

To consider

Comprehensive Review of Our Approach to the Quality Assurance of Medical Education and Training

Issue

1. The scope of our proposed review of the quality assurance of medical education and training.

Recommendation

2. To endorse proposals for the focus of a comprehensive review of quality assurance in medical education and training as described in paragraphs 8-53.

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602

Background

4. Key Aim 1 of our 2011 Business Plan is to continue to register only those doctors that are properly qualified and fit to practise. Key Aim 3 is to provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career. This paper relates to both aims. Linked to those aims, our GMC Education Strategy 2011-2013 commits us to a comprehensive review of our approach to the quality assurance of education and training.

5. The Quality Improvement Framework (QIF) published earlier this year consolidates our previous work on the quality assurance of basic medical education (QABME) and of the Foundation Programme (QAFP), and the work inherited from PMETB covering the quality assurance of specialty including GP training.

6. Over the next two years we will be looking to enhance the operation of the QIF by piloting different approaches to visiting medical schools and postgraduate deaneries, by developing a smarter evidence base to help shape those visits, and by establishing a Quality Scrutiny Group (QSG) to provide more consistent analysis of the operational outcomes of quality assurance activity. The learning from these initiatives and from research commissioned into other UK and international models of quality assurance will help to inform our review. The Chair and members of the QSG have now been appointed.

7. However, changes to the healthcare environment and in the expectations of those who regulate it mean we also need to take a broader view of our whole approach to quality assurance and therefore to the questions that our review needs to address. This paper seeks to identify those issues and point the way to some possible solutions that we may wish the review to consider.

Discussion

8. Our work in recent years, and that of Postgraduate Medical Education and Training Board, has brought greater rigour, consistency and transparency to the quality assurance of medical education and training. This is borne out by the conclusions of independent evaluations of our Quality Assurance of Basic Medical Education (QABME) and Quality Assurance of the Foundation Programme (QAFP) processes commissioned from KPMG in 2006. But much has changed in the last five years and this brings new challenges. They are encapsulated in the Government's expectation that professional regulation must impose 'the least cost and complexity consistent with securing safety and confidence for patients, service users, carers and the wider public'¹.

¹ Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers, February 2011

9. We try to achieve this balance of rigour and proportionality through the three tiers of our quality assurance model (the QIF): quality assurance by the GMC, quality management by the medical schools and deaneries, and quality control by the local education providers (LEPs). The GMC sets the standards, requirements and outcomes for medical education and training. The medical schools and deaneries provide the GMC with evidence that the standards are being met by the LEPs. The medical schools and LEPs ensure that students and trainees receive education and training which meet the required standards.

10. However, despite the progress we have made, it will be important for the review to start from first principles, using our planned research into international models for quality assurance in the health sector and elsewhere to ensure we develop a system that is robust and proportionate, and that commands widespread support.

11. The following paragraphs, structured around the four elements of the QIF (approval against standards, shared evidence, visits and responses to concerns) set out the proposed focus for the review of our quality assurance activities.

Approval against standards

Consistency and divergence in our quality framework

12. Despite the QIF bringing coherence to our various quality assurance activities overall, there remain significant differences in our approaches to undergraduate and postgraduate training that our review should consider. Those differences reflect the respective legal frameworks governing the undergraduate and postgraduate stages. For example, in relation to postgraduate training we approve curricula and assessment systems but do not do so for undergraduate education where instead we set outcomes. For postgraduate training we approve, at a fine level of granularity, posts and programmes, whereas for undergraduate education our quality assurance is based on recognition of institutions.

13. We need to consider whether these fundamentally different approaches are each fit for purpose and whether we should move to a single model. On the one hand, changing our arrangements for postgraduate training to a model more closely aligned with that for undergraduate training might allow greater emphasis on the generic elements that contribute to developing the behaviours that society (and we on behalf of society) expect of doctors. It might also enable us to develop a more consistent focus on professionalism, while allowing individual specialties more scope for innovation and responsiveness to changing needs. However, the risk is that the reduced regulatory burden and costs that might result could be accompanied by greater divergence of standards and loss of regulatory control over developments.

14. A key issue for the review, therefore, should be to consider the most appropriate approach.

Approving the educational environment

15. Lord Patel's review recommended that the GMC should work with others to explore the benefits of accrediting or approving the education and training environment in addition to approving individual posts and programmes. He argued that by considering the institution as opposed to elements of the training, all the factors which contribute to an excellent and safe learning environment can be considered. He also believed that accreditation of the environment may have the benefit of bringing greater recognition to training, enabling healthcare providers which have been selected as training institutions to be recognised for excellence.

16. Such an approach would imply a significant change in our approach to quality assuring medical education and training. For example, we would need to consider the most appropriate unit for analysis. Should it be at the level of approving a whole Trust or approving individual departments or units within a Trust, since we know that problems in an institution may be localised rather than general? A number of options could be considered including direct or indirect approval, the development of regulatory quality outcome indicators (see paragraph 20 below) or simply closer engagement with the healthcare organisations in which doctors train. The resources consequences of these various options would also need to be evaluated

17. We cannot make decisions on this in isolation. There would be far reaching implications for the NHS if some environments were not approved as training environments. We would also need to acknowledge the work of others in this area, including that of the systems regulators and Medical Education England's (MEE) *Better training, better care* programme.²

Reporting

18. The reports on the outcome of our quality assurance activities are published on our website. They include details of any requirements and recommendations that an institution is expected to meet as a result of a QIF inspection. The review will need to consider whether the current reporting mechanisms are sufficiently accessible and transparent for others. For example, the reports currently give no indication of an organisation's performance in comparison with others. The review should consider whether ranking performance or acknowledging excellence could contribute to driving quality improvement, or whether it would risk distorting behaviours in undesirable ways.

² The *Better training, better care* programme has been developed by MEE at the request of the Secretary of State for Health to meet the recommendations and key themes arising from Professor Sir John Temple's report *Time for Training*, Professor John Collins' report *Foundation for Excellence*, and related work on maintaining quality of training in a reduced training opportunity environment. (MEE Update Issue 4. January 2011.

19. One of the differences between our quality assurance of undergraduate medical education and postgraduate training is the potential outcome for the institutions concerned. While we may introduce various recommendations or requirements that medical schools are expected to meet in order to retain GMC recognition, the outcome is essentially binary. The school is either recognised or it is not. Therefore, we can either exercise the nuclear option of de-recognition or take no formal action at all. In the postgraduate arena we have slightly more flexibility in that we can grant conditional approval for a training programme or post, and this may include time limiting the approval. We can also withdraw approval from a particular specialty programme.

20. In both cases we would expect to work with an organisation to try and address deficiencies before a decision on approval or recognition is taken. However, a finer gradation of regulatory sanctions could help improve the transparency of our quality assurance reporting. For example, there might be a role for formal warnings or the introduction of 'special measures' for struggling institutions or, conversely, the flagging of excellence. For students and trainees, these might signal more clearly than our present reporting arrangements the quality and standing of the institution in which they are training or thinking of training.

21. Developing quality outcome measures (as opposed to measuring processes) on which we can report is extremely difficult. Lord Patel's report noted that quality assurance activity must add value by measuring the things that matter most and not just the things that are most easily measured. The overriding objective must be to measure outcomes that will ensure students and trainees have the skills and qualities to enable them to become good doctors. He invited the GMC to consider whether the current focus of its quality assurance activities on institutional processes provides sufficient assurance of the quality of outcomes and individual trainees produced by those processes and of their progress through training.

22. A priority for our review must be to identify the sort of quality indicators that will give the required assurance. There are a range of different solutions the review may wish to look at. For example, the Medical Programme Board of MEE has been undertaking work to identify indicators might support a judgement of high quality teaching. The aim would be to use these metrics in the commissioning of undergraduate and postgraduate medical education and training. The quality indicators proposed fall into two categories (the educational environment and outcomes) and are built on the standards already set by the GMC in Tomorrow's Doctors and The Trainee Doctor. A similar initiative was recently announced by the Department of Health and another is being taken forward in Scotland by NHS Education Scotland. Clearly, it would be necessary to bring these separate strands together.

23. The review should also look at how quality in training might link with patient outcomes. Although much of medical care is delivered by doctors in training there are acknowledged difficulties in capturing the patient experience of the care provided by trainees. They may not always be aware that they have been treated by a doctor in training and the level of their contact with trainees may vary.

24. Nevertheless, there are indications from our National Trainee Survey that the quality of care is better and safer where trainees are well supervised. Supervision by senior and accessible trainers is linked with a culture in which reporting of incidents is encouraged and followed up.³ Effective clinical governance is likely to go hand in hand with effective educational governance. Positive patient outcomes may therefore be a pointer to the quality of training provided within an organisation. Our review may therefore need to consider what data produced by others about the patient experience might be used to target our own quality assurance activity.

Overcoming regulation by proxy

25. As Lord Patel's report intimated, much of the quality assurance activity currently undertaken is a proxy for our real concern: the student, the trainee the doctor and of course ultimately the patient he or she treats. Although the QIF is built upon an established and proportionate quality assurance methodology it inevitably has limitations. For example, it means that our principal (albeit not the only) means of engaging with the educational environment is through the deaneries (or whatever structures might replace them in the future). We are dependent on others to identify and report concerns. Careful triangulation of evidence from different sources helps to mitigate that risk and the paragraphs below on 'Shared evidence' will explore a number of ways in which we might reinforce our evidence base by obtaining better and fuller data.

26. Another approach would be to look more directly at outcomes and at the individuals emerging from training to assure ourselves that new doctors possess the qualities we expect. Our response to the Patel report indicated that we do not, at this stage, support the idea of a national assessment of students. We are working with the Conference of Postgraduate Medical Deans (COPMeD) on a project to explore what aggregated data about trainee progression tells us about the quality of training in programmes and across deaneries. However, we may wish the review to consider whether there is a case for auditing of individual trainee progression data (such as ARCPs) or selective sampling of the decisions taken by others (but on which we rely), and what form this might take.

Shared evidence

27. The more direct the sources of evidence upon which we rely (such as surveys, inspections, meeting students, trainees, trainers and patients), and the more effectively we can triangulate that evidence, the more robust our quality assurance regime is likely to be. At the same time, the review will need to be mindful of the costs and burdens that any quality assurance system imposes. We must not duplicate the work of others or seek information ourselves which may be reliable generated by others.

³ National Training Surveys 2010 Key Findings (page 30).

28. We have made good progress in building the evidence base upon which our quality assurance judgements rely. The National Training Survey is well established. This is complemented by, among other things, Annual Deanery Reports, Annual Specialty Reports and, for undergraduate education, the Enhanced Annual Returns from medical schools. We are also gathering softer intelligence about the education and training environment generally through our roundtable discussions with students, trainees and others. The introduction of Employer Liaison Officers and Regional Liaison Officers will, over time, add further richness to the picture, and greater GMC visibility at local and regional level.

29. Building on the work of the National Trainee Survey which reports trainees' feedback on their posts, we will be working with the Medical Schools Council to produce a standard questionnaire which seeks information from students about the quality of their placement experience in NHS settings. In addition, for our visits to medical schools starting in Autumn 2011 we are piloting a survey of medical students with two of the schools. If the pilot is successful it will be rolled out for all future school visits. The survey includes questions on teaching, assessment, feedback provided to students on their progression, and pastoral and academic support. Visit teams can only meet with a relatively small sample of students during a visit, so this additional evidence from students will assist visitors in making judgements. The review will be an opportunity to consider the merits of us undertaking regular surveys of all UK medical students, similar to the National Training Surveys of trainees and trainers.

30. As well as looking at the experience of students and trainees, we also need a more inclusive and systematic approach to understanding how well trainees have been prepared for medical practice by their training. To this end we might survey Trusts about the readiness of doctors for different stages of their careers (we already have some evidence of new graduates being unprepared for Foundation Training⁴), gather the views of trainees about the previous stages of their training and the views of new consultants about the quality of the training they received and how well it prepared them for their new role. This would build on exploratory discussions already taking place as part of our work to engage more closely with doctors

31. Other healthcare regulators are undertaking their own quality assurance activity and gathering information. The review should consider how we might better co-ordinate our respective quality assurance regimes and share the intelligence that we each gather. This will not only sharpen our focus but also reduce the burden on the institutions we are regulating. Developing the Healthcare Workforce has set out proposals for a multi-professional approach to the organisation and delivery of healthcare education in England. The GMC and other professional regulators will need to consider what this may mean in terms of their quality assurance regimes, and the review will enable us to develop our thinking.

⁴ Including work by Jan Illing and others

32. The accumulation of such intelligence will only pay dividends if the information can be gathered in real time (so that emerging risks can be acted upon promptly) and properly triangulated. This includes making better use of information derived from our other regulatory functions, such as fitness to practise and revalidation, to determine the overall risk profile of an organisation or department in which education and training are provided. While this would not enable us to form any conclusions about an organisation, it might help to tell us whether the organisation or department merits further scrutiny. Of course, interpreting such data will not be straightforward. Should we be more or less re-assured by the education provision in a Trust which refers no doctors into our fitness to practise procedures or where all the doctors are recommended for revalidation?

33. Equally, if our quality assurance activities show that a Trust is failing to meet our standards for education and training this could have implications for its ability to support robust recommendations in the area of trainee revalidation. We must be able to read across our separate functions and respond in a way that is coherent for regulation as a whole.

A unified quality assurance function?

34. The need to draw on information from across our regulatory functions may also point to a case for a single GMC quality assurance function spanning all relevant sections of our business. Our current quality assurance activities are focused on education and training. To a lesser extent we have also been concerned with the approval of practice settings for doctors new to UK practice so that we are assured they are working in environments where there are supportive clinical governance systems capable of providing appropriate support and identifying emerging problems. With the introduction of revalidation there will be a further layer of auditing and quality assurance. There is a risk of adding both complexity and regulatory burden to the healthcare environment.

35. While each of these activities is looking at slightly different issues and aspects of our business, there are obvious overlaps. The review should therefore consider the scope not only for the sharing of data across our functions but for the consolidation of all our quality assurance activities.

36. Underlying these issues are the different statutory powers that apply to our different functions. While we have explicit powers to quality assure education and training – for example, to undertake visits - we have no such powers in relation to those organisations which will deliver revalidation at a local level. This may not necessarily matter where an organisation is functioning effectively, but we will inevitably face situations in which we discover that the quality of educational provision within an organisation is very poor because of a serious failure of its educational governance. When such a case arises, as it surely will, we will need to consider our willingness to rely for revalidation purposes on the outputs of the same organisation's appraisal and clinical governance systems. At minimum, we undoubtedly need to be able to use the information we gather from one part of our business to inform our activities in the others. In doing so, we will also need to be mindful of the regulatory role of others, such as the systems regulators, and work closely with those bodies to ensure the effectiveness of the system as a whole.

Visits

37. As part of the QIF the GMC undertakes visits to medical schools and to the deaneries as the bodies responsible for the quality management of education and training. This includes visits to individual LEPs. The visits are planned and targeted according to the evidence base that has been assembled from other sources.
38. The visits enable us to share good practice, review management of concerns and investigate any other areas indicated by the evidence base to ensure that medical schools and deaneries are complying with the relevant standards.
39. In addition to operating a five year cycle of visits, the GMC also carries out targeted and random checks. Targeted checks allow the GMC to respond to areas of risk that warrant exploration outside of the usual cycle of visits, while random checks help to examine the effectiveness of the QIF by looking, for example, at how evidence for annual reports is being collected.
40. The issue for the review to consider is the proper purpose, function and form of visiting in our inspection regime. Indeed, the language that we use may shape our understanding of our purpose in this area. Although the Medical Act uses the term 'visits', we may feel that our regulatory intent would be more clearly signalled by reference to 'inspections'.
41. We have made good progress in enhancing the rigour, efficiency and focus of our inspections, but there are a range of issues the review should consider.
42. Visits generally operate on a five year cycle for those organisations that are performing satisfactorily. However, we should look at the scope for varying both the frequency and intensity of visits where the evidence base suggests this. Although visits may be triggered where we have cause for concerns, we should also look at the case for unannounced visits. At the other end of the spectrum, organisations that are performing well might be rewarded with an element of earned autonomy.
43. The review should also look at the implications of the new role of the Regional Liaison Officers (RLOs). Their ongoing contacts with an institution will help to inform our risk assessment and may affect the way we approach our more formal, statutory quality assurance visits.
44. All members of our visit teams undergo training. Each visit team will have a medically qualified member (for example, a Training Programme Director (or equivalent) or other senior clinician), a lay member and a student or trainee as standard, plus a GMC staff Education Quality Analyst. One visitor will be identified as the team leader. Visitors are recruited to teams from the GMC's pool of Associates based on their knowledge and experience and how these match the specific areas identified as risks in the GMC's evidence base. Additional team members are recruited based on their specific area of expertise (for example, experts in assessments).

45. The review should consider the scope to 'professionalise' the leadership of visit teams. It should also look at the composition of the teams and the role of the medical Royal Colleges in the process. Although the Colleges make a vital contribution to the quality assurance regime overall, there is currently no specific College or Faculty representative on the visit team. That is, in part, because the visits to deaneries are generic not specialty specific. Where the evidence base which informs the visit structure points to there being specialty specific issues which require investigation the visit team may include someone from the relevant specialty. Where possible the input will be obtained from a GMC Associate with relevant expertise, though this will not always require them to participate in the visit. Alternatively, input may be sought from the relevant College or Faculty.

46. The review should consider whether appropriately trained and appointed individuals from within the Colleges and Faculties should be selected to be part of the GMC visit teams where the visits are likely to be focusing on specialty issues. However, it would need to be clear that they would be acting as part of the regulatory regime under the auspices of the GMC and not as independent College visitors.

Responses to concerns

47. The final element of the QIF is the process for responding to concerns raised. Again, good progress has been made. It now extends to undergraduate education as well as postgraduate training, the process is given greater prominence on our website and we more systematically follow-up concerns raised in the free text sections of the National Trainee Survey.

48. For all this, the response to concerns process is not widely used. There may be cultural and process reasons for this. Students and trainees may, for understandable reasons, be reluctant to report issues (such as bullying, for example) and uncertain of the scope and threshold for intervention by the GMC. The review should consider how the reporting of concerns can be better understood and utilised. This might include better guidance as to what type of issues should be raised, with whom and how the GMC will deal with them.

Contextual issues

49. We need to acknowledge that any fundamental review of our approach to quality assurance over the next few years will be set against a background of significant change in the NHS.

50. At the time of writing, the Government has just completed a consultation which proposes the replacement of deaneries in England (the key element in ensuring quality management in postgraduate medical education). The current proposal advocates the creation of healthcare provider skills networks which may take on the responsibilities of postgraduate deaneries. As noted above, this is envisaged alongside a move in England to multi professional education and training commissioning which is likely to drive greater coordination in professional regulators' approaches. The extent to which these plans will survive the Government's current 'listening exercise' during the pause in consideration of the Health and Social Care Bill remains to be seen. Whatever the outcome, it will be important to ensure that any approach to quality assurance takes account of the supporting quality structures that exist, and to recognise that these structures may be different in England, Wales, Scotland and Northern Ireland.

51. There are also likely to be lessons for us from our recent experience quality assuring Swansea Medical School, and the Undergraduate Board will be considering how, through a review of the process, we build on that experience.

52. We will also need to consider the outcome of the Independent Inquiry into Mid Staffordshire NHS Trust which has the potential to influence significantly how quality assurance is undertaken.

53. Finally, we need to be aware of the economic situation facing not just the NHS but also the higher education environment. This will put more pressure than ever before on us to ensure that our quality assurance processes are proportionate and minimise the burden on those being subject to regulation, provided always that we have sufficient evidence to assure ourselves of the quality of education and training being provided. In the higher education sector, the economic pressures may give further impetus to proposals from a number of universities to develop further medical courses, either privately delivered in the UK or overseas. Both of these present challenges to our quality assurance capability and we will need to bear these in mind as we develop new proposals.

Recommendation: To endorse proposals for the focus of a comprehensive review of quality assurance in medical education and training as described in paragraphs 8 to 53.

Resource implications

54. We estimate that initial research to be commissioned to inform the work of the review will cost in the region of £60,000. The review would be taken forward by a small working group of Council members together with a series of workshops with key interests at a total cost of around £20,000 to £30,000.

Equality

55. Any future quality assurance programme developed by the GMC will need to have a full equality impact assessment undertaken before implementation. Equality, diversity and opportunity is a key domain in both Tomorrow's Doctors and The Trainee Doctor, and current and future quality assurance approaches must assess compliance with standards in this domain.