SAS GMC-led CESR workshop, 25th November 2020

Q&A Transcript

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GETTING STARTED

Q) Once an application has been started, are applicants assigned a GMC adviser?

JB: An adviser is assigned only when an application is submitted, not when an application is opened. You can contact us at the GMC at any time beforehand, but you won't have a dedicated GMC adviser until you submit.

AUTHENTICATION

Q) I came to the UK via IPTS, the old version of MTI, in 2005. All my primary and secondary qualifications were verified, authenticated and accepted by the GMC; do I have to re-verify them for submission to the GMC?

JB: If you are applying for a CESR and you already hold full registration with the GMC, there is no need to provide your primary medical qualification again as it's been accepted, unless you are applying to register for a licence at the same time. If you submitted your other qualifications in 2005, our requirements have likely changed by now, and CESR is a separate application process to anything previously submitted, so these should be re-submitted in line with GMC current requirements and guidance.

Q) Do I need to have every paper signed and stamped by my verifier before uploading?

JB: No – this was the previous verification process where each printed page required to be signed and stamped; that process has been replaced by the proforma that was discussed in the presentation. The only documents that need to be signed and stamped are any authenticated documents.

Q) Can a UK solicitor authenticate an overseas degree certificate?

JB: Yes. The key part is that a solicitor is checking that document.

Q) Am I right in understanding that each page of the 1,000 page document will need to be authenticated by a solicitor, in addition to the original verification by consultants with medical supervisory roles?

JB: Only overseas medical qualifications need to be authenticated by a solicitor, the rest can be verified by a colleague at your institution via a pro forma, not page-by-page. Please don't have a solicitor verify everything for 1,000 pages as that would be very expensive, as well as unnecessary.

Comment: Thanks for your earlier response – I understand you said I'll need to authenticate again, which I'll do, but it's difficult to reach out to supervisors and verifiers who were there 25-30 years ago to get anything verified.

JB: That certificate can be authenticated by a solicitor or awarding body; it doesn't need to be a supervisor who was there at the time. Your awarding body can also provide the curriculum it was awarded against. If it's as long as 25-30 years ago, all that's required is the qualification and curriculum, since it's so long ago it's not representative of your current skills.

AUDIT

Q) Many paediatricians are so embedded in day-to-day clinical services delivery that we have not been specifically involved in research but have been doing local audits. Should we feel deterred if we don't have research documentation?

JB: There are different ways to demonstrate research skills, including local audits or involvement in journal clubs; check in the SSG for Paediatrics. All the specialty curricula have an element of research in them, but there are different ways to demonstrate that such as good clinical practice and research methodology courses, which show you understand the principles of ethical research and the methodologies behind them. It is not necessary be the lead author on publications to demonstrate that you have the relevant knowledge, although some applicants will need to wait to gain experience if they've been focussed on clinical work rather research.

Q) Regarding the need to complete the loop of audit, how flexible is the GMC on this if multiple evidences of audit activity have been submitted but not a series fulfilling all aspects on the same topic. Also, where a published audit which is accessible on PubMed has been submitted, can this be accepted as satisfactory for all stages of audit?

JB: You need to be satisfied that you've demonstrated the five stages of audit. Certain curricula have certain requirements; some will require submission of more than one cycle, some just need an understanding of the cycle – it depends on the specialty. A published audit would likely be strong evidence, but it would need to demonstrate the same thing as a usual presentation of audit showing the meetings, assessment, etc.

Q) Is it enough to describe audits with their learning points and verify them by a supervisor or do we have to submit data and other audit-related stuff?

JB: Not just data – evidence of the 5 stages is required. It's not just the description but the audit report, parameters, examples of where you've presented audit at meeting to disseminated findings, evidence of doing re-audit and reflected on any change on practice. The important thing is showing the five stages.

EXAMS

Q) I'm aiming to submit an application within the next 6 months for General Surgery. What is the impact of COVID on the 5-year timeline for evidence as I was delayed submitting due to a cancelled FRCS exam and my ATLS qualification will expire before I can apply? Are there any exceptions given to the 5-year evidence window in this circumstance, given the delay brought about by COVID?

JB: It is appreciated that COVID has had an impact on the profession and particularly on CESR applicants who may have lost opportunities to gain experience. Advice would be that if you don't have everything at the moment and you are pre-application, you should wait until you're ready to apply. If there are some small things, such as the ATLS, different Colleges use different approaches to what they'll accept but can be quite flexible. Your College is flexible and will likely accept a Workplace Based Assessment (WBA) as an alternative to a recertification for ATLS. Showing you're booked onto a course will also show you're aware of the importance of maintaining skills.

Re: the 5-year timeframe; for surgical CESR applications, up to 6 years is accepted given the length of training for those specialties. It is important that the competencies are recent, however. Some flexibility is offered on the time period because of COVID. For instance, for surgical applicants, it is understood that not all elective procedures are being performed. If you contact us with a bit more information on when you want to apply and how far along you are, more detailed advice can be provided in light of your personal circumstances.

Q) I haven't done Royal College exams; would attending conferences and courses be enough to cover the requirements for my curriculum?

JB: It will depend on the specialty, but the short answer is no, conferences and courses are not enough. The knowledge exam for most specialty curricula is tested in a particular way and includes practical and written elements; if you haven't passed it, you need to demonstrate that you have equivalent knowledge to the breadth of that exam syllabus and could deal with all the possible elements that you could be tested on. They'll also want to make sure that you're demonstrating that knowledge through an equivalent test, so it's unlikely that you'll be able to do so without a qualification of some sort. Experience of research and audit counts towards showing equivalent understanding of particular areas of practice, but it would need to be a vast portfolio to cover all the elements of the exam. The most straightforward way of demonstrating the knowledge required for your curriculum is to sit the College exam.

Q) Does the 5-year expiry date apply to specialist required formal examinations and qualifications?

JB: In terms of exams, it should be a version of the exam that is comparable to the current curriculum. Most of the UK exams will still be acceptable, but there are some exceptions; Ophthalmology in particular, where there only certain versions of the FRCOph that are acceptable, so check your SSG to see if there are any particular requirements around your exams.

If it's an equivalent exam, you'll probably need to demonstrate that you've maintained that knowledge, so if it's more than 5 years ago you'll need to show its equivalence to the UK exam for your curriculum. You may also need to demonstrate how you've maintained that knowledge, probably through your research, audit and day-to-day practice.

Q) What does 6 months' continuous training mean for a CCT-approved specialty? I plan to apply for Geriatric Medicine and worked in non-training jobs for over 6 years. Is it mandatory to get on a training post?

JB: In terms of eligibility, you need either the qualification *or* the training post *but not both*. If you're applying in Geriatric Medicine, you'll probably want to have the speciality certificate to apply anyway as that will demonstrate your knowledge and make you eligible to apply. If you have only done 6 years in unapproved posts then it would not meet the training requirements, so if you aren't planning to sit the exam and you don't have anything else to demonstrate the eligibility criteria then you'd need to find yourself an approved training post for 6 months. Locum appointments for training as eligible posts are accepted, although it is appreciated these aren't readily available.

Q) In connection to my previous question regarding requirement of 6 months on a training post - I am struggling with the logic of getting on a training post. I am gathering evidence that match the curriculum required for trainees in geriatric medicine, and I plan to sit the speciality exit exam.

JB: If you are sitting the exam, you will meet the eligibility criteria. The 6 month training post is set out in legislation so while you may be competent already, to be eligible to apply it must be a 6 month training post; however, it is not required if you're sitting the specialty exam.

Q) For Haematology we need to do 6 months in Paediatrics and 6 months in Transplant. Would that experience also need to be logged within the 5-year period prior to submitting the CESR application? And would MRCPath need to be passed within the 5-year period or would there be no time limit?

JB: For the first point, yes, the experience would need to be logged within the 5-year period prior to applying. The exam would not have a time limit for as long it's in the curriculum, so once you've passed the College exam it will remain valid unless there's a substantial change to it, which is unusual.

Q) Could my application clock be assessed in terms of the MRCPCH exam results in 2013?

JB: As it's a core training level exam, the curriculum is looking for high level. It's your evidence the college will be looking at, to determine that you meet the curriculum requirements for Paediatrics.

Q) Sorry if this was answered earlier. I have a Speciality Certificate but not the full exams for MRCP. I have been told by my department that I will need the full MRCP for CESR. I also worked 6 months in a training post recently. If applying for CESR without the full exams, does not having the full MRCP then require a higher burden of evidence?

JB: The RCP demonstrates your core competencies for a CESR, and for the physician specialties, both core and specialty competencies must be demonstrated. The MRCP is one way of doing that but you would need supplementary evidence in any case. If you can demonstrate you have equivalent knowledge to MRCP and the core physician training (CMT) you could be successful another way. MRCP is not an absolute necessity for CESR, but is the easiest way to show core knowledge, whereas your Speciality Certificate will cover that for your specialty.

Q) I have been a Specialty Doctor in Old Age Psychiatry for 10 years and have passed a postgraduate exam in Egypt. If I can get that certificate, will it substitute for UK Royal College exams?

JB: You don't officially need Royal College exams, and other qualifications can make you eligible. However, if it was that long ago it won't be evidence of your current knowledge and core competencies, so you'll need that in your application. The UK membership exam makes you eligible, and because we know it covers our core competencies for Psychiatry, we take that as acceptable. We don't have the same assurance for overseas qualifications.

(Q continued from above) What is the best evidence I could provide to substitute for the exam?

JB: Day to day practice, case reports, medical reports for doctors – look in core Psychiatric SSG and core and speciality curricula for Psychiatry; these are clear about the case studies required and the breadth of areas required to cover – you'll need to cover a broad range of ages and presentations to meet core requirements, as well as the Old Age Psychiatry-specific cases for your own specialty.

(Q continued from above) The SSG for Old Age Psychiatry doesn't mention that I should cover different ages?

JB: The SSG guidance is there for what evidence to provide; the curriculum is what you need to look at for what the content is. The Old Age Psychiatry curriculum focuses on old age, whereas core psychiatry covers a breadth of presentations including those outside of old age; it's important to show you've established those skills too.

LOGBOOKS

Q) Regarding recent assessments from previous applications; in general surgery, I need to meet the curriculum in numbers of procedures performed, plus 3 WBAs from 3 different assessors for each procedure to demonstrate competency. All WBAs would be from within last 3-4 years, but in a few cases the number of procedures I've performed within the last 6 years won't be sufficient. I have evidence on e.g. 15 colon resections from last 6 years, and past that enough to meet the requirement for 20. Would that be acceptable? I would have demonstrated in recent assessments that I've continued to have those competencies, and I have supplementary evidence of logbook from 6+ years ago.

JB: This can be submitted but it may not be enough; the College would require the logbook and consolidation reports to support that. Unfortunately, surgical colleges are quite strict on meeting the required numbers within the 6-year period, as it's such as a practice-based field, so they'd want that assurance. They're also stringent in PBA numbers – if you have 3 assessments and one is a little older than the other 2, that would be acceptable, but all 3 are required, and all from within the last 6 years. Advice would be to try and meet the numbers required within 6 years.

Q) It is difficult to get a list of patients I've seen in medical wards in the past 5 years - how can one overcome that if one was not organised and didn't get a list prospectively?

JB: These are probably not required – a list of every patient seen is not necessary; what the evaluators are looking for is a sample of the wards you're managing and types of presentations that you're seeing. Check your SSG and consider what you do in day-to-day practice. Do you keep a logbook, like surgeons, ophthalmologists and obstetricians/gynaecologists? For others, a patient log will just have name and diagnoses – that won't give assessors an idea of your competence.

Q) How is providing list of patients as discussed in a previous question different to a logbook in a medical specialty that doesn't collect numbers of procedures? What should you include in a logbook?

JB: I don't think it is different; it's looking at what is normal practice for your speciality. Your SSG will say if you need logbooks and/or patient lists or not, as will your curriculum. If there is a particular period to spend in a specific clinic, sometimes logbooks etc can be helpful, but it depends on the specialty.

Q) If trainees don't provide a logbook, do we need to?

JB: If it is relevant to a specialty then do so, but if not in procedure-based specialty you probably don't keep one or need it to apply. This is not a "yes or no" answer; it depends on what you do.

Q) With regards to verifying procedures, would procedures done in another hospital within the same Health Board be performed by one verifier (my CD who will verify my logbook from the current job over the last 6 years)? Also, out of interest, we perform organ retrievals in different hospitals across Scotland and Northern Ireland as part of the transplant service; would the CD be able to verify those procedures performed in other hospitals, since it's basically linked to the transplant surgery job?

JB: It depends on how they are able to confirm that experience. If the hospitals are in the same Health Board and share information, then yes, one person can verify evidence from another hospital. You probably want to contact someone from the hospitals, if they're outside your Board, to get them to verify, as it's usually verified by the hospital or Board that the procedure was performed in.

Q) Can I access the CESR route for Audiovestibular medicine, having had previous ENT training outside the UK in an EU country which enabled me to join the Specialist Register in Otolaryngology? If so, can I provide evidence from my previous Otolaryngology curriculum?

JB: Audiovestibular medicine and Otolaryngology are two separate specialties in the UK, although there is some crossover in terms of knowledge. Core training in Audiovestibular medicine can be the core surgical training route and if you have a qualification equivalent to the FRCS in ENT, that would be useful in demonstrating your knowledge for Audiovestibular medicine. If your European qualification wasn't in the last 5 years, you should provide some evidence towards the Audiovestibular curriculum.

Q) If documents within the submitted evidence are accidentally not anonymised, will there be any penalty?

JB: It is appreciated there is an element of human error and the applications are very large, so sometimes a name or part of an address may be missed. If an adviser sees you've missed an anonymisation, they will delete those documents and return them to you. You'll be invited to submit a reflection or go through an updated data protection course to demonstrate that you understand patient confidentiality in line with good medical practice and that it was a genuine mistake. If you

hadn't attempted to anonymise anything, that would be more of a cause for concern, but for routine issues the usual procedure would be followed and it would not cause a problem.

Q) You showed CESR success rates being around 55% in a variety of specialities; with such a rigorous application process via the GMC prior to submission to the Royal Colleges, why is more advice regarding inadequate evidence not given at the GMC stage, rather than allowing applications to go forward to the Colleges and being rejected, and candidates having to appeal?

JB: There is no need to appeal; the review process is in place for that. The GMC team are not clinically trained and cannot pick up on certain things, such as particular procedures or areas within a curriculum that your evidence doesn't cover, whereas the College assessors are completely aware of the training requirements for your curriculum. The GMC team can pick up things like expired course certificates, logbooks for the right period of time, and adequate numbers of WBAs. Applicants will know best what experience they have and where they've had training, so they should make sure the best evidence is submitted on first application and it is more likely to be successful; that is the most important thing.

Q) How strict is the 5-year limit for evidence? For example, an infrequently performed procedure on the curriculum as a DOPS but dated 6 or 7 years ago – would this be inadmissible as evidence and need updated?

JB: 7 years is may be too long; it will depend on how long the training requirements are for that curriculum. The example of passing a driving test could be used here; if you've passed your test but not driven a car for 7 years, would you be confident that you'd be safe to drive on the roads alone? It is appreciated there are procedures that don't happen very often or that applicants may be competing with CCT trainees for opportunities to gain experience, but if it is a curriculum requirement then it is required, and the more recent it is the better.

Q) Can my verifier be one of my referees as well?

JB: Yes. They will likely be appropriate to do so if they work with you currently and can attest to your evidence.

Q) I've finished my specialist medical qualification outside of the UK – they didn't have WPBA where I did my training, but our consultants used to assess us and give feedback to our dedicated educational supervisors. How can I prove that I was assessed during the training, and what can I submit as an alternative to WPBA?

JB: The easiest way to demonstrate clinical competencies is to provide the UK WPBAs – you've not said how long ago your specialist medical training was, but if it was over 5 years ago you need to be providing more recent assessments in any case. However, equivalent documents to the UK assessment forms will be accepted, but they need to demonstrate that they cover the same areas of assessment, so ensure it has a comparable rating system (ours specifies if someone is ready for CCT / Consultant standard) and what that assessment covers. If it's equivalent to a case-based discussion, for example, does it cover the same topics, and does it have the same level of detail as a UK

assessment? Your Royal College website is a good place to start for those – most have the forms used by trainees available for non-trainees to look at, so you can compare those to the evidence that you do have from your overseas training, see if they're comparable, and if not, prospectively look at completing some assessments based on your current practice.

Q) [follow up to above] I'm planning to apply for a non-CCT speciality, specifically Paediatric Anaesthesia; do I need to provide evidence from other specialties such as Adult Anaesthesia as well? For reference? I completed my training in 2015 as an MD in Anaesthesia which was an approved test of knowledge for FRCA.

JB: If it's an approved test of knowledge that is acceptable. For a non-CCT specialty, the standard of a Consultant would apply to your application, so as a Paediatric Anaesthetist are you expected as a consultant to complete any other areas of anaesthesia within your day-to-day practice? You are probably best placed to judge that. In terms of further detail, you'd probably need to contact me so I can look into it, as we don't often get non-CCT Anaesthetics applications. Demonstrating the advanced areas of Anaesthesia, particularly in relation to Paediatric Anaesthesia, would be a minimum, but I can look into it to see if any other areas are required as part of your application.

Q) With reference to verifying evidence, if the supervisor from a previous institution is no longer in that place, do they need to be chased or can a colleague currently working in the institution do it?

JB: The colleague will need to work at the institution at the time you're submitting your application to the GMC, as it should be someone with current access to the relevant records that can verify your evidence. You should approach a new colleague to get that evidence verified if your previous supervisor has left.

Q) How do we present CPD diaries as evidence of learning and development. Do we pick out aspects of it and submit as evidence? Since specialty doctors don't have supervisors, will the evidence be accepted as been assessed by Appraisers?

JB: Yes. Make sure you meet the minimum CPD points annually for your specialty which can be evidenced through your CPD diary and demonstrate the type of CPD you've obtained, and that it's a mix of self-learning, attending conferences, etc. That will triangulate with your appraiser as they will be checking in on your maintaining CPD and keeping yourself up to date.

Q) We appreciate that submissions will be specific to the college requirements. Would it be possible to have a college-specific sample of CESR applications, bearing in mind that our application may look very different but at least it would provide a college-based framework. Though there is guidance from the RCPCH, it is still somewhat vague with focus on generic competencies about what can and cannot be submitted.

JB: Paediatrics is a good example as it's one of the first specialties to move to generic professional capabilities. The reason the curriculum is vague is because it looks at outcomes, so when you look in the SSG and the curriculum, it will state what the overall outcome is, and give some examples of how you can demonstrate you've achieved it. The outcomes are broad, e.g. managing a sick child, but the

requirement is not that to prove you know of every possible symptom a child may have and how to manage them, just that you can appropriately manage and treat a general acute case on a paediatric ward when a child is admitted. That makes it easier, as you have more freedom to be creative with your evidence; don't give ten examples of treating one condition, do make sure it's a mix, but it's up to you to look at what to submit towards the overall outcome.

If you are unsure about things like this it's a good idea to speak to trainees at your hospital, or educational supervisors, as they know what they have to do to get a CCT, which is assessed against the same standards as a CESR. If you can get the same sort of experience as CCT training, it's very likely that will be accepted in your CESR application.

Q) If you are working as a Specialty Doctor in a hospital that does not have trainees in that specialty (Haematology in my case) can you still collect evidence and CESR in the specialty?

JB: Yes, it doesn't need to be an approved location for training as you're not a trainee yourself; it's based on whatever experience you've had, so if it's relevant to your specialty and curriculum requirement you can use that experience and put that in your application.

LM: To add a comment on behalf of the SAS Development Programme, if it was felt that you needed a period of time based in a unit where trainees are based, in order to fully complete your training and achieve your final competencies, please approach your SAS Education Adviser and we can see whether we can support a secondment into such a training setting, enabling you to augment your evidence and demonstrate e.g. experience in an acute setting.

JB: Yes, if your SSG does state that you need experience in a particular setting you'll need to arrange that, but you can get your evidence from anywhere relevant, it doesn't have to be an approved post.

Q) Do WPBAs done on the e-Portfolio need verified, as they already have the consultant details?

JB: The GMC do not have access to your e-Portfolios as these are mostly owned by the Royal Colleges and Faculties. Someone should verify the printout of your e-Portfolio as a true copy. One of your colleagues should be able to do that given it's already been signed off appropriately by consultants in the e-Portfolio system.

Q) We do not have students in my own department (Radiology) and hence do not have teaching sessions. How can I cover this gap?

JB: If you don't have any teaching experience, you'll need to get that. It doesn't necessarily have to be teaching trainees; you need to look at what your own curriculum requires. Most curricula will ask for a range of different teaching settings and styles. There may be other ways you can demonstrate those competencies. If you have nothing from your post so far, I would suggest you look for some ways to obtain that evidence; there should be examples in the SSG for Radiology.

LM: With COVID, there are opportunities unique to now, as there is more opportunity to deliver online training; you could offer to provide remote training for other Health Boards without having to travel there in person. If you structure the session, with learning outcomes and ask for feedback afterwards, you can submit that as evidence.

GMC CESR Advisor JK re: Question about showing evidence of teaching experience in Radiology

JK: The specific clinical radiology examples are example presentations (at least 2) or confirmation of delivering presentations, alongside learner feedback/assessments of teaching. Clinical radiology guidance is quite specific on that. Unfortunately, without those, it will likely be deemed a deficiency in the application.

Re: Question on whether case reports on which the applicant is primary or co-author would suffice in the research requirements?

JK: In terms of research activity, the clinical radiology guidance is less specific; it gives examples of publications, posters, abstracts, research projects, ethical committee participation, good clinical practice certificates and patient consent forms. That does make it more flexible; I would advise looking at those bullet points and providing a mix of evidence. As non-clinical advisers at the GMC, we can't guarantee specific content will make an application successful, but the examples are there.

Q) I worked as a Consultant in a teaching institute in India for 5 years before moving to the UK. Can my experience there be counted as teaching experience for CESR? How can I submit this evidence?

JB: If within the last 5 years, then yes you can. Someone from that institute should verify it, so you should contact your former colleagues and have someone complete that proforma document. Any evidence you provide can come from any country in the world if it's recent enough, i.e. with the last 5 years; but make sure it's demonstrating the teaching competencies needed here in the UK.

[Follow-up to above] Q) I have case reports as a primary and co-author. Will this suffice in the research section?

JB: I would have to refer to the guidance for your specialty as I don't know what the research element would be in your case. I'd check the guidance for that, and we can look it up for you afterwards if need be.

Q) I am currently paying for an e-Portfolio for the Haematology curriculum so I can collect evidence. Haematology training is 5 years. How long would I have to collect all the evidence and put in the application? Would it still have to be done within 5 years or would I have longer?

JB: 5 years is recent evidence of competence and what it takes for a trainee starting from scratch and learning skills as they go along. If you have experience it may not take the full 5 years to gather that evidence. If you start now, it only takes you 3 years and you're satisfied that you've covered your curriculum requirements, you're welcome to submit your application.

Q) I'm assuming I can sit MRCPath as a non-trainee?

JB: Yes, this is available for everyone to sit.

Q) If we're listing a verifier from an overseas institution, the only email I have for my verifier is not institutional; is it okay if it comes from a private email such as Yahoo, Gmail, etc.?

JB: This will always be questioned in the first instance; most doctors connected to a hospital have a professional email, although we appreciate they might not when overseas. There is an extra form to be completed to confirm their identity and ability to act as verifier, so it's not necessarily a problem, but we will check with them to see if they can respond from a professional email.

Q) Does an advanced academic degree cover the CESR requirement for research methods skills?

JB: It depends on your specialty, but very likely yes, particularly if it was within last 5 years. Some specialties require advanced degree or it forms part of requirements (surgery). If there's a research module within an advanced degree, that would cover it, but make sure you provide information on what's covered in that qualification.

Q) Could we describe clinical cases which are linked to specific domains, signed by a supervisory consultant, and also submit a reflective piece on it? Is that a good type of evidence to submit?

JB: Yes. Depending on your specialty, you can take a case, demonstrate which domain of the curriculum it addresses and provide a reflection on that which is very good evidence. You don't need a reflective piece on everything you're providing, but cross-referencing a few is definitely advantageous.

Q) Where the SSG has not specified the number, are we required to provide at least as many WPBAs as the total a regular CCT trainee will gather over their years of training?

JB: Very likely yes. It should be noted that the SSG itself isn't your standard of assessment, it's guidance on what you should probably submit. If there are no set numbers in your SSG, make sure that there are none in your curriculum. For physician specialties, if you review the ARCP decision aid that may say a trainee needs to complete a minimum number of assessments per year, so you're very unlikely to succeed if you haven't got the same number. The assessment numbers are in the new curricula as well as the companion CCT guideline document that outlines what trainees are expected to do; that's your best blueprint for what the standard looks like.

Q) What is the success rate in Psychiatry for passing CESR?

JB: It is lower than average, mostly because applicants don't have the MRCPsych and not having that knowledge, they are assessed against all core and specialist competencies for the Psychiatric specialties. Also, some psychiatrists only practice in one particular specialty area; the curriculum requires practice in different settings such as emergency ones. Make sure you review the curriculum and cover all the areas required. For more information, please contact us at the GMC directly.

Q) Much of what I want to upload in terms of evidence would come from SOAR (Scottish Online Appraisal Resource) – is it possible to transfer data straight from SOAR to the GMC application?

JB: I'm not aware that we're set up to transfer data between us at the moment; however you can submit that data but you'd have to download it from SOAR and upload it to the GMC. There are unfortunately so many systems, such as College e-portfolios, that we're not currently set up to directly receive data from them.

Q) For clarification, do we submit evidence from last 5 years only or submit from years before knowing that they might not have enough weight?

JB: As addressed, your GMC adviser would ask why you're submitting anything from more than 5 years ago; it would be strongly advised to stick to the last 5 years unless you have a very good reason to submit something older, as it won't hold that much weight. Something recent is required to show that your competencies have been maintained.

Q) Is there a standard CV pack you'd recommend?

JB: Yes - in the pack A of the handouts provided, there is a link to the GMC website with advice on CV formatting in line with the four domains of good medical practice; there is a particular order to present your experience in, listing your posts from most recent to your primary medical qualifications. Be careful to watch dates of each post and ensure they match evidence you are providing.

Q) I am struggling to get a response from the overseas university I attended, for them to stamp and confirm the curriculum that I completed to get my MBBS degree in 1995 and my Masters degree in Paediatrics in 2000. Will this not being submitted cause rejection of my CESR application?

JB: No, you can provide that speciality medical qualification as that will demonstrate your competency, given how long ago your training was. It is not a problem if you cannot provide that evidence, it will just be for your background on training, whereas the assessor's conclusions will mostly be based on the last 5 years.

Q) How do Medical/Clinical Directors give any structured references - is that they know that we have not been in any major trouble and that there's been no complaints from our departments regarding us?

JB: Yes, they're in a position to oversee your practice and give comments on those things.

Q) The guidance says not to upload theatre lists or rotas but the application asks for theatre lists and rotas to substantiate the evidence. Can you please clarify this?

JB: Check the guidance – some application forms are generic where the curricula are not yet updated but we should only be asking for what we need. If you are not sure, confirm your specialty and get in touch for clarification. For surgical specialties in particular, theatre lists or patient lists are not required so please don't provide these.

Q) How do I include CESR to become part of my job plan so that there is an allocated paid component that has earmarked time for extra programme activities for general adult psychiatry etc, during which I am not expected to do my regular day work?

LM: This is a conversation for everyone individually to have with their clinical director or whoever does your job plan. You are not "entitled" to have specific time in your job plan for CESR unless you've been employed on the basis that the team will allocate you time in your job plan to help you through CESR. However, as part of your appraisal and PDP, if you state that you aim to apply for CESR and have this discussion with your team, we'd hope that they would want to support you to achieve the competencies that you can't get in your day-to-day job. It might be that they could facilitate you rotating round to a different clinic that you don't normally have access to, in order to get that breadth of the curriculum. Try and get that time to gain experience and e.g. workplace based assessments – where you might ask supervisors/senior clinicians: "I am about to perform a procedure – please can you observe me doing this and sign me off afterwards/give me feedback?". It is a case of looking ahead to get this evidence in your day-to-day job – "please come and watch/sign me off" (even if I was the one who trained you in this procedure in the first place!) Find opportunities locally to do these pieces of work to gain the evidence. If you are not managing to gain the competencies in your normal job, do speak to your SAS Education Adviser about having some time for secondment. Getting your evidence in an organised fashion, finding and uploading the documents is something that you will have to do in your own time, as not many CDs will give you this time in your job plan. Get the practical evidence, get involved in research / audit; hopefully you can talk with your CD and get these as part of your job plan.

Q) What is the success rate in CESR for neonatal medicine?

JB: All paediatric specialties have a 100% pass rate on review if they were unsuccessful on their first attempt last year. Paediatric requirements are very specific for review applications, so even if not successful the first time, there is a higher than average review success rate. It is all to do with personal experience, how much you engage with the guidance and the evidence you provide.

Q) Has anyone achieved CESR in Learning Disability Psychiatry?

JB: Yes, they will have done but it is not one of the most common applications in psychiatry (these are general/old age/child).

Q) Should feedback letters from medical students be verified as well?

JB: If it is not listed on the proforma on the GMC website, it doesn't need to be verified (feedback 360, patient feedback, etc). There is nobody who can verify it because the GMC can't go to each individual patient or anonymised trainee and ask them to confirm if they provided feedback. This is considered to be "secondary evidence" which will triangulate with the primary evidence of you completing those teaching activities.

GENERAL ADVICE

Overall CESR Application Advice - JB

Read the specialty specific guidance – it's there to help you and is also used by the GMC. Make sure you know the curriculum inside out, make sure you read your guidance which will tell you what you need. The GMC are also here to help. If you think of anything else that comes up, send it to Lynne or Phil and they'll forward to me or contact us on the details provided. We are happy to help with any questions.

CESR Peer Support Network Information - LM

A survey has been circulated to everyone in Scotland to ask if SAS grades are interested in CESR and ascertain what stage they are at with their applications. Based on the information collected, the aim is to link everyone up with others in their specialty via email in order to share information and support one another through the CESR application process. If you are interested in this, please email the SAS Development email and we will give you a short survey to complete so that we have your permission to share your details with colleagues in Scotland. This is very much a Scottish database, to link up those applying for CESR in NHS Health Boards within Scotland. For those doing one CCT specialty which nobody else is, the aim is to link you up with like-minded others in a related specialty, where possible and practical, although it may not always be possible to provide a perfect match. The overarching idea is to link you up with someone/others who can help you as a result of their own experiences in applying for CESR. If you have any requirements for top-up training to get any of the competencies that Jess has mentioned today, we can help with this – this is generally up to 6-months training in one financial year, and occasionally a further short period of training can be supported. It is never too early to plan ahead and look for things like this. If you do have a gap that's been identified- maybe your training programme director has highlighted a gap in your experience- then you can hopefully gain these necessary additional competencies.

May 2021 – Update

The CESR Peer Support Network as described above, which started out via email, is now up and running on Microsoft Teams, to allow for faster and more convenient communication. It is a dedicated space to meet others from Health Boards across Scotland who are interested in applying for CESR or have started the process and would like some help and support from others going through the same process, or who have already achieved it. The Teams group is a place to meet, chat, share tips/resources/materials/challenges/solutions for all things CESR without the need to compose lengthy emails.

The group currently has 98 members including mentors who have already achieved CESR in their specialties and SAS Education Advisers from the regional Health Boards.

LM General Advice

Ask the GMC, keep in touch with your colleges and your senior clinicians in your specialty, chat to the other trainees in the department and get their advice/tips on how best to achieve things, who else can help, what else do we need to do?

SAS Development funding is available which is ongoing – and speak to your SAS Education Adviser.