To consider

Approving Educational Environments

Purpose

1. This discussion paper considers whether the GMC’s system of quality assurance for medical education and training should include approval of the environments within which education and training take place and, if so, the form that any such approval should take.

Further information

2. Richard Marchant 0207189 5024 rmarchant@gmc-uk.org
Discussion Points

Discussion point 1: The GMC standards for the delivery of education and training should include explicit descriptors of the educational environments expected in local education providers. (paragraphs 29-33)

Discussion point 2: The GMC’s standards for the delivery of medical education and training contained in Tomorrow’s Doctors and the Trainee Doctor are being reviewed. A provisional list of descriptors for the educational environment, which draw on the existing standards, the work of MEE’s Medical Indicator Group and the Educational Outcomes Framework, is provided at Annex A. Are these the correct descriptors? Are there things that should be added or taken away? (paragraphs 29-33)

Discussion point 3: Do you agree that the deaneries (in England, HEE regions) should be responsible under the QIF for ensuring that the standards for educational environments are met (as they are for other standards) and that GMC approval of courses, posts and programmes should have regard to those standards? (paragraphs 29-33)

Discussion point 4: What are the options for better co-ordination of regulatory activity across educational, patient safety and service concerns? (paragraphs 34-46)

Discussion point 5: Do you agree that the approach described in discussion points 1-3 of this paper, coupled the options explored under point 4, would provide a proportionate way of ensuring the quality of the educational environment, without the need for a formal approval of deanery/local environments? (paragraphs 34-46)
Background

3. The terms of reference for our review of quality assurance (QA) of medical education and training state that education and training are more likely to be effective when delivered in environments where they are valued. The review is therefore required to:

‘...consider the case for and against a quality assurance model based on recognition of the quality of the educational environment as a whole, as opposed to the programmes of training provided within those environments. This should include consideration of the characteristics of a safe and excellent training environment, the potential unit of approval, the implications of such a model for our relationship with system regulation and for the institutions within which training takes place.’

4. This paper explores these questions and offers for discussion some ideas about the role of regulation in assuring the quality of learning environments.

5. It is important to stress that these ideas do not necessarily represent current or future GMC policy. Nor are they exhaustive. Some of the ideas in this paper will have more merit than others. Readers may have additional ideas that are not covered in this paper. If so, we would be keen to hear them. The aim here is simply to begin to explore options and identify those which might be worth pursuing as part of the review.

Discussion

What do we mean by the educational environment?

6. The educational or learning environment can be defined in various ways. At its simplest it can mean the physical surroundings within which learning takes place, such as access to library facilities, seminar rooms or simulation equipment. However, references to the environment generally also encompass broader and less tangible notions of educational ‘climate’, ‘culture’ or ‘ethos’. The American Medical Association (AMA) defines the learning environment as:

‘a social system that includes the learner (including the external relationships and other factors affecting the learner), the individuals with whom the learner interacts, the setting(s) and purpose(s) of the interaction, and the formal and informal rules/policies/norms governing the interaction.’

7. AMA goes on to describe it as comprising three broad components in any institution or setting: institutional culture, curriculum (both formal and informal) and educational climate. NHS Scotland takes a similar approach referring to educational governance as the ‘systems and standards through which organisations control their

---

1 American Medical Association (AMA), Initiative to Transform Medical Education. Strategies for transforming the medical education learning environment. Phase 3: Program implementation. Final report of the December, 2008 working conference
educational activities and demonstrate accountability for continuous improvement of quality and performance.'

8. In 2011 the Medical Education England (MEE) Medical Indicator Task and Finish Group went even further, writing that:

‘An effective educational environment depends on the quality of the leadership, the quality of patient care, the nature of the infrastructure, and the preparation and support of trainers so that they are able to deliver their educational role.’

9. In its broadest sense then, an educational environment is anything which impacts upon the learner’s capacity to develop the appropriate professional attributes, and that includes the ‘quality of patient care’. It comprises the ‘conditions, forces, or factors within or exogenous to an educational setting capable of influencing the setting or those within it’. These may or may not be part of the formal educational governance system.

10. Such a broad definition presents problems for a regulator thinking of approving an educational environment. Measuring the effect of the ethos, climate and culture of the environment is fraught with difficulty. Further, the AMA notes that the link between elements of the learning environment ‘and the development of the learner’s professional identity, as exemplified by attitudes, values and behaviours, has not been established in a rigorous way’.

Measuring the educational environment

11. Nevertheless, various efforts have been made to describe the features of an organisation where learning is part of the culture and where educational governance is given importance. In its strategies for transforming the medical education environment, the AMA gives practical examples of the sort of measures needed to enhance the learning environment, such as a reward system for faculty and administrators which includes the expectation that they support the educational role in general and demonstrate positive behaviours that contribute to a positive learning environment, as well as sanctions for negative behaviours.

12. The MEE Medical Indicators Task and Finish Group identified a range of indicators as the best measures for judging the quality of an educational environment. Survey tools, such as the Dundee Ready Education Environment Measure (DREEM), have been developed to enable ‘global readings and diagnostic

---

3 MEE, Medical Indicators Education Commissioning for Quality, April 2011
4 http://www.education.com/definition/educational-environment/
analyses of undergraduate environments in medical schools and other health professions institutes.  

Does environment matter?

13. If evidence of the effectiveness of a positive environment on learner outcomes is limited, the negative effects of an adverse climate seem to be well recognised. AMA, for example, refers to supervisors’ lack of professionalism during interactions with patients and trainees, pressure on learners to behave in ways they may perceive as unprofessional and the presence of harassment or bullying.

14. On the other hand, the GMC’s 2011 State of Medical Education and Practice (SOMEP) report points to the effects of a positive environment. It notes research which ‘suggests that medical students and trainees gain from practical experience and positive role models’.  

SOMEP also refers to the results of the GMC’s 2010 trainee survey which underlines the relationship between a trainee’s perception of safety culture in the department where they work and the reporting of serious medical errors. Unsurprisingly, trainees were more likely to state that medical errors were reported if they worked in departments where they perceived that reporting was encouraged and followed up. They were also more likely to report serious medical errors themselves if they worked in a department where reporting was encouraged and followed up.  

As the SOMEP report notes, this suggests that trainees’ own practice is influenced by the culture of reporting where they work. So it is not just about formal educational governance systems, but the prevailing climate of the workplace more generally.

15. In the final report of Public Inquiry into events at Mid-Staffordshire NHS Foundation Trust, Robert Francis attaches considerable importance to regulation of the educational environment. He notes that Tomorrow’s Doctors contains ‘no explicit requirement with regard to the general standards of the establishment’ providing undergraduate training placements. He similarly noted that under PMETB the quality assurance standards for the Foundation Programme included criteria ‘focused on the supervision and assessment of the trainee rather than the environment in which he or she had to work’. And again, in relation to The New Doctor, that under the domain relating to patient safety the criteria to be demonstrated for this standard focused on the supervision and assessment of the trainee rather than the environment in which he or she had to work. Francis observes that these standards are concerned with protecting patients from potential risk posed by students and trainees and not with ensuring provider compliance with ‘fundamental patient safety and quality standards’ per se. He argues that the standards placed insufficient emphasis on the risk presented to patients from placing students and

---

6 A Practical Guide to using the Dundee Ready Education Environment Measure (DREEM)
7 GMC, State of Medical Education and Practice, 2011, page 58.
8 Ibid p 59.
10 Ibid p1208, paragraph 18.31
11 Now superseded by The Trainee Doctor
12 Ibid p1208 paragraph 18.31
trainees in an environment which does not comply with minimum safety and quality standards because trainees are likely to be less able than their senior colleagues to detect and address any risks arising. He concludes that ‘their training will suffer in such surroundings, but more importantly patient safety may suffer as well’.  

16. Francis acknowledges the need to avoid duplication with the work of the systems regulators and the lack of a clear relationship between the quality of care and quality of training. He nevertheless insists that GMC QA activity should ensure that no ‘provider of clinical placements should be permitted to receive or employ students and trainees in areas or services not complying with minimum patient safety and quality standards’ and that it is not ‘acceptable for training to take place in a training environment in which poor standards of care persist’.  

17. In responding to this call for the GMC to regulate the environment it is worth returning to the regulatory framework and standards currently in use.

Regulating the environment: approved practice settings, approved institutions, programmes and educational environments

18. Although the GMC is primarily a regulator of individual registered doctors, it is also already, in some limited and specific ways, a regulator of systems and environments.

Approved practice settings

19. Under section 44D of the Medical Act 1983 the GMC restricts doctors who are new to UK medical practice to work in ‘approved practice settings’ (APS). These settings are not intended to support a specifically educational function, but provide for a more general acclimatisation to UK practice. To that end, the settings are environments where individuals are subject to clinical governance systems which include appropriate supervision and appraisal. In practice, virtually the entire NHS is made up of APS, as are large parts of the independent health sector. But the language of the Act, the concept of an ‘approved’ setting and the implication that APS environments differ in quality from other, non-approved settings which in reality scarcely exist, has led Francis infer that they should involve much more intrusive regulatory control and quality assurance.  

20. Because the GMC lacks both the statutory powers and resources to inspect every existing or potential ‘approved’ environment in the way that might be expected of a systems regulator, it has based its approval decisions on the conclusions of systems regulators (such as the CQC) about that environment. This is

---

13 Ibid p1213 paragraphs 18.50-18.51
14 Ibid p1213, paragraphs 18.54
15 Ibid p1214, paragraphs 18.55
16 Ibid p1214, paragraphs 18.55
17 Ibid recommendations 164 - 168
18 This view is questioned by Francis.
the approach envisaged in the legislation.\textsuperscript{19} However, the GMC has recognised the severe limitations of the model, indeed to the point where it is hard to say whether APS has had any demonstrable impact on patient safety. The GMC has indicated that it wishes to abolish APS and is undertaking a review of alternative approaches - later in this paper we will return to the link between such settings and the assurances the GMC requires about the standard of education and training.

Approved institutions, programmes and educational environments

21. In relation to its education functions the GMC’s role is much more clearly that of a systems regulator. In the undergraduate arena it approves medical schools, not individuals, while for postgraduate education and training it recognises courses, training posts, programmes, examinations and assessment systems. (The GMC is currently seeking powers to approve undergraduate programmes rather than medical schools.)

22. It would be wrong to think that the GMC does not already regulate the educational environment. If the learning environment is the prevailing ‘climate’ in which learning takes place then, notwithstanding Robert Francis’ observations, many of the existing standards for undergraduate and postgraduate training are about the learning environment. They cover the physical surroundings:

‘The educational facilities and infrastructure must be appropriate to deliver the curriculum.

Students will have access to appropriate learning resources and facilities, including libraries, computers, lecture theatres, seminar rooms and appropriate environments to develop and improve their knowledge, skills and behaviours.’\textsuperscript{20}

23. They cover organisational infrastructure:

‘All employing organisations, as LEPs\textsuperscript{21} of postgraduate training, must consider postgraduate training programmes at board level.’\textsuperscript{22}

24. They cover organisational culture:

‘Trainees must have the opportunity to learn with, and from, other healthcare professionals.

Trainees must not be subjected to, or subject others to, behaviour that undermines their professional confidence or self-esteem.’\textsuperscript{23}

\textsuperscript{19} Section 44D(6) of the Medical Act 1983
\textsuperscript{20} Tomorrow’s Doctors, 2009, Domain 8 – Educational Resources and capacity, p72.
\textsuperscript{21} Local Education Providers
\textsuperscript{22} The Trainee Doctor: foundation and specialty including GP training, Domain 7 – Management of education and training, p33.
They cover the importance of all doctors acting as role models:

‘Every doctor who comes into contact with medical students should recognise the importance of role models in developing appropriate behaviours towards patients, colleagues and others.’

And, of course, they cover the more obvious environmental factors such as curricula, assessment systems, supervision and the role of trainers.

In fact, Tomorrow’s Doctors and The Trainee Doctor are full of examples of standards, criteria and evidence which attempt to define the environment within which learning should take place, even if they are not explicitly identified as such.

What they do not do, and what the Francis report recommends they should do, is link the provision of education with the quality of care provided in an institution.

They do not say that education and training should not be provided in an environment where the quality care received by patients is sub-standard.

In any event, we need to remember that provision of high quality patient care does not, in itself, guarantee an adequate learning environment. Even where the quality of care is high, if there are insufficient patients, or there is not the right patient mix to provide the necessary learning opportunities and experience, the environment will be unsuitable for training.

Should we be approving and what does this mean in practice?

There are some obvious risks for the GMC in attempting, unilaterally, to assure the quality of, and thereby ‘approve’, the overall healthcare environment.

First, we cannot afford confusion of purpose. Parliament has not tasked us with regulating the overall quality of care in the healthcare system. Second, our experience of APS demonstrates the problem of attempting to approve without the necessary legislative and regulatory tools. Third, there is a risk, as with APS, of creating false expectations about our role. Fourth, and linked to the notion of false expectation, is the danger of failing to recognise the boundaries between the GMC’s role and that of the system regulators. Apart from the additional regulatory burden on providers that this would impose, what if the GMC declined to approve an environment which had been endorsed by the relevant system regulator, or vice versa? For the reasons given in paragraph 28 above, the GMC may decide that training requirements would be better met in a larger establishment, even though patient care is good. Finally, there would be the question of the unit of approval. We know that the quality of care provided within a single institution may vary considerably between departments, so any system of approvals would need to operate at a fine level of granularity. This could result in the GMC having to approve many thousands of individual units across the UK. In short, if we want to take...
account of the wider environment within which learning occurs we need to develop a much more nuanced and creative approach.

**Describing the educational environment**

31. Our first task is to be clear about the components of a good educational environment. The GMC’s response to the *Shape of Training Review Call for Evidence and Ideas* encapsulates what is needed.

> ‘The characteristics of a good training environment need to be described and training organisations evaluated for their ability to meet those criteria. Above all, organisations which train must demonstrate their commitment to delivering high quality training.’

32. As we have seen, many of these characteristics are already embedded within our existing standards for the delivery of education and training, but they are not explicit. Through the review of education standards which is being undertaken as part of the quality assurance review, they should be made explicit. In doing so, we should consider incorporating the quality indicators for the educational environment identified by MEE’s Medical Indicator (ECQ) Task and Finish Group in April 2011 and the relevant metrics from the Department of Health (England) Education Outcomes Framework. This will result in descriptors of the standards, criteria and evidence for the educational environment. Using the Quality Improvement Framework (QIF) those responsible for managing the delivery of education and training (the deaneries/HEE regions) would be expected to demonstrate to the GMC that the standards and criteria for an educational environment are being met.

33. The provisional list of descriptors for the educational environment shown at Annex A is lengthy and detailed, but we hope it is a helpful starting point from which to seek feedback. It should also be noted that these descriptors would form one part of the overall standards against which education and training are judged, but would not represent the entirety of the standards.

**Discussion point 1:** The GMC standards for the delivery of education and training should include explicit descriptors of the educational environments expected in local education providers.

**Discussion point 2:** The GMC’s standards for the delivery of medical education and training contained in Tomorrow’s Doctors and the Trainee Doctor are being reviewed. A provisional list of descriptors for the educational environment, which draw on the existing standards, the work of MEE’s Medical Indicator Group and the Educational Outcomes Framework, is


26 The Education Outcomes Framework was published in March 2013. At the time of preparing this paper we are awaiting publication of the related metrics.
provided at Annex A. Are these the correct descriptors? Are there things that should be added or taken away?

**Discussion point 3**: Do you agree that the deaneries (in England, HEE regions) should be responsible under the QIF for ensuring that the standards for educational environments are met (as they are for other standards) and that GMC approval of courses, posts and programmes should have regard to those standards?

*Linking the educational environment to the healthcare environment: pooled sovereignty*

34. The development of clear standards and descriptors will give us regulatory purchase on the educational governance of an institution by insisting that organisations demonstrate their commitment to providing quality training. But standards and descriptors will not necessarily help us get to grips with the wider culture of an organisation, or of a unit within an organisation, in the way that Robert Francis recommends.

35. Developments such as the accreditation of services which are now being offered by some of the medical royal colleges provide a way of understanding the quality of a service (rather than the educational provision) at departmental level. But service accreditation schemes are voluntary and not, as yet, widespread. We would expect colleges operating such schemes to bring to the attention of the deaneries/HEE regions and the GMC any serious service deficiencies likely to have an adverse effect on education and training. However, attempting to harness these schemes to a specifically regulatory objective could undermine their real purpose and have unhelpful unintended consequences.

36. APS has illustrated the difficulty for the GMC of attempting to regulate the wider service environment. The GMC has had to use the work of the system regulators as an imperfect proxy for approving settings and has been reluctant to exercise its powers to refuse or withdraw recognition because to do so risks damaging patient care as a result of services being withdrawn. In part this arises from the unilateral nature of the action the GMC would have to take. The GMC would have to pursue its regulatory objective independent of the wider needs of the system of care. What is needed is not independent regulatory action, but action in concert with others.

37. The Francis report is just the latest of many Inquiries to call for better sharing of information between the different parts of the healthcare and regulatory system. That is starting, albeit slowly, to take place. But this can only ever lead to a piecemeal and fragmented improvement in the environment overall as each participating organisation pursues its own interests using the bits of data that it needs for its own purposes. To affect the environment we require a more holistic approach to the problems facing an institution and to the proposed solution. Without such an approach, problems will continue to slip through the regulatory gaps.
38. There is nothing new in this idea. Others have recognised the need for regulators to work together more effectively. For example, the Law Commission consultation on reforms to the legislation governing healthcare professional regulation looks at ways of improving the interface between organisations, facilitating joint working and introducing a duty of co-operation. This includes the possibility of regulators choosing not to act, or to reduce their activity, in a complex environment where other agencies are performing similar tasks. Such suggestions point to a need to consider more broadly the proper fit between professional and systems regulation.

39. Even without the sort of changes proposed by the Law Commission, shared regulatory responsibility is becoming a feature of medical regulation. Thus, revalidation is a process largely based upon systems of local clinical governance managed by others. There is no doubt that revalidation is the GMC’s responsibility but policing clinical governance is a matter for the systems regulators.

40. Earlier in this paper (see paragraphs 30 and 36) we referred to the dangers of the GMC acting outside its regulatory borders. We have seen in relation to APS that it is less effective when it attempts to do so alone. We also have feedback from struggling LEPs that one of the difficulties they face in turning a failing institution around is the myriad of separate requirements imposed by different regulators each pursuing their own ends. If regulators acted in concert they would be in a position to approach problems more holistically and bring greater pressure to bear on providers, while imposing less regulatory burden through overlapping but competing demands. There are different ways this could be achieved, involving different degrees of regulatory co-operation and integration.

41. At the furthest extreme would be a system of pooled sovereignty which would have the effect of creating a single, multi-professional approvals framework covering both the provision of patient care and education. This would clearly be a major change in approach from the current arrangements, would require legislation and a great deal of policy and operational work over several years to bring about. Even if such an approach carried support, the scale of the enterprise would bring significant risks and it would be a long term direction of travel rather than something that could be achieved in the foreseeable future.

42. A lighter touch (and possibly more realisable) version of the same idea would be to build on the sort of joint working that is already taking place between different parts of the regulatory system. For example, at a local level in England, the establishment of Quality Surveillance Groups and the arrangements for Quality Risk Summits now encourage the involvement of deaneries and regulators where education and training may be affected by issues under discussion. At national level the GMC and CQC are starting to facilitate better sharing of information, but it is not yet specifically directed towards more co-ordinated regulatory action. As a

---

28 Ibid, Part 6
29 National Quality Board, How to organise and run a risk summit: 2012/13
starting point we might explore the use of such action in cases where a serious concern has emerged.

43. ‘Pooling sovereignty’ in this way (or at least securing collective assurance) may require regulators to sacrifice some independence of action but could inspire a more coherent approach to effecting change. It may also enable the GMC and the system regulators to cross the border between the educational environment, approving practice settings and the service environment.

44. Whatever approach is taken, we need to be clear about the risks and limits of collective assurance. It should not result in a simple homogenisation of regulatory approaches; the educational environment needed to train a general nurse, for example, may not be the same as the environment required for training specialist surgeons. Furthermore, the GMC has statutory responsibility for the regulation of doctors and the regulation of medical education and training. We do not regulate the quality of care overall. When something goes wrong (and we should acknowledge that something will always go wrong) there must be no doubt about which organisation is accountable and has the legal and operational responsibility to act in relation to which matters. But, as the example of revalidation shows, confusion of responsibility is by no means inevitable as long as roles and lines of accountability are clear.

45. Similarly, in the arena of education and training, it should be possible to achieve co-ordination whilst preserving clear demarcation of roles. Arrangements are being developed for the GMC to alert the relevant systems regulator when, for example, the National Trainee Survey highlights ongoing concerns about patient safety which have not been addressed locally. Lead responsibility for tackling such concerns would rest with the relevant system regulator, but with professional regulation playing a supporting role in tackling any related educational implications.

46. Between the extremes of simply getting better at sharing information across regulatory borders and pooling regulatory sovereignty, the challenge is to agree how best to ensure an environment which provides both high quality care and quality education.

Discussion point 4: What are the options for better co-ordination of regulatory activity across educational, patient safety and service concerns?

Discussion point 5: Do you agree that the approach described in discussion points 1-3 of this paper, coupled the options explored under point 4, would provide a proportionate way of ensuring the quality of the educational environment, without the need for a formal approval of deanery/local environments?
Provisional quality indicators and descriptors for the educational environments expected in local education providers

Management of education and training: board level engagement

Standard

All employing organisations, as LEPs of postgraduate training, must consider postgraduate training programmes at board level.

Measure

1) The LEP Board has regular discussions about training. Every LEP should have a clear education plan to achieve high quality training and the Board will monitor and record progress. The plan should include a framework for developing educational leadership and succession planning.

2) The LEP has a designated executive or non-executive director at board level who is responsible for supporting training programmes in the organisation, setting out responsibilities and accountabilities for training and producing processes to address underperformance in training.

3) The LEP has a clear strategy for ensuring the delivery of GMC standards and implementing the agreed curricula and assessment systems, including action plans developed as a result of Medical School and Deanery monitoring processes and evidence that these are enacted.

4) The must be clear accountability, a description of roles and responsibilities, and adequate resources available to those involved in administering and managing training and education at institutional level, such as directors of medical education and board level directors with executive responsibility, such as medical director, finance director, or director of clinical governance.

5) The LEP has mechanisms in place to communicate, consult and disseminate information related to education and training issues throughout the organisation, including the outcomes of other regulatory reviews that impact on education.

6) The LEP can demonstrate the prevalence of teaching and learning which promotes a culture of multi professional working.

7) The LEP can demonstrate time and resources are provided for training including; educating the trainers - allocation of resources, monitoring of uptake.
8) The LEP has a clear framework to ensure safe patient care and safe education.

9) The LEP has a clear framework to ensure that there is effective handover of learners between trainers and to escalate concerns to the Responsible Officer where appropriate.

Clinical leadership and clinical and trainee engagement

Standard

Medical leadership must extend through the medial hierarchy.

Measure

1) The LEP has a clear purpose to provide high quality education and training including leadership through role modelling and workplace opportunities (with clear descriptions for learners of how the LEP will deliver the curriculum to them in that post)

2) The LEP manages and rewards performance both in clinical care and in medical education

3) Doctors working in the LEP encourage and facilitate change, recognising that the underlying values of the NHS must be visible and articulated. Individual and team performance is a focus of regular report and discussion.

4) Everyone involved in education medical students and trainees will be appropriately selected, trained, supported and appraised.

5) Trainers must be involved in, and contribute to, the learning culture in which patient care occurs.

6) Every doctor who comes into contact with medical students or trainees should recognise the importance of role models in developing appropriate behaviours towards patients, colleagues and others. Doctors with particular responsibility for teaching students must develop the skills and practise of a competent teacher and must make sure that students are properly supervised.

7) If the LEP has a CEO, he or she:

   a. Seeks and arranges informal opportunities for face-to-face meeting with medical staff and has fixed formal meetings with clinicians outside the medical staff committee structure.
b. Participates in all consultant appointments through informal meetings and sitting on panels

c. Meets all newly appointed consultants/principals as part of their induction programme

d. Spends a significant amount of time involving doctors in all aspects of running the business treating doctors as partners and moving towards structures where doctors lead whole areas of the business with support from general managers and specialists such as human resources and finance

8) Senior Managers demonstrate commitment to staff development and communicate this to employees.

9) The LEP devotes resources to organisational development through talent management and ensures adequate resources and access to programmes that develop leaders.

**Safe supervision**

*Standard*

Trainees must be supervised safely, in a graded way so that they learn to take decisions in a safe environment and know who and when to call when they are working with more remote supervision.

Trainees are not placed in environments where the quality of patient care is sub-standard.

*Measure*

1) The responsibilities, related duties, working hours and supervision of trainees must be consistent with the delivery of high-quality, safe patient care. Trainees must be supported to acquire the necessary skills and experience through induction, effective educational and clinical supervision, an appropriate workload, relevant learning opportunities, personal support and time to learn.

2) Medical schools must provide robust ways for concerns about patient safety to be reported in confidence and communicate these to trainees. Support and guidance must be provided for those who raise concerns about the health or conduct of anyone else, in order to protect them from victimisation. The process for raising such concerns must be made clear to students and trainees.
1) Trainees/students must have an effective induction/introduction to their place of work.

2) Trainees and students must work in an environment where they can ask for help without reprisals and where they have regular (weekly for trainees) meetings with a trainer who is able to talk through their difficult situations with them to assist learning.

3) Trainees must be able to hand over their care of their patients safely and in a way where a senior clinician is able to review their decisions with them to ensure safe patient care and learning from the duty period.

4) Trainees must work with graded supervision, where the level of supervision is consistent with their experience and competence. When trainees cover unfamiliar wards out of hours it is essential that other health care professionals are aware of the grade of the trainee they have called and the trainee’s previous experience. It should be common practice to ask for and give this information away from patients and relatives.

5) There must be clear easily accessible protocols for commonly encountered conditions and the trainees must know which consultant/GP they should call for support and advice.

6) When called, the consultant/GP should make a careful evaluation about their need to see the patient and should agree a clear plan including when next contact should be made between consultant/GP and trainee.

7) The LEP should have an agreed range of simulated environments for the trainees/students to undertake procedures without causing risk to patients.

8) The LEP should undertake regular audit of consent to ensure trainees/students are only taking consent after training and assessment.

9) The LEP should undertake regular audits of prescribing and give effective personalised feedback to trainees when they stray from agreed prescribing protocols.

10) The LEP must have an effective SUI reporting system that explores error in a no-blame environment. Common SUIs should be used to inform induction for all trainees/students.

11) The LEP has clear audited processes used by trainers to handover their conclusions about their learner to the next trainer.
Team working

Standard

The LEP must create a culture which supports effective team working.

Measure

1) LEPs must ensure that students and trainees work with and learn from other health and social care professionals. Opportunities should also be provided for students and trainees to learn with other health and social care students and trainees, including use of simulated training environments with audiovisual recording and behavioural debriefing. This will help them understand the importance of teamwork in providing care.

2) Opportunities for inter-professional learning are encouraged and attendance recorded.

3) Attention is given to formal development of team working skills, including theoretical understanding and practical skills.

Selection, Appointment and Review of Trainers

Standard

All those involved in the education of doctors and other professional groups must be recruited and trained to high standards and their continuance as trainers made subject to formative review.

Measure

1) Trainers are appointed to the role against agreed criteria.

2) Trainers have appropriate induction into the curriculum that applies to their learners and its requirements of them and of the learner.

3) Trainers are trained and ‘calibrated’ in the assessments that they are required to conduct for their learners.

4) Trainers have their education role and responsibilities included in their job descriptions and their expected competencies defined in their job specification. Their educational role is explored in their NHS appraisal and that role is included in their revalidation as a doctor.
5) Each trainer has current approval, and those who do not adequately fulfil their role as trainers do not continue in that role.

6) The LEP is able to demonstrate that there is a sufficient supply of trainers/training posts/placements to meet Deanery and Medical School requirements

7) The LEP is able to demonstrate that the educational development of trainers is integrated in the LEP education plan

8) The LEP is able to demonstrate that medical education is being discussed meaningfully at trainer appraisal and job plans being designed to accommodate educational activity.

**Educational infrastructure**

*Standard*

The educational facilities and infrastructure must be appropriate to deliver the curriculum

*Measure*

1) Students and trainees will have access to appropriate learning resources and facilities including libraries, computers, lecture theatres, seminar rooms and appropriate environments to develop and improve their knowledge, skills and behaviours.

2) Students and trainees must have opportunities to develop and improve their clinical and practical skills in an appropriate environment (where they are supported by teachers) before they use these skills in clinical situations. Skills laboratories and centres provide an excellent setting for this training.

3) The overall educational capacity of the organisation and any unit offering training within it must be adequate to accommodate the practical experiences required by the curriculum, including appropriate patient numbers and case-mix.

4) There must be access to educational facilities, facilities for a range of investigations and resources (including access to the internet in all workplaces) of a standard to enable trainees to achieve the outcomes of the training programme as specified in the approved curriculum.

5) There must be a suitable ratio of trainers to trainees. The educational capacity in the department or unit delivering training must take account of the impact of the training needs of others (for example, undergraduate medical students, other undergraduate and postgraduate healthcare professionals and non-training grade staff).
6) Educational resources relevant to, and supportive of, the training programme must be available and accessible, for example technology enhanced learning opportunities.

7) Trainees must have access to meeting rooms, teaching accommodation and audiovisual aids.

8) Trainees must be enabled to develop and improve their clinical and practical skills, through technology enhanced learning opportunities such as clinical skills laboratories, wet labs and simulated patient environments. Foundation doctors must have these opportunities, where they are supported by teachers, before using these skills in clinical situations.

**Time for trainers to train**

*Standard*

Trainers must have protected time for preparation, delivery and reflection in respect of any education and training they provide for learners.

*Measure*

1) Trainers, including clinical supervisors and those involved in medical education must have adequate time for training identified in their job plans.

2) The trainer has time allocated for specific educational purposes adjusted for the number of learners, in accordance with guidance from the AoMRC.

3) The LEP allows trainers time to plan and provide teaching and feedback, obtain peer review and receive development opportunities in education.

4) Feedback from trainees and students is appropriately considered and acted upon within the LEP.

**Time for trainees (support for learning and reflection)**

*Standard*

Adequate time must be available for learning to take place including time for learners and their trainers to be away from the provision of direct clinical care for teaching sessions, and time for learners and trainers to sit together for feedback sessions which underpin training in a clinical setting.
Measure

1) The LEP allows and schedules time in learners’ days for learning and reflection; this could be through a supervised handover.

2) The number of SLEs, compared to the expectations for each learner and the time for feedback recorded on them (particularly Case-based Discussions, which centre around discussion of the care planned by the trainee, rather than the technical discussions around DOPS).

3) LEPs provide introductory sessions for newly qualified doctors/newly-admitted students about learning in the clinical environment, expectations, requirements for feedback and review sessions and adult learning theory.

4) Students and trainees must receive both academic and general guidance and support, including when they are not progressing well or otherwise causing concern. Everyone teaching or supporting students must themselves be supported, trained and appraised.

5) Students and trainees will have appropriate support for their academic and general welfare needs and will be given information about these support networks.

Individual review meetings

Standard

Postgraduate learners should meet regularly with their educational supervisor to discuss clinical and other issues which should by supplemented by more formal, documented meetings at the start, middle and end of their placement.

Measure

1) The LEP audit of individual review meetings

2) Evaluation of the quality of the interaction.

3) Evaluation of student opinion on one to one feedback.

Local mechanisms for learning through audit including Significant Event Audit

Standard
Each unit should espouse to a culture of effective clinical audit, should ensure that learners working on the unit understand the principles of clinical audit, including management of change and encourage learners to audit their own work and learn from audit how to improve the care that they personally provide.

**Measure**

1) The LEP includes feedback as part of its significant event (SUI) reporting, this includes trainees and students where they have been involved.

2) The LEP has a framework to ensure that learners receive feedback on complaints from patients, their carers and health care professionals.

3) The LEP has a culture of clinical audit, actively encourages learners’ involvement.

**Educational governance including audit and trainee feedback on their training experience**

**Standard**

There must be clear reporting arrangements, audit and use of external perspectives on the quality of the training experience.

**Measure**

1) The LEP has a published educational governance framework, which includes patient and/or lay involvement as appropriate.

2) The LEP collects learner feedback (e.g. exit interviews) about the quality of training, analyses it and plans action to improve identified weaknesses based on it.

3) The LEP identifies and reports changes made in response to the feedback.

4) The LEP is able to demonstrate increased learner satisfaction.

**Supporting learners in difficulty**

**Standard**

Struggling learners should be identified early, supported and where necessary mediated, and hopefully improve their performance as a result.
Measure

1) LEP to demonstrate processes and culture in place to support struggling learners - including: provision of regular training for educational supervisors; clear records of trainees with problems; following the protocols agreed with the Deanery; an early alert system; timely notification to the relevant Deanery/ Medical School of issues and willingness to take trainees with problems.

2) Deaneries and Medical Schools to identify LEPs used to support learners in difficulty.