered how these groups could be best supported.

[4] https://www.hee.nhs.uk/our-work/developing-our-workforce/supporting-doctors-training/enhancing-junior-doctors-working-lives

Overview of Annual Review of Competency Progression for Doctors in Training

Annual Review of Competency Progression (ARCP) is the UK-wide process by which doctors in postgraduate training present information to demonstrate their progress in meeting the requirements set out in the medical Royal College curriculum covering their training programme. Assessments to measure progress against these curricula are developed by the relevant medical Royal College.

ARCP is also how doctors in postgraduate training undertake their annual full scope of work review for the purposes of meeting medical revalidation requirements. To meet revalidation requirements trainees are required to self-declare their full scope of work, involvement in any unresolved significant events and complaints, compliments and good standing regarding health and probity.

The Reference Guide for Postgraduate Specialty Training in the UK (known as The Gold Guide)[5] describes the overall purpose and approach to ARCP for core and specialty training (the Foundation Guide[6] provides similar information for doctors on the UK Foundation Programme) to assess a trainee's progress against their curriculum and undertake the annual full scope of work review to satisfy revalidation requirements.

The significance of the ARCP process to the professional development, progress and revalidation of doctors, necessitates a robust system which both evaluates trainees' performance in their clinical context and enables trainees to steer their learning towards optimum clinical and patient outcomes. This is crucially important to ensure that our future senior doctors are well prepared for their clinical roles and equally play a full part in the wider role of shaping services to best meet patients' needs.

The Gold Guide was first published in 2007 and provides guidance to Postgraduate Deans on the delivery of postgraduate medical specialty training in the UK. The Gold Guide sets out the arrangements agreed by the four UK health departments for specialty training programmes including detailing the purpose and process of the ARCP and assessment. The roles of Education Supervisor, panels and the Postgraduate Dean are defined. Evidence collection, outcome, quality assurance and the way the ARCP process should be adapted for out of programme, academic and trainees who are training less than full time is also included.

The ARCP process outlined in the Gold Guide is below and describes many stages of regular educational assessment and appraisal, against an educational agreement, that should take place on a face-to-face basis between the trainee and the Educational Supervisor (ES). This forms the evidence for an ARCP panel which is a one-off event usually occurring annually.

[5] https://www.copmed.org.uk/images/docs/publications/Gold-Guide-6th-Edition-February-2016.pdf
[6] http://www.foundationprogramme.nhs.uk/pages/curriculum-eportfolio/e-portfolio/reference-guide

The purpose of ARCP

There is agreement across the Gold Guide, the UK Foundation Programme ARCP guidance, and the GMC's Generic Professional Capabilities implementation guidance that the purposes of the ARCP are to:

1. **Assess trainee achievement and learning, and suitability to progress to the next stage of their training, including identifying trainees who are not achieving or progressing satisfactorily:**
- Judge trainee performance to date (achievement of competencies) against curricula.
- Judge trainee progression (achievement of competencies at a defined rate) to date against curricula.
- Judge trainee suitability to progress to the next stage of training or complete training.
- Provide advice to the medical Royal College/Faculty about completion of training.

2. **Provide trainees with feedback to remediate poor performance:**
- Provide trainees with feedback to guide any additional training they may need to enable them to demonstrate performance and progress to the next stage.

3. **Demonstrate rigour and fairness:**
- Be a fair, defensible, consistent, documented method of judging trainees.

4. **Quality assure medical training and medical practice:**
- Provide advice to the Responsible Officer about revalidation, specifically the trainee provides an account of their full scope of work since their last ARCP / appraisal and self-declares involvement in any significant events, complaints and other investigations and good standing in health and probity.
- Provide information to contribute to the quality assurance of training programmes.
- Flag concerns about patient safety or fitness to practise.
- Provide patients and employers with reassurances about trainee competence.
- In addition, for revalidation purposes, the panel is required to make a statement to confirm that there are no unresolved concerns about the doctor's fitness to practice.

Section 2: Methodology

Engagement and Collaboration

With the ARCP process required by over 650 training programmes and approximately 55,000 trainees, HEE undertook comprehensive engagement and co-design with a broad range of groups and organisations to ensure a full range of contributions and feedback. This included three stakeholder co-design events attended by over 240 individuals and organisations; including the GMC, medical Royal Colleges, employers, doctors in training, lay representation and representatives from the devolved nations.

The review also established a dedicated Learner and Trainer Engagement Group, led by HEE Clinical Fellows to enable meaningful involvement and insight in to the root cause of the issues for trainees and trainers. The group reviewed every branch of the review, gathered a wide-reaching perspective and ensured that the emerging findings and recommendations are grounded in practical solutions to address the issues raised.

The review also established learner and trainer reference groups and explored the perspectives of specialty and associate specialist grade (SAS) doctors and wider healthcare professionals, such as Advanced Clinical Practitioners, as well as engaging with provider organisations and relevant professional bodies to shape sections 5 and 6 of this report.

As part of the review lay representatives were also invited to share their insights. Their unique roles on the ARCP panels ensure consistency and fairness, as well as representing the public and patient voice and asking the question, 'would I want this Doctor treating my friends and family?'.

Call for Evidence

To aid the development of evidence-based recommendations, HEE launched a call for evidence in August last year which included seven questions seeking views on the current ARCP process and ways in which it could be improved. The questions used in the Call for Evidence are included in Appendix 1.

To encourage as much freedom and creativity as possible within responses the call for evidence allowed 'free text' answers to all questions. This meant that the range of responses was very broad and varied, both in terms of content and detail, but common themes emerged which were central to the considerations of the review.

Submissions were received from trainees throughout their education journey and from a range of specialties. HEE formally received 680 responses from individuals and organisations including the General Medical Council (GMC), the British Medical Association (BMA) and several medical Royal Colleges. While it is not possible to capture the full depth and specificity of all the individual responses in this summary report, all were considered.

An academic review by University College of London (UCL) provided an independent evidence base together with an internal mapping exercise of current ARCP related activity provided by HEE local offices and providers.

Lay representation

As a part of the engagement undertaken to shape this report, a focus group was held with lay representatives from a sample of HEE teams who frequently sit on ARCP panels. Feedback received from this group broadly aligned with the five themes identified above and was crucial in shaping the recommendations contained within this report. Lay representatives were also key members of the working groups that were established to undertake the review. Their insight and constructive challenge has been invaluable in considering the evidence and shaping of the recommendations.

Section 3: Discussion of Findings

Theme 1: Delivery of Educational and Clinical Supervision

All doctors in training must have a named Educational and Clinical Supervisor for each placement within their specialty training. These roles are usually performed by different people. An Educational Supervisor is a named trainer, who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The Educational Supervisor is jointly responsible with the trainee for the trainee's educational agreement.

Organisations that provide work-based placements for doctors in training should explicitly recognise that supervised training is a core organisational responsibility, which ensures both patient safety and the appropriate supportive development of the medical workforce to provide for future service needs.

Educational Supervisors should be trained in accordance with GMC requirements[7], demonstrate their competence in educational appraisal, feedback and assessment methods, including the use of the specialty specific assessment tools set by the relevant medical Royal College. It is also essential that Educational Supervisors are given sufficient time to perform their supervision duties and that they are appraised on their performance as a supervisor as a part of their regular appraisal. The number of trainees each Educational Supervisor has responsibility for varies by geography and specialty, although on average the ratio of supervisors to trainees is around 1:3.

The role of an Educational Supervisor is to ensure their trainees have the necessary access to resources and experience to meet training and employment needs including induction, regular meetings throughout their training programme at agreed intervals and access to any necessary remediation and pastoral support.

Educational Supervisors are responsible for providing feedback to the trainee throughout their placement, highlighting excellence and providing advice on personal development including agreeing action plans if concerns or issues are identified.

Educational Supervisors are responsible for writing and sharing the Educational Supervisors report which forms a key part of the evidence provided to ARCP panels. This report should be shared with the trainee in advance of the panel, as part of good practice, to reduce the chance of receiving an unexpected outcome.

Within each placement, each trainee should have a Clinical Supervisor, who is responsible for ensuring that educational governance requirements are met. The Clinical Supervisor is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement which may lead to the roles of Clinical and Educational Supervisor being merged. In integrated academic training, a trainee will also have a named Academic Supervisor.

In secondary care the responsibility for both appointing and training Educational and Clinical Supervisors lies with the provider organisation, whilst within primary care the appointing of Educational and Clinical Supervisors is the responsibility of the Head of School.

What we heard

There was a breadth of strong views on the effective delivery of educational supervision, which focused on quality and availability of the supervisor to provide in depth, bespoke feedback which would enable trainees to steer their learning and reflect upon their practice.

All stakeholders agreed that effective educational supervision was integral to the concept of high quality training and was vital in helping trainees progress through training, including preparation for ARCP panels. There was general agreement that this includes supporting trainees to set learning objectives, offering and receiving feedback (from doctors in training), set performance expectations and provide granular feedback where appropriate.

"The Educational Supervisor (ES) meeting is the core of the training experience and is very much valued in comparison. The time with my ES gives me some headspace to reflect on not what I am learning but where I wish to go and how I might best get there. If it doesn't work as well as it might, then that is because the ES role is generally unsupported in terms of paid time and because it is not valued by the employer. A commitment to valuing and resourcing the ES role strikes me as one of the only levers to improve training experience given the current workforce and financial position of the service."

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There was also an acknowledgement that the provision of clinical services can often mean that finding the time to provide (and receive) supervision and feedback can be difficult and supervisors and trainees both have huge demands on their time.

Trainees felt that finding time to plan and complete work-based assessments could be difficult, so when time for supervision became available this was not always utilised as effectively as it could be. Many felt it was vital to ensure that sufficient time was included in both trainee and supervisor job plans and that this time must be found despite service pressures.

[7] https://www.gmc-uk.org/education/10264.asp

The review heard that there was a degree of inconsistency in how Educational Supervisors were appointed, trained and appraised by Trusts which was seen to be a significant contributing factor to the trainees' varied experiences. We heard anecdotes from supervisors who felt that the role of Educational Supervisor was often bestowed upon the newest consultant within a department, regardless of whether they had expressed a strong interest in education or not.

At times, this was compounded by supervisors receiving inadequate training about both the ARCP process and how to provide effective supervision to offer trainees necessary support. Throughout the review there was agreement that appropriate training should be provided to Educational and Clinical Supervisors, with a clearer set of expectations communicated to trainees and Educational Supervisors on their shared responsibilities. For example, the review heard directly from trainers that opportunities to be part of an ARCP panel was one of the most effective ways to enable them to understand how they could support trainees.

We also heard from trainers, that whilst their appraisal should encompass the entire scope of their practice, on occasions the educational supervision element of their role was not covered. Trainers told us this left them feeling isolated and that work was required to clarify the importance of supervisors and ensure it was established as a role to aspire to.

Trainers also told us that more could be done to facilitate sharing of good practice between supervisors within both providers and specialties and that they need to be engaged with the educational opportunities associated with ARCP processes and wider opportunities to improve the training environment for individuals and multi-disciplinary teams. In addition, we heard that greater clarity is needed about the many roles in education that support trainees, including those of Clinical Supervisors, Training Programme Directors, Heads of School and Mentors to ensure this crucial infrastructure is as effective as possible in supporting doctors.

We heard from trainees who felt that outside of the GMC National Training Survey[8], they were often unsure of the mechanisms available to share feedback about the quality of both their clinical placements and on the quality of supervision received. Health Education England manages and improves the quality of placements (and of Educational Supervision within those placements) using the HEE Quality Framework[9]. During 2018/19, we will ensure there is a focus on the quality of Educational Supervision through the framework's implementation.

Finally, some trainees voiced their concern that there may be a 'failing to fail' culture amongst some Educational Supervisors who felt failure could reflect poorly on them and the placement provided. There was agreement that greater support should be offered to supervisors in managing trainees experiencing difficulties.

The following recommendations relating to **Theme 1 of the review: Delivery of Educational and Clinical Supervision:**

Recommendation 1
Trainees should have regular high-quality formative feedback, which includes preparation for, and timely feedback after the ARCP, and should include career discussions at appropriate points.

Recommendation 2
The ARCP decision should not be a surprise to trainees, and trainees who are not progressing should be identified and supported in a timely way.

Recommendation 3
Educational Supervisors should be appropriately supported, trained and given adequate time in their jobs plans to fulfil the role. Clinical Supervisors providing day to day support for those they are training should have regular contact with the Educational Supervisor.

Recommendation 4
Educational Supervisor reports should be quality assured to ensure they provide a consistent and high quality summative assessment of progress.

[8] https://www.gmc-uk.org/education/surveys.asp
[9] https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf

Theme 2: Consistency of ARCP panels

For the ARCP process (and specifically the ARCP panel) to be effective, it is essential that all stakeholders have confidence that the outcomes reached by the panel are consistent, reliable and valid. Whilst the Gold Guide states trainee progression and performance should be judged against the relevant curriculum, it does not explain the procedures by which panels should use to go about making their judgements. There are many different specialty and sub-specialty curricula and the Gold Guide does not give details about which aspects of the curriculum are most important for panels to consider.

Curriculum-specific guidance has been issued by some medical Royal Colleges in the form of ARCP decision aids. These documents are developed by some specialty-specific education committees within some of the medical Royal Colleges and describe the expectations for a minimally competent trainee at each stage of training.

The Gold Guide outlines that each ARCP panel must consist of at least three members, one of which must be either the Postgraduate Dean (or their nominated deputy), the Head of School or a Training Programme Director (TPD). Additionally, the panel should have input from a lay member and an external advisor (who may be a college/faculty representative if not otherwise represented on the panel) who should review at least a random 10% of the outcomes and evidence supporting these and any recommendations from the panel about concerns over performance.

The Gold Guide notes that the following evidence should be reviewed by the panel:

– the Educational Supervisor's Report (but not the Clinical Supervisor's)
– workplace based assessments
– examinations
– self-reflective learning logs.

It also states that logbooks, audit or quality improvement reports/projects, research activity and publications 'may be required to demonstrate progress'. As described above, the Gold Guide cannot provide a definitive list of, for example, the number and type of workplace-based assessments that should be reviewed at ARCP. These criteria are set by the relevant medical Royal College.

The ARCP process needs to be able to accurately distinguish between satisfactory and unsatisfactory performance and progression, and to describe different types of unsatisfactory progression. However, the process does not currently distinguish various levels of satisfactory progression.

Increasing the amount of information about a trainee's performance will generally improve the accuracy of judgements. The reliability of an assessment can be thought of as its reproducibility: if the same trainee were to submit the same evidence to a different ARCP panel on a different day in a different part of the country, what is the probability that the trainee would get the same outcome? The reliability of the ARCP depends on both the reliability of the panel decision-making, and on the reliability of the evidence submitted to the panel.

What we heard

We found that all processes observed followed the requirements of the Gold Guide in terms of membership, but some local offices included additional panel members such as administrators, TPDs from related specialties and other Educational Supervisors. Some panels also used external representatives more frequently than the required 10% with a view to improving consistency and quality assurance. As a part of our engagement with trainees, trainers and local HEE local teams, we found that this variation in the composition of panels led to inconsistent trainee experience.

We also heard that the training and accreditation for panel members varied across local offices and across specialty. The Gold Guide outlines that all panel members should be suitably trained to fulfil their role, however there was a significant variation in the type and delivery of training provided, with some offices insisting that all panel members are trained together in a face to face session and others offering e-learning modules. We heard that the performance of the panel members can have a huge impact upon the validity and consistency of the outcome reached and also on the quality of the feedback given to the trainee after the panel.

We heard from trainees and ARCP panel members that there were significant variations in how 'post-decision' feedback was delivered to trainees. In some localities trainees were invited to meet with the panel once an outcome had been reached, which enabled detailed feedback to be provided and developmental points to be identified. In others, trainees were notified by e-mail of the panel decision, and feedback mechanisms varied. Some were slightly more unclear, with TPDs and Educational Supervisors offering feedback later in the process, and for some no feedback was provided at all. All trainees valued receiving feedback when this was offered, but many also reported that when this came from a panel, it was perceived as being intimidating and as a 're-examination'. This highlighted another area of inconsistency in panels relating to whether trainees are asked to attend panels or whether they are conducted in absentia.

The Gold Guide is clear in stating panels should be held in absentia, with trainees only being asked to attend if there is the possibility of an unfavorable outcome being reached, which then needs to be communicated after an in-depth discussion. In most of cases this is the practice across localities and specialties. The review did highlight that on occasions trainees were invited to attend panel to discuss performance and receive support. This clearly has created confusion in the process (as outlined in theme 5) and could impact of the perceived validity of the outcome reached as well as undermine trainees' morale.

"When the outcome from the ARCP panel is provided only via the e-portfolio or an e-mail it can often be poorly received if it is not coupled with a feedback session with educational supervisor. Essentially it becomes a unidirectional transfer of information with no career planning."

Learner & Trainer Engagement Group

The review of the validity and consistency of the ARCP process undertaken by University College London found that:

'The Gold Guide and the Foundation Programme Reference Guide to panels making 'systematic' judgements, but there is limited detail about how this should happen in practice. The Foundation Programme guidance does provide some information about how many panel members should review a trainee's portfolio and what should be done if two panel members disagree. Furthermore, both the Gold Guide and the UKFPO ARCP Guide reproduce forms for recording some aspects of the panel decision-making. It is likely these forms contribute to standardising the decision-making process and thereby improving its reliability.'

It is therefore essential that all ARCP panels have access to the tools required to make consistent judgements across both locality and specialty.

Finally, we heard throughout the review that well-structured and easily accessible e-portfolios vastly improved the functioning of ARCP panels and allowed panel members to easily access and appraise evidence submitted by trainees. However, we heard that e-portfolios are not always available, and that trainees find the process of maintaining, updating and submitting portfolios burdensome, and at times inconsistent with the demands of providing patient care. Many of those participating in the review felt there was an opportunity to look at a more generic e-portfolio mechanism which could also aid the consistency of panel processes.

We also heard how e-portfolios can be potentially be a valuable tool to support professionals to meet a range of requirements linked to their Continuing Professional Development (CPD). The potential benefits are clear, namely coherent management of a variety of achievements and pieces of work which support learner centred rather than course centred view of learning. These can be restructured and viewed in different ways for different purposes, for example, for reviewing learning, planning future learning, or providing evidence for ARCP panels or revalidation and helping trainees take control of their learning and their lives, by reflecting on their activities and planning future career directions.

Aligned to this we heard from many trainees that there was significant disparity with regards to the number, type and quality of assessment required by medical Royal Colleges and that the review of all curricula by 2020 in line with the GMC generic professional capabilities offers an opportunity to consider improvements. Throughout the review we heard that trainees felt existing assessment requirements were not necessarily the most effective indicator of competence.

The following recommendations are made with regard to **Theme 2 of the review: Consistency of ARCP Panels:**

Recommendation 5
Formative feedback is crucial to empower trainees. As per the Gold Guide, ARCP decisions should be made in absentia. Therefore, post-ARCP feedback, including recognition of the achievements of those performing well, should be offered to all trainees in a timely and supportive process.

Recommendation 6
Training and national guidance should be provided to ARCP panels to aid consistent decision making, with provision of decision-aids that are applicable nationally and are consistent in quality across specialties.

Theme 3: Professional and personal support for trainees

The ARCP process provides an opportunity to identify doctors in training who are not progressing as expected and to signpost support services for all trainees. These support services can be vital, in providing functions ranging from targeted programmes for distinct areas of practice to careers guidance. The provision of these services and the way in which they are accessed varies between HEE local offices, as does the awareness of their existence amongst the trainee and trainer community.

What we heard

The ARCP process was seen by some to be impersonal and inflexible to trainees who are either struggling to achieve the level of competencies in their specialty or those who are excelling and want to accelerate the pace of their training or develop additional competencies. Better feedback processes will help get the most out of the annual review for trainees.

Trainees in difficulty felt that often both they and their Educational Supervisors were unaware of the support packages available, and more needed to be done to promote understanding of the available professional support and how trainees could access this support. Work is required to ensure there is a standard offer of support that trainees can access.

The following recommendation is made with regard to **Theme 3 of the review: professional and personal support for trainees:**

Recommendation 7
Educational Supervisors, ARCP Panels and trainees should be provided with high quality information about the professional and personal support available to all trainees.

Theme 4: Standardisation of quality assurance and quality management processes

The structure behind an annual collation of evidence for assessment can help ensure trainees continue to build and enhance their portfolio to aid personal development through, for example, reflection on practice, clinical audit and quality improvement.

It also has the potential to demonstrate to the public that a rigorous, standardised process is in place certifying that doctors in training are competent to continue practicing through meeting the requirements of their medical Royal College curriculum and standards of their regulatory body.

Individual medical Royal Colleges should perform reviews of their requirements to ensure the number and structure of assessments are appropriate and reflect the different needs of doctors who, in some cases, progress through their training with nearly a decade of working in the NHS. Ensuring sufficient quality assurance of the ARCP panel process is essential for building confidence in the consistency and validity of outcomes and the continued safety of patients.

What we heard

The review found that a well-planned ARCP process provides a road map of what needs to be achieved for personal and professional development and ensures competency for progression to next stage of training (see diagram in appendix 2). To deliver this process, it is essential that panels are managed and administered consistently for the reasons outlined in theme 2.

We heard from a range of panel members that the use of decision aids is a significant tool in informing the panel's decision and ensure a like for like comparison between trainees against the set curricula.

There is a significant variation in the amount and type of training provided to panel members, from training covering the role of each panel member to e-learning. All panel members felt that training in basic areas such as the role of the panel, potential outcomes, appropriate questioning, equality and diversity and providing effective feedback should be provided consistently.

Lay representatives and external panel members (often sourced from medical Royal Colleges) were perceived as being crucial in ensuring consistency within a region (in the case of lay members) and within a specialty (in the case of external representatives).

The Gold Guide stipulates that external and lay representatives must attend at least 10% of panels and all panels where there is the possibility of a less than favourable outcome. As a part of our engagement we spoke to several lay representatives who felt that their role varied hugely depending on panel, and that they could be utilised more effectively. All ARCP panel members should be clear on their role to ensure the process works effectively and within the agreed scope.

Wherever possible panels should come together virtually supported by the necessary audio-visual technology, for example, Skype to minimise travel, time away from clinical work and to improve the reliability of the professional judgments they make of the evidence presented.

The following recommendation is made with regard to **Theme 4 of the review: Standardisation of quality assurance and quality management processes:**

Recommendation 8
HEE should work with the AoMRC and medical Royal Colleges to ensure a standardised approach to improving the quality of ARCP processes, ensuring that good practice is shared across specialties and geographies.

Theme 5: Defining and communicating the ARCP process

For the ARCP process to deliver valid, consistent outcomes it is essential that all parties are clear on their role and responsibilities, and on the overall purpose of the ARCP cycle. It is important that information regarding the process is easily accessible to all, to ensure a transparent and effective process.

What we heard

Many of the responses focused on the lack of clear, thorough, systematic and timely communication on the overall ARCP process and the component parts within it. Throughout engagement many trainees informed us that they were unsure what the ARCP process was, what a good outcome was and what trainees and Educational Supervisors expect from the process.

We also heard that there was a degree of confusion regarding how the revalidation process fits with ARCP. This needs to be clear, especially for trainees in Less than Full Time (LTFT) training and those looking to progress through training more quickly.

Trainees want clearer information about the ARCP process and the specific requirements of their programme and curriculum at the start of each year. This would allow them to plan effectively to meet the competences and complete e-portfolio's well in advance of their ARCP panel. They want the opportunity to take more responsibility but felt that the resources needed to facilitate this process were either unavailable or were not sufficiently signposted.

Trainees should also know the competencies they need to achieve at the start of a training year and the criteria against which this will be assessed should be understood upfront and free from unexpected changes during a training year.

"At my hospital, FY1 trainees were told at induction that we needed to complete 50 reflections on the e-portfolio to "pass the year". There was a lot of resentment towards reflective practice because of this. Towards the second half of the year, trainees complained to the Medical Education Manager about the high number of reflections required and it was circulated by word-of-mouth that we would only need 25 reflections."

FY1

Clarity is required about the functioning of the ARCP panel, and the complete annual cycle. This includes the formative 'appraisal' functions that trainees should receive in placements from Clinical and Educational Supervisors which are essential to their continued development.

Finally, many thought ownership of communications about the ARCP process was needed in explaining the ARCP process to doctors in training and updating them with any changes. Foundation doctors especially felt they lacked information and that Educational and Clinical Supervisors were not equipped to answer questions about the process.

The following recommendations are made with regard to **Theme 5 of the review: Defining and communicating the ARCP process:**

Recommendation 9
A shared understanding of the purpose of the ARCP (as described in the Gold Guide), is needed, with clarity on the steps involved including those required for revalidation by the GMC.

Recommendation 10
All involved in ARCP processes should understand their responsibilities and trainees should know the competencies they need to achieve at the start of a training year and these should be free from unexpected amendments.

Recommendation 11
National training bodies, should coordinate and implement system wide communications to set out the expectations of the system, and empower trainees.

Section 4: Promoting flexibility in postgraduate training

Context

Doctors in training can take time out of a training programme through the system set out in section 6 of the Gold Guide. The "rules and regulations" are perceived as complex and only time in a prospectively approved post can be 'counted' towards completion of training. It is difficult for a doctor to simply "step-off" a training programme to reflect on their career aspirations, gain experience in other fields, gain clinical experience or just do something different. The linear nature of training programmes can make trainees feel they are on a 'conveyor belt' and can discourage innovation and flexibility both in meeting service needs and educational and professional development.

The current "taking time out of programme" system needs to be changed to enable trainee doctors to move out of a traditional training pathway for a period of time, knowing that the experience and skills they gain could be collected in a portfolio, so that when they move back into training they could demonstrate competence and progress faster, where possible. For those outside the training pathway, application of principles 2 and 3 set out above would support a more flexible approach whilst at the same time allowing the opportunity for a more rapid progression through subsequent training posts. HEE's Supported Return to Training (SupoRTT) programme will make this option more explicit and supportive for trainees and safe for patients.

This does not require a change to regulations governing the ARCP process, but it does require a change to the way the system currently recognises competencies and progression. It also requires a shift in the thinking of those who assess trainees during the annual review so that trainees with prior knowledge and skills are supported to progress more quickly should they demonstrate the required competence.

This theme is not new and was identified in the GMC's 2017 review of how flexibility in postgraduate medical training could be improved, in Professor Sir John Tooke's 2009 review of postgraduate training (Aspiring to Excellence)[10] and in Professor David Greenaway's 2013 review (Securing the future of excellent patient care).[11]

What we heard

An overwhelming number of views highlighted the difficulties trainee doctors have in taking time out of training programmes. Whilst there may be inconsistencies in how approvals are granted the perception is that taking time out of training is generally not welcomed and that unless there is a strong case may be declined.

[10] http://www.asit.org/assets/documents/MMC_FINAL_REPORT_REVD_4jan.pdf
[11] https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

We heard from many doctors who expressed a desire for a more flexible and inclusive system that enables doctors to move in and out of training seamlessly. To address the lack of support for doctors not in training posts they would like access to a supervisor and a portfolio to capture their skills and experience.

Many respondents to the review expressed their concerns that there is no mechanism to recognise knowledge and skills development outside of training programmes, with rigid rules around the competencies achieved within the clinical year, which may impact on less-than-full-time trainees significantly. We heard stories such as "The Master's degree I hold in palliative medicine does not count towards my training because it was completed before I started my specialty training". The approach to competency progression should enhance career flexibility and value a wider variety of trainee experiences that together support innovation in health care.

Deferred entry

We have explored the concept of extending the process of start date deferral, which is available to General Practice trainees, to other specialties. We have heard that deferral would be attractive to some, but not all trainees. The process can support more flexible career development and allow young doctors to widen their experience before entering training, but we have heard that the process presents logistical challenges. We will fully evaluate the work undertaken in GP training to inform potential options for deferred entry more widely in the future.

Less Than Full Time Working

The higher Emergency Medicine less than full time (LTFT) pilot is currently exploring the provision of more opportunities and wider access to LTFT. A more flexible approach may reduce 'burn out' and attrition, improve morale and aid recruitment. The pilot is designed to improve the working lives of higher Emergency Medicine trainees by offering an opportunity for improved work-life balance.

This pilot is supported by the Department of Health, HEE, NHS Employers, NHS Improvement, the GMC, the BMA and the Royal College of Emergency Medicine. It will be evaluated later in 2018, to review its outcomes and inform future opportunities and access.

Through the review, we have heard that currently the principles for requesting LTFT may be misunderstood or may be applied inconsistently.

All trainees should, therefore, have equitable principles applied to requests to train less than full time (LTFT).

The review has agreed the following principles:

- Trainees should not have to justify a request to train less than full time
- Those with health issues and caring responsibilities should be prioritised
- What trainees do in their "spare time" is their own business
- Extra NHS locum shifts, or clinical work should be periodic and declared
- HEE should normally support less than full time training percentages of 50%, 60%, 80% and 90%
- Those with caring responsibilities should if possible be able to fix their working pattern

The following recommendations are made with regard to: **promoting flexibility in postgraduate training:**

Recommendation 12
Out of Programme (OOP) arrangements should be adapted to allow a 'Step-on Step-off' approach that allows a more flexible training pathway.

Recommendation 13
Building on our evaluation in GP training, deferred entry should be explored in other specialties in the future.

Recommendation 14
All trainees should have equitable principles applied to requests to train less than full time (LTFT).

Section 5: Utilising the ARCP model for supporting SAS grade and developing trust grade doctors

Context

In planning for the medical workforce, HEE's decisions are made in the context of a range of constraints, including limits to funding but also training capacity. However, a more fundamental constraint is the limited supply of trainees – home and international - available to fill training posts. Between 600 and 700 posts at ST1 (core, ACCS and run-through) go unfilled each year. More sought-after geographies and specialties fill at the expense of those that are less sought after. However, there are doctors working at all levels of professional care in trust posts as well as in more long-term SAS grade posts. These doctors make up 9% of our medical workforce and HEE's recently published consultation document, 'Facing the Facts, Shaping the Future; A draft health and care workforce strategy for England to 2027'[12] called for a genuine focus on supporting and recognising the value of these two groups of doctors.

What we heard

Most SAS or trust grade doctors choose to work in these posts and are content and fulfilled in working within their current grade. However, a significant minority want the option to enter or return to training. The review found support for the ARCP process to be broadened to allow these doctors to gain recognition for competencies gained, where they chose to do so. This could be either when they enter training at different stages, or to support the parallel evidence needed for the alternative route to the specialist register.

We also heard that the support available to SAS or trust grade doctors through employers and across HEE can vary significantly in terms of best practice, support, career enhancement, and funding opportunities. There was support for a cross-organisational review of service need and support available to trust and SAS grade doctors.

The following recommendation is made with regard to: **Utilising the ARCP model for supporting SAS grade and developing trust grade doctors**

Recommendation 15
There should be a more flexible, evolving approach to supporting the professional development for SAS grade and trust grade doctors.

[12] https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%252c%20Shaping%20the%20Future%20%281%29.pdf

Section 6: Competency progression within the wider workforce

New ways of working across health and care are stimulating the further development of advanced clinical practice (ACP) roles. ACP roles are an effective and increasingly attractive workforce solution for employers, to realise the potential of the wider workforce, to recruit and retain high calibre clinicians and deliver complex NHS services. The launch of the ACP Framework[13] in November 2017 supported the standardisation of this level of practice and established the framework within which this workforce can be safely and effectively developed, integrated within teams, and governed in practice.

Due to the diverse nature of ACP roles, different approaches will be required in different areas to optimise learning and build trust and confidence within and across whole teams. There is an opportunity to agree the core principles for assessment, spanning the professions, taking a robust, standardised approach to the assessment of clinical competence and capability. This will have a focus on patient safety and enable staff of all professions undertaking the same activities to be assessed to the same standards, in the same way.

The ACP framework emphasises the attainment of clinical competence, capability and confidence. This in turn emphasises work-based learning and the assessment and progression of competence. HEE has worked with the Royal College of Emergency Medicine to trial collaboration across service, professions, post graduate schools of medicine and universities to develop the ACP role in the Emergency Department. Work is also ongoing across the system within other specialties and across profession groups. These look to develop the assessment of clinical competence and capability, as part of innovative workforce developments within health and care working with universities, post graduate medical education teams and other providers.

The Shape of Training[14] and The Shape of Caring[15] share the intention, and establish opportunities, to support the development of the wider workforce, across the professions. The shared objective is to build workforce transformation at the bedside, in the consulting room or in the community, by training individuals and teams side by side to meet the needs of the populations served.

[13] https://www.hee.nhs.uk/sites/default/files/documents/HEE%20ACP%20Framework.pdf
[14] https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf
[15] https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

The ARCP review has considered the principles of the ARCP process and its relevance to ACP assessment, in the context of the ACP framework; and in the absence of an education support infrastructure which exists within medicine. The review has highlighted a key set of principles that should be applied to the competency progression and assessment of the wider workforce. These principles are applied once there is a clear and agreed view as to the minimum requirements of the role to be developed:

1. Healthcare professionals developing their competence, capability and scope of practice should do so within the framework of an agreed outcome-based curriculum that sets out the knowledge, skills, values and behaviours that are required. The curriculum should specify appraisal and assessment requirements.

2. Learners should have access to a portfolio that allows collection and presentation of evidence that demonstrates competency progression.

3. Learners should be supported by trained supervisors / Mentors / tutors with available time, resources and access to professional support where necessary.

4. There should be a widely recognised, valid and reliable assessment process to review progression against the curriculum that provides a consistent standard to protect patient safety and supports transferability of competences across employers (this will involve a range of methods and is not a linear process)

5. Once a defined level of competence has been achieved this should be recognised by a credentialing process and documented within a register recognised by learners, faculty, employers and the wider public.

For the wider workforce attention is also needed to clarify a mechanism to support the assessment of equivalence and revalidation requirements to ensure the ongoing maintenance of capability, this is outlined within the ACP Framework.

The Emergency Care work and more recently developing ACP pilots with surgery, primary care and eye health are beginning to explore this approach to the development and assessment of transferable capabilities and for staff of all professions undertaking the same activities to be assessed to the same standards in the same way.

The ACP framework articulates the capabilities required to work at the level of Advanced Practice and offers the generic component of the 'curriculum'. Clinical area specific capabilities are required, and in the pilots, this has been/is being crafted across service, the professional bodies and medical Royal Colleges, building upon existing curricula to good effect. Portfolios are being made available either through the specific colleges, academic programmes or the piloting of an HEE portfolio.

Further work is required in 18/19 to explore the work in detail and with ACP curricula in place, start to evaluate potential assessment processes, learner support, the concept of 'credentialing' or specific registers and seek to debate and clarify the issue of regulation. This will require close working with key stakeholders across clinical and academic sectors to build upon existing processes and infrastructure, and to understand the opportunities offered by closer collaboration within a system. This work will collaborate with service, existing higher education institution provision, the Council of Deans, Association of Advanced Practice Educators (APPE), the ACP apprenticeship as it develops, and closer working with post graduate medical education, to craft a sustainable and achievable process.

'After years working as a departmental sister in the Emergency Department I was ready for a new challenge. I love the environment and don't want to leave it but apart from management roles there seemed to be few opportunities for me. Training as an ACP changed all that and I love the work. To begin with, nobody knew who we were and what we were – but that has changed, people now understand our role and notice now if we are not there! I have recently completed my credential, this has demonstrated what I have achieved. I have completed my master's degree and I have developed specialist clinical skills in emergency medicine, which are very important. This is the first time ACPs have been able to demonstrate a consistent clinical standard which I think is important for patient safety and has given me recognition for what I do. In my Trust, you cannot train to be an Emergency Care ACP unless you are working towards a credential'.

The following recommendation is made with regard to: **Competency progression within the wider workforce**

Recommendation 16
HEE will work with stakeholders to further explore and pilot a structured, consistent and sustainable national clinical competency process in line with the five principles above to support Advanced Clinical Practice development across several specialties.

Section 7: Next Steps

In December 2017, Health Education England published 'Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027' for consultation which looked to ensure there was a system wide understanding of healthcare workforce requirements for the next decade. Many of the themes identified within this report, specifically in terms of exploring how greater support can be offered to SAS and trust grade doctors and Advanced Clinical Practitioners are already identified within the consultation document. Following consultation, the strategy will be published later this year, and this represents an opportunity to embed effective competency progression within the groups identified within this report.

Many of the recommendations within this report build upon work that is either already in progress such as the improved flexibility in training programmes for doctors in training and links closely to the Supported Return to Training (SuppoRTT) programme. The commitment to explore how Advanced Clinical Practitioners can be supported fits with work HEE is engaged with to establish a 'modern firm'. Others build upon guidance that is already in existence in the Gold Guide.

To realise the ambitions outlined in this report, HEE and system partners have agreed a series of actions.

1. Educational Supervision

This report has identified the vital role that effective Educational Supervision has in providing a high-quality learning experience for doctors in training. To ensure that supervisors are funded for an allocated sufficient time to fulfil their duties, and trained and supported appropriately, HEE will work with NACT to review the role and scope of the Educational Supervisor and the wider roles in education that support trainees. As a part of this review we will engage with supervisors, employing bodies and other relevant partner organisations including the General Medical Council (GMC).

We will also work with colleagues in the Academy of Medical Royal Colleges (AoMRC) to enhance the quality and consistency of Educational Supervisor reports which we know are an invaluable tool to ARCP panels that will improve the consistency of panel outcomes.

2. Consistency of ARCP panels

Throughout this report we have heard how there is a degree of inconsistency in how ARCP panels operate, with variation across both geographies and specialties. HEE will work with all specialties through the AoMRC and at local level through the Specialty Schools and Postgraduate deans to ensure a uniform, consistent approach across England. Health Education England will lead a programme of work throughout the 2018/19 year to ensure that there is greater consistency across panels by April 2019.

We will also work with colleges and the AoMRC to explore how assessment methodology needs to shift throughout training with a reflective appraisal approach for more senior doctors, and how this can link with the refresh of curricula aligned to the GMCs Generic Professional Capabilities[16].

3. Professional and personal support for trainees

We have been made aware throughout this review that through Professional Support Units and similar functions there are excellent facilities available to support all doctors in training, specifically those experiencing difficulties. Where trainees have difficulties we recognise that more can and should be done. HEE will work to ensure that trainees across England have equitable and timely access to professional and personal support services, and that all involved in the training and educating of trainees (including trainees themselves) are aware of these facilities and how to access them.

4. Standardisation of quality assurance and quality management processes

Throughout this review we have encountered some examples of good practice, where the ARCP function aids doctors in training with their development whilst safeguarding patient safety. We have also heard how HEE local teams and specialties have worked to reduce bureaucracy and ensure the process works as efficiently as possible. To ensure that this good practice is shared, HEE will work with the AoMRC and medical Royal Colleges to ensure all specialties support best practice by April 2019.

5. Defining and Communicating the ARCP process

We have heard that many involved in ARCP process, specifically trainers and trainees, that they are not clear on the purpose and functions contained within the ARCP process. This includes understanding the role of the specific medical Royal College and the GMC. To aid this understanding, HEE will develop and implement a communications strategy for ARCP within England by June 2018. We will also work with the General Medical Council (GMC) to develop a guide to revalidation which will help to clarify the responsibilities of doctors in training, and identify key individuals within the process, including where doctors step out of training programmes for a period of time. Furthermore, we will work with the devolved authorities to ensure that communications around ARCP are standardised across the UK.

6. Promoting flexibility in postgraduate training

Within this report we have committed to ensuring that the ARCP process supports increased flexibility in postgraduate medical education, and that the recommendations from this report are consistent with Enhancing Junior Doctors Working Lives and changes resulting from Shape of Training within HEE's Medical Education Reform Programme.

[16] https://www.gmc-uk.org/education/postgraduate/GPC.asp

To support the recommendation to adapt Out of Programme (OOP) arrangements to allow a 'step-on step-off' approach to training, HEE will explore:

- A mechanism for recording skills and experience in service and other posts prior to entry to training or during training
- How skills and experience gained prior to training or between training posts could be verified after entry to a training programme
- Pilots of the process in several specialties and geographies to better recognise prior skills and experience
- All trainees should have equitable principles applied to requests to train less than full time (LTFT).

HEE will also review evidence coming from the GP deferred start pilot to help inform whether deferred entry to training could be implemented in other areas. This element of work requires close collaboration and support from the GMC and will be delivered through a UK-wide programme of work.

7. Utilising the ARCP model for developing SAS Grade and Trust Grade Doctors

In this report we have discussed how HEE can better support SAS and Trust Grade Doctors with professional development. To progress this work, HEE will work with these doctors, employing bodies and other system partners to explore whether enhanced support through an ARCP style process could be a positive step to engage, develop and value this workforce.

8. Competency progression within the wider workforce

To help us realise the ambition to ensure that all healthcare learners are supported in their career development, HEE will work with stakeholders to further explore and pilot a structured, consistent and sustainable national clinical competency process in line with the five principles to support Advanced Clinical Practice development across several specialties.

Appendices

Appendix 1: Questions from the Call for Evidence

1. How confident can we be that the outcomes of current ARCP processes are a reliable indicator of competence? How could the process be developed to improve confidence?

2. What value do you see in trainees receiving a formal appraisal undertaken by the Educational Supervisors? What challenges are there with this?

3. How could the ARCP process be adapted improve alignment with revalidation processes for doctors in non-training grades to enable a smoother transition for doctors moving in and out of training programmes?

4. As a part of the review we are considering whether the balance between formative appraisal activity and summative assessment activity should shift, based upon the specific requirements of different stages of training. Do you feel that such an approach would be helpful? Do you think there is less requirement for a 'tick box' exercise later in training and more need for an emphasis on qualitative appraisal?

5. In considering the development of an ARCP type process for the wider workforce do you have examples of best practice we could review? (e.g. a portfolio or documentation which could support the process?)

6. What are the benefits and potential outcomes for individuals involved in the process?

7. What may be the wider system challenges in developing this approach for the wider workforce?

Appendix 2: The ARCP Process through the training year (including roles and responsibilities)

Continual process of compiling their e-portfolio of evidence including: Professional examinations, courses and educational activities linked to attainment of the curriculum, work-place based assessments, self-reflective learning logs, skills logs, QI projects/audits, publications and research

Trainees (T):

Start of training year	Mid-way through training year	1 month prior to ARCP date	At ARCP panel	Before the end of the training year
T & ES review curriculum requirements & plan activities to achieve successful ARCP outcome outcome	T & ES meet to review trainee's progress in collating e-portfolio & outstanding ARCP needs	T & ES meet, review trainee's e-portfolio, discuss outstanding ARCP needs and likely outcome	ARCP panel meet, review trainee's e-portfolio (inc. ES reports), and issue outcome using decision aids	T & ES meet to discuss trainee progress, ARCP outcome, & plan next year's education activities
Clarify ARCP requirements	*Induction meeting*	*Mid-point review*	*Panels receive standardised training*	*Panel provides ARCP result with feedback*
Induction meeting			*T submits revalidation paperwork – Form R*	*T completes any outstanding activities*
			ES completes & submits Trainer's report	*ES completes End of Placement report*

END OF TRAINING YEAR

Educational Supervisor (ES):

Supervision activity includes collation of evidence on trainee performance from the clinical supervisor and others informally involved with supervising the trainee; the ES should also provide regular formative appraisal and career guidance through the course of the training year, sign-posting educational needs for the future

- **Where a trainee's placement is < 1 year, an induction, mid-point and end of placement review should be conducted for each placement**

Blue = Trainee
Dark Blue = Educational Supervisor
Purple = Royal College
Grey = ARCP panel

Appendix 3: Key Definitions

Appraisal: For the purposes of this report, the term appraisal is used to describe the ongoing formative process that takes place between a doctor in training and their Educational Supervisor, Clinical Supervisor or other individuals. The process intends to offer feedback on progression and advice on future development to address the developmental needs of the doctor in training, including areas such as careers advice and setting out learning plans to meet identified learning needs

Assessment: The term assessment is used to describe an assessment of competence, either in terms of a single assessment within placement or in a wider sense when a doctor in training has competence assessed by an ARCP panel.

Feedback: Feedback is the provision of information about performance, to enable doctors to have greater insight into their performance, noting what they do well and highlighting areas where the doctor can improve their practice. Throughout the review we heard that feedback about performance in a placement (usually from an educational or clinical supervisor) and about presentation of evidence at the ARCP panel (in terms of presentation of evidence) was incredibly valuable in shaping development.

The 'Panel Event': The panel event is the ARCP panel that usually occurs annually for doctors in training and assesses their readiness to progress to the next stage of training, as well as their continued safety to practice. This is done by reviewing the evidence on competence acquisition and progression provided by the doctor in training. More information is included within Section 1 of this report.

Revalidation: Revalidation is the process overseen by the General Medical Council by which licensed doctors are required to demonstrate that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. All doctors with a licence to practise are normally subject to a revalidation recommendation every five years. For doctors in postgraduate training an additional recommendation is made the point that they achieve CCT.

Certificate of Completion of Training (CCT): A CCT confirms that a doctor has completed an approved training programme in the UK and is eligible for entry onto the GP Register or the Specialist Register.

Appendix 4: Infrastructure and Resources to Support Training

HEE invests £1.9 billion in postgraduate medical and dental education covering just under 50,000 commissioned posts, there is additional investment in our education support infrastructure (£104 million) and investment by providers in Trust Funded Training Posts.

It is not possible to fully identify our investment in the wider workforce as this will be part, but not all of our investment in training advanced clinical practitioners (total is £23.4 million) and workforce development investment (total is £83.5m).

These amounts are what HEE invests, and for postgraduate medical trainees in hospitals it is subject to an interim national tariff. However, it is recognised that the actual costs to deliver training may differ and there has been data collected by the DH from Trusts to estimate the cost to deliver training.

Both the tariff and the costs collected are split into two components, the trainee's salary for time being trained and placement support. Items that the placement support tariff is designed to cover includes:

- Direct teaching, including one to one tutorials
- Additional time taken if teaching is delivered whilst delivering patient care compared to if they had not been present
- Supervision and checking of trainee's work
- Costs of training required by staff to supervise or mentor trainees
- Libraries and education centres and clinical skills facilitties
- Proportion of overheads that indirectly relate to training activities

The following table compares the average estimated costs per trainee with the tariff.

	Medical Staff: Estimated avg costs			Interim National Tariff*		
	Salary	Placement	Total	Salary	Placement	Total
FY1	16,885	22,841	39,726	14,415	12,152	26,567
FY2	19,606	22,587	42,193	17,879	12,152	30,031
ST1	20,059	23,159	43,218	19,105	12,152	31,257
ST2	20,366	24,286	44,652	20,274	12,152	32,426
ST3	21,752	24,605	46,357	21,907	12,152	34,059
ST4	21,720	24,325	46,045	22,894	12,152	35,046
ST5	20,360	24,547	44,907	24,085	12,152	36,237
ST6	21,396	28,537	49,933	25,277	12,152	37,429
ST7	21,240	24,354	45,594	26,468	12,152	38,620
ST8	20,973	23,449	44,422	26,468	12,152	38,620

*London and Fringe areas have a higher salary contribution to reflect high cost area supplements

This implies that there is some cross subsidisation between payments for delivering services and educational activities. Whilst there are some data quality issues with estimating the cost to deliver training, not least how to split a trainee's time between educational activities and delivering services, it does provide some interesting insights. One key insight is that there is considerable variation between Trusts in the trainee's time recorded as related to training and for the placement costs.

Appendix 5: Diagram of ARCP process and list of outcomes

Educational Agreement (EA)	Educational Reviews (ER)	ES Report (ESR)	ES/ Trainee discussion	Trainee completes form R	ARCP panel	ARCP outcome form
Per training placement	Frequent	Summary against EA	Discussion of ES report	Annual return	Educational process against EA	Outcomes 1-7 (&8)
Specific/ individual aims and learning objectives	Formative. Part of continuous process of appraisal	Feeds ARCP	No surprises-transparent	For revalidation purposes	Sign off for revalidation	Includes expected (and possibly adjusted) CCT date
Can be modified through discussion	2 way: ES & Trainee	Summative	Done as another educational review	Enables renewal of registration	Sign off for programme progression	
Based on curriculum & stage of training	Professional conversation based on EA	Structured, based on portfolio	Not for trainee to influence content		Trainee meets panel after decision if outcome 2-5	
Agreed between ES & trainee	Enables problems to be picked up		Trainee can submit view to panel		At least annually	
Recorded	Recorded	Recorded	Recorded		Recorded	

There are eight different categories of outcome:

Outcome 1: Achieving progress and the development of competences at the expected rate
Outcome 2: Development of specific competences required – additional training time not required
Outcome 3: Inadequate progress by the trainee – additional training time required
Outcome 4: Released from training programme with or without specified competences
Outcome 5: Incomplete evidence presented – additional training time may be required
Outcome 6: Award of Certificate of Completion of Training (CCT)
Outcome 7: Fixed-term Specialty Trainee (FTSTAs) or LATs
Outcome 7.1: Satisfactory progress in or completion of the LAT / FTSTA placement
Outcome 7.2: Development of specific competences required – additional training time not required
Outcome 7.3: Inadequate progress by the trainee
Outcome 7.4: Incomplete evidence presented
Outcome 8: Out of programme (for those currently undertaking research or experience)

Appendix 6: Acknowledgements

ARCP Review Chairs and Leads:

Professor Sheona MacLeod	ARCP Review Chair
Sam Illingworth	ARCP Review Co-Chair
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Beverley Harden	Health Education England
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Stakeholder Engagement Events Attending Organisations

Academy Trainee Doctors' Group
British Medical Association
Chartered Society of Physiotherapists
Central Manchester University Hospitals
Guy's and St Thomas' NHS Foundation Trust
Health Education England
Health and Social Care Northern Ireland
Hospital Consultants and Specialists Association
Joint Royal Colleges of Physicians Training Board
Junior Doctors Committee
Lay Representatives
NHS Education for Scotland
NHS England
NHS Wales
National Institute for Health and Care Excellence
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynecologists
Royal College of Pathologists
Royal College of Pediatrics and Child Health
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Royal College of Surgeons
The Society and College of Radiographers

Organisational Submitted Written Evidence

British Medical Association
General Medical Council
Joint Royal Colleges of Physicians Training Board
Royal College of Anesthetists
Royal College of Surgeons of England

Organisational representatives for working groups

Academy of Medical Royal Colleges
Association of Surgeons in Training
British Medical Association
Chartered Society of Physiotherapists
College of Paramedics
COPSAS
Defence Medical Deanery
Derby Teaching Hospital
Health Education England
Frimley Health Foundation Trust
Foundation School, Severn Deanery
Lay representation
London South Bank University
Leeds Teaching Hospital
Membership of the Royal Colleges of Physicians of the United Kingdom
NHS Education for Scotland
NHS Improvement
NHS Employers
NHS England
National Institute for Health and Care Excellence
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Radiologists
Royal College of Surgeons
Sheffield Hallam University
Sussex MSK Partnership
Trainee Representatives
Trainer Representatives
University Hospitals of Leicester
University of Birmingham
University College London
University of Salford

The breadth of involvement in this review demonstrates the significant contribution from across the system who are working together to improve the education and support to our doctors in training, our doctors working in SAS or Trust posts and our wider clinical professionals. We have been overwhelmed by the enthusiasm, energy and commitment of all stakeholders who have supported the work of this review and want to express our thanks to all individuals and organisations who have engaged with us so collaboratively.

We look forward to harnessing your expertise further in implementing the recommendations in this report and the wider Medical Education Reform Programme.

Sam Illingworth (Associate Director of Education Quality & Reform) and Professor Sheona MacLeod (Deputy Medical Director for Medical Education Reform)

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