Education

Quality Improvement Framework

for Undergraduate and Postgraduate Medical Education and Training in the UK

General Medical Council

Regulating doctors
Ensuring good medical practice

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health.

To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date
  - Recognise and work within the limits of your competence
  - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately
  - Respect patients' right to confidentiality
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences
  - Give patients the information they want or need in a way they can understand
  - Respect patients' rights to reach decisions with you about their treatment and care
  - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
  - Never discriminate unfairly against patients or colleagues
  - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Contents

The GMC Quality Improvement Framework for Undergraduate and Postgraduate Medical Education and Training in the UK

Introduction

1 The General Medical Council (GMC) protects the public by ensuring proper standards in the practice of medicine. We do this by setting and regulating professional standards not only for qualified doctors' practice, but also for both undergraduate and postgraduate medical education and training.

2 A number of organisations play different roles in ensuring the quality of medical education and training, and this quality improvement framework (QIF) will align this activity. In doing so, it will:

- deliver a robust, rigorous set of processes that will assure the public and the medical profession about the standards of medical education and training in the UK
- demonstrate value for money, be fit for purpose and reflect fully the principles of better regulation
- drive standards in the quality of medical education and training
- empower local solutions and mean the GMC only intervenes when necessary
- engage students, trainees, patients and the public
- ensure that high quality education and training of the medical workforce is maintained within the health services by engaging employers through local education providers (LEPs).

3 This document sets out how the GMC will quality assure (QA) medical education and training in the UK from 2011-2012.

4 The institutions and structures referred to in this document reflect the system at the time of publication.

5 The outcomes of the Department of Health (England) consultation *Liberating the NHS:Developing the Healthcare Workforce* and the command paper *Enabling Excellence Autonomy and Accountability for Healthcare Workers*, *Social Workers and Social Care Workers* will need to be considered in terms of the QIF. The proposals in *Developing the Healthcare Workforce* will, if implemented, bring about radical structural changes to the organisation and delivery of medical education and training in England. However, our statutory powers are sufficiently broad and flexible to accommodate such changes, and the principles and approach set out in the QIF would remain valid whatever structures may emerge. The QIF is a living document which will and must be responsive to change.

6 In this publication we have used the term 'deaneries' in the absence of certainty about what body or network may take on the quality management (QM) of postgraduate medical education and training in England.

Background

7 The GMC's responsibilities for medical education and training include:

- setting standards, requirements and outcomes
- identifying where these are not being met through quality assurance and ensuring that those responsible take appropriate action
- driving improved standards in medical education and training across the UK.

8 Our powers in this area are determined by the Medical Act 1983 and subsequent amendments to the act.

9 The QIF builds on the GMC's existing work to drive up standards in the quality of every stage of medical education and training in the UK. This work includes our Quality Assurance of Basic Medical Education (QABME) programme, our Quality Assurance of the Foundation Programme (QAFP) and the Quality Framework for Specialty Including GP Training (QF).

10 The QIF gives an overview of how we will QA undergraduate and postgraduate medical education and training in the UK until 2012. Having such a framework will ensure consistency and transparency in QA. The institutions and structures referred to in this document reflect the system as it operates today. However, this does not preclude changes in the future.

11 A number of organisations are involved ensuring the quality of medical education and training in the UK in different ways and these can be split into three types of activity: QA, QM and quality control (QC).

12 The GMC is responsible for QA of both undergraduate and postgraduate education and training. Medical schools, meanwhile, are responsible for QM of the education and training they are delivering to undergraduate medical students and deaneries for postgraduate trainees. Medical students and trainees also receive education and training within the health service and the health services are responsible for the QC of this. (The differences between these three types of activity are explained in the section entitled 'The Quality Improvement Framework introduced' later in this document.)

13 The UK Foundation Programme Office (UKFPO) and Royal Colleges/Faculties are involved in all three types of activity. For example, they advise the GMC's undergraduate and postgraduate boards, design curricula and assessments and enable their implementation. The Royal Colleges/Faculties also complete Annual Specialty Reports (ASRs) for the GMC and have a regional presence within LEPs.

14 The last cycles of QABME, QAFP and the QF show that QM in deaneries and medical schools has matured. QC within LEPs, however, is less developed and the monitoring and evaluation of their progress by deaneries and medical schools following QM activity such as local visiting is not being carried out to a consistent standard.

15 The QIF will be supplemented by an Operational Guide, to be published in Summer 2011. The Operational Guide will give a detailed 'how to' and explains the processes and elements of the QIF for those with an active role in medical education and training. The Operational Guide is a 'live' document that changes as the QIF is implemented. This means that processes and protocols will be developed and refined through experience and feedback.

Principles of better regulation

16 Development of this QIF was guided by the five principles for assessing and improving the quality of regulation originally established by the Better Regulation Task Force and updated in the Better Regulation Task Force Annual Report for 2004/5:

Proportionality Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.

Accountability Regulators must be able to justify decisions and be subject to public scrutiny.

Consistency Government rules and standards must be joined up and implemented fairly.

Transparency Regulators should be open, and keep regulations simple and user-friendly.

Targeting Regulation should be focused on the problem and minimise side effects.

17 The following table sets out the principles and how these are addressed in this QIF.

18 Complementary to the principles of better regulation, there is a need to ensure that the QIF is agile and adaptable. The principles of QA, QM and QC set out in the QIF can be applied flexibly and be responsive to: diverse medical schools; the changes to medicine and the NHS brought about by a change in government and varying arrangements for commissioning and providing education and training within and between the four UK countries.

Principle	How the QIF addresses it
Proportionality	QA activities are proportionate in time and focus. The QIF is based around medical school and deanery QM and the ways in which they work with LEPs and Colleges/Faculties at a local level. The GMC is moving towards a risk based QIF, saving money and reducing burden while targeting the areas that need it most. The GMC is committed to working with other regulators to share information and coordinate activities and will, where possible, receive and use data that are gathered once and used for all partners. Activities such as visiting will be coordinated across all stages to reduce the burden on LEPs being visited and, where possible, to coincide with scheduled events.
Accountability	The GMC will base its decisions on an evidence base made up of information generated both internally and externally. Degrees of accountability at all levels have been identified. The GMC will introduce a Quality Scrutiny Group to ensure consistent consideration by experts of all outcomes of the QIF.
Consistency	The QIF links all the elements of the GMC's QA activities for undergraduate and postgraduate medical education and training. Through our QA activity we are creating a picture of undergraduate and postgraduate medical education and training which will contribute to more consistent and informed QA by building on the outcomes of QABME, QAFP and the QF. The GMC is moving away from the cyclical and repetitive review of the units we already know to be functioning reasonably well. The GMC will publish a calendar of activity to support the QIF from 2011 to 2012 in its operational guidance..

Principle	How the QIF addresses it
Transparency	The QIF and supplementary documentation make it clear what is required from partners. Within the QIF, partner organisations are asked both to take action and to provide evidence of those actions. Medical school and deanery self assessment will be undertaken against the GMC's published standards, requirements and outcomes. The public, patients, students, trainees and employers can access published QIF guidance, QA reports and action plans on the GMC website.
Targeting	QA activities will focus on the problems, aiming for improvement and on the dissemination of good practice. Visits will be focussed on issues identified from the evidence base and responses to concerns will be targeted and appropriate.

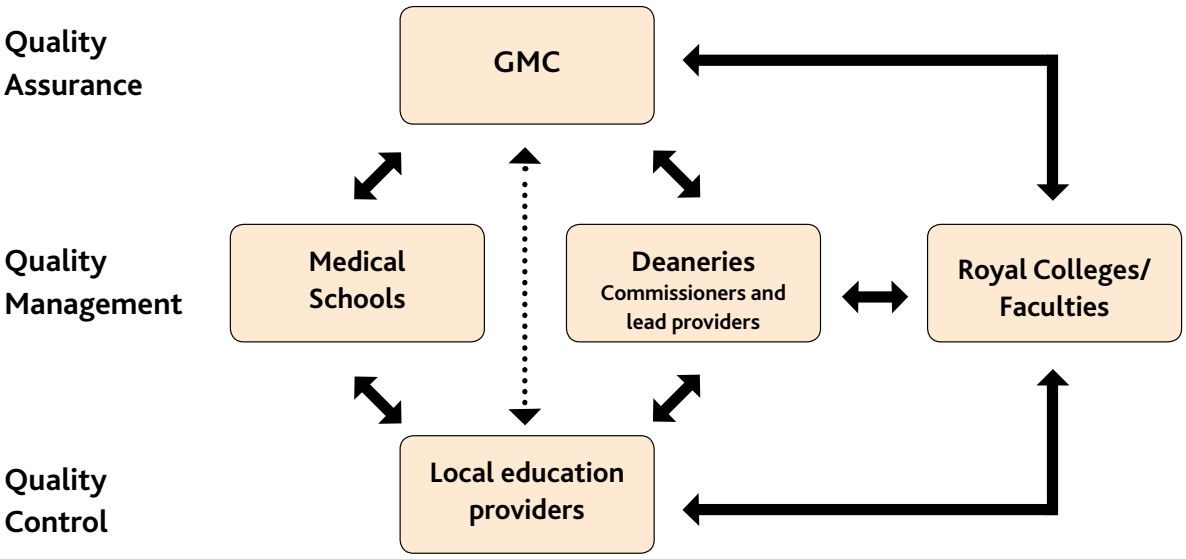
The Quality Improvement Framework introduced

Key messages

- The QIF builds on the good work that has previously been carried out in this area. We have improved our approach to QA by making more use of our evidence base and targeting our activity where it is most needed to maintain standards and improve quality.
- By coordinating QA of all stages of medical education and training we will be better positioned to generate a comprehensive picture of medical education and training across the UK.
- The GMC is committed to delivering a more risk based and proportionate approach to QA.
- We are moving away from a one size fits all model of QA to be responsive to the needs and challenges of individual medical schools and deaneries.

19 The diagram below shows how the different levels of QA, QM and QC relate to each other.

20 Currently, medical schools and deaneries are the units which manage the quality of medical education and training, maintaining and improving standards over time. But the model is flexible enough to adapt to future structures should this change. It emphasises the importance of the distinct role that quality managers have in ensuring that training programmes and students/trainees meet the required standards and outcomes.



Quality assurance

21 QA includes all the policies, standards, systems and processes in place to maintain and enhance the quality of medical education and training in the UK. The GMC carries out systematic activities to assure the public and patients that medical education and training meets the required standards. This activity is carried out within the principles of better regulation (see page 7-8).

22 QA is based on the statutory remit of the GMC which is to set standards, requirements and outcomes for all stages of medical education and training. Decisions regarding approval will be informed by assessment against these standards. For the purposes of this document, the term 'approval', which is used throughout, includes:

(a) the recognition of programmes under Part 2 of the Medical Act 1983

(b) the recognition of specialties

(c) confirming which organisations can deliver the Foundation Programme

(d) the list of those universities which are recognised as meeting the standard in respect of qualifying exams at undergraduate level

(e) curricula and assessment systems and specialty programmes.

23 The GMC quality assures:

(a) bodies responsible for medical educational and training locally (universities and deaneries)

(b) training posts and programmes (foundation and all specialties including GP)

(c) curricula and assessment systems underpinning training programmes (the Foundation Programme and all specialties including GP).

24 Medical schools and deaneries are asked to provide the GMC with reports that show how they are meeting the published standards and outcomes supported by evidence and accompanied by an action plan.

25 The GMC's approach to QA combines the principles of peer review and consistent scrutiny. Elements such as visits and, sometimes, responses to concerns will be by peer review. The reports of these visits and other elements of the QIF such as medical school, deanery and specialty reports, self assessment, curriculum and assessment system approvals will be subject to consistent scrutiny by a fixed membership Quality Scrutiny Group. The final decision on approval remains with the GMC.

Quality management

26 QM refers to the arrangements through which a medical school or deanery satisfies itself that LEPs are meeting the GMC's standards. These arrangements normally involve reporting and monitoring mechanisms.

27 Medical schools are responsible for the educational governance of university and LEP based undergraduate medical education. The school's curricula and assessment system/s are reviewed against the standards and outcomes of Tomorrow's Doctors.

28 Deaneries are responsible for the educational governance of all approved foundation programme and specialty including GP training programmes. All foundation and specialty including GP training takes place within training programmes approved by the GMC against the

standards and outcomes of *The Trainee Doctor.*

29 The GMC expects medical schools and deaneries to demonstrate compliance with the standards and requirements that it sets. To do this, they will need to work in close partnership with the medical Royal Colleges and Faculties, NHS trusts and health boards and other LEPs. This means that QM should be seen as a partnership between those organisations because it is only through working together that medical schools, deaneries, Royal Colleges and Faculties, with LEPs, can deliver medical education and training to the standards required.

30 Medical schools, deaneries and Royal Colleges/Faculties may benefit from carrying out their own surveys, but should avoid doing so at the time of the annual national training surveys. Such surveys may be supplemented by asking students and trainees to evaluate student assistantships, clinical placements, posts and programmes. Medical schools and deaneries may also wish to use multi-source feedback and/or peer review to monitor the quality of teaching.

31 As part of their QM activity, medical schools and deaneries, in conjunction with medical Royal Colleges and Faculties, may need to carry out a form of local visiting with the goal of improving education and training opportunities. This may be helpful to the LEPs and enable local problem solving and dissemination of good practice.

32 If medical schools and deaneries do carry out local QM visits, they should bear the following in mind.

(a) Only the GMC can award or withdraw approval of training, so such visits will be advisory and focus on improving the quality of training.

(b) Visits to a medical school or deanery cannot be undertaken without the agreement of its dean.

(c) Visits should include expertise external to the programme being reviewed.

(d) Visits should have a very clear and articulated purpose, ensuring that the GMC's standards and requirements are met and promoting quality improvement.

33 Wherever possible, trusts, health boards and other LEPs should be allowed to monitor their own performance against GMC standards and requirements.

34 Any Royal College or Faculty, or indeed any other interested party such as students, trainees or patients, can raise concerns with the GMC. As set out in Good Medical Practice, it is a professional requirement of all registered medical practitioners to protect patients from risk of harm and to report when there is good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems. If there are concerns about a medical school or deanery, the GMC expects these to be raised with the medical school or deanery first so that they can provide reassurance. If problems persist, the individual or organisation should then contact the GMC and we will investigate promptly. If medical schools or deaneries remove students or trainees from an LEP due to concerns about the quality of training or patient safety they must inform the GMC.

35 Day-to-day reassurance that medical education and training is being delivered to the standards required will be at QM level.

36 Colleges/faculties will continue to need information about individual trainees in order to prepare the evidence for submission to the GMC for an award of CCT.

37 It is expected that medical schools and deaneries will not have to provide different information from each partner body but to draw upon the same information for QA as QM and QC.

38 External scrutiny is important in maintaining standards at both undergraduate and postgraduate level and can be achieved in a number of ways. One of the most important ways of doing so in medical schools is the use of external examiners. Tomorrow's Doctors (2009) requires that medical schools have in place 'a mechanism to ensure comparability of standards with other institutions and share good practice. The mechanisms must cover the appointment of external examiners. The duty and powers of external examiners must be clearly set out'. Supplementary advice regarding external examiners will be published in early 2011. Universities UK has also led a review and the QAA is developing minimum expectations of the role.

39 Deaneries must ensure active external scrutiny in the QM processes. This can be addressed in two ways. Firstly, at specialty level, external advice should be obtained on all the processes of delivery, assessment and evaluation of specialty including GP training. The GMC expects that such specialist advice will normally come from the medical Royal Colleges and Faculties. Secondly, deaneries should consider external advice about the management of specialty including GP training, for example through the engagement of employers; NHS Education for Scotland (NES), Strategic Health Authorities (SHAs), their successor or equivalent organisations; or other health professions or other deaneries.

40 External advisers must have appropriate expertise and be independent of the deanery. They should include educationalists, trainees, patients and the public as well as members of the medical profession.

41 Medical external advisers should have expertise appropriate for the programme, course or foundation/specialty school being considered and will normally be drawn from other deaneries, Royal Colleges, Faculties or specialty associations.

42 Medical schools and deaneries must be able to demonstrate that all external examiners and advisers are independent of the programme, course, foundation/specialty school or deanery, have the relevant expertise and have no conflicts of interest.

The role of the dean in relation to serious concerns

43 If there are training concerns, deans can remove one or more groups of students or trainees from a setting or organisation. Such a change should involve the appropriate medical Royal College or Faculty at postgraduate level. It must be reported to the GMC immediately and recorded as part of the school or deanery report to the GMC, setting out the actions taken to remedy the situation where appropriate in the accompanying action plan.

Quality control

44 QC is the arrangements through which LEPs (health boards, NHS trusts, the independent sector and any other service providers that host and support medical students and trainees) ensure that medical students and postgraduate medical trainees receive education and training that meets local, national and professional standards.

45 LEPs should normally have a board level officer accountable for this function.

46 The GMC quality assures medical education and training through the medical schools and deaneries but day-to-day delivery is at LEP level. This delivery involves medical staff, medical education managers, undergraduate and postgraduate medical centre staff, other health professions and employers. Clinical placements, student assistantships, individual foundation programme and specialty including GP training are delivered through careful supervision and assessment by specialists in the relevant discipline advised and overseen by regional and local staff from the UKFPO, the Academy of Medical Royal Colleges and the relevant medical Royal College or Faculty.

47 Each LEP must demonstrate how the GMC's standards and requirements are being achieved. Medical schools and the deaneries should support LEPs in doing this and ensure that systems of delivery and QC are consistent across specialties and LEPs.

Risk-based regulation

48 The GMC accepts and endorses the principle of risk-based regulation. QABME and QAFP both included robust processes to QA all medical schools and all deaneries against all of the standards and outcomes in Tomorrow's Doctors (2003) and The New Doctor. This has provided a wealth of data and a useful, recent picture of the state of undergraduate medical education and foundation training. The GMC is using the outcomes of these programmes to set a baseline for risk assessment. Risk assessment against such a baseline allows us to direct regulatory resources where they can have the most impact.

49 This targeted and focused risk based approach is in line with the principles of better regulation and the GMC will engage and work with all partners to develop the necessary structures and processes.

50 The QIF must also continue to celebrate and disseminate good practice and it is important to recognise that innovation and development for the better can occur more frequently where risks are taken.

Quality Improvement Framework – the four elements

51 There are four elements to the QIF:

(a) approval against standards

(b) shared evidence

(c) visits including checks

(d) responses to concerns.

The standards are the framework against which all QA activity is undertaken and the evidence base supports and focuses QA activity.

Approval against standards

Key messages:

- The GMC approves bodies or combinations of bodies to award UK primary medical qualifications; deaneries responsible for foundation training; LEPS delivering foundation and specialty including GP training; foundation and specialty including GP curricula and assessment systems and foundation and specialty including GP programmes.
- The GMC requires medical schools to comply with the standards and outcomes of Tomorrow's Doctors (2009) by August 2011.
- Standards, requirements and outcomes for the foundation programme and specialty including GP training are being aligned and will be published in a single document. They will be substantially reviewed from 2013.
- Trainers' approval status will be published enabling deaneries to maintain a current list.

52 Standards for education and training are an essential element of the QIF. They form the backbone of the framework against which the other elements are developed and measured.

53 The standards and outcomes for undergraduate medical education and training, including curricula and assessment systems, are set out in Tomorrow's Doctors. The GMC consulted widely when drawing up the revised standards and outcomes. Medical schools must meet the standards and outcomes of Tomorrow's Doctors (2003) while working towards compliance with Tomorrow's Doctors (2009) by the beginning of the academic year 2011-12. The GMC will publish supplementary advice in early 2011.

54 The standards and outcomes for postgraduate medical education and training have been aligned following the merger of PMETB with the GMC. *The Trainee Doctor* combines the standards and outcomes previously set out in *The New Doctor*, the *Generic Standards* for *Specialty Including GP Training* and the *Standards for Trainers and Standards for Deaneries*. The combined standards will be reviewed substantively from 2013.

55 The standards and outcomes for the foundation and specialty including GP curricula are set out in the Standards for Curricula and Assessment Systems.

56 The GMC approves the following against the above standards:

(a) new institutions to deliver undergraduate medical education or the decoupling of institutions which previously jointly delivered it

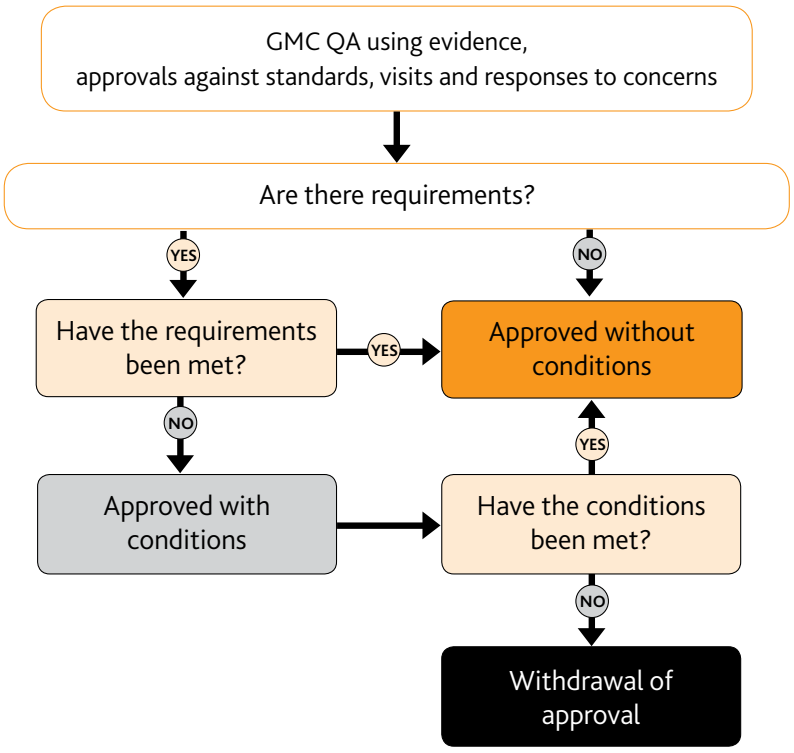
(b) programmes of education or training

(c) trainers

(d) foundation, specialty including GP and subspecialty curricula and assessment systems.

57 Medical schools and deaneries are reviewed against the relevant set of standards for each of the above and are then either granted approval or approval is withdrawn. Where necessary, the GMC will set requirements that medical schools and deaneries must meet to ensure conditions are not placed on their approval. If such conditions are not met, we will then take steps to withdraw approval.

Approvals against standards



58 The GMC assesses whether medical schools and deaneries are meeting the required standards through the following QA activities.

(a) Medical schools and deaneries submit reports to the GMC setting out their activity against the relevant standards, outcomes and requirements. (The structure of the report and when it must be submitted are set by the GMC.) The reports must draw on evidence gained through the QM and QC processes and include action plans that address how any problems are being tackled. This should include updates on any conditions, requirements and recommendations made in visit reports, how good practice is being disseminated and the goals for the year ahead.

(b) The GMC carries out routine visits to medical schools and deaneries.

(c) The GMC carries out 'triggered visits' or other responses to concerns where necessary. (Triggered visits, as opposed to routine visits, are undertaken to investigate possible serious educational failure or risk to patient or trainee safety.)

(d) The medical Royal Colleges and Faculties submit annual summary reports to the GMC confirming that the curriculum and associated assessment systems continue to meet GMC standards and requirements.

(e) The GMC carries out national training surveys every year and examines other evidence sources where available, for example through collaborative activities, to confirm that standards are being met.

(f) The GMC re-approves curricula and associated assessment systems.

59 The process for the withdrawal of approval is available on the GMC's website at www.gmc-uk.org/education

Post and programme approval

60 The GMC is the sole authority responsible for the approval of bodies awarding UK medical degrees; foundation programmes and specialty including GP training posts; courses and programmes, including applications for re-approval of expired posts and programmes.

61 Approval at undergraduate level relates to:

(a) the process through which new, coupling or decoupling institutions are quality assured and recognised by the GMC and added to the list of bodies able to issue UK PMQs

(b) the continued approval of bodies able to issue UK PMQs through annual reporting and the visit process, and by the approval by the GMC of any major changes.

62 Deaneries will now be approved to deliver foundation programme and specialty including GP training through the QIF as a single process. (Previously, deaneries have been approved separately to deliver foundation training through the QAFP process and specialty including GP training posts and programmes through the QF). They will be approved against *The Trainee Doctor* using shared evidence, national training surveys, a single visiting process and responses to concerns. The GMC will receive programme approval data for foundation programmes from deaneries as it does for specialty including GP programmes.

63 All specialty including GP posts, courses and programmes (full time and less than full time) intending to lead to the award of a CCT must be approved in advance by the GMC. This includes academic integrated pathways and periods spent out of programme for research (OOPR) or other training (OOPT) or learning opportunities. Activity relating to the approval of programmes and posts within those programmes is set out within this QIF.

64 Where the GMC has granted conditional approval to posts and programmes, we will monitor these through the annual reports submitted to us by medical schools, deaneries and medical Royal Colleges/Faculties; the national training surveys and visits. Medical schools and deaneries, along with medical Royal Colleges and Faculties and LEPs, will be expected to monitor training at a local level. This monitoring will form an important part of the QM and QC activity.

Trainer approval

65 Criteria for the approval of GP trainers were developed by the Royal College of General Practitioners and agreed by PMETB. Deaneries identify which trainers meet these criteria and are currently delivering training through locally delivered processes and provide this data to the GMC. We then grant approval of trainers based on this data.

66 We are committed to delivering a framework for all trainers, so we will be looking again at the process through which this is currently done and seek to QA the data through the other elements of the QIF. This could include an audit of approval processes during a visit, information from the national trainer survey and/or response to concerns.

67 In the short term, we will move from historical to real time information sharing and approvals with deaneries and publish information which reflects those trainers approved to deliver training.

Curriculum and assessment systems approval

68 The GMC ensures that curricula and assessment systems for the foundation programme and specialty including GP training meet GMC standards and that there is consistency in standards across medical specialties in the UK.

69 Consistent standards in curricula help ensure that all doctors are equipped with the necessary skills, knowledge and behaviours to perform effectively in a constantly changing health service provided in a wide range of settings.

70 Approval of undergraduate medical curricula and their associated assessment systems is against the standards and outcomes of *Tomorrow's Doctors* (2009) and through the other elements of the QIF. These include the evidence base, visits and responses to concerns.

71 The GMC approves the foundation programme curriculum and all specialty including GP training curricula which lead to CCTs and subspecialty curricula that lead to the award of a certificate against the Standards for Curricula and Assessment Systems. Medical Royal Colleges, Faculties or other interested parties are responsible for submitting proposals for new specialties to the department of health and for new subspecialties to the GMC for approval. The GMC will then approve the curriculum and associated assessment system of new specialties and subspecialties as appropriate.

72 The GMC wants to be responsive and enable the development of curricula and assessment systems in innovative ways. This is important to ensure that any significant change is fully considered and approved prior to implementation. Organisations developing curricula and assessment systems are responsible for ensuring that changes - minor or major - are clearly communicated to the GMC and, once approved, to the deaneries in a timely fashion. Major changes to curricula must only be made where there is a clear service need or development within the specialty that must be reflected in the curriculum to avoid deaneries having to deliver different curricula for the same specialty or subspecialty at the same time.

73 In 2009/10 a formal review of all specialty and subspecialty curricula was undertaken against the 17 Standards for Curricula and Assessment Systems. The outcomes of the review were published in the GMC Quality Framework: Learning Points (July 2010).

Shared evidence

Key messages

- The evidence base includes evidence from different stages of medical education and training from the GMC's other functions such as registration and fitness to practise and from external sources such as health systems regulators. The evidence base is being strengthened and will inform all aspects of regulatory QA.
- To undertake proportionate QA the evidence will be used to identify risks for exploration.
- Over time, the GMC will focus on collecting the most relevant information and spend more time analysing information and less time processing it.
- Greater emphasis will be placed on benchmarking and sharing information with partners to support effective quality management and quality control.
- Information within the evidence base that is relevant to other elements of the QIF will be shared with those undertaking QA activity on behalf of the GMC.

74 The evidence base is maturing. As this becomes more comprehensive and robust it provides a firmer basis for targeting QA activity where regulatory intervention is most effective.

75 The purpose of the shared evidence is to:

(a) identify areas of risk that need further investigation by the GMC

(b) triangulate (verify) the evidence provided by different partners and check whether it is consistent and comparable

(c) identify trends or patterns which lead to thematic QA activity by the regulator where the GMC considers an aspect of medical education and training across undergraduate and postgraduate education and throughout the UK and makes wide-ranging judgements on the quality of delivery of that aspect

(d) identify trends leading to new items included in the national training surveys

(e) identify trends or patterns which lead to targeted checks

(f) enable the GMC to fulfil its statutory function of approving and monitoring training in the UK through a range of evidence.

Sources of evidence

76 Medical schools, deaneries and medical Royal Colleges/Faculties are key sources of evidence. Data required from these key sources are defined and transparent, with the minimum dataset requirements identified. This is supplemented by data from other healthcare regulators and organisations.

77 Evidence is also drawn from the four UK health departments, healthcare systems and organisations and from other elements of the QIF and GMC functions.

78 The shared evidence for the QIF will include:

(a) reports and action plans from medical schools and deaneries

(b) annual specialty reports from medical Royal Colleges and Faculties

(c) the approval of posts, programmes, trainers, curricula and assessment systems

(d) previous visit reports

(e) both GMC and external surveys data

(f) reports from bodies to which deaneries are accountable (namely SHAs, NES, Welsh Assembly Government (WAG), Department of Health, Social Services and Public Safety of Northern Ireland (DHSSPS))

(g) other audit and quality assurance bodies (for example the NHS Litigation Agency (NHSLA), the Care Quality Commission (CQC), Quality Improvement Scotland (QIS), Health Inspectorate Wales (HIW) and Regulation and Quality Improvement Authority (RQIA)).

Reports from medical schools and deaneries to the GMC

79 All medical schools are required to submit a report to the GMC in the required time and structure, which will be detailed in the operational guidance. Medical schools are required to complete an enhanced annual report (EAR) which allows the GMC to monitor progress towards implementation of Tomorrow's Doctors (2009).

80 Due to the nature of postgraduate medical education and training within the clinical environment, the GMC is moving from collection of historical data to real time shared data based on current training. Deaneries will therefore be required to update their reports and associated action plans at six monthly intervals and report any patient or trainee safety and immediate risks through the responses to concerns element of the QIF.

81 Reports from both medical schools and deaneries should set out how the issues identified through external scrutiny, for example GMC visits, are being addressed. They should also set out the outcomes of local QM they have carried out and QC undertaken by LEPs and other partners delivering medical education as part of the medical school's programme/s. Deans must be able to provide evidence to support their action plans if requested by the GMC.

82 An action plan in response to GMC visits and local QM and QC activity should be submitted as part of the school/deanery report. Medical schools and deaneries should take prompt and effective action (where appropriate) in response to all QA, QM and QC activity. Through their QM, medical schools and deaneries should be aware of the issues affecting medical education and training for their students and trainees and ensure that the responses are proportionate, measured and evaluated. Action plans are a useful tool to show improvement and dissemination of good practice as well as how problems have been addressed.

83 Medical school and deanery action plans will be published on the GMC's website at www.gmc-uk.org/education.

84 Specific additional information may be requested to support analysis of risk, concerns and good practice. These requests will be kept to a minimum.

85 Wherever possible, the GMC wants to receive and use data that are gathered once and used for all partners. Information will be shared once all data protection issues have been fully addressed.

Annual specialty report from medical Royal Colleges and Faculties to the GMC

86 The GMC receives information from Royal Colleges and Faculties in the form of annual specialty ASRs. The reports provide an essential specialty perspective, a national overview by specialty and subspecialty, and will be particularly useful for small specialties.

87 A pro forma is provided to assist medical Royal Colleges and Faculties to structure their reports. The reports should focus on analysis of information from activity such as national exams, training courses, externality the college or faculty has provided to deanery QM activities such as attendance on a deanery visit to an LEP.

88 The report should identify good practice, concerns and trends by deanery, LEP, specialty programme and country from the perspective of the Royal College/Faculty. The specialty expertise of the Colleges and Faculties is crucial and the GMC will seek their advice on areas of risk to curriculum delivery and assessment systems. This could take the form of, but is not constrained to, comments in the ASR which contribute to the evidence base for identifying risks to be investigated, contribution of questions for the national surveys and/or questions to be addressed during visits and raising concerns.

89 Royal Colleges and Faculties need to work with deaneries to share appropriate information to inform QM and QC and to ensure the annual reporting to the GMC is accurate and informed.

Surveys

90 The GMC's national training surveys are an important part of the evidence base because they reveal perceptions of training from both trainer and trainee perspectives by country, deanery, specialty including GP training, foundation programme, graduating medical school and at a local level. The findings of the surveys may require action by deaneries, which will be monitored by the GMC through reporting, results of future surveys, trends and visits. Findings will also inform the GMC's visits and responses to concerns.

91 While the surveys are an important source of evidence, their outcomes must be viewed in the context of all four elements of the QIF. Deaneries have access to a range of evidence and QM should not focus entirely on the surveys.

92 The trainee survey asks trainee doctors to reflect on their undergraduate education, for example their preparedness for medical practice. Data from survey items which relate to undergraduate medical education will be shared with medical schools.

93 The GMC has identified the points of transition (from medical school to the foundation programme, from the foundation programme to specialty including GP training and from specialty including GP training to CCT) as points of potential risk. As a result, we also survey these groups.

94 The surveys of trainees and trainers enable the GMC to identify, at a national level, aspects of medical education and training which require further investigation as potentially good practice and which may need to be improved. Survey reports are sent to deaneries, Royal Colleges and Faculties and LEPs; outcomes of the surveys are published and available online.

National survey of trainee doctors

95 The survey provides a snapshot of trainee doctors' perceptions of their training posts and programmes providing the GMC with invaluable information to help monitor changes to the training environment. Feedback from the survey helps shape the future of postgraduate medical education in the UK. The trainee survey has specialty-specific questions, as well as questions relevant to the GMC standards for postgraduate medical education and training.

National survey of trainers

96 The GMC also conducts a survey of all trainers in the UK, including those who train medical students, foundation doctors and specialty trainees. The national survey of trainers aims to collect evidence on whether trainers are able to undertake their duties as trainers effectively, how these duties are formally recognised in job plans and training, and how supported trainers feel in their role. Trainers are considered to be experienced practitioners who are involved in training and supervision in the workplace. Trainers therefore include educational supervisors, clinical supervisors and other doctors and qualified professionals providing clinical supervision of medical students and doctors in training.

Development of the surveys

97 The GMC will develop the surveys function further. For example we will pilot reflective evaluation by newly qualified GPs and consultants of how their training programmes prepared them for their roles.

98 By developing existing or introducing supplementary surveys we will be able to produce better information about graduates' preparation for practice. This will be used to inform the GMC's work and will also be provided to partners.

99 The GMC will also investigate how best to collect data regarding small specialties where the small number of trainees precludes us from reporting survey results.

Visits including checks

Key messages

- Visits will be designed on an individual basis to reflect the differences between deaneries and medical schools and will be targeted towards areas of risk.
- Visits will be coordinated across all stages of medical education and training within a region.
- Thematic QA will be explored both within visits and by undertaking supporting activities.

100 All medical schools have been visited once since 2004 and most deaneries have been visited three times (and at least twice) in the five years before the introduction of this QIF. The evidence submitted to the GMC shows that QM within these institutions is maturing and quality systems are becoming embedded. But the outcomes of previous visit cycles suggest that the development of QC within LEPs is less developed at both undergraduate and postgraduate level. The GMC will therefore agree a yearly programme of visits across the UK where the order in which institutions will be visited and the areas for exploration during visits are identified using the evidence base. These visits will share good practice, review medical school and deanery management of concerns and investigate other areas as indicated by the evidence base.

101 The GMC has gathered feedback about visits and suggestions for improvement from medical schools, deaneries, GMC visitors and other partner organisations during 2009 and 2010. As a result, we will pilot an aligned and enhanced visits programme in 2011 and 2012 which will achieve the following.

(a) Employ a mixed and flexible model to QA for medical schools, deaneries, themes (for example, assessment) and small specialties against the GMC standards, requirements and outcomes.

(b) Take a regional approach to visiting, so that all medical schools and deaneries within a particular geographical area will be visited within the same cycle.

(c) Bring together the QA of foundation and specialty including GP training into one process.

(d) Use time and resources appropriately so that the benefits of the process to medical schools and deaneries outweigh the burden of preparing for a visit.

(e) Recognise that there needs to be some differences between the QA of undergraduate and postgraduate medical education and incorporate this in the process.

(f) Take into account evidence from all elements of the QIF and from other regulatory bodies and reduce the need for the provision of evidence immediately before a visit. Orientation documents provided by the schools and deaneries before a visit will be reduced in size to reflect this.

(g) Target areas for consideration where appropriate, rather than examination of areas that the evidence base shows are already working well.

(h) Have the capacity and flexibility to respond where the evidence base suggests there is a need with more and enhanced QA activity where there is greater risk, particularly to patients, students and trainees.

(i) Be subject to continuous evaluation and improvement.

102 While the individual unit being reviewed will remain the medical school or deanery, we will coordinate our work across stages to give a regional view of both undergraduate and postgraduate medical education and training and so will also engage with more LEPs. Where only a small or a few risk/s has/have been identified this will be reflected in the size of team and the duration of the visit.

103 Themes for exploration, identified through the evidence base, may form part of the action plan for all visits or a discrete visit.

104 The visit process will be supplemented by a range of activities. The GMC is aware that a meeting may not be the best and most cost effective means of exploring a potential risk. So we will also employ technology with the use of videoconferencing, podcasts and online forums for visit teams to share analysis.

105 The 2011-2012 pilot visits to medical schools will verify schools' compliance with Tomorrow's Doctors (2009), particularly in areas where the new edition of Tomorrow's Doctors sets standards that differ significantly from the previous edition. Visits will also address schools' QM of clinical placements and student assistantships within LEPs and will inform postgraduate visiting.

106 The 2011-2012 pilot visits to deaneries will cover foundation training, and specialties where the evidence base suggests that there is a need for verification of the deanery's compliance with the standards. There will also be an increased focus on deanery QM of QC within LEPs, how this is monitored and how deaneries ensure that problems identified have been resolved.

Regional visits

107 The 2011-2012 pilot visits to deaneries and medical schools will achieve the following:

- **(a)** external scrutiny and verification of self assessment made in school/deanery reporting to the GMC
- **(b)** peer review, including the benefit of lay, student, trainee and employer visit team membership
- **(c)** published reports which inform students, trainees and the public about the quality of the provision of undergraduate and postgraduate medical education and training
- **(d)** consider improvements made by medical schools and deaneries in response to visit reports.

Thematic quality assurance

108 Thematic QA sits within the visits element of the QIF, but can also be addressed through the evidence base, inclusion of items within regional visits to medical schools and deaneries, discussion at regional or national meetings and research. Thematic QA will be bespoke and proportionate to the risk identified.

109 Themes for investigation are identified through the outcomes of visit reports, the national surveys, suggestions that there are UK wide areas for investigation and targeted analysis of medical school, deanery and specialty reports.

Checks

110 An additional way that the GMC may monitor the quality of training and the compliance of medical schools, deaneries and LEPs is through the use of targeted and random checks, which will be outside the normal cycle of visits. Checks made through random selection are in line with the principles of good regulation and are a useful tool to examine the effectiveness of the QIF as well as monitor a specific area of interest when a regional visit is not imminent but concerns do not warrant a triggered visit. The GMC will conduct such checks with medical schools, deaneries or LEPs to explore, for example, the identification of exceptions, progress on agreed actions, or to examine information that is being collected. Targeted checks will allow the GMC to respond to areas of risk, rather than a concern, which warrant exploration outside of the cycle of visits but do not require a triggered visit.

111 Checks will help to test the accuracy of the annual reports and monitor the efficacy of the visits to medical schools and deaneries and may, for example, include verification of documentation supporting an action plan.

112 Checks will sit alongside the visiting and responses to concerns processes. The GMC might request information or undertake a targeted visit out of cycle if the evidence base suggests an area for exploration. We might also undertake random checks from time to time.

Composition of GMC visit teams

113 The visitor teams for the 2011-2012 pilot visit will always include a team leader, a member with direct medical school or deanery experience, a student or trainee and a lay member. The GMC and team leader will agree, dependent on the risks identified for exploration, the skills and experience required of the remaining team members. The pool of visitors available will include:

(a) medical educationalists
(b) medical specialists
(c) foundation training programme directors (or equivalent)
(d) employers
(e) specialty trainees
(f) foundation doctors
(g) medical students
(h) lay members.

114 Although teams may not include a specialist from the specialty being visited, there will be specialty support in place for the duration of the visit through the Royal College/Faculty or GMC Associate from that specialty.

Responses to concerns

Key messages

- Raising a concern is not a punitive process. The GMC will work with partner organisations to resolve training problems before considering withdrawal of approval.
- As part of the risk based approach it will be increasingly important for partners to raise concerns.
- The GMC should be advised of local responses to concern through the exception reporting process, or immediately if students or trainees have been withdrawn from posts/ placements.
- The response to concerns process allows the GMC the agility to take proactive action when evidence of concerns about risks to patient, student and trainee safety and the quality of medical education and training are raised, outside of scheduled QA activity.

115 The fourth element of the QIF is the GMC's range of responses to concerns that standards for medical education and training are not being met. Through our responses to concerns, the GMC will ensure patient, student and trainee safety and high quality medial education and training.

116 Concerns can be identified through the GMC's evidence base or raised by anyone (patients, students and trainees, deaneries, medical schools, medical Royal Colleges and Faculties or by external bodies). As the QIF becomes even more risk based, the importance of the response to concerns element increases, as does the requirement for partners to report areas of concern.

117 While the final sanction will normally be withdrawal of approval for training, responding to concerns should not be seen as punitive. As with all elements of the QIF, the purpose of engagement with partners about concerns is to maintain the quality of all stages of medical education and training. All responses to concerns are normally undertaken by the GMC working cooperatively with a medical school, deanery, an LEP and the relevant Royal College and Faculty if it is a specialty-specific concern.

118 When a concern is identified, we will assess its validity against the appropriate GMC standards, with the medical school and/or deanery, or with multiple schools and/or deaneries where appropriate.

119 The actions we may take in response to a concern include:

- **(a)** seeking a response from the medical school and/or deanery to find out what is being done about a concern
- **(b)** examining the evidence base to determine whether an issue has been resolved
- **(c)** continuing to monitor progress in addressing the issue
- **(d)** undertaking a GMC-triggered visit to examine the issue and prompt a quick response
- **(e)** initiating withdrawal of approval for training.

120 If we are satisfied with the deanery or medical school's approach to the concern, it may be determined that no further regulatory action will be taken but monitoring updates may be required. Local resolution of issues is always encouraged and medical schools and deaneries are also encouraged to work together to investigate and respond to concerns about training in LEPs. Medical schools and deaneries should make use of available options to arrive at local solutions for concerns, including withdrawing students and trainees from posts/placements where training is not meeting the standards.

121 The deanery or medical school should notify the GMC immediately if students/trainees are withdrawn from a post or placement.

122 Once a concern is established, typically the process will be:

- **(a)** the GMC will contact the medical school or deanery directly to ask for a formal account of the issue, a summary of actions taken so far, and a timeline for future actions
- **(b)** assessment by the GMC of the action planning by the medical school, deanery and, where appropriate, the LEP

123 This assessment may result in one or more of the following options.

- **(a)** Action planning and monitoring of progress in addressing the issue: this will involve direct correspondence between the GMC and medical schools/deaneries to investigate the concern, and action plans may be requested within given timelines.
- **(b)** Organising a meeting for the regulator to meet with medical schools, deaneries, or other relevant staff, for example from LEPs: this option offers an immediate assessment by representatives of the GMC and may be undertaken in a situation where either:
  - **i.** a more rapid response than a full, triggered visit is required, or
  - **ii.** a triggered visit may not be necessary to resolve the issues, but detailed discussion with the regulator is required.
- **(c)** A triggered visit taking place to further examine the issue and prompt an effective response.
- **(d)** A full visit to the medical school, deanery, and where appropriate the LEP, could be organised and undertaken to investigate the concern in considerable depth and breadth. This would normally be undertaken only if the concerns indicated more widespread or fundamental problems at medical school or deanery level.

124 The GMC reserves the right to take any actions it considers necessary whenever direct or indirect evidence indicates a possible problem with medical education and training.

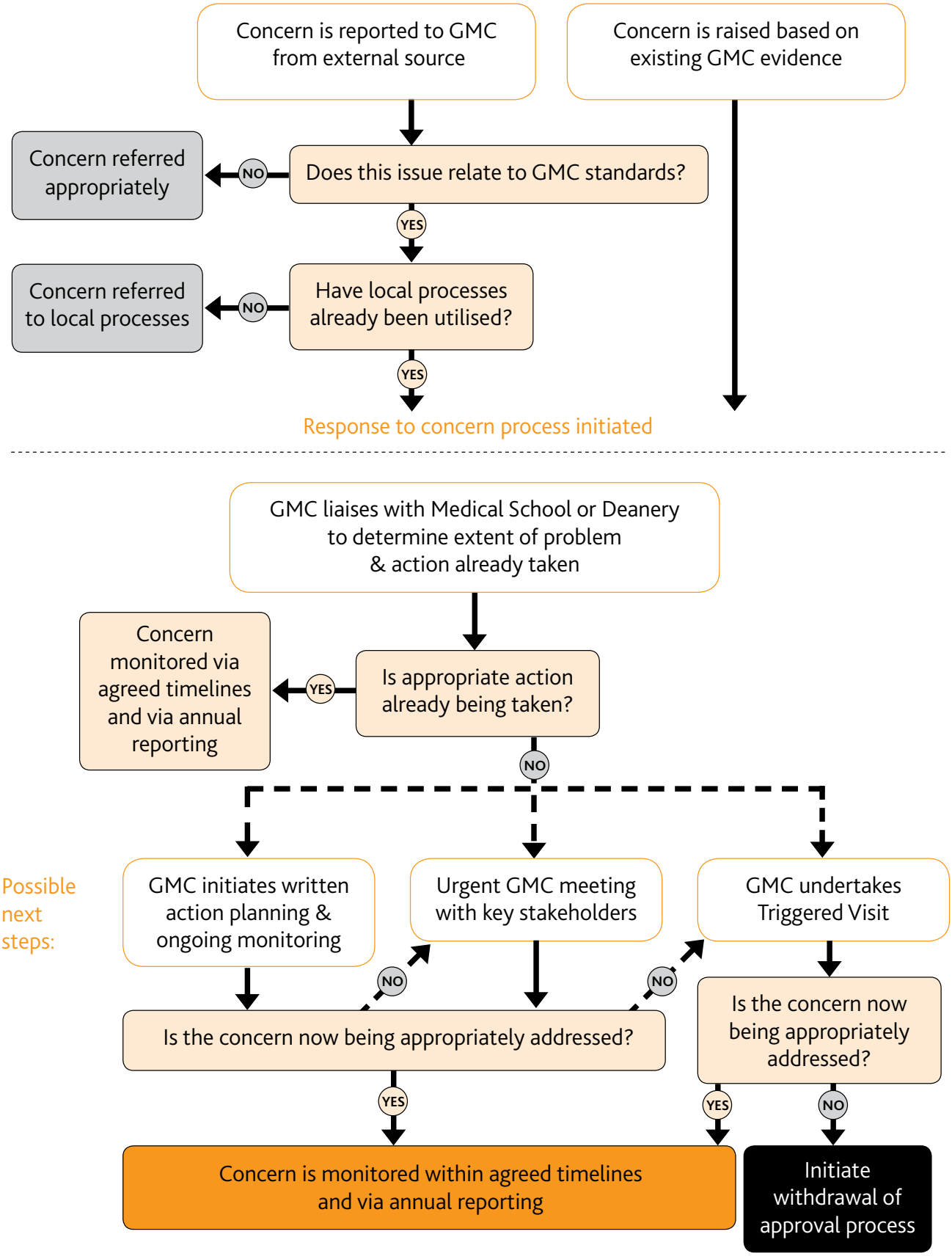
Triggered visits

125 Triggered visits are undertaken to investigate possible serious educational failure or risk to patient or trainee safety. Examples of such issues include:

- **(a)** serious and persistent lack of supervision
- **(b)** students or trainees being persistently required to undertake tasks for which they are not competent
- **(c)** lack of opportunity for students or trainees to learn new skills under supervision such that they are unable to reach the required competences
- **(d)** failure of the medical school, deanery or employer to tackle behaviour by educators, trainers or colleagues that is undermining students' or trainees' confidence and could lead to unsafe practice.

126 Triggered visits are arranged by the GMC in partnership with a medical school or deanery, a local education provider if appropriate, and, in the case of specialty or GP, the relevant Royal College or Faculty.

Responses to concerns process



Good practice

Key messages

- Identification and sharing of good practice is vital in quality improvement.
- We will continue to use multiple mechanisms to share good practice in an accessible way.

127 Good practice includes areas of strength, good ideas and innovation in medical education and training. Good practice should include exceptional examples which have potential for wider dissemination and development, or a new approach to dealing with a problem from which other partners might learn. The sharing of good practice has a vital role in driving improvement, particularly in challenging circumstances.

128 We have gathered information on good practice across the UK in a number of ways:

(a) from medical schools, deaneries and medical Royal Colleges/Faculties, in their self assessed reports and action plans
(b) through the submission of curricula
(c) from visit teams during QABME, QAFP and VTD visits.
(d) through the national trainee/trainer surveys.

129 Good practice identified through these processes is published in visit reports and in The State of Basic Medical Education: Reviewing quality assurance and regulation and the Notable Practice in Specialty including GP Training Report 2010. The Tomorrow's Doctors Implementation Workshops, which brought together employers, medical schools, deaneries and students, also provided a valuable opportunity to identify and share good practice across different stages of medical education and training.

130 We will continue to use multiple mechanisms to share good practice in an accessible way. These will include:

(a) greater sharing of outcomes data such as on progression through the stages of medical education and training
(b) greater use of benchmarking so that medical schools, deaneries and LEPs can see at a glance how the training they are responsible for compares to training in other locations
(c) publishing learning points reports and good practice reports
(d) sharing case studies
(e) face to face events to discuss the sharing of good practice
(f) using networks for quick feedback on the scope for sharing good practice identified in quality assurance activities
(g) embedding peer review within visit processes.

Governance

Key messages:

- A core group will scrutinise the QIF operational outcomes in detail. This group will include both experts in medical education and assessment systems and those who make recommendations to the GMC Boards on trends, policy and process issues and where training is not meeting the required standards.
- The GMC Boards will continue to develop policy and make decisions on approval or withdrawal of approval.

131 The GMC's Education Quality Team and GMC Associates carry out significant and detailed operational activity which requires expert scrutiny. In order to ensure an efficient use of resources, a consistent and rigorous approach throughout and a proper overview of trends, a single Quality Scrutiny Group will advise the GMC.

132 The GMC's Council and Boards will continue to develop policy across the different stages of medical education and training and make decisions on approval or withdrawal of approval of bodies responsible for medical education and training locally.

Glossary of Terms

Approval	Granted by the GMC to bodies; programmes, curricula and assessment systems, for the purposes of the QIF approval is synonymous with recognition and determination.
Condition	Placed on approval, if conditions are not met the GMC will take steps to withdraw approval.
Deaneries	The bodies currently commissioning and delivering postgraduate medical education and training within the UK.
Foundation programme	The Foundation Programme is a two-year generic training programme which forms the bridge between medical school and specialist/general practice training.
Operational guidance	Supplementary documentation provided by the GMC to explains the processes and elements of the QIF for those with an active role in medical education and training.
Requirement	An outcome of a quality activity, such as a visit, where a medical school or deanery is failing to meet the relevant GMC standard. Failure to meet requirements can lead to conditions being placed on approval.

Acronyms

ADR	Annual Deanery Report
ASR	Annual Specialty Report
CCT	Certificate of Completion of Training
CEGPR	Certificate of Eligibility for GP Registration
CESR	Certificate of Eligibility for Specialist Registration
CHRE	Council for Healthcare Regulatory Excellence
CQC	Care Quality Commission
DHSSPS	Department for Health, Social Services and Public Safety
EAR	Enhanced Annual Return
EU	European Union
GMC	General Medical Council
GP	General Practice
HIW	Health Inspectorate Wales
LEP	Local Education Provider
MSC	Medical Schools Council
NES	NHS Education for Scotland
NHS	National Health Service
NHSLA	NHS Litigation Authority
OOPR	Out of Programme Research
OOPT	Out of Programme Training
PMETB	Postgraduate Medical Education and Training
PMQ	Primary Medical Qualification
QA	Quality Assurance
QAA	Quality Assurance Agency for Higher Education
QABME	Quality Assurance Basic Medical Education
QAFP	Quality Assurance of the Foundation Programme
QC	Quality Control
QF	Quality Framework
QIF	Quality Improvement Framework
QIS	Quality Improvement Scotland
QM	Quality Management
RQIA	Regulation and Quality Improvement Authority
SHA	Strategic Health Authority
PCT	Primary Care Trust
UK	United Kingdom
UKFPO	United Kingdom Foundation Programme Office
VTD	Visits to Deaneries
WAG	Welsh Assembly Government

LONDON
Regent's Place, 350 Euston Road, London NW1 3JN

MANCHESTER
3 Hardman Street, Manchester M3 3AW

SCOTLAND
5th Floor, The Tun, 4 Jackson's Entry, Holyrood Road, Edinburgh EH8 8PJ

WALES
Regus House, Falcon Drive, Cardiff Bay CF10 4RU

NORTHERN IRELAND
9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

Telephone 0161 923 6602
Email gmc@gmc-uk.org
Website www.gmc-uk.org

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