General Medical Council

Regulating doctors
Ensuring good medical practice

Small Specialties Thematic Review

Quality Assurance Report for occupational medicine

2011/12

Contents

Executive Summary

1. The review of occupational medicine looked at medical education and training within the speciality and how the stakeholders work together to assure the quality of the training. These stakeholders include the Faculty of Occupational Medicine (FOM) and the Regional Specialty Advisors (RSAs) which provide a link between the FOM and the deaneries. We also met with representatives from two deaneries (the West Midlands and the West of Scotland) as well as the lead dean for the specialty, and a cross section of trainees and newly qualified consultants from a range of deaneries. More detailed information on the activities that the team took part in during this review can be found in annex B of this report.

2. All those that we spoke to during the course of this review acknowledged the challenges of quality managing a small specialty like occupational medicine, which has a low number of trainees, a number of whom may train in isolation and across a range of different sectors – NHS, industry and defence. We found a number of examples within the deaneries of efforts to adapt their established and embedded quality management (QM) processes to provide more relevant and meaningful quality data on the specialty.

3. Those we spoke to also acknowledge the challenges that the specialty faces in terms of recruitment and demand for qualified consultants, and the impact that changes within the field of occupational heath has had on the specialty. We found that although there had been attempts by the stakeholders to work together, this could be developed further for the mutual benefit of all stakeholders.

4. At the deaneries we found that the Training Programme Director was pivotal in supporting QM processes. We also found that RSAs appointed by the faculty held a similarly important role (and the two roles sometimes overlapped) and that these roles could be developed and clearer guidance provided.

5. We spoke to a cross section of trainees, the majority of whom had a very positive view of their training. However, we repeatedly heard that the dissertation assessment component was a challenge and that the level of support for the dissertation varied.

6. This review is part of a pilot investigating the quality of training in small specialities. It differs from other GMC quality assurance reviews as the focus is on a single specialty rather than on a deanery or medical school. This report cannot be read as a review of QM processes at either the deaneries or the Faculty visited – rather those that we visited are to be treated as exemplars and findings related to these deaneries may be of interest to other deaneries, colleges and faculties.

Key Findings

7. Requirements are made where change must be achieved in order for the stakeholder(s) to meet the standards. Recommendations are made where standards are being met, but improvements could be made to develop the quality of provision. Good practice is innovative practice that can be shared.

Requirements

8. No areas of non-compliance with GMC standards were identified.

Recommendations

Paragraph number			Standards Reference
Para. 62	01.	Postgraduate deaneries and the FOM should continue to work together to promote the specialty, especially to medical students and doctors in training to ensure that competitive recruitment and selection enhances the quality of trainees. They should also seek to engage and collaborate with other bodies with an interest in the specialty (eg the Society of Occupational Medicine).	Standards for deaneries standard 5
Para. 81	02.	Postgraduate deaneries and the FOM should improve the flow of quality data (e.g. demographic information on trainees) to ensure accuracy of trainee information.	TD 2.2
Para. 88	03.	Postgraduate deaneries should ensure that there are processes in place to quality manage all occupational medicine specialty training posts, particularly in industry, where there may be less reliable quality data available.	TD 2.2
Para. 93	04.	The deaneries and the FOM should consider national recruitment as an opportunity to ensure consistency and enhance the quality of the intake.	TD 4.2
Para. 105	05.	Postgraduate deaneries should formalise the externality and lay input in the ARCP process, and information from the ARCPs should be shared with the FOM, including outcomes and feedback from trainees.	SD 3.2, 4.2 and 4.6

Para. 107	06.	The FOM and the Postgraduate deaneries should ensure that all educational supervisors receive guidance on their role in supporting trainees, especially with regard to the dissertation. The FOM should also consider developing a process to monitor and provide additional support for trainees who are experiencing difficulties with their dissertation.	TD 6.35
Para. 116	07.	Postgraduate deaneries should continue their efforts to provide trainees with the opportunity to give feedback in confidence, acknowledging the challenges of doing so in a small specialty.	TD 6.7
Para. 121	08.	Postgraduate deaneries should ensure that those trainers with educational responsibilities are recruited, trained and appraised appropriately. Postgraduate deaneries and the FOM should ensure that where consultants have multiple roles that there are clear responsibilities assigned to those roles and that support is provided to those individuals. The FOM should also ensure that all Regional Specialty Advisors are aware of their roles and responsibilities, as set out in the role description, and put in place a process for the monitoring and appraisal of those in post.	TD 6.36

Good Practice

Paragraph number			Standards Reference
Para. 63	01.	In the West Midlands three F2 training posts have been created to provide foundation doctors with exposure to the specialty. This was initiated in August 2011 and has been extended again this year.	

Were any Patient Safety concerns identified during the visit?	
Yes ☐ *(include paragraph reference/s)*	No ☒
Were any significant educational concerns identified?	
Yes ☐ *(include paragraph reference/s)*	No ☒

Has further regulatory action been requested via the responses to concerns element of the QIF?	
Yes ☐	No ☒

Background to the review

9. The quality assurance of small specialties – that is, specialties with fewer than 250 trainees across the UK - has traditionally been a challenge. This is largely due to difficulties in identifying issues and good practice in the GMC evidence base, a result of the low headcount and wide geographical spread of trainees within each specialty which means that the specialty is not visible in the National Training Survey or deanery reports to the GMC.

10. The aim of this project is to develop a process that will support the quality assurance of small specialties, and to identify effective methods to assess training in these specialties. For this purpose we have carried out three separate quality reviews of the following specialties: occupational medicine, psychotherapy, and paediatric cardiology.

11. The aim of each quality review is to assess the quality of training within the specialty to ensure that it meets the standards set out by the GMC in *The Trainee Doctor* and the *Standards for Curricula and Assessment Systems*. Each review has focused on the provision of postgraduate education within the specialty and considered the policies, processes and systems in place to support this provision.

12. Each review has resulted in a report, which contains good practice, requirements and recommendations. These reviews have involved the following stakeholders: the college/faculty responsible for the curriculum and assessment system of the specialty; one or more postgraduate deaneries; and one or more local education providers.

13. There will also be an evaluation of the processes adopted for each review and a proposal for an over arching process that can be adopted for any future review of a small or sub-specialty.

The Report

Part One: Occupational Medicine

Background to the specialty

14. Occupational medicine is the branch of clinical medicine most active in the field of occupational health. It primarily concerns the effect of work on health, and health on work. However issues of health promotion and treatment (e.g. first aid, vaccinations) are also involved.

15. The GMC 2012 national training survey (NTS) identified 79 occupational medicine trainees across the UK in thirteen different deaneries. These trainees work at 44 sites across the UK, although only three of these sites have sufficient numbers of trainees to report NTS findings without fear of compromising the anonymity of respondents.

Deanery	Number of trainees
London Deanery	17
Defence Postgraduate Medical Deanery	16
NHS Education for Scotland (West Region)	12
North Western Deanery	7
Northern Deanery	4
Severn Deanery	4
Yorkshire and the Humber Postgraduate Deanery	4
NHS West Midlands Workforce Deanery	3
Oxford Deanery	3
East Midlands Healthcare Workforce Deanery	2
Wales Deanery	2
Northern Ireland Medical & Dental Training Agency	1
Wessex Deanery	1

Table 1. Number of occ med trainees in postgraduate deaneries

16. According to information from the NTS and the Annual Review of Competence Progression (2011) just over half of trainees are female (53%). The largest ethnic group is white (42%), and the largest BME group is Asian/Asian British. 68% of trainees qualified in the UK while 29% received their qualification from the rest of the world. One trainee declared a disability, and 13% of trainees said they were working less than full time – 90% of whom are female.

17. There are approved occupational medicine training posts within the NHS, industry and defence sectors. Unlike the majority of specialties almost half of current trainees are in posts outside of the NHS (NHS: 51%, Industry: 28% and 21% in defence). Posts in NHS and industry are directly managed by the host deanery, defence posts are managed by the Defence Postgraduate Medical Deanery, which was last reviewed by the GMC in 2011.

18. Occupational Medicine operates in the field of occupational health. Occupational health is a multi-disciplinary field involving health and non-health professionals, including: occupational health nurses; occupational hygienists; health and safety and human resource managers; ergonomists; and other scientists or technicians. This means that the delivery of occupational health is not restricted to doctors. Although to a large extent doctors and other professionals complement each other, there may be an element of competition as the former are generally more costly than the latter.

19. This multi-disciplinary aspect also has an impact on the organisations that oversee it. Membership of the Society of Occupational Medicine (the SOM) is open to doctors and, since 2012 other associated healthcare professionals working in occupational health (though not necessarily with a qualification in occupational medicine). The Faculty of Occupational Medicine is responsible for postgraduate specialist training as well as offering qualifications for non-specialist doctors, and membership is restricted to qualified doctors only.

Entry into the specialty

20. Competitive entry into occupational medicine normally takes place at ST3. Applicants must demonstrate that they have achieved the Foundation competencies as set out in the Foundation curriculum.

21. Applicants must also demonstrate other competencies, as listed in the FOM's curriculum. Specifically there must be evidence of achievement of the end competencies of any one of the following:

- Core Medical Training (CMT) or
- Psychiatry in general or
- Phase 1 of the Faculty of Public health training curriculum or
- General practice training to the ST3 level.

22. Training from ST3 onwards is specific to occupational medicine, and training to the Certification of Completion of Training (CCT) requires the completion of both core and higher approved training in a GMC approved training post, normally over a period of four years.

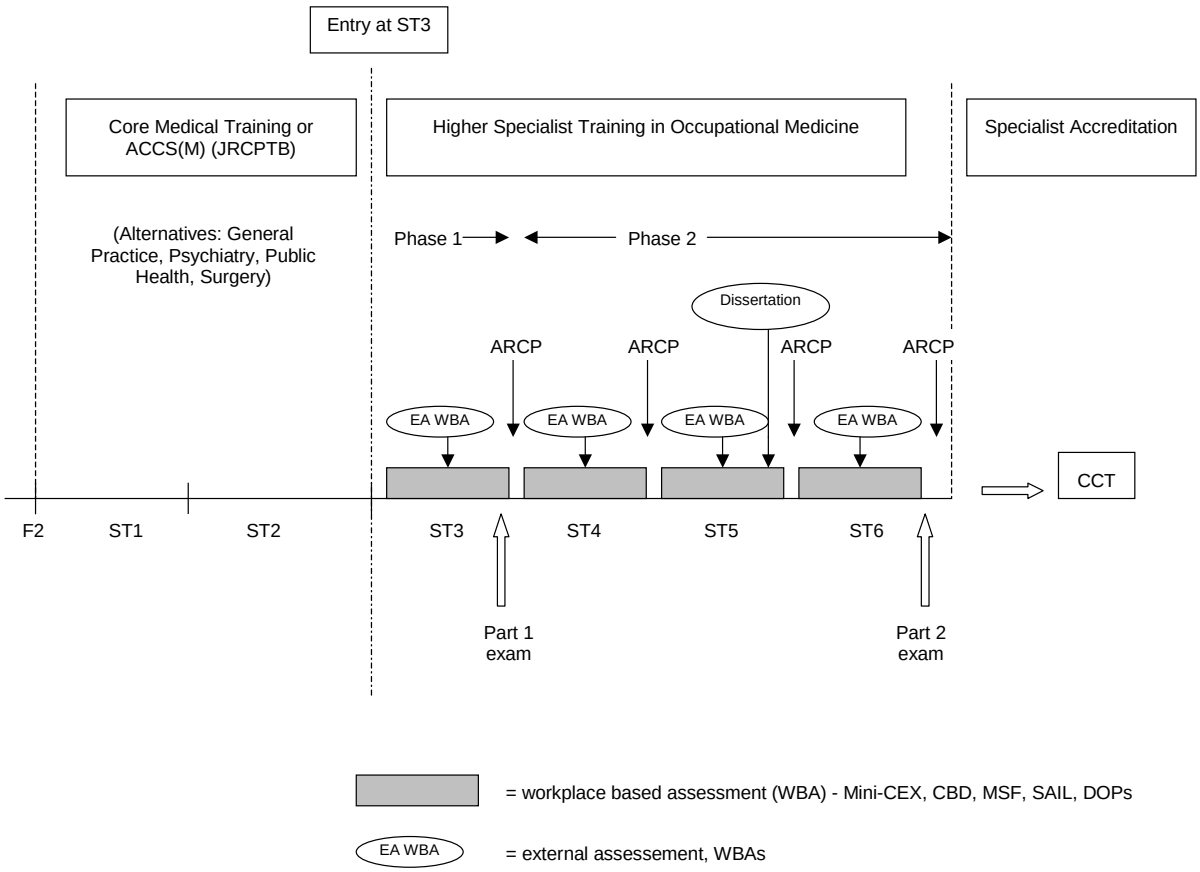

Table 2. Entry and progression through the specialty.

Curriculum and Assessment

23. The specialist training curriculum for occupational medicine, approved by the GMC in August 2010, is a 'spiral curriculum' in that it contains a set of core competencies which trainees revisit in each year of training as they progress towards CCT. In addition, trainees are encouraged to pursue aspects of training relevant to their intended careers and which take them beyond the core competencies. In this respect the training content of the curriculum will adhere to the principles of 'core plus'.

24. To be awarded a CCT, all specialist trainees have to pass examinations in the first (ST3) and final years of specialist training, pass a dissertation and be assessed as meeting the required standard at each ARCP review; they must meet all of the curricular competencies.

Workplace-Based Assessments

25. The assessment of trainees in occupational medicine has historically given emphasis to written examinations. Under the 2010 curriculum these written examinations have been supplemented with Workplace-Based Assessments (WPBAs) – on the job assessments of day-to-day performance. The following assessments are used across the specialty:

- The mini-cex (Clinical Evaluation Exercise)
- Multi-source feedback
- Case-based discussion (CBD)
- Sheffield assessment instrument for letters (SAIL (OH))
- Directly observed procedures (DOPS)

26. The WPBAs are formative assessments, conducted on several occasions during training to assess the trainees' developing abilities and to help inform the Annual Review of Competence Progression (ARCP) carried out by the deaneries.

27. In addition there are a number of external assessors appointed and trained by the FOM whose role is to supplement the deanery appointed assessors in relation to WPBAs and enable the FOM to make comparisons across sites. The FOM has also carried out extensive evaluation of WPBAs, the findings of which will be used by their WPBA Committee, and these findings indicate that good standards in WPBAs have been achieved by trainees, as assessed by both educational supervisors and Faculty appointed external assessors.

E-portfolio

28. The FOM currently does not use an e-portfolio although there are on-going discussions with NHS Education for Scotland over the development of a version specific to the speciality. It is hoped that this version will be ready for use in mid 2013.

Membership of the Faculty of Occupational Medicine Examinations

29. Specialty training in occupational medicine requires trainees to pass two exams. Part 1 MFOM is taken in the first year, ST3, and is a multiple choice question paper. Part 2 MFOM, which is a multiple choice question paper, a modified essay paper and an observed structured practical examination, is taken after successful ARCP at ST4.

30. Prior to 2011 the submission of a dissertation was a pre-requisite for entry to the Part 2 exam, but the FOM regulation has now been relaxed, although the acceptance of a dissertation is still a requirement for a CCT.

Membership of the Faculty of Occupational Medicine Dissertation

31. Types of projects submitted as dissertation are varied and can include epidemiological field studies, analyses of existing databases, systematic reviews and qualitative interviews. Trainees can also submit a university thesis or a body of published work, as well as substantial audits.

32. Support for the dissertation is through the trainee's educational supervisor. Some educational supervisors may have a research background, whereas others will be aware of research techniques through their evidence-based research practices. Trainees are also encouraged to seek additional support elsewhere should it be required, for example through the completion of a Masters of Science (MSc).

33. Trainees should submit a protocol to the FOM's Chief Examiner, who then appoints two assessors to review the protocol and provide advice and feedback to the trainee. The FOM recommends that the trainee submit this protocol within the first 18 months of training. Trainees who complete the dissertation as part of an MSc programme are not required to submit a protocol.

34. The final dissertation must be submitted and approved prior to the trainee being awarded a CCT: the FOM again appoints two assessors to review the final dissertation and provide feedback for the dissertation to be approved. Approval of the dissertation is, alongside success in Parts 1 and 2 of the MFOM examination, a requirement for the trainee being awarded a CCT in the specialty.

Faculty of Occupational Medicine

35. The Faculty of Occupational Medicine is a faculty of the Royal College of Physicians of London and was set up in 1978 to provide a professional and academic body empowered to develop and maintain high standards of training, competence and professional integrity in occupational medicine.

36. The role of the FOM in relation to specialist training is to:

- promote the curriculum
- deliver the centrally administered components of the approved assessment system (examinations)
- promote WPBAs as suitable tools of local assessment
- appoint external assessors of WPBAs
- offer advice on whether applications to approve or re-approve training posts or programmes meet the standard.

37. The FOM Board is advised on speciality training by the Specialist Advisory sub-Committee (SAC). Membership of the SAC is drawn mainly from the FOM but also includes the lead dean for occupational medicine, a representative from the Regional Specialty Advisers (RSAs) and a trainee representative. Meetings are held twice yearly.

38. RSAs are appointed and trained by the FOM, and are accredited specialists. RSAs act as a link between deaneries and the FOM, and meet twice yearly where they receive training and feedback. RSAs can perform a variety of local faculty

functions – for example some may act as Training Programme Directors, others as Educational Supervisors, and often as both. Support for RSAs includes regular e-mail correspondence and at the twice yearly meetings, and there is a clear support structure in place between the FOM and the RSAs.

FOM support for trainees

39. There is a trainee representative on the FOM Board, the SAC and in attendance at the RSA meetings. There is also a dedicated FOM Training Co-ordinator and FOM Dissertation Co-ordinator who can provide support to trainees throughout their training.

40. The FOM provides information for trainees and trainers through its website and handbook. The website was reviewed and relaunched in early 2012, and the handbook, which is available in both hard copy and online, was reviewed in 2008 and is updated as and when required by changes in the FOM regulations.

41. The FOM also provides training days on WPBAs and the dissertation, as well as *ad hoc* emails and a newsletter. There is also a trainee forum.

Deaneries

42. There are occupational medicine trainees across fourteen deaneries within the UK (see *Table 1.* Number of occ med trainees in postgraduate deaneries). As part of this review the visit team met with representatives of both the West Midlands deanery, which has a low number of trainees, and the West of Scotland deanery, which has a relatively high number of trainees, to explore in greater detail the quality processes at work. Both deaneries are used as exemplars and we recommend that all deaneries consider the relevance of our findings.

West Midlands Workforce Deanery

43. According to the NTS 2012, the West Midlands Workforce Deanery has three occupational medicine trainees in post with an additional two posts that are due to be filled shortly (May 2012). Three of the posts are within NHS and two are in industry. All three trainees hold a PMQ from outside the UK and Europe, and all work full-time.

44. The Postgraduate Medical Dean for the West Midlands is also the Lead Dean for occupational medicine, and is a member of the FOM SAC (paragraph 37).

45. Occupational medicine sits within the Postgraduate School of Medicine (PGSoM), which offers 26 specialty training programmes – all of which come under the Joint Royal College of Physicians' Training Board (JRCPTB) except for this specialty. Each specialty has a Specialty Training Committee (STC) and the chair of each committee is a member of the PGSoM Board.

46. The RSA for the deanery is a medical inspector for the Health and Safety Executive, and the deputy RSA is also the Training Programme Director.

47. The Deanery was last reviewed by the GMC in the 2011/2012 cycle of regional visits; the report is available on the GMC website. Occupational medicine was not one of the specialties reviewed as part of the visit, though the wider QM processes were.

48. Further information on the West Midlands Quality Framework can be found at: http://www.westmidlandsdeanery.nhs.uk/QualityFramework.aspx.

West of Scotland Deanery

49. The West of Scotland Deanery manages the Scottish national occupational medicine training programme on behalf of the NHS Education for Scotland (NES) postgraduate deaneries. According to the 2012 GMC NTS, the West of Scotland Deanery has 12 trainees, again in a mix of NHS and industry posts across the four deaneries. The majority of trainees are female (seven), and of the four trainees who work less than full-time all are female.

50. Occupational medicine has its own STC within the Deanery – this committee then feeds into the deanery Medical Quality Management group, which then feeds into NES Central.

51. The Training Programme Director for the deanery sits on the STC, and also acts as a trainer.

52. There is also a Specialty Training Board (STB) that covers occupational medicine, general practice and public health. This is one of eight STBs which feed separately into NES Central. It is important to note that STBs have a slightly different function to that of the PGSoM in the West Midlands Deanery and that the focus is on workforce and educational planning, although quality management is an agenda item and of interest.

53. The Deanery was last reviewed by the GMC in 2010 - the report is available on the GMC website. Occupational medicine was not one of the specialties reviewed as part of the visit, though the wider QM processes were.

54. Further information on the approach of NES to quality management can be found at: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/medicine/about-medical-training/quality-management/nes-quality-management.aspx.

National Recruitment

55. Occupational medicine is facing challenges both in terms of demand for consultants across both NHS and industry posts, and the supply of trainees.

Demand for consultants

56. Occupational medicine consultants are employed across a number of sectors including the NHS, industry and defence. The FOM estimates that there are 800 specialists (equivalent to consultant grade within the NHS) working in the UK, of which approximately 80 work in the NHS, which demonstrates the fact that the specialty belongs to all sectors of employment and that the NHS is a small a part of this. There is often movement between NHS and non-NHS organisations and many NHS occupational health services provide a service to non-NHS organisations.

57. The NHS Workforce Review Team findings in 2008 concluded that at least 173 full-time equivalent (FTE) occupational medicine consultants would be needed within the NHS. The 2011 NHS Information Centre Census reports that there were 83.4 FTE consultants employed within the NHS as of September 2010, although this number is forecast to rise slightly over the next decade.

58. The substantial majority of consultants are employed within industry and the FOM reports a significant undersupply of occupational medicine consultants within this sector relative to its public health needs assessment. This is the result of a number of factors including the downturn in the general economy and financial pressures on employers, which have led to the outsourcing of occupational health by employers and the tendency of outsourced providers not to train. This has had an impact on the NHS where NHS consultants migrate into industry posts. The multi-disciplinary nature of occupational medicine has also meant that private sector employers tend to prefer less costly alternatives wherever possible, e.g occupational health nurse advisors.

Supply of trainees

59. The fall in demand for consultants is coupled with a reduction in the number of trainees: according to the FOM, recruitment rates for 2000-2009 averaged 27 new trainees per year. This rate currently stands at 14 -15 per year. Of particular concern is the fall in the number of industry trainees, which declined by 34% from 2009 - 2011.

60. There is a geographical disparity in the supply of trainees. According to the Department of Health Monitoring of Recruitment, the specialty had a fill rate of 54% across England (as of October 2010) although this varied geographically with the East of England, Northern, Peninsula, West Midlands and Wessex deaneries failing to fill any of their posts while in contrast London, Severn, and Yorkshire and Humber deaneries had filled all their posts.

61. The FOM states that possible reasons for the number of vacant posts include lack of funding, and not being able to find appointees of a suitable standard. The FOM has also provided evidence that some posts are left ‘fallow’ (although the training position is viable and there are funds) due to a desire for trusts to reduce costs.

Part Two: Summary of Findings

Findings by Key theme

National recruitment was identified by both the FOM and the deaneries visited as a challenge, both in terms of recruitment into the specialty and then into consultant posts following CCT (see para 55).

Recruitment into the specialty

62. Both of the deaneries visited reported that occupational medicine training posts were under subscribed, and that the lack of competition at recruitment had had an impact on the quality of trainees that were accepted into the specialty. The West Midlands deanery provided a recent example of seven applicants for one post, none of whom were appointable. Reasons for the low number of applicants were reported to be uncertainty over the career pathway and the NHS training grade salary, both factors which might deter prospective candidates from considering the specialty.

63. Both deaneries were able to provide examples of efforts they had made to promote the specialty to prospective trainees: in the West Midlands three F2 training posts have been created to provide foundation doctors with exposure to the specialty. This was initiated in August 2011,has been extended again this year. This initiative supports one of the recommendations of *the Collins report* that foundation students complete a rotation in a community placement. In the West of Scotland Deanery, occupational medicine sits on the same Specialty Training Board as public health and general practice, and this has helped collaboration and the development of cross-specialty training, for example collaboration in the setting up of a post-GP training occupational health fellowship year, and the review of the GP curriculum to include some new competencies in occupational health for GP training.

64. The FOM has also taken a number of steps to promote the specialty to medical students, for example the provision of teaching materials and teaching leads, fellowships and careers fairs. The FOM however recognises that this is a long-term project and that improving recruitment rates is not the only solution, and that there needs to be posts for those who have completed their specialist training.

Recruitment of trainees into consultant posts post CCT

65. The Chief Executive of the FOM provided examples of their active involvement in influencing the Government agenda to raise the profile and reputation of the specialty, and strengthening the demand for occupational medicine consultants. Examples include the setting up of Safe Effective Quality Occupational Health Services (SEQOHS), a voluntary accreditation system operated by the Royal College of Physicians on behalf of the FOM, which applies to core clinical occupational health services (ie those that involve doctors, nurses and occupational health technicians). Further examples of work to raise the profile of the specialty includes a training package on health, work and well-being originally developed by the FOM and funded

by the Department of Work and Pensions. This has been embedded within e-GP, the Royal College of General Practitioners (RCGP) internet-based learning tool.

66. We welcome these initiatives and encourage the continued collaboration, particularly between the FOM, the RCGP and the Society of Occupational Medicine to improve the profile of the specialty.

The Trainee Doctor

Domain 1: Patient safety

67. This domain is concerned with the essential safeguards on any action by trainees that affect the safety and wellbeing of patients. Patient safety (with the worker as patient in many instances) is central to occupational medicine. We noted that all stakeholders we spoke to during this review viewed patient safety as being less of a risk than for other specialties, for a number of reasons.

68. Firstly, invasive procedures, shifts and on-call rotas are rare or non-existent in occupational medicine. Trainees tend not to exceed the Working Time Regulations (WTR): this is reinforced by findings from the GMC 2012 National Trainee Survey which supports the view that work intensity is not a major issue in this specialty. We found some exceptions to this, most notably in industrial training posts where some trainees did report a high level of work intensity.

69. Feedback from some trainees suggested that although their working hours do not exceed WTR, it was sometimes difficult to secure protected time for teaching within their normal working hours. This is more of an educational concern than of patient safety.

70. Secondly, many consultants do not handle clinical cases that merit handover or work in teams large enough for handovers to occur. We found no issues with handovers and the continuity of care, mainly due to the out patient nature of the specialty.

71. In addition, the patients for whom occupational physicians have responsibility are workers, and therefore, on average, relatively healthy in comparisons with the patients seen by most NHS medical services.

72. We found robust processes for identifying, reporting and managing patient safety concerns at both deaneries that we visited.

73. We found from those that we spoke to that trainees work within competence and with the adequate day to day supervision of a named supervisor, although this supervision was not always face to face. We received overwhelming feedback from a cross section of trainees and newly qualified consultants that there is usually a close working relationship between the trainee and their supervisor, and that supervisors are accessible either by telephone or email if not on-site. We recognise this as a

strength of the specialty. This meant that advice and guidance could be accessed if and when required by the trainee.

74. We found evidence of systems for identifying, supporting and managing trainees whose progress or performance, health or conduct gave rise to concern at both of the deaneries visited. Both deaneries had professional support units in place, and both trainers and trainees spoke positively about the support offered. In Scotland, a national advisory group provides standards and consistency for doctors in difficulty across all the Scottish Deaneries. The West Midlands deanery has also carried out considerable work on implementing its doctors in difficulty process to ensure that it is applied consistently across all specialties (this was a requirement in the 2011-12 GMC visit report). We found that both trainers and trainees that we spoke to at the deanery were aware of and had confidence in the process.

75. We acknowledge the difficulty in ensuring that deanery-wide processes were relevant to and followed in all posts. For example trainees in industry may be remote and removed from the deanery, their processes and systems may not be easily accessible and databases that are used to share information, such as Intrepid, may not be available to those outside of the NHS. The different nature of the employment relationship between the deanery and those trainees in industry posts can also place a limit on what the deanery can do in practice. We would therefore encourage deaneries to ensure that their processes are as relevant and visible to those training outside of NHS as those within, as we received feedback from a number of trainers and RSAs that existing processes were focused on the NHS and were less relevant to posts outside.

Domain 2: Quality management, review and evaluation

76. We spoke to a number of stakeholders to explore this domain, all of whom acknowledged the challenges when quality managing a small specialty. We noted the efforts made by the deaneries to include small specialties in their quality systems and processes and where necessary made changes so that they are more effective.

FOM

77. The primary responsibility for the quality management of training lies with the deaneries and the FOM considers that its main functions are to quality control the curriculum and to advise on standards, alongside reviewing applications for CCTs and making recommendations to the GMC. The FOM provides accredited specialists (RSAs) who act regionally within deaneries and are appointed and trained by the FOM (see para. 38).

78. We spoke to RSAs from a range of deaneries and observed differences in their substantive roles – some of whom acted as educational supervisors, others as training programme directors, and some as both. Not all of the RSAs that we met with were aware of the job description, or of any formal monitoring of their performance within the role, although we were assured by the FOM that each RSA did receive a job description upon appointment. We also learnt that additional

training and feedback was provided to RSAs at the twice yearly national meetings. The team also noted that the RSAs served for a three year period, which could be extended to six on the recommendation of the Specialty Advisory Committee (SAC – see para 37) but it is not clear what criteria would be used to make this decision and how this linked to the monitoring of their performance as a RSA.

79. We noted that trainees and RSAs each have one representative on the SAC, and that in order for these representatives to fully represent the views of all the deaneries and the variety of posts and trainees within each deanery, there must be support for the representative roles in the form of guidance and feedback. We were not able to explore this support and how these roles worked as part of this review but acknowledge the key function that these roles fulfil.

80. We also noted the role that the lead dean played within the specialty, and how joint working with the FOM would benefit the specialty. For this purpose we would suggest that both the lead dean and the FOM review the lead dean role as laid out by the Conference of Postgraduate Medical Deans (COPMeD), to look at how this joint working can be developed further for mutual benefit, for example in workforce planning.

81. As part of their role in making recommendations about CCT application to the GMC, the FOM hold the ARCP data on all trainees. The FOM reported that not all information on new trainees is passed on by the deaneries in a timely manner. We also heard some examples of the FOM first becoming aware of a trainee only when they receive the trainee's ARCP results. There are also discrepancies in the number of trainees in post, with the figures from the FOM and GMC varying from that of the deaneries. The FOM has written to all deaneries in the past six months in order to carry out a data clean-up exercise.

82. It is the responsibility of the deaneries to ensure that trainers are supported in their role and have access to training for their role, although the optional training days provided by the FOM on subjects such as the dissertation for those acting as supervisors or assessors are valuable and important in ensuring consistency. We found that neither the FOM nor the deaneries that we visited had up to date lists of those with training responsibilities. While it is also part of the RSAs job description to advise the FOM on the appointment of educational supervisors, we found no evidence that this was being done other than through information received through the registration of new trainees. However, there is no formal requirement for the FOM to hold up to date lists of trainers although it might be beneficial for them to do so, especially as they offer a lot of support to trainers.

Deaneries

83. We found that both the West Midlands and West of Scotland deaneries had established quality management systems in place. Information on the deaneries quality systems can be found earlier in this report (see para 48 and 54).

84. In the West Midlands deanery each Specialty Training Committee (STC) holds the responsibility for the routine quality management of their specialty, with the support of the Deanery's quality team. The quality team carries out scheduled reviews of each specialty programme over a five-year period. The review of occupational medicine is due to start this year, and will form a multi specialty review along with sport and exercise medicine. Each review has external involvement, usually a SAC member. The deanery confirmed that at the time of our visit there were no current concerns with the specialty.

85. The quality management of occupational medicine within the West of Scotland deanery is different to that of other specialties within the deanery as the deanery manages the national programme on behalf of the other deaneries in Scotland. This means that NTS data cannot be relied upon as a trigger for action as the trainees are spread over a number of deaneries and LEPs across Scotland. The Deanery does not have a programme of scheduled visits to each specialty programme. Instead there is a focus on triggered and targeted visits to areas where there is a concern or a priority.

86. Both deaneries acknowledged the difficulties in gathering meaningful quality data on a specialty with so few trainees, and we found that there was a reliance on feedback for this purpose, both formal and informal, e.g. NES post-assessment questionnaires and ARCP feedback. Trainees may though be less likely to be critical due to their responses being clearly identifiable, though we acknowledge the clear challenges in finding a perfect solution to this challenge.

87. The West of Scotland Deanery highlighted the use of the post-assessment questionnaire for gathering meaningful data on the programme, and that feedback from this questionnaire is anonymised in the same way that NTS data is. This questionnaire is also applied across the whole Scottish programme which gives it a wider trainee base than a deanery wide version.

88. We found that although each new training post is approved by the Training Programme Director as part of the GMC approvals process, there was no evidence of any routine or random checks of existing training posts in either of the deaneries that we visited outside of their risk-based approach to quality management. None of the trainers that we spoke to were aware of their posts being checked. While we acknowledge the resources required to quality manage a specialty where each training post is unique, we would suggest that as there are usually a few posts in each deanery, formal visits to quality check each post might help to compensate for the lack of reliable qualitative or quantitive data from other sources.

89. The West Midlands deanery acknowledged difficulties in ensuring that sufficient training time is allowed in job plans, and that there is a clear tension between commercial and educational pressures within industry posts which can affect supervision. The deanery is keen to retain these posts as they offer trainees a wide variety of training experiences.

Domain 3: Equality, diversity and opportunity

90. We found evidence that there was access to less than full time (LTFT) posts within the specialty if the trainee met the deanery criteria.

91. We interviewed a cross section of trainees from a range of deaneries who provided evidence to support this finding, and the majority said the process was very smooth and reported little problem in making the change from full time to LTFT whether due to family commitments or ill health. This view was supported by the RSAs we spoke to.

92. Both deaneries have an Associate Dean with responsibility for LTFT. There is a national process in Scotland and contact with the dean who holds responsibility for doctors in difficulty if appropriate. At the time of the visit, three of the 14 trainees were in LTFT in West of Scotland deanery, although this figure had risen by the time this report was written (see para. 16).

Domain 4: Recruitment, selection and appointment

93. There are clear challenges to recruitment into the specialty, and the specialty may benefit from a national approach to recruitment to help address the varying experiences of deaneries when recruiting (see para. 60). We understand that there have been efforts to review this in the past, but given the continued challenges in the area of recruitment we feel there might be benefit in further consideration of a national approach to recruitment.

Domain 5: Delivery of approved curriculum, including assessment

94. This domain is concerned with ensuring that the requirements of the curricula set by the medical Royal Colleges and faculties are being met at the local level and that each post enables the trainee to attain the skills, knowledge and behaviours as envisaged in the approved curriculum.

95. The occupational medicine curriculum and assessment has undergone a series of changes since 2007 – these are detailed earlier in this report (see para 23).

96. The FOM states that it is the deaneries' function to ensure that the approved curriculum is being followed in approved posts, and that it is the role of RSAs to regularly visit posts to ensure quality (when requested to do so by the deanery). Although we found no evidence that these visits happen we feel that they should be considered as part of the quality management process (see para. 88).

97. In the West Midlands deanery, the monitoring of the curriculum is the responsibility of the Specialty Training Committee, and ARCP feedback and trainee surveys would highlight any issues with the delivery of the curriculum. Trainees maintain spreadsheets of their learning and this is checked at ARCP. The Deanery is looking at harmonising ARCP processes across small specialties, and all panellists have had to complete the London deanery online training.

98. Trainees must be able to access and be free to attend regular, relevant, timetabled, organised educational sessions and training days. Trainees we spoke to reported that while they were able to meet their curriculum requirements, they were not always able to attend organised educational sessions and training days. This was often due to a range of factors.

Breadth of experience across posts

99. Occupational medicine is different to most other specialties in that trainees may spend their training programme in one post, particularly in industry. We received feedback on the lack of rotations from a variety of stakeholders, including deanery representatives, trainers and trainees, and we noted that the opportunity for rotations varied from one post to another and from one deanery to another. For example, feedback from trainees within NHS posts in the West of Scotland deanery suggests that rotations across Scotland were easy to arrange. This compares favourably to feedback from the trainees in industry we spoke to at the FOM Winter Conference, which suggests that this was not always the case.

100. Feedback from trainees however supported the view that the challenges with rotations were not a barrier to gaining a broad range of experiences, both in terms of clients and workplaces. Trainees in NHS posts (particularly those in income generating posts) were able to demonstrate a variety of workplaces and client groups, particularly where occupational health services are sold to local industry. The majority of training posts within industry are bespoke and, unless the post is within an organisation that provides this function to other workplaces, opportunities for rotations are limited. Some trainees commented that this lack of exposure to the NHS was not a concern, as they had no desire to work in the NHS, although they did consider that such exposure might benefit their training. The trainees that we spoke to within the defence sector were able to demonstrate their exposure to a variety of workplaces and clients.

101. We also found that the responsibility for arranging off-site visits lay with the trainee or the RSA rather than the deaneries.

102. The specialty benefits from trainees entering the specialty later in their medical career and in many cases having extensive medical experience – many of the trainees that we spoke to moved into the specialty from general practice or from overseas. Whilst the experience of trainees is strength of the specialty, as trainees they still require training, support and assessment.

WPBAs

103. Information on the workplace based assessments (WPBAs) is provided earlier in this report (see para. 25) and we received a great deal of feedback from trainees, particularly on the Directly Observed Procedures (DOPS) which were considered to be not as relevant to the specialty by some of the trainees that we spoke to. The FOM confirmed that work to strengthen DOPs is ongoing. By contrast, the case-based discussion assessments were considered as being relevant and were valued.

104. A number of trainees reported difficulties in getting their paperwork signed off by the assessor after completing WPBAs, although the majority of trainees received timely verbal feedback and most reported that written feedback followed. This was supported by our discussions with trainers.

ARCP

105. The Gold Guide states that both a lay member and external trainer from within the specialty, but outside of that training programme or school, should review 10% of ARCPs. We observed that although this usually did happen, the lack of formal processes did not guarantee that this would always happen. We were also not able to check that information from the deaneries was shared with the FOM to track trainee progression.

106. We found that the both the FOM and the RSAs endorsed the view that ARCPs should be held face-to-face with all trainees and not just those who were borderline. We were unsure how widely this happened in practice (it did not in at least one of the deaneries that we visited).

Dissertation

107. There was significant feedback on the dissertation from all of stakeholders we met. The completion of a dissertation is a requirement for membership of the FOM (see para 30) and we were keen to consider the dissertation and the variable support that trainees received as this was identified as a key area of concern for the trainees we spoke to.

108. We spoke to trainees who had either completed their dissertation as part of an MSc or whose education supervisor had a background or an awareness of research, and they voiced no concerns over the dissertation. We also spoke to trainees who did not have access to the same support, and some of whom (but not all) found the dissertation a challenge. We were concerned about the lack of access to educational resources and support for industry trainees from their educational supervisor, for example the Local Research and Ethics committee is open to non-NHS trainees but there is a fee for usage. Information from the FOM also showed that 2009-2011 a higher proportion of industrial trainees submitted an MSc, compared to 17.6% for NHS trainees and 10.0% of military trainees, which does suggest that industry trainees favour the MSc option and this could be for a number of reasons.

109. We also noted that those trainees undertaking an MSc were not required to submit a protocol to the FOM and that this could lead to trainees only discovering an issue with their dissertation when the final version is submitted. However, the FOM confirmed that there had only been one example of an MSc dissertation being rejected as unsuitable in the past four years, and that the submission of a protocol would not have prevented this rejection.

110. We explored the different levels of support available to trainees at the FOM assessors' meeting. The assessors stated that the MSc is one route into the dissertation but not the only route, and that the majority of educational supervisors would be competent to support this element of the training. This reinforced the view of the RSAs. The assessors also stated it was the trainees' responsibility to seek additional support if they felt their education supervisor was unable to provide the level of support required, and that any gap would be picked up in the trainee's ARCP.

111. Both of the deaneries that we spoke to were able to provide details of additional support available to those trainees who might need it, for example the Interactive Skills unit in the West Midlands deanery, and in West of Scotland deanery trainees are encouraged to access support from Aberdeen University.

112. The FOM provides training to their appointed assessors, a number of whom also act as educational supervisors. We also found that although the FOM handbook provides extensive guidance on both the dissertation and the role of the educational supervisor in supporting this (FOM speciality training handbook section 3), this could be further strengthened by amending the responsibilities of the educational supervisor to include this (section 2).

Domain 6: Support and development of trainees, trainers and local faculty

Trainees

113. Throughout the review we observed that trainees were supported in their learning through adequate departmental induction, variety of workload, and learning opportunities. This was supported by evidence from the 2012 NTS. The same survey suggests that trainees view the clinical and educational supervision that they receive less favourably when compared to other specialties (see para. 68).

114. In the West Midlands deanery all trainees must complete an 18 module online induction, supplemented by induction at their local education provider (LEP). The West of Scotland deanery similarly provided induction, and then a tailored departmental induction for the trainee, arranged by their educational supervisor.

115. We found that although many trainees worked in isolation from other occupational medicine trainees, there is formal and informal support from other trainees. For example the national training days were one example which was valued by trainees not only for educational reasons. We found that there were informal opportunities within each deanery, although these varied greatly and were usually organised by either the trainees or the RSAs. Those trainees in defence posts that we spoke to also felt there was an opportunity to formalise peer support across the Defence Postgraduate deanery, which in effect acts as a national deanery.

116. We found that both deaneries had robust and established procedures for trainees in difficulty, although there are challenges associated with this process due to the close knit nature of the specialty. The West Midlands deanery was auditing

their trainers to ensure awareness of their process (see para 74). We found that the trainees we spoke to knew of the processes and who to contact should they need support, and all trainees regardless of the sector their post was based in had access to this support.

Trainers

117. Deaneries are responsible for the approval and training of trainers, and we found evidence of formal training in both of the deaneries that we visited. Both deaneries reported difficulties in maintaining up to date lists of trainers and the training they had received. Similarly, the FOM does not have a central record of trainers, although it does provide training to assessors of both the dissertation and the WPBAs.

118. Both deaneries utilised the supervisor training available on the London Deanery website, supplemented by their own provision. In West of Scotland trainer training is provided by Supporting Clinicians on Training in Scotland (SCOTS) courses, which were set up as a joint Royal Colleges and NHS Scotland initiative to promote the quality of training. These have developed into courses that focus on particular roles, eg educational and clinical supervisors, TPDs, and aspects of each role. All trainers have access to these courses, they are supported by additional e-learning resources, and they have been promoted across LEPs in Scotland. Attendance on an educational supervision course will be mandatory from 2013.

119. All the trainers we spoke to had received training for their role as educational supervisors, and were aware of their responsibilities which are in their job plan and are defined in the FOM handbook. Responsibility for their appraisal as trainers lay with their trust or employer and we found no evidence of the deanery feeding into this process.

120. We found some concern from the RSAs that we spoke to on the matter of training in industry posts, as training for educational supervisors could be perceived as an additional cost which might be off-putting to prospective employers.

121. We also found inconsistency in the selection, training and guidance provided to the Training Programme Director role and would remind deaneries of their responsibility to provide this. We found this role to be critical in the flow of quality data and so it is important that those in that role are supported to carry out their responsibilities. This was of particular concern when one individual may act as educational supervisor, RSA and TPD and there may be conflicting and competing demands.

Annex A: The GMC's role in medical education

122. The GMC is responsible for setting and maintained standards and outcomes for medical education and training in the UK. The Quality Improvement Framework (QIF) sets out how the GMC will carry out this duty in 2011-2012, and how we will work with other organisations working in this area such as colleges/faculties and postgraduate deaneries.

123. The GMC's Quality Assurance (QA) activity will be targeted towards areas of risk identified through the GMC's evidence base. This will include, but is not restricted to, information gathered through National Training Surveys, Annual Specialty Reports (ASRs), Annual Deanery Reports (ADRs) and Annual Review of Competence Progression data (ARCP). Additional evidence could also be gathered from visits to deaneries and responses to concerns.

124. In order to ensure a coordinated approach, the GMC will identify common risks across all stages of medical education and training, and ensure that risks are explored across both the small specialty review process and the regional visits process.

125. You can find out more about the GMC's responsibility and quality assurance activity here: http://www.gmc-uk.org/education/postgraduate/information_for_trainee_doctors.asp

Annex B: Visit overview

Visit Team Leader	Abdol Tavabie
Visit Team members	Frank Gallagher Christine Barrett Nicholas France
Education Quality Analyst	Robin Benstead

Date	Activity	Comment
13 December 2011	Visit to Faculty of Occupational Medicine	Exploratory meeting with lead Faculty staff, followed up by attendance at Regional Speciality Advisors (RSA) meeting.
14 December 2011	Visit to FOM Winter Conference	Meeting with ten occupational medicine trainees who were in attendance at the conference. This gave the team an opportunity to speak to a cross section of trainees on their experiences.
14 & 16 February 2012	Individual telephone interviews with 12 trainees, newly qualified consultants and those who had withdrawn from training.	Opportunity to meet and interview trainees from all of the deaneries – this was attended by approximately 25 trainees. Areas for exploration included trainee support.
12 March 2012	Attendance at FOM Assessors Workshop	To explore the MFOM dissertation with assessors.
22 May 2012	Visit to West Midlands Deanery	To explore at a local level some of the issues established in previous visits; to explore how the specialty is quality managed at deanery level; to meet with Lead Dean for the specialty.
23 May 2012	Meeting with NES (West) Deanery – video conference.	To explore at a local level some of the issues established in previous visits; to explore how the specialty is quality managed at deanery level.

Annex C: Action Plan

Requirements

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		No requirements were identified during this review.				

Recommendations

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
01.		Postgraduate deaneries and the FOM should continue to work together to promote the specialty, especially to medical students and doctors in training to ensure	As mentioned in paragraph 64 of the GMC's report, the Faculty is already taking steps to promote the specialty to medical students – e.g. (i) provision of teaching materials and lead teachers to every medical school; (ii) training fellowships for undergraduates; (iii)	The Faculty will work with other major stakeholders (Lead Dean, English Deans, Welsh Dean, COPMED, the Head of the London School, a London LETB and other parties – e.g. HEE, to further the development of a new single national body	Substantial progress with this plan is expected in 2013-14, following authorisation of London South LETB in April 2013. National	**COPMED:** Lead Dean, Liz Hughes **Faculty:** Professor Keith Palmer and Dr Ian Aston Working with… **London**

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		that competitive recruitment and selection enhances the quality of trainees. They should also seek to engage and collaborate with other bodies with an interest in the specialty (eg the Society of Occupational Medicine).	careers fairs; (iv) online materials for undergraduates; (v) occasional articles in student BMJ. We also seek to recruit from general practice, and raise visibility in the specialty through (vi) articles on occupational medicine in GP trade magazines; (vii) promotion of the Diploma of Occupational Medicine; (viii) promotional activities at GP conferences; (ix) preparing online teaching materials with RCGP (embedded in e-GP). (x) We have also developed an online learning package in occupational medicine for secondary care. However, boosting recruitment is a long-term project and far more is needed. In anticipation of this:	with centralised control of training contracts, to assume overall national responsibility for specialty training. The proposed model will comprise a new national school of occupational medicine and lead LETB covering, in the first wave, all NHS and industrial specialty trainees in England and Wales.* There is near full consensus among the English Deans and from the Welsh Dean for this plan. (We hope to incorporate StRs from Scotland and Northern Ireland and trainees from the Armed Services over the longer term, subject to agreement.)	recruitment to be in place for 2013-14 intake.	**School:** Professor John Harrison The Faculty and London School will share in the co-ordination of meetings. Lead Dean: to work with Defence Postgraduate Medical Deanery

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			xi) In 2012, the Lead Dean discussed a new structural model (described in the next column) with COPMED in an open business session and in one-to-one meetings with many of the English Deans, as well as at a meeting of English Deans; also, with the Director of NES, the Postgraduate Dean from Northern Ireland, the Defence Dean, and the Head of the London School and Postgraduate Dean for the London Deanery. xii) In 2012, approval to work towards the model in the next column was granted by the Board of the Faculty and embedded in its objectives for 2013-14. xiii) In Jan 2013 the Academic Dean and Lead Dean instituted discussions with the Director of NHS Employers and the Director	A working group has been established by the Head of the London School, Professor John Harrison, to bid to establish a national school of occupational medicine; the Faculty is represented on this group by Professor Palmer and there has been extensive liaison with the Lead Dean. Dr Diana Hamilton from the nascent London South LETB has offered, in principle, to consider acting as lead LETB host to a new London-based national school (although other configurations may be possible). Recommendation 1, that the Faculty and deaneries work together to promote		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			of National Programmes Medical Education, Health Education England about national recruitment. HEE has pledged a staff representative to work with the Faculty and Lead Dean on national recruitment and raising the specialty's profile. xiv) In 2012-13 there have extensive exchanges between the Faculty and the Head of the London School regarding a new structural model. See our proposed future actions.	the specialty and to maximise recruitment, will best be accomplished by a national school and single LETB assuming overall responsibility for recruitment and producing a visible national focus for recruitment. It will be relatively straight forward within this plan for the Faculty and a new school to integrate functions – e.g. the Faculty's Director of Training and Chair of the Faculty's Specialist Advisory Committee could be a board member of the new school and the new Head of School a member of the Faculty's SAC. A new national school would need to consider		

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				how to best align recruitment process and cycles across NHS, industry and military * Exact details may vary as the concept is developed, as models of commissioning of medical education are in a degree of flux at present.		
02.		Postgraduate deaneries and the FOM should improve the flow of quality data (e.g. demographic information on trainees) to ensure accuracy of trainee information.	A reasonable flow of data already occurs – e.g. registration of new trainees, annual ARCP outcomes. The Faculty agrees that the problems referred to in paragraph 81 of the GMC's report are real however. Our impression is that they are patchy (some deaneries are exemplary) and likely to relate to timeliness of information flow more than completeness. Nonetheless, the GMC and Faculty	1) In the short-term the Faculty will raise again, with COPMED, through the Lead Dean, the current problems in the flow of quality data. 2) The Faculty will work with other major stakeholders (Lead Dean, English Deans, COPMED, the head of the London School, a London LETB and other players – e.g. HEE, to	1) At the next available Faculty SAC meeting in June 2013. 2) Substantial progress with this plan is expected in 2013-14, following authorisation of London South LETB in April 2013.	**COPMED:** Lead Dean, Liz Hughes **Faculty:** Professor Keith Palmer and Dr Ian Aston Working with… **London School:** Professor John Harrison

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			databases of trainees did not tally when interrogated. At intervals the Faculty writes to all deaneries to carry out data clean-up exercises; and the issue has been raised with successive Lead Deans. In this way, discrepancies have been kept to a minimum, but not eliminated. However, we think this situation can be improved upon.	further the development of a new national school of occupational medicine and national lead LETB. See our response above for further details. Recommendation 2 will best be met through the proposed consolidation at deanery level and close partnership working with the Faculty and its SAC – see the plans in relation to recommendation 1.		
03.		Postgraduate deaneries should ensure that there are processes in place to quality manage all occupational medicine specialty training	Existing actions in the West Midlands Workforce Deanery and the West of Scotland Deanery are commented upon in the report - see paragraphs 83-85, 87, 88, 92, 97, 111, 113, 114, 116-119, 73 and 74. These may be	1) The Lead Dean will raise the issues of quality management raised by the report with COPMED. 2) The Faculty and Lead Dean believe that quality management	1) The next available meeting of COPMED in 2013. 2) As above in relation to recommendation	1) Lead Dean 2) As above in relation to recommendation 1.

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		posts, particularly in industry, where there may be less reliable quality data available.	exemplars, but similar arrangements are likely to exist across other deaneries. (A few relative weaknesses were also suggested – paragraphs 88, 105, 121.)	processes will be easier to develop, implement, and police within new single national body with centralised control of training contracts, which assumes overall national responsibility for specialty training. (Additionally, if posts in industry are funded by a lead LETB, rather than by the industrial employer, tighter contracts can be negotiated.) Hence, we propose implementing the plan described above under recommendation 1.	1.	
04. *and* 05.		1) The deaneries and the FOM should consider national recruitment as an opportunity to	1) Arrangements for recruitment have varied, from local, to national, and back to local again. National recruitment is perceived to have certain	See above in relation to recommendation 1. 1) A new national school and lead LETB would ensure a more	1) See above. The issue will also be discussed at the next available SAC meeting in	1) **Faculty:** Professor Keith Palmer and Dr Ian Aston *Also*

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		ensure consistency and enhance the quality of the intake (04). 2) Postgraduate deaneries should formalise the externality and lay input in the ARCP process (04), and 3) information from the ARCPs should be shared with the FOM, including outcomes and feedback from trainees (05).	*disadvantages* by potential LEPs, especially those from industry, and by applicants. Doctors tend to enter training later than in other specialties and feel less mobile, owing to family ties; employers in industry prefer to recruit as the need arises, rather than to an inflexible national timetable forced on them by NHS time scales. However, explicit recruitment templates already exist and are promulgated by the Faculty's SAC to ensure a consistency of approach and consistency of standard in recruitment. 2) The report noted that this usually did happen within the deaneries sampled, but that "the lack of formal processes did not	consistent approach to recruitment. Consideration will be given within the plan to a system of national recruitment based around centrally negotiated training contracts, and ideally involving funded industrial training experience within improved rotational programmes. 2) The Lead Dean will raise the matter at COPMED and remind deaneries of this responsibility and ask them to raise formal processes and report back on them. 3) The Lead Dean will raise the matter at COPMED and remind deaneries of this	June 2013 (although a final decision on it may be held over until a clearer picture emerges regarding a national school). 2) The next available meeting of COPMED in 2013. 3) The next available meeting of COPMED in 2013.	**COPMED:** Lead Dean, Liz Hughes. *Working with...* **London School:** Professor John Harrison 2) Lead Dean 3) Lead Dean

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			guarantee that this would always happen" (paragraph 105). 3) (i) See Recommendation 2 above. A reasonable flow of such data already occurs. In evidence, the FOM provided the GMC visit team with an audit of the outcome of ARCPs among StRs nationally for 2011, overall, by sector of training, by stage of training, and by ethnicity. It is possible (although the Faculty has no evidence on this) that some ARCP outcome data are transmitted with delay or are incomplete. (ii) Feedback from trainees is possible via the representative of trainees, who is a member of the Faculty's Board and via the trainees' forum (paragraphs 39-41 of the report) and via	responsibility. 3) The new national school, lead LETB and Faculty SAC will plan a list of quality management data that need to be shared, including ARCP outcomes and trainee feedback.		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			the National Trainees Survey, although trainees' feedback is not relayed by deaneries.			
06.		1) The FOM and the Postgraduate deaneries should ensure that all educational supervisors receive guidance on their role in supporting trainees, especially with regard to the dissertation. 2) The FOM should also consider developing a process to monitor and provide additional support for trainees who are experiencing	1) (i) The FOM stresses that educational supervisors already receive extensive guidance from the Faculty on their role in supporting trainees, generally and especially with regard to the dissertation – see Appendix 2 of our response (to suggest otherwise is to be misleading). (ii) Also, in 2012, while the GMC's review was progressing, the Chief Examiner for this unit of assessment instituted a regular series of training newsletter briefings to all stakeholders on different aspects of dissertation preparation – this support will continue. (iii) The deaneries sampled provide training to their	Notwithstanding these comments: 1) The FOM will amend Section 2 of the Training Handbook, as suggested in paragraph 113 of the GMC report to repeat and reinforce existing advice to supervisors. 2) (i) The Faculty and Lead Dean will explore with COPMED, mechanisms for monitoring trainees in difficulty with their dissertation. (ii) Please also see above. An important further improvement, going forwards, will be to maximise opportunities	1) By May 2013. 2) (i) Will be discussed at the next available COPMED and SAC meetings in 2013. 2 (ii) See above.	1) Academic Dean, FOM 2 (i) Lead Dean, supported by Academic Dean, FOM and Chief Examiner Research Methods, FOM. 2(ii) As above in relation to recommendation 1.

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		difficulties with their dissertation	educational supervisors (report paragraphs 118 and 119). 2) (i) The Faculty already monitors statistics relating to problems with the dissertation (and made some available to the review team). (ii) The Chief Examiner for this unit of assessment already offers all trainees an open invitation to discuss their dissertation problems (although this advice will be repeated via the training newsletter). (iii) It is highlight that the responsibility and funding for this lie with local educational providers, deaneries, and their agents and that arrangement for periodic review is integral to approved programmes (e.g. educational planning meetings between trainees	for formal academic supervision. The advent of a new national school would underpin better support, more uniformity of provision. 3) A goal for a new national school, assuming funding can be identified, would be the prospect that all trainees will in future take a university MSc. Consideration of this will be undertaken at an early stage, assuming that a new school is established; economies of scale may make this goal obtainable. It is accepted that 'Recognition and Approval of Trainers' (GMC) will require that all trainers have		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			and supervisors; ARCP panel reviews of training progression). As such, mechanisms for monitoring difficulties should already exist among those with whom the responsibility rests.	evidence to support their status as a trainer by 2016 at the latest, whatever the structure that contracts with them.		
07.		Postgraduate deaneries should continue their efforts to provide trainees with the opportunity to give feedback in confidence, acknowledging the challenges of doing so in a small specialty.	Existing actions in the West Midlands Workforce Deanery and the West of Scotland Deanery were sampled and commented upon in the report in paragraphs 116 and 74. Expected standards are currently met.	The report leaves unclear what further improvements are needed, as the sampled arrangements were commended. However: 1) The Lead Dean will draw to COPMED's attention the exemplar arrangements in the sampled deaneries and confirm what happens in other deaneries. 2) The Faculty and Lead Dean feel that the challenge of maintaining	1) The next available meeting of COPMED in 2013. 2) See above under recommendation 1	1) Lead Dean 2)) See above under recommendation 1

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
				confidentiality, which is ever present in a very small specialty, would be more easily underpinned if contracts were let on a national basis, drawing on national resources to explore particular local problems. Part of the action is therefore to work towards a national school and lead LETB, as set out in recommendation 1 above. 3) The Faculty to explore providing an email address for trainees to provide feedback on their training.		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
08.		1) Postgraduate deaneries should ensure that those trainers with educational responsibilities are recruited, trained and appraised appropriately. 2) Postgraduate deaneries and the FOM should ensure that where consultants have multiple roles that there are clear responsibilities assigned to those roles and that support is provided to those individuals. 3) The FOM should also	1) Existing actions in the West Midlands Workforce Deanery and the West of Scotland Deanery were sampled and commented upon in the report in paragraphs 117-119. Expected standards are currently met. 2) Because the specialty is so very small, many players wear several "hats", which is potentially confusing but inevitable. **RSAs** are the Faculty's appointed agents; as such their roles are defined by the Faculty. They are appointed by the Faculty's SAC. They apply in open competition. Certain minimal criteria are required and a job description is supplied when posts are advertised (Appendix 3 of the FOM response). There is significant support: they are	1) The Lead Dean will draw to COPMED's attention the exemplar arrangements in the sampled deaneries and confirm what happens in other deaneries. 2) (i) The Lead Dean will draw to COPMED's attention the concern expressed and investigate how roles and responsibilities are defined, clarified and allocated. (ii) The FOM will undertake a review whether clearer advice can be given to RSAs and in the Training Handbook. (iii) More fundamentally, the Faculty and Lead Dean will seek to reduce the number of overlapping roles by developing plans for a unified national school and	1) The next available meeting of COPMED in 2013 2) (i) The next available meeting of COPMED in 2013; (ii) By December 2013; (iii) see above under recommendation 1 3) By December 2013	1) Lead Dean 2) (i) Lead Dean; (ii) Director of Training FOM; (iii) see above 3) FOM Director of Training

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
		ensure that all Regional Specialty Advisors are aware of their roles and responsibilities, as set out in the role description, and put in place a process for the monitoring and appraisal of those in post.	briefed regularly by the Faculty in e-mail correspondence and at twice yearly face-to-face meetings; the Faculty office maintains contact as issues arise; there is correspondence between RSAs and their professional lead in the Faculty, the Director of Training, over matters of concern to either party and when an RSA seeks advice. By contrast, **TPDs, chairs of local STCs, college members serving on ARCP panels**, **and educational and clinical supervisors** are agents of the deaneries whose roles are defined by deaneries; the Faculty's specialty Training Handbook defines the qualifications and experience expected of educational and clinical	lead LETB with rationalisation of functions (see above) including the appointment and training of trainers. 3) The FOM will design and introduce a system of three-yearly performance appraisal for its RSAs. RSAs were notified of the need in December 2012. 4) Consideration to be given to how to support trainers in industry – a new national school would need to consider how to support trainers from industry and military as well as NHS.		

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			supervisors, as a guide to stakeholders. As appointments other than of RSAs are made by deaneries, their specifications may in theory vary by deanery, as for other disciplines. The FOM assumes that clear job descriptions and support mechanisms exist, although the report found some inconsistency in relation to support for TPDs (para 121). 3) Please see above. (i) RSAs already have job descriptions and (ii) there are many existing support mechanisms for them (this is acknowledged in para 40 of the report). Hitherto the FOM has not considered it necessary to appraise and reappoint RSAs (its agents) as they have a maximum term of office; performance			

Report Ref	Due Date	Description	Action taken to date	Further action planned	Timeline for action (month/ year)	Lead
			standards have appeared high with no apparent problems; and, lacking economies of scale, the FOM actively seeks to minimise additional administration so that limited manpower can be targeted at training priorities.			

Good practice

Report Ref	Due Date	Description	Details of dissemination	Any further developments planned to enhance the area of good practice	Timeline for action (month/ year)	Lead
Para 9		In the West Midlands three F2 training posts have been created to provide foundation doctors with exposure to the		1) To be discussed at COPMeD. 2) This is an initiative that the new national school should consider emulating, to be discussed by the forward working group.		1) Lead Dean 2) Academic Dean, FOM

Report Ref	Due Date	Description	Details of dissemination	Any further developments planned to enhance the area of good practice	Timeline for action (month / year)	Lead
		specialty. This was initiated in August 2011 and has been extended again this year.				

Response by the Faculty of Occupational Medicine to the Small Specialties Thematic Review: Quality Assurance Report on Occupational Medicine

1. The Faculty welcomes this review into quality assurance of specialist training in occupational medicine. At a time of increasing demand nationally for high quality occupational health services, such a report is timely and valuable. How best to develop the future consultant workforce and how best to provide specialty trainees with high quality training are matters of considerable priority to the Faculty, and – we suggest – to government.

2. It is reassuring to note that the review finds no concerns relating to patient safety, no significant shortfalls in educational supervision or provision, and no areas of non-compliance with GMC training standards. It is encouraging that a number of activities were considered to represent 'potential good practice', despite the difficulties the review team had in confirming all of these by triangulation (an acknowledged difficulty and initial motivation for the review). The Faculty is pleased particularly to note that many trainees were enthusiastic about their training experience.

3. Substantial differences exist in the arrangements and resources for training for occupational medicine, a discipline often practised outwith the NHS, relative to counterparts in large, exclusively NHS-based specialties. Inevitably, therefore, the Faculty has identified several points of nuance and misunderstanding within the report which bear comment. Major and contextualising issues are taken up in the body of our response; Appendix 1 also addresses a few misunderstandings at the margin.

4. We focus, however, on the main challenges as we see them facing specialty training in occupational medicine; and the actions the Faculty favours and will seek to promote in relation to the review's recommendations.

Recruitment

5. The review notes a sustained and significant shortfall in recruitment to training over the past few years (paragraph 59, GMC report). It also recommends further work by the Faculty and other players to promote the specialty (recommendation 1) and suggests consideration of national rather than local recruitment (recommendation 4).

6. Several factors have contributed to this shortfall in recruitment, including the downturn in the general economy and financial pressures on employers within and outside the NHS; the outsourcing of occupational health by industrial employers and the tendency of outsourced providers not to train; and the growing stringency of training requirements, which have proved especially off-putting to industrial organisations that see training as a non-core optional activity. Formerly, training posts in industry were among the best in the speciality, both in quality and in breadth of experience but such posts in England largely go unsubsidised by deaneries, in contrast to those in the NHS.

7. Paradoxically, the decline arises despite increasing recognition nationally that high quality occupational health provision is strategically important to government, employers, the national economy, and the public health, including that of an ageing workforce. Arresting the decline is vital, to underpin the future provision of accredited specialists and specialist advice to workers (patients), employers and government. The Faculty of Occupational Medicine undertook a needs assessment in 2011 which identified the circumstances in which a specialist is likely to be required (rather than an allied health professional) and which estimated the national number needed to train to ensure a sufficient continuing supply. This number is small in absolute terms (37 new specialists per year), but above the long-run average of new CCTs (27 per year) and well above the numbers entering training since 2008

(14-15 per year).

8. The Centre for Workforce Intelligence has forecast that the number of full-time equivalent NHS consultants in occupational medicine will rise over the next eight years (paragraph 57, GMC report). The Faculty has contested this estimate, believing it to be deeply misleading: with present recruitment rates running at only 50% of their long-term average, and the number of doctors in training lower than at any time since 1997, projections for a rise in specialist supply in the short-term are implausible. Rather, a major priority exists in stabilising the recruitment base and then trying to grow it.

9. This has been recognised by the GMC in its first recommendation. The Faculty already has several initiatives underway to promote the specialty (e.g. paragraph 65, GMC report), but we think that more radical action is needed. Later in this response we propose ways in which the 1st and 4th recommendations might be met.

Resources

10. Occupational medicine is a small specialty, limited (as noted above) in its funding, but especially in its human resources. The large and increasing variety of roles demanded in training (e.g. Faculty officers, examiners, members of STCs, regional representatives of college, training programme directors, chairs of ACPs, educational supervisors, clinical supervisors) ill fit a specialty with a finite small supply of unpaid Members and Fellows volunteering time to support the training base. Remarkably, it has been estimated that some 50% of our membership have engaged in specialty training in some capacity – a higher proportion, we suspect, than in many if not all other disciplines.

11. Necessarily, the burden of that cover leads to volunteers wearing several “hats” – sometimes acting for the employer as an educational supervisor, sometimes for the Faculty as an examiner, sometimes for deaneries and local educational providers, and not unusually, in several such capacities, either at the same time or with overlap. Not surprisingly, the role of the Regional Specialist Adviser (RSA) has been somewhat misunderstood in this report (although helpfully challenged). We comment on this in our response to recommendation 8.

12. A pressing issue is how to make effective use of the available supply of willing and qualified volunteers; division of roles between more helpers and placing additional demands on those helpers is not sustainable in the long run. In seeking to promote best standards in training, the Faculty, the deaneries, and local educational providers share in common the challenge that the specialty lacks economies of scale. A good case exists, therefore, for structural reform.

13. We believe that such reform would be the most efficient and best way to address almost all of the recommendations arising from the GMC’s review. We develop this thinking below in the form of a partially enacted action plan.

Quality management issues & communications

14. A very small specialty, with few and sometimes no trainees per deanery, is relatively less visible to those responsible for quality management at local level. As the review correctly notes, the Faculty sometimes experiences difficulty in abstracting data from deaneries about specialty trainees, while the two-way flow of information is not always optimal (paragraph 81; recommendation 2).

15. We imagine that for deaneries the relative effort of monitoring and promulgating standards (recommendation 3) is great, since, in common with the Faculty, there are no off-setting economies of scale. We imagine the challenge for them may be greater also, when training arrangements are non-standard (e.g. training programmes in industry) and when the

specialists available to support them are few in number, doubling up their functions (recommendation 8).

16. These factors reinforce the argument for structural reform as a means of addressing identified challenges. Later we set out our intended actions.

Support for the MFOM dissertation

17. Unusually among medical specialties, the Faculty requires its specialty trainees to complete a dissertation. We think this necessary for various reasons. Briefly, consultant occupational physicians have responsibility for workforces as well as the individuals in their clinics; and they advise managers who discharge health and safety responsibilities, fund well-being initiatives, and adopt health-related policies that impact on workforces. Often the specialist must provide practical evidence-based advice in unique circumstances, and with limited or no input from the DH, secondary care experts, NICE, and the HSE; the capacity to assemble and critically appraise relevant evidence, and to marshal coherent arguments influencing deployment of resources, are pointers which distinguish the specialist from the generalist.

18. The dissertation represents a challenge to trainees and delays in submission for assessment contribute not infrequently to delays in completion of training. There are many reasons for this, some relating to available support and some personal to the trainees themselves. Membership regulations permit a relevant MSc to be submitted in lieu of a thesis written for purpose and in recent times about 50% of submissions have been of this kind; clearly, trainees fortunate enough to be funded to this level will receive good support in preparation for this assessment. For other trainees, as indicated in the review, levels of support and academic mentorship can vary. In 2009-11 a greater proportion of trainees from industry received MSc sponsorship than trainees from the NHS, a factor that needs to be considered going forwards. The disparity may reflect differential access to funding, but may also in part reflect selection (some universities seek to filter and enrol the academically stronger candidates into their courses) or self-selection and motivation.

19. To ensure that trainees outwith MSc courses are not unduly disadvantaged, the Faculty (i) lays on preparation events for all-comers, (ii) provides feedback on the outline protocols of trainees writing dissertations for purpose, and (iii) from 2007, widened the field of admissible topics to include those within the compass of trainees unable to access MSc supervision (e.g. a substantial review or substantial audit). Additionally, some deaneries offer additional support to trainees who need it (paragraph 111, GMC report).

20. The GMC review team recommends that the Faculty should “consider developing a process to monitor and provide additional support for trainees who are experiencing difficulties with their dissertation” (recommendation 6). We agree that such a function is necessary and important.

21. We highlight that the responsibility and funding for this lie with local educational providers, deaneries, and their agents (e.g. educational supervisors, TPDs, ARCP panels) and that arrangements for periodic review are integral to approved programmes (e.g. educational planning meetings between trainees and supervisors; ARCP panel reviews of training progression). As such, mechanisms for monitoring difficulties should already exist among those with whom the responsibility rests. The Faculty also monitors statistics relating to problems with the dissertation (and made some available to the review team), provides the support described above, and offers all trainees an open invitation to discuss their dissertation problems with the Chief Examiner for this unit of assessment.

22. Nonetheless, we think more resource can be brought to bear, and take this up below.

A new national school for occupational medicine and lead LETB

23. At several stages during the review, and in correspondence with the visit team, the Faculty has made the case for developing a new body with centralised control of training contracts, which would assume overall national responsibility for specialty training. We assume, for simplicity of account, that this would best be configured as a new national school within a lead national LETB, although alternative structures may conceivably offer similar advantages.

24. Such a configuration would greatly assist quality assurance and improvement of specialty training, and address many of the issues identified above and drawn out by this review. Specifically, such a national school would make it easier to: (1) advertise expected standards; (2) harmonise standards across different local educational providers (LEPs); (3) police expected standards (collect comparative data, identify problems and address them at an early stage); (4) develop cost-effective policies for quality management and quality improvement at local level; (5) implement a uniform recruitment policy; and (6) support training by LEPs which train infrequently. A central body (7) could also develop an in-depth knowledge of training in the specialty (in contrast to deaneries with few trainees that represent a small occasional part of the business); (8) it should improve two-way communications between deanery and Faculty (and between the deanery and GMC); and (9) would potentially be sparing of membership manpower – a more efficient and sustainable position. Additionally, (10) a body with greater critical mass for training in occupational medicine could serve to increase the specialty's profile and act as a proactive focus of recruitment. Importantly, also, it would bring (11) more latitude to deal with trainees in difficulty, (12) more flexibility to support part-time training, and (13) greater scope to organise rotational attachments and to let contracts with trainers from industry. Economies of scale could lever additional funding, which in turn could be used (14) to support industrial attachments and (15) to let block contracts with academic institutions, improving support for the MFOM dissertation. A national entity would also be easier for the GMC to inspect and to hold accountable, consistent with the GMC's own mandate on efficient targeting of inspection resources.

25. Many of the review's recommendations would best be addressed by working towards this goal. Specific examples are given below.

26. **Recommendations 1 and 4:** It would be easier and more efficient for the Faculty and deaneries to work together to promote the specialty and to maximise and harmonise recruitment if a national school and single LETB assumed overall responsibility for recruitment, producing a visible national focus for recruitment. It would be relatively straight forward for the Faculty and such a body to integrate these functions. For example, the Faculty's Director of Training and Chair of the Faculty's Specialist Advisory Committee (SAC) would be a board member of the new school and the new head of school a member of the Faculty's SAC.

27. **Recommendation 2:** The two-way flow of information would quickly improve. By contrast, the Faculty has sometimes failed, despite repeated attempts, to obtain all of the information it needs from the many deaneries to which it presently relates. In the short-term, in tackling recommendation 2, we will work with the Lead Dean to improve existing avenues of communication; but a new national school would offer a much tighter, better model for flow of quality-related and other data.

28. **Recommendation 3:** Although this is a recommended action on deaneries, we venture to suggest that a school which lets central contracts with LEPs would exercise tighter, more uniform control over quality management, both within and outside the NHS, than is presently achievable.

29. The Faculty has no special concerns about the quality of training in industry; but we do recognise the importance of preserving these posts, the rich education value they bring, and the desirability of improving opportunities for rotational training – ideally, including experience in industry. At present, with few exceptions, industry funds all of the industrial training posts in England, and this in turn hampers the freedom of deaneries to dictate terms without threatening the viability of training. If funding came from NHS resources, within integrated rotational programmes, tighter contracts could be issued, since the NHS would become the customer. We would hope and expect that a national school and lead national LETB would leverage funding for the industrial component of training, supported by the Faculty. Plans of this kind have already been discussed (see below).

30. **Recommendation 5:** Although this is a recommended action on deaneries, we venture to suggest that information from ARCPs would be shared with the Faculty more surely and effectively if there were a single body with oversight of ARCPs and training to which the Faculty could relate, and if a close working relationship existed between the head of that body and the Faculty's SAC.

31. **Recommendation 6:** It is said in paragraph 120 of the GMC report that the Faculty's Training Handbook omits to mention the role of educational supervisors in supporting trainees with their dissertation. This is incorrect, as pointed out previously in correspondence – Appendix 2 lists again the guidance that is already provided. Nonetheless, there is a need to garner more support for trainees preparing for the dissertation and for their supervisors. An important further improvement, going forwards, will be to maximise opportunities for formal academic supervision. As mentioned above, responsibility for this and for its funding, rests with deaneries; but the advent of a new national school would underpin better support, more uniformity of provision, and ideally, the prospect that all trainees will in future be funded to take a university MSc (as happens in public health medicine). The Faculty supports this ambition, subject to availability of funding; exploration of this should be undertaken at an early stage in the life of the new national school. (We believe that additional costs to the School might significantly be offset if present delays to completion of training were in future avoided.)

32. **Recommendation 7:** This is a recommended action on deaneries. The Faculty is pleased to hear how well current arrangements for confidential feedback are working in the two exemplar deaneries (paragraph 116, GMC report). We suggest that the challenge of maintaining confidentiality, which is ever present in a very small specialty, would be more easily accomplished if contracts were let on a national basis, by a bigger entity that could draw on national resources to explore particular local problems.

33. **Recommendation 8:** The recommendation in relation to recruitment, training, and appraisal of trainers is addressed to deaneries, and we agree that they hold these responsibilities. The Faculty supplies guidelines (e.g. expected qualifications and experience) and remains happy to continue doing so. It should be noted that in practice, potential trainers, especially from industry, tend to volunteer themselves after identifying a training need within their organisation; in effect, the choice is to accept or refuse approval of the post or programme (having tested whether the appropriate standard has or could be met).

34. We appreciate the sense behind the GMC standard that all trainers should be trained as trainers and assessed in relation to their training activities. We are concerned, however, that the requirement could lead some employers to withdraw support for training altogether, especially in industry, where costs will be weighed against alternatives, such as contracted-out services by non-training commercial providers. We would hope that a central body for letting training contracts would be able to bring additional resource to bear to address the training and appraisal needs of trainers, especially those outwith the NHS, for whom there is

presently no funding, only an employing organisation's goodwill.

An action plan

35. The Faculty intends working with other major stakeholders to further the development of a new single national body with centralised control of training contracts, to assume overall national responsibility for specialty training. It is envisaged that recommendations 1, 2, 3, 4, 5 (in part), 6, 7, and 8 (in part) will be addressed through this mechanism.

36. The Board of the Faculty of Occupational Medicine, Royal College of Physicians London, has endorsed this goal. It has been embedded in the Faculty's objectives for 2013/2014, although work on it commenced as early as 2012.

37. The plan is being coordinated for the Faculty by the Academic Dean (currently Professor Keith Palmer), the Director of Training (currently Dr Ian Aston), and members of the Faculty's SAC. These officers are responsible to the Faculty's Board through its Executive Committee and will report progress against the objective to the Executive and Board.

38. The Lead Dean, Liz Hughes, a member of the Faculty's SAC, endorses the goal and is collaborating pro-actively with the Faculty to develop and lead planning from the deanery side. She has been championing it among a wide range of stakeholders.

39. In the latter part of 2012, the Lead Dean discussed the model extensively with COPMED in an open business session and in one-to-one meetings with many of the English Deans, as well as at a meeting of English Deans. Derek Gallen, representing Wales (and chair of COPMED), also welcomed such a plan. A near complete consensus has been established in favour of a new national school and lead LETB for occupational medicine, which would cover all NHS and industrial specialty trainees in England and Wales.

40. The Lead Dean also discussed with the Director of NES, the Postgraduate Dean from Northern Ireland, and the Defence Dean, the option to develop a configuration which would incorporate StRs in Scotland, Northern Ireland and trainees from the Armed Services. This model would seem more challenging to accomplish in the short-term. Moreover, a national deanery already exists for trainees from the Armed Services, while Scotland is well configured. Therefore, effort will be focused on establishing a workable English and Welsh template, complete integration being a longer-term ambition.

41. At present, only one school of occupational medicine exists, based in the London Deanery. (Elsewhere, occupational medicine is embedded in other schools – e.g. of public health or general medicine.) The head of the London School, Professor John Harrison, has secured agreement to bid to establish a national school of occupational medicine, congruent with these proposals. A working group from the London School is being established, with representation from the Faculty and in liaison with the Lead Dean, who is acting as an advisor.

42. Reconfiguration within the NHS is likely to see the London Deanery replaced by a central hub and three LETBs, which are presently undergoing a process of authorisation. Assuming authorisation in a few months time, Dr Diana Hamilton from the nascent London South LETB has offered, in principle, to consider acting as lead LETB host to a new London-based national school.

43. Clearly, many details will need to be considered before such a radical new arrangement can be firmly set in place. Commissioning of medical education is in a degree of flux, with various structures being discussed (e.g. different models of a Lead Provider sub-contracting with other local providers). In a year's time more of these details will be fixed. Assuming, however, a new national school and a lead LETB, we expect that action will be taken on the

GMC's recommendations relating to: promotion of the specialty (recommendation 1), flow of quality data between stakeholders (recommendation 2), quality management processes (recommendation 3), national recruitment (recommendation 4), information sharing regarding outcomes and feedback (recommendation 5), support for educational supervisors and trainees preparing for the dissertation (recommendation 6), opportunities for confidential feedback (recommendation 7), and recruitment, training and appraisal of educational supervisors (recommendation 8). Inevitably, responsibilities for this will be shared; but the Faculty officers, Lead Dean, and present head of London School are all mindful of these needs and intend embedding them in future plans.

Other actions

44. It is recognised that our action plan should not be wholly contingent on major change, in case attempts to establish a new school are delayed; also, to cover trainees whose parent deaneries may not participate in the first wave of consolidation. Moreover, a number of the GMC's recommendations can be, and are being addressed in other ways; some are relatively simple to accomplish, others less so, or less well achievable without restructuring. We offer below, therefore, additional elements of the action plan, which are at varying stages of execution.

Recommendation 1

45. WHAT: The Faculty's Academic Dean and the Lead Dean have spoken with Dean Royles, Director of NHS Employers and Patrick Mitchell, Director of National Programmes Medical Education, Health Education England (HEE) about national recruitment; HEE has pledged a staff representative to work with the Faculty and Lead Dean on national recruitment and the specialty's profile. WHEN: With immediate effect. HEE also supports the development of a national school/lead LETB as a vehicle around which to build a recruitment strategy over the next few years.

Recommendation 2

46. WHAT: The Faculty will write again to deaneries, through the Lead Dean, highlighting current problems in the flow of quality data; we will ask the Lean Dean to raise this with her colleagues through COPMED and will continue to monitor the situation. WHEN: The initial actions will be fixed at the next available SAC meeting in 2013.

Recommendation 3

47. This is an action on deaneries. WHAT: The Lead Dean has agreed to discuss the issues of quality management raised by the report with COPMED. WHEN: At the next available meeting of COPMED in 2013.

Recommendation 4

48. WHAT & WHEN: (i) We support reinstatement of national recruitment, within the context of a single recruiting body. The issue will be discussed between the Faculty and Lead Dean at the next available SAC meeting in 2013, although a final decision on it may be held over until a clearer picture emerges regarding establishment of a national school. (ii) We reiterate that explicit recruitment templates already exist and are promulgated by the Faculty's SAC to ensure a consistency of approach and standard of recruitment; this allows some time to reflect on the optimal arrangement. However, the Lead Dean will check and confirm with her counterpart in the Armed Services that there is harmonisation of recruitment standards (and ideally, a matching timetable). (iii) The Lean Dean will remind her colleagues in COPMED about the responsibility for externality and lay input into the ARCP and ask them to raise formal processes and report back on them. Initial discussions will be held at the next available meeting in 2013.

Recommendation 5

49. WHAT: The Lead Dean has agreed to raise the matter at COPMED and remind

deaneries of this responsibility. WHEN: At the next available meeting of COPMED in 2013.

Recommendation 6
50. We stress that educational supervisors already receive extensive guidance from the Faculty on their role in supporting trainees, generally and with regard to the dissertation – e.g. Appendix 2. WHAT & WHEN: However, (i) by May 2013 we will amend Section 2 of the Training Handbook, as suggested in paragraph 112 of the GMC report to repeat and reinforce existing advice to trainers; (ii) in 2012, while the GMC's review was progressing, the Chief Examiner for this unit of assessment instituted a regular series of training newsletter briefings to all stakeholders on different aspects of dissertation preparation – this support will continue; (iii) the Faculty will explore with deaneries, via the Lead Dean, mechanisms for monitoring trainees in difficulty with their dissertation – this will be discussed at the next available SAC meeting in 2013 and then at the next available COPMED meeting; (iv) In 2012 the Faculty developed a more detailed framework of time-related milestones for assessment of dissertations within ARCPs. The Lead Dean will promulgate this via COPMeD to all Deaneries at the next available meeting in 2013 and it will be featured in a training newsletter (in February 2013). The measure should raise awareness of the target timetable among stakeholders (trainees, trainers and ACRP panels) and thereby help to identify trainees who need further help with the dissertation at an earlier stage.

Recommendation 7
51. This is an action on deaneries. WHAT: The Lead Dean has agreed to draw to COPMED's attention the exemplar arrangements for providing trainees with the opportunity to give feedback in confidence in the sampled deaneries and confirm what happens elsewhere. WHEN: At the next available meeting of COPMED in 2013. Additionally, (although an action on deaneries), the Faculty will offer trainees an e-mail contact so that they can raise concerns in confidence with the Faculty's Director of Training or Deputy should they wish; the facility will be advertised via the training newsletter and the Board's trainee representative; this action will be completed in 2013.

Recommendation 8
52. We feel the issue of "hats" and job descriptions is misunderstood. We offer these comments, suggestions and actions.

53. Regional Specialist Advisors (RSAs) are the Faculty's appointed agents; as such their roles must be defined by the Faculty. Since Training Programme Directors, chairs of local STCs, college members serving on ARCP panels, and educational supervisors are agents of the deaneries, their roles should be defined by deaneries. However, the Faculty's specialty Training Handbook lists the qualifications and experience we expect educational and clinical supervisors to possess as a guide to assist deaneries and other stakeholders; and we are open to supporting deaneries wherever possible. Closer links between the Faculty and a new national body for training would further clarity these roles; more fundamentally, it would offer the prospect of reducing the number of "hats" worn and making more efficient use of limited specialist manpower.

54. RSAs and their deputies are appointed by the Faculty's SAC. They apply in open competition. Certain minimal criteria are required and a job description is supplied when posts are advertised (Appendix 3). They are briefed regularly by the Faculty in e-mail correspondence and at twice yearly face-to-face meetings; the Faculty office maintains contact as issues arise; there is correspondence between RSAs and their professional lead in the Faculty, the Director of Training, over matters of concern to either party and when an RSA seeks advice. We stress that a support structure already exists for these agents of the Faculty. (This is acknowledged in paragraph 38 of the report but expressed as unconfirmed in the last sentence of paragraph 79, while recommendation 8 appears to call for support, as if more is needed.)

55. These Faculty appointments exist for two primary reasons: (i) to provide intelligence to the Faculty on local training arrangements and needs, and (ii) more fundamentally, as a resource (college expert) made available to deaneries to be used as the deaneries require.

56. Formerly, before the advent of PMETB, RSAs also had a third primary responsibility, for the formal inspection and approval of training posts. Under current arrangements deaneries, rather than the Faculty, carry this responsibility. Quite often deaneries use RSAs to advise on standards and share in visits, as previously, and we welcome this. (Paragraph 96 of the GMC's report is mistaken, however, in supposing that we can insist that RSAs regularly visit posts as a term of their appointment with us; similarly, paragraph 82 is wrong in supposing that RSAs will *de facto* know automatically of the appointment of every educational supervisor – the Faculty is amending this aspect of the job description, given that we have no formal requirement for this information, which in any case comes to us by other routes.)

57. We have not considered it necessary hitherto to appraise and reappoint RSAs, as: (i) their supply is strictly limited (adverts attract relatively few applications); (ii) they have a maximum term of office; (iii) performance standards have always appeared high; (iv) we are not aware of problems in practice (e.g. complaints from deaneries, concerns of the Director of Training); (iv) lacking economies of scale, we actively seek to minimise additional administration, so that limited manpower can be targeted at training priorities.

58. We recognise, however, that with the advent of revalidation, RSAs will value appraisal in relation to their college work as well as for other aspects of their medical practice. WHAT: The Faculty will therefore design and introduce a system of three-yearly performance appraisal for its RSAs. WHEN: We notified RSAs of the need for appraisal in December 2012; we will introduce the new system during 2013.

59. While a job description for RSAs has long existed (Appendix 3), we recognise that not all RSAs who were interviewed could recall this. WHAT: We will remind RSAs again of their roles and responsibilities. WHEN: At each appraisal. Responsibility for this will rest with the professional lead for RSAs, who is the Faculty's Director of Training.

Professor Keith Palmer
Academic Dean
(on behalf of the Faculty of Occupational Medicine)

March 8th 2013

Appendix 1: Additional comments *(Paragraph numbers refer to the GMC report)*

Para 58. Training posts in the NHS are under threat; but not because of movement of trainees or specialists between sectors. Rather, the pressure is felt because NHS trusts are also outsourcing occupational health services to contractors who do not find it economic to train.

Para 79. We are surprised that the review team were not able to explore the support available to RSAs, as extensive comment was made on this by the Faculty when reviewing an earlier draft of this review report – see our response above and see Appendix 3.

Para 88. The Faculty has not encouraged random periodic inspections hitherto, as manpower in a small specialty appears too limited and stretched to further this ideal.

Para 108. It is not clear to us that industrial trainees are at a disadvantage; as noted, a higher proportion of them are funded to the level of MSc, which may be to their advantage. Anecdotally, trainees from industry enjoy unusually good IT facilities, and their ARCP outcomes are not significantly different from trainees who come from other employment sectors.

Para 110. As mentioned in a previous response, trainees who undertake an MSc are not asked to submit a protocol because they receive the required level of advice from the university with which they are training. The option to submit an outline exists for non-MSc trainees to ensure that they have a *similar opportunity* to have input at the design stage from those with research experience.

Para 113. As highlighted in an earlier response to the reviewers, although a slightly lower proportion of trainees viewed their clinical and educational supervision as favourable relative to other specialties in the 2012 NTS, differences were trivial and not statistically significant; as judged by the NTS, occupational medicine is more favourably viewed by trainees in several respects – e.g. the last three national surveys recorded higher mean scores than other specialties for: adequate experience, access to educational resources, feedback, local teaching, access to study leave, and acceptable workload; the 2010 survey reported that 92.6% of trainees in occupational medicine had consultant supervision as compared with 68.4% across all specialties, reflecting that clinical supervision is typically delivered in a one-to-one relationship between a trainee and a consultant; the 2012 survey records that 85% of trainees believed that they “have (or will have) the opportunity to participate in research” in their post. Trainees also value a regular work schedule with minimal or no out of hours work. We think the NTS statistics provide evidence of a supportive training environment with a number of notable strengths and advantages that are not captured by the report.

Para 115. Most trainees also belong to the Society of Occupational Medicine, which hosts local and national meetings. In a small specialty, these give an excellent forum for trainees to meet their peers and consultant colleagues.

Appendix 2: Handbook references to the responsibility of educational supervisor in relation to the dissertation

LINK TO SPECIALTY TRAINING HANDBOOK 4th EDITION
http://www.fom.ac.uk/education/speciality-training/training-handbooks-for-occupational-medicine/specialty-training-handbook-4th-edition-april-2008
LINK FROM THAT WEBPAGE TO HANDBOOK GUIDANCE FOR STAKEHOLDERS ON THE DISSERTATION
http://www.fom.ac.uk/wp-content/uploads/t_rdissguid.pdf

p3
SUBMITTING THE OUTLINE PROPOSAL
….“You should discuss your thoughts about the dissertation with your **educational supervisor**. They will be an important source of professional advice and an important link with the management structure of your employing organisation. If your study will involve access to workers and workplaces you will be advised about what is feasible within the organisation. You can identify and discuss any ethical issues and ensure that the necessary resources will be made available to you.”

P4
WRITING THE DISSERTATION
“If you are in higher specialist training, your **educational supervisor** must be involved, and will be a valuable source of advice and encouragement.”

P9
SUMMARY OF ROLES AND RESPONSIBILITIES

The educational supervisor
“The educational supervisor should encourage early identification of a research topic and submission of the outline proposal. Progress on this is likely to feature in the Annual Review of Competencies Progression (ARCP) or RITA review, and the Faculty recommends an outline proposal to have been submitted no later than the end of the 18th month of full-time training (or part-time equivalent).

The **supervisor** should ensure that any project is realistic and that there will be adequate resources to sustain the work until completion.

Progress with the dissertation should be monitored, via regular formal meetings. This will allow problems to be identified at an early stage and solutions identified. It may be helpful for the **supervisor** to alert the Chief Examiner (Research Methods) to problems that will affect the project significantly.

There is an expectation that the **supervisor** will advise the candidate on the quality of the final submission, although the final responsibility for the standard of the final submission rests with the candidate.

Educational supervisors who do not feel well versed to supervise their trainee’s dissertation should discuss with the trainee *how adequate support and supervision can be brought to bear* (eg, they may wish the trainee to enroll with an academic centre or an independent academic supervisor).”

Appendix 3: Recent job advertisement – Regional Specialist Advisor

REGIONAL SPECIALTY ADVISERS and DEPUTIES

Applications are invited for these honorary roles within the Faculty. These should be made on the application form and returned, together with a brief CV, to emma.coxsmith@fom.ac.uk by **Friday 19 October 2012**.

The vacancies for Regional Specialty Advisers and Deputies are as follows:

- Northern – Deputy RSA
- South of Scotland - RSA
- North West Thames (North West/West London, Hertfordshire and Bedfordshire) – RSA & Deputy (The Deputy position will be available from December 2012)
- South West Thames (South West London, Surrey and West Sussex) – RSA and Deputy
- North East Thames (Essex, North East London, East London and City of London)

Please read the following information before making your application.

Roles and Responsibilities

Regional Specialty Advisers and their deputies are appointed by the Faculty Specialty Advisory Committee (SAC) to assist in the process of specialty training in occupational medicine in the regions, and to represent the Faculty locally. Their appointment is initially for three years, which may be extended to six years on the recommendation of the SAC.

The Faculty indemnifies RSAs for the performance of their work for the Faculty, as outlined below:

1. Faculty Representation

- RSAs represent the Faculty in their region in all matters related to specialty medical training in occupational medicine. They are therefore expected to have appropriate knowledge of specialty training, and the Faculty's processes and procedures, and to keep up-to-date with any changes.

2. Principal responsibilities

The Regional Specialty Adviser:

- Advises the Faculty on the process of education and training in occupational medicine in their region, and on any particular problems that the region may be experiencing;
- Is responsible for advising employers on the establishment of training posts, and carries out the initial approval of the post before it can receive GMC recognition;
- Advises the Faculty on the appointment of educational supervisors;
- Provides advice to prospective and current trainees on the training process, and assists with careers fairs and other events where Faculty representation is required;
- Reviews job descriptions and advertisements for Specialty Registrar and NHS Consultant appointments, acts as a member of the Advisory Appointments Committee for StR and Consultant appointments when invited, and reports back to the Faculty;
- Should attend the twice yearly RSA meetings of the Faculty, usually held in May and December;
- Should attend (when requested) training post inspection visits.

3. Postgraduate Deanery Specialty Training Committee

- The RSA should be a member of the Deanery Specialty Training Committee. In many cases the RSA will also fulfil the role of Deanery STC Chair, but must be aware that the Chair of the Deanery STC is appointed by the Postgraduate Dean, and is indemnified by the deanery when acting in that capacity. The roles and responsibilities of RSA and Deanery STC Chair should not be confused.
- The RSA will assist the deanery in monitoring progress of trainees, may be a member of an ARCP panel and will advise generally on the training process.

Person specification

Applicants must:

- Be a Member or Fellow of the Faculty;
- Be recorded on the GMC Specialist Register as an occupational physician, with at least three years experience as a specialist;
- Be in good standing with the Faculty (paid all fees and subscriptions due from them to the Faculty, signed a declaration of faith and complied with the minimum requirements of the Faculty's or other appropriate continuing professional development scheme).

and ideally:

- Have experience as an educational supervisor;
- Have experience of ARCP procedures;
- Have knowledge of NHS and non-NHS OH practice;
- Have done previous work for the Faculty.

Expenses

This is an honorary role; any travel and other necessary expenses incurred in travelling to meetings and carrying out the role will be reimbursed in accordance with the Faculty's business travel and expenses policy.