



# GMC Education Strategy 2011-2013

Shaping the future of medical education and training

General  
Medical  
Council

Regulating doctors  
Ensuring good medical practice





# GMC Education Strategy 2011-2013

## Background – challenges and opportunities

The importance of our education function was significantly strengthened in April 2010 when the GMC assumed statutory responsibility for all stages of medical education. For the first time in the UK, a single regulator oversees every stage of doctors' training and professional development including:

- undergraduate medical education
- the foundation years
- specialty including GP training (or while they develop their careers in other ways)

- continuing professional development (CPD) and for ensuring, through revalidation, that doctors remain up to date and fit to practise.

It is against that background, and to ensure that the full benefits of this single continuum are realised, particularly through the integration of the principles underlying the different stages, that we have developed this strategy.

The strategy builds on solid foundations, in particular the recent review by Lord Patel in which,





following extensive engagement with key interest groups and then a full public consultation process, he set out recommendations and options for the future regulation of education and training ([www.gmc-uk.org/4\\_Annex\\_B\\_Outcome\\_of\\_Consultation\\_on\\_the\\_Review\\_of\\_the\\_Future\\_Regulation\\_of\\_Medical\\_Education\\_and\\_Training.pdf\\_31275463.pdf](http://www.gmc-uk.org/4_Annex_B_Outcome_of_Consultation_on_the_Review_of_the_Future_Regulation_of_Medical_Education_and_Training.pdf_31275463.pdf)).

As Lord Patel noted, the landscape in which medical education and training take place is changing and a number of different organisations have a role in shaping the environment in ways that affect doctors' careers.

In addition, a number of other developments may impact on medical education and training (including

reviews of the Foundation Programme and work flowing from the recent review of the European Working Time Directive and the White Paper from the Department of Health (England) *Equity and excellence: liberating the NHS*).

Regulation also has to be sufficiently agile to respond appropriately and proportionately to significant changes taking place in healthcare needs and delivery across the UK. These changes include the increasing incidence of chronic illness; rapid advances in biomedical sciences such as genetics; multi-disciplinary team working both in hospitals and in the community; and changes in the demographics and expectations of patients and the medical profession. All of these

changes are taking place against the backdrop of a difficult financial climate for all public services, including healthcare.

The challenge for the GMC is to set, maintain and enhance standards within a framework that is robust but flexible enough to be applied regardless of structural, cultural or other changes that may take place within the UK healthcare systems.

The purpose of this document is to set out the GMC's plans for enhancing the regulation of medical education over the next three years from 2011 to 2013. It sits beneath, and supports, the *GMC's Corporate Strategy 2010-2013* ([www.gmc-uk.org/Corporate\\_Strategy\\_2010\\_13.pdf\\_29731738.pdf](http://www.gmc-uk.org/Corporate_Strategy_2010_13.pdf_29731738.pdf)). The focus of the strategy is on

work which the GMC will lead. But we will continue to play an important role in contributing to work which others are leading and in which the regulatory perspective is important.

It sets out our principles, vision, aims and objectives grouped under four headings, and how we will measure success. We intend that this strategy will be a living document. An earlier draft of it was considered at the GMC's Education Conference in October 2010, and it has been amended in the light of feedback at that event. We will review progress annually.





## Principles

Supporting this strategy are a number of principles which underline the GMC's commitment to doing the following:

- Protect the public and patients through improvement of the quality of medical education across all stages and to use our powers decisively where patient safety or the integrity of training are compromised.
- Act as guardian and promoter of educational excellence.
- Be sensitive to the local context in each country of the UK while setting regulatory requirements that apply UK wide.
- Ensure that all our work is governed by the principles of good regulation in order that what we do minimises burdens and is cost-effective.
- Ensure that medical education and training reflects the needs of patients, the service and trainees.
- Promote equality and diversity in all of our policies and processes.
- Listen, learn and act by working with all organisations and individuals which have a stake in medical education in the UK and internationally.

# Vision

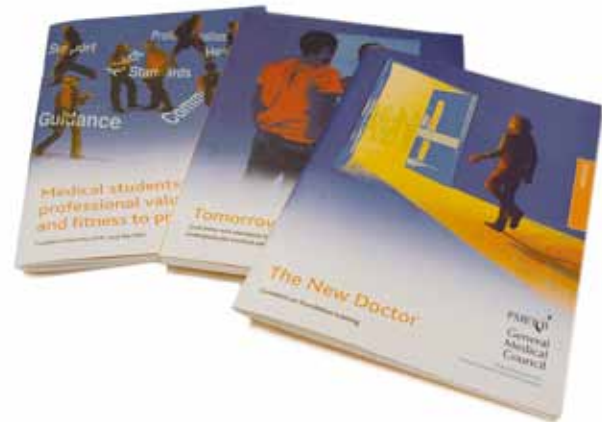
Through delivery of this strategy we will put in place a framework for the regulation of education and training in which, by 2013:

- There is a clear and shared commitment by the GMC and its partners constantly to improve the standards and quality of medical education in the UK.
- The outcomes of medical education and training are clearer, coherent and complementary across all stages.
- The standards we set are appropriately consistent across all stages and are clear, proportionate and measurable.
- There are clear progressions between the various stages.
- Our quality assurance activity is transparent, proportionate, coordinated and focused primarily on working with those, including students and trainees, who have a stake in medical education and training to ensure high standards, are maintained.
- The GMC's education function is fully integrated with our other functions of registration, standards and fitness to practise.
- We are working more closely with our key interests to improve standards of medical education, and we have improved mechanisms to feedback to them what we have learned to encourage learning and improvement.
- A more fit for purpose, flexible, legislative framework has been devised and is on track towards implementation.

## Key aims and objectives 2011-2013

We have grouped our aims and objectives under four headings:

- Setting and assuring standards, and valuing education and training
- Promoting effective selection, transition and progression
- Defining outcomes for education and training
- Working with partners and promoting feedback and learning.



## Setting and assuring standards, and valuing education and training

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**Aim:** *Ensure that the standards we set provide a framework for excellence and that we are proactive in maintaining compliance.*

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### Why is this important?

It is essential that we set clear standards that provide assurance to patients (and others) that medical education and training produces doctors with the appropriate knowledge, skills and behaviours. The standards should also make it clear what we expect from those responsible for delivering training, and they should promote the value of training. The environment in which education and training take place must be appropriate and positive: regulation should support trainers in embodying good professional role models for students and trainees to emulate. And, more broadly, with the expansion of the GMC's

responsibilities from 1 April 2010, we are determined to ensure that doctors in training have the right environment in which to learn.

Where we find failings in the delivery of education and training we will work with partners to leverage change and improvement where it is needed. But our commitment to high standards means that we will provide robust and transparent feedback where it is required. If patient safety or the integrity of training are compromised, we will act decisively including, albeit as a last resort, using our powers under Section 34 I (4) of the *Medical Act 1983* to withdraw training recognition.

## What we will deliver by 2013

### Alignment and review of standards

We will consolidate in one document the Foundation and specialty including GP standards. We will have completed this in time for visits to deaneries in 2011, thereby simplifying regulation.

By 2013 we will also begin a more fundamental review of our standards to ensure that they are fit for purpose by supporting excellence, being clear, proportionate, measurable and coherent across the GMC's four functions.

### Valuing training

By 2013, we will have developed and implemented an approvals framework for all trainers of undergraduate and postgraduate learners, building on the process for selecting, training and appraising GP trainers. It will promote and enhance the value of training both in individual job plans and within the organisations that employ doctors involved in training.

Working with others we will determine whether we should approve the educational environments in which doctors train. This could involve a range of options including the development of direct or indirect arrangements for approval, the development of regulatory educational quality outcome indicators and, at minimum,

much closer engagement with the healthcare organisations in which doctors train.

In 2011 we will explore whether regulation should do more to provide support for doctors in less than full time training.

### Developing a smarter evidence base

During 2011-2013 we will strengthen our evidence base. This will include the evidence we gather ourselves (surveys, visit reports), the evidence we commission (annual reports from medical schools, postgraduate deaneries and medical Royal Colleges) and other relevant information from other audit and quality assurance bodies including the systems regulators, including patient feedback.

This more systematic evidence gathering will be accompanied by more systematic analysis of data to identify trends and increase our understanding of what is happening on the ground. It will also enable us to be more effective in monitoring compliance with our standards and reduce the burden we place on medical schools and deaneries at the time of quality visits by enabling a more targeted approach.

### Consolidating quality visits and oversight

In 2011/12, we will pilot in two areas of the UK a geographic approach to visiting medical schools and postgraduate deaneries in order to promote an integrated approach to quality assurance whilst maintaining an appropriate focus on the different

requirements of undergraduate and postgraduate education.

In 2011 we will establish a group of medical and lay reviewers to examine and provide feedback on the reports of all quality visits (and other evidence). This will ensure a more consistent approach to maintaining compliance with standards and maximise the opportunity for sharing good practice.

### Reviewing our approach to quality assurance

In 2012, we will begin a comprehensive review of our approach to quality assurance. This will take into account the outcomes of the pilot visits, the impact of the strengthening of our evidence base and our conclusions on whether we should approve the educational environments in which doctors train.



## Promoting effective selection, transition and progression

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**Aim:** *Ensure there are clearer progressions between the stages of medical education and that risks associated with transitions are better managed.*

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### **Why is this important?**

It is critically important for patients that prospective medical students, and, once graduated, trainees, understand the commitment they will be making at each stage of their careers and that they possess or have the potential to develop the qualities required. At the point of entry to medical schools it is also essential that selection processes are fair and do not deter suitable candidates from socially disadvantaged or otherwise under-represented groups from applying.

Research evidence shows that there is heightened regulatory risk at key

transition points in doctors' careers, for example when they take on new levels of responsibilities. Regulation should help to mitigate the risks around such transitions, and the opportunity to do so is a key benefit of establishing a single regulator with responsibility for all stages.

### **What we will deliver by 2013**

#### **Selection into medical school**

In 2011 we will work with the Medical Schools Council and others to identify examples of good practice in relation to the selection of medical students, based on the best available evidence. We will commission further research if

necessary, including into predictors of performance and whether these might be used to inform student selection methods used by medical schools.

A number of medical schools have widening access programmes, intended to encourage applications from under-represented groups in medicine such as black males or those from disadvantaged socio-economic groups. We will continue to support these developments and work to take forward recommendations in the 2009 report *Unleashing aspiration*.

### Supporting disabled students and trainees

Our Gateways guidance provides practical advice to medical schools on how they can ensure that disabled students do not face unnecessary barriers to their undergraduate education. We have updated this guidance in light of the *Equality Act 2010*. By 2013 we will also examine the challenges that doctors with disabilities face at all stages of education and training and any implications for the regulatory framework.

### Transitions

We expect that the implementation of *Tomorrow's Doctors 2009* will do much to address past concerns about the preparedness of some graduates to enter the workplace. Nevertheless,

we will continue to work closely with others to support the critical transition in responsibility from medical student to new doctor. In 2011 we will take forward recommendations in the report of the Basic Medical Education Fitness to Practise Working Group. We will continue to contribute to groups established by the Medical Schools Council and Medical Education England looking at, respectively, transitions and shadowing. We will prioritise the development and implementation of arrangements that ensure, for the protection of patients and in the educational interests of trainees, that appropriate information about graduates is shared between medical schools and their Foundation Programme educational supervisor.

### Selection into specialty including GP training

In 2011, in considering whether further research should be commissioned into the selection of students into medical school we will also consider whether research should be commissioned in relation to the discharge of our existing responsibilities to set standards for selection processes into specialty including GP training.

### Review of CPD

By the end of 2011, working with the medical Royal Colleges and other key interests, we will complete a review of the appropriate role for the GMC in relation to CPD in order to support doctors in using CPD activity to help improve medical practice and bring about better patient care. The review will lead to consultation on revised GMC guidance on CPD.



## Defining outcomes for education and training

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**Aim:** *To ensure consistency and clarity, we will define clear outcomes which must be met by students and trainees on the completion of different stages of training.*

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### Why is this important?

The regulatory framework needs to provide patients, employers and doctors with a clear understanding of the levels of competence expected of doctors at successive stages of their training. There is scope to improve such clarity at all stages of education and training.

### What we will deliver by 2013

#### *Tomorrow's Doctors 2009*

We will publish supplementary advice to *Tomorrow's Doctors 2009* before the start of the academic year 2011/12 on student assistantships, teachers and trainers, assessment and patient and public involvement.

In 2013, we will begin a process to evaluate the impact of *Tomorrow's Doctors 2009* in providing greater assurance about the consistency of outputs of the UK's 32 medical schools. In the light of that evaluation, which will be thorough, measured

and inclusive, we will subsequently re-consider the case for introducing a national examination. Rather than approaching this as a simple binary decision – introduce a national examination or not – we will instead take into account evidence about the impact of work by medical schools to develop common approaches to assessment. That work includes the development of a Prescribing Skills Assessment by the Medical Schools Council and the British Pharmacological Society, and the development of a common bank of questions by the Medical Schools Council Assessment Alliance, building on the Universities Medical Assessment Partnership. We will consider the extent to which those initiatives, together with the more

prescriptive approach to outcomes in *Tomorrow's Doctors* 2009, have allayed concerns about the consistency of the outputs of the UK's medical schools, while retaining the strengths of the diversity within UK undergraduate medical education. However, if significant differences in approach are to be maintained, they will need to be justified and transparent to the public, the NHS and prospective medical students.

#### Foundation Programme

In light of the outcome of the ongoing reviews of the Foundation Programme, in 2011 we will define the outcomes required to complete the second year of the Programme.



#### Generic outcomes for specialty curricula

In 2011, we will begin to consider the scope for setting out generic outcomes for postgraduate training (for example, key components of the *Good Medical Practice* framework for appraisal and assessment such as leadership, communicate effectively, establish and maintain partnerships with patients, share information with



other healthcare professionals for safe and effective patient care, put into effect systems to protect patients and improve care and apply knowledge and experience to practice). To this end, we will shortly commission an external review of the 61 specialty curricula and 40 sub-specialty curricula, and the related assessment systems. The review will help determine the extent to which existing curricula already reflect core elements and the scope to develop this further. If there is such scope, we will take forward a further programme of work in 2011/12. We will work closely with the Academy of Medical Royal Colleges and draw upon their existing work in relation to core and generic elements of the curricula.

### Equivalence routes to the Specialist and GP Registers

By the end of 2011 we will review these routes so as to ensure they maintain the high standards required for entry to the specialist and GP registers and that they continue to command the confidence of all key interests. The review will make recommendations for any necessary changes (including any changes required to legislation).

## Working with partners and promoting feedback and learning

**Aim:** *We will work with all those organisations, groups and individuals who have a stake in medical education and training. We will develop mechanisms to feedback what we have learned to encourage learning and improvement.*

### Why is this important?

Many different organisations and individuals have a role in contributing to the provision of high-quality medical education and training: they include regulators, teachers, trainers, doctors and other healthcare professionals, the health department in each UK country, NHS organisations, the independent sector and other health services, the BMA, the medical schools and medical Royal Colleges, NHS Education Scotland, Medical Education England, the Wales Deanery, the Northern Ireland Medical and Dental Training Agency and other UK postgraduate deaneries.

In this complex and rapidly changing environment, the role of the GMC as the single medical regulator for the UK becomes increasingly important in providing a framework for assuring standards and promoting excellence. We are committed to strengthening the positive working arrangements which have already been established with all those who have an interest in the organisation and delivery of medical education and training. In doing so we will explore the potential for initiatives such as GMC regional liaison and affiliates to support our education partners at local and regional levels.





The GMC is not responsible for workforce issues such as the numbers of doctors in particular specialties, but aggregate data which we hold and are planning to enhance can be of great value to others. In particular, such data can help in ensuring an appropriate match between the future health needs of the nation on the one hand, and, on the other, the overall shape of the profession and the aspirations of individual medical students and doctors.

### **What we will deliver by 2013**

**Closer engagement with students, trainees, non-training grade doctors and consultants, and with patients and the public**

We will continue to develop a programme of engagement with medical students using a variety of means: at medical schools and through newsletters and podcasts.

Beginning immediately, we shall host a series of roundtable discussions with trainees, non-training doctors and newly appointed consultants and GPs in order to provide an ongoing source of rich feedback about the quality of medical education and training and challenges faced by those undergoing it, including issues around supervision, knowing where

to access support, preparedness for practice and the content of future surveys. And we will broaden and deepen our engagement with patients and the public, in particular, to test views about how effectively medical education is producing doctors with the attributes necessary to work in partnership with patients. We already engage effectively with patient groups at national level, but we will pilot work to improve our engagement with patients at local level.

**Evaluate the case for student registration**

In 2011 we will reexamine the case for student registration in the light of the effectiveness of our student engagement programme. This will explore whether the benefits outweigh the disadvantages. The key test will be

whether it will contribute positively to the promotion of professional values and to supporting a smoother transition to practice (rather than merely being a mechanism for addressing serious fitness to practise issues amongst a very small minority of students).

### Developing the use of surveys

Surveys are an important (but by no means the only) source of regulatory evidence. In 2011 we will, with the Conference of Postgraduate Medical Deans, review survey data collection processes to take advantage of the stronger IT infrastructure within the GMC.

We will review and revise the content of the trainee and trainer surveys to explore the scope to reduce the length

of the surveys while increasing their effectiveness through the inclusion of a smaller number of key 'smart' questions. We will also improve the functionality and usability of the online surveys reporting tools. In the light of that work, changes to the content and delivery of the surveys will be introduced in 2012.

By 2013 we will have piloted extensions to the scope of surveys, including about the experiences of SAS doctors and perceptions of recently qualified doctors and consultants and GPs about how well prepared they were by their medical education for their new responsibilities. At that stage we will go on to consider whether the survey should cover all doctors holding a licence to practise.





### Feedback and learning

We will continue to hold regular events or conferences for key interests on regulation and medical education.

We will report publicly on our activities, in order to promote improvement. In doing so we will build on existing mechanisms such as our Learning Points reports.

In 2012, in the light of the quality assurance pilots undertaken in 2011 and as part of a wide review of our approach to quality assurance (page 11), we will examine how we can make our quality assurance reports more transparent and accessible for the public. This will include exploring whether the outcomes of quality assurance visits should be presented in

a more graduated way rather than in terms of whether our standards have been met or not.

We will commission further research into medical education and training issues including, but not limited to, areas for research identified in this document. Among other areas we will consider the potential value of research into understanding how changing patient and societal expectations of doctors – and their own changing professional needs – should be reflected in the outcomes we determine, and questions around issues of mental health, stress, attrition rates and burnout amongst doctors at all stages of their careers.

## Equality and diversity

A number of the work programmes in this strategy have significant equality and diversity implications. A full equality impact assessment will be carried out as part of each project. Examples of some of the equality and diversity implications arising from this strategy are set out below.

International Medical Graduates are proportionately over represented among SAS/specialty doctors and among applicants for CESR/CEGPR. Some doctors in this group have also reported challenges around accessing CPD. Reforms in these areas have the potential to bring significant benefit.

Women now represent around 60% of UK medical students and it is estimated that they will constitute a majority of UK doctors by 2017. Changes to the structures of

postgraduate training, particularly if they impact on flexibility of training programmes, are likely to impact disproportionately on women.

The Gateways guidance has promoted better opportunities for disabled students wishing to enter medicine. The establishment of a single continuum for medical education presents an opportunity to take an overview of equality and diversity issues at all stages.



## Conclusion

It is important that we can demonstrate the success of this strategy. Our overall aim is to demonstrate, by 2013, significant, visible, progress towards a coherent and proportionate framework for regulating all stages of medical education and training. It must be a system that has continuous improvement at its heart and includes standards, outcomes and a quality assurance process that can command the confidence and support of all key interests.

We will demonstrate the benefits of the merger of PMETB with the GMC have been realised, not just in terms of efficiency but also demonstrating a coherent cross continuum approach to the regulation of medical education and training.

We will ensure that the needs of our key interest groups are being met. In particular, before the end of the life of this strategy we will survey employers about whether the UK is producing competent and confident doctors, and whether there are inconsistencies in outputs. Subject to piloting we will routinely ask students and trainees whether they are receiving the education and training they need to prepare them for a career in medicine.

This will be important evidence in demonstrating to patients that they are being treated by appropriately trained and professional doctors, which is the ultimate test of success.

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