Use of an accreditation process to embed UK-equivalent Core Medical Training in an international context

D Black[1]

Education

Abstract

Background The Joint Royal Colleges of Physicians Training Board (JRCPTB) on behalf of the Federation of the three Royal Colleges of Physicians started a process of implementing UK-equivalent Core Medical Training internationally in 2014. An accreditation process was developed to ensure that training standards were at least equivalent to the current position in the UK and that a developmental process was embedded to ensure long-term program viability.

Methods This paper describes developing the appropriate standards, the types of accreditation being offered and the process of a full accreditation visit.

Results The outcomes and learning from the first three accreditation visits, two visits to Iceland and the first to Kochi in Kerala, India, are described. Significant improvement over time has been demonstrated in Iceland as well as very high standards of training in Kerala.

Conclusions The accreditation process is providing early evidence that UK-equivalent Core Medical Training can be delivered successfully in different international contexts. The findings emphasise the importance of externality as part of effective governance. Partners need to be carefully chosen with a high degree of commitment to the process of both implementation and ongoing development. Longer term evaluation will need to consider other dimensions, such as exam results, and trainee and trainer satisfaction.

Keywords: accreditation, Core Medical Training, international

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Introduction

The Joint Royal Colleges of Physicians Training Board (JRCPTB) on behalf of the Federation of the three medical Royal Colleges of Physicians (Edinburgh, London and Glasgow) started work on developing UK-equivalent Core Medical Training (CMT) programmes internationally in 2014.[1,2] The first started in Iceland in 2015, followed by Kochi in India and Dubai in 2017, then Wayanad, KIMS Trivandrum and Max, New Delhi, all in India in 2018. The programmes were designed to be, as far as possible, equivalent to current UK CMT and involved the use of the current UK ePortfolio, the UK curriculum and an annual review of competence progression (ARCP) process with both lay involvement and UK expert medical externality.

To implement each programme, senior educators attended an intensive development day at the JRCPTB offices in London.[2] Then the Royal College of Physicians (RCPL) Education Department provided 5 days of educational development onsite to all the Educational and Clinical Supervisors who were to take part in each project. This included ePortfolio familiarisation for the trainers and the first cohort of trainees. A requirement for regular JRCPTB (Federation) accreditation was a contractual obligation for each centre, in order to ensure that UK-equivalent standards were met as the programmes continued to improve, including replication of future UK curriculum developments in the UK.

However, the accreditation literature is vast and the simple word 'accreditation' can mean multiple different things to different people.[3] Processes may vary on a continuum, from a very strict adherence to standards, to a much more supportive participative and developmental approach. It is generally accepted though that accreditation has been shown to be effective in both identifying problems in postgraduate programmes and then being the lever to successfully solve those identified programmes.[4]

The Federation eventually approved the statement that 'accreditation is the recognition granted to an institution that

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Box 1 Four General Medical Council themes

1. Learning environment and culture
2. Educational governance and leadership
3. Supporting learners
4. Supporting educators

meets the standards or criteria established by the competent authority or association. The general purpose is to promote and ensure educational programme quality'. In the case of this programme 'the purpose is to promote and ensure high quality physicianly education and programme quality'. The process is a self-assessment with external peer assessment to accurately assess the level of performance in relation to established standards and to implement ways to continuously improve. Accreditation was also seen by the Federation as being a part of a partnership and an ongoing developmental process.

Standards used were to be based on:

- The current General Medical Council (GMC) standards for postgraduate medical education (with approval) as country appropriate.[5]
- The current CMT curriculum.[6]

This paper describes the methodology used for the current accreditation process, the levels of accreditation approved by the Federation, and the results and learning from the first three accreditation visits undertaken using this process.

Methods

The current GMC standards for education and training were reviewed to identify those standards that only related to postgraduate medical education and only seemed appropriate in an international context. The four themes currently used were all thought to be appropriate (Box 1).

Using these themes and considering the international context, a total of 36 requirements were identified. These became the core set of themes, standards and requirements to be used in each international environment. The Federation also approved three types of accreditation (Box 2),[1] the highest being UK CMT international accreditation Level 3. Achieving this signified that in the view of JRCPTB and the Federation, the programme was considered to be equivalent in terms of educational delivery of the curriculum to current UK programmes. The accreditation process was then developed and run through several stages.

- The accreditation visit could not occur until the programme had been up and running for one full year, including an ARCP with externality.
- The curriculum had to be the current CMT curriculum and fully implemented. The adapted set of GMC standards were then shared with the partner asking if any were thought to inappropriate in their local context. Neither Iceland nor Kochi for the first three visits wished to change any of the standards.
- The programme was asked to do a self-assessment against each of the 36 requirements, with examples of the evidence that could be triangulated on a visit. They were restricted to a maximum of a 100 words. This had to be provided at least 4 weeks prior to the visit.
- The visiting team scrutinised the self-assessment and any other evidence already provided to identify any particular issues or focus for the visit.
- The visiting team, as a minimum, comprise two senior physician educators from the UK and one experienced administrator in postgraduate medical education. Other

Box 2 Types of accreditation

UK CMT International Accreditation: Level 3

This approves training equivalent to full UK CMT. Trainees successfully completing this training programme and passing all parts of MRCP(UK) will fulfil the 'experience' criteria required to apply directly for higher specialty training in the UK. That is their clinical experience and competences would be considered the exact equivalence to someone completing CMT in the UK.

JRCPTB International Accreditation: Level 2

This reflects the provision of the detailed local curriculum for the early years of physicianly training with a modern competency-based curriculum. All parts of the MRCP(UK) form part of the programme of assessment of this locally determined curriculum. The accreditation process will be undertaken using local curricula as well as relevant generic standards of postgraduate education derived in part from the UK GMC standards.

JRCPTB Preparatory International Accreditation: Level 1

The provision of an organised local training programme that allows candidates to prepare for all parts of the MRCP(UK) examination as part of that training programme. The programme will be assessed against relevant generic standards based on GMC UK standards and will have evidence of an active process of developing and implementing a modern competency-based curriculum.

CMT: Core Medical Training; GMC: General Medical Council; JRCPTB: Joint Royal Colleges of Physicians Training Board

visitors are allowed if independent of the programme to be visited, and do not necessarily have to be from the UK.
- In each case so far, the visiting team observed the annual ARCP process on day 1 and on day 2 undertook the visit to the programme to identify evidence for all 36 requirements and to triangulate issues raised through prior information from the ARCP visit (Box 3).
- Following the visiting day:
  - the report documents against each requirement, whether it has been achieved, partially achieved or not achieved;
  - a list of mandatory requirements and recommendations are confirmed;
  - once the report is produced the local team is given a maximum of 2 weeks to correct factual inaccuracies; and
  - the full report with the mandatory requirements and recommendations is sent to the Federation Board for consideration and approval.

The Federation Board may not give accreditation, or they accredit for 1, 2 or 3 years, 3 years being the maximum.

Box 3 Structure of visiting day

1. Presentation on the current state of postgraduate physician education and local activities for the process. Discussion on progress with the Senior Team.
2. Private meeting of the accreditation team with the doctors in training for a minimum of 1 hour.
3. Private meeting with other clinical and educational supervisors for a minimum of at least 1 hour.
4. Visit to see educational or clinical facilities or other areas of interest or concern raised during the day.
5. 2 hours for the team to consider its findings.
6. 30 min feedback of mandatory requirements and recommendations to the local senior educators and senior manager and relevant senior managers.

Results

Iceland in 2016 had 15 trainees in their programme. There were multiple areas of notable practice that were commented on. The report found two areas of significant concern that had mandatory requirements and another five areas of significant for development recommendations. The full report was successful accreditation with conditions for 2 years from the Federation Board with a requirement for an informal review of the areas of significant concern at the ARCP in 2017.[7]

In 2018, a further full accreditation visit was undertaken, at this stage there were 42 trainees in the programme.

Table 1 tabulates the two areas of significant concern from the June 2016 recommendations and findings from follow up in 2018. Both these mandatory requirements had been successfully addressed; there had been considerable progress with many of the recommendations. In 2018, a further 17 requirements and recommendations were made, these were all further developments of the programme and none related to areas of significant concern. The programme was again recommended for approval for 2 years but without any conditions.

In Kochi, the first accreditation visit was undertaken in 2018 after the programme had been running for 1 year, the day after the first ARCP visit. The 12 trainees in the programme provided astonishing evidence that everyone of the 36 requirements had been met. A comment from one of the visitors (a UK Head of School) was that this was by far and away the most impressive visit that he had ever undertaken to a CMT programme. The only mandatory requirements were about planning for the conversion and introduction of the new Internal Medicine curriculum and ensuring future supply of trained educational and clinical supervisors.

Discussion

The ambition of JRCPTB, on behalf of the Federation of the Physicianly colleges, was to support and develop high-quality international training, in particular an ambition to provide UK-equivalent CMT internationally. From the very start it was clear that the governance of the process of both implementation and then delivery was going to be crucial to realising this ambition. In setting up the programmes, considerable effort went into ensuring that only partners that understood the commitment and were genuinely driven by a wish for world-class education would be accepted. There was also a requirement that every single educational supervisor and clinical supervisor was trained in all aspects of competency-based medical education. Efforts were also made to train the very first cohort of trainees in each site. It all took time, effort and money but JRCPTB was clear with each partner that it would only accept trainees having equivalent training where there had been a successful accreditation process.

The methodology used was a standard model, used by postgraduate deans and the GMC in the UK to assess graduate training and, in particular, problems in training. Indeed, it is very similar to the structures used by the Royal Colleges when they had full responsibility for training placements prior to the advent of Postgraduate Medical Education and Training Board.

The final success or otherwise of this programme of developing UK-equivalent international training, will eventually be measured in a number of ways: the number of trainees passing all parts of MRCP(UK); trainee satisfaction with the programme; applicant numbers and competition; competitive environment for training places; employers view and benefit or otherwise of having trainees in such a programme; and, finally, JRCPTB evaluation through this accreditation process. It will also simplify ST3 recruitment for those who wish to

Table 1 Concerns and mandatory requirements from accreditation visit in 2016 and follow up in 2018

Visit rating	Summary of concern	Recommendation in June 2016	Follow up in June 2018
Area of significant concern	Development of a process for managing medical admissions from the emergency department	There must be clear, agreed guidance for the management of patients awaiting admittance to a medical ward, via the emergency department As a priority it is essential for there to be clear reporting and escalation lines so that trainees and consultants are clear as to which service has responsibility for the patient at which stage in their hospital stay Whilst the Accreditation Team are unable to advise as to the physical location of the unit, it seems that the development of a formal 'Medical Assessment Unit' managed by consultant physicians may be most appropriate, in the medium to longer term	We were pleased to visit the newly located Medical Assessment Unit. The Unit had adequate resources and physical spaces for patients as well as clear protocols to ensure consultant responsibility and patient safety CLOSE
Area of significant concern	Nonclinical staffing for programme	At present there is a deficit in appropriate management/administrative support for this programme. The Faculty should be applauded for the work they have carried out in developing and maintaining the programme but the Accreditation Team are concerned about sustainability. Appropriate staffing is needed for duties including: • management of annual review of competence progression/other training meetings • induction arrangements • arranging and managing training sessions (including records of attendance) • continued development of policies and procedures, as per the newly developed Icelandic Gold Guide • rota planning and programme management	We are pleased to report that appropriate management/ administrative coordinator has been appointed and demonstrates the appropriate support required to deliver a sustainable programme. However, further enhancement of this support would be beneficial to support faculty and trainers CLOSE

gain further training in the UK and have been able to meet UK immigration requirements.

Learning from these first three visits appears to cover a number of areas. Firstly, it is possible and practical to implement UK-equivalent CMT in an international context. Partners need to be carefully chosen and a high level of commitment is essential, particular ensuring that all the educational and clinical supervisors are trained before the programme starts. The accreditation process has also shown that the current curriculum is a useful tool internationally and has validity the same way that the MRCP(UK) exams do in many international countries. Workplace-based assessments, including multiple source feedback, can be properly implemented and indeed, as we found in Kochi, with an enthusiasm from all parties by both trainer and trainees that is rarely seen in the UK. The ePortfolio works well internationally as does the ARCP process, which critically has long-term UK externality. The accreditation process was found to be acceptable to international partners, indeed taken very seriously, and concerns are properly addressed. So there is a real feeling that for both parties of this there is a genuine partnership between the UK and the local organisations. Importantly, both sides anecdotally reported significant changes and improvements in patient care with feedback coming from both trainers and managers. In Kochi run time analysis of cardiorespiratory arrest calls showed a 50% drop following the introduction of the CMT.

Are there any problems or criticisms of this approach? It could be argued that JRCPTB owning implementation of the programme and also undertaking the accreditation process is a case of 'marking your own homework'. However, the safeguards against this is the use of independent UK Heads of School on the accreditation team, an approach that sets out to be developmental, and importantly the final reports

are scrutinised and signed off by the Federation Board, which has no role in the implementation. There is also a cost to the accreditation process; however, it is the overall governance of the whole process and the fact that it can be seen to be demonstrably equivalent to UK CMT training that adds strength and value to the programme. Finally, there will be an ongoing need to support changes to the latest UK curriculum, including for the new Internal Medicine curriculum for 2019.

The JRCPTB is growing increasingly confident that it can work with international partners to implement UK-equivalent CMT internationally. It appears to have benefits for trainees and patients. The governance of the whole process, which helps in delivery and in ensuring long-term equivalence and quality, is essential. The accreditation process that we have developed and described appears to work on practical grounds with early demonstrable change being evident.

Long-term evaluation of this programme must include multiple dimensions beyond accreditation, such as exam results, trainee, trainer, employer and patient satisfaction, and long-term competition for the programme.

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