2 October 2014

Strategy and Policy Board

To consider

Quality Scrutiny Group Annual Report 2014

Issue

1  The annual report from the Quality Scrutiny Group.

2  The Quality Scrutiny Group has identified key themes and recommendations, and suggestions for future areas of work that may deliver added value for the GMC.

Recommendation

3  The Strategy and Policy Board is asked to:

   a  Consider the group’s key themes and recommendations and suggestions for future areas of work.

   b  Agree that in future the outcome of the Quality Scrutiny Group meetings will be formally considered by the Director of Education and Standards.

   c  Agree that the Quality Scrutiny Group will report annually to the Strategy and Policy Board.
Issue

4 The Quality Scrutiny Group (QSG) convenes up to four times a year to provide consistent scrutiny of our education quality assurance activity, to identify trends and themes, and to identify process improvements. Since March 2013, when Dr Denise Coia was appointed Chair, the QSG has met five times and outcomes of meetings have been reported to the Strategy and Policy Board. A summary of the areas of our work that we have asked the QSG to review are at Annex A.

5 The QSG has provided an annual report of its activity since March 2013, and identified themes and recommendations for the GMC, at Annex B. The QSG has also suggested areas for future work and invited the Strategy and Policy Board to outline its future expectations for the group.

6 The QSG Annual Report provides a summary of the key themes that have been discussed over the past year. The Education and Standards Directorate will consider the QSG’s suggested areas for future work as we plan the meetings for 2015, once the operational plan for the Directorate is set.

Future governance reporting

7 Outcomes of the QSG meetings have been reported to the Strategy and Policy Board, following a similar model to previous arrangements of reporting to the Postgraduate and Undergraduate Boards. However, in practice, the Education and Standards directorate is responsive to recommendations made by the QSG on a more immediate basis than the Strategy and Policy Board meeting cycle. The Assistant Director of Postgraduate Education recently undertook an appraisal of Dr Coia’s leadership of the QSG, and reflected that the QSG provides a valuable forum to receive constructive, and on occasion challenging, feedback about our work and that the QSG is well chaired and discussion is well directed.

8 We consider that it is timely to revise the governance reporting arrangements given that the group is operating effectively within the Education and Standards directorate’s work. We seek the Strategy and Policy Board’s agreement that in future the outcome of the QSG meetings will be formally considered by the Director of Education and Standards and that the QSG will report annually to the Strategy and Policy Board, with a focus on identifying themes and recommendations for the GMC.

Key themes and recommendations

Good practice
9 The QSG considers our approach to quality assurance of education and training is working well and the GMC, through the Education and Standards directorate, is able to demonstrate it is a listening and learning organisation.

10 The QSG recommend the use of the ‘checks’ be extended and consideration given to their further utilisation in the quality assurance of undergraduate education and training. We will continue to schedule checks in our programme of quality assurance activity.

Parity of scrutiny and quality assurance

11 The QSG recommend the GMC give consideration to strengthening the quality assurance processes around undergraduate education and consider introducing a range of interventions that provide quality assurance on a continuous basis.

12 The recent Review of Quality Assurance noted the need for a wider range of regulatory sanctions for undergraduate education to support more effective and timely quality assurance (QA) interventions. Regulatory sanctions will take some time to change, however we are refining our QA processes for new and overseas medical schools and programmes and will continue to review the annual reports we receive from medical schools to ensure that they provide appropriate data for QA monitoring. Our recent audit of undergraduate assessment has provided a detailed insight into assessment practice at all medical schools and will help us target our QA activity in this area.

Regional reviews

13 The QSG noted that regional reviews provide a good overview of the quality assurance process and could be improved by an enhanced focus on extracting the key issues that require to be addressed and making these clear and prioritised in the action plans. Our regional reviews are subject to continuous review and improvement and feedback from the QSG will be included in this.

14 The QSG noted that the snapshot and tracking methodology of the reviews works well but a longitudinal study of a significant issue may facilitate more rapid change in an area of serious concern and provide wider learning for example about the cooperation between the GMC and other agencies such as the Care Quality Commission. We are now looking at data from the National Training Survey longitudinally and this evidence will support us in requiring rapid change in areas where issues have been ongoing for a number of years.

Prioritisation – identifying what’s important

15 The QSG would welcome a fast track, clear and transparent process for addressing serious concerns raised in the QSG and other parts of the organisation when
information from different sources comes together. This would provide public assurance of our quality assurance processes.

16 The QSG noted that a range of service delivery issues are having an impact on the education and training of doctors. Resolving these may be out-with the remit of the GMC. However it is essential that the GMC is robust in promoting the prioritisation of educational governance at NHS board level and ensuring it is linked to clinical governance, clinical audit and risk management.

Transparency/Public assurance

17 The QSG recommend that there is a need for greater clarity around the processes in place for referral to other regulators that clearly demonstrates the feedback loop to the GMC to provide assurance that concerns have been addressed. We will consider how the processes can be clarified and how we can monitor how information we pass to other regulators is acted upon.

Looking forward – developing a culture of quality improvement

18 The QSG has suggested the following areas for future work and invited the Strategy and Policy Board to outline its future expectations for the group.

a The role of medical Royal Colleges in contributing to the QA work of the GMC.

b The uses made of the National Training Survey and its fitness for purpose, and how issues around confidentiality are addressed.

c How recurring themes in deans’ reports are addressed for example around care in the acute setting: A&E, Acute Medicine/Surgery/Psychiatry.

d More opportunity to comment on proposed policy and quality methodology developments.

e Suggestions for future areas of work that may deliver added value for the GMC.

f Future expectations for the QSG.
Supporting information

How this issue relates to the corporate strategy and business plan

19 Strategic aim 2: Help raise standards in medical education and practice.

If you have any questions about this paper please contact: Susan Redward, Policy Manager, sreaward@gmc-uk.org, 020 7189 5287.
Summary of Quality Scrutiny Group activity in 2013/14

Quality Scrutiny Group meetings in 2013/14

1. The Quality Scrutiny Group (QSG) met to review our quality assurance (QA) activity five times during 2013/14, on:
   a. 12 March 2013
   b. 3 July 2013
   c. 24 September 2013
   d. 12 March 2014
   e. 30 June / 1 July 2014.

2. At each meeting the QSG considered and commented on a selection of reports and summaries which are listed below.

Meeting on 12 March 2013

Medical school checks reports

3. The QSG looked at reports of targeted check visits made in quarter four of 2012 to:
   a. Aberdeen
   b. Leeds
   c. Queen’s University Belfast.

Medical School Annual Reports (MSARs) and medical school monitoring

4. The QSG considered themes and trends in 2012 MSARs, scrutinised operational activity and reflected on process improvement, looking at:
a MSAR summary of 2012 scrutiny

b MSARs, evidence summaries, and monitoring for:

i Bristol

ii Cardiff

iii Warwick.

Annual specialty reports (ASRs)

5 The QSG reviewed the scrutiny process for college and specialty activity for the reporting period 2011/12, looking at:

a Report reviewing ASRs of 2011/12

b ASRs:

i Faculty of Public Health

ii Joint Committee on Surgical Training

iii Royal College of Radiologists/ Faculty of Clinical Radiology, Faculty of Clinical Oncology.

Deanery reports (DRs) progress update

6 The QSG reviewed a summary of the scrutiny process for the DRs submitted in October 2012, and an example of a feedback letter sent to a deanery:

a Progress update on Deanery Reports

b East Midlands Deanery feedback letter.

Meeting on 3 July 2013

London regional visit

7 The QSG reviewed reports and other documents from the London regional visit which took place in 2012, looking at:

a London regional review summary report

b London deanery report

c Medical school reports, action plans and responses for:
Meeting on 24 September 2013

Annual Dean’s Reports (ADRs)

8 The QSG scrutinised operational activity, identifying trends and themes, and considered process improvements and the ADR cycle, looking at:

a Selected Dean’s Report April 2013 scrutiny

b Deanery reports, feedback letters and responses for July 2013 for:

i Yorkshire and Humber

ii North West
A4

East of England

Wales.

Responses to concerns

9 The QSG received an oral update on publishing concerns, closing open concerns and the process for managing concerns identified in the National Training Survey (NTS). They gave positive feedback and suggested amendments to help navigate the publishing tool.

Emergency medicine check visits

10 The QSG reviewed checks to emergency departments undertaken in quarter 4 of 2012, looking at a summary report published in July 2013 and check reports:

a Medical education’s front line: a review of training in seven emergency medicine departments

b Check reports:

i Jersey General

ii Kings Mill Hospital

iii Leeds General Infirmary

iv Queens Medical Centre

v Royal Bournemouth

vi The James Cook University Hospital

vii University Hospital of North Tees.

Meeting on 12 March 2014

Dean’s reports (DRs)

11 The QSG reviewed selected DRs from October 2013:

a East of England

b North West

c Wales
d Yorkshire and Humber.

**Good practice guide for DRs**

12 The QSG reviewed the draft document:

a Dean’s reports good practice guide.

**Data question returns (DQR)**

13 The QSG considered how to make best use of the 2014 DQR in terms of types of questions asked and how to share what we learn, looking at:

a Summary of postgraduate deans’ responses to the DQR 2013.

**Emergency medicine checks**

14 The QSG considered a monitoring update on an emergency check visit and whether the monitoring has provided assurance to the public, looking at:

a Jersey Hospital action plan, monitoring letter, post visit, and visit summary.

**Enhanced monitoring (EM)**

15 The QSG received an oral update on plans to publish limited information on cases being managed through EM and reviewed:

a Cases closed locally

b Open cases to be closed.

QSG statement of purpose

16 The QSG reflected on its purpose in light of governance changes.

**Meeting on 30 June / 1 July 2014**

QSG annual report

17 The QSG discussed the work they had done during the year and agreed on format and content for the annual report.

North West England visit

18 The QSG looked at reports of the North West England visit which took place in 2013, and considered whether they provided appropriate assurance and identified issues
effectively, and whether the regional report worked as a standalone study for the public or could be improved:

a  North West England regional report

b  Review of Health Education North West

c  Review of medical schools

i   Lancaster (Royal Lancaster Infirmary)

ii  Liverpool (Aintree University Hospital; The Walton Centre)

iii Manchester (Manchester Royal Infirmary; North Manchester General Hospital; Royal Preston Hospital).

London monitoring update

19 The QSG reviewed the monitoring update which was received from the London LETBs in April 2014, following the London regional visit in 2012, and considered the assurance it provided.
Annual Report from the Quality Scrutiny Group

Purpose

1. The purpose of our report is to inform the Strategy and Policy Board by giving assurance that GMC processes provide: the right information, in the right way, at the right time, for the right audiences and for the right purposes in relation to the quality and safety of education and training delivered to UK doctors and medical students.

Who we are and what we do

2. We provide consistent scrutiny of the GMC’s quality assurance activity across the continuum of medical education and training. We identify trends, themes and process improvements in the outputs of GMC quality assurance work. Our work is reported regularly to the Director of Education and Standards and the Strategy and Policy Board.

3. The wide range of documentation provided by the Education and Standards directorate to the QSG from deaneries and local education and training boards (LETBs), medical royal colleges and faculties, medical schools and the health service allows us to form a comprehensive overview of the GMC’s quality assurance processes.

4. For our annual report we have identified a number of key themes that we hope will provide feedback, learning, and support continuous improvement in quality assurance activity. This report is not intended to be a comprehensive summary of our work, which can be accessed through our minutes.

What we found – Key themes and recommendations

Good practice

5. The GMC approach to quality assurance of medical education and training is working well and the GMC (education and standards directorate) is able to demonstrate that it is a listening and learning organisation.
There have been significant improvements in the data we have received and in the responses to our recommendations. GMC staff demonstrate an openness to improvement and willingness to engage with our findings.

We made a number of suggestions around the design and language of reports, which have resulted in changes in the construction, content and presentation of reports and are now reflected in themed reviews, regional reviews, annual speciality reports and deans’ reports.

We like the clarity, specificity and firmer language that are developing in the use of evidence, decision making, actions, escalation and timelines. Examples are the enhanced monitoring process with standardisation of forms, improved links to the Care Quality Commission in England and improved processes around tracking and closing concerns. We are also positive about the response to concerns publishing tool and made suggestions for improvements that were adopted, improving navigation around the tool.

We were pleased to see the excellent progress in refining the deans’ reports that has made these a valuable source of evidence in the quality assurance process in postgraduate education.

**We commend the use of the ‘checks’ and recommend they be further utilised in the quality assurance of undergraduate education and training.**

We consider the check visits/methodology to be an extremely useful quality assurance tool the use of which could be extended. We were impressed with the Accident & Emergency check visits and the change they were able to drive. There has been good joint working between the deaneries and LETBs and health regulators. We see check visits as an important part of the GMC QA framework.

The methodology continues to be refined and in relation to criteria for checks, more focus on risks being explored and more focused judgements around findings would be welcome.

Parity of scrutiny and quality assurance

**We recommend the GMC give consideration to strengthening the quality assurance processes around undergraduate education and consider introducing a range of interventions that provide quality assurance on a continuous basis.**

There are notable discrepancies in the QA process and standards between postgraduate and undergraduate education. Although universities have QA processes for all undergraduate education, the training of young medical professionals is of particular interest to the GMC. The GMC role in providing public assurance of the quality of doctors through statutory regulation of education and training processes...
requires robust quality assurance of the undergraduate medical curricula, as well as postgraduate curricula.

15 We have reviewed postgraduate and undergraduate quality assurance processes for education and training. We have observed a significant difference in the Medical School Annual Reports (MSARs) provided to the GMC in relation to undergraduate education compared to that for postgraduate education, with the latter being evidently more comprehensive and frequent. There is a need to reduce the disparity between the two as there should be a continuous QA from medical student to consultant. In the context of undergraduate medical education we have highlighted concerns around the development of new curricula, assessment methodology, availability of clinical placements, information provided to students, and in particular poor responses to concerns raised by the GMC around timelines and lack of appropriate action.

16 We are also concerned that the quality assurance/scrutiny system is linked to a 5 yearly review cycle. We think there is merit in the GMC introducing a range of interventions that provide quality assurance on a continuous basis. For example these could include: benchmarking against the new draft education and training standards to improve specificity and focus on outcomes; continuing to develop check visits around specific areas of risk; tougher action on imposing deadlines for reporting progress on actions, escalation of concerns when schools are not engaging with GMC processes and a fuller suite of regulatory sanctions to drive timely change.

17 Whilst we acknowledge that in general medical education and training experience in the UK is good, there are considerable challenges posed in delivering regulation of new schools (including those in private sector), in existing schools where there is reorganisation of the curriculum, or where NHS service change impacts on clinical placements.

Regional reviews

18 Regional reviews provide a good overview of the quality assurance process supporting the delivery of high quality undergraduate and postgraduate training.

19 The snapshot and tracking methodology of the reviews works well but a longitudinal study of a significant issue may facilitate more rapid change in an area of serious concern and provide wider learning for example about the cooperation between the GMC and other agencies such as the Care Quality Commission and other care regulators in the devolved administrations.

20 The regional quality assurance visiting process including deanery and LETB and medical school reports provides a good overview of training and education across the undergraduate to postgraduate continuum. Relationships are being strengthened
between the GMC and localities, rather than structures, providing more flexibility if there is future structural change. The overview reports produced by the GMC have improved in clarity and focus and are becoming more accessible to public readership. Overall this is a positive change, but it does have its challenges. There is a need to strike a balance between risk-based, targeted inspection (which will check basic compliance) and a more detailed approach to get an overall view. The GMC needs to be responsive to ensure that where structural changes occur, that its standards continue to be met by those responsible.

Prioritisation – identifying what’s important

21 We would welcome a fast track, clear and transparent process for addressing serious concerns raised in the QSG and other parts of the organisation when information from different sources comes together. This would provide public assurance of our quality assurance processes.

22 A range of service delivery issues are having an impact on the education and training of doctors. Resolving these may be out-with the remit of the GMC. However it is essential that the GMC is robust in promoting the prioritisation of educational governance at NHS Board level and ensuring it is linked to clinical governance, clinical audit and risk management as a powerful tool to improve patient safety and care.

23 We question whether the current level of involvement/oversight into deanery/LETB concerns transfers some of the quality management functions from the deanery/LETB to the GMC. Whilst the GMC does need to have insight into events at a LEP level, particularly where there are concerns, the deaneries and LETBs must be supported to have robust QM processes that are not dependent on the GMC.

24 One of the main challenges to any quality assurance organisation is to make sense of the wealth of data received and not to lose sight of key issues that require to be addressed. We have examined several regional reviews and consider the analysis and interpretation of information could be further strengthened to provide a more focused, accessible, and clearer view of how well the organisation is doing in relation to education and training and what needs to be improved.

25 In particular deans’ reports do not always make it clear which are the most pressing priorities and what is the strategic direction of the organisation. The large spreadsheets in which information is presented are unwieldy and the extensive horizontal columns and descriptive language do not easily allow us to identify key areas of risk to be identified or to track actions. The RAG rating system could be more effective if it was more explicit about how it is used.

26 Action plans to operationalise requirements and recommendations arising from visits do not distinguish urgent and important from lesser issues. We found a number of organisations where it appears serious issues were being dealt with effectively in very
difficult circumstances. The current system cannot acknowledge their significant achievements or effectively spread good practice. To improve the reviews it may be useful to consider revising the layout to give greater visibility to key areas for improvement. This could be complemented by extracting narrative themes around headline issues and selecting priority topics for a more in depth longitudinal review. This would complement themed reports, for example in emergency medicine, which effectively highlighted issues around workforce and training.

27 We have access to data from a wide range of reports that are not always pulled together in this format elsewhere. Occasionally this leads us to identify serious issues from triangulated evidence around education, training and patient safety that we think requires attention. We wonder if other groups in the GMC may have similar experiences and would welcome a fast track process to address issues raised from such forums.

28 We note recurring themes around service delivery issues i.e. workload, handover, supervision, job planning, major structural reconfiguration that are having a major impact on the education and training of doctors and medical students. We also note patient safety issues in relation to clinical concerns being raised by doctors in training. We expect the majority of these to be investigated, validated and dealt with at a local level. Whilst the GMC is not directly responsible for resolving these we consider the GMC should have a consistent policy in this area across the organisation given its key objective to protect patients.

29 It is clear to us that the processes of educational governance driven by the GMC and deaneries and LETBs often shine a light on issues of clinical governance and patient safety, and we think it is essential that the GMC is robust in promoting the prioritisation of educational governance at NHS Board level and ensuring it is linked to clinical governance, clinical audit and risk management as a powerful tool to improve patient safety and care.

Transparency/Public assurance

30 There is a need for greater clarity around the processes in place for referral to other regulators that clearly demonstrates the feedback loop to the GMC to provide assurance that concerns have been addressed.

31 We have seen good evidence of transparency around the internal ‘raising serious concerns’ process and good practice in ‘closing the loop’ when dealing with concerns. We have also been pleased to note that concerns expressed by the QSG when examining a range of documentation and responses around particular medical schools and deaneries were acted on by the GMC and resolved.

32 However, there is still a need to demonstrate greater transparency in relation to concerns that are passed on by the GMC to other regulatory bodies e.g. CQC. In particular to demonstrate they have been picked up, acted on and resolved and that
the outcomes have been fed back to GMC and individuals raising the issues. This would give us assurance that there is an effective ‘external’ feedback loop in place in relation to other regulatory bodies and addresses one of the key criticisms in the Francis report that regulatory agencies failed to act on information provided to them.

33 We have looked at how the GMC’s reporting mechanisms should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. We concluded that whilst the GMC continues to improve its reporting in this respect there is more work to be done in this area which may require specialist communication expertise to develop the ‘public face’ of the organisation. We consider that further comment on this is out-with the remit of the QSG.

Looking forward – developing a culture of quality improvement

34 The GMC as a regulator operates in a complex and changing health and social care environment across four jurisdictions with very different healthcare delivery systems. The ‘Shape of Training’ will also have a major impact on training and education of doctors in the future.

35 We therefore welcome the draft standards for medical education and training as an effective framework through which to quality assure medical education and training in a difficult environment. We also think many of the themes we identified in our report may be addressed by implementation of the standards and their quality assurance. We particularly welcome the intention to produce one set of standards for the continuum of education across undergraduate and postgraduate phases. The proposed four quality themes provide a more focused framework for identifying key issues of concern and resolving them.

36 Given the robustness of the quality assurance process we see an opportunity to reduce the frequency of scrutiny in areas that are working well and concentrate more on areas requiring further development and improvement. This means we are keen to focus on areas that have been given less attention by our group as they have been in the early stages of redesign or development:

a The role the Colleges play in contributing to the QA work of the GMC, including to whom they are accountable, and if their annual reports reflect this role, and the role of the GMC in College exams, particularly as they are mandatory for progression in post graduate training. We consider there is a need to improve the Annual Specialty Reports, standardise them and be explicit about information sought.

b The uses made of the national training survey and its fitness for purpose and how issues around confidentiality are addressed.
c How recurring themes in deans’ reports are addressed, for example, around care in the acute setting: A&E, Acute Medicine/Surgery/Psychiatry.

37 We have valued opportunities to critique proposed policy and methodology developments in order to support the GMC’s work in these areas.

38 We recognise that many of our themes based on analysis of the evidence presented to us, are similar to those raised in the QA review of education and training approved by Council. This perhaps strengthens the recommendations in this paper and provides a focus for our monitoring activity.

39 We would welcome feedback from the Strategy and Policy Board on our recommendations and your suggestions for future areas of work that may deliver added value for the GMC. We also welcome feedback on your future expectations for the group.