To note

Report from the Education and Training Advisory Board

Issue

1 This paper is a report of the fourth meeting of the Education and Training Advisory Board on 3 June 2014 and includes an update on our proposed plans for reviewing the Board’s membership.

Recommendation

2 The Strategy and Policy Board is asked to note the report.
Report from the Education and Training Advisory Board

Issue

3 The Education and Training Advisory Board (ETAB) was established to advise the Chief Executive on matters concerned with the delivery of undergraduate and postgraduate medical education and training and on-going career progression. ETAB also provides a forum for us to engage widely and effectively with key interest groups on education and training matters across all countries of the UK.

4 The draft minutes of the meeting on 3 June 2014 are at Annex A and will be approved at ETAB’s next meeting on 14 October 2014.

5 We have also included an update on our proposed plans for reviewing the membership of ETAB planned to take place in the autumn.

Review of undergraduate assessment

6 ETAB considered a preliminary summary of the key findings of our review of undergraduate assessment. The summary highlighted variation across all medical schools around the reliability, validity and quality management of assessments; assessment of professionalism; and guidance and procedures on student progression.

7 ETAB advised that:

   a The provisional findings outlined in the paper would be relevant and useful to those involved in medical education and patients and the public more generally.

   b The findings of the assessment audit should be considered separately to that of the issue of a UK-wide licensing examination.

   c Further research on the best way to assess medical students would be of value in order to inform how we should address the issue of variability across medical schools, particularly in relation to assessing students’ professionalism.

   d The GMC should have a role in supporting schools to manage the challenges that arise when implementing assessment policies and procedures for medical students and ensuring compliance with University wide policies and roles, particularly around issues related to students’ professionalism.

8 Due to the timing of the meeting and timeline for review we were unable to share the full draft report with ETAB. ETAB noted that, whilst recognising that the work was in progress, a full consideration of the findings would have been enhanced by having the full draft report. ETAB also noted that there appeared
to be some differences between the outcomes of the audit and some of the findings of earlier GMC quality assurance visits.

ETAB noted the important distinction between medical and other healthcare graduates, and other university graduates, and supported our efforts to remind Vice Chancellors and Principals that they must ensure that medical graduates are not only intellectually capable but also have the required professionalism, including appropriate behaviours, necessary for practice as a licensed doctor.

ETAB noted that we will continue with our work on reviewing assessment and that we will follow-up with those schools at both ends of the spectrum highlighted within the report. The full report will be circulated to ETAB as soon as it is finalised ready for publication.

\textit{Review of education training and standards}

ETAB supported our draft proposals for new high level standards for the management and delivery of medical education and training across the continuum.

ETAB noted a number of helpful comments, including emphasising the importance of assuring the best possible patient experience; emphasising that the learning environment is also a service environment within which safe and good quality care takes place, and in which the GMC has a legitimate interest; supporting our partnership working with other regulators; extending the quality theme of supporting learners to trainers, and reflecting on the use of the word ‘must’ and ‘should’ within the detailed requirements to ensure that they were set at the appropriate level.

ETAB noted that we plan to refresh the Quality Improvement Framework to clarify lines of responsibility and governance accountability.

We will reflect on ETAB’s comments as we finalise the standards for public consultation in 2015.

\textit{Education surveys plan 2014-17}

ETAB was supportive of the proposed programme of education surveys work covering the period 2014-17, including the cohorts of students and doctors with whom we should engage, the order and the pace of the programme. ETAB also acknowledged that the most effective means of engagement with doctors was not always necessarily through surveys, particularly with regards to Staff and Associate Grade doctors.

ETAB supported our plans for surveying students, and recently qualified consultants and GPs, subject to further thought around timing and frequency.
ETAB was supportive of plans to engage with Staff and Associate Grade (SAS) doctors in order to support our greater understanding of this cohort of doctors. ETAB acknowledged that SAS doctors are not a homogeneous group and therefore it will be difficult to engage with this group of doctors using survey methodology. Further consideration would be given to how we should engage with the 16,000 doctors employed with the SAS job title and associated terms and conditions.

The Royal College of General Practitioners agreed to share data gathered through its GP exit survey, carried out at the end of specialty training; and the Welsh Government agreed to share data from its recent engagement with SAS doctors.

Membership

We plan to undertake a review of ETAB’s membership in the autumn. The review has been prompted by a number of factors, including:

a The changing roles of a number of members. Although most ETAB members were invited to join in a personal capacity, we want to ensure that ETAB’s membership continues to include a range of our key interests.

b Governance best practice advocates a regular review of effectiveness. In order to ensure that ETAB continues to develop as a useful and constructive forum to advise the executive, we will reflect on whether any further changes to the membership are required, this will include consideration of members’ attendance at meetings and ETAB’s future work programme.

Any proposed changes to ETAB’s membership that impact on the its agreed Statement of Purpose will be submitted to the Strategy and Policy Board for approval.

In addition, any changes to individual membership will be agreed in consultation with the Chief Executive.

Any changes to membership will be implemented as required, depending on the circumstances of the individual member concerned, or by January 2015 at the latest.

Next meeting

ETAB will meet again on 14 October 2014.
Supporting information

How this issue relates to the corporate strategy and business plan

24 Strategic aim 2 of the Corporate Strategy 2014-17 is to help to raise standards in medical education and practice. The advice of ETAB will be crucial as we develop policy in this area and in ensuring that Council is fully briefed before major decisions are made.

25 ETAB is not the sole means of engaging with our key interests groups on education and training matters. We continue to meet with key interests to discuss specific projects and matters of joint interest, and we have a programme of engagement that includes regular meetings with (among others) the Medical Schools Council, Health Education England/NHS Education Scotland, medical royal colleges, postgraduate deaneries, BMA committees etc.

If you have any questions about this paper please contact: Martin Hart, Assistant Director, Education and Standards, mhart@gmc-uk.org, 020 7189 5408.
Draft minutes of the Education and Training Advisory Board meeting on 3 June 2014
Draft as of 27 June 2014

To approve

Minutes of the Meeting on 3 June 2014

Members present

John Connell, Chair

Sue Bailey
Gill Bellord
Derek Gallen
Amanda Howe
Chris Jones
Stewart Irvine

Elizabeth Manero
Ben Molyneux
Wendy Reid
Alice Rutter
David Sowden
Tony Weetman

Others present

Niall Dickson, Chief Executive
Judith Hulf, Interim Director of Education and Standards
Martin Hart, Assistant Director – Education and Standards
Nathan Lambert, Projects and Planning Manager – Education and Standards
Patsy Morrissey, Board Secretary

Vicky Osgood, Assistant Director – Education and Standards
Kirsty White, Head of Planning, Research and Development – Education and Standards
Hannah Watts, Quality Assurance Programme Manager – Education and Standards (item 3)
Susan Redward, Policy Manager – Education and Standards

Chair’s business

1 The Chair welcomed members to the meeting of the Education and Training Advisory Board and in particular, Amanda Howe, who attended on behalf of Nigel Sparrow, and Chris Jones, who attended on behalf of the UK Scrutiny Group.
2 Apologies for absence were noted from Iain Cameron, Malte Gerhold, Andy Heeps, Jackie Smith, Nigel Sparrow, Radhakrishna Shanbhag and Ian Starke.

Minutes of the meeting on 4 February 2014

3 The Board approved the minutes as a true record, subject to one amendment at paragraph 25a to add the words ‘in prescribing’ after the word ‘competence’. The paragraph would now read:

That NHS Employers was currently seeking legal advice on the position of FY1 doctors from the EEA to ascertain if they can take action to ensure that they meet the level of competence in prescribing expected of a UK graduate, recognising that it is the role of employers to ensure that doctors are fit for purpose.

Matters arising

4 There were no matters arising.

Review of undergraduate assessment

5 The Board considered a preliminary summary of the key findings of our review of undergraduate assessment, particular aspects of which the Board’s advice was being sought ahead of the publication of the final report in September 2014.

6 The Board advised that:

a The provisional findings outlined in the paper, and in particular the key finding related to variation across all medical schools around the reliability, validity and quality management of assessments; assessment of professionalism; and guidance and procedures on student progression, would be relevant and useful to those involved in medical education and patients and the public more generally.

b The findings of the assessment audit should be considered separately to that of the issue of a UK-wide licensing examination. We would require a greater understanding of the issues related to assessment, particularly in relation to professionalism in order to help to support our endeavours to embed professionalism across the continuum of medical education and training. Our greater understanding would, of course, inform any discussions about a UK-wide licensing exam.

c Further research on the best way to assess medical students would be of value in order to inform how we should address the issue of variability
across medical schools, particularly in relation to assessing students’ professionalism.

d The GMC should have a role in supporting schools to manage the challenges that arise when implementing assessment policies and procedures for medical students and ensuring compliance with University wide policies and roles, particularly around issues related to students’ professionalism.

7 During discussion, the Board noted:

a That, whilst recognising that this was work in progress, a full consideration of the findings would have been enhanced by having the full draft report. For example, the adequacy of assessment and assessment blue-printing in a small number of medical schools seemed to be in question but it was difficult to judge the significance of these and related issues without the level of granularity that Board members anticipated would have been provided within the full draft report.

b That there appeared to be some differences between the outcomes of the audit and some of the findings of earlier GMC quality assurance visits.

c That action was required to reduce the level variability across medical schools with respect to the delivery of GMC standards but that the aim of reducing such unwanted variability was not to create a homogeneous system of undergraduate education. Medical schools could differ in their educational approaches as long as the GMC’s standards for education and the interests of the public were met.

d The important distinction between medical and other healthcare graduates, and other university graduates. Vice Chancellors and Principals must ensure that medical graduates are not only intellectually capable but also have the required professionalism, including appropriate behaviours, necessary for practice as a licensed doctor. Given that professionalism applied to all healthcare professionals it was suggested that a more unified approach looking at professionalism issues related to assessment, health and fitness to practise should be considered and that this could be undertaken in collaboration with the involvement of Medical Schools Council and other relevant bodies.

e The difficulties associated with the reliable and valid assessment of professionalism.

f Given that research on variability across medical schools was already in progress, a summit to build consensus across medical schools on these issues might be the way forward. The visits process could also offer an opportunity to look in more depth at the issue of variability.
g) That while student progression is ultimately a university issue, the GMC might legitimately take a view on, for example, the optimal duration of a medical degree.

h) That private medical schools were required to operate to the same standards applicable to publicly funded medical schools and were subject to the same Quality Assurance systems.

8) The Board noted that we would continue with our work on reviewing assessment and that we would follow-up with those schools at both ends of the spectrum highlighted within the report. The full report would be circulated to the Board as soon as it was finalised.

**Review of education training and standards**

9) The Board considered our draft proposals for new high level standards for the management and delivery of medical education and training across the continuum.

10) The Board agreed:

   a) With the purpose and principles used to guide the development of the standards which would apply to both undergraduate and postgraduate education and training.

   b) With the proposed four quality themes: learning environment and culture; educational governance; supporting learners; and developing curricula and assessment, around which the standards had been grouped.

   c) That the standards set out in Annex B described an appropriate level of quality that organisations must meet.

   d) That the descriptions adequately covered undergraduate and postgraduate education and training.

   e) With the level of detail in the requirements, subject to further refinement in light of the Board’s comments.

   f) With the development of exploratory questions as set out in Annex B of the paper which would be used to determine if the standards had been met.

   g) With our approach to identifying developmental requirements which would be based on evidence from good practice and other quality assurance activity.

   h) With the concept of publishing explanatory guidance or good practice examples of how to meet the standards.
During discussion of the purpose and principles used to guide development of the standards, and the four quality themes around which the standards are grouped, the Board noted that:

a. The ethos behind the principles would need to be embraced by Local Education Providers in order to avoid a ‘target/tick box’ approach.

b. The principles around assuring patient safety and compassionate care should extend to assuring the best possible patient experience. It would be necessary to ensure that the doctors have the skills required to achieve this.

c. Patient safety and patient experience would underpin the four quality themes identified; express reference would be made to these vital principles in the introduction to the themes.

d. It would be helpful to:

i. Reference the tension between the training environment and service delivery either within the existing proposed headings or within a separate heading.

ii. Emphasise that the learning environment is also a service environment within which safe and good quality care takes place, and in which the GMC has a legitimate interest.

e. The principles for the standards included partnership working between professional and systems regulators as it was recognised that the learning environment for doctors was the same learning environment for other professionals; if the learning environment was not adequate for doctors, it would invariably be inadequate for other healthcare professionals. The simple structure of the new high level standards would support our partnership working with other regulators.

f. It would be helpful to consider how our standards map to other inspection/regulatory processes and whether there was scope to reduce the regulatory burden, particularly on smaller providers such as GPs in small practices within the learning environment in the community.

g. The theme of supporting learners should be extended to supporting trainers.

h. Equality and diversity considerations should run through the entire training experience.

During discussion of the standards for education and training framework at Annex B, the Board noted that:
a The high level standards would be applicable throughout the UK and that the supporting explanatory guidance could be used to address any specific points related to responsibilities and perspectives across the four countries of the UK.

b In meeting the requirements of the standards, organisations should be measured on their education and training outcomes, rather than on their processes. For example, the requirement at 1.6 relating to the design of the service should focus on evidence of successful delivery rather than service design.

c We should reflect on the use of the words ‘must’ and ‘should’ within the requirements as the current wording of some the requirements meant that they were not set at the appropriate level. For example, requirement R3.15 - doctors ‘should’ not be required to regularly carry out routine tasks that have little educational or training value. In the context of education being delivered in a service environment it would be unrealistic if this requirement was set as a ‘must’.

d It would be helpful to highlight the different roles and responsibilities of educational and clinical supervisors; recognising that some overlap would be inevitable.

e In relation to educational governance and evaluating the outcomes of programmes, we should reflect on the risk of duplication with work already being undertaken by other national bodies such as HEE, NHS Education Scotland, the governments in Wales and Northern Ireland, colleges, faculties and specialty associations.

f In relation to developing and delivering curricula and assessment:

i Requirement 4.3 also applies to trainee doctors, not just students.

ii Requirement 4.10 requires further development.

13 The Board noted that we would also look to refresh the Quality Improvement Framework to clarify lines of responsibility and governance accountability.

14 The formal consultation on the draft standards would commence in 2015.

**Education surveys plan 2014-17**

15 The Board considered the proposed programme of education surveys work covering the period 2014-17.

16 The Board was supportive of the programme of work outlined in the paper, including the cohorts of students and doctors with whom we should engage,
the order and the pace of the programme. The Board also acknowledged that the most effective means of engagement with doctors was not always necessarily through surveys and that other mechanisms, including focus groups and building on engagement work already being undertaken by others, could and should be utilised. It was, therefore, appropriate that the paper did not assume that the end result of the work programme would be a new survey for each cohort identified.

17 The Board advised that:

a A GMC survey of medical students could provide a number of benefits, including promoting closer engagement between the regulator and students, gaining additional views on the training environment, benchmarking education and training as a means to improve quality and supporting the view among students that their feedback is valued. We should explore the following areas for the survey of medical students: the learning environment, training provision, student experience and professionalism.

b We should consider surveying medical students at two or three points within their time at medical school and not just in later years, recognising that depending on their point in training and the nature of their medical school’s curriculum there would be some questions that individual students would not be able to answer. We should recognise that many medical schools already survey students on entry.

c The Francis Report on the Mid-Staffordshire NHS Foundation Trust recommended the development of student and trainee surveys to enable them to raise concerns. However, our learning from the NTS survey indicated it would be more effective if we supported the reporting of immediate safety concerns and local issues around the clinical environment via local short loop feedback systems; where possible, local issues should be dealt with by local providers.

b Our survey of medical students should be carried out at a different time to the National Student Survey in order to reduce the burden on students and encourage high response rates. Care should also be taken to avoid surveying students immediately before their finals; recognising that the timing of finals varies between schools.

c Our existing revalidation processes may in time provide useful information on the outcomes for recently qualified consultants and GPs.

d There may also be value in surveying doctors at five and ten years post-CCT, particularly in light of the implementation of the recommendations arising from the Shape of Training Review.
e  The Royal College of GPs would share its data gathered through its GP exit survey, which is carried out at the end of specialty training.

f  Engagement with staff and associate grade doctors would support our greater understanding of this cohort of doctors and would also provide valuable service insight, including that related to patient safety.

g  Staff and Assistant Grade (SAS) doctors are not a homogeneous group and, therefore, it would be difficult to engage with this group of doctors using survey methodology. Further consideration would be given to how we should engage with the 16,000 doctors employed with the SAS job title and associated terms and conditions.

h  Efforts had already been undertaken in Wales to reach out to SAS doctors. The resulting data would be shared with the GMC.

Any other business and date of next meeting

18  The Board noted the date and time of its next meeting at 10:00 on Tuesday, 14 October 2014.

Confirmed:

John Connell, Chair 14 October 2014