

Report of the Review of Quality Assurance of Medical Education and Training

To consider

Issue

- 1 In 2011 the GMC decided to undertake a review of its arrangements for quality assuring medical education and training. The review was carried out during 2012/13.
- 2 This paper invites Council to consider the conclusions of the report of the review.

Recommendation

- 3 Council is asked to endorse the report of the review at Annex A.

Report of the Review of Quality Assurance of Medical Education

Issue

- 4** The review of the GMC's approach to the quality assurance of medical education and training was commissioned by Council following Lord Naren Patel's 2010 report *Recommendations and Options for the Future Regulation of Education and Training*. The need for the review was a direct consequence of the 2010 merger of the Postgraduate Medical Education and Training Board with the GMC. This had made the GMC responsible, for the first time, for regulating both undergraduate and postgraduate medical education and training. However, while bringing regulation under one roof, it also brought together two different approaches to quality assurance. The review report therefore sets out recommendations for the next steps in the evolution of the GMC's quality assurance systems.
- 5** The report of the review is at Annex A. The draft report was discussed by the Education and Training Advisory Board on 4 February 2014. The Board supported the conclusions of the review and made suggestions for areas of work that would merit future exploration.

Supporting information

How this issue relates to the corporate strategy and business plan

- 7 Strategic Aim 3 of our 2012 Business Plan was to continue to provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career. This included a commitment to review the way we carry out our Quality Assurance (QA) work.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

- 8 Section 2 of the report at Annex A describes how the review was undertaken. Subject to approval by Council we plan to undertake a consultation on key recommendations from the report.

What equality and diversity considerations relate to this issue

- 9 One of the recommendations of the review concerns the development of a new suite of standards for the management and delivery of medical education and training. These will take account of equality and diversity considerations.

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Annex A

Report of the Review of Quality Assurance of Medical Education and Training

February 2014

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List of Recommendations

Recommendation 1: The GMC should endorse the development a single, coherent set of standards for management and delivery of education and training covering both undergraduate and postgraduate arenas. The way in which those standards are met and evidenced will need to reflect the different contexts in which learning takes place. *(Paragraphs 20-21)*

Recommendation 2: The new suite of QA standards should include both core and developmental standards. All organisations must meet the specified core standards or face regulatory sanction by the GMC (see section 7). Developmental standards should be used to highlight good practice beyond compliance with the basic core. Performance against both core and developmental standards should be reflected in the GMC's QA reporting (see section 10). *(Paragraphs 22-28)*

Recommendation 3: Both core and developmental standards should be explicit and measurable and address outcomes as well as process. They should also have regard to the multi-professional aspects of training and care and, where appropriate, create opportunities for alignment with standards used by others. *(Paragraphs 22-28)*

Recommendation 4: The GMC's suite of core and developmental standards for QA should include descriptors required in any educational environment *(Paragraphs 29-31)*

Recommendation 5: The GMC should seek a broader suite of escalating regulatory sanctions to support more effective and timely QA interventions. *(Paragraphs 33-39)*

Recommendation 6: Inspections are an essential part of the QIF. The GMC needs to ensure that the language it uses to describe the role of inspections does not appear to prioritise them over other elements of the QA process. They are simply one of the tools available to the GMC. *(Paragraphs 40-47)*

Recommendation 7: To aid transparency GMC QA reports should reference the evidence that has been relied upon to inform the report conclusions. *(Paragraphs 40-47)*

Recommendation 8: The GMC should pilot the idea of enabling deanery/HEE region/medical school representatives the opportunity to observe the inspection team's deliberations at specified stages of the inspection process. *(Paragraphs 40-47)*

Recommendation 9: 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. Programmed visits should be complemented by more frequent use of check visits in response to identified risks. *(Paragraphs 48-53)*

Recommendation 10: Specialists used within GMC QA inspections should be jointly badged as college and GMC accredited and this should be explicit in the inspection reports. *(Paragraphs 54-63)*

Recommendation 11: The GMC should consider options for joint training and/or reciprocal recognition of training for QA functions with other regulators. *(Paragraph 65)*

Recommendation 12: GMC inspection teams should observe the environment in which clinical teaching occurs. *(Paragraphs 66-69)*

Recommendation 13: The deans/HEE regions, GMC and colleges should support the work now being led by the AoMRC to professionalise and clarify the role of external advisors in the quality management process. *(Paragraphs 70-76)*

Recommendation 14: The GMC should work with the colleges to implement the new approach to ASRs by 2015. *(Paragraphs 78-80)*

Recommendation 15: The GMC's reporting mechanisms should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. *(Paragraphs 81-88)*

Recommendation 16: Once the GMC's medical education risk profiles have been piloted and developed they should be shared with the organisations concerned. *(Paragraph 89)*

Recommendation 17: The GMC should work towards more transparent use of the data collected through its QA processes. *(Paragraphs 90-91)*

Recommendation 18: GMC QA reports should provide explicit judgements (with supporting evidence) about whether standards have been met based on the new set of core and developmental standards. This should be accompanied by an organisation's action plans for addressing those standards which have not been met. *(Paragraphs 92-94)*

Recommendation 19: There is an urgent need to re-structure the QA sections of the GMC's website to ensure that findings are transparent and accessible for all audiences. *(Paragraphs 95-96)*

Recommendation 20: QA data development should to be linked to the GMC's overall data strategy to ensure coherence and consistency of approach and the proportionality of data demands imposed on others. *(Paragraphs 97-98)*

Recommendation 21: The GMC should explore with other agencies the feasibility of collective regulatory assurance with a view to future piloting.
(Paragraphs 104-109)

Section 1: Introduction

- 1 Prior to the 2010 merger of PMETB with the GMC, statutory responsibility for assuring the quality of medical education and training was split between the two organisations. The GMC was responsible for basic medical education, comprising the undergraduate years of medical school and Foundation Year 1. PMETB was responsible for Foundation Year 2 and postgraduate GP and specialty training leading to the award of the CCT. Following the merger the quality assurance of all stages of medical education and training fell to the GMC.
- 2 Although there was close co-operation between GMC and PMETB, particularly in relation to the Foundation Programme where they had shared processes and standards, they took different approaches to quality assurance. In part, this reflected the different legal frameworks within which they operated and the contextual differences between undergraduate and postgraduate education. There were also some fundamental differences in policy approach.
- 3 In the lead up to the merger Lord Naren Patel was invited to consider options for the future regulation of medical education and training. His report¹ recommended that the GMC should review its approach to quality assurance. Among other things, he was interested in whether it was possible to achieve greater coherence and consistency across the undergraduate and postgraduate arenas and whether the regulator should focus less on assuring processes and more on the quality of individual trainees produced by those processes. He also invited the GMC to consider whether it should be approving not only individual posts and programmes of training, but the wider educational environment within which they existed.
- 4 Lord Patel's emphasis on the importance of educational environments was given added resonance by a number of high profile failures in institutions where medical education and training took place, such as Mid-Staffordshire. This has since been reinforced by the recommendations of the report of the Francis Inquiry.²

¹ Final Report of the Education and Training Regulation Policy Review: Recommendations and Options for the Future Regulation of Education and Training, section 16. 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

² Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013

- 5 There were also other changes within the healthcare landscape which were likely to affect the way quality assurance was undertaken. The NHS in England was to be re-structured, the introduction of revalidation was imminent and the interface between professional regulation and systems regulation was developing. In addition, more and richer data capable of informing the GMC's approach to quality assurance was starting to become available.
- 6 In June 2011 Council decided to review the GMC's approach to quality assuring medical education and training. It was a review which was born not out of the failure of the existing regime but from recognition of the need to meet the challenges of a changing environment and seize the opportunities brought about by the merger. The terms of reference for the review are at Appendix 1.

Section 2: Methodology

- 7 The QA review began in 2012. Independent research was commissioned to look at both the academic literature surrounding quality assurance and at how other regulators both in the UK and overseas, in the health sector and elsewhere, undertake quality assurance.³
- 8 This initial research helped to inform a series of stakeholder workshops during the course of 2012 in London, Manchester and Edinburgh. These workshops were used to draw on external stakeholders' experience of the GMC's QA processes and capture ideas for future ways of working. They also provided a forum in which we could begin to test some early propositions. The outputs from these workshops are on the GMC's website.⁴
- 9 Further workshops were run with the staff of the GMC's Education Directorate, (including those involved in QA), with representatives of the GMC's Patient and Public Reference Group, and with the GMC's Quality Scrutiny Group (QSG). The QSG had been established by the GMC in 2011 to provide critical scrutiny (referred to by its Chair as 'tertiary assurance') of its QA process. This Group therefore brought detailed knowledge of the processes and external expert challenge.
- 10 The insights gained from these sessions were used as the basis for a series of discussion papers which sought to develop some of the key themes of the review and test possible review recommendations. The discussion papers were widely circulated to stakeholders for comment. They also formed part of the

³ Colin Wright Associates; GMC research: Developing an evidence base for effective quality assurance: http://www.gmc-uk.org/Developing_and_evidence_base_for_effective_quality_assurance_of_education_and_training_May_2012.pdf 48643906.pdf

⁴ http://www.gmc-uk.org/QA_Review_Summary_of_workshops.pdf 49775408.pdf

regular briefing updates about the review provided for the Quality Managers of the medical royal colleges and the deaneries/HEE Regions and others.

- 11 The emerging conclusions of the review were then further tested in a workshop held in October 2013.

Early implementation

- 12 As the establishment of the QSG as a critical friend suggests, the Education and Standards Directorate of the GMC has a culture of continuous improvement. This has been demonstrated throughout the course of the review. When questions were raised about the way in which requirements imposed by the GMC following QA visits were monitored and followed-up, staff had already identified this as an issue and measures introduced to address a systemic weakness.
- 13 Similarly, the Directorate has been quick to act on opportunities for change, arising both from the review and from its own internal monitoring, without necessarily waiting for the review to conclude. Action on some of the recommendations contained within this report is therefore already in train.

Section 3: The Purpose of the GMC's QA

- 14 QA, like all regulatory activity, must be proportionate to the regulatory purpose and to the risk posed.⁵ It must avoid imposing unnecessary burden.⁶ This is particularly important when health service resources are under so much pressure.
- 15 At the same time, we need to remember the high stakes involved; the need to make sure that education and training properly equip doctors with the skills and professionalism they will need. Further, as the Francis Inquiry has shown, we cannot ignore the wider healthcare environment in which much of education and training take place and the direct implications for patient care. This points to an approach to QA which goes beyond basic compliance with minimum standards and towards a system which will help to drive improvement in local systems for the management and delivery of education and training. This review has therefore pursued three objectives for the GMC's QA systems:

⁵ <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation>

⁶ Better Regulation Task Force: Principles of Good Regulation.
<http://webarchive.nationalarchives.gov.uk/20100407162704/http://archive.cabinetoffice.gov.uk/brc/upload/assets/www.brc.gov.uk/principlesleaflet.pdf>

- Ensuring that the management and delivery of education and training equips doctors leaving training with the knowledge, skills, attributes and professionalism they will need.
- Ensuring effective monitoring of compliance with the standards for education and training set by the GMC and the ability of systems to respond appropriately to concerns, particularly where patient safety is at risk.
- Supporting and driving improvement in local systems for the management and delivery of education and training.
- Ensuring compatibility with best practice in QA.

Section 4: The way we are now

- 16** The GMC's current approach to QA is described in the Quality Improvement Framework (QIF).⁷ This gives the GMC overall responsibility for quality assurance. The GMC is supported in carrying out this task by a system of quality management (QM) through which medical schools and deaneries/HEE regions must satisfy themselves that local education providers (LEPs) are meeting the GMC's standards. LEPs are expected to have in place arrangements for quality control (QC) to ensure that trainees receive education and training that meets local, national and professional standards. The GMC assures the effectiveness of the system through a combination of inspections, surveys and other data gathered from across the system. The diagram at Appendix 2 shows how the elements fit together.
- 17** The QIF is a well-recognised QA methodology. Independent research commissioned to support the review states that the GMC is seen by a number of commentators as 'at the forefront of excellence' in regulatory practice. Indeed, we have found nothing to suggest that the GMC model for QA is either fundamentally flawed or poorly executed. The Professional Standards Authority's Performance Review Report for 2012-2013 states that the 'GMC's performance against standards in this function has been innovative and displayed good practice'.⁸
- 18** Nor have we detected any appetite among stakeholders for the QIF model to be jettisoned in favour of a wholly different approach. At the present time, any major restructuring of our approach would be needlessly disruptive for local systems.

⁷ http://www.gmc-uk.org/Quality_Improvement_Framework.pdf_39623044.pdf

⁸ <http://www.professionalstandards.org.uk/docs/scrutiny-quality/performance-review-report-2012-13.pdf?sfvrsn=0>

- 19 Even so, this should not be grounds for complacency and this report makes a number of recommendations for how the QIF should be enhanced.

Section 5: Standards for the management and delivery of education and training

- 20 The GMC currently carries out its QA activities against two separate sets of standards for the management and delivery of education and training; *Tomorrow's Doctors* covers undergraduate medical education while *The Trainee Doctor* deals with Foundation Programme and specialty training. The single set of postgraduate standards provided by *The Trainee Doctor* was an early win from the merger of PMETB with the GMC. But the existence of separate standards is a continuing legacy of the split between undergraduate education and postgraduate training prior to the merger. The logical next step is to see if it is possible to achieve greater coherence overall.
- 21 Although there are many similarities between the two sets of standards they are not a perfect fit. The GMC's move to regional QA visiting since 2011 in which the educational provision for both undergraduate and postgraduate are inspected across a single region have sometimes highlighted the differences. On a simple, practical level, it would be far easier for inspection teams to have to deal with a single suite of standards. This does not mean that the GMC can disregard the very real differences that exist between the undergraduate and postgraduate arenas. It should, however, be possible to develop a common set of regulatory standards across the educational continuum, while recognising that the way in which organisations meet those standards will be different in different settings.

Recommendation 1: The GMC should endorse the development of a single, coherent set of standards for management and delivery of education and training covering both undergraduate and postgraduate arenas. The way in which those standards are met and evidenced will need to reflect the different contexts in which learning takes place.

- 22 Developing a single suite of standards should consolidate, but need not discard, the whole of the existing standards. In many cases the existing standards work perfectly well. However, feedback from GMC QA teams and staff is that some are no longer fit for purpose; for example they are not sufficiently explicit or measurable, and insufficiently focused on the outcomes of training. If compliance with the standard cannot be measured it is difficult for those managing training to demonstrate that they are meeting the GMC's requirements. Equally, it can be difficult for the GMC to be confident of compliance.
- 23 Increasingly, the bodies we inspect are also quality managing and reporting across other professions. The new suite of standards must therefore have

regard to the multi-professional aspects of training and care and, where appropriate, create opportunities for alignment with standards used by others.

- 24** Feedback from those subject to GMC QA inspections has also highlighted a further issue with GMC QA standards. The system has been reasonably effective at monitoring compliance with GMC standards but relatively poor at highlighting and promulgating good or notable practice. Although such practice is picked out by the GMC's QA reports⁹ and also recorded on the GMC website, organisations have commented on the slightly arbitrary nature of the practice singled out for praise. There is uncertainty about whether it is good, innovative or, indeed, best practice which is being singled out and organisations are sometimes unclear why some things are identified as notable and others not.
- 25** This is the inevitable result of the current approach to measuring standards for the management and delivery of education and training. The GMC has described what compliance looks like, but there is no benchmark for what 'notable', 'good', 'better' or 'best' look like. Organisations have been commended in relation to initiatives which have long been regarded as standard practice in other locations.
- 26** The ability to distinguish the excellent from the merely acceptable should help to inform the choices of students and trainees about where they wish to study and train. In feedback to this review students and trainees have said that they would welcome greater transparency from the QA process (see section 10 on reporting of outcomes)
- 27** The focus on confirming regulatory compliance rather than acknowledging excellence can also have a de-motivating effect on those responsible for quality management and quality control at a local level. The Review heard from quality managers that the effect of a QA inspection can be to leave them with the sense, if things have gone well, that they haven't failed to comply with GMC standards. But there is little sense that that they may actually have succeeded or excelled.
- 28** It is not the GMC's role to motivate local quality managers. Nevertheless, the QIF is dependent upon their excellence and should therefore enable proper acknowledgement of good practice within an organisation. This is also consistent with the GMC's aim that its QA arrangements should help support and drive improvement in local systems.

Recommendation 2: The new suite of QA standards should include both core and developmental standards. All organisations must meet the specified core

⁹ The Regional Review of Medical Education and Training in London: 2012-2013 cites a number of examples of good practice: http://www.gmc-uk.org/Regional_Review_Report.pdf_51940876.pdf

standards or face regulatory sanction by the GMC (see section 7). Developmental standards should be used to highlight good practice beyond compliance with the basic core. Performance against both core and developmental standards should be reflected in the GMC's QA reporting (see section 10).

Recommendation 3: Both core and developmental standards should be explicit and measurable and address outcomes as well as process. They should also have regard to the multi-professional aspects of training and care and, where appropriate, create opportunities for alignment with standards used by others.

Section 6: Educational environments¹⁰

- 29** In his 2010 report Lord Patel asked whether the GMC should approve not only training posts and programmes but the wider educational environment within which they are located. This question was given added resonance by the report of the Francis Inquiry which attached considerable importance to regulation of the educational environment. Francis concluded that it is not 'acceptable for training to take place in a training environment in which poor standards of care persist'.¹¹
- 30** We are in no doubt about the importance of the environment in which learning takes place and have carefully considered how this should be reflected in the GMC's approach to QA.¹² In doing so we have been conscious of the distinction between the role of the GMC and that of the systems regulators who have statutory responsibility for regulating the different settings where healthcare is provided. We also noted the practical difficulties the GMC has faced in regulating the system of approved practice settings under existing legislation.
- 31** Nevertheless, the GMC's responsibility for ensuring that education and training are provided in environments which properly support the learning needs of students and trainees is already implicit in many of the standards contained in *Tomorrow's Doctors* and *The Trainee Doctor*. Feedback from stakeholders supports the view that this should now be made explicit within the new core and developmental standards. An attempt during the review to define the

¹⁰ In one of the discussion papers prepared as part of this review we considered what is meant by an educational environment. We decided to define it broadly as 'anything which impacts upon the learner's capacity to develop the appropriate professional attributes, and that includes the quality of patient care. http://www.gmc-uk.org/Educational_Environments_May_2013.pdf_52096709.pdf

¹¹ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, p1214, paragraph 18.55

¹² GMC *Approving Educational Environments* May 2013. http://www.gmc-uk.org/Educational_Environments_May_2013.pdf_52096709.pdf

characteristics expected in an educational environment provided a helpful starting point, but resulted in a list of descriptors that was too long and unfocused. Further work to refine a set of measurable and deliverable descriptors is now being taken forward as part of the review of QA standards. That review is also considering the need for the educational environment to form a specific theme within the standards.

Recommendation 4: The GMC's suite of core and developmental standards for QA should include descriptors required in any educational environment.¹³

- 32** Although it is important to recognise the distinct statutory remits of the GMC and other professional regulators on the one hand, and the system regulators on the other, it is equally important that these organisations are not ploughing their own regulatory furrows, indifferent to the implications for other parts of the environment. Much progress has been made in recent months in improving co-operation between regulators. Section 12 of this report looks at what more might be attempted.

Section 7: QA sanctions

- 33** A sanction is any measure imposed by a regulator in response to a failure to meet standards. During this review we heard criticism that the GMC has been unwilling to use its regulatory powers even when the standard of education and training is known to be poor. In part, such criticism reflects the fact that the GMC has tended not to be open about steps that it is taking with local managers and providers to address problems for fear of jeopardising remedial actions.
- 34** But the GMC has also been hampered by the fact that the regulatory sanctions available to it are quite narrow. In the undergraduate arena its only power is to refuse or withdraw recognition of an organisation.¹⁴ For understandable reasons the GMC has been reluctant to deploy this nuclear option and close a medical school.
- 35** The GMC has slightly broader powers in relation to postgraduate training.¹⁵ As well as refusing or withdrawing recognition it can impose conditions limiting the time or scope of approval. But until recently it has been reluctant to exercise even these powers, seeing them as the last resort after every other conceivable

¹³ This recommendation will support implementation of the Francis Inquiry Report Recommendations 158 and 162

¹⁴ Medical Act 1983 (as amended), section 4.

¹⁵ Medical Act 1983 (as amended), section 34I

local avenue has been exhausted. We have noted examples of NHS Trusts where significant issues with the provision of training have persisted over several years without being resolved and where the GMC has monitored the situation and provided moral support to the deanery, but little in terms of practical and decisive regulatory action.

- 36** These are clearly difficult issues requiring sensitive handling. The GMC must be careful that its interventions do not exacerbate problems which could be successfully managed locally. At the same time, if it is unwilling to act on issues persisting over several years it risks becoming irrelevant.
- 37** Other recent examples have shown a greater readiness by the GMC to act in concert with postgraduate deans to withdraw training recognition where that was clearly in the interests of trainees and patients. But this has required the GMC to exercise its nuclear option. Withdrawal of recognition has implications not only for trainees but for the ability of the service to care for patients in the places where those trainees are located.
- 38** What is needed, therefore, is a more nuanced and escalating suite of regulatory sanctions available across both undergraduate and postgraduate QA. This should include issuing public warnings in relation to specific failings which put an organisation on notice of further action if these are not addressed; conditions limiting the time or scope of approval; temporary suspension of approval; and complete withdrawal of approval.
- 39** A broader suite of sanctions does not mean they should be deployed at every opportunity, but they need to be available in the regulatory toolbox. Their use, or even the threat of their use, may support local managers to secure change before the nuclear option becomes a necessity. The introduction of a broader range of available sanctions will require legislation.

Recommendation 5: The GMC should seek a broader suite of escalating regulatory sanctions to support more effective and timely QA interventions.

Section 8: QA Visiting

- 40** GMC QA visits fall into four broad groups: routine regional visits, check visits, triggered visits, and visits to new medical schools or programmes. A summary is provided at Appendix 3.

Terminology and transparency

- 41** QA visits provide 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.
- 42** 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: 2012-1013* 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.
- 43** This has given the impression that oral evidence received during the visits is 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.¹⁶ Those inspected have told us they are unclear how, if at all, the material they provide in advance for the visit teams is taken into account.
- 44** In fact, the reports are based upon the totality of the evidence the GMC has received before and during the visit. Visits themselves can only provide a snapshot 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. They are not

¹⁶ GMC Review of Quality Assurance in Medical Education and Training: Visiting and Inspection. July 2013. http://www.gmc-uk.org/QA_Visits_FINAL.pdf_52663663.pdf

an end in themselves. Yet this is not always understood, or at least felt, by those being inspected.

- 45** 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. This requires a high degree of professionalism on the part of the visiting team, but can help to give the process greater transparency.
- 46** Transparency would be further enhanced if the final QA reports showed how evidence is used to inform the visit process and the outcome. This would help to demonstrate that the outcome of the QA process is dependent on more than what the visiting team hears on the day. The Keogh Mortality Review outcome reports show how this can be done using a data pack and the questions raised by the data that were asked on the visits.¹⁷
- 47** The language surrounding the process should also be updated. Feedback during the review suggests there are mixed views about whether the term 'visits' or 'inspections' is preferable. Some felt that 'visits' was less threatening and more accurately reflected the co-operative nature of the activity. But it is disingenuous in not expressing the real regulatory intent. While the terminology of the QA 'visit' reflects the current wording of the legislation¹⁸ it is out of step with that used by other regulators. A new Bill covering all of the healthcare professional regulators is expected in 2014 and this should provide an opportunity for consistency of language across the professions.

Recommendation 6: Inspections are an essential part of the QIF. The GMC needs to ensure that the language it uses to describe the role of inspections does not appear to prioritise them over other elements of the QA process. They are simply one of the tools available to the GMC.

Recommendation 7: To aid transparency GMC QA reports should reference the evidence that has been relied upon to inform the report conclusions.

Recommendation 8: The GMC should pilot the idea of enabling deanery/HEE region/medical school representatives the opportunity to observe the inspection team's deliberations at specified stages of the inspection process.

¹⁷ <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx>

¹⁸ Medical Act 1983 (as amended), Sections 7, 34M and 34N

A new inspection strategy

- 48** All medical schools and deaneries/HEE regions within a particular geographical area can expect to be inspected at least every five years. The 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 not being met. This risk based approach 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.
- 49** Even so, we should not underestimate the scale of the enterprise involved. Regional visits are large, set-piece reviews which 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 depending on 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, but we should acknowledge that the regulatory burden was significant both for the regulator and the regulated.
- 50** The risk based approach used by the GMC also raises some practical and conceptual problems. First, a risk based approach is set up to address actual or potential failure to comply with standards. It necessarily focuses on risks rather than strengths. But it is less concerned with helping to 'support and drive improvement in local systems'. While it is logical to consider risk in relation to compliance with core standards that everyone must meet, it is not a helpful measure of attainment for developmental standards. A different visiting strategy is needed.
- 51** Evaluation against both core and developmental standards requires the GMC to take a more holistic view of the overall quality of education and training in a particular location or region. Consideration of areas of identified risk should be part of that evaluation, but not the only 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, five years in advance when its visit was scheduled and could plan accordingly.
- 52** But the GMC also needs 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 across a number of organisations.

- 53** The focused nature of check visits enables the GMC 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.¹⁹ 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.

Recommendation 9: 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. Programmed visits should be complemented by more frequent use of check visits in response to identified risks.

Unannounced visits and earned autonomy

- 54** The review was asked to consider whether the GMC should also undertake unannounced inspections. We noted that some regulators, such as Ofsted, inspect with little or no notice. However, the healthcare environment is very different from the classroom and inspections must avoid disrupting patient care. Many of those the team will want to interview are likely to be involved in frontline care. Furthermore, while unannounced visits have an obvious utility in giving a snapshot of service provision, the added value when trying to gain a broad view of medical education is less clear. Feedback during workshops suggests that they are more likely to add value (and be more practicable to undertake) when led at deanery/HEE region level.
- 55** Despite the practical challenges it would be unwise to rule out the possibility of unannounced visits (in conjunction with the LETB/deanery or system regulator) in exceptional circumstances where significant patient safety concerns had been identified. However, the combination of programmed visits, more frequent

¹⁹ 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.

check visits and the rapid response RCAT process recommended in this report are likely to prove more efficacious in most cases.

- 56** This new inspection strategy also removes the need for an earned autonomy model in which organisations that have in the past complied with standards earn the right to a much lighter regulatory touch.

Role of the medical royal colleges and faculties in GMC inspections

- 57** Inspection teams need credibility. This requires individuals with a range of knowledge, skills and other attributes who have been selected and trained for the purpose and who are accountable to the GMC.
- 58** 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 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'.²⁰ 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.
- 59** There is a persistent, but misleading, view that GMC inspections do not consider specialty issues and do not include relevant medical specialists in the inspection teams. In fact, specialists have always been involved in GMC inspections. The issue, therefore, is to make sure that those used command the confidence of the professional bodies and other stakeholders, as well as the GMC.
- 60** Feedback from the review workshops showed that most had little appetite to return to the arrangements for college visiting which had existed before PMETB was established. The report of the Bristol public inquiry and later work by PMETB had highlighted the shortcomings of those arrangements and the world has moved on.^{21 22} With the GMC as the national regulator for medical education and training, inspections need to be part of the regulatory framework with the requirements for quality assurance, transparency and accountability this brings.
- 61** Using specialists endorsed by the colleges within GMC inspections would ensure that our teams have credibility with the specialty concerned and benefit from the expertise of the colleges which have developed the curricula. In small

²⁰ QIF, p23, paragraph 113

²¹ PMETB consultation on the future arrangements for quality assurance of training, 2005.

²² Grant et al. The cost of hospital inspection visiting. Open University Centre for Education in Medicine. April 2003

specialties there may be difficulties finding sufficient suitable recruits and it may be that some GMC visitors take on specialty portfolios, similar to the way in which there is a lead dean for each specialty.

- 62** College endorsed specialists would need to be appointed, trained, appraised and accountable to the GMC to enjoy the same status as other team members. Although college endorsed they would act as agents of the GMC and not as representatives or nominees of the colleges. The task for the colleges would be to identify suitable specialists.
- 63** We heard different views about how suitable specialists should be identified. Some favoured the colleges encouraging those with the relevant skills to apply direct to the GMC to join its pool of visitors. Others thought the colleges could maintain their own pools of specialty experts for use by the GMC when specialty specific matters are at issue. It ought to be possible to operate a mixed economy depending on the preferences of the different colleges. But however they are recruited all specialty experts would 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 appraised in the same way as other team members. Visit reports should identify the specialists used as 'college and GMC accredited'.

Recommendation 10: Specialists used within GMC QA inspections should be jointly badged as college and GMC accredited and this should be explicit in the inspection reports.

- 64** Adoption of this recommendation will be consistent with the recommendation of the Francis Inquiry report that the royal colleges 'should be enlisted to support [training] visits'.²³

²³Francis Inquiry Report Recommendation 155

Recruitment and training issues for specialty expertise

65 Review workshops highlighted the growing demand across the sector for specialist input into the inspection processes of different organisations. Given the limited number of suitable experts, the pressure this places on hospitals to release consultants to provide their services and the need to train participants, there is a pressing case for looking at how resources are shared and activities co-ordinated. Section 12 of this report looks at better co-ordination of regulators' QA activity in the longer term. More immediately, regulators should look at options for joint training and/or reciprocal recognition of those aspects of the training for their QA functions which require a common or similar skill set.

Recommendation 11: The GMC should consider options for joint training and/or reciprocal recognition of training for QA functions with other regulators.

Students and trainees in GMC QA visits

66 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.²⁴

67 The challenge 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. An opportunity to submit comments via an email box or by undertaking an online survey (as is now done with visits to medical schools) might go some way to addressing this problem. Feedback to the review showed support for trying to gather the views of students, doctors in training and trainers,²⁵ but pointed to the risk of survey fatigue. For this reason, comments received in this way may not be determinative, but could be triangulated with other evidence to help direct lines of enquiry for the visit team to test once on site.

68 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 lecture theatres, but more to be gained by visitors walking the floor and seeing the environment in which clinical teaching takes place. They will be helped in this by explicit reference to the educational environment in the new suite of core and developmental standards.

²⁴ See Francis Inquiry Report recommendation 161

²⁵ In addition to the GMC's existing trainer and trainee surveys.

69 Some respondents questioned whether direct observation of the environment, and, indeed, visiting local education providers at all, meant the GMC straying from quality assurance into the quality management remit of the postgraduate deans and quality control by the LEPS. We are in no doubt that GMC inspections need to cover both what is happening on the ground as well as how it is managed. We note the criticism previously levelled by Francis 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

Recommendation 12: GMC inspection teams should observe the environment in which clinical teaching occurs.²⁷

Section 9: Role of the colleges

70 The medical royal colleges and faculties are in a unique position as they and their representatives have a role at all levels within the learning environment. They operate locally and regionally through their networks of college tutors, and regional advisors and through their work with the deans. At a national level the Specialty Advisory Committees work with deans to ensure that curricula are delivered at a local level. Colleges also work through the Academy of Medical Royal Colleges and through their contributions to the GMC's work.

71 Colleges are also central to the design and delivery of specialty training. They are the authors of the GMC approved curricula and assessment systems, the hosts of the trainees portfolios and they administer the national specialty examinations which are a crucial element of postgraduate assessment systems.

72 Section 8 of this report makes recommendations for enhancing the colleges' role in GMC led inspections. But GMC inspections are only part of the picture.

73 The extent of the colleges' involvement has caused some of them to want clarification of where, precisely, they fit into the GMC QIF model overall. In practice, there is no single place. Their influence is more pervasive than that. However, workshops with the colleges and others identified why that influence is sometimes impaired and how their contribution to the QIF might be enhanced.

²⁶ Francis Inquiry Final Report, Chapter 18, page 1256, paragraph 18.222

²⁷ See Francis Inquiry Report recommendation 161

External scrutiny of quality management ('externality')

- 74** The QIF requires deaneries/HEE regions to ensure external scrutiny of the quality management process. Externality may come from a number of sources, but at a specialty level such advice normally comes from the colleges and faculties. External advisors are expected to have appropriate expertise and be independent of the deanery/HEE region. However, feedback from colleges, deans and others during the review highlighted the variable quality and training of external advisors. This had affected the appetite of some deans for drawing upon college expertise whether for deanery/HEE region led visits or to support the ARCP process.²⁸
- 75** To address this variability in quality the AoMRC, supported by the GMC QA review and representatives of the colleges and deans, is seeking ways to professionalise the role of external advisors. It has begun to develop a generic role and person specification. The aim is that all colleges would follow the core requirements of the specification but could add other requirements as appropriate to their specialty.
- 76** The QIF also notes that as part of their quality management activity deans, 'in conjunction with medical Royal Colleges and Faculties, may need to carry out a form of local visiting with the aim of improving education and training opportunities'.²⁹ Indeed, visits 'should include expertise external to the programme being reviewed'.³⁰ But linked to concerns about the variable quality of the expertise there has been little consistency about when college expert advisors should participate in local quality management visits. Prompted by the findings of this QA review, the AoMRC is now leading work with the colleges and the deans to develop a shared protocol for obtaining external advice from medical specialists.

Recommendation 13: The deans/HEE regions, GMC and colleges should support the work now being led by the AoMRC to professionalise and clarify the role of external advisors in the quality management process.

- 77** The work to professionalise the role of external advisors has identified the need for them to undergo common training. As recommended in paragraph 66 of this report, elements of that training could be provided through the GMC's existing training programme for its QA visitors. Those trained in this way could then be jointly badged or endorsed as GMC/college approved.

²⁸ http://www.gmc-uk.org/QA_Review_Summary_of_workshops.pdf_49775408.pdf

²⁹ QIF paragraph 31

³⁰ QIF paragraph 32

- 78** The ASRs provided by the colleges for the GMC have been singled out by both as a pressing priority for reform.³¹ The QIF states that the reports are intended to provide 'an essential specialty perspective, a national overview by specialty and subspecialty...' However, in practice the colleges were uncertain about what the GMC sought to achieve through the ASRs and about how the information they collected for the ASRs was actually used. Added to this were complaints about the considerable burden of collecting the information and the retrospective and anecdotal nature of much of the specialty evidence assembled.
- 79** Nevertheless, all parties recognised the potential of ASRs to provide that 'essential specialty perspective' on the state of training. Through the review, therefore, the GMC has worked with the colleges to agree the principles for a new approach to ASRs (see Appendix 4). This describes the purpose, function and basis for defining the future content of ASRs. The key element is the prospective identification by the GMC and colleges together of a rolling programme of themes and questions to be addressed in order to support better planning and collection of evidence.
- 80** Coupled with this, the GMC should make available to the colleges the specialty data that it holds to better inform their analysis.

Recommendation 14: The GMC should work with the colleges to implement the new approach to ASRs by 2015.

Section 10: Reporting the findings of QA activity

- 81** The purpose of the GMC's QA reporting should be to drive improvement in the organisations being quality assured by providing a clear account of their performance against GMC standards.
- 82** During the course of this review, and often independent of it, the GMC has made significant progress in the way it reports its QA findings. Several of the proposals described in this section are already starting to be reflected in the GMC's work.

³¹ http://www.gmc-uk.org/College_Workshop_Summary_Report_FINAL.pdf_50982718.pdf

Understanding the audiences

- 83** There are a number of different audiences with a potential interest in GMC QA reporting. They include deaneries/HEE regions, medical schools, LEPs, students, trainees, commissioners of training, patients and the public. The needs of these groups will be different, but we should not assume that that they are either fixed or mutually exclusive.
- 84** QA reports have traditionally been lengthy, detailed, technical reports aimed at those responsible for commissioning, managing and delivering training. This is certainly the key audience. But, as the feedback from this audience confirmed, such reports are not calculated to get the attention of Chief Executives and Trust Boards seeking summaries of the action points they need to prioritise. The QA reports from the 2013 London Regional Visits show that the GMC has been responsive to such concerns.
- 85** But the GMC also needs to display greater transparency in its reporting by showing how the evidence which has informed each report has been used (see recommendations in section 8 of this report).
- 86** Although the QIF refers to information available to the public, little if any of the GMC's QA reporting is explicitly undertaken with their needs in mind. There is an assumption (voiced by some during the review workshops) that patients and the public have no interest in the quality assurance of medical education and training. While patients and the public may not be the primary audience for this material in terms of driving change, the GMC nevertheless has a duty to regulate in a way which is transparent and accessible if it is to maintain public trust.
- 87** There was similar scepticism voiced about whether students and doctors in training would be interested in such information or would use it to inform their choices about where to study or train. Needless to say this was not a view shared by the students and trainees who took part in the review.
- 88** In fact, the GMC makes a considerable amount of information about its QA activities available on its website but the material is not easily accessible. We might contrast this with Ofsted reports which are directed to the parents and children who use the school, and the example of the QAA and Education Scotland which tailor their reports to several different audiences.

Recommendation 15: The GMC's reporting mechanisms should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees.

Driving improvement

89 The evidence base to support the GMC's QA activities is stronger than ever before. This is now starting to be used to develop risk profiles which will inform future visit programmes and identify concerns earlier. This work is at an early stage but should, in future, be used to shape the behaviour of the organisations being regulated. Organisations should be able to see where they sit on a spectrum of risk indicators compared with other institutions or regions. Even if others on the spectrum are anonymised an organisation would be able to reflect on the reasons for its own profile and, where necessary, address areas of potential weakness before they require regulatory intervention by the GMC.

Recommendation 16: Once the GMC's medical education risk profiles have been piloted and developed they should be shared with the organisations concerned.

90 But this does not amount to full transparency. The GMC is therefore planning shortly to publish all validated concerns identified through its QA processes, together with the action plans of the organisation concerned.

91 More generally, the GMC should explore making more transparent use of its data. The National Trainee Survey (NTS) now yields a wealth of material which can be cut in different ways, such as perceptions of preparedness for practice analysed by respondents' primary medical qualifications. While it is always important to be wary about treating such data as an objective measure of quality, it is nevertheless valuable in its own right. Being more transparent about the data held should also help the Colleges with their own analysis for future ASRs (see paragraph 81).

Recommendation 17: The GMC should work towards more transparent use of the data collected through its QA processes.

The nomenclature of reporting

92 This report has already touched on the way in which the presentation of our QA reports affects the accessibility of the material for audiences. Although significant progress has been made over the last year on the clarity of reporting, the overall judgement on the quality of education and training in an organisation, whether it meets or falls short of the expected standards, is not always obvious.

93 UK health regulators vary in their use of scoring to express a judgement, but there is a preference for terms that are, as far as possible, simple and

unambiguous.³² More explicit judgements in GMC reports will depend upon making the standards against which they are made more explicit, measurable and outcome focused than they are at present. But work is also needed on the nomenclature of the judgements. The GMC currently imposes a mixture of 'requirements' and 'recommendations'. The meaning of a regulatory 'requirement' is clear enough. If it is not followed, regulatory action should be taken. But to an outside observer the meaning of a recommendation is less clear. The GMC's reporting template states:

'We set recommendations where we have found areas for improvement related to our standards. Our recommendations explain what an organisation should address to improve in these areas, in line with best practice.'

- 94** This begs the questions, have the standards been met or not and what action is the regulator going to take? In fact, no action will follow. This is not to say that making recommendations is pointless. We know that they can give organisations leverage in securing the resources necessary to drive improvement. But this effect could be achieved in a more explicit and transparent way through the new core and developmental standards. This would enable the GMC to show whether an organisation is simply meeting the essentials or exhibiting particular strengths. It would also allow observers to compare organisations in a way which is not currently possible.

Recommendation 18: GMC QA reports should provide explicit judgements (with supporting evidence) about whether standards have been met based on the new set of core and developmental standards. This should be accompanied by an organisation's action plans for addressing those standards which have not been met.

Comparing performance

- 95** The recommendations in this report aimed at greater transparency of data, sharing risk profiles and more explicit judgements about an organisation's performance in relation to core and developmental standards will inevitably lead users to compare the performance of those organisations.
- 96** Some will object that all comparisons are invidious because they do not take account of location, resources and other variables which may affect performance. However, such comparisons are already possible with some of the data now held. For example, the results of the National Training Survey can be interrogated through the GMC's website to compare trainee experience in different specialties in different parts of the country. But locating and

³² GMC research: Developing an evidence base for effective quality assurance. Final Report. Colin Wright and Associates, March 2012, p6.

interrogating the information in order to make such comparisons requires luck, perseverance and aptitude. It is a system designed for those involved in QA and is neither intuitive nor accessible for other audiences. Where comparative data exists, the GMC must do more to make it accessible. It should, for example, be possible to see at a glance the comparative results of QA visits in relation to individual standards.

Recommendation 19: There is an urgent need to re-structure the QA sections of the GMC's website to ensure that findings are transparent and accessible for all audiences.

Section 11: Data, Progression and Adding Value

97 As this report has already noted, since the merger of PMETB with the GMC, it has begun to have available more and better data than ever before to inform its QA processes. Part of the challenge for the GMC is to make sense of this data and not be overwhelmed, or overwhelm others, by the appetite for information.

98 There are a number of initiatives currently being pursued within the GMC's Education team for improving both the quality and access to data needed for QA, and the way in which information is collected, stored and shared with other agencies. Alongside these are improvements in the way information is shared across different parts of the GMC. These initiatives now need to be linked to a wider data strategy for the GMC as a whole to provide a coherent and properly co-ordinated approach across the organisation. Work on that wider strategy is now underway.

Recommendation 20: QA data development should be linked to the GMC's overall data strategy to ensure coherence and consistency of approach and the proportionality of data demands imposed on others.

99 Feedback to the review has also pointed to some simple, practical measures in the shorter term. These include being more open about how the information provided for the GMC's QA processes has been used both to inform QA judgements and shape policy; the timeliness of data requests so that organisations have the opportunity to put systems in place to collect the relevant material; and the importance of piloting data questions so that compliance is feasible and requirements easily understood.

100 Although the GMC is increasingly data rich, there is a notable contrast between the wealth of evidence collected to support the QA of postgraduate training and the relatively limited information used to support the QA of undergraduate education. For undergraduate medical education the GMC is largely dependent upon the annual self-assessments provided by the medical schools (MSARs) verified through the evidence of periodic inspections. That there is less

information available in relation to undergraduates than for postgraduate trainees is not surprising. The GMC must also be proportionate in its information requests, bearing in mind that universities are also subject to quality assurance by the QAA.

- 101** Nevertheless, the GMC's plans to develop a medical student survey comparable to the highly regarded NTS completed by doctors in postgraduate training are to be supported.³³ This will strengthen the triangulation of evidence and address the criticisms of those who argue that the National Student Survey does not provide a proper reflection of the views of medical students for the purposes of the GMC's QA.

Measuring quality and adding value

- 102** The review of the standards for the management and delivery of medical education and training recommended earlier in this report should help the GMC to focus on training outcomes as well as process.
- 103** However, the larger aim should be to better understand progression from the point of entry to medical school through the postgraduate years and identify where value is added or subtracted along that journey. For example, what is the link between recruitment scores into specialty training and examination results and CCT outcomes in different regions? Recent years have seen the GMC and others begin to make progress in this area (for example through the collection and reporting on ARCP progression data and proposals for a UK Medical Education Database) and it should continue to pursue this goal.

Section 12: Working together

- 104** The Francis Report is 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.
- 105** This nothing new. The Law Commission consultation on reforms to the legislation governing healthcare professional regulation looked at ways to improve the interface between organisations, facilitating joint working and

³³ See Francis Inquiry Report recommendation 159

introducing a duty of co-operation.³⁴ This includes the possibility of regulators choosing not to act, or reduce their activity, in a complex environment where other agencies are performing similar tasks.³⁵ Such suggestions point to the need for a better fit between professional and systems regulation.

106 Feedback from struggling LEPs suggests 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.

107 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. Even if such an approach carried support, it is probably not achievable in the foreseeable future.

108 A more realisable goal would be to work towards more co-ordinated regulatory action with the aim of securing collective assurance. This may require regulators to sacrifice some independence of action and it would be important to avoid the blurring of regulatory roles and responsibilities.

109 For example, arrangements are being developed for the GMC to alert the relevant systems regulator when 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.

Recommendation 21: The GMC should explore with other agencies the feasibility of collective regulatory assurance with a view to future piloting.

³⁴ Regulation of Health Care Professionals, Regulation of Social Care Professionals in England (2012), Law Commission Consultation Paper No.202, Part 12.

³⁵ Ibid, Part 6.

Section 13: Conclusion

- 110** The challenge in quality assuring medical education and training, as with all regulation, is one of proportionality. As the Francis Report amply demonstrates, the stakes are high for students and trainees as well as for patients and the institutions being assured. On the other hand, hyperactive regulation risks overwhelming the system. The further challenge is that medical education and training is something of a moving target. Expectations are high, pressures on the healthcare system are increasing, the supporting structures are changing, multi-professionalism is becoming more important and the data to inform QA activity is improving.
- 111** The GMC's approach to QA has shown it to be sensitive to these pressures. This report sets out a series of recommendations for how, working with others, it might enhance that approach. What is absolutely clear is that the GMC cannot run an effective and proportionate QA system without effective engagement with, and co-operation from, other agencies. This is self-evident from the structure of the QIF. It also becomes a pressing priority with the increasing need to link the data held by different players so as to better inform regulatory interventions and provide collective assurance.

Review of Quality Assurance: Terms of Reference

Background

- 1 The Quality Improvement Framework (QIF) consolidates previous work by the GMC on the quality assurance of basic medical education (QABME) and the Foundation Programme (QAFP), and arrangements inherited from PMETB.
- 2 The GMC is now looking to enhance the QIF by piloting different approaches to 'inspecting' medical schools and postgraduate deaneries, by developing a better evidence base to inform those visits and by having established a Quality Scrutiny Group to provide more consistent analysis of the outcomes of quality assurance activities.
- 3 These initiatives will help to refine existing operational processes. However, the recent expansion of our regulatory remit, combined with proposed changes to NHS structures (described in *Developing the Healthcare Workforce: from Delivery to Design*) and some high profile failures within NHS hospitals which deliver training, have prompted us to undertake a more fundamental review of the way we carry out our quality assurance role.

Purpose

- 4 To examine the GMC's arrangements for assuring the quality of undergraduate and postgraduate medical education and training and make recommendations regarding:
 - Their fitness for purpose in ensuring that the management and delivery of education and training equips doctors leaving training with the knowledge, skills and attributes needed for their specialty and professionalism consistent with the application of *Good Medical Practice*.
 - Their ability to monitor compliance with GMC standards for education and training and respond appropriately to concerns, particularly where patient safety may be at risk.
 - Their ability to support and drive improvement in local systems for the management and delivery of education and training.
-

- Compatibility with best practice in quality assurance in the light of commissioned research.

Underlying principles of the review

- 5** In addressing the key tasks set out below the review must have regard to the following principles:
- The need for fairness, equality and consistency in the provision of education and training
 - Proportionality: The system must balance rigour and effectiveness with recognition of the need to minimise regulatory burdens and acknowledgement of risk.
 - Flexibility: The model must be capable of being applied regardless of changes to the way that education and training are delivered locally.
 - Working with others: The model must seek to make the best possible use of information and activities undertaken by others.
 - Adding value: Activities undertaken for the purposes of quality assurance must demonstrably add value in relation to the overall purpose described in paragraph 4 above.

Key Tasks

- 6** Building on the issues contained in the report to Council of 8 June 2011 the review should examine the following themes:

Theme 1: Approval against standards: Consistency and divergence in the GMC's quality framework

- 7** The different approaches to the GMC's quality assurance of undergraduate and postgraduate training are largely shaped by the underpinning legislation. The review should consider the case for greater overall coherence and consistency across the continuum and the most appropriate approach. This should include consideration of our approach to the setting of standards across all stages of education and training, and the actual and potential outcomes of the quality assurance process for the entities being assured.

Theme 2: The case for approving the educational environment

- 8** Education and training are more likely to be effective when delivered in environments where they are valued. The review should 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.

Theme 3: Reporting the outcomes of quality assurance activities

- 9** The review should consider how the outcomes of quality assurance activities are reported, having regard to the purpose to be served by the reporting methods, their accessibility and transparency for the intended audiences and the need both to encourage improvement and highlight failings.

Theme 4: Quality measures: measuring systems and measuring outcomes

- 10** The review will examine whether the current processes provide sufficient assurance of the quality of outcomes and of individual trainees and their progress through training.

This should include considering options for indicators of quality in training.

Theme 5: The QIF

- 11** The QIF has been designed to provide a proportionate and practical quality assurance methodology which recognises the limits on the regulator's ability to undertake comprehensive monitoring of the delivery of all education and training. At the same time, it is a system which places the regulator at several removes from trainees and it is heavily dependent on the activities of intermediaries to deliver the required levels of assurance.
- 12** The review should consider whether the existing framework provides the appropriate focus and levels of accountability and whether the risks associated with dependency on others are adequately mitigated.

Theme 6: The use of evidence to support decisions on quality

- 13** The review should consider the source, nature and extent of the evidence used to inform quality judgements having regard to issues of proportionality, efficacy, the regulatory burden involved in its collection and the potential for better use of shared evidence between organisations and across the GMC.

Theme 7: The purpose and nature of 'visits'

- 14** The review will consider the purpose, function, form, pattern and nomenclature of visiting, and the composition of teams.
- 15** It should also examine the implications of the new Regional Liaison Officer role for our visits regime.

Theme 8 Responding to concerns

- 16** The review will consider whether the mechanisms for responding to concerns are effective in facilitating early identification of, and response to, appropriate issues.

Theme 9: The role of the medical Royal Colleges

- 17** The medical Royal Colleges have an important role providing external perspective and speciality expertise. The review should examine how that expertise can be best used within the regulatory framework for quality assurance operated by the GMC.

Theme 10: Legislative reform

- 18** The current quality assurance arrangements are shaped, in part, by the legislative framework. In the light of its conclusions regarding the themes described above, the review should consider the adequacy of the legislative framework and identify any changes needed to existing legislation. This should take into account the current Law Commission review on the GMC's legislative framework.

Working methods and phasing of the review

- 19** The review will be led from within the GMC's Education Directorate, but separate from the Directorate's Quality Team.
- 20** The review will be informed by the results of externally commissioned research into quality assurance models, both in the UK and overseas, surveys, workshops and seminars with GMC and external stakeholders.
- 21** The review must also take account of the learning that will emerge during 2012 from GMC initiatives such as the piloting of regional quality assurance visits covering both undergraduate and postgraduate education and training, greater use of risk profiling to plan visits and developments in the response to concerns process. Other key developments affecting the review will include the implications for standards in education and training of the new edition of *Good Medical Practice* (to be published in autumn 2012), the work to develop generic outcomes for postgraduate training, and the results of the Mid-Staffordshire Inquiry. In the light of these developments, the review will be undertaken in two phases.

Review Phase 1: 2012

- 22** Phase 1 of the review will involve an examination of current quality assurance methodology and recommendations to Council on our future approach.

Review Phase 2: 2013

- 23** Phase 2 of the review will develop the GMC's standards in education and training in the light of the new edition of *Good Medical Practice* and work to develop generic outcomes for training, and their implications for quality assurance.

Outputs

- 24** A written report from each phase of the review setting out conclusions in respect of each of the key areas described in themes 1-10. The Phase 2 report will include a revised draft set of standards for consultation with key interests.

Accountability

- 25** The review will report to the Education and Training Committee of the GMC.

Timescale

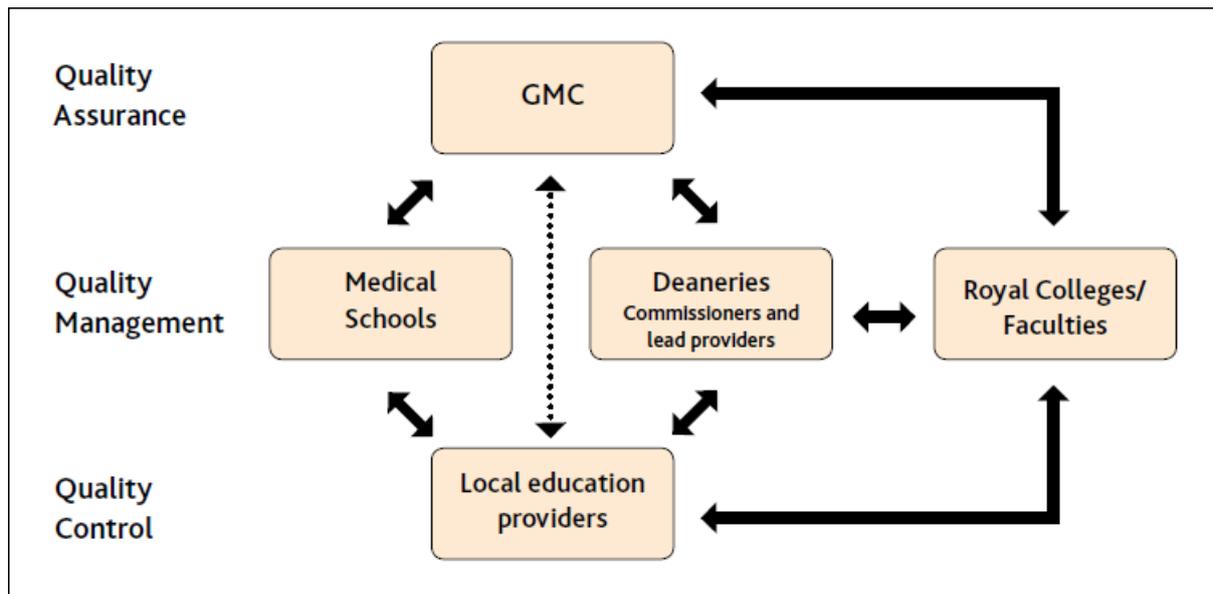
Phase 1

- 26** The findings and recommendations from Phase 1 of the review will be reported to the Council of the GMC in December 2012.

Phase 2

- 27** The findings and recommendations from Phase 2 of the review will be reported to the Council of the GMC by or before December 2013.

GMC Quality Improvement Framework (QIF)



[DRAFT] Report of the Review of Quality Assurance of Medical Education and Training

- 1 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.³⁶ 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 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 starts admitting students and continuing until the first cohort of students graduates.

³⁶ Most deaneries were visited at least twice between 2005 and 2010 (GMC Quality Improvement Framework (QIF), paragraph 100)

[DRAFT] Report of the Review of Quality Assurance of Medical Education and Training

Annual Specialty Reports

- 1 The form, function and purpose of the Annual Specialty Reports provided by the colleges and faculties to the GMC should be revised as follows:

Purpose:

- To help guide the GMC's regulatory interventions by contributing to the GMC's understanding of the state of specialty training across the UK and, in particular, whether standards for training in the specialty and the requirements of the curricula approved by the GMC are being met.
- To enable colleges and faculties to contribute to the quality assurance of their speciality and influence policy development at a national level.

Function:

- 2 To meet this purpose, the ASRs should in future be based on the prospective collection of information so as to enable the GMC to:
 - Identify trends and issues which affect the quality of training in a specialty
 - Inform the evidence base for identifying risks to be investigated
 - Triangulate college information with information obtained from other sources
 - Support the GMC planning processes such as curriculum approvals, policy developments and QA inspections
 - Provide feedback to colleges and faculties on operational and policy issues identified in ASRs.

Form and content:

- 3 The information collected through the ASRs should be guided by the following principles. Information collected should be:

- Forward looking
 - Evidence based (rather than anecdotal)
 - Enable triangulation with other sources of evidence (for example from deans' reports and the NTS).
- 4** The information collected must include:
- Specialty exam data at individual trainee level
 - A small number of questions each year on particular themes which have been agreed in advance with the colleges (for example, pressure on trainers). There would be a rolling programme of questions which would enable planning for the prospective collection of evidence
 - Identification of notable practice in the specialty which might be transferrable to other specialties
 - Information to support QA planned policy developments within the GMC.
- 5** The GMC should make available to the colleges the specialty data that it holds to better inform their analysis.