To consider

**GMC Review of Quality Assurance in Medical Education and Training: Visiting and Inspection**

**Issue**

1. This paper looks the GMC’s approach to visiting institutions as part of its quality assurance (QA) process and discusses possible changes.

**Further information**

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Discussion Points

**Discussion Point 1:** Visits are one essential element of the Quality Improvement Framework, but the GMC needs to ensure that the language it uses to describe the role of visits does not appear to prioritise them over other elements of the quality assurance process. They are simply one of the tools available to the regulator (paragraphs 19-21).

**Discussion Point 2:** The GMC should consider allowing deanery/HEE region/medical school representatives the opportunity to observe the visiting team’s deliberations at specified stages of the visit process (paragraphs 19-21).

**Discussion Point 3:** The GMC should move to a fixed programme of announced visits on a cycle of 5 years. These programmed visits would take a global view of the overall quality of medical education and training in a region against GMC core and developmental standards. Do you agree? (paragraphs 30-35)

**Discussion Point 4:** Do you agree that programmed visits should be complemented by more frequent use of check visits in response to identified risks (paragraphs 30-35)

**Discussion Point 5** Do you agree that GMC QA visits need to focus on both the management of training by the deans and the delivery of training by the LEPs? (paragraphs 30-35)

**Discussion Point 6:** Do you think that the GMC should have the ability to undertake unannounced inspections? (paragraph 36)

**Discussion Point 7:** Professional input from relevant specialties already forms part of the GMC visit process. However, to ensure that the specialties have confidence in the specialists used, the medical royal colleges should encourage suitable candidates to apply to the GMC for inclusion in its pool of visitors. Alternatively, colleges should develop their own specialty pool from which the GMC could draw. Any specialists used by the GMC within visits would need to be selected and trained by the GMC for purpose and accountable to the GMC for their performance (paragraphs 38-43).

**Discussion Point 8:** Would there be value in visit reports identifying college accredited specialists who have been part of the visit? (paragraphs 38-43)

**Discussion Point 9:** Building on the use student surveys in advance of the 2012/3 regional visits, the GMC should also seek to solicit the views of local doctors in training and trainers in advance of a QA visit (paragraphs 44-51).

**Discussion Point 10:** Would there be value in GMC visit teams observing the environment in which clinical teaching occurs? (paragraphs 44-51)

**Discussion Point 11:** Do you agree that the GMC should explore the feasibility of using LEP patient feedback to help inform its picture of the educational environment in advance of a QA site visit? Are there other ways in which the GMC should be
attempting to capture the patient experience to support its QA activity? (paragraph 44-51)

Discussion Point 12: Should the GMC follow other regulators and use the term ‘inspection’ to describe this aspect of its QA of medical education? (paragraph 15)
Background

3. The terms of reference for our review of quality assurance (QA) of medical education and training require us to consider the role of visiting in the GMC’s quality improvement framework. This includes looking at the purpose, function, form, pattern and nomenclature of visiting, as well as the composition of visit teams.

4. This paper explores these issues and offers for discussion some ideas about the future of visiting.

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 others do: research findings

6. To support the work of this review we commissioned research looking at how others approach the task of quality assurance.¹ This included arrangements for visiting (sometimes referred to as inspection). Some of the key features of QA visiting by other regulators are summarised below.

The purpose of visiting and inspection

7. Visiting is a standard part of the QA methodology of most regulators. Visits are usually for the purposes of approval, routine monitoring, in response to changes (for example in a curriculum) or in response to concerns about the regulated organisation. Regulators describe them as a means of verifying organisations’ self-assessments, an opportunity to speak directly to relevant people (such as staff and students), review documentation and triangulate evidence. Interestingly, among the health regulators reviewed, there is no indication that visits are seen as a means of helping to drive up standards by raising the profile of local issues, acknowledging good practice or motivating those involved in local quality management and control. This does not mean that they are uninterested in QA as a means of enhancement, only that it is not described as being the purpose of visiting. By contrast some non-healthcare regulators refer to visits as part of maintaining an ongoing constructive dialogue between the regulator and the provider.²

¹ Colin Wright Associates; GMC research: Developing an evidence base for effective quality assurance: http://www.gmc-uk.org/about/research/13039.asp
² Colin Wright Associates section 4.4
Visiting cycles

8. The cycle of regulators’ inspections ranges from three years to 10 years, although the typical pattern is every five years.

9. The cycle is usually bolstered by a system of triggered visits which enable regulators to respond to identified risks, concerns or curriculum change. However, some regulators’ inspection regimes are wholly risk-based and there is no standard cycle of approval and re-approval. A variation on this approach is seen in Ofsted, where the frequency of the cycle is determined by the past performance of the organisation. Others also use past performance to vary the intensity of inspections, as reflected in the duration of the visit and the size of the visiting team. This features, for example, in a recent QAA consultation on its approach to inspections.

10. In addition to cyclical approvals, most non-healthcare regulators also undertake thematic reviews/inspections which are focused on particular topics and enable regulators to look at emerging issues and identify and share good practice.

Notification of visits

11. In the health sector providers are typically given an average of one year’s notice of a re-approval visit, though notice is shorter where an inspection is prompted by a need to investigate a risk or concern. By contrast, the typical notice period outside the health sector is two to three months. Ofsted provides schools with only one or two days’ notice of an inspection and, in some cases, makes unannounced visits, as does the Care Quality Commission (CQC). In paragraphs 36-37 we look at whether this model would work for the QA of medical education.

Composition of the visit team

12. The size and composition of the visit team varies according to the size and scope of the provision being assessed. Among healthcare regulators, all teams include professional/peer members and are usually led or co-ordinated by a representative of the regulatory body. Around half include lay members, although the definition of what constitutes a lay member varies. With the exception of the GMC, no UK health regulator includes students or trainees on its visit teams, although they are more common in other sectors.

13. A minority of regulators use international reviewers as part of their inspection teams in order to bring an international perspective on QA and enhancement, although these tend to be used by countries with small populations from which to draw their visitors.

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3 Health Professions Council and Education Scotland
4 http://www.qaa.ac.uk/Publications/InformationAndGuidance/Documents/HER-draft-handbook.pdf
5 Northern Ireland Social Care Council, QAA, Her Majesties Inspectorate of Constabularies and Ofsted (see Colin Wright Associates section 5.1)
6 Colin Wright Associates, section 4.5, QAA Scotland, New Zealand Universities Academic Unit.
14. Many of the elements described above are already features of GMC QA. We will look later at which other approaches should feature in the QA of medical education.

*What you’ve told us we should do: QA review seminars*

15. In 2012 we held a series of stakeholder workshops to gather ideas about how our QA arrangements should operate in the future. Participants considered a number of themes, including the purpose and nature of visits/inspections. The full feedback from the workshops is on our website.7 Some of the key points made by stakeholders about visiting were:

**Purpose of visiting**

- Visits enable the regulator to substantiate and triangulate information gathered from other sources, but they are not an end in themselves
- Visits provide a means of identifying good practice

**Value of visiting**

- Visits can affirm what is good.
- The value of walking around the physical environment should not be underestimated
- The status of GMC visits means they can provide those responsible for managing the delivery of education and training with leverage to secure local change.
- Visits provide an opportunity for face-to-face meetings which are important in gathering soft evidence.
- Examples of good practice observed by specialist visitors can be adopted in the visitor’s own region.

**Perceived weaknesses of the GMC’s current approach to visiting**

- Visits are too remote from the delivery of training because they have not looked at what is happening on the ground (although this is something the GMC has tried to address with its most recent regional visits through greater focus on LEPs)
- Visits are expensive and intensive

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• Visits which focus only on identified risks may miss examples of good practice. There needs to be a broader view of the quality of education and training overall. This was also a concern raised in feedback on the regional visits conducted in 2011 and 2012.

• Visits can be de-motivating for the those involved in quality management if the outcome merely acknowledges compliance with standards without providing positive reinforcement about what is good.

• Visit reports do not distinguish between good and best practice.

• Some visit reports can give the impression that the visitors have sought too doggedly to identify some supposed good practice purely for presentational reasons in a report which would otherwise be very critical.

• Visits to local education providers (LEPs) risk taking over the quality management role of the deaneries and it is unclear what value this adds.

• Visits should focus more on LEPs.

• Visits focus too much on assuring processes rather than outcomes of training, so weaknesses and failures can be hidden.

• Visits are too generic and not sufficiently targeted at specialty issues.

• Some participants felt that the loss of college visits has had a negative impact on patient care.

• Insufficient use is made of college intelligence to help target visits.

Ideas for the future

• GMC staff should be active participants in future visits.

• Interaction with students and trainees is important.

• The training, composition and leadership of visit teams are crucial to ensuring consistency of approach.

• Visit teams should include a college specialist who will know the curriculum needs for their specialty. However, any college specialist involved in a visit should be present as a representative of, and accountable to, the GMC in the same way as any other member of the visit team.

• There were mixed views about whether specialists on the visit team needed to be endorsed in some way by the relevant college.
• There were mixed views about the desirability and feasibility of unannounced or short-notice visits. On the other hand, large set-piece visits risked being staged in a way that makes it difficult to see the real picture.

• There was support for targeted interventional visits for urgent situations

• Some felt that the GMC should participate in local deanery visits (members of the GMC’s Response to Concerns Assessment Team sometimes support dean visits where serious concerns have been raised)

• Visits should focus on certain core themes, with a rolling programme of additional themes, rather than trying to quality assure everything on every visit

• The introduction of regional visits covering both undergraduate and postgraduate education and training were seen as a positive development. However, it was important to recognise that undergraduate and postgraduate training were different.

• Involving other regulators in visits could help to provide a broader perspective.

• There were mixed views about the nomenclature used (‘visits’, ‘inspections’, ‘reviews’). It was the outcome that was seen as important, not the description of the process – nevertheless a change of name may more accurately reflect what we are trying to achieve in assuring patients and the public of the quality of medical education.

**Discussion Point:** Should the GMC follow other regulators and use the term inspection to describe this aspect of its QA of medical education?

**What do we do now?**

16. GMC QA visits fall into four broad groups:

• Routine regional visits: These involve all medical schools and deaneries/HEE regions within a particular geographical area being visited in the same cycle. The cycle is not currently fixed, but organisations can expect to be visited at least every five years. These visits are risk based. This means that rather than looking at an organisation’s compliance across all of our standards, the focus is on areas where the GMC has concerns that particular standards are potentially not being met.

• Check visits: These visits may be targeted at particular institutions or specialties in response to identified risks (informed by the GMC’s evidence base) or conducted on a random basis. They enable the accuracy of the

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8 Most deaneries were visited at least twice between 2005 and 2010 (GMC Quality Improvement Framework (QIF), paragraph 100)
evidence to be tested, including the accuracy of organisations’ self-assessments and their progress against any requirements that have been imposed. Check visits do not provide a global view of an organisation’s performance, but instead focus on issues relating to a subset of the standards from *Tomorrow’s Doctors* or *The Trainee Doctor*.

- Triggered visits: Triggered visits may be undertaken to investigate possible serious educational failure or risk to patient safety as part of the GMC’s responses to concerns process. In practice triggered visits have now been replaced by the GMC’s Response to Concerns Assessment Teams (RCAT) which support the deans in investigating serious concerns. The RCAT process is not discussed in this paper, but will be looked at separately within the review.

- Visits to new medical schools and undergraduate programmes: These are cycles of visits to new medical schools or programmes which take place over a number of years, starting about a year before the institution begins admitting students and continuing until the first cohort of students graduates.

The focus of this paper is on regional and check visits.

*Why we visit*

17. The answer to the question why we visit may seem so obvious that it is hardly worth posing. Visiting provides direct scrutiny of the quality of education and training in a location which gets beneath an organisation’s self-assessment of its own performance. The physical presence of inspection teams on site helps to ensure that regulated organisations know and feel that they are being held to account for their compliance with standards. The knowledge that there will be an inspection, the results of which will be publicly available, focuses minds on meeting those standards. Coupled with this, managers tell us that the status and profile accorded to visits can help provide local leverage to secure quality improvement. Visits are also a means of identifying good practice which can be disseminated more widely.

18. Despite the failings of the previous visit regimes uncovered by the Francis Inquiry, there was no suggestion that visiting should be discontinued. Rather, it needed to be more effective. For it to be effective, we need to be clear about its purpose, how far current arrangements meet that purpose and where visiting can add most value.

*Understanding the purpose of visiting*

19. Because of the planning, resources and choreography required, and the pressure of the human interactions involved, visits can seem to dominate the GMC’s QA process. The GMC’s own language adds to this impression. The introduction to the *Regional Review of Medical Education and Training in London: 2012-2013* states that ‘the findings come from our visits to the local education providers (LEPs), medical schools and deanery in the region’. The reports on the individual LEPs are described as reports about visits to those institutions. It is noteworthy that at the
evaluation workshop following the London regional review, several participants expressed concern that oral evidence received during visits appeared to be given precedence over other material submitted as part of the QA process, and worry that one or two disgruntled individuals, or the particular interests of a visitor, had the potential to distort the visiting team’s perceptions. They were not clear from the final reports how, if at all, other material had been taken into account.

20. In fact, the reports are based on the totality of the evidence received. Visits themselves can only provide snapshots of elements of the education and training provided by an organisation. Their purpose is to enable the GMC to triangulate and test that other evidence through meetings with a range of individuals and through observation, and thereby to achieve a balanced judgement on the evidence overall. As one of the workshop participants observed, they are not an end in themselves. Yet it seems that this is not always understood, or at least felt, by those being inspected.

21. Ofsted tries to address similar concerns by allowing the head teacher of the school under inspection to observe some of the visiting team’s private deliberations at key stages during the visit. This enables them to see how the evidence is being evaluated and, at the invitation of the team leader, to suggest any further evidence the team may wish to consider. Clearly, this requires a high degree of professionalism on the part of the visiting team, but can help to give the process greater transparency.

**Discussion Point:** Visits are one essential element of the Quality Improvement Framework, but the GMC needs to ensure that the language it uses to describe the role of visits does not appear to prioritise them over other elements of the quality assurance process. They are simply one of the tools available to the regulator.

**Discussion Point:** The GMC should consider allowing deanery/HEE region/medical school representatives the opportunity to observe the visiting team’s deliberations at specified stages of the visit process.

**Risk based regulation and the implications for visiting**

22. Like many other regulators, the GMC has moved towards a risk based approach to QA visiting. This is entirely consistent with the principles of good regulation established by the Better Regulation Task Force. The aim is to behave proportionately, use regulatory resources efficiently and to minimise the burden imposed on the organisations being regulated. But the GMC has not abandoned the notion of a cycle of routine visits. It operates a mixed economy.

23. It is worth being clear about the nature of the risk the GMC is guarding against. Specifically, this refers to a potential failure to meet standards (particularly where patient safety is concerned) and having regard to the extent to which that risk

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is being effectively managed locally. An immediate and serious patient safety issue may trigger rapid intervention under our response to concerns process, in the form of a deanery visit supported by one or more members of our RCAT team. But where the deanery/HEE region has effective processes for identifying risks and they are effectively managed this should not require immediate GMC intervention, although they may come under scrutiny at a routine regional visit. Similarly, requirements and recommendations imposed on an organisation as a result of issues identified following a visit are likely to be the focus of continuing regulatory interest during subsequent visits if there is no evidence of them having been addressed.

24. Although one of the virtues of risk based regulation is said to be that it helps minimise the regulatory burden on organisations, we should be clear about the extent to which this is currently achieved in practice. Regional visits are large, set-piece reviews which usually require about nine months’ planning. Visits to the organisations involved are spread over two or three months and typically include around 12 days of visits, although this depends upon the size of the region. Organisations spoke of feeling ‘flooded’ by the experience of the 2012 London Regional visits, and referred to the considerable volume of evidence which had to be assembled and submitted to the visit teams in advance. They did not necessarily feel this was disproportionate (although this was the view of two organisations surveyed following the West Midlands visit in 2011, and two following the 2012/2013 London visit), but we should acknowledge that the regulatory burden was significant both for the regulator and the regulated.

25. Feedback from the workshops also suggested uncertainty among some as to whether it was the deanery quality management or the LEP’s quality control that was under scrutiny. This arose from the greater focus on LEPs than had been used on previous occasions. The reality was that the GMC was looking at both elements and it should be explicit about this. Some at the workshops argued that this approach means the GMC doing the quality management job of the deans. However, this criticism should be set against the findings of the Francis Report that ‘PMETB/GMC Deanery-wide reviews focused on Deanery systems of quality management resulting in only a superficial examination of the standards being observed by LEPs’.

26. The risk based approach as used by the GMC also raises some practical and conceptual problems. First, as the terms of reference for this review make clear, one of our aims is to ‘support and drive improvement in local systems for the management and delivery of education and training’. In part, this is about addressing potential or actual failure to comply with standards. But it also means ensuring ‘proper standards in the practice of medicine’. A risk based approach necessarily focuses on risks rather than strengths.

10 Review of medical education and training in the West Midland 2011-2012
11 Evaluation of the regional visits 2012/2013 draft report, paragraphs 38-46
12 Francis Inquiry Final Report, Chapter 18, page 1256, paragraph 18.222
27. This is not to say that good practice is ignored. The London Regional Report\textsuperscript{14} lists many examples of good practice observed by the visiting teams. Examples of good practice are also included on the GMC website. But this review has heard numerous comments about the slightly arbitrary nature of the practice singled out for praise. Organisations have been commended in relation to initiatives which have long been regarded as standard practice in other locations. There is uncertainty about whether it is good, or innovative, or, indeed, best practice which is being identified and organisations are sometimes unclear why some things are identified as notable and others not.

28. In part, this is the inevitable result of our current approach to measuring standards for the management and delivery of education and training. We have described what compliance looks like, but we have no benchmark for what notable, good, better or best look like. In a previous paper for this review\textsuperscript{15} we proposed moving to a system of core and developmental standards against which organisations should be evaluated. This should help us to identify good and best practice in a more consistent manner so as to help drive improvement.

29. There is another reason why this is important. Organisations have spoken of the de-motivating effects of the visit process and the resulting report on the staff responsible for driving quality improvement locally. They can be left with the dispiriting sense that their main achievement has been not to have failed to comply with the required standards. While it is not the regulator’s job to motivate an education provider’s staff, the GMC clearly does want to encourage their efforts to enhance education and training in their area. A different approach to standards and how good practice is acknowledged may help this. On the other hand, the GMC has to beware of being seen as a cheerleader for particular institutions at the expense of others who may be equally good but happened not be included in the visit.

\textit{A new visits strategy}

30. A focus on core and developmental standards would have other implications for the way we use risk to guide our QA visiting. While it is logical to consider risk in relation to compliance with the core standards that everyone must meet, it would not be a helpful measure of attainment for developmental standards. A different visiting strategy would be needed.

31. Evaluation against core and developmental standards would require the GMC to take a holistic view of the overall quality of education and training in a particular location or region. Consideration of areas of identified risk would form part of that evaluation, but would not be the main driver. This global assessment of the overall quality of education and training in a region could therefore take place on a more or less fixed programme of visits. A published programme would enable each region to know, say, 5 years in advance when its visit was scheduled and could plan accordingly. It may also help to address the criticism made in feedback on the 2011

\textsuperscript{14} \url{http://www.gmc-uk.org/Regional_Review_Report.pdf_51940876.pdf}

\textsuperscript{15} \url{http://www.gmc-uk.org/Reporting_outcomes_discussion_paper.pdf_50511199.pdf}
regional pilots that specific examples were sometimes extrapolated to support general statements which were not always sustained by the evidence overall.

32. We should not underestimate the burdens of the regional approach to visiting in which the visit teams examine both undergraduate and postgraduate provision across a whole region. Nevertheless, a published programme of visits will help organisations and the GMC manage this burden.

33. Clearly, though, the GMC would need to remain responsive to risks which arise between the programmed visits. Emphasis should therefore be placed on the more regular use of check visits. These, mainly targeted, visits enable the GMC to draw on its existing evidence base to focus on a particular issue. Check visits may be used to verify that requirements previously imposed on an organisation have been addressed. Alternatively, they allow investigation of identified themes (emergency medicine is an example of a recent theme) across a number of organisations.

34. The focused nature of check visits enables the regulator to be agile and incisive while minimising the regulatory burden. Typically, they are around half to one full day in duration because they are focused on a small number of specific issues. They draw on pre-existing evidence rather than requiring providers to generate volumes of new material, and may involve a smaller visit team (usually four people) than required for routine regional visits (the recent London visits involved approximately 40 visitors across 16 sites). Unlike the more choreographed regional visits, they can usually be organised in around eight weeks because they require much less preparation. Focusing on particular issues in this way has proved effective, as shown by a recent series of check visits in emergency medicine which highlighted a patient safety concern and enabled immediate solutions to be put in place. Check visits will inevitably provide only a partial view of an organisation’s performance against standards, but should complement the programmed global evaluations.

35. Under current GMC policy, check visits can also be undertaken on a random basis. The stated aim of such visits is to allow the GMC to test the accuracy of its evidence base in relation to a particular institution. To date, no random visits have taken place so it is impossible to form a view of their efficacy. However, it seems likely that such visits would need to occur with reasonable frequency if they are to have any value in either testing the evidence base or influencing the behaviour of organisations - if the chances of incurring a random visit are so remote organisations are unlikely to take the prospect seriously. It may be the greater use of targeted checks would, in any case, render random checks obsolete.

**Discussion Point:** The GMC should move to a fixed programme of announced visits on a cycle of 5 years. These programmed visits would take a global view of the

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16 A full evaluation of the 2012 London review visits is currently being prepared and this will inform further thinking about the future of regional visiting within the QA framework.

17 It is not possible to organise visits in much less than eight weeks because NHS clinicians now need to give employers at least six weeks’ notice.
overall quality of medical education and training in a region against GMC core and developmental standards. Do you agree?

**Discussion Point:** Do you agree that programmed visits should be complemented by more frequent use of check visits in response to identified risks.

**Discussion Point:** Do you agree that GMC QA visits need to focus on both the management of training by the deans and the delivery of training by the LEPs?

*Unannounced visits and earned autonomy*

36. We noted earlier that some regulators, such as Ofsted and CQC, conduct visits with little or no notice. The nature of healthcare (many of those the visit team will want to interview are likely to be involved in frontline patient care), the complexity of the environment within which much of medical education and training take place, the need to avoid disrupting patient care and the need for QA visitors employed by the NHS to have at least six weeks’ notice, all mean that unannounced visits would present significant practical challenges. Furthermore, while unannounced visits have an obvious utility when seeking a snapshot of service provision, the added value when trying to gain a broad view of medical education is less clear. As an alternative, the combination of periodic programmed visits, more frequent check visits and the rapid response RCAT process would appear strike an appropriate balance. Even so, the ability\(^{18}\) to undertake unannounced inspections (possibly in conjunction with the LETB/deanery or the system regulator) could send a powerful signal to providers.

37. The idea of earned autonomy from regulator visits is one which has been favoured in some sectors and supported by those keen to reduce the burden of regulation. Under this model, organisations which have in the past complied with standards earn the right to a much lighter regulatory touch. There are risks with this, as the failings in financial regulation in recent years have shown. There may also be public resistance in the wake of high profile failures in places such as Mid-Staffordshire. In any case, earned autonomy would seem to add little value if the GMC adopts the approach suggested in paragraphs 30-35 above.

**Discussion Point:** Do you think that the GMC should have the ability to undertake unannounced inspections?

*Composition of the visit teams and the role of the medical royal colleges*

38. Visit teams need credibility. This requires individuals with a range of knowledge, skills, experience and other attributes who have been selected and trained for the purpose and who are accountable to the GMC.

39. The GMC maintains a pool of approximately 150 QA visitors. They include medical educationalists, medical specialists, foundation programme directors (or equivalent), employers, specialty trainees, foundation doctors, medical students and

\(^{18}\) This may require legislation,
lay members. The team will always include ‘a team leader, a member with direct medical school or deanery experience, a student or trainee and a lay member’. The precise combination will depend upon the risks identified for exploration and the skills and experience needed. Visitors are appointed and trained by the GMC and accountable to the GMC.

40. The team will always be supported by a Quality Analyst from the GMC whose role is to ensure the smooth administration of the visit and that the visit follows protocols and GMC standards. This review has looked at whether, as with some other regulators, a member of the GMC staff should lead the visit team as a means of ensuring consistency across visits and visible GMC ownership of the process. However, there is no evidence that the current approach is not perceived as sufficiently ‘owned’ by the GMC and the recent use of a regional coordinator on the London visits has helped provide a consistent overview. Leading a visit team also requires a level of seniority, experience and face validity for which the GMC would need to deploy its most senior staff. This is probably not practical given the scale of the enterprise.

41. There is a persistent, but misleading, view that GMC visits do not consider specialty issues and do not include relevant medical specialists on the visiting teams. The Royal College of Surgeons recently called for the GMC to involve medical professionals in inspection teams. As we note in paragraph 39, this is already the case and has been since the GMC assumed responsibility for regulating postgraduate training in 2010 (and, indeed, previously under PMETB). The issue, therefore, is to make sure that the specialists used command the confidence of their professional bodies and other stakeholders, as well as the GMC.

42. In a previous paper for this review we looked at the role of the medical royal colleges in the QA process. That paper explored a range of ways in which college specialty expertise could be brought to bear on different elements of the QA process and we are now working with the Academy of Medical Royal Colleges to take some of these forward. Specifically in relation to GMC visits, all team members must be appointed, trained and accountable to the GMC. It would be inappropriate for specialists simply to be appointed as college nominees or representatives as this would give them a different status from other team members and compromise their accountability to the GMC. But it is clearly important that specialists used in visits have credibility with the colleges that have developed the specialty curricula. Probably the most straightforward means of achieving this would be for colleges to encourage those they regard as possessing the necessary expertise and other qualities to apply to the GMC to join its pool of visitors. Suitable candidates could then be appointed and trained by the GMC as required.

43. An alternative would be for the individual colleges to maintain their own pools of specialty experts for use by the GMC when specialty specific matters are at issue.

19 QIF, p23, paragraph 113
20 http://www.rcseng.ac.uk/policy/documents/CareBillHoLsecondreadingbriefing.pdf
22 http://www.gmc-uk.org/Workshop_follow_up_2.pdf_52381935.pdf
However, these specialty experts would still need to be appointed and trained by the GMC on the basis of their competence for the role in the visit teams and their performance on visit teams appraised in the same way as other team members. The Colleges could therefore establish their own pool of GMC accredited, college approved visitors who could undertake work for the GMC and for the college. However, some colleges may feel that there is little value, and some burden, in maintaining their own separate pool. Either way, visit reports could, when listing the names of the visitors on the team, identify a particular visitor as ‘college accredited’ or similar.

Discussion Point: Professional input from relevant specialties already forms part of the GMC visit process. However, to ensure that the specialties have confidence in the specialists used, the medical royal colleges should encourage suitable candidates to apply to the GMC for inclusion in its pool of visitors. Alternatively, colleges should develop their own specialty pool from which the GMC could draw. Any specialists used by the GMC within visits would need to be selected and trained by the GMC for purpose and accountable to the GMC for their performance.

Discussion Point: Would there be value in visit reports identifying college accredited specialists who have been part of the visit?

Mid-Staffordshire and the report of the Francis Inquiry

44. The report of the Francis Inquiry makes three specific recommendations relating to the conduct of visits to local education providers.23

45. Francis argues that the royal colleges ‘should be enlisted to support [training] visits’. In paragraph 42-43 above we set out how college expertise can be incorporated within GMC teams. We also note the work now being taken forward through the Academy to utilise college specialty expertise within LETB/deanery led visits to LEPs.

46. Francis calls for GMC visits to involve seeking information directly from trainees and for direct observation of the training environment. Students and trainees are already an integral part of GMC QA visits as members of the visit teams. They are also routinely included in the groups interviewed during the course of visits.

47. The challenge, however, is that trainees who have a contribution to make may be unavailable on the day or, as sometimes happens, find themselves called out of meetings with visitors to attend patients. This applies equally to trainers. One way of addressing this would be to provide them with an opportunity to comment in advance of the visit.24 This might be, for example, in the form of an open letter of invitation to submit views via an email box or by undertaking a short online survey.

23 Francis Inquiry Report Recommendations 155, 156 and 161.
24 Trainee views are already sought annually through the National Trainee Survey.
(as is now done with visits to medical schools), although we acknowledge that there may be resistance to yet another survey. Whatever the mechanism used, views received in this way may not be determinative, but could help to direct lines of enquiry for the visit team to test once on site. Feedback suggests that the survey of undergraduate students undertaken prior to the 2012/2013 London regional review yielded useful evidence for the visit.25

48. To date the GMC’s QA process has struggled to capture the views of patients and the public (as distinct from the views of the GMC’s lay visitors) on the quality of training provided. This is not surprising given that patients’ will be more immediately concerned with the care they receive than with the training of those who provide it, and the issues on which patients are in a position to comment may be limited. They may not even know whether the person who treated them was a doctor in training. Attempting to gather patient feedback in the ways suggested for students and trainees may not be fruitful. However, in institutions where much of the care will be provided by doctors in training, it would be wrong to assume that patients have nothing to contribute. Most LEPs have mechanisms for capturing patients’ views. The GMC should explore whether the information which LEPs are already routinely gathering could usefully contribute to its evidence base about the educational environment for scheduled visits (every 5 years). As with the student and trainee surveys suggested above, the information would not be determinative, but may help to inform lines of inquiry during a visit.

49. Francis recommends that visits should include observation of the training environment so that poor practice can be detected. There is probably little value in observing undergraduate students in a lecture theatre, but possibly more to be gained by visitors walking the floor and seeing the environment in which clinical teaching takes place. In a discussion paper issued in May 2013 as part of this review we set out a range of quality indicators and descriptors for the educational environment. If these are accepted, they can be incorporated within the future standards for QA against which visits take place.

50. Francis proposes that visits should provide an opportunity to ‘share and disseminate good practice with trainers and management’. In paragraphs 27-29 above we explain how a new approach to core and developmental standards will support identification of good practice.

51. Francis recommends that routine LETB/deanery visits to LEPs should include patient or lay representation, should be informed by all other sources of information and, if relevant, coordinated with the work of the systems regulators. The GMC cannot dictate how LETBs/deaneries deploy their resources. However, the review of the standards for the management and delivery of education and training which is part of the QA review, will look at how the standards relating to patient safety are to be met.

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25 Evaluation of the regional visits 2012/2013
Discussion Point: Building on the use student surveys in advance of the 2012/3 regional visits, the GMC should also seek to solicit the views local doctors in training and trainers in advance of a QA visit.

Discussion Point: Would there be value in GMC visit teams observing the environment in which clinical teaching occurs?

Discussion Point: Do you agree that the GMC should explore the feasibility of using LEP patient feedback to help inform its picture of the educational environment in advance of a QA site visit? Are there other ways in which the GMC should be attempting to capture the patient experience to support its QA activity?