To note

Report from the Education and Training Advisory Board

Issue

1 This paper is a report of the meeting of the Education and Training Advisory Board on 14 October 2014.

Recommendation

2 The Strategy and Policy Board is asked to note the report and the update on the Education and Training Advisory Board’s membership.
The Education and Training Advisory Board (ETAB) was established to advise our 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.

The draft minutes of the meeting on 14 October 2014 are at Annex A and will be approved at the next meeting on 4 February 2015.

Further to our last update, we have also made a number of changes to the membership of ETAB, the full details of which are detailed below.

Publication of evidence on undergraduate medical education

ETAB considered the key conclusions of the package of evidence published on 8 October 2014 on aspects of undergraduate education, including our reports on The state of medical education and practice 2014, and Be prepared – are new doctors safe to practise?

ETAB advised that:

a Very few UK medical graduates were very poorly prepared and that, in time, the expectation was that the student assistantship programme would help to address issues of preparedness. However, as our evidence clearly showed that there were potential concerns about the consistent quality of undergraduate medical education, a deeper understanding of the issues was required in order to determine what action should be taken to promote a more consistent quality of undergraduate medical education. Further clarity around factors, including the geographical spread of feelings of unpreparedness across the UK, and the extent of the variation in how medical schools approach assessment, should be sought.

b While the majority of graduates feel prepared for practice, schools that consistently failed to prepare their medical graduates for practice should be helped to take cognisance of the work that needs to be done to ensure that the results of medical education are such that students are prepared to take up employment within the NHS. Medical schools have a responsibility to doctors, employers and patients to ensure that students are prepared for employment.

c While it was thought to be unnecessary to be too prescriptive about the content of the student assistantship period, the quality of the educational environment was identified as a vital component to ensuring that students are adequately prepared for the broad range of clinical work required, and to promote the professionalism
required of doctors. The quality of the assistantship period, and not just the time spent as an assistant to a junior doctor, was vital. The educational and clinical experiences within the assistantship period required coordination in order to deliver the required increase in the preparedness of the medical student to start practice as a Foundation Year 1 (F1) doctor. It was recognised that existing work to support improvements to the educational environment, and the GMC review of education training and standards, would be expected to drive improvements to the assistantship period and ensure that it delivers as required.

8 Further points were noted during ETAB’s discussion and these are detailed in the minutes at Annex A.

National Licensing Exam

9 ETAB considered a brief summary of the case for, and challenges of, the introduction of a National Licensing Exam (NLE).

10 ETAB advised that:

a An NLE providing assurance that those on the medical register had reached a common standard was desirable. However, the detail of the development and implementation of a UK NLE would require robust consideration. While the momentum for exploring the case for an NLE should be maintained it would be important to engage with the profession on the benefits of this change for doctors, the NHS, and patients.

b The question of whether an NLE should be a pass/fail or ranking test required further consideration. While a pass/fail test would be simpler to administer and would provide a clear answer on the question of whether a doctor is fit to hold a licence to practise, an exam that could work across the system aiding selection to the Foundation Programme and elements of which were linked to medical schools’ assessments could be more cost effective. As there were pros and cons associated with both options, the level of discussion required would be better served with the input of a range of other interests, including experts in educational assessment.

c We should carefully consider any arguments for an NLE based on patient safety and quality issues. Any such arguments should be based on sound evidence. It would be helpful for ETAB to see the report of the research that had been commissioned by Council.

d Encouraging employers to make passing the NLE a condition of employment offered a partial solution to the issue of whether EEA doctors could be required to sit such an exam. However it was recognised that NHS employers would require clarity on the legal position of such a requirement before they made a pass a mandatory condition of employment. In addition, private providers within the NHS
could employ doctors on different terms, although this could be managed through collaboration with the Care Quality Commission and its inspection programme.

e Updating a doctor’s record on the GMC register to reflect a ‘pass’ in the NLE might not be a straightforward process and would ultimately depend on the design of the exam, which could be linked to other mechanisms outside our control. Although it would be possible to say from a certain date that there was an assumption that registration would mean the doctor had passed the NLE, the purpose of the exam would need to be defined prior to any decision regarding how it might be reflected on the medical register.

f A doctor that failed the NLE would not be allowed to practice, but a programme of remediation should exist to support those that fail. Limiting the number of re-sits, in line with our existing arrangements for the Professional and Linguistic Assessments Board (PLAB) examination, would be appropriate.

g While the NLE would be taken forward as a GMC initiative, the exam would be developed closely with key interests in medical education across the UK, including medical schools, Health Education England and the devolved administrations.

11 Further points were noted during ETAB’s discussion and these are detailed in the minutes at Annex A.

The link between doctors’ medical schools and future progression

12 ETAB considered the progress that we had made, working with others, to understand the factors that may influence doctors’ progression through training programmes.

13 ETAB noted the development of reporting tools for medical schools on the outcomes of their graduates and received a live demonstration of the on-line tableau reports.

14 ETAB advised that while the data should not be seen as performance data on medical schools, the reports were useful tools for medical schools, commissioning bodies and employers and could be used to help inform conversations on a range of issues, including workforce supply and funding.

Key education work streams

15 ETAB noted a progress update on our key education work streams, including our review of standards for medical education and training, generic professional capabilities, continuing professional development and credentialing.

16 ETAB advised that the development of ‘apps’ to support our standards work on end of life care and the continuing professional development of doctors should supplement, and not replace, our existing guidance work. Our work in this area should offer

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sign-posts to other sources of professional guidance and ‘apps’ already developed by others, where suitable.

Membership

17 We have completed our planned review of ETAB’s membership, which had been prompted by a range of factors, including the changing roles of a number of members.

18 In consultation with the Chief Executive the following membership changes were made:

a Dr Muj Husain replaced Sue Bailey, who stood down from ETAB in June 2014. Muj is Chair of the Academy of Medical Royal Colleges’ Trainee Doctors Group (ATDG) and the London Representative on the Royal College of Psychiatrists Trainees Committee.

b Dr Katerina Kolyva, Director of Continued Practice, NMC, replaced Jackie Smith.

c Dr Alice Rutter remains on ETAB in her capacity as a doctor in training.

d Dr Ben Molyneux remains on ETAB membership in his capacity as a newly qualified GP.

e Dr Malte Gerhold stood down from ETAB. Professor Nigel Sparrow, continues to provide a CQC perspective to ETAB’s work as part of his role as CQC, Senior National GP Advisor and Responsible Officer.

f Amy Butlin has been appointed to ETAB in her capacity as a medical student. Amy will take up the role on 1 January 2015.

In attendance

19 Denise Platt, GMC Council member, attended the meeting to observe the work of ETAB, which is an important part of our formal engagement governance structure.

Next meeting

20 ETAB will meet next on 4 February 2015. We are still in the early stages of agenda planning for the next meeting, but we expect to seek ETAB’s advice on mapping educational outcomes against Good medical practice, student fitness to practise, the trainers survey, and the review of standards for education and training.
Supporting information

How this issue relates to the corporate strategy and business plan

21 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.

22 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 held on 14 October 2014
4 February 2015

Education and Training Advisory Board

Draft as of: 26 November 2014

To approve

Minutes of the Meeting on 14 October 2014

Members present

John Connell, Chair
Gill Bellord
Derek Gallen
Muj Husain
Stewart Irvine
Katerina Kolyva
Elizabeth Manero
Ben Molyneux
Wendy Reid
Alice Rutter
Radhakrishna Shanbhag
David Sowden
Nigel Sparrow

Others present

Niall Dickson, Chief Executive
Mark Dexter, Head of Policy – Education and Standards
Judith Hulf, Interim Director of Education and Standards
Ben Griffith, Policy Manager – Education and Standards
Martin Hart, Assistant Director – Education and Standards
Nathan Lambert, Projects and Planning Manager – Education and Standards
Patsy Morrissey, Board Secretary – Office of the Chair and Chief Executive
Vicky Osgood, Assistant Director – Education and Standards
Denise Platt, GMC Council member (Observer)
Kirsty White, Head of Planning, Research and Development – Education and Standards
Derek Yuen, Evidence Quality Analyst – Education and Standards
Chair’s business

1 The Chair welcomed members to the meeting of the Education and Training Advisory Board and in particular new Board members, Katerina Kolyva and Muj Husain who attended for the first time.

2 Katerina Kolyva, Director of Continued Practice at the Nursing and Midwifery Council, replaced Jackie Smith as a member of the Board. Muj Husain, replaced Sue Bailey as a member of the Board. Denise Platt, GMC Council member, attended the Board meeting as an observer.

3 The Board:

a Congratulated Alice Rutter on the completion of her medical school finals and noted that she would remain on the Board in her capacity as a doctor in training.

b Noted that a new student member, Amy Butlin, had been appointed to the Board and would take up the role in January 2015.

4 Apologies for absence were noted from Iain Cameron, Andy Heeps, Ian Starke, Tony Weetman and Paddy Woods.

Minutes of the meeting on 3 June 2014

5 The Board approved the minutes as a true record, subject to one amendment at paragraph 6a to clarify how patients and the public might find the information arising from our review of undergraduate assessment useful. The revised paragraph would read:

_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 as a tool for quality assurance and quality management, and would also aid transparency for patients and the public more generally._

Matters arising

6 The Board noted that the assessment audit report referred to at paragraph 8 of the minutes of 3 June 2014 had not been circulated to the Board but a link to the report had been included in the paper at item 3 of the agenda - Publication of evidence on undergraduate medical education. An electronic copy of the full report would be circulated to the Board for ease of reference.
The Board considered a paper outlining the key conclusions of the package of evidence on aspects of undergraduate education that had been published on 8 October 2014. The evidence was comprised of our reports:

a) *The state of medical education and practice 2014.*

b) *Be prepared – are new doctors safe to practise?*

c) *How prepared are UK medical graduates for practice?*

d) *How are students assessed at medical schools across the UK?*

e) Tableau reports, our new on-line reporting tools giving detailed information relating to individual medical schools.

The Board advised that:

a) Very few UK medical graduates were very poorly prepared and that, in time, the expectation was that the student assistantship programme should help to address the outstanding issues of preparedness, highlighted in the recent reports. However, our evidence clearly showed that there were potential concerns about the consistent quality of undergraduate medical education across the UK. Thus, a deeper understanding of the key issues was required in order to determine what action should be taken to promote a more consistent quality of undergraduate medical education. Further clarity around factors, including the geographical spread of feelings of unpreparedness across the UK, and the extent of the variation in how medical schools approach assessment, should be sought. While the majority of medical graduates feel prepared for practice, schools that consistently failed to prepare their graduates for practice should be helped to take cognisance of the work that needs to be done to ensure that the results of medical education are such that students are prepared to take up employment within the NHS. Medical schools have a responsibility to doctors, employers and patients to ensure that students are prepared for employment.

b) While it was thought to be unnecessary to be too prescriptive about the content of the student assistantship period, the quality of the clinical and educational environment was identified as a vital component to ensuring that students are adequately prepared for the broad range of clinical work required, and to promote the professionalism expected of doctors. The quality of the assistantship period, and not just the time spent as an assistant to a junior doctor, was vital. The educational and clinical experiences within the assistantship period required coordination in order to deliver the required increase in the preparedness of the medical student to start practice as a Foundation Year 1 (F1) doctor. It was recognised that existing work to support improvements to the educational environment, and the GMC review of education training and standards, would be
expected to drive improvements to the quality of the assistantship period and ensure that it delivers as required.

9 During discussion, the Board noted that:

a Transition stages, by their very nature, involve feelings of unpreparedness and that there was the possibility of a mismatch between what students thought would be expected of them, hence feelings of unpreparedness, and the actual reality of what was expected of them in their role as a F1 doctor. Indeed, there had to be some concern about the potential for overconfidence if students reported themselves fully prepared for the next stage of their training.

b It would be difficult for the undergraduate curriculum to prepare students as employees who fully meet the expectations of NHS employers. The expectations of an employee differ from those of a student, and employers would need to continue to support the doctors in training with the transition from student behaviours to the professional behaviours expected of a doctor.

c Employers need to have realistic expectations of doctors in training, recognising that the first year of the Foundation Programme is an intense learning experience and that there will always be a material difference between being a medical student and an employed doctor.

d Not all schools had moved the timing of their finals to before January in the final year, which meant that some students found it difficult to focus on the assistantship period while also studying for finals. Board members anticipated that the other schools would make similar changes in the near future.

e Issues with preparedness around prescribing presented a potential patient safety issue but the Prescribing Safety Assessment, which was provided by all medical schools, was expected to go some way to addressing the concern.

f Achieving appropriate standards of professionalism would be difficult within educational environments associated with the provision of suboptimal care and where appropriate professional standards are not routinely exhibited; there may potentially be some clinical environments which the GMC should deem unsuitable for the delivery of medical education.

g Further evidence on the benefits of student assistantships would be available by September 2015 and would provide further evidence as to the extent of the issue of preparedness and thus whether additional, specific steps needed to be taken.

h The GMC should consider making assistantships subject to our check visits process, in order to drive further improvements.
Our data strategy would in time enable us to better understand the trends and variations in medical education and practice.

There were linkages between our work in this area and developing the case for a National Licensing Exam as a means of driving consistency in the assessment of graduates from all medical schools.

National Licensing Exam

The Board considered a presentation summarising the case for, and challenges of, the introduction of a National Licensing Exam (NLE).

The Board advised that:

a. An NLE providing assurance that those on the medical register had reached a common standard was desirable. However, the detail of the development and implementation of a UK NLE would require careful and robust consideration. While the momentum for exploring the case for an NLE should be maintained it would be important to engage with the profession on the benefits of this change for doctors, the NHS and patients.

b. The question of whether an NLE should be a pass/fail or ranking test required further consideration. While a pass/fail test would be simpler to administer and would provide a clear answer on the question of whether a doctor is fit to hold a licence to practise, an exam that could work across the system aiding selection to the Foundation Programme and elements of which were linked to medical schools’ assessments could be more cost effective. As there were pros and cons associated with both options, the level of discussion required would be better served by input from a range of other interests, including experts in educational assessment.

c. We should carefully consider any arguments for an NLE based on patient safety and quality issues. Any such arguments should be based on sound evidence. It would be helpful for the Board to see the report of the research that had been commissioned by Council.

d. Encouraging employers to make passing the NLE a condition of employment offered a partial solution to the issue of whether EEA doctors could be required to sit such an exam. However it was recognised that NHS employers would require clarity on the legal position of such a requirement before they made an NLE pass a mandatory condition of employment. In addition, private providers within the NHS could employ doctors on different terms; although this could be managed through collaboration with the Care Quality Commission and its inspection programme.

e. Updating a doctor’s record on the GMC register to reflect a ‘pass’ in the NLE might not be a straightforward process and would ultimately depend on the design of the exam; which could be linked to other mechanisms outside our control.
purpose of the exam would need to be explicitly defined prior to any decision regarding how it might be reflected on the medical register.

f A doctor that failed the NLE would not be allowed to practice, but a programme of remediation should exist to support those that fail. Limiting the number of re-sits, in line with our existing arrangements for the Professional and Linguistic Assessments Board (PLAB) examination, would be appropriate.

g While the NLE would be taken forward as a GMC initiative, the exam would be developed closely with key interests in medical education across the UK, including medical schools, Health Education England, NHS Education for Scotland, Wales Deanery and the Northern Ireland Medical and Dental Training Board

12 During discussion, the Board noted:

a That while there were clear advantages to requiring doctors from the EEA and International Medical Graduates (IMGs) to sit the NLE, the advantages of requiring UK medical students to sit the exam were not so well defined, although it was recognised that this offered an essential benchmarking for any such assessment, and would offer employers and the public reassurance that all medical graduates had met a defined standard. It was, however, noted that UK medical students were already subject to a well regulated system, and students and junior doctors would be concerned about the risks of over-assessment and stresses associated with an NLE.

b The challenges with making an NLE a requirement for EEA doctors, and the risk of undermining the exam if they were not were recognised. The GMC would continue to work through the legal issues around this point.

c That there is likely to be some opposition from parts of the profession including medical students and junior doctors’ but that there had previously been opposition amongst the profession to other changes to medical education and regulation, including the introduction of the Foundation Programme and revalidation, and that over time the profession had recognised the benefits of such changes.

d That while discussion of the design of the exam was some way off, it was envisaged that it would have a major practical element. The risks of over-assessment could be minimised if the NLE dovetailed with university assessments and linked to our IMG processes.

e That the issues currently being considered would be taken forward as we continue to engage with key interests on an NLE, ahead of Council’s decision in 2015 on the development and implementation of an NLE.
The recommendations of the review of the Professional and Linguistic Assessments Board (PLAB) examination would be taken forward regardless of the work on an NLE.

The link between doctors’ medical schools and future progression

13 The Board considered a report outlining the progress that we had made, working with others, to understand the factors that may influence a doctor’s progression through postgraduate education and training programmes.

14 In response to the Board’s feedback a suite of interactive reporting tools had been developed and published on our website on 8 October 2014.

15 The Board noted the development of reporting tools for medical schools on the outcomes of their graduates and received a live demonstration of the on-line tableau reports.

16 The Board noted that:

   a The first report used data from the 2012-2014 trainee surveys and looked at the link between a doctor’s medical school and how prepared they felt as new doctors. It was expected that this report would be used by schools to improve the preparedness of their graduates, and to assess the impact of any changes made.

   b The second report used data from the medical register and looked at the link between doctors’ medical schools and their future specialty training. It was expected that this report would help schools and colleges to drive quality management changes.

   c The third report used data from annual review outcomes and looked at the link between medical schools and future trainee progression. It was expected that this report would help schools to assess the impact of curriculum changes in the medium term.

17 The Board advised that while the data should not be seen as performance data on medical schools, the reports were useful tools for medical schools, commissioning bodies and employers and could be used to help inform conversations on a range of issues, including workforce supply and funding.

18 During discussion, the Board noted that:

   a The next ‘wave’ of reports would look at medical school exam outcomes and would explore the use of recruitment data.

   b We would look at attrition rates in order to gain a better understanding of the characteristics of those that do not complete training.
Given that some schools produce significantly more GPs and others produce low numbers of particular specialty doctors, we should gain a better understanding of the factors that drive doctors to choose one specialty over another and the extent to which the environments created at medical school influences those outcomes.

Board members were invited to forward any further comments to Kirsty White or Derek Yuen.

Key education work streams

The Board noted a progress update on our key education work streams.

The Board advised that the development of ‘apps’ to support our standards work on end of life care and the continuing professional development of doctors should supplement, and not replace, our existing guidance work. Our work in this area should offer sign-posts to other sources of professional guidance and ‘apps’ already developed by others, where suitable.

During discussion, the Board noted:

a That the report of the Shape of Training Implementation Group, which was expected to be submitted to the four UK governments at the end of 2014, would be circulated to the Board for information.

b We would discuss the framework for generic professional capabilities with employers.

Any other business and date of next meeting

The Board noted the date and time of its next meeting at 10:00 on Tuesday, 4 February 2015.

Confirmed:

John Connell, Chair

4 February 2015