Education policy team  
General Medical Council  
Regent’s Place  
350 Euston Road  
London NW1 3JN  

3 November 2016  

Dear education policy team,

Standards for postgraduate curricula and regulated credentials

The British Medical Association is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. On average our membership this year has been around 170,000.

We welcome the opportunity to respond to the consultation on new standards for postgraduate curricula and regulated credentials. Our views are provided below, with references to specific standards and requirements where our views relate to them most directly.

Structure of the standards document

Q1. Do you agree that the four domains are a helpful way of organising the standards?

The new domains are a helpful way of structuring the standards. However, it is important to recognise that significant components cross between domains such as research, which is critical to informing each.

Q2. Do you agree that the structure of setting out the purpose, standards, and requirements under each domain is helpful?

We agree that introducing a statement of purpose for each domain improves upon the format of the previous standards.

Q3. Is the section at the beginning about patient safety, excellence, and fairness clear and helpful?

This section is a clear articulation of core principles. The challenge is in how these are translated into greater detail later in the standards document.

We suggest the aspiration of ‘excellence’ should also refer to the importance of equipping learners to advance medicine, mitigate relevant clinical risks, cascade knowledge and continue their ongoing
professional development beyond their curriculum. This could involve participating in opportunities to undertake research or teaching in appropriate areas of a curriculum.

We welcome the introduction of fairness as ‘a guiding principle’. We suggest this high level section should also state that data on impacts and outcomes ‘should be monitored, analysed and published’ to help ensure progression is fair and transparent. We agree there should be a mechanism for the GMC to allow an organisation to withhold publication where this would risk identifying individuals due to very small numbers, however the ‘where possible’ caveat in the draft wording is unnecessary and risks implying there may be circumstances when monitoring and analysis may not be conducted either.

**Q4. Is the section at the end describing responsibility and relationships clear and helpful?**

It is helpful to set out relevant responsibilities and relationships in the process of curriculum design.

**Content of the standards document**

**Domain 1: Purpose**

**Q5. Have we identified the right standards and requirements for curriculum development and design under this domain?**

We agree that the ultimate purpose of medical training should be to meet the long term needs of patients, populations and healthcare services (S1.1 and R1.2).

We have concerns about possible unintended consequences in relation to how ‘service needs’ may be defined in future. Employer perceptions of service need are likely to be influenced by recruitment and retention challenges, and considering curriculum standards from this perspective could lead to a creeping reduction of standards and training, and lead to a less research friendly environment. In areas of shortage, one interpretation of service need could allow for a partially but more rapidly trained doctor, which would have adverse impacts in the longer term.

This could be mitigated by providing a clear definition of what is meant by service need and providing for assessments of service need through a national structure with a specific remit that excludes consideration of local or short term workforce shortages.

In defining the purpose of a credential (R1.2), it must be a requirement that this does not overlap or compete with an existing specialty or sub-specialty training programme. There should be consensus on this (R2.3) among colleges or faculties who identify an interdependency with such a programme for which they are responsible – and if this is not immediately forthcoming, an organisation proposing a credential should work with them to achieve this. This relates to our response to question five.

**Domain 2: Governance and quality assurance**

**Q6. Have we identified the right standards and requirements for curriculum development and design under this domain?**

Governance processes (S2.1) should be informed by relevant research. We suggest the required process of ‘scoping out’ (R2.1) is more fully defined. There should also be a defined, transparent process for dealing with the possibility of competing credential proposals from different credible professional bodies.

In considering the interdependency of a credential (R2.2) it must be a requirement that it not overlap or compete with an existing specialty or sub-specialty training programme. There should be consensus on this (R2.3) among colleges or faculties who identify an interdependency with such a programme for which they are responsible – and if this is not immediately forthcoming, an organisation proposing a credential should work with them to achieve this. This relates to our response to question five.
We support the improved monitoring and evaluation requirements. Evaluating their differential impacts (R2.7) will be especially important in light of the higher level focus of curriculum components as noted in our response to question seven.

The mechanisms to keep curricula up to date (R2.8) could also include reference to how those who have passed through a curriculum could be kept up to date with later changes to it.

The BMA will be pleased to help facilitate the required input from learners (R2.10), especially those who share protected characteristics, as well as to provide professional and expert including academic input where relevant. We note the draft wording makes it possible for an organisation to meet this requirement superficially, without engaging with us or other established professional including trainee groups. We suggest the standards should specify in clause R2.10d that involvement should include relevant trainee groups, and in clause R2.10e that this should involve relevant professional bodies as well as those engaged in research in the relevant field. It is important to note that ‘service providers’ in clause R2.10a are not exclusively within the NHS. It may be helpful to give fuller consideration to the definition of ‘key groups’ (R2.1) in general.

Domain 3: Learning outcomes, approaches and experience

Q7. Have we identified the right standards and requirements for curriculum development and design under this domain?

We welcome a reduction of the burden upon trainees of granular, competency heavy curricula (S3.1). We believe this change towards outcomes has been a positive step in the Foundation Programme. We also support the emphasis this enables upon facilitating training of ‘excellence’ beyond binary competency levels (R3.5, and see also our response to question three). Our main concern is how this will be implemented in practice. An emphasis upon higher level, more broadly defined capabilities must not obscure a trainee’s ability to draw actionable learning points that they need to progress. Learners must still be able to expect useful feedback, tailored to their individual needs, to help them meet required outcomes. A curriculum should also describe how learners who are struggling will receive additional support (R3.7).

Implementation with respect to assessment must also avoid the risk that higher level, less well defined capabilities could invite greater subjectivity, undermining standardisation and fairness, including due to unconscious bias. The new monitoring requirements noted in our answer to question six will be important in ensuring this is identified and mitigated. These points on feedback and assessment also relate to our response to questions eight and 12.

Trainees already feel burdened by the levels of examination and other assessment. Curricula developed according to the new standards should not introduce more progression points than trainees have in practice at present (R3.4).

We welcome the opportunity presented by this new curriculum structure to improve the transferability of recognised learning between curricula, for example when a trainee changes specialty programme or a doctor returns to training in a new specialty. The current structure makes this burdensome or impossible, despite the existing framework for the accreditation of transferable competencies. To avoid this, we suggest the requirements should be explicit that a curriculum must recognise equivalent learning already recognised as part of a training programme based upon another curriculum.

Domain 4: The programme of assessment

Q8. Have we identified the right standards and requirements for curriculum development and design under this domain?
We support the principles in the standards, including the emphasis on standards of assessors and the importance of resourcing them (R4.12–14), however the detailed assessment guidance will be critical to their success in practice. This is an area of acute concern for our members and we would welcome involvement in the development of this guidance.

We welcome the emphasis on regular, constructive and meaningful feedback for trainees (R4.3), which is especially important in light of the higher level focus of curriculum components as noted in our response to question seven. Feedback regarding summative assessment must be helpful in guiding further learning (R4.11).

We believe that relevant metrics must be disclosed for all significant assessment, not only ‘high stakes’ assessment (R4.10). This is particularly the case if high stakes assessment excludes workplace based assessment, which can also place a significant burden upon trainees and the wider training system. Such assessments of poor quality should similarly be disclosed to encourage improvement or replacement. We suggest the GMC should retain and publish relevant assessment information including performance metrics that it receives from providers (R4.8), to ensure such data are easily accessible.

Q9. Do you think the standards and requirements under this domain are likely to help improve the quality of assessments?

They certainly have this potential, but how well they do so in practice will largely depend upon the further detailed implementation guidance (see our response to question eight).

Q10. Are the standards and requirements under this domain sufficiently flexible to enable organisations to carry out assessments in a way which is most appropriate to the needs of their area of practice?

See our response to question nine.

Q11. Do you think the standards and requirements will help embed the principles of fairness and equality in programmes of learning and programmes of assessment?

See our response to question nine.

Q12. Do you think the standards and requirements are likely to adversely affect any particular groups of doctors or other people who share protected characteristics?

As noted in our response to question seven, we have a concern that assessing higher level capabilities could invite greater subjectivity if capabilities are inadequately defined. We recognise the benefits of enabling assessors to make more holistic professional judgements. However, this could undermine standardisation and fairness, including due to unconscious bias in assessors. The new monitoring requirements noted in our response to question six, along with the standards and implementation guidance discussed in our response to question eight, will be important in mitigating these concerns.

The standards overall

Q13. How clear is the draft standards document?

We have no concerns about the clarity of the document, though we would suggest an amendment to the glossary. The preceding section setting out responsibilities and relationships references ‘credible professional bodies’; we suggest the definition of ‘Organisations designing and developing curricula or credentials’ similarly includes the term ‘professional’ in its current references to ‘credible organisations’ and ‘credible bodies’.

Q14. Is there anything missing from the draft standards document, or anything that should be removed?
Our main comments are covered in response to the questions above.

Q15. Do you have any other comments on the draft standards document?

Our main comments are covered in response to the questions above.

Transition and implementation

Q16. Will it be straightforward to develop new curricula or review current curricula based on these standards?

These new standards entail significant changes to the content and structure of curricula. The work involved in transitioning will be significant, and organisations involved will need to devote appropriate time and resources.

Q17. What would be a reasonable transition period for all curricula to meet the new standards and requirements?

We suggest this should be informed by the consultation responses from organisations currently responsible for curricula. The guiding principle should be to do this properly rather than quickly.

Q18. Do you think these standards will be suitable for the design and development of regulated credentials?

See our responses to questions five and six.

Quality assurance and quality management

Q19. We think that organisations that develop and design curricula should have a more formal role in our quality assurance of curricula and programmes of assessment at the local level. Do you agree?

We have no objection to this, provided that any potential conflicts of interest are appropriately managed.

Q20. What information and evidence should we consider?

We have no specific views.

Q21. We think curricula and credentials should be reviewed every 3-5 years to make sure they remain relevant. This could involve a process for ‘retiring’ elements of the curriculum, learning outcomes, or the curriculum itself, when no longer relevant. Do you agree?

We have no objection to regular review, provided this continues to involve relevant stakeholders as required for initial approval by the standards and does not introduce a disproportionate burden.

Q22. We think generic professional capabilities, in order to be responsive to workforce and service needs, should be reviewed every 3-5 years. Do you agree?

Again, we have no objection to regular review.

Support and structures

Q23. We know that there are some requirements that some organisations might struggle with. What kind of support, structures or bodies might be helpful to you in developing or revising curricula or credentials?

We would not anticipate developing or revising curricula or credentials ourselves.
Q24. We want to introduce a system that ensures that the service and patients have meaningful input into development of curricula, and workforce needs are consistently identified and addressed. Do you agree that this would be helpful?

See our response to question five.

Q25. How can we ensure four-country agreement for curricula or credentials?

We suggest building upon the existing four-nations mechanism and ensuring that a sufficient range of other stakeholders are involved in these discussions.

Q26. We will be providing explanatory guidance on applying these standards and on our curricula and credential approval processes. What particular areas would you like to see addressed?

Explanatory guidance will be valuable regarding a number of areas of the new standards. Our main concern is regarding the planned assessment guidance, as discussed in our response to question eight.

We hope you will find this response helpful. We would be happy for our comments to be identified and attributed to us in future reporting.

Yours sincerely,

Raj Jethwa
Director of policy
Policy directorate