ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW

CONSULTATION:	Discussion Paper on Approving Educational Environments
ORIGINATING SOURCE:	General Medical Council
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28th June 2013

Mr Richard Marchant
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By email to : rmarchant@gmc-uk.org

Dear Mr Marchant

Approving Educational Environments

Please find attached the Royal College of Physicians and Surgeons of Glasgow comments on the discussion points in your papers on Approving Educational Environments

With kind regards

Yours sincerely

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Honorary Secretary

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Royal College of Physicians and Surgeons of Glasgow
Response to discussion paper on Approving Educational Environments

Discussion point 1: We endorse the GMC's recognition of the relationship between the environment in which training is delivered and the quality of that training. Similarly we recognise that environments regarded as not delivering safe patient care are likely not to be suitable for training.

Discussion point 2: We agree that the GMC standards for the delivery of education and training should include explicit descriptors of the educational environments expected by local education providers.

We note the suggested extensive list of indicators and descriptors and have concerns as follows:

1. *Overlap with other standards*: It is unclear how such standards will be used alongside existing standards such as those for Trainers and Tomorrow 's Doctors. There appears to be overlap in the indicators and descriptors specified across these standards. This could lead to duplication of measurement and reporting as well as to lack of impact of standards on practice. It is recommended that a more concise list, cross- referencing to other standards as required is considered.

2. *Duplication within the annex itself*: We appreciate that these indicators are drawn from several existing frameworks, but within the list of indicators specified there is clear repetition, e.g. items 1,6,7 and 8 of 'educational infrastructure' and items 1&2 of 'safe supervision' as compared with the rest of 'safe supervision'. As a support to effective deanery - LEP partnership in the implementation off such standards, it would be helpful if any overlap across the document was removed.

3. *Language and format used in the 'measures'*: The specification of both standards and measures is helpful. However, the 'measures' specified are often really standards and do not delineate a measure of such a standard. At times very specific requirements are outlined and at others, the measure is presented only in principle. For example:
    I. It would be helpful to have clarity and consistency of understanding about what is perceived to be sufficient access to educational resources. At the very least, wording could include the suggestion that an 'appropriate level' of such resources should be accessible.
    II. It is perhaps unrealistic to expect that LEPs will always be able to demonstrate 'increased learner satisfaction'.
    III. We are surprised at the recommendation of specific weekly trainer meetings for all trainees, rather than a recommendation of access to support in association with meetings and assessments as delineated by curricula and portfolios.
    IV. It may be more appropriate to recommend that 'opportunities exist' for trainee to work with other health and social care professionals, rather than to state that LEPS must ensure that such working and learning takes place.

4. *Criteria to be measured*: The practical implementation of such standards is crucial to effecting the impact that they will have on training and service. We recommend that each 'measure' is 'tested' before inclusion as a measure, by the additional delineation (perhaps in

a separate table) of examples of how Deaneries may know if the measure has been achieved. If such examples are not readily forthcoming, then it is likely that the measure is not measurable in practice and not a practical tool. Rather it may be a standard for which a measure should then be defined.

5. *Missing elements*:
   I. We acknowledge the work of previous groups in identifying areas of concern in relation to educational environment on which this list is based. However, we are surprised at the lack of mention of measures to ensure issues of equality and diversity in the training environment are addressed.
   II. Similarly, we believe that there is increasing evidence that trainee involvement in local quality improvement activity is beneficial both to training and to patient care. Promotion of such trainee activity is not sufficiently covered by the mention of audit and should be included.
   III. We note the inclusion of the section on teamwork. It is appropriate that this includes measures to ensure trainees develop an awareness of the multidisciplinary team. However, we believe that the prevailing negative issues with team culture in the educational environment that impact on patient care increasingly include issues with the integrity of the medical team and not just those of the wider healthcare team. Larger consultant teams, rotational movement of trainees and patterns of work have resulted in an increasing disintegration of the medical clinical team. This disconnect is a key contributor to lack of feedback to trainees and lack of effective clinical supervision. We believe it is of crucial importance that standards focusing on an clinical educational environment also address this emerging issue within this environment.

Discussion point 3: We do believe that Deaneries and comparable organisations are well placed to monitor application of such standards by LEP, as part of related work in regard to the monitoring of quality of training. However, for this to support consistency in the application of such standards and the production of comparable reports across the UK, the greater use of 'measures' with defined and measurable criteria is required, as is clarity in respect of what can evidence attainment of criteria.

Discussion point 4: This requires close liaison between national service and training organisations. NHS Scotland is in the early stages of developing such liaison processes currently. It is important to retain clarity of remit for each stakeholder in this process. The regulation of patient care and its safe provision should not become a deanery or GMC activity. The current process regarding the GMC national trainee survey data in respect of patient safety concerns illustrates the tensions in such relationships between the Deanery and the Service over such issues. Trainees are a very valuable source of such information. Deanery awareness of issues will facilitate Deanery further enquiry and recommendations where such comments may indicate a problem with training. However, the use of the Deanery as conduit, reporter and monitor of such comments, and the actions in respect of them, to the GMC is not an efficient or appropriate response. Rather, National Health Service Patient Safety Organisations should have access to such information and assume responsibility for any necessary action. Similarly, where National Health Service Patient Safety Organisations or Colleges are aware of concerns about patient care in any LEP, Deaneries should be made aware of this and should direct any necessary action in respect of trainee placement, in partnership with the GMC.

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Discussion point 5: Subject to the concerns detailed above, about what is to be measured and reported, both in respect of the environment and patient safety, we believe that the approach as outlined is, in principle, a proportionate and practical way of supporting the quality of the educational environment and that a more formal approval system is not required. Such an approval system is also likely to utilize fixed points of approval and periodic inspection rather than the continuous monitoring embedded in Deanery processes. As such it may be more laborious, yet less effective.

Professor Hazel Scott
Honorary Secretary

28th June 2013