How can good regulators effectively quality assure education and training?

General Medical Council

GMC Education quality assurance review

Paul Clayton

UCL Stakeholder research

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Working with doctors Working for patients

UCL Medical School
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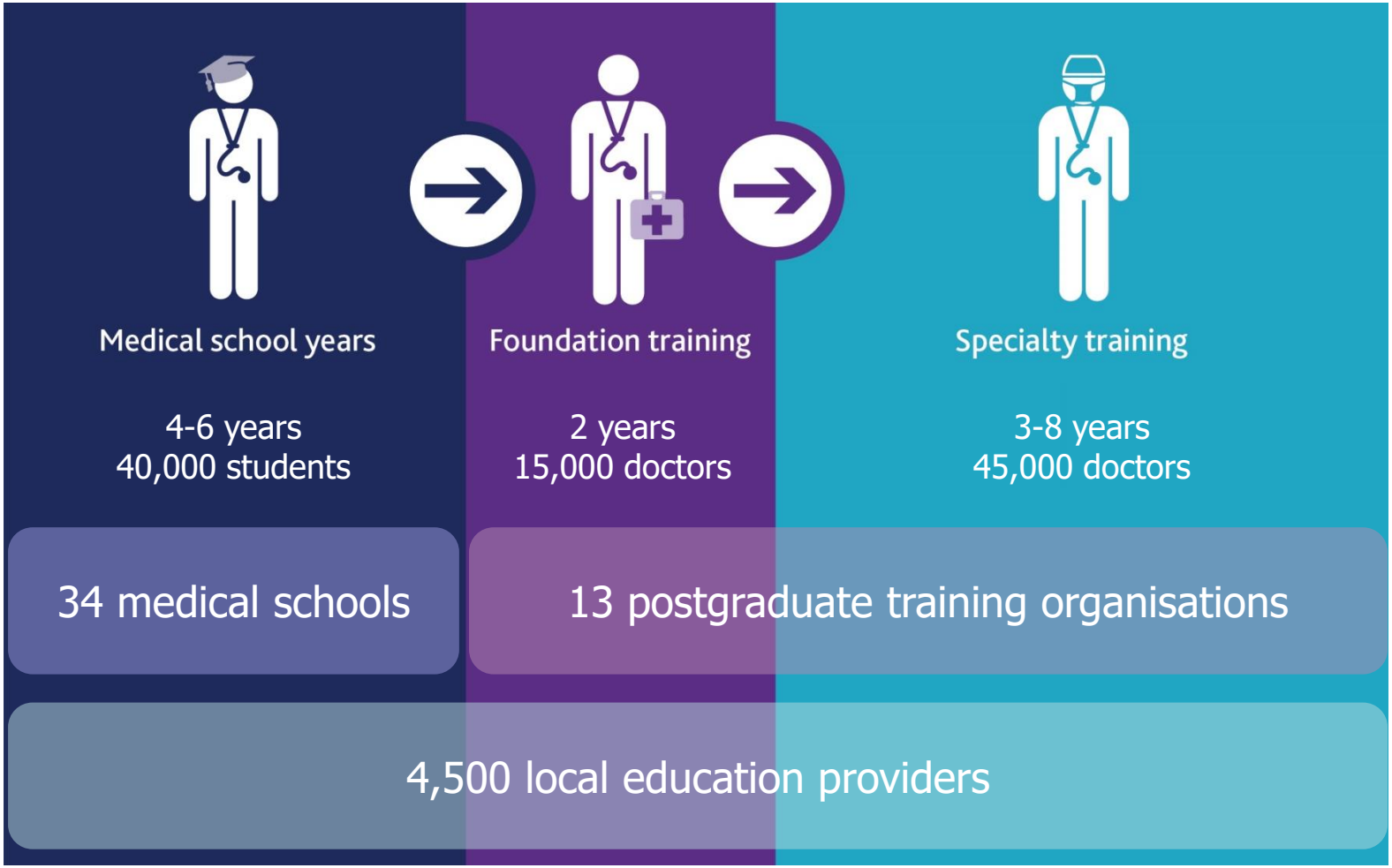
Research Department of Medical Education

Training pathway



Organisations in our QA structure

General Medical Council

Checks that medical schools and postgraduate organisations meet GMC standards

Quality assurance

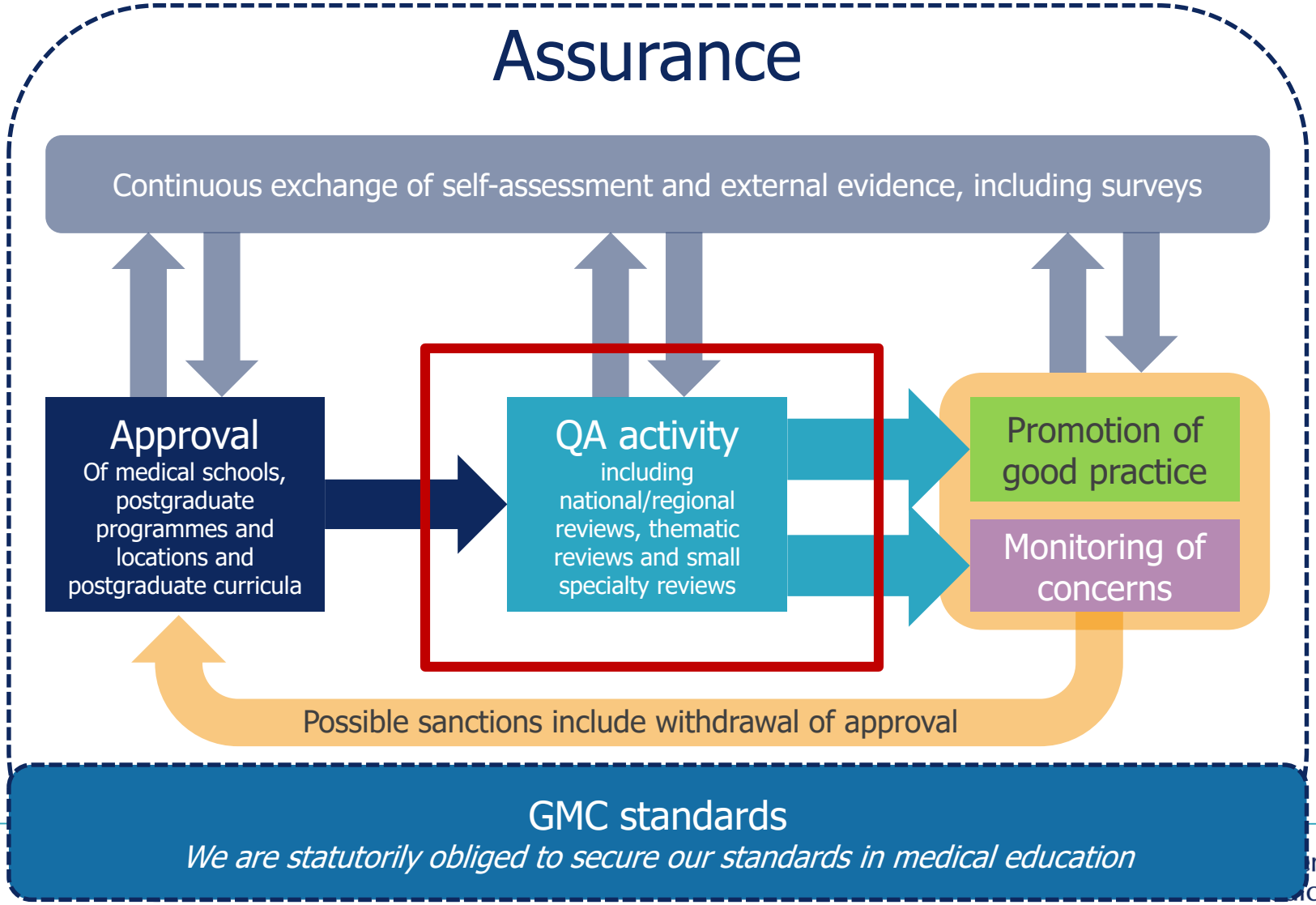
Medical schools and postgraduate training organisations conduct quality management activity to ensure that local education providers meet GMC standards

Quality management

Around 4,500 local education providers deliver education and training that meets GMC standards

Quality control

Assurance is achieved through a variety of activities



Assuring the quality of undergraduate and postgraduate UK medical education: an evaluation

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Purpose of research

- To synthesise a wide range of perspectives from key stakeholders about the effectiveness of GMC's current quality assurance processes

- To highlight aspects of quality assurance under review or being developed by other regulators

Research questions

1. What are the **strengths and weaknesses** of the GMC's quality assurance framework?
2. What suggestions, if any, do stakeholders have for **improvement**?
3. What are stakeholder's views on the **quality assurance of standards for equality and diversity?**
4. How **effective and proportionate** is the approach to quality assurance?
5. Would **collaboration** with other professional bodies/ system regulators improve effectiveness and proportionality?
6. How does the GMC's approach align with current **best practice** in quality assurance?

Methods

- Rapid literature review
- Telephone interviews
- Case studies

Stakeholders

Undergraduate and postgraduate medical settings including Royal Colleges

Other medical stakeholders and system regulators

Other professional regulators: non-medicine and education

Partners and non-partners

Quality assurance partners (QAPs)

Medical schools **(QAUG)**

Deaneries/LETB **(QAPG)**

Royal Colleges **(QARC)**

Non-quality assurance partners

Medicine: Membership organisations and healthcare systems regulators **(HealthMed)**

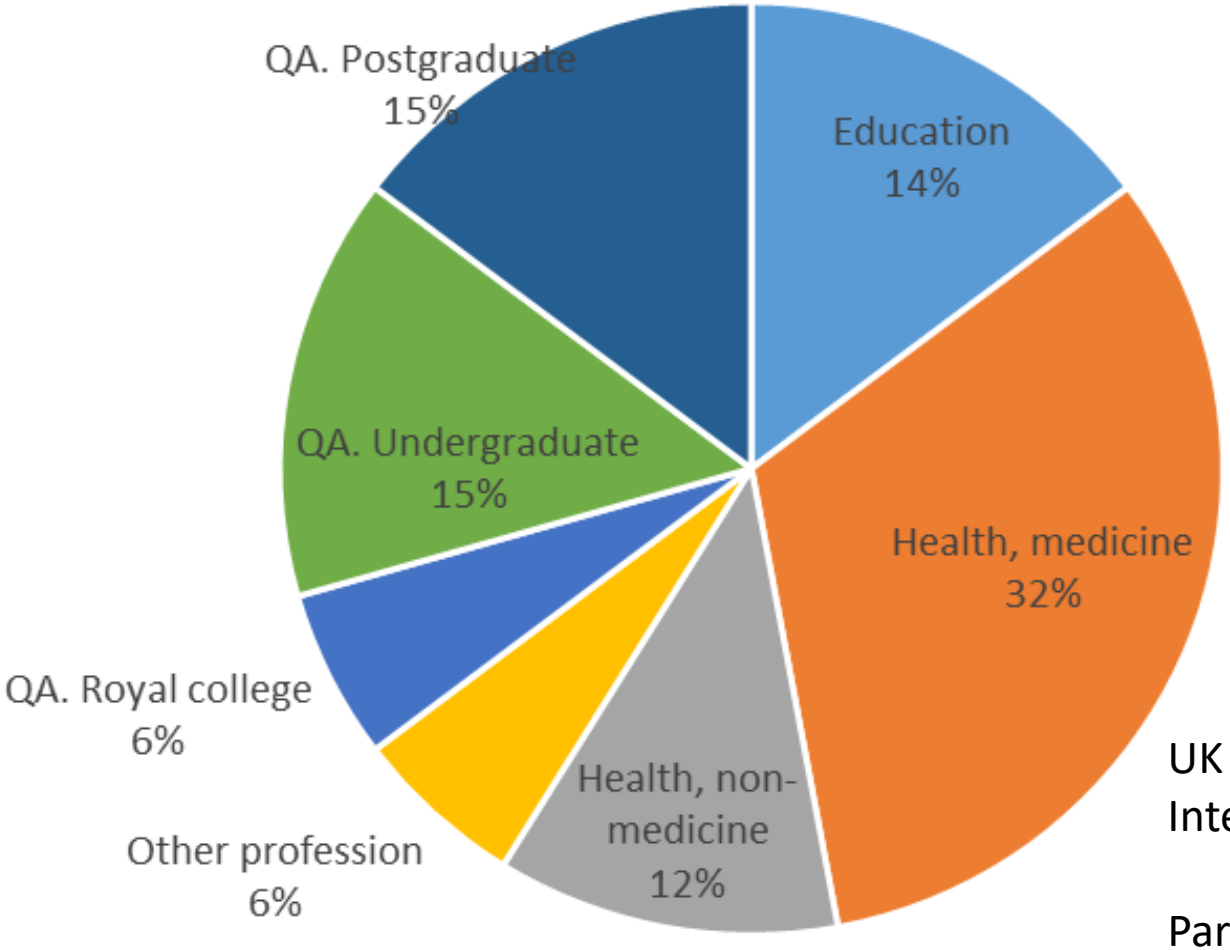
Other healthcare regulators **(HealthNon-med)**

Education regulators/bodies **(Education)**

Other professional regulators **(Professional)**

Results

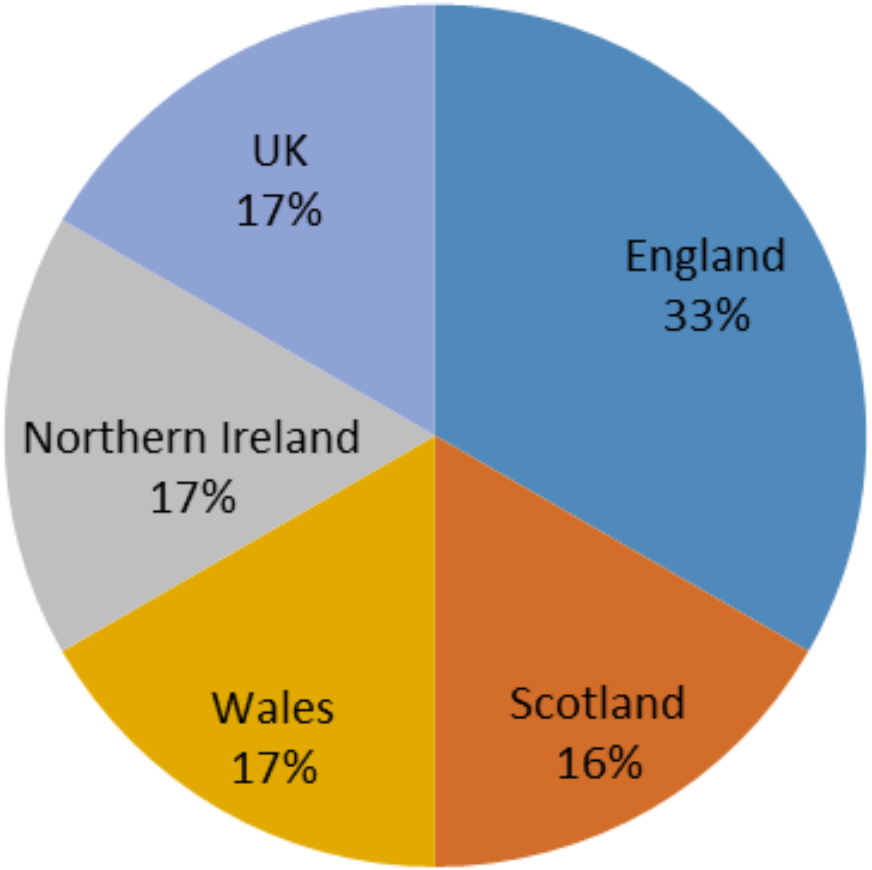
Sample of interviewees (N = 36)



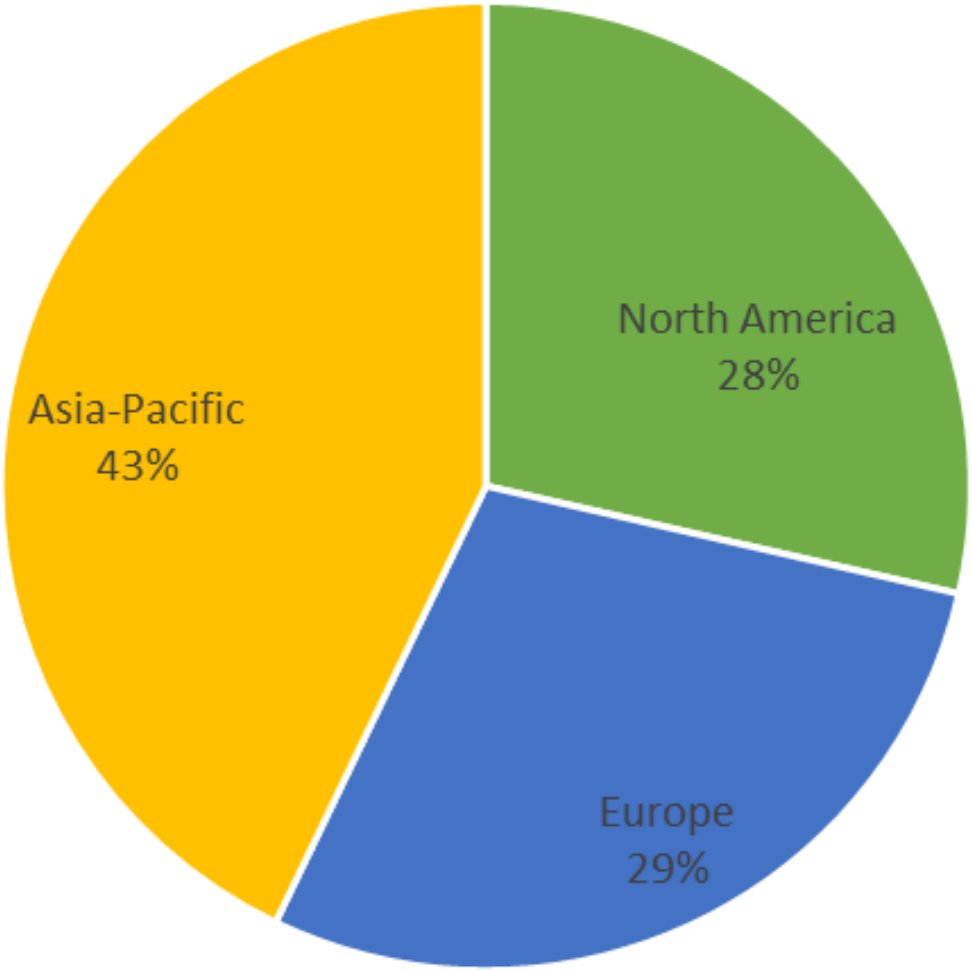
UK = 79%
International = 21%

Partners = 35%
Non-partners = 65%

Sample breakdown of QA partners by geographical area



Sample breakdown of international stakeholders by geographical area



Results: Comparative analysis

- Throughout the analysis we compared themes by the different stakeholder groups
- Main differences between QAP vs non-QAP organisations
- QAPs had critical insights from **directly experiencing** QAF
- Non-QAPs spoke more **theoretically** and largely referred to their own QA processes

What were the strengths of the overall approach?

- The comprehensiveness of the QAF;
- The influence of the GMC;
- The national training survey;
- Informal relationships.

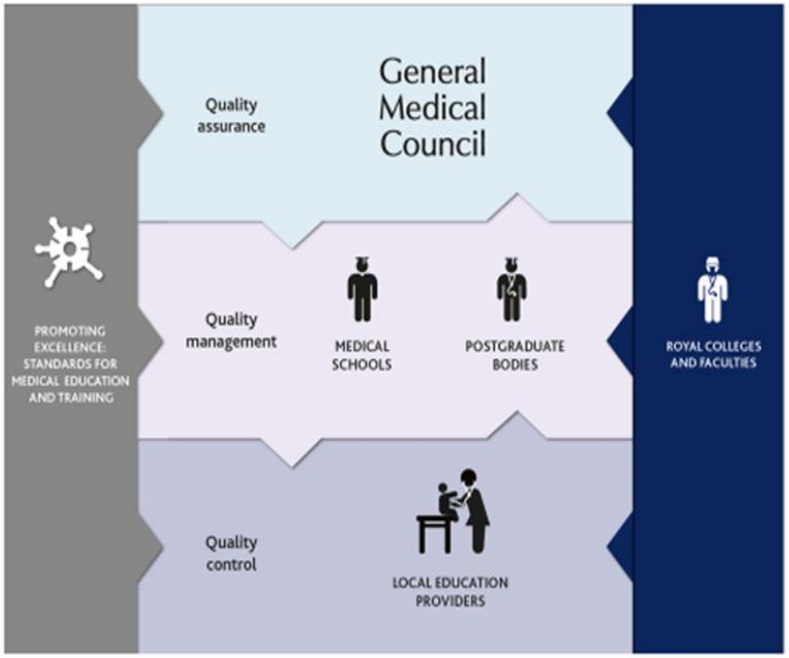
I believe a lot of national and international organisations aspire to the GMC standards. HealthMedINT34

We have a very good working relationship with the GMC team based here in [location]. So in terms of sharing it, sometimes evidence will come via that office and it's always immediate, as soon as they get it, we get it. QAPG12

So we talk about having this annual discussion meeting and it's largely about relationships... Well, it's got a very important relationship building function. EducationUK17

What were the weaknesses of the overall approach?

- The conflicting nature of multiple QAFs;
- Working across the three tier model;
- Communication, formal reporting routes and lack of feedback;
- Data-driven approaches to QA



I suspect [PG organisation] ignores them because they've come up with their own quality framework. QARC3

Clarifying why we need slightly different things, and sometimes it's about one or other of us saying, well, if you're producing this piece of information for that body, then that's good enough for us and we won't ask you to do the same thing again. EducationUK17

How does the GMC's assurance work differ or complement or overlap with that of other players, such as the CQC... Other aspects for me would be around how the GMC promotes consistency among the other organisations in the three-tier model. EducationUK31

At the moment, they're [GMC] looking [at] trainee burnout. So they're generating all this data at the moment and I don't think they're clear about what they're going to do with it, and my concern is they will just dump it on us for us to fix, and I don't think we can. QAPG10

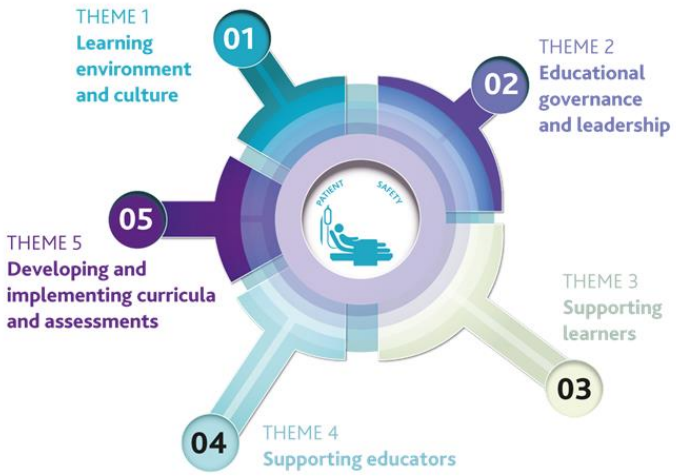
Effectiveness of different quality assurance activities…

Standards

Clear guides of what should actually be happening in the trainees' day-to-day lives and in the arrangement and management of education, the leadership and the governance of education. QAPG16

It has allowed UK medical schools within the framework to differ in how they implement that framework. HealthMedINT1

The language that they are using in the standards, in comparison with the other regulators, it's straightforward. You know, we can read those standards and cut to the chase. We know what they are looking for. QAUG29



Approvals

- Definition of “approval” unclear and when it’s required
- UG partners more positive than PG partners about approval process
- Moving to time-limited met with mixed views

✓ more accurate record keeping of training sites

✗ Impractical in medical schools

Sanctions

The “nuclear options” should remain, with an incremental approach

It’s a bit of a lightning rod situation, but I think it should remain as the ultimate sanction…If trust management realised for example that they wouldn’t lose their trainees as a result of not providing a safe and effective training environment… I think [it would] slip further down their list of priorities. QARC24

So, there’s sort of an approach that gives a warning notice, then you get the conditions, then after that it is the really serious enforcement stuff which is proposal to close an organisation. HealthMedUK26

Monitoring

- Monitoring had an important role in keeping organisations ‘on their toes’ (HealthMedUK23)
- Monitoring took account of large data-sets, from a range of perspectives but it was noted that their were markers of concern including change of leadership
- Non-QAPs felt that self-assessments were a crucial part of QA
- Done well its gave regulators trust in the organisation

A vital and pivotal element in anything regarding quality assurance because this is the way an institution connects itself with given standards
EducationINT32

Self-assessment: the QAP perspective

Less positive, criticisms included:

- Time-consuming, tick-box exercise
- Lack of clarity about what is required and providing the ‘wrong data’
- Does not reflect contextual differences
- A lack of feedback making the exercise seem less meaningful and QAPs felt undervalued and disengaged

An absolute nightmare…over the years…it seems to get worse rather than better. QAPG10

Enhanced monitoring

QAPs often considered it problematic:

- A real sense of confusion about what enhanced monitoring actually was in practice and how an organisation could be put ‘under’ and then later ‘escape’ this process
- Some found the leverage of the GMC helpful to effect change
- Trust versus surveillance the mechanisms which appeared to influence effectiveness.

The GMC seem to be very reluctant to take a specialty out of enhanced monitoring. QAUG5

Visits: strengths

- Visits are a very important part of the QAF
- Allow regulators to get ‘a feel’ of the organisation, verify data, meet other key stakeholders
- Visits triggered an internal review process;
- Respected and trained visiting teams were deemed crucial
- Working in partnership and trust essential for making them meaningful

I was prepared to be completely open and honest with the GMC…If [visits] are going to be effective, relationship building is actually more important than what you're doing collecting evidence. HealthMedUK21

We put the inspectors under quite a lot of pressure actually because we are asking them to evidence-base their judgements…the quality assurance panels are quite intense from the inspector's point of view and they have to present their findings. HealthMedUK26

You're there onsite just to answer any questions and help the group out. So, …to provide technical assistance…it's sort of an inverse risk thing, where someone believes they have risk and they reach out to us and ask for assistance. HealthMedINT20

Visits: weaknesses

- Had significant workload issues
- Failing organisations being visited by more than one regulator
- Unintended consequences and felt as punishment
- The impact of visits could be undermined by unclear objectives, inadequate evidence, unclear assessment frameworks, under resourced visiting teams, miscommunication and being too superficial.

There's got to be an element of having a **look a little bit further. QAUG19**

The GMC's approach to reporting

Non-QAPs were positive

- Transparent
- Accessible
- Providing public confidence

QAPs were more critical

- Unbalanced, reporting minor issues
- Out of context – comparing 'apples with pears'

I don't think there's a huge sense of kind of putting reports in context and linking them up. There's a tendency to sort of throw them out there and, I think, in some ways hope it has some value. QARC3

To discuss later…

The good regulator:
key trends in quality assurance

Accountability versus enhancement?

The majority of stakeholders reported that the current trend within quality assurance is an enhancement-oriented approach.

As such, stakeholders felt that resource allocation should favour enhancement activities.

Why?

- Good standards
- Enhancement more likely to effect change
- Fits in with a prevention agenda
- Celebrate the success of those doing well

Those in favour of accountability

- Did not feel minimum standards were uniformly present
- Stressed the patient safety context
- QAPG partners emphasised the important role of scrutiny

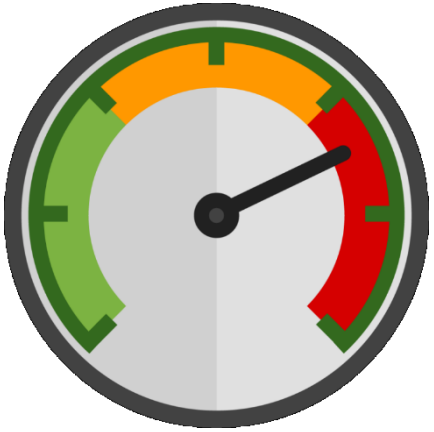
Encouraging enhancement approaches

- Internally driven
- Require leadership and resources
- The role of the regulator is to assess organisational awareness
- Act as a signpost

Proportionality & Risk

- Is the GMC's approach to QA medical education and training proportionate to the risks involved?

- Context dependent



- Perceived differently inside vs outside medicine (patient safety)

- Perceived differently in UG vs PG medicine (patient safety)

Risk-based versus Cyclical visits

- A hot topic!
- The risk-based approach was more economical
  - Putting resources into organisations that needed them the most
  - Catching organisations who are struggling and thereby making the greatest difference
  - Some organisations, inside and outside of healthcare, had already adopted an entirely risk-based approach

- However
  - Misses identifying and sharing good practice;
  - Inappropriate in healthcare because it would mean intervening too late

Sharing good practice & collective assurance

- Good to share
- But, what is good practice? One organisations idea of good practice is not necessarily another's…its contextual
- Opportunity to reduce workload and improve efficiency by streamlining processes
- In theory its useful, but has practical challenges
- Not commonly practised yet, no evidence
- Monitoring an area ripe for collective assurance
- However, some regulators did QA together and offered learning opportunities

Opportunity to learn more effective ways of doing things from inspectorates.
EducationUK31

Stakeholder suggestions for improvement…

- Clarity on **roles and boundaries** across the three tier model
- **Streamlining processes**
- **Self-assessmen**t - shorter returns and greater feedback which would lead to greater engagement
- The GMC to provide clearer guidance about interpreting and **demonstrating compliance with the standards**
- Use of **existing data**: for example, the NSS could compliment the GMC's monitoring processes
- **Internal quality assurance mechanisms**: more explicit guidance about how the GMC internally quality assures its activities; how it makes and moderates judgements, trains its visiting team

Key findings

- Insights differed between partners and non-partners
- GMC commended for having comprehensive processes
- Largely proportionate to risks, but could be improved by tailoring activities
- Role and remit confusion caused by the three-tier model and working with other regulators
- Multiple QAFs not well aligned creating duplication and confusion
- Workload burden of monitoring activities, unclear purpose, little feedback

Key findings

- Risk is context dependent, opportunities for tailored activities, its tangibly different in UG and PG settings
- Sharing best practice is context dependent and impacts on perceived relevance
- Visits important for relationships, partners favoured a move to risk-based approach
- Opportunities to enhance **feedback and informal relationships** were critically important and mentioned by all stakeholders

Considerations

Effective working relationships, informal communication and good relationships→ safe environments → trust and earlier disclosure

The three tier model and across multiple QAFs → clarifying roles and boundaries → effective sharing and collective assurance

Data-generated approaches (monitoring & self-assessment) → demands for data & lack of feedback → disengagement

Risk-based approaches (visits) → role of the regular and nature of interactions →reduced approachability

Enhancement-led approaches → organisational autonomy and insight →supportive regulatory relationships

GMC moving quality assurance forward…

General Medical Council

Practical application of the findings

Paul Clayton

Working with doctors Working for patients

New QA process

Re-declaration against standards

Self-assessment to assure the GMC

Triangulation and gap analysis

Quality activity

- Medical schools and postgraduate training organisations make a re-declaration against the standards every four years.
- We will work with each organisation to help them assure us they meet each standard over the QA period.
- We don’t expect them to declare perfection – what we’re keen to see is that they know about their strengths and weaknesses and are working to address concerns

New QA process

Re-declaration against standards

Self-assessment to assure the GMC

Triangulation and gap analysis

Quality activity

- Medical schools and postgraduate training organisations complete an annual questionnaire to tell us what evidence they hold and what activity they'll be undertaking.
- They can also tell us if opportunities arise in-year. For example if another regulator is visiting or they are undertaking some unplanned activity that we can observe.

New QA process

Re-declaration against standards

Self-assessment to assure the GMC

Triangulation and gap analysis

Quality activity

- We use our extensive data, evidence and intelligence to identify areas of concern and good practice, including information from other sources, such as other regulators.
- We have strong signalling mechanisms from students, doctors in training and trainers through our surveys and other reporting channels.

New QA process

Re-declaration against standards

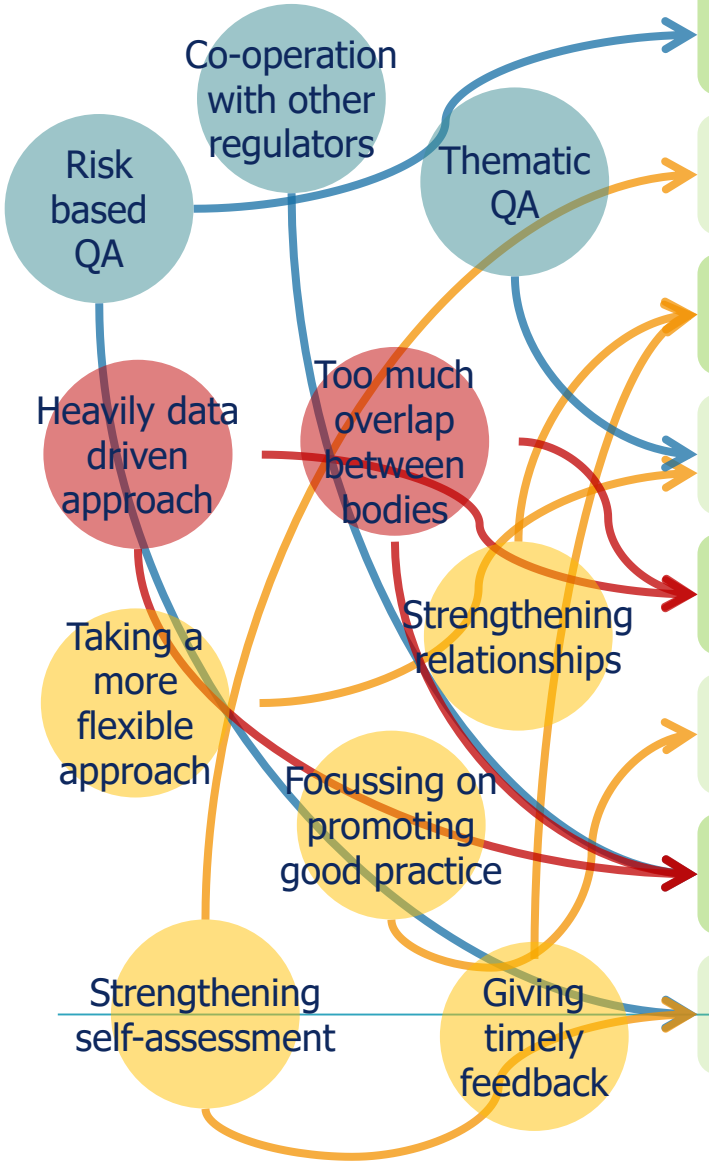
Self-assessment to assure the GMC

Triangulation and gap analysis

Quality activity

- Our aim is to be as light touch as possible, only asking for evidence where required.
- We will hold an annual meeting with each organisation where we will agree what evidence and activity we should see.
- We will observe QM activity where possible, rather than looking at documents.
- For areas we aren't assured, we will select activities from our QA toolkit, such as GMC-led visits, audits of QM decisions, surveys, thematic reviews.

Applying research findings to operational changes



No 'grand tour' of regional reviews	They are expensive and not frequent enough to assure us
Re-declaration points	Limits risks of indefinite approval Positive assertion from bodies
Supportive, ongoing dialogue, more frequent, but lighter-touch, contact	Strengthens relationships More frequent or continuous assurance Improves our ability to respond to concerns
Collaborative, flexible approach	Works in all contexts and locations
Less information requested, clearer about how we will use what we do ask for	Less duplication Reduces wasted administration time Less confusion
Observe a broader range of quality management activities	Broader assurance against full range of standards More opportunity to promote good practice
More GMC and external intelligence used in assurance process	Better use of intelligence Collective effect
Regulatory activity based on triangulation of self-assessment and wider intelligence	Risk-based

General Medical Council

- Thank you

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- Questions?

Discussion

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Areas to discuss...

- What does the good regulator look like:
  - Accountability versus enhancement?
  - Proportionality tailored to contexts?
  - Risk-based approaches?
  - Sharing good practice and collective assurance?