Assuring the quality of medical education and training

We set the standards for medical education and training across the UK, and monitor undergraduate schools and postgraduate training environments to make sure these standards are met.

Our standards help to make sure the learning environment is safe for patients, medical students and doctors in training and of sufficient quality for learners to progress.

We regularly ask students and doctors in training about their experiences and respond to any concerns. And we constantly seek to support improvements to performance.

We have, for example, continued to explore why some groups of graduates, such as black and minority ethnic doctors both from the UK and overseas, do not progress as well through medical education as others.[8] We ran a pilot with several deaneries and Health Education England local offices, which gave them access to data on this for the first time and enabled them to take action, and we commissioned research that highlighted some of the barriers to change. As a result, we have already seen a number of interventions to improve the situation.

In this section we show other ways in which our work can make a difference to medical students and doctors in training, triggering change and ultimately impacting on public safety.

National training surveys: taking action to support learners

Our annual national training surveys[9] of more than 75,000 doctors in training and their trainers are a vital tool in telling us just what is happening in medical education and training across the UK. That in turn enables us and providers to take action where necessary to make sure our standards are upheld.

Case study: Altnagelvin Area Hospital A&E department, Northern Ireland

Our 2015 national training surveys highlighted serious concerns about the level of support that doctors in training were receiving from senior staff in Altnagelvin's emergency department. It also indicated that supervision was inadequate.

Although the feedback came as an unwelcome surprise, consultants took it to heart and used our findings to lobby management for more senior and middle grade staff, stressing this was essential to preserve public safety and maintain the department's training accreditation.

8 See www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment

9 See www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys

As emergency department consultant Paul Bayliss noted: 'When junior doctors say they don't feel adequately supported they are likely telling us that our patients' safety is potentially at risk.'

As a result the department received a significant funding increase which allowed them to make radical changes to consultant rosters and provide doctors in training with more appropriate direct clinical supervision. The training programme was also refreshed. Feedback from junior doctors in the 2016 and 2017 surveys indicates the changes have led to significant improvements.

Satsifaction rates

	2012	2013	2014	2015	2016	2017
Overall satisfaction	78.67	77.60	80.44	66.86	81.00	88.55
Clinical supervision	72.96	79.10	71.33	76.43	85.59	94.55
Clinical supervision - our of hours				67.00	83.25	92.73
Work load	28.13	40.63	30.79	23.21	32.81	43.18
Induction	85.83	90.00	82.78	84.29	93.13	90.91
Feedback	61.67	68.52	73.15	57.74	90.84	80.00

Post Specialty: **Emergency Medicine**, Altnagelvin Area Hospital A&E department

How enhanced monitoring helps to maintain training standards

As part of our work we institute enhanced monitoring at education and training sites[10] where we have serious concerns about the quality or safety of medical education and training.

We work together with providers, deaneries, and health education local offices to make good the failings until there is evidence of a turnaround.

In 2017 we dealt with 94 issues that needed enhanced monitoring. In the case of 39 organisations we found evidence of improvements and were able to close our enhanced monitoring process. Here are two examples:

10 See www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring

Case study: Addenbrooke's Hospital, Cambridge

We began enhanced monitoring at Addenbrooke's Hospital after Health Education East of England told us it had found service priorities and the demands of administrators were being prioritised over training and educational standards in ophthalmology.

Together with Health Education East of England we set and monitored new requirements, including a named appropriate consultant for every doctor in training, a revised theatre list to make sure doctors in training get sufficient experience, monthly protected teaching and greater support for educational supervisors.

While our 2016 national training survey showed little progress, the 2017 survey revealed dramatic improvements. Our enhanced monitoring team attended a Health Education East of England visit to the provider that also found a greatly changed environment. There was now good support from ophthalmic consultants as well as guaranteed time in theatre and formalisation of out of hours support. As a result we were able to lift our enhanced monitoring measures.

The number of enhanced monitoring cases monitored and closed in 2017

94 cases were monitored

39 cases were resolved

Case study: North Middlesex University Hospital NHS Trust, London

We take any concerns about poor standards of medical education and training very seriously and act quickly to address them in partnership with others. Sometimes these concerns require serious action so that we can protect and improve the training, health and wellbeing of individual doctors.

Our national training surveys showed that doctors in training at North Middlesex University Hospital's emergency department had to deal with situations beyond their competence because of an absence of senior supervising doctors. This was closely related to recruitment problems that meant only 30% of substantive medical posts in the department had been filled.

In the spring of 2016 we made a visit together with Health Education England (HEE), which showed a culture of bullying as well as inadequate supervision and deficiencies in doctors' competence and capabilities.

Working closely with our partners we laid down a number of conditions that, if not met, would mean that the doctors in training were removed from the department. As a result, the trust agreed to move in resources from neighbouring trusts to support the department as well as making changes in the senior and clinical leadership. A series of follow-up visits showed that doctors in training were now receiving better support and these improvements were confirmed in our 2017 national training survey.

Given the trust's continuing recruitment problems, there is a risk that, once neighbouring trusts withdraw their loaned resources, the situation will worsen. We will continue to work with all organisations involved to keep the situation under review to make sure that doctors in training are being properly supported.

In some enhanced monitoring cases we have also had to go further and make sure that doctors in training were removed from specific departments. It was the case at East Kent Hospitals University NHS Foundation Trust, for example, where we were concerned that there was a poor level of clinical supervision that was creating an unsafe and unsupportive environment for doctors in training and, if left unchecked, it could impact on public safety. In partnership with Health Education England we arranged for doctors in training to be removed from some medicine specialties on the Kent and Canterbury site and relocated to other sites across the trust.

The real challenge in situations like those at North Middlesex and East Kent is to achieve sustainable improvement. We now have a seat on the NHS Joint Oversight Group which gives us greater influence in determining how we can monitor and support high risk organisations.

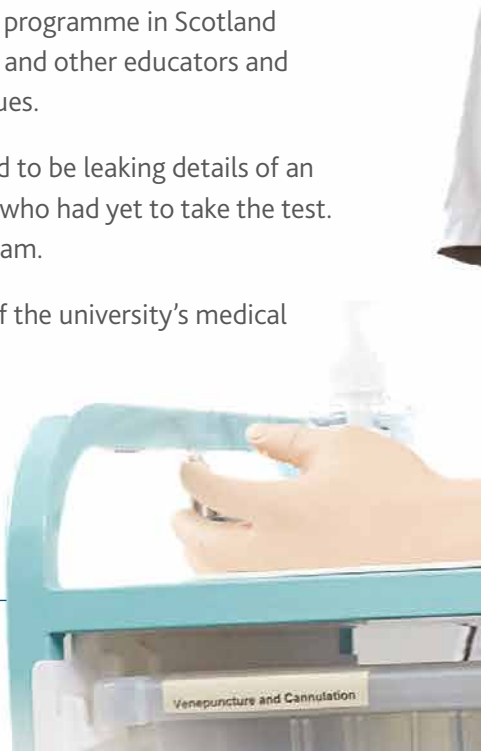
Using student engagement to highlight probity issues

We made significant improvements to our student engagement programme in Scotland in 2017, working more closely with school professionalism leads and other educators and tailoring our events to the local curriculum as well as topical issues.

> "The session put my mind at ease that the GMC exists to support us all."
>
> **Medical student.**

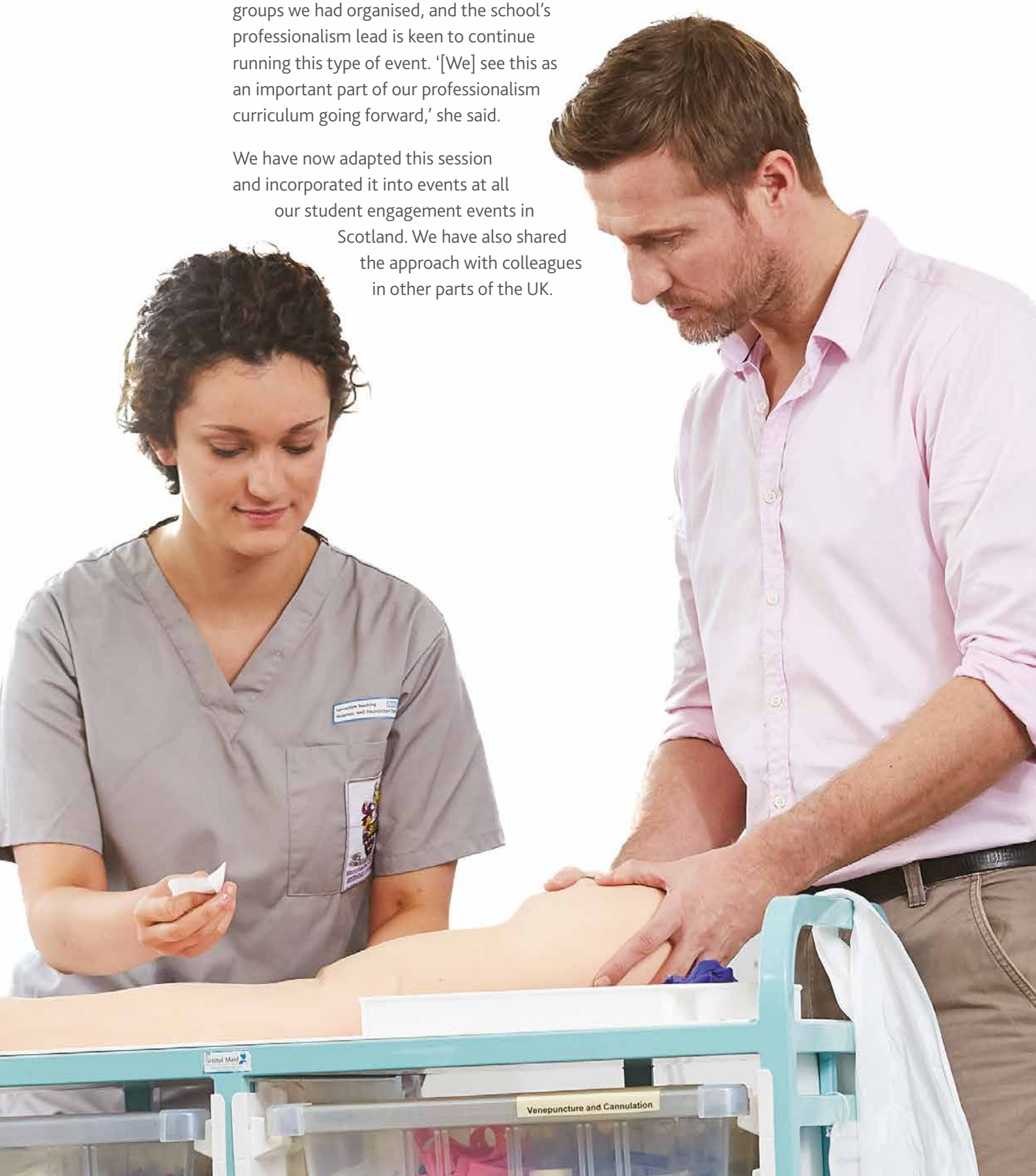
For example, some medical students were found to be leaking details of an assessment through social media to colleagues who had yet to take the test. As a result the entire cohort had to re-sit the exam.

We responded by collaborating with the head of the university's medical school and the professionalism lead to deliver an interactive session for third year students highlighting relevant guidance on honesty, probity and raising concerns about exams. The session included group work using scenarios from our existing resources as well



as specially devised scenarios about the exams. Students and educators were both very positive about the session. We received feedback from 15 of the student discussion groups we had organised, and the school's professionalism lead is keen to continue running this type of event. '[We] see this as an important part of our professionalism curriculum going forward,' she said.

We have now adapted this session and incorporated it into events at all our student engagement events in Scotland. We have also shared the approach with colleagues in other parts of the UK.



New standards to make postgraduate training more flexible for doctors

In 2016 contract negotiations between the Department of Health (England) and the BMA's Junior Doctor Committee and consultation with stakeholders identified that doctors in training were concerned about the lack of flexibility in training. In particular, the structure and processes in training created barriers for doctors in training who seek to change specialty.

So we began a review of flexibility in postgraduate training,[11] and in March 2017 we shared our action plan for improving it with the health ministers of the four UK countries, identifying key actions we will take with others to increase flexibility and options in this field.

> "Inclusion of generic professional capabilities in all curricula will ensure that professionalism receives the priority and emphasis it requires during training."
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> **Bill Allum, Chair of the Joint Committee on Surgical Training, and the Academy of Medical Royal Colleges' lead for production of generic professional capabilities implementation guidance for colleges.**

We then introduced medical education reforms to support this work, again aiming to make postgraduate training more flexible for doctors. We set out that by 2020 medical colleges and faculties will update all 103 existing postgraduate medical curricula against our new *Excellence by design* standards.[12] All the curricula will have to demonstrate how the proposed training will promote the vision of a more generalist and more broadly skilled workforce.

Integral to these new standards is our new Generic professional capabilities framework.[13] The framework covers capabilities in broader areas of professional practice, such as communication and team working, necessary for all doctors to provide high quality care, and which given their generic nature, should be transferable across most specialties.

Welcoming the new generic professional capabilities framework, Bill Allum, Chair of the Joint Committee on Surgical Training, and the Academy of Medical Royal Colleges' lead for production of generic professional capabilities implementation guidance for colleges, said: 'Inclusion of generic professional capabilities in all curricula will ensure that professionalism receives the priority and emphasis it requires during training, in order to ensure doctors develop the key professional values and behaviours, knowledge and skills required'.

11 See www.gmc-uk.org/education/standards-guidance-and-curricula/projects/promoting-flexibility-in-postgraduate-training

12 See www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design

13 See www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

In November 2017 we also published an updated position statement on less than full time training[14] (LTFT), confirming that training providers must agree to LTFT arrangements, and setting out conditions to make sure the duration and level of quality of LTFT training is not less than that of continuous training.

We will continue this work to better support doctors and achieve our vision to give them clarity and confidence on what switching specialties will mean for them. We recognise that to do that in full we need the UK government to make the law less restrictive, so that we can be more agile in approving training.

As health service difficulties grow so the pressures on medical students and doctors in training increase. We must therefore redouble our efforts to make sure their training environment is a healthy and secure one.

We want to instil increased confidence in the ability of training environments to support doctors who are learning. We also want to be trusted to speak out on learners' behalf where training or practice environments or culture jeopardise their ability to meet the standards we set for good medical practice.

Over the next three years we will:

- develop a medical student engagement plan aimed at preparing students to become part of the registered profession
- target our regulatory action more effectively where training systems for doctors are under pressure
- develop a protocol or toolkit for how organisations will work together when serious concerns are raised about training environments. We will explore a framework for joint quality assurance by professional regulators and system regulators.

14 See www.gmc-uk.org/news/media-centre/media-centre-archive/gmc-statement-on-less-than-full-time-ltft-training