The GMC Quality Framework for specialty including GP training in the UK

April 2010

In April 2010 the Postgraduate Medical Education and Training Board (PMETB) was merged with the General Medical Council (GMC).

There are significant benefits to be delivered through a more seamless and consistent approach to education and training throughout doctors' careers. A single point of responsibility from admission to medical school, through postgraduate training, to continued practice until retirement will help to ensure consistency of expectations and standards.

Through the merger, the GMC has acquired the legal functions formerly performed by PMETB in relation to the regulation of specialty including GP training. These functions include setting standards for specialty including GP training and providing quality assurance of the delivery of specialty including GP training against those standards.

Documents and webpages that continue to apply have been reviewed and where necessary updated to reflect the merger.

The Quality Framework was originally produced by PMETB in 2007 prior to its merger with the GMC and has been updated in light of the merger.

Please note the use of the following terms throughout this document:

a. **deaneries** mean all postgraduate deaneries of the UK;

b. **colleges/faculties** mean all medical Royal Colleges, colleges, faculties and specialty associations;

c. **specialties** mean the specialties (including general practice) and subspecialties recognised by the GMC as the competent authority in the UK.

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Introduction

1. The General Medical Council (GMC) is the independent statutory body that regulates undergraduate medical education and postgraduate training in the UK. Postgraduate training covers both the Foundation Programme and specialty including GP training.

2. This document provides an overview of the GMC's Quality Framework (QF) for specialty including GP training. It sets out the development and objectives of the QF. The GMC recognises that there are levels of activity and responsibility when making sure that standards are being met through quality assurance. The GMC has responsibility for the quality assurance of medical education and training, while Postgraduate deaneries will be accountable for the quality of the postgraduate medical education (PGME) for their trainees. However the GMC recognises that the trainee's experience of PGME is that set within the health services, whatever the setting. These three levels: quality assurance, quality management and quality control will be explained, including the responsibilities of the bodies with an interest and stake in specialty including GP training. The Framework has five elements: standards incorporating approval; shared evidence; surveys; responses to concerns, and visits to deaneries.

3. The QF has been agreed and is applicable until further notice.

4. This document is supplemented by a detailed Operational Guide, published originally in January 2008. The Operational Guide provides a detailed 'how to' and explains the detail of the processes and elements of the QF for those with an active role in specialty including GP training. The Operational Guide is a 'live' document that changes as the QF is implemented. The GMC expects that processes and protocols will be developed and refined through experience and feedback.

5. The QF will be reviewed formally by the Council of the GMC. This review will be informed by an ongoing evaluation of all activities by the GMC.

The GMC's responsibilities for specialty including GP training include:

a. establishing standards and requirements

b. making sure that these standards and requirements are met through quality assurance (QA)

c. developing and promoting specialty including GP training across the UK.

6. The GMC's statutory powers in relation to specialty including GP training are determined by the Medical Act 1983 following the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC in April 2010.

The overall purpose of the GMC is:

to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Development of the Quality Framework

7. The Quality Framework was originally developed by the Postgraduate Medical Education Training Board (PMETB) which was merged with the GMC from April 2010.

8. In May 2007, PMETB launched a national consultation on a Quality Assurance Framework which concluded at the end of July. The consultation was supplemented by road shows across the UK. A full report on the outcomes of the consultation was published in September 2007.

9. PMETB and its stakeholders agreed that there needed to be a single overarching Quality Framework, which linked all activities when approving specialty including GP training. The QF integrates a number of QA processes through which approval information is obtained from deaneries, colleges and faculties, and local education providers (LEPs). The QF has quality improvement as well as quality assurance as a key focus. The aim is first to measure specialty including GP training using a range of evidence, and then to promote and maintain improvement.

The QF will:

a. provide public and professional reassurance about the standards and quality of specialty including GP training in the UK, through a robust, rigorous set of processes;

b. reflect fully the principles of good regulation, demonstrate value for money and be fit for purpose;

c. enable improvement and enhancement of the quality of specialty including GP training;

d. ensure specialty focus is maintained at local and national level by working with the Academy of Medical Royal Colleges (AoMRC), colleges/faculties and postgraduate deaneries.

Principles of good regulation

10. In developing the QF, PMETB was guided by the five principles for assessing and improving the quality of regulation originally established by the Better Regulation Task Force:

Proportionality: Policy solutions should be appropriate for the perceived problem or risk.

Accountability: Regulators must be able to justify the decisions they make and should expect to be open to public scrutiny.

Consistency: Government rules and standards must be joined up and implemented fairly and consistently.

Transparency: Regulations should be open, simple and user-friendly. Policy objectives, including the need for regulation, should be clearly defined and effectively communicated to all stakeholders.

Targeting: Regulation should be focused on the problem, aiming to minimise side effects and ensure that no unintended consequences will result from the regulation being implemented.

11. The QF adopted the Better Regulation Executive's principles; the table below sets out the principles and how these are addressed in the QF.

Principle	How the QF addresses it
Proportionality	QA activities are proportionate in time and focus. The QF is based around deanery QM and their working with colleges/ faculties at local level.
Accountability	The GMC will base its decisions on the evidence base which is made up from different sources of information. Degrees of accountability at all levels have been identified.
Consistency	The QF links up all the elements of the GMC's specialty QA activities. Through our QA activity we are creating a history of deanery provision which will contribute to more consistent and informed QA.
Transparency	The QF and supplementary documentation makes it clear what is required from stakeholders. Within the QF, people are asked to take actions and demonstrate evidence of those actions. Deanery self-assessment will be undertaken against the GMC's published standards and requirements. The public, trainees and patients have access to published QF guidance, QA reports and action plans on the GMC website.
Targeting	QA activities will focus on the problems, aiming for improvement, and on notable practice. Visits will be focused on issues identified from the evidence base, and responses to concerns will be targeted and appropriate.

The Quality Framework Introduced

Quality assurance and its relationship to quality management and quality control

12. The diagram below demonstrates the different levels of Quality Assurance (QA), Quality Management (QM) and Quality Control (QC) and how they relate to each other. It recognises postgraduate deaneries as the units of accountability for managing the quality of postgraduate medical education and training, responsible to the GMC for maintaining and improving standards over time.

QF Diagram

Quality Assurance

Definition of Quality Assurance

13. This encompasses all the policies, standards, systems and processes directed to ensuring maintenance and enhancement of the quality of specialty including GP training in the UK. The GMC will undertake planned and systematic activities to provide public and patient confidence that specialty including GP training satisfies given requirements for quality within the principles of better regulation.

14. QA is based on the statutory remit of the GMC. The GMC sets standards and requirements, and so approves all specialty including GP training (all modes of delivery, and all specialties and subspecialties) that leads to a Certificate of Completion of Training (CCT) or equivalent certificates in the UK. Together with its stakeholders, GMC seeks to improve and promote specialty including GP training. The focus is on enabling the providers of education at national, deanery and local level to concentrate on the delivery, evaluation and demonstrable improvement of specialty including GP training. The GMC will receive and verify information that ensures it can both maintain and promote specialty including GP training.

15. GMC quality assurance uses the principle of peer review of each deanery and local education provider's self-assessment in the annual deanery report against published standards. Peers will be GMC partners who are selected against published criteria and are either medical specialists or trainee specialists or lay (not medically qualified) partners. All parts of the QF will draw upon the experience and expertise that these three groups bring, with teams and panels being constituted from these groups. The final decision remains with the GMC.

16. Save in an exceptional case, approval is given if the standards and requirements set are met by the relevant body or bodies, judged against the standards and requirements set by the GMC.

GMC approval comes through quality assurance by:

a. Post and programme approval (including GP trainers).

b. Approval of specialty and subspecialty curricula.

c. Approval of assessment systems blueprinted against the approved curricula.

Ongoing GMC approval is retained through quality assurance by:

a. Annual reports from deaneries to the GMC against the standards and requirements. The reports must draw on evidence gained through the QM and QC processes. The reports to the GMC must be comprehensive but focused on exceptions only. The structure of the report and timing for receipt is set by the GMC; ongoing approval is based on the satisfactory receipt and content of the annual report to the GMC. The reports will include action plans that address how problems are being tackled, how notable practice is being disseminated, and the goals for the year ahead.

b. GMC visits to deaneries .

c. GMC triggered visits or other responses to concerns where necessary.

d. Annual college summaries from colleges and faculties to the GMC confirming that the curriculum and associated assessment systems continue to meet GMC standards and requirements.

e. Verification and confirmation through the GMC national surveys and other evidence sources where available, for example through collaborative activities. The GMC will always aim to triangulate the evidence for its decisions.

f. Re-approval of curricula and associated assessment systems.

Quality Management

Definition of Quality Management

17. This refers to the arrangements by which the postgraduate deanery discharges its responsibility for the standards and quality of specialty including GP training. It satisfies itself that local education and training providers are meeting the GMC standards through robust reporting and monitoring mechanisms.

18. Postgraduate deaneries are responsible for the educational governance of all educationally approved training programmes. All specialty (including general practice) training takes place within GMC approved training programmes.

19. JACTAG, the Joint Training Advisory Group of the Academy of Medical Royal Colleges (AoMRC) and Conference of Postgraduate Medical Deans (COPMeD), has been an important source in the development of the QF. Equally, PMETB worked with colleagues in NHS Education for Scotland (NES) to share respective developments and this iterative process has been helpful and illuminating. Wherever possible, the GMC ensures that the QF is complementary to the work being undertaken by COPMeD, NES and the AoMRC.

20. The GMC expects the deaneries to demonstrate adherence to the standards and requirements that it sets down. This is to be accomplished by close working with specialties through the colleges and faculties and with NHS Trusts and Health Boards and other local education providers.
    The development, implementation and evaluation of specialty education and training will be achieved through active co-operation between the colleges and faculties, and deaneries. QM should be seen as a partnership between those organisations; it is only through working together that deaneries, and colleges and faculties, with local education providers, can deliver specialty including GP training to the standards required.

21. Deaneries and colleges may benefit from undertaking their own surveys, but **must** avoid such activity at the time of the national annual surveys.

22. For QM, deaneries in conjunction with colleges and faculties may need to have a form of local visiting with the goal of improving the education and training opportunities. This may be helpful to the local education providers (LEPs) and enable local problem solving and dissemination of notable practice at specialty level. 'All such visits will be targeted and proportionate to the concerns identified prior to the visit' (JACTAG (then JACSTAG), January 2007). Wherever possible, autonomy should be given to Trusts, Health Boards and other LEPs to monitor their own performance against GMC standards and requirements.

Deaneries with colleges and faculties, need to undertake local QM visits within the following parameters:

a. Such local visits will be advisory and focus on improving the quality of training. Only the GMC can award or withdraw approval of training.

b. Visits are not to the deanery but with the deanery. Visits cannot be undertaken without the agreement of the dean.

c. Visits should have a very clear and articulated purpose and should be kept to the minimum needed to ensure that the GMC's standards and requirements are met and to promote improvement.

23. However, any college or faculty, or indeed any other interested party such as trainees or patients can raise concerns with the GMC (see responses to concerns). If there are concerns about the deanery itself, these must be raised with the deanery to enable them to provide reassurance. However, if problems persist, the individual or organisation may contact the GMC and an investigation will be undertaken promptly.

24. Day to day reassurance that the specific specialty including GP training is being delivered to the standards required will be at quality management level. The college or faculty will continue to need information about individual trainees in order to prepare the evidence for submission to the GMC for an award of CCT. It is expected that the deaneries will not have to provide different information to each stakeholder body but to draw upon the same information for QA as that used for QM and QC.

25. Deaneries *must* ensure active external scrutiny in the QM processes. This can be addressed in two ways. First, at specialty level, there must be external advice on all the processes of delivery, assessment and evaluation of specialty including GP training. **The GMC would expect that such specialist advice will normally come from the medical Royal Colleges and faculties.** Secondly, deaneries should consider external review by others in relation to the management of specialty including GP training, for example, through the engagement of employers; NES, SHAs or equivalent organisations; or other health professions or other deaneries.

External advisers

26. External advisers must have appropriate expertise and be independent of the deanery.

27. Medical external advisers will have expertise appropriate for the programme, course or school being considered and will normally be drawn from the colleges, faculties or specialty associations.

28. Deaneries must be able to demonstrate that all external advisers are independent of the programme, school or deanery, have the relevant expertise, and have no conflicts of interest. See also the *Standards for Deaneries*.

The role of the dean in relation to serious concerns

29. If there are very serious training concerns, postgraduate deans can, with college/faculty involvement and awareness, remove one or more groups of trainees from a setting or organisation. Such change must be reported to the GMC **immediately** and recorded as part of the annual deanery report, with identification within the action plan of the actions taken to remedy the situation where appropriate.

Quality Control

Definition of Quality Control

30. This relates to the arrangements (procedures, organisation) within local education providers (Health Board, NHS Trusts, independent sectors) that ensure postgraduate medical trainees receive education and training that meets local, national and professional standards.

31. The organisations that are responsible for QC are the local education providers such as Health Boards, all NHS Trusts, the independent sector and any other service provider that hosts and supports trainees. These organisations should normally have a Board level officer accountable for this function.

32. The deanery is accountable to the GMC for the quality of specialty including GP training; however, the day-to-day delivery is at LEP level. This delivery involves medical staff, medical education managers, postgraduate medical centre staff, other health professions and employers. The individual specialty including GP training is achieved through careful supervision and assessment by specialists in that discipline, with advice and oversight by regional and local staff from the relevant college or faculty. Structures will vary nationally and NES, for example, has identified ways in which the quality of local provision can be controlled. Each organisation must take responsibility so that it can demonstrate how the GMC's standards and

requirements are being achieved. The postgraduate dean and the deanery are to provide support and ensure that systems of delivery and QC are consistent across specialties and local education providers.

Risk based regulation

33. The GMC accepts and endorses the principle of risk based regulation. There is agreement that risk assessment is an essential means of directing regulatory resources where they can have the maximum impact on outcomes. The GMC intends to use the best evidence available to reduce administrative burdens while concentrating on those areas that need most help.

34. In the early stages of the QF, the concept of risk has been used simply. Risk at this stage has been seen as those aspects of delivery of specialty including GP training that do not, or potentially do not, meet the GMC's standards and requirements. The GMC will engage and work with all stakeholders to develop the structures and processes so that a fully risk-based approach can then be undertaken.

35. The GMC wishes to move towards a more sophisticated model including a fully risk-based Quality Framework but a QF that also continues to celebrate and disseminate notable practice. Moderate or significant risk may be an adjunct to an opportunity. Innovation and development can occur more frequently where risks are taken.

Quality Framework - the five elements

Five Elements Diagram here

Standards

36. Standards for training are an essential element of the QF. They form the backbone of the framework against which the other elements (national surveys of trainees and trainers, a shared evidence base, visits to deaneries and responses to concerns) are developed and measured.

Insert Standard Diagram here

Approvals

37. Approval is normally not time-limited. Approval may be given or maintained:

    a. with no conditions or recommendations or,

    b. with no conditions but with recommendations or,

    c. with conditions but with no recommendations or,

    d. with conditions and recommendations.

38. Where there are conditions, they must be achieved to the satisfaction of the GMC in the timescales set, or approval is not given. Where there are recommendations, there is no requirement to address them before delivery of the specialty including GP training. However, they will be followed up and progress monitored through ongoing QA activity.

39. The withdrawal of approval process is published and is available on the GMC's website.

Post and programme approval

40. The GMC is the sole authority responsible for the approval of posts, courses and programmes, including applications for re-approval of expired posts and programmes. Each application is assessed against GMC standards and requirements, and granted conditional or unconditional approval, taking into account the views of the deanery and college or faculty.

41. All posts, courses and programmes (full time and less than full time) intending to lead to the award of a CCT must be prospectively approved by the GMC. This includes academic integrated pathways, and periods spent out of programme for research or other training or learning opportunities.

42. Where the GMC has granted conditional approval to posts and programmes, monitoring of the conditions will be ongoing. Deaneries, along with colleges and faculties, and local education providers, will be expected to monitor training at a local level. This monitoring will form an important part of the QM and QC activity.

43. Approvals will be a key source of evidence for the QF. Information about the actual numbers of approvals, as well as the process of obtaining the data from deaneries, provides good evidence about deanery QM systems. Deaneries with good and well established processes submit applications of a high standard and, where conditional approval is granted, they respond appropriately within agreed timeframes. This information will be essential to triangulate and assess the deanery's annual report.

Curriculum and assessment approval

44. One of the GMC's roles is to ensure that college and faculty specialty including GP training curricula meet GMC standards and that there is consistency in standards across medical specialties in the UK. Consistent standards in curricula are important, as this will help to ensure that doctors are trained and equipped with the necessary skills, knowledge and behaviours to perform effectively in a constantly changing health service which is provided in a wide range of settings. The GMC approves all specialty including GP training curricula which lead to CCTs and subspecialty curricula that lead to the award of a certificate.

45. The GMC is keen to enable colleges and faculties to continue to develop their curriculum and assessment systems in a responsive and innovative way. The published protocol will enable colleges and faculties to develop their specialties with minimum administrative burden, and also ensure that any significant change is fully considered and approved prior to implementation. Colleges and faculties will be responsible for ensuring that changes, minor or major, are clearly communicated to GMC and once approved, to the deaneries in a timely fashion.

46. All curricula change and develop. Curricula will therefore need to be reviewed by the GMC.

47. Colleges and faculties will continue to be able to access advice and guidance from the GMC.

Approval through visits to deaneries

48. Visits to deaneries will have three possible outcomes: the GMC standards and requirements are 'met', 'met with conditions' or 'not met'.

49. 'Met' means that all standards and requirements expected of a deanery and associated LEPs are met. It does not preclude the deanery or LEPs having issues, concerns or problems that impact on posts, programmes or courses. All providers of education and training will have challenges and difficulties to overcome when delivering specialty including GP training; the 'met' judgement means that the standards are still being achieved notwithstanding that actions may be in hand to address such concerns.

50. 'Met with conditions' means that meeting the standards has mostly, but not completely, been achieved. Deanery QM systems may be incomplete or partial in coverage; or it may be that the QM systems are efficient and effective but an LEP has failed to meet all the standards for a particular programme or in a particular department. In that case, GMC teams can identify only those specialties or posts or programmes or departments that must meet conditions, recognising that the remainder have demonstrated that the standards are met.

51. 'Not met' means that one or more standards are not being demonstrated and fully reflected in the management and delivery of the specialty including GP training. The ability to recognise those that have met the requirements and those that have not remains essential. A decision of 'not met' for specialty or subspecialty posts or programmes will always involve medical specialists from the relevant college/faculty.

52. In all cases, as part of their annual report to the GMC, deaneries will be asked for an action plan that confirms how they are addressing issues or concerns.

    a. If 'met', the deanery will provide an action plan through the annual report, and be subject to responses to concerns when necessary.

    b. If 'met with conditions', for serious concerns the deanery will provide an immediate action plan focusing on the relevant standards not fully met. The annual report will document progress on all other conditions.

    c. If 'not met', the deanery will have another GMC visit within one year, focusing on those areas that did not meet GMC standards and

requirements. If this further visit concludes that the standards are still not met, the withdrawal of approval process will commence.

53. Approval can be granted at level of programme, post or group of posts, unit or departmental, trust or equivalent organisation. It may also be granted by specialty or across specialties, or exceptionally, at deanery level.

Shared evidence

54. Evidence is fundamental to the other elements of the QF. A key source of data is the deaneries; data required from deaneries is defined and transparent, with the minimum data set requirements identified. The evidence will include an annual report from each deanery that self-assesses against GMC standards and requirements. Other evidence will be from the annual specialty data from colleges and faculties, information from other healthcare organisations, from the national trainee and trainer surveys and the approvals work. This shared evidence is a necessary underpinning for each element (that is, approvals, national surveys, visits to deaneries, and responses to concerns).

55. The purpose of the evidence base is to:

    a. define a set of data, for all the GMC's stakeholders, that are measurable and transparent;

    b. identify minimum data set requirements and specify the details of what is collected (definitions and format);

    c. triangulate the evidence provided by different stakeholders and check whether it is consistent and comparable;

    d. enable the GMC to fulfil its statutory function of approving and monitoring training in the UK through a range of evidence.

56. The evidence base for the QF will include:

a. a minimum data set that:

    i. is generated or gathered by the deanery;

    ii. is reported to the GMC in annual reports;

    iii. includes population data on numbers of trainees by specialty and where necessary by training provider in the annual deanery report;

    b. annual specialty reports from colleges and faculties including information on trainee assessment data per specialty including examinations;

    c. approvals: programme, GP trainer, post, curriculum and assessment system;

    d. previous QA reports;

    e. deanery action plans in response to internal and external scrutiny;

    f. GMC trainee and trainer surveys data;

g. clinical governance reports;

h. reports from bodies to which deaneries are accountable, namely Strategic Health Authorities (SHAs), NES, Welsh Assembly Government (WAG), Northern Ireland Medical and Dental Training Agency (NIMTDA);

i. other audit and quality assurance bodies, for example, the NHS Litigation Agency (NHSLA) and the Care Quality Commission (CQC).

Annual reports from deaneries to GMC

57. All deaneries will be required to provide an annual report submitted to the GMC in the required time and structure. This report will include:

    a. a self-assessment against the GMC's standards and requirements;

    b. an action plan that identifies actions taken to resolve areas of concern with levels of response, for example using a traffic lights system, and areas of notable practice, and plans for the future;

    c. the minimum data set.

58. The annual report will document the responses to key issues identified through external scrutiny, for example, GMC visits, national survey outcomes for that deanery, and also the outcomes of local QM and QC. The report should focus on exceptions, either concerns or problems, and notable practice; it should not be a summary of deanery activity. Detail is needed at QM and QC level, not at the level of annual reporting. However, deans must be able to provide the evidence for their action plans to the GMC if requested by the GMC.

59. The GMC has a proforma that deaneries must use for their annual reports to the GMC.

60. This annual report will be important in helping to identify areas of concern or focus for planned GMC visits to deaneries, including the exploration of any specific specialty programmes.

Minimum data set from deaneries

61. The minimum data set will be submitted by all UK deaneries to the GMC as part of the annual report. It will include a requirement for population data on all trainees in approved training programmes or posts that the GMC needs for its QF work.

62. The minimum data set will include the following:

a. population data for trainees - by specialty and by specialist training year. The local education provider should be identified where there are exceptions;

b. completion rates (deanery, per specialty). The local education provider should be identified where there are exceptions;

c. attrition rates (deanery, per specialty). The local education provider should be identified where there are exceptions.

d. individuals should not be identified.

63. Additional specific information may be requested for the surveys; these requests will be kept to a minimum.

64. Wherever possible the GMC will wish to receive and use data that is gathered once and used for all stakeholders. Sharing of information will start once all data protection issues have been fully addressed.

Action planning

65. An action plan, as part of the annual report, in response to the findings of the national surveys, GMC visits and local QM and QC activity will be required by the GMC. It is expected that deaneries and LEPs will take prompt and effective action, where appropriate, in response to all QA, QM and QC activity. It is the very essence of QM that deaneries should have a grasp of the issues affecting specialty including GP training for their trainees, and that the responses are proportionate, measured and evaluated. As the regulator, the GMC requires an overview of the exceptions that occurred in the previous year and evidence of the plans for the coming year. Action plans are a useful tool to show improvement and dissemination of notable practice, as well as how problems have been addressed. The action plans will be published.

66. Where there is a problem or issue requiring a more immediate report to the GMC, timescales will be communicated to the deanery.

Annual Specialty report from colleges and faculties to the GMC

67. It will be important for the GMC to receive information from colleges and faculties. Such information would provide an essential specialty perspective, a national overview by specialty and subspecialty, and would be particularly useful for small specialties.

68. The advisory structure for the annual specialty report and the requirements for examination data are set out in the Operational Guide.

69. The analysis of such data by the colleges and faculties will ensure that specialty-specific issues and context are fully taken on board by the GMC.

70. Colleges and faculties need to work with deaneries to share appropriate information to inform QM and QC, also to ensure the annual reporting to the GMC is accurate and informed.

Surveys

71. The national surveys of trainees and trainers form an important part of the evidence base by providing perceptions of training by deanery, specialty and specialty including GP training level. The findings of the surveys will require action by deaneries, which will be monitored by the GMC. Findings will also contribute to GMC's visits and responses to concerns.

72. The GMC will determine arrangements for administration and reporting.

National trainees' survey

73. The survey provides a national picture of trainees' perceptions of their training posts and programmes and gives the GMC invaluable and direct information to help shape the future of postgraduate medical education in the UK. The trainee survey has specialty-specific questions, as well as questions relevant to the generic standards for training.

National trainers' survey

74. The GMC also conducts a survey of all trainers in the UK. The national trainer survey aims to collect evidence on whether trainers are able to undertake their duties as trainers effectively, how these duties are formally recognised in job plans and training, and how supported trainers feel in their role. Trainers are considered to be experienced practitioners who are involved in training and supervision in the workplace. Trainers, therefore, include educational supervisors and clinical supervisors, and other doctors and qualified professionals providing clinical supervision of doctors in training.

75. The two surveys will enable the GMC to establish, at a national level, which aspects of training are notable and which need improvement. Survey reports are sent to deaneries, colleges and faculties and local education providers; outcomes of the surveys are published and available online.

Visits to deaneries

76. Visits are a critical element of the QF. Visits will focus on the QM of deaneries, the QC by LEPs, and the relationship that deaneries have with local education providers (QC) and with colleges and faculties to deliver training and support to trainees and trainers.

77. Visits to deaneries will:

    a. maintain the principle of periodic external scrutiny and verification of self assessment claims made in the annual reports;

    b. maintain the principle of peer review, including the benefit of lay and trainee team membership;

    c. seek to identify the more implicit benefits of interaction between deanery, local education providers and their peers;

    d. lead to the production of published reports which inform the trainees and the public of the quality of the postgraduate medical education provision;

    e. focus on improvement, identified by responses to the visit team's report provided by the deanery in the annual report.

78. The GMC will ensure:

    a. the robust nature of the scrutiny by drawing on a range of evidence that is not solely provided by the deanery;

    b. targeting of the areas for particular scrutiny, rather than examination of those areas that are already working well;

    c. that time and resources are used appropriately, so that the benefits and outcomes outweigh the burden;

    d. that activity is proportionate to the risk to patients and trainees, with more and enhanced QA activity where there is greater risk to these groups;

    e. that the processes are based on the principle that deaneries are responsible for the management of the specialty including GP training within their area and that the postgraduate deans are accountable to GMC.

Specialty focus in GMC visits

79. The GMC expects that the QM and QC activity will clearly and strongly focus on delivery and evaluation of specialty including GP training. This day-to-day management is crucial to the success of the outcomes of specialty including GP training as well as the process of delivery.

80. GMC visits to deaneries will focus on specialties specifically where problems or notable practice have been identified. The visits will test and audit the deanery management through such exploration. There will not be a 'sampling' process for specialties in GMC visits to deaneries, as all the specialty programmes and posts will be both quality managed and quality controlled all the time. The deaneries and the colleges and faculties will work together to ensure that training is delivered to meet GMC standards and requirements. GMC visits will verify the claims made through the annual reporting, against the available evidence and so confirm ongoing approval where appropriate.

Composition of GMC visit teams

81. GMC visits will continue to use teams of medical specialists, trainee specialists and lay members. If there is a particular need to explore a specialty or group of specialties further, there would be additional relevant medical specialists in the visit team.

GMC visit reports

82. Visit reports are structured around GMC standards and requirements, and are written by the visit team against a template. The report structure highlights positive or notable practice first, prior to identifying points of concern and action. The GMC will continue to scrutinise such reports and confirm approval and points of action by the deanery. The reports have an explicit referencing to evidence by visit teams, both from direct experience and including the evidence base. Guidance for the teams on the best way of dealing with single sources of evidence, and the level of investigation required before findings are included in visit reports, is provided.

83. The response from the deaneries and local education providers will normally be included in the annual report as part of the action plan and record of progress. However, if there are issues and concerns that need a more immediate response, then the deanery must provide that to the timescales set by the GMC.

Thematic QA

84. Quality assurance by the GMC should not draw upon a single model and apply this model in all situations. The nature of postgraduate medicine means that the specialties and subspecialties are fundamentally important. The flexibility of the QF structure and levels means that the GMC has a range of models that can be applied sensitively for the most appropriate outcomes. Thematic QA is a term used to describe ways that the GMC might work with colleges/faculties and other organisations to explore, assure and develop specialty including GP training beyond the deanery confines.

85. The following examples are three ways that the GMC may choose to meet its statutory objectives. One way would be to identify a particular issue from the evidence created through the QA activity, and explore this issue across the UK. An example of this would be to target an issue such as reliability of trainee workplace based assessments across all deaneries and one or more specialties. Examples of notable practice could also be explored nationally, to identify commonalities and so promote dissemination.

86. Smaller specialties with a limited number of trainees (10 or fewer) across the UK could be reviewed nationally. This would be a more appropriate way of examining smaller specialties and would ensure the anonymity of trainees. This work would be undertaken in close co-operation with the relevant colleges and faculties.

87. Similarly, national programmes that are delivered across more than one deanery could be considered, and this is particularly relevant in Scotland. Lead postgraduate deans for the particular specialties would also be integral to this. Pharmaceutical medicine is delivered outside the health services and has therefore formed the first example of thematic QA.

88. Themes could be identified at a number of different levels:

a. UK wide;

b. national work with colleges and faculties;

c. deanery evidence through deanery self-assessment;

d. at local education provider level – this may be an opportunity to explore the impact of a particular national policy on the provision of the specialty including GP training at local level.

Responses to concerns

89. The fifth element of the QF is the GMC's range of responses to concerns to ensure patient and trainee safety. Concerns can be raised at any level – from the GMC's own evidence base, by trainees or by external bodies or individuals. There will be a range of responses, including direct correspondence with deaneries, ongoing monitoring, triggered visits, random checks and exploring themes identified through the national surveys of trainees and trainers.

90. The final sanction will normally be withdrawal of approval for training.

91. Concerns will be identified or drawn to the GMC's attention, and initiate a response, through a variety of mechanisms including:

    a. quantitative data;

    b. themes from the national surveys data;

    c. information from visits;

    d. requests from other bodies and stakeholders such as deaneries, colleges and faculties, SHAs, NES, Directors of Medical Education (DMEs), trainees;

    e. complaints from trainees, trainers or others in the training community;

    f. random checks by the GMC.

92. The GMC's response will start with assessing the validity of the concern with the deanery, or with deaneries where appropriate.

93. All responses to concerns are normally undertaken by the GMC working co-operatively with a deanery, an LEP, and the relevant college and faculty.

94. Actions can occur at various levels, including:

    a. seeking a response from the deanery to find out what is being done about a concern;

    b. examining the evidence base to determine whether an issue has been resolved;

    c. continuing to monitor progress in addressing the issue;

    d. undertaking a GMC triggered visit to examine the issue and prompt a quick response;

    e. initiating withdrawal of approval for training.

95. Typically the process will be:

a. Direct correspondence between the GMC and deanery to investigate the concern. If the concern is identified as a 'live' issue, then the next stage would be a letter from the GMC requesting an action plan within a given timeline from the deanery, showing what action had been taken, and then the delivery of that action plan from the deanery.

b. The next stage will be an assessment of the action plan written by the deanery and where appropriate the LEP, by the GMC.

c. That assessment would then go to a GMC panel for a decision. The decision could range from panel agreement that the action plan satisfactorily dealt with the concern and met GMC standards, to the instruction to instigate a triggered visit.

d. If necessary a GMC officer will meet with the dean and relevant colleagues to clarify any issues, explore progress and provide advice.

e. Undertaking a triggered visit would be the next level of escalation in the range of responses. This would be a day-long focused visit carried out by a team of two or three individuals selected in relation to the risk.

f. Lastly, a full visit to the deanery, and where appropriate the LEP, could be organised and undertaken to investigate the concern in considerable depth and breadth. This would normally be undertaken only if the concerns indicated more widespread or fundamental problems at deanery level.

96. The GMC reserves the right to undertake any actions it considers necessary whenever direct or indirect evidence indicates a possible problem with specialty including GP training.

Triggered visits

97. Triggered visits are an important option for responding to concerns. They are undertaken where there may be possible serious educational failure which needs an investigation and where concerns cannot be satisfied in any other way. Examples are: serious and persistent lack of supervision; trainees being persistently required to take on tasks for which they were not competent; lack of opportunity for trainees to learn new skills under supervision such that they were unable to reach the required competences; and failure of the employer to tackle behaviour by trainers or colleagues that was undermining trainees' confidence and could lead to unsafe practice.

98. Triggered visits are arranged by the GMC in partnership with a deanery, a local education provider, and the relevant college and faculty.

Random checks

99. An additional way that the GMC may monitor the quality of training and the compliance of deaneries and LEPs is through the use of random checks. Checks made through random selection are in line with good regulation and are a useful tool to examine the effectiveness of the QF. The GMC will conduct such checks with deaneries or LEPs to explore, for example, the identification of exceptions, progress on agreed actions or examine information that is being collected.

100. Random checks will help to test the accuracy of the annual reports and monitor the efficacy of the visits to deaneries. They will be undertaken as part of the monitoring process once action plans have been produced as part of the annual report. Random checks will complement the other QF activities well and provide an important tool for the GMC to use.