

Quality Assurance of Basic Medical Education

Report on the University of Bristol Medical School

November 2009

**General
Medical
Council**

Regulating doctors
Ensuring good medical practice

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The GMC's role in medical education

1. The General Medical Council (GMC) sets and monitors standards in medical education. The standards for undergraduate medical education are set out in the publication *Tomorrow's Doctors*.
2. In order to ensure that UK medical schools maintain these standards the GMC runs a quality assurance programme, which involves regular assessments and visits to schools. This programme is called Quality Assurance of Basic Medical Education (QABME) and is carried out on behalf of the GMC by a team of medical and educational professionals, student representatives and lay members.
3. The team makes determinations as to whether these schools are meeting the standards in *Tomorrow's Doctors* after analysing school documentation and completing a range of quality assurance activities at the School and partner institutions. The determinations in this report have been scrutinised by the GMC's Undergraduate Board.

Introduction

4. This is the 2008/09 quality assurance report to the GMC Undergraduate Board on the established medical school at the University of Bristol (the School).
5. The last GMC review of the School was in January 2000, prior to the establishment of the QABME programme. Areas identified for further consideration at that time included: establishing a medical education unit, particularly to enhance the student selected module (SSM) programme and to develop the scheme of assessment; ensuring that the Year 3 student selected component (SSC) is not devoted to remedial study for students who have done badly in examinations and ensuring that teaching by NHS clinicians is consistent and to develop a scheme for providing consistent feedback about students' clinical competence and skills.
6. Bristol provides a five year undergraduate course leading to a Bachelor of Medicine and Surgery (MB ChB), as well as a separate four year Graduate Entry Programme MB ChB and a six year combined MB ChB and pre-medical course. The current curriculum was introduced in 1995 and the first group of students to complete this graduated in July 2000.
7. In 2000 Bristol was awarded a 50 per cent expansion of student places and moved from a single site medical school to establishing seven clinical academies of equal status, two based in traditional acute-care teaching hospitals in Bristol (Bristol South and Bristol North) and five in the surrounding counties: Gloucestershire (Gloucester and Cheltenham); Somerset (Taunton and Yeovil); North Somerset (Weston super Mare); Bath, and Swindon. Students rotate between clinical academies every half academic year, alternately based in and outside Bristol.
8. The five year MB ChB course consists of:
 - a. Phase I (first two terms of Year 1): An introduction to medical science based subjects with some community based placements.
 - b. Phase II (third term of Year 1 and Year 2): Systems based teaching integrated across pre-clinical disciplines. Initially scientific teaching is predominantly delivered by academic staff in the School of Medical Sciences. The proportion of clinical teaching increases as the student progresses through the curriculum.
 - c. Phase III (Years 3 to 5): a foundation in basic clinical medicine including a session preparing students for clinical practice in Year 5.
9. For the MB ChB graduate entry course the first two years of the standard course are taught in one year and much of the scientific basis of medicine is removed as the course is aimed at students who have at least a BSc degree or equivalent. The combined MB ChB and pre-medical course follows the standard five year course with an additional pre-medical year for students without a science background. Around 40 per cent of students choose to undertake an intercalated

degree within a range of medical science subjects, or bioethics, medical humanities and international health, normally after Year 2.

10. Unless the report refers to a specific cohort of students, our findings are based on all entry routes into the MB ChB programme.

The QABME team

11. The visiting team members appointed by the GMC Undergraduate Board to undertake the quality assurance visits were:

Professor Jim McKillop (Team Leader, stood down as of 1 January 2009, see paragraph 12)

Professor Peter McCrorie (Deputy Team Leader, subsequently Team Leader, see paragraph 12)

Professor Steven Heys

Professor Roger Green

Mrs Sara Nathan

Professor Robert Peveler

Dr Gina Radford

Mr James Read

Dr Rafik Taibjee

12. Following his appointment to the GMC on 1 January 2009, Professor Jim McKillop stood down from the visiting team because of the conflict of interest that his appointment to the GMC presented. Professor Peter McCrorie became the Team Leader in place of Professor McKillop. Prior to standing down, Professor McKillop did not attend any of the quality assurance visits (see paragraph 14).

13. Miss Elizabeth Leggatt (GMC Education Quality Officer) supported the QABME team.

Our programme of visits in 2008/09

14. The team conducted six quality assurance visits on: 5-6 March, 8 May, 12 May, 1 June, 24 June and 15 July 2009.

15. The findings of the team have been reached by reviewing documentary evidence submitted by the School and undertaking the following activities:

- a. Meetings with members of the School responsible for curriculum development, assessment, student support, selection and widening participation, quality management etc.
- b. Observation of teaching sessions in general practices and both the main university teaching hospital and district general hospitals.
- c. Site visits to various NHS Trusts/teaching academies.
- d. Site visits to various general practices.
- e. Discussions with students.
- f. Discussions with teachers, including general practitioners and consultants in a range of medical specialities.
- g. Discussions with Foundation Year 1 (F1) doctors and their educational supervisors.
- h. Observation of the final examination of clinical skills.
- i. Observation of the final examination board.

The report

Summary of our key findings

16. Subject to the requirements in paragraph 19, the School's MB ChB programmes meet the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983.

17. Although we have recommended some areas for improvement by the School, these should be read in the context of our overall findings.

18. The School is requested to respond to the requirements with the timelines for action within the 28 day right of reply to the report.

Requirements

19. The School is required to:

a. Agree a consistent approach to the teaching of clinical and practical skills, with clearly defined learning outcomes, and deliver this across the academies to ensure all students can perform all required clinical and practical skills safely and effectively prior to graduation (see paragraphs 36, 37, 41 and 91). In addition ensure that clinical and practical skills are appropriately assessed and/or signed off (see paragraph 37).

b. Ensure a mechanism is in place to deliver curriculum renewal and change efficiently and in a timely fashion (see paragraph 66).

c. Ensure the School has a coherent assessment strategy and a mechanism in place to implement assessment, and any required changes to assessment, efficiently across the programme (see paragraphs 108, 110 and 124) in order to:

i. Ensure all assessment tools are in line with current best practice (see paragraphs 109, 113, 114, 115, 118 and 119).

ii. Fully implement a policy on standard setting in line with current best practice and enforce this throughout the programme (see paragraph 120).

iii. Significantly improve the reliability of the Long Case assessment or discontinue its use (see paragraph 123).

iv. Ensure all examiners are appropriately trained and briefed for all summative assessments, particularly final examinations (see paragraph 125).

Recommendations

20. To enhance the quality of the School's programme, we have identified the following recommendations. The School should:

- a. Communicate the learning outcomes to students in a consistent way across the programme (see paragraph 23).
- b. Review whether the level of detail of the basic sciences taught and assessed in Years 1 and 2 is appropriate for undergraduate medical students and has clear clinical relevance (see paragraph 29, 69 and 111).
- c. Review learning opportunities in primary care and community settings throughout the five-year programme to ensure that they are sufficient to address all core cases and learning outcomes (paragraphs 31, 87 and 88).
- d. Review the teaching of prescribing and therapeutics skills to ensure that all students are adequately prepared for Foundation Year 1 (see paragraph 40).
- e. Enhance the integration and signposting of public health within the rest of the curriculum, particularly clinical teaching (see paragraphs 53 and 54).
- f. Implement changes to the vertical themes fully across the programme to enhance the spirality of the curriculum and increase staff and student awareness of these themes (paragraph 57).
- g. Promote learning styles which prepare students for learning in a clinical environment, so that students are ready for the significant transition between the 'preclinical' Years 1 and 2 and the 'clinical' Years 3 to 5 (see paragraph 70).
- h. Encourage clinical teachers, particularly those at the academies, to contribute to curriculum development, and to have a greater awareness of, and input into, the content of Years 1 and 2 in order to facilitate greater integration across the programme (see paragraph 71).
- i. Review the provision of student feedback after assessments and ensure that students have sufficient information about their progress and performance (see paragraph 128).
- j. Continue to review the use of the Professional Behaviour Assessment Form to ensure it is a valid and reliable way of assessing student attitudes and behaviour and is completed appropriately (see paragraph 129).

Areas of innovation and good practice

21. We commend the School on the following areas of innovation and good practice:

- a. Teaching sessions run by a clinician and lawyer focusing on key issues around end of life care (see paragraph 32).
- b. The Peer Assisted Learning Scheme (PALS) SSC (see paragraph 44).
- c. The integration of the Ethics and Law vertical theme (see paragraph 51).
- d. The opportunities for creative expression in Years 1 and 2 (see paragraph 62).
- e. The Preparing for Professional Practice (PPP) course (see paragraph 89).
- f. Simulator based teaching in Years 1 and 2 (paragraph 94).
- g. The positive approach taken to ensure fitness to practise procedures are in line with current GMC and Medical Schools Council guidelines (see paragraph 135).

Curricular outcomes, content, structure and delivery

The principles of professional practice

22. We are satisfied that the curricular outcomes are based on the principles of professional practice set out in set out in *Good Medical Practice*.

Outcomes

23. The School has mapped its core curriculum to the essential areas set out in *Tomorrow's Doctors*, shown through its web-based MB ChB Curriculum Database. In reviewing course handbooks we noted that some elements have clear objectives but that these were not in a consistent format across the programme or expressed in terms of learning outcomes for students. We recommend that the School communicates the learning outcomes to students in a consistent way across the programme.

24. Overall F1s and their educational supervisors were positive about how the undergraduate programme at Bristol had prepared the F1s for Foundation Year 1, with the exception of prescribing and certain acute care scenarios (see paragraphs 30 and 40).

Content

25. We are satisfied that the curriculum is intellectually challenging and places a greater demand on students as they progress.

26. We found the curriculum to be very crowded in Year 1, with a lack of time for reflection, which was confirmed by students and F1s (see paragraph 46).

The scientific basis of practice

27. We found that the content of Years 1 and 2 provides students with detailed knowledge of the basic sciences. Most students appreciated this grounding in basic sciences before progressing to the clinical years.

28. F1s considered the teaching of anatomy to be good and enthusiastically taught in the first two years. We are concerned that this may not be sustainable with the loss of anatomy demonstrators (see paragraph 85). F1 educational supervisors stated that although F1s lacked a detailed knowledge of anatomy their level of knowledge was adequate for practising as an F1.

29. An external examiner commented in a post-exam report that the Bristol programme was very demanding and included a biochemistry paper of 'Masters level'. The School stated that this enables students to undertake high quality intercalated degrees. We consider the School should ensure the level is appropriate for undergraduate medical students and has clear clinical relevance.

Treatment

30. Emergency clinical scenarios are demonstrated as part of the Immediate Life Support course using human patient simulators, but F1s considered this different from responding to real life situations. F1s and their educational supervisors stated that students would benefit from greater training in dealing with the initial management of acutely ill patients in critical situations.

31. We recognise the School's attempt to provide two contrasting experiences in the two different general practices in Year 4. However we consider the two two-week blocks spent in general practice (GP) placements limits student exposure to patient management and the opportunity to review chronically ill patients in the community (see paragraph 88).

32. The palliative care and oncology module in Year 5 covers identification of symptoms, principles of treatment, managing pain and end of life care. We observed a Year 5 teaching session on ethical, legal and professional issues at the end of life which we considered of a high standard. This session built on students' experience earlier in the curriculum and directly followed the students' palliative care block on the wards. We commend the teaching sessions run by a senior lecturer in palliative medicine and a lawyer, showing spirality and inclusion of the vertical themes.

33. We found the assessment of prescribing skills as part of the Data Objective Structured Clinical Examination (DOSCE) in Year 5 to be appropriate, although we have concerns about the standard setting method used for this assessment (see paragraph 120).

34. Complementary therapies are covered in Whole Person Care in Year 1 with a range of different therapists presenting to students. The School also has close links with Bristol Homeopathic Hospital. Students stated that complementary therapies may be discussed during GP placements but this was variable.

Clinical and practical skills

35. Students are taught clinical and practical skills for the first time in Year 1 as part of the systems based teaching, which includes taking a basic history from a patient. In Year 2 an Introduction to Clinical Skills course at the academies focuses on communicating with and examining patients. Students are also expected to learn clinical skills during GP placements. From Year 3 clinical skills are taught through GP and hospital placements within each specialty, mainly through bedside teaching with some use of the clinical skills centres, though this is dependent on the academy.

36. The School stated that all students are expected to have attempted a number of clinical and practical skills by the time that they attend the academies in Year 3. However students and teachers based at the academies stated that students needed some retraining, especially those who had intercalated. We found variation at the academies in both the provision of clinical skills facilities (see paragraph 91) and techniques used to deliver teaching, a view supported by teaching staff and students. Some students stated that there is a lack of clarity about when they are supposed to learn certain procedures in the curriculum.

37. The School confirmed that students are not required to have all their practical skills signed off as competently performed. Some skills are formally signed off within some units, such as anaesthetics and obstetrics & gynaecology, but not in others. We found some basic clinical and practical skills to be formally assessed for the first time in the Year 5 Objective Structured Clinical Examination (OSCE) which we consider late in the programme. We require the School to set a minimum standard for the teaching of clinical skills, with defined learning outcomes, and to deliver this across the academies, ensuring that all students can perform all clinical and practical skills safely and effectively prior to graduation. In addition the School must ensure all practical procedures are appropriately assessed and/or signed off as competently performed.

38. A new clerking portfolio in Year 3 was considered an improvement by staff and students, encouraging students to see more patients on the wards. Some students stated that they had difficulty getting skills they had achieved signed off due to a lack of available staff.

39. F1s and Year 5 students stated that they needed to be proactive in gaining the required clinical experience in Year 5 and in recognising personal areas of weakness. We note the GP reflective log book was positively regarded by students and staff in encouraging reflection on areas for further development.

40. F1 educational supervisors stated that the teaching of prescribing could be improved but that this was an issue for all F1s and not specific to Bristol graduates. Students stated that teaching around therapeutics was often undertaken during

different attachments in different years. We recommend that the School reviews the teaching of prescribing and therapeutics to ensure that all students are adequately prepared for F1.

41. The Year 5 surgical skills sessions were considered excellent by all students and F1s. Clinical tutors and students stated that this course would be better placed before students undertake their final year surgery attachments. We agree that much of the content should be covered earlier in the course but this session in the final year is a helpful revision of these skills close to graduation. F1s stated that generally the programme had prepared them well in terms of clinical and practical skills and this was supported by their educational supervisors.

Communication Skills

42. In Year 1 students have a short introductory session to communication skills before starting their placements focusing on asking patients open questions, active listening and building rapport. GP tutors stated that Year 2 attachments allow students to consolidate work previously done around communication skills. In Years 3 and 4 communication skills sessions give students the opportunity to act out a range of patient scenarios with actors.

43. Students recognised communication skills as a recurring vertical theme running throughout the programme as part of individual units. Students and F1s were happy with the communication skills training they had received and felt it to be a strength of the programme. F1s stated that they had been given many opportunities to practise difficult communication scenarios such as breaking bad news and educational supervisors confirmed this, reporting that graduates were able to communicate clearly and effectively with patients and colleagues.

Teaching skills

44. Staff and students considered the PALS SSC in Year 5 a strength of the programme, providing teaching skills required for F1. Year 5 students are given basic theory in teaching and learning, then devise and deliver teaching sessions to students in Year 2 or 3, with a high level of support from a tutor. Year 2 students were positive about the teaching they had received from students in Year 5 and we commend this course as good practice.

45. We found no formal mechanism of peer teaching other than the optional PALS SSC, in which 29 per cent of students participated in 2007/08. Teachers reported that more students would like to undertake the PALS SSC than can be accommodated and we encourage the School to explore opportunities to enable all students to teach their peers.

General skills

46. Year 5 students stated that the programme was intensive in terms of factual knowledge during the first two years. This was particularly apparent during the first two terms of Year 1, with little time for reflection or self-directed learning. We encourage the School to consider the balance of reflective learning time and the intensity of the scheduled curriculum.

47. We found general skills to be well covered in the SSC portfolio, which includes developing research skills, self-directed learning, and presentation skills.

The working environment

48. We found that the School offers students several opportunities to work with, and learn about, other health care professionals. Year 5 students we met were enthusiastic about their experiences working with palliative care nurses, midwives, pharmacists and physiotherapists.

49. There are limited opportunities for interprofessional learning during the programme, including a conference with nursing and allied health professional students from the University of the West of England. Students we met had mixed views about this conference; some felt it was unhelpful and did not meet their learning needs. F1s stated that interprofessional learning could be improved. The School acknowledged that progress has been slow due to lack of funding for joint curriculum activities. We encourage the School to explore further innovative ways to increase interprofessional learning.

50. Staff and students from a number of year groups praised the system of rotation around the academies, allowing students to gain experience of a wide variety of hospitals and learning environments.

Medico-legal and ethical issues

51. Teaching staff and students considered the Ethics and Law in Medicine vertical theme well developed and signposted throughout the programme. Students stated that ethical issues were considered during their interaction with patients. F1s reported that ethics had been well taught and showed evidence of considering ethical issues while in practice. We consider the integration of the ethics and law vertical theme an area of good practice with evidence of spirality throughout the curriculum (see paragraph 32).

Disability and rehabilitation

52. We are satisfied that disability and rehabilitation is covered appropriately through the Disability, Disadvantage and Diversity vertical theme. There is a week long Disability Matters course in Year 2, which students rated highly, and also an optional deaf studies SSC in Year 2. However this vertical theme was not as clearly

integrated within units or as well communicated to staff and students as other themes (see paragraph 57). We are encouraged by the recent appointment of a lead for this vertical theme which should address this issue. We note the innovative disability station in the final OSCE which was also praised by an external examiner.

The health of the public

53. We found public health to be taught in two main blocks within the programme. Students are introduced to the topic through the Human Basis of Medicine (HBoM) (Society Health and Medicine) in Year 1 and the majority of teaching occurs in Community-Orientated Medical Practice (COMP) 1 in Year 4. However we found little evidence that public health is fully integrated into the curriculum or that it is included in bedside teaching, a view supported by staff and students.

54. The School stated that there is an informal process in place to encourage teachers to pick up public health themes in a clinical setting. However some clinical teachers stated that the School had provided them with no guidance about the inclusion of public health. The School acknowledged that public health is taught in units and that integration at all stages could be improved. We recommend that the School increases the integration of public health themes within the rest of the curriculum, particularly clinical teaching.

The individual in society

55. The social and cultural environment in which medicine is practised is covered through the Society, Health and Medicine module in Year 1. Students also explore the effects of psychiatric conditions on the patient, carers and families in psychiatry in Year 3 and the effects of neurological disorders on the patient and their family in senior medicine in Year 5. After reviewing documentation and speaking to students we noted a lack of coverage of equality and diversity.

56. In addition GP tutors stated that primary care placements offer students the opportunity to understand the social context of medicine, where their behaviour towards patients and staff is assessed through professional behaviour forms. We consider the total amount of time students spend in the GP block to be short which limits the opportunity to observe the patient journey.

Structure

57. Staff and students were more aware of where some vertical themes appeared in the curriculum than others. The School acknowledged that student and staff knowledge of the vertical themes needs to be improved and is in the process of reviewing and updating the vertical themes, which we support. However, after reviewing minutes from the Annual Programme Review (APR) we note the development of all themes has taken considerable time to be implemented. The School reported that a lack of resources available to fund vertical theme leads had contributed to this slow pace of change. We recommend that the School implement

the changes to the vertical themes fully across the programme and increase staff and student knowledge of these vertical themes.

58. The School has decided to amalgamate the two Year 3 medicine and surgery units to create a joint junior medicine and surgery block, a change which originated through evaluation from academics. A single management structure was introduced this academic year, along with a clerking portfolio and an integrated assessment, but change is being introduced slowly and will not be complete until 2010/11. We encourage this development which will make it easier for students to integrate knowledge between the two units. We note that this change will take considerable time to be fully implemented.

Student selected components

59. The School has an appropriate balance of core curriculum and SSCs required by *Tomorrow's Doctors*. In Years 3 and 4 each unit has an internal SSC which relates to the content of that unit and is marked as part of the unit. Students have a choice of external SSCs unrelated to specific units in Year 2, Year 3, Year 5 and the Year 5 elective.

60. Year 5 students stated that there was sufficient choice for SSCs and that the School had advised them to undertake a breadth of topics and to consider their future career choice. Students are provided with a list of tasks which are either mandatory, recommended or should be completed only once as part of SSCs, which students found helpful.

61. The SSC portfolio enables students to record and reflect on the skills, knowledge and attitudes developed as part of the external SSCs.

62. Opportunities for creative expression in Years 1 and 2 (including Whole Person Care, HBoM in Year 1 and an SSC in Year 2) by which students can submit reflections of a patient journey in media such as poetry, dance or painting was praised by staff and students and we consider this good practice. We reviewed highlights of project submissions which were of a high standard, and had led to the publication of a compilation in book form.

63. The consistency of external SSCs is successfully maintained by the School using clear marking schemes, criteria for the selection of a suitable supervisor and an external examiner for the SSC programme.

64. We note that the School runs a successful Erasmus European student exchange scheme. Students in Year 3 who meet the qualification criteria are given the opportunity to undertake two of their clinical units at European universities, which students found highly valuable. The School recognises the need to ensure that outgoing students are appropriately supported and assessed on their return to the programme.

Delivering the curriculum

Supervisory structures

65. The School has appropriate supervisory structures in place with clear lines of responsibility. The process of curriculum change is consultative and the School aims to gain consensus from all before implementing change. The Medical Education Committee (MEC) has overall responsibility for the course led by the Programme Directors.

66. The School stated that changes to the programme would be dealt with by the following APR, but that an important change could be implemented more quickly if necessary. After reviewing the minutes from the APR we consider the School's supervisory structures appear to take considerable time to deliver change, which may be due to the aim to achieve consensus before sanctioning changes. An example is the time taken to implement changes to the vertical themes, which were proposed in 2004/05 and are not yet complete. We require the School ensure a mechanism is in place that delivers curriculum renewal and change efficiently.

67. The Academies Management Group chaired by the Programme Director is used to share ideas across the academies. The Academy Deans stated that they meet on a regular basis to compare and standardise teaching and learning across the academies.

68. Students are appropriately involved in the supervisory structures and this includes representation on the MEC, the Academies Management Group and Staff/Student liaison groups.

Teaching and learning

69. Some Year 5 students stated that they would have found the first two terms of Year 1 of greater interest if they had been shown the clinical relevance of the basic medical sciences that they were being taught. We encourage the School to address this.

70. We note the difference in learning styles between Years 1 and 2 and that in Years 3 to 5. There are limited teaching methods in Years 1 and 2 and we are concerned that students are not encouraged to use adult learning strategies until Year 3. Students in Years 3, 4 and 5 reported that they had found the transition from Year 2 to Year 3 particularly challenging and clinical tutors stated that they had to begin to teach students the learning techniques necessary to cope with clinical medicine when they entered Year 3. The School recognised that students experience a significant change in their learning environment and acknowledge that preparation for this could be improved. We recommend that the School better prepares students for the transition to the clinical years of the course by promoting learning styles which prepare students for teaching in a clinical environment.

71. Teachers based centrally were aware of the routes by which curricular change could be effected and considered the programme is becoming more integrated. However clinical and GP tutors based at the academies felt less involved and considered there is little integration between the clinical and pre-clinical years. Many lacked knowledge of the content of the curriculum in Years 1 and 2 and stated that they would like to be more involved in curriculum development. Although we acknowledge that clinicians are involved in teaching aspects of the early years they do not have a major role in shaping the curriculum. We found that clinicians' knowledge of the learning outcomes could also be improved. The School should encourage clinical teachers, particularly those at the academies, to contribute to curriculum development and to have a greater awareness of, and input into, the content of Years 1 and 2 in order to facilitate greater integration across the programme.

72. Year 5 students felt that there was inconsistency in what students were exposed to during each placement at each academy. The School accepted that there is variability between academies in terms of the delivery of teaching but that learning outcomes are uniform and variability is mainly in areas of innovation. Academy Deans reported that student feedback and student performance in assessments is used to monitor differences across academies and there are rarely any outliers identified. We support the School in continuing to explore how it can offer an equivalent student learning experience at clinical sites and better communicate the consistency of core teaching to students.

73. Academy Deans consider the competitive nature between the teaching staff at the academies aids continuous improvement and development in teaching.

74. We recognise the School's increasing use of web-based learning packages to deliver an equivalent student learning experience across the academies. The School reported a very high proportion of students had made use of these teaching packages. Clinical tutors reported that paediatrics, obstetrics & gynaecology and geriatrics share PowerPoint presentations across academies, which are displayed on the School's online virtual learning environment, Blackboard.

75. The School stated that central control of teaching remains in Bristol and there are regular visits to the academies to monitor the quality of teaching. We found effective communication channels in place between the School and each academy through the Academy Deans. Responsibility for teaching is devolved to the academies and they have some discretion in timetabling depending on individual circumstances.

76. We note the quality and enthusiasm of GP and clinical teachers at all sites. Students stated that there are some very enthusiastic consultants at each academy. GP tutors stated that they would appreciate greater involvement in teaching and curriculum development.

77. Teaching staff reported that in some instances peer observation of teaching occurred, but this was on a voluntary basis.

78. GP tutors found their yearly training event provided by the School helpful in understanding the aims of the department and sharing experiences. However they stated that it was sometimes difficult to attend and was not mandatory. We noted that some GP tutors had not attended face to face training in the last five years. We consider that the School could do more to encourage uptake of training courses.

79. We consider the establishment of the Centre for Medical Education (CfME), which has recently been reformed, a positive development. It is responsible for a Teaching and Learning for Health Professionals programme open to clinical and non-clinical University staff and had been utilised by a number of the teachers that we met.

80. We found Clinical Teaching Fellows to be a valuable teaching resource at most academies, posts which had been created in response to a previous issue of the non delivery of teaching. Clinical Teaching Fellows study for a certificate of medical education but reported that the School provides no formal induction or training for the post, although reportedly staff on site are supportive.

81. University staff are appraised separately by both the NHS and the University and we note that the School and NHS generally do not share information. NHS staff receive a standard NHS appraisal, which includes some questions on their teaching. Academy Deans stated that they provide information for teachers to use in their own NHS appraisals.

82. Student evaluation is collected by each unit, each academy and also centrally. Action on student evaluation is either through the termly Staff Student Liaison Committee or through the MEC. The School are considering centralising student evaluation to avoid duplication and we support this co-ordinated approach. Students stated that the School had given them plenty of opportunities to evaluate the programme and was receptive to their views but could improve the communication of changes made as a result of student evaluation.

83. At Bristol South Academy programmed activities for teaching were not included in job plans, unlike at the other academies. As a result we noted that staff and students perceived that teaching was a lower priority than at other academies. In response to this the Academy Dean had appointed senior staff as unit coordinators to provide leadership within the trust and to enhance the profile of teaching.

84. The School recognises that there will be a continuity and succession issue next year when the Programme Director leaves his post and most of the Academy Deans come up to completion or renewal of their terms of office. The School does not consider that changes in these senior posts will impact the delivery of the curriculum and risks are being actively managed. We found the succession planning process to be preliminary and encourage the School to address this issue as a priority.

85. The School stated concerns about the funding arrangements for medical demonstrators at a time when student numbers had increased and face to face teaching decreased. Students stated that they valued the role of the anatomy demonstrators. We are concerned that any possible restriction or reduction in

funding may affect the delivery of teaching and the School needs to ensure that if this occurs it will not impact on the quality of the educational programme.

86. The School uses a wide range of teaching methods in Years 3 to 5. Learning opportunities include learning in the clinical environment, on wards, in out-patient clinics, in operating theatres and in primary care.

87. We support the use of the core cases in primary care, written by a general practitioner and considered specifically relevant to general practice. However in reviewing general practitioner evaluation we noted that a high number of GP tutors stated that they did not have sufficient time to cover all core cases.

88. We found the programme offers experience in a variety of environments through the clinical academy system and community placements, such as time spent with a practice nurse and in house services in Year 4. Students considered that these placements had enabled them to effectively develop the ability to communicate with a wide range of patients. However the School should consider whether learning opportunities in primary care and community settings throughout the programme are sufficient to address all core cases and learning outcomes.

89. The School stated that the PPP course in the final year formally tests that students are ready to enter F1 and is run in partnership with the Severn Deanery and NHS Trusts. F1s found the second part of the course, a period of two weeks spent shadowing in the hospital where the student will be doing their first F1 job, good preparation for F1 and more useful than the classroom based activities in Part 1. However not all students gain this experience as approximately a third of the cohort take up F1 posts outside Severn Deanery. We consider the PPP course an example of good practice.

90. Graduate entry students, who complete the first two years of the standard programme in one academic year, experience conflicts in core timetabling in Year 1. The School advises students that some components are self-directed and clinical experience should take precedence. Students had found ways to effectively manage this conflict. Year 3 GP sessions are arranged by the tutor rather than timetabled centrally and as a result students are occasionally required to miss important hospital based activities to attend. We encourage the School to explore ways to avoid conflicts in the timetabling of core learning opportunities in the programme.

Learning resources and facilities

91. We noted variability in the resources available at each academy, most apparent in the provision of the clinical skills facilities and the associated staff members. The Gloucestershire Academy has a dedicated room in which students can attend drop in sessions to practise various skills and access the room at other times for additional practice. At the Bristol South Academy the clinical skills room appeared to lack resources and the Academy Dean stated it is used less frequently since the loss of the only member of clinical skills teaching staff, whom they are keen to replace. Bristol North also lacks a dedicated member of staff to run the clinical skills room and students felt that the facility was underused. We encourage the

School to ensure the provision of a good basic level of clinical skills facilities at all academies, to aid the delivery of consistent clinical skills teaching across academies in line with our requirement.

92. A clinical anatomy suite (part of the School's Applied and Integrated Medical Sciences Centre for Excellence in Teaching and Learning) containing computer-aided technology, specimens and radiographs is used to integrate anatomy with surgery, radiography and pathology. This has enabled the School to maintain the standard of anatomy teaching while the number of demonstrators has been reduced. While this is a good resource discussions with teaching staff indicated that there could be greater integration with clinical teaching and clinicians themselves.

93. We note the high quality of the computer based virtual microscope used to teach histology and histopathology in Years 1 and 2. Students stated that this learning tool was easily accessible off site.

94. We observed simulator-based teaching in Years 1 and 2 and found this to be a good example of integrated teaching. This integrates physiological changes in critical illness with a simulation mannequin which responds to student suggestions and we commend this as good practice.

Student selection

95. We acknowledge the School's participation in University wide initiatives to widen participation such as the 'Access to Medicine' courses open to local schools.

96. We found the selection procedures valid, open and fair but consider that the School should explore reasons for the low number of ethnic minorities who accept places at the School.

97. The School has appropriate procedures in place to make reasonable adjustments for applicants with disabilities on a case by case basis.

Student support, guidance and feedback

98. All students we met identified effective avenues of support at the School. The Director of Student Affairs has overall responsibility for pastoral support in Years 3 to 5, and the Deputy Programme Director of Medical Education for Years 1 and 2.

99. We found effective support systems in place at the academies. The Academy Deans are the first point of contact and students also have a specific tutor at each academy. Unit coordinators and unit tutors meet students on a regular basis and GP tutors feedback on student attendance and issues with professional behaviour. Students praised the role that academy staff play in providing support. We note that academies have a general practitioner attached locally who students can see if they have a health problem on placement.

100. The School stated that a Faculty Student Adviser had replaced the personal tutor scheme three years ago as it was not functioning at the level expected. Although some students missed the personal tutor system most stated that personal tutors were variable and the Student Adviser system works better and support is easy to access. The role had been extended to cover students in Years 3 to 5 from September 2008, but it is too early to assess whether the demand will exceed capacity.

101. Some students found it difficult to identify with an individual member of staff throughout the programme, which was compounded by rotation around the academies and the short stay in any one unit. Year 4 students stated that they missed the tutorial sessions in Year 2, which had offered continuity in teaching. However students praised the close one to one relationship that they have with GP tutors, who provide careers advice and complete references for the Foundation Programme.

102. The School provides appropriate avenues of support for the external SSCs run by other departments and for the elective in Year 5.

103. The student society 'Galencials' arranges peer mentoring for pastoral or academic issues where appropriate or onward referral to the Student Adviser. Students were highly supportive of the current Welfare Officer and stated that the society is active in ensuring the School takes action on their programme evaluation. We acknowledge the good work that the student society does in providing support but note that this is dependent on the holder of the Welfare Officer post who is taking this on in addition to their studies.

104. We note that the School takes into account a wide range of special circumstances when allocating clinical placements such as disability, mature students with families, exam board requirements and sporting commitments, which students appreciated. Accommodation is also provided by the School free of charge for placements at academies outside Bristol. Some students stated that they would like to receive earlier notification of their placements.

105. The School reported that a dedicated person within the University's careers service works specifically with medical students. The Director of Student Affairs also has overall responsibility for careers advice and preparation for F1 posts.

Assessing student performance and competence

The principles of assessment

106. We note a clear policy on compensation set out in student unit handbooks. We support the School's policy of not allowing a failure in clinical components of the final examinations to be compensated by the written components. However we consider the policy of not allowing compensation for a failure in the Long Case inappropriate due to the low reliability of the assessment (see paragraph 123).

107. The School reported that individual units are responsible for mapping their own curriculum outcomes to the assessments for their unit. These are recorded in unit and year handbooks and are checked at the APR. The teaching methods for each unit determine the assessment tools used and each year takes a slightly different approach.

108. The Assessment Committee advises units about setting assessments. We found the Assessment Committee's role to be operational and not strategic. It does not have executive authority to change assessments but can recommend changes to the MEC.

109. We note that, in general, best practice assessment tools have been adopted by COMP2 (Care of the Elderly, Dermatology, and Primary Care) but that these need to be translated to the rest of the programme.

110. We consider the programme lacks effective oversight of assessment, which limits the dissemination of good practice. The School must ensure it has a coherent assessment strategy and a mechanism in place to implement change to assessment efficiently across all years and units.

111. Students stated that there had been some very intensive examinations at the beginning of the course, particularly in the first two terms of Year 1, a view supported by reports from external examiners (see paragraph 29). We consider that there should be wider scrutiny of the level of the examinations set in different units to ensure the level is appropriate for medical students, and that more could be done to integrate clinical relevance.

Assessment procedures

112. We note the School's recent efforts to ensure consistency across the SSC programme and consider the assessment of SSCs to be well standardised.

113. We identified variation in assessment blueprinting methods between years and units. The School recognises this variability and is moving towards a more rigorous approach to blueprinting, which we support.

114. The use of negative marking for knowledge based examinations is determined by each individual unit and as a result is used by some and not others. The School stated that the lead of COMP2 is exploring the use of best of five answers without negative marking and we require the School to adopt this approach across the programme.

115. We support the School's decision to move away from using true/false Multiple Choice Questions (MCQs), but the School is required to implement this across the programme.

116. We support the use of a template and banding scores based on specific criteria to standardise the marking of essays in HBoM, ethics and law and the reflective essay in the PPP course.

117. We noted variation in the way in which Clinical Teaching Fellows were used for assessments. For example they were not involved with formal assessments at the North Bristol Academy but appeared to have a larger role in Year 3 assessments at other academies.

118. Individual units are responsible for recruiting their own external examiners. We consider that a centralised committee should have a greater role in appointing external examiners and that the School should recruit an external examiner to look across all assessments.

119. We note that a viva voce is used to assess Year 3 psychiatry despite external examiners questioning their use. The School had made efforts to standardise the viva using a proforma, indicating areas for examiners to explore. However, reliability is compromised through variability in sampling and performance being case-specific. The use of the viva is not considered to be best practice.

120. We note good examples of standard setting in some units. However other units maintain that standard setting is not possible for the type of assessment in use. Pilot standard setting was run in parallel this year for the written final examinations and will be rolled out next year, which we strongly encourage. We discourage the practice of using of a standard 10 per cent fail rate for the DOSCE examination. The School is required to fully implement a policy on standard setting in line with current best practice and enforce this throughout the programme.

121. We found the Year 5 OSCE stations provided realistic and appropriate scenarios. The simulated patients used in the Year 5 OSCEs delivered a consistent performance.

122. We found the use of video clips and photos in the DOSCE appropriate for assessing acute conditions, where patients would be unable to be examined via an OSCE or long case.

123. We consider that the reliability of a single long case is compromised by wide variability of patients and symptoms, examiner performance and the physical surroundings. F1s stated that the Long Case in Year 5 was a difficult examination which they saw as subjective, depending on the examiner involved. The School recognised that the long case has low reliability but has good content validity and reflects the job students will be doing as F1s. The School are considering replacing one long case with a series of long cases. We require the School to considerably increase the number of cases seen by each student in order to significantly increase the reliability of the assessment, or to discontinue its use.

124. We note that each discipline is responsible for setting its own final OSCE station, including provision of examiners and patients, guidance, training and mark sheets. We found this lack of centralisation allowed for significant variation in the mark sheets and consider that they should be of a more comparable format. We consider that this should be an integrated examination and the School must introduce greater central coordination, in line with our requirement to ensure a coherent assessment strategy.

125. We found a lack of consistent training in place to ensure examiners carry out their role and apply assessment criteria consistently. This was noted at the final OSCE examination where there was great variation in what was provided. Some departments held group training sessions while others sent written information, which we consider inadequate. As a result we observed variation in examiner performance. We require the School to introduce a generic examiner training session for all high stakes examinations, irrespective of the station that they are examining, and to ensure uptake. There should also be a compulsory examiner briefing before every cycle of the OSCE.

126. The School were surveying all examiners during the final Long Case examination to monitor their experience and training, which we support and encourage.

127. All students observed during final examinations appeared to be aware of what was expected of them. Students have the opportunity to attempt an assessment formatively before completing a summative one of the same format.

128. The School recognised that feedback given to students after assessments could be improved. For written examinations students are given their score and ranking in their peer group. Failing students are told the areas where they performed poorly and borderline students can speak to the unit lead about issues. Students stated that they would like to receive more feedback and that remedial teaching was variable across units and years. The School should review the provision of individualised feedback to ensure students have sufficient information about their progress and performance to address areas of concern.

Appraisal

129. Professional Behaviour Forms are completed at the end of each unit by unit leads and coordinators and counter-signed by the student. They were generally positively regarded by staff and students. However we reviewed a sample of the completed professional behaviour forms and noted variability in the level of detail included. Some students also stated that they had not always seen the forms. The School reported that they are in the process of reviewing the assessment of professional behaviour and are undertaking a qualitative study of both tutors and students. We encourage this and recommend the School ensures that these forms are a valid and reliable way of assessing student attitudes and behaviour and are completed appropriately.

130. Students who have issues with their professional behaviour are referred by the Investigating Officer to a two-week remedial course. The School reported that the course is effective at encouraging self-reflection and that those who completed the course had no subsequent problems in this area. A student had recently integrated this course alongside a unit in Year 4 thereby adding no additional time to the programme.

Student progress

131. We are satisfied with the provisions in place for students who have made the wrong study choice. There are two exit routes from the programme; students who successfully complete the first three years are eligible for an unclassified degree and those with the ability can complete an extra year in the Faculty of Medical and Veterinary Sciences to receive an honours BSc degree.

132. Overall we found the Final Exam Board to be well run. The School followed clear processes and students were treated fairly. Compensation was awarded appropriately and there were clear rules on marks deducted as a result of late submission of work. We support the School's policy of separating mitigating circumstances from the decision as to whether a student should pass. All extenuating circumstances were considered in advance of the Final Exam Board by the Extenuating Circumstances Panel.

133. Concerns about a student's professional behaviour can be raised through a Professional Behaviour Assessment Form at the end of each unit or through a Student Concern Form at any time in the programme. We consider the processes for monitoring these forms to be appropriate.

134. The majority of students were aware of whistleblowing and the purpose of the Student Concern Forms. All students knew where to find the student Code of Conduct.

Student health and conduct

135. We found the way the School deals with student fitness to practise to be effective and commend the positive approach taken to ensure processes are in-line with the current GMC MSC guidelines on student fitness to practice, *Medical students: professional values and fitness to practise*. The role of Investigating Officer increases the transparency of the processes.

136. We note that student awareness of the School's fitness to practise procedures could be improved.

137. The School has links with the postgraduate deanery through the Clinical Dean, who sits on the F1 Supervisory Committee where he receives feedback about the performance of F1s from Bristol. This allows the School to track students who have personal or professional problems.

Acknowledgement

138. The GMC would like to thank the University of Bristol Medical School and all those they met during the visits for their co-operation and willingness to share their learning and experiences.

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Professor Jim McKillop
Chair, Undergraduate Board
General Medical Council
(sent by e-mail 12th October 2009)

Dear Professor McKillop

Re: University of Bristol Medical School's QABME report for 2008/09

Thank you for the opportunity to respond to this report and to include with it our action plan for dealing with the required and recommended changes to our practice. We found the visit to the medical school by the QABME team to be a useful and constructive exercise. We intend to use the report to our advantage as a driver for change. Action points are italicised for easy reference.

Requirements

19. The School is required to:

a. Agree a consistent approach to the teaching of clinical and practical skills, with clearly defined learning outcomes, and deliver this across the academies to ensure all students can perform all required clinical and practical skills safely and effectively prior to graduation (see paragraphs 36, 37, 41 and 91). In addition ensure that clinical and practical skills are appropriately assessed and/or signed off (see paragraph 37).

Action Plan

We have been in discussion with the Clinical Skills lead to bring together a series of skills which escalate in complexity throughout the course from Year 1 to Year 5. The current list of these is attached and has been reviewed in the light of the recently published version of Tomorrow's Doctors.

We have designed a log book, which will be ready for our Final Year students on their return in November from electives and we will then pilot it for the rest of this academic year. We would value input and guidance from the GMC as we work through the real issues that surround the appropriate assessment and sign off of these skills.

We aim to introduce this logbook throughout all the years the following academic year.

b. Ensure a mechanism is in place to deliver curriculum renewal and change efficiently and in a timely fashion (see paragraph 66).

Action Plan

We will review and revise the structure of the management process by which changes are made in the curriculum.

We appreciate the points made in the report in this regard and plan to have this revision process in place by Spring 2010. The revised process is likely to focus heavily on working groups/project groups with short term life spans, reporting to a central teaching committee with recommendations. This is happening in practice in the current academic year in the form of a small group looking at changes to the structure of Year 5, consulting with others as necessary. We note the comments specifically in paragraph 66, recognising that there were both resource and institutional delay issues at play in that matter.

c. Ensure the School has a coherent assessment strategy and a mechanism in place to implement assessment, and any required changes to assessment, efficiently across the programme (see paragraphs 108, 110 and 124) in order to:

i. Ensure all assessment tools are in line with current best practice (see paragraphs 109, 113, 114, 115, 118 and 119).

ii. Fully implement a policy on standard setting in line with current best practice and enforce this throughout the programme (see paragraph 120).

iii. Significantly improve the reliability of the Long Case assessment or discontinue its use (see paragraph 123).

iv. Ensure all examiners are appropriately trained and briefed for all summative assessments, particularly final examinations (see paragraph 125).

Action Plan

We note the report's emphasis on this matter. The report requires a move away from both negative marking methods and using true/false Multiple Choice Questions. We note the comment regarding the closer attention to be paid to the recruitment of external examiners and have already incorporated those requirements into the faculty board structure, but this will need full implementation throughout the curriculum. We note with regret the report's requirement to remove the *viva voce* which is presently used to assess Year 3 Psychiatry and will transmit that to the relevant Unit, asking them to propose suitable and acceptable alternative methods.

We understand from the cited paragraphs that the report supports our use and full implementation of blueprinting and of using best of five answers Multiple Choice Questions. These changes will all be in place by the end of this academic year.

A move towards standard setting began two years ago with training sessions and support being provided by staff from our Teaching and Learning for Health Professionals programme. Uptake was greater in the latter three years of the programme and in all three years, pilot standard setting took place last year to a greater or lesser extent. In the present academic year 2009-2010, we expect the majority of the Units in the latter three years, and especially Finals in its entirety will move to be standard set. Training sessions have been set up, as before, this Autumn for all Units who haven't yet move towards this.

Pilots for standard setting will be place for all the Year 1 and Year 2 Units for this academic year with full implementation in the academic year 2010-2011. The latter three years have in the majority undertaken pilots in standard setting last year and we would expect them to be moving towards full implementation this academic year.

We consider the Long Case to be an important part of our Finals assessment portfolio and therefore, recognising the anxieties expressed in the report, we intend to introduce a model of having three Long cases, over three months, with both a formative and summative component. Unsatisfactory performance would lead to a fourth (summative) Long Case. We consider that this

will improve the reliability by widening the patient and examiner exposure for any individual student.

This will be piloted this Academic year to examine its feasibility, and we expect it to be implemented next academic year as part of the major re-structuring of the Final year.

We note the report's concerns about the briefing and training of Final year examiners.

We will rectify this and ensure that for OSCE and Long Cases, structured training will be provided and records kept. A formal briefing session will also be put in place in advance of the OSCE and Long Cases.

This has wider application to assessments throughout the curriculum.

We will ensure that for all assessments wherein evaluation of performance takes place that briefing and training are integrated.

Recommendations

20. To enhance the quality of the School's programme, we have identified the following recommendations. The School should:

a. Communicate the learning outcomes to students in a consistent way across the programme (see paragraph 23).

Action Plan

Handbooks were found not to consistently describe and clarify the learning outcomes for all the Units throughout the curriculum. This will be addressed and remedied. As the Handbooks have already been prepared for this academic year since July 2009, it is not possible to change for this academic year, but these changes will be put in place by the end of this academic year by a review process which will look at all handbooks (Year 1 – Year 5) and confirm whether learning outcomes are clear.

We intend to use externally validated criteria to judge these handbooks and report through the Medical Education Committee, the level of compliance in Units, directing those Units where further clarity could be achieved. This will be completed by the end of this academic year 2009-2010.

b. Review whether the level of detail of the basic sciences taught and assessed in Years 1 and 2 is appropriate for undergraduate medical students and has clear clinical relevance (see paragraph 29, 69 and 111).

Action Plan

We understand from the cited paragraphs that the report refers to levels of knowledge taught particularly in Year 1 MCBOM that are more demanding than might be appropriate and that could be more clinically relevant, and that assessments might be set at a level more intensive and deeper than required for the appropriate level of knowledge. Paragraph 29 in particular refers to the depth of knowledge being compared with that taught in Biochemistry at undergraduate MSc level, rather than postgraduate MSc.

Our response to this is two fold: we need to review the level of material taught and evaluate whether it is being set at a level of relevance both to future careers in medicine generally equipping students with a scientific background that will enable them to undertake medical research in their future careers - an important and essential part of improving and developing therapies and diagnosis; we must also consider how best to serve the needs of students who want to intercalate as to how best those students' learning needs can be addressed.

We think that such a major review will require this academic year to allow adequate examination of the issues to be evaluated and, in the light of those findings, the Units in Years 1 and 2 need to be engaged on the content and material covered in those years.

We envisage using the recommendations of (h) to recruit teachers from the academies to form the core group to review the clinical relevance of this material, and in the future to continue to have some of the membership of those Units consisting of academy clinicians in order to act as a balance to the introduction of additional scientific knowledge without due consideration being given to its clinical application.

Overall, we consider that following this recommendation is likely to take two years to work through. This is because the urgent need for these Units to introduce standard setting and change assessment formats to “best of four or five” will be prioritised and much of their time is likely to be devoted to this in the next year.

c. Review learning opportunities in primary care and community settings throughout the five-year programme to ensure that they are sufficient to address all core cases and learning outcomes (paragraphs 31, 87 and 88).

Action Plan

We understand from the cited paragraphs that the report refers to the limiting effect of having two GP attachments in Year 4, the inability to cover all the core cases by tutors and questions whether there is adequate exposure to cover all these. We have entered into discussion with Primary Care teachers on this since the report was published. This has been very fruitful and draft proposals to address the first and third issues have already been tabled to the Programme Director.

In essence, the proposals plan to have (i) a single four week attachment in Year 4, allowing students more time to settle in a practice and follow patients through the course of a disease, and (ii) a further primary care attachment in Year 5 which would address the issues raised in Recommendation (c) but this time could also be structured to address the Recommendation (d) below, as well as how to write a referral letter and a useful discharge summary.

The feasibility of these changes will depend on whether resource streams can be found to support them, and if this is the case then managing the second issue above will follow, we believe. If not, then some regrettable restriction of those core cases may be required.

d. Review the teaching of prescribing and therapeutics skills to ensure that all students are adequately prepared for Foundation Year 1 (see paragraph 40).

Action Plan

We understand from the cited paragraph that the report refers to the comments from F1 educational supervisor on the global deficiencies seen in all F1s, not just Bristol graduates. In addition, our own students consider that teaching of prescribing and therapeutics could be more integrated and focussed.

We will discuss this with the lead in clinical pharmacology and draw up a plan which will address this issue within this academic year, with the changes to be in place for 2010-2011. There may be areas of real deficiencies in integration and focus. There may also be issues of signposting which will address this further.

e. Enhance the integration and signposting of public health within the rest of the curriculum, particularly clinical teaching (see paragraphs 53 and 54).

Action Plan

We understand from the cited paragraphs that the report refers to the lack of full integration of public health into the curriculum and lack of guidance about the inclusion of public health.

Teaching of public health and evidence based medicine (EBM) is in two blocks, approximately equal in time: clinical epidemiology in the first year as part of Human Basis of Medicine which is extended in the fourth year as an element of Community-Orientated Medical Practice 1. EBM as a vertical theme is integrated with the rest of the curriculum.

We acknowledge that the integration and signposting of public health with other parts of the curriculum is not as well developed, and we will draw up a plan to integrate and make the signposting clearer as part of EBM and Public Health vertical theme.

f. Implement changes to the vertical themes fully across the programme to enhance the spirality of the curriculum and increase staff and student awareness of these themes (paragraph 57).

Action Plan

We understand from the cited paragraph that the report refers to both increasing awareness of the vertical themes themselves and completing the review and updating of the vertical themes. Since the end of the academic year 2008-2009, there are now appointed leads in place for all the vertical themes and so the second part of the recommendations has already been achieved.

With regard to the first, working with the vertical theme lead, we will draw up a plan to develop a meaningful awareness of the vertical themes by students and staff. With regard to staff, the focus needs to be on the Unit leads in the first place to ensure that the themes are being appropriately represented within their units. We will achieve this within this academic year.

g. Promote learning styles which prepare students for learning in a clinical environment, so that students are ready for the significant transition between the 'preclinical' Years 1 and 2 and the 'clinical' Years 3 to 5 (see paragraph 70).

Action Plan

We understand from the cited paragraph that the report refers to the differences in approach to learning between Years 1 and 2 and the subsequent more clinically orientated years. Concern is expressed in the report that adult learning strategies are not promoted or used by students in these years. Our understanding from discussing the content of this recommendation with staff on our TLHP programme, is that learning styles are individual to a person whereas teaching styles are broader. We might, more effectively, talk about how teaching styles affect students' approach, or, maybe more importantly, how the style of assessment affects their approach. This would then imply looking at the curriculum, at delivery style and also at assessments.

We envisage incorporating the concerns raised in this recommendation into the review of teaching proposed in (b) and working with the timescales of that review.

h. Encourage clinical teachers, particularly those at the academies, to contribute to curriculum development, and to have a greater awareness of, and input into, the content of Years 1 and 2 in order to facilitate greater integration across the programme (see paragraph 71).

Action Plan

We understand from the cited paragraph that the report refers to the lack of awareness by clinical teachers especially those in the academies of the curriculum content of Years 1 and 2, together with a real and perceived lack of integration between Years 1 and 2 and the latter years.

In paragraph (b), we have proposed a review of teaching in Years 1 and 2 and envisage this being undertaken by teachers in the academies, in all likelihood those with responsibilities for delivery of clinical teaching, as they have a wider perspective of the curriculum and will be able to bring that breadth to bear to effectively review the curriculum, bringing about the desired effect of greater integration across the programme.

In addition, primary care teachers across the academies have dedicated interactive training days, some directed towards the individual year of study they teach in and some broader, reaching out

to new teachers in the academies by holding these in individual academies (Bath and Cheltenham in this year).

i. Review the provision of student feedback after assessments and ensure that students have sufficient information about their progress and performance (see paragraph 128).

Action Plan

We understand from the cited paragraph that the report refers to the provision of individualised feedback to students about progress and performance. In the past academic year, we have drawn up a list of targets for expected feedback, agreed between the Curriculum group and the student society, Galenicals. Not all these are being achieved.

We will review these targets with the leadership of Galenicals to ensure these are still current. In the course of the coming academic year, we will bring these reviewed targets to the Curriculum group for approval and then audit their adherence.

In addition, under the chairmanship of the chair of MEC, a working group has been established to look at all aspects of our performance in the National Student Survey, including assessments and feedback and this will report to the Pro-Vice-Chancellor with responsibility for Teaching and Learning.

j. Continue to review the use of the Professional Behaviour Assessment Form to ensure it is a valid and reliable way of assessing student attitudes and behaviour and is completed appropriately (see paragraph 129).

Action Plan

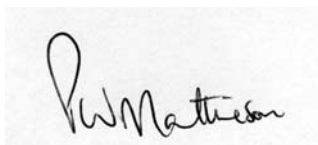
We understand from the cited paragraph that the report refers to the poor validity and reliability of the forms because of inconsistencies in both the level of detail included and in whether the forms are being filled out in consultation with the individual student.

Our response to these concerns is to review the content of the form to ensure that the level of detail requested is realistic, required and meaningful, and also to set standards for the return of the forms to Units and their review by examination boards in the Faculty.

We have discussed this at length in Faculty and Academy meetings since the report was published and there was considerable interest and appetite for this. We are confident that this review will provide a useful method of assessing professional behaviour.

Thank you to all your colleagues at the General Medical Council for the fair, professional and inclusive manner in which this process has been completed.

With best regards, yours sincerely

A handwritten signature in black ink, appearing to read 'P. Mathieson', is written over a light grey rectangular background.

Peter Mathieson

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29th November 2009

Dear Professor McKillop

Bristol's 28 day right of reply response to the 2008/09 QABME report

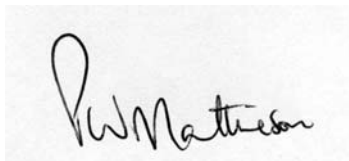
Thank you for the opportunity to clarify how we are dealing with the concerns you have raised about the Long Case component of our Finals examination. We were very pleased that David Cahill, our Programme Director, had an opportunity to discuss this in some detail on Thursday afternoon last with Kirsty White, and I understand they agreed that some written clarification to the Undergraduate Board would be appreciated to show how we are responding to your queries in detail.

To address your questions directly, all the three Long Cases will be summative and contribute to the student's passing of the Long Case component. The first two of the three will additionally be formative, in the sense that feedback on performance will be given. In terms of weight and balance of marks, a student will be deemed to have passed the Long Case component of Finals if they pass two of these three Long Cases, one of which must be the third (summative only) Long Case. If they do not pass this component, they will be offered a fourth (summative only) Long Case, which they must pass to be deemed to have passed this component.

We are presently considering the ways in which we can improve consistency and reliability in the Long Case component. This will include examiner training and improved marking schemes, and we will provide further details on this in the near future.

With best wishes.

Yours sincerely



Peter Mathieson