

Quality Assurance of Basic Medical Education

Report on St George's Medical School,
University of London

November 2009

**General
Medical
Council**

Regulating doctors
Ensuring good medical practice

Contents

The GMC's role in medical education.....	2
Introduction	3
The QABME team.....	5
Our programme of visits in 2008/09.....	6
The report.....	7
Summary of our key findings	7
Requirements.....	7
Recommendations	7
Areas of innovation and good practice	7
Curricular outcomes, content, structure and delivery.....	8
Outcomes.....	8
Content	8
<i>The scientific basis of practice</i>	9
<i>Treatment</i>	9
<i>Clinical and practical skills</i>	10
<i>Communication skills</i>	10
<i>Teaching skills</i>	11
<i>General skills</i>	11
<i>The working environment</i>	12
<i>Medico-legal and ethical issues</i>	12
<i>Disability and rehabilitation</i>	12
<i>The health of the public</i>	12
<i>The individual in society</i>	13
Structure	13
Delivering the curriculum.....	13
<i>Supervisory structures</i>	13
<i>Teaching and learning</i>	14
<i>Learning resources and facilities</i>	17
<i>Student selection</i>	17
<i>Student support, guidance and feedback</i>	18
Assessing student performance and competence	19
The principles of assessment.....	19
Appraisal	22
Student progress.....	22
Student health and conduct	23
Acknowledgement	23

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 and endorsed by the GMC's Undergraduate Board.

Introduction

4. This is the 2008/09 quality assurance report to the GMC on the established medical school at St George's, University of London (the School).
5. The last GMC review of the School was in November 2000, prior to the establishment of the QABME programme. The areas identified for further consideration at that time included increasing the amount of student selected special study modules, monitoring of professional attitudes, development of robust Fitness to Practise procedures and confirmation that clinical and practical skills are fully covered and assessed in the final year in preparation for practice.
6. Medicine has been taught at the School since 1733. The original site was at Lanesborough House at Hyde Park Corner, but transferred to the Tooting site in 1976. In 2000 the School introduced the UK's first Bachelor of Medicine Bachelor of Surgery (MBBS) Graduate Entry Programme (GEP), a four year fast-track medical degree course open to graduates of any discipline. GEP students share a common final year with students on the five year course.
7. The School currently has approximately 1040 undergraduate students, with an average of 200 students in each cohort and approximately 300 GEP students with around 70 students in each cohort.
8. In 2005/06 the School carried out a strategic review of its two courses. The result was a unified MBBS 2007 with separate four year and five year entry streams, with different clinical science structures but sharing the same clinical practice attachments. The course is divided into two parts:
 - a. The Clinical Science years: separate Years 1 and 2 for the five year stream and Year 1 for the four year stream.
 - b. The Clinical Practice years: both streams merge in Year 3 of the five year stream and Year 2 of the four year stream sharing a common Transition (T) year, Penultimate (P) year and Final (F) year.
9. During 2008/09, the School ran the following courses in parallel:
 - a. Original five year MBBS course (Years 3, 4 and 5).
 - b. Original four year GEP MBBS course (Years 2, 3 and 4).
 - c. MBBS 2007 five year stream (Years 1 and 2).
 - d. MBBS 2007 four year stream (Year 1).
10. Four longitudinal themes run through the original and new courses. These are Basic and Clinical Sciences; Patient and Doctor; Community and Population Health and Personal and Professional Development. The course is sub-divided into six

modules which spiral up the curriculum, these are: Life Cycle; Life Protection; Life Support; Life Maintenance; Life Structure and Life Control.

11. Key changes to the MBBS 2007 five year stream include:
 - a. A reinforced spiral design related to the modules in the first three years, moving away from the old systems based design.
 - b. The expansion of early clinical experience through the introduction of Good Medical Practice clinical placements.
 - c. A reduction in the amount of clinical placements in the T year.
 - d. An increase in the mental health component by one week.
 - e. The expansion of the three-week Interprofessional Practice Placement to all final year students instead of only GEP students (an increase of 70 placements to 250).
 - f. The integration of public health in the final year elective.

 12. The changes in the new four year entry stream from the original GEP include the introduction of:
 - a. 18 weeks of clinical attachments linked to basic science learning which will replace 18 weeks of Problem Based Learning (PBL).
 - b. Complementary therapies in two modules in Year 1.
 - c. Clinical governance in PBL sessions and NHS structures through audits in general practice and through student selected components (SSCs).
 - d. Summative assessment throughout Year 1 and end of year summative assessment at the end of the T-year to address progression into the P year.

 13. The learning opportunities provided throughout the courses include case based learning, problem based learning depending on the entry stream, lectures, tutorials, practical classes, clinical and communication skills training, independent learning including research projects, clinical attachments and supported reflection in student portfolios.

 14. The School works with over 20 partner institutions in addition to over 170 general practices to provide clinical attachments for students over a large geographical area from London to South Devon. The main clinical teaching site is St George's Hospital. Clinical teaching is also provided at the nearby St Helier, Epsom, Kingston, Mayday and Queen Mary's hospitals and the South West London and St George's Mental Health Trust.

 15. Assessment includes a mixture of written knowledge tests, objective structured clinical examinations (OSCEs) and mini-clinical evaluation exercises
-

(mini-CEXs) to test clinical and communication skills and project work to test critical analysis and writing skills.

The QABME team

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

Professor Paul O'Neill (Team Leader)

Professor Maurice Savage (Deputy)

Dr Mohammad Akhtar

Dr Mike Gill

Miss Ruth Heseltine

Professor Robert Mansel

Dr Gemma Mullen

Dr Bruno Rushforth

Dr Suzanne Shale

17. Miss My Phan (GMC Education Quality Officer) supported the QABME team.

Our programme of visits in 2008/09

18. The team conducted six quality assurance visits on: 29 October 2008, 4-5 and 25 February 2009, 28 May 2009, 10-12 June 2009 and 29 July 2009.

19. 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 and quality management.
- b. Site visits to St George's Hospital, St Helier Hospital, Mayday Hospital and Queen Mary's Hospital.
- c. A tour of the teaching facilities at the School and visited sites.
- d. Demonstration of e-learning resources.
- e. Discussions with students in all years and courses.
- f. Discussions with teachers, including PBL and Case Based Learning (CBL) tutors, general practitioners and clinical consultants on and off site.
- 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

20. Subject to the requirements in paragraph 23, the School's MBBS courses meet the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983.

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

22. 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

23. The School is required to:

a. Evaluate the continued implementation of MBBS 2007. In the 2010/11 GMC Annual Return, the School must provide a detailed report on the implementation of the T year and the further development of the plans for the P and F years (see paragraphs 31, 32 and 63).

b. Increase substantive choice in the student selected components (SSCs) (see paragraphs 62-65).

c. Specify the framework for exercising discretion about students with a borderline performance in the final examinations (see paragraph 121).

Recommendations

24. To enhance the quality of the courses, we advise the School to review the reporting and monitoring systems with NHS partners, including in general practice (see paragraphs 46, 67, 68 and 76-78).

Areas of innovation and good practice

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

a. The teaching and assessment of communication skills (see paragraphs 47-50).

b. The thorough embedding of ethics and law within the curriculum and an innovative approach to teaching in ethics (see paragraph 58).

- c. The Assistant House Officer placements in preparing students for practice (see paragraphs 87 and 89).
- d. The development and implementation of a comprehensive assessment strategy (see paragraphs 112, 117-118 and 120).

Curricular outcomes, content, structure and delivery

Outcomes

26. We are satisfied with the School's overall aims, final learning objectives and curricular outcomes and consider these to be matched closely to *Tomorrow's Doctors*. We reviewed the curriculum maps for all courses which show where the standards in paragraphs 4 - 37 of *Tomorrow's Doctors* are delivered in the courses.

27. The outcomes are signposted for students in their handbooks and students demonstrated awareness of these and GMC guidance publications, including *Good Medical Practice*, on our visits. We note that further work is needed to ensure the comprehensive theme coverage of the learning objectives and where they are addressed within the new curricula.

28. F1 doctors from St George's and their educational supervisors considered the basic medical training enabled them to meet the outcomes required for entering the first year of the Foundation Programme.

Content

29. We are satisfied the curricula are sufficiently challenging for students and topics are revisited in increasing difficulty. We reviewed evidence presented around diabetes, the cardiovascular systems and the final year past papers.

30. We reviewed a sample of portfolios and timetables and consider students have adequate time for reflection during the vertical Personal and Professional Development (PPD) theme and portfolio. Students confirmed this, but reported heavy workloads for the four year course.

31. We are content with the plans for the T year after reviewing full curriculum documentation and having detailed discussion with the School on implementation. We note that the amount of work needed to plan, implement and evaluate the T year required appointment of a dedicated administrative lead and that this work will need to be ongoing. The School identified resource challenges for the T year and actions to address these. We encourage the School to review these actions regularly, but consider the School is on track to deliver the T year in autumn 2009. The School must report to the GMC on the implementation and evaluation of the T year as part of the 2010/11 GMC annual return.

32. We reviewed the plans for the P and F years and note that further work is needed to finalise the details of these years. We require the School to develop their plans and evaluate the new MBBS 2007 course as it rolls out. The School must report on the development plans for the P and F years in the 2010/11 GMC annual return.

The scientific basis of practice

33. Knowledge and understanding of basic sciences are adequately covered in lectures, PBL and CBL sessions and are integrated with clinical skills in early clinical practice through the vertical Basic and Clinical Sciences theme. We note the increase of basic sciences in the Clinical Science years of the MBBS 2007 streams. We found that course objectives and blueprints are clearly laid out in the handbooks for the new courses.

34. F1 doctors and GEP students expressed concerns about the balance of anatomy teaching within the early years of their curricula. Before 2005, anatomy was under-represented in examinations. We are satisfied this has been addressed within the new course by moving towards teaching functional anatomy and increasing the examination content of anatomy.

35. Understanding of behavioural and social sciences is covered in the Community and Population Health theme and through the Life Control module using PBL cases in Years 1 and 2 in the GEP.

36. Understanding of normal and abnormal structures and function is integrated in all years of the curricula through the Basic Clinical Science and Patient and Doctor themes. This is covered in PBL sessions and clinical attachments.

37. Students learn about scientific methods including research methodology and critical appraisal as part of the PPD theme, and in the student selected and public health components.

Treatment

38. The principles of treatment are integrated in the curriculum in the PBL and CBL cases, ethics sessions, as part of the Life Control and Life Protection modules, the PPD portfolio and clinical attachments. We reviewed the student formulary and final year learning outcomes and found that these adequately covered pharmacology and prescribing during the courses.

39. There were mixed views from the F1 doctors about teaching on pharmacology and preparation for prescribing; some F1s from the five year course felt this was well covered, but others found prescribing to be difficult in practice. We note that the new Advanced Clinical Practice placement in the final year of MBBS 2007 will include prescribing in preparation for practice. We encourage the School to evaluate its effectiveness and consider further prescribing practice. F1 educational supervisors expressed no anxieties about the F1 doctors' preparedness to prescribe.

40. The School is looking to introduce a summative online prescribing assessment in the F year from 2012. We encourage use of this as a formative tool until the Senate approves the change to a summative clinical skills assessment.

41. We reviewed the PBL cases and lecture materials covering the role of lifestyle, diet and nutrition and found these appropriately covered learning objectives in this area.

42. The School identified that the mapping of *Tomorrow's Doctors* outcomes for alternative and complementary therapies needed further coverage in the curriculum, and introduced this in MBBS 2007 in two PBL cases in Year 1 of the four year stream. We reviewed these cases and tutor notes in this topic and found these appropriately covered the learning objectives.

Clinical and practical skills

43. In 2007/08 the clinical skills curriculum was reviewed and updated, taking into account the final year objectives and existing objectives for the MBBS, GEP and new MBBS 2007, the standards in *Tomorrow's Doctors* and the *Scottish Doctor*. The clinical skills curriculum follows a spiral model in the first three years.

44. We reviewed the student guidance for the Good Medical Practice Clinical Attachment handbooks and found that this was comprehensive and instructive. We reviewed the final year attachment certificates on which students must be signed off for practical skills, we noted that details of the exact skills are not provided on the forms.

45. Formal assessment includes mini-CEXs, direct observation of procedural skills (DOPS) and OSCEs. We observed the 2009 final year OSCEs and considered there was limited emphasis on practical skills.

46. F1 educational supervisors commented that the F1 doctors are confident in their abilities in history taking, clinical examination and procedures. However, we found variation in the sign-off of clinical placements, with individual initiatives being used at sites in addition to the School's sign-off forms and reports of students who have not fully participated being signed off. We recommend that the School takes this into account in reviewing the reporting and monitoring systems with NHS partners.

Communication skills

47. We consider the overall approach to teaching and assessment of communication skills to be an area of good practice. Communication is integrated throughout the core curriculum in the Patient and Doctor theme, and is included as part of the interprofessional education strands and in all placements. The School has made changes to the communications skills teaching to relate to the practice needs of students, such as moving the breaking bad news module to the later years of the course where it is more relevant.

48. We commend the use of patients as teachers with direct experience of some of the issues explored in communication, for example, a profoundly deaf person. Actors with Down's syndrome are used both in teaching and in OSCE assessments and provide opportunities to learn about communicating with patients who have learning disabilities. Students also found the use of actors in role plays to be useful.

49. Communication skills are included in the assessment blueprints and are assessed by a mixture of short answer questions, OSCEs and through portfolio work. We observed the 2009 final year OSCEs and found several stations that focused on communication skills and others in which communication contributed heavily towards an overall station mark.

50. All students, F1 doctors and F1 educational supervisors that we spoke to considered the communication skills training in the curriculum to be valuable and a strength of the course.

Teaching skills

51. There is a peer tutoring scheme using a bank of approximately 200 senior students to teach clinical skills, communication skills, PBL cases and anatomy to junior students. All students can apply to become a peer tutor, but due to limited capacity not all students have this opportunity. Peer tutors receive full training, have a probationary period and evaluate their teaching through reflective analyses.

52. There were mixed reviews on the effectiveness of the scheme from junior students who felt knowledge was limited to the session. Peer tutors found the scheme reinforced their knowledge of the topic areas they taught. The F1 doctors we spoke to who were not peer tutors considered they were given little training outside of the scheme for developing teaching skills. The School may wish to review this.

53. We recognise that peer tutor opportunities are limited but consider the scheme to be a good model of developing teaching skills in preparation for practice.

54. We are satisfied that understanding of the importance of audits and appraisals is covered in the curriculum through lectures, audits and the Interprofessional Education (IPE) strands.

General skills

55. F1 educational supervisors confirmed that F1 doctors from St George's had competence in general skills such as time management and problem solving. Students considered the course enabled them to develop general skills. The curriculum maps show where learning in general skills occurs within the courses, but we note that there are no specific learning outcomes in the final learning objectives books.

56. The principles of risk management were identified by the School as being an area that requires further coverage in the curriculum. We encourage the School to explore ways to include this in the continuing development of MBBS 2007.

The working environment

57. Understanding of the working environment is covered in the attachments in the Clinical Practice years, including the Assistant House Officer (AHO) posts, general practice (GP) placements, IPE and public health components of the courses. F1 doctors found the attachments helped them to understand the structures and functions of the NHS.

Medico-legal and ethical issues

58. Medical ethics and law is fully integrated in the curriculum through the PPD theme. The curriculum maps show teaching in ethics in all years across the courses and we are satisfied that this meets the standards in *Tomorrow's Doctors*. The School runs ethics roadshows which take place on the clinical sites and facilitate discussion of perceived or actual concerns about professional practice in a safe environment. There is a focus on ethical behaviour and exploration of student generated issues. We commend the continuing focus on developing appropriate responses to ethical issues and the ongoing development of the inclusion of ethics in students' patient presentations in grand rounds.

Disability and rehabilitation

59. Students learn about disability and rehabilitation through the Life Control module, ethics and communication skills teaching, and GP and clinical attachments in the Clinical Practice years. Students were able to identify learning in this topic. We found teaching in this area to be a strength of the courses.

The health of the public

60. The vertical Community and Population Health theme covers learning in, and understanding of, population health, promotion of health and prevention of disease. Public health concepts are threaded through the Life Support, Life Protection, Life Control and Life Maintenance modules, GP attachments, SSCs and final year public health attachments. We reviewed the CBL case on nutrition and lecture materials on health promotion and found this to be satisfactory. Students considered the population health dimension to be integrated within the curriculum and gave examples of health screening and smoking cessation covered in primary care and audits in the final year.

The individual in society

61. Psychology and sociology are covered in the Clinical Science years within the Community and Population Health theme, and integrated with the Life Cycle module, communication skills sessions, GP attachments and IPE strand. We are satisfied that students are exposed to a diverse patient population within placements in the South West London region.

Structure

62. The School acknowledged that it has not made progress since the GMC's last review and recommendation to increase the proportion of SSCs in the course. The overall proportion of SSCs within the curricula across the different courses is between 10 and 14 per cent.

63. We reviewed the detail of the SSCs currently available in all courses and the SSC plans for the new T, P and F years. We approve the plans to introduce an SSC for each attachment in the new P year in order to provide wider choice within the course. The School must report on the planned SSCs in the GMC annual return for 2010/11.

64. We found that the current SSCs provide opportunities to develop research skills, present the results of the work through essays and poster presentations and to consider potential career paths. However, we found that some of the SSCs were used to cover core curricula, limiting substantive choice and this was reflected in students' comments.

65. There must be sufficient protected time in the course to allow students the opportunity to explore topics outside of the core curricula in depth. We require the School to provide substantive student choice within the course.

Delivering the curriculum

Supervisory structures

66. We are satisfied that clear lines of authority and responsibility are set out through the University and School supervisory structures to plan, implement and review curricula and associated assessments. We consider the membership of the various committee structures to have an appropriate range of expertise and knowledge. Student representatives sit on the course committees and felt that their views are listened to and acted upon by the School. However, we note there was limited representation from the key partner sites in the governance structures.

67. We reviewed evaluation data from particular sites, the minutes of the Undergraduate Medicine and Bioscience Education Committee and discussed with the School and NHS partners the arrangements to monitor the quality of teaching at placement sites. Overall, we are content that processes are in place to monitor the

MBBS courses and that appropriate actions are taken in response to issues identified through the evaluation process. However, we found:

- a. The reporting systems from the different sites were variable with limited central oversight from the School.
- b. Student evaluation was not compulsory and therefore limited.
- c. Some NHS partners did not feel closely involved in the development of the new curriculum.
- d. Clinicians at the key placements at the major partner sites did not have protected time for teaching in their job plans.

68. We found the quality of education at partner sites could be monitored more systematically by the School and we recommend that the reporting systems with partner sites are reviewed to ensure that the quality of placements remains fit for purpose.

Teaching and learning

69. The School uses new technologies to deliver teaching. These include the virtual learning environment, Moodle, the Virtual Patients modules and simulation facilities.

70. We found Moodle to be a good learning resource and sampled the support available for learning on diabetes. There is a voluntary policy for staff to upload teaching material and stream lectures. The Associate Dean for E-Learning reported that over 90 per cent of teaching resources are available on Moodle and it is used extensively by students. Students and tutors gave mixed reviews of Moodle, with some complaints about inaccessible information, out-of-date resource links and difficulty in use.

71. From 2009/10 the T year will use the Virtual Patients resource for paperless PBL cases. These allow students to take a non-linear route through a case, with the ability to branch off according to decisions taken regarding patient management. This will be evaluated and may be rolled out to all years if successful.

72. We note the School's development of e-learning resources and evaluation of its usefulness to support delivery of teaching.

73. Students are required to reflect on how clinicians act as role models in their communication skills training to help develop appropriate attitudes and behaviours towards patients and colleagues. The students we consulted recognised the importance of this. Practising F1 doctors reported the value of this training.

74. Staff development programmes include a Postgraduate Certificate in Medical and Healthcare Education, a two day Introduction to Teaching and Training in Primary Care course for GP teachers, a one day induction course for anatomy

demonstrators, a three day teaching skills course, and mandatory education and training courses for OSCE examiners. All new members of the lecturing staff are required to complete the Postgraduate Certificate in Teaching Skills, unless they already have an equivalent qualification.

75. The majority of teaching staff we met both on and off site were aware of the training opportunities available, with some undertaking the development courses. We reviewed the content and uptake data of the staff training courses and tutor handbooks and were satisfied that staff are appropriately trained to carry out their teaching and examining roles. However, some GPs and clinicians on distant placement sites commented that the timetabling of courses often clashed with teaching commitments, opportunities were limited and not well advertised, and some were not remunerated to attend.

76. The quality of teaching is monitored and reported on in the annual monitoring reports through the course committees. This includes evaluation of placements from students and partner site feedback, regular meetings with clinical sub-deans at partner sites, annual visits to partner sites and the annual Service Increment for Teaching (SIFT) funding monitoring process with NHS London.

77. Clinical sub-deans at six of the key partner sites oversee the organisation of teaching within the Trust and monitor educational experience on-site. We note that the effectiveness of the sub-deans on the partner sites is not appraised by the School. We consider the role of the sub-dean within delivery of medical education could be improved. We encourage formal input from the School into the Trust appraisal of the clinical sub-dean post.

78. For those partner sites without clinical sub-deans, and in primary care placements, the main source of information on the quality of teaching is student evaluation. This is not compulsory, leading to low response rates. We reviewed the available student evaluations and concluded that the data collection process was unsystematic. We also note that once GP placements are approved, they are not revisited. We recommend that the School reviews its monitoring processes for all partner sites and primary care placements to ensure that they remain fit for purpose.

79. From review of student timetables and handbooks we are satisfied that there are diverse teaching and learning opportunities available and that these are appropriate to student learning needs. These include small group teaching in CBL and PBL sessions, tutorials, dissection, clinical skills including peer tutoring; large group lectures and expert forums; interactive learning sessions; practical classes; community placements; clinical attachments including the training ward; and self-directed learning.

80. Students have the opportunity to work and learn with other health and social care professionals in community visits, primary and secondary care attachments, mixed clinical skill groups, and through the interprofessional teaching components of the curriculum. This includes a three week Interprofessional Practice Placement (IPP) on a training ward in the final year, with students from nursing, occupational therapy, pharmacy and physiotherapy taking responsibility for a group of patients undergoing rehabilitation.

81. Up until 2007/08, the IPP was only available for GEP students. In 2008/09 this was extended to include one third of all final year students. From 2009/10, all final year students will have this opportunity as it is rolled out to other sites.
82. Students gave mixed evaluation regarding the interprofessional training ward. Some students questioned its timing in the final year and described their variable experiences, as representation from other health professions was inconsistent due to timetabling conflicts. However, the majority of participating students that we spoke to valued the practical experience of managing a ward.
83. We consider the training ward model has the potential to provide students with valuable interprofessional education, but that at present the School is not able to fully sustain this consistently. We note the School's plans to offer this experience to all students and encourage the developments in this area at other sites.
84. MBBS 2007 for both streams focuses on integrating clinical and basic sciences. There is now a reinforced spiral design related to the six core modules, with the early clinical attachments integrated with the subject areas. The intention is for subject leads to develop the spiral across all years into the P and F years. The four vertical themes run throughout the curricula and there is a clinical and communication skills component in all years. Integration was less evident on the GEP, with limited basic science teaching in the later years.
85. We reviewed the extensive list of placements in over 47 trusts and Primary Care Trusts and 16 charities and voluntary organisations. We note that MBBS 2007 is increasing the amount of time in mental health to reflect the changing patterns of healthcare.
86. We are satisfied that from the beginning of the courses there are multiple opportunities to interact with people from a range of social, cultural and ethnic backgrounds, and students are supported to consider and reflect on the implications of these differences. Year 1 students undertake visits to patients as part of CBL learning on the five year stream and Year 1 graduate entry students follow a pregnant mother as part of an SSC. Students also have clinical attachments in the local area, which provides a diverse patient population.
87. In the final year, the focus is on preparation for practice. Students undertake a one week Advanced Clinical Practice (ACP) placement, a 10 week attachment in AHO posts in medicine and surgery which include night shifts, the three week IPP and a compulsory two day 'Becoming an F1 Doctor' course after the final assessment. Shadowing is not always possible for the foundation posts that graduates will be starting.
88. The ACP placements were introduced in 2008 and cover key areas in communication, skills and anatomy. These include focused case presentations, ward handovers and prescribing. A student formulary supports the prescribing training with a list of drugs commonly prescribed by newly qualified doctors.
89. All F1 doctors, F1 educational supervisors, clinicians, and final year students spoke positively about the AHO placements. All considered them to give good

experience in developing clinical skills by providing opportunities to clerk patients, perform physical examinations and interpret findings and make clinical decisions. We commend the AHO posts as an area of good practice.

Learning resources and facilities

90. The School has invested around £18 million since 2001 in updating and providing new learning resources and facilities to accommodate the increasing student numbers. The School identified concerns with capacity for small group teaching rooms in the annual monitoring reports and the validation report. We note the actions taken and encourage the School to continue to review this.

91. We toured facilities at the School, including the dissecting room, pathology museum, library and PC rooms and found these all to be well resourced. We found the newly refurbished PBL rooms to be of very high quality and the lecture theatres to be adequate. The facilities on placement sites were observed to be variable and some GPs reported that space for teaching can be limited. Space for OSCEs was not considered to be a particular problem by the School and we observed the final year OSCEs and support this view.

92. Opportunities to develop and improve clinical and practical skills are available in the clinical skills and simulation facilities. The simulation facility was very well resourced and well used, with committed and active staff.

93. Staff, F1 doctors and students that we interviewed were content with the learning resources and facilities at the medical school and placement sites. We consider that the facilities provided are of a satisfactory standard.

Student selection

94. We are content that the student selection procedures are appropriate. Information about the admissions system, selection process and guidance about how places are offered is published on the School's website. Full details of the admissions and selection procedures are detailed in the School's validation report.

95. Dedicated admissions officers for medicine assess applications using set criteria. Applicants for the five year stream are ranked by their UK clinical aptitude test (UKCAT), predicted A-levels and GCSE scores. The graduate medical schools admissions test (GAMSAT) scores have been used since the start of graduate entry to rank four year stream applicants.

96. We are satisfied that all interviewers receive appropriate training covering equal opportunities and scoring of applicants through the interactive, simulated mandatory half day training sessions. We note that interview times have increased by 10 minutes and are structured for the four year stream and semi-structured for the five year stream and scored against set criteria. To reduce bias the interview panel does not have access to applications and decisions are not made at the interview.

97. We are pleased to note the School has investigated the low proportion of successful applicants to entry for the GEP from ethnic minorities. Consultation with experts in the field confirmed the entry tests are not culturally biased. Failure to reach the interview stage was attributed to GAMSAT and previous degree performance.

98. We are satisfied with the School's initiatives to widen participation and note the number of schemes in place. These include a Junior Doctors programme, Experiments Road Shows, Summer Schools, Clinical Skills days, a Taste of Medicine multimedia resource, 'compact' agreements with local schools to provide work experience and medical student shadowing, and consideration of access to medicine courses at two specific colleges. Since 2003, the School accepts students with lower A-level grades on condition they are 60 per cent above the school average. We encourage the School to continue to develop its work in this area.

99. Subject to certain criteria, the School also accepts transferring students into Year 3 of the five year MBBS from the Universities of Oxford and Cambridge, the International Medical University in Malaysia, the University of Brunei Darussalam from 2008/09 and from the St George's Biomedical Science BSc course.

Student support, guidance and feedback

100. The School's student support diagram shows the wide range of support services available for academic and general welfare needs, with contact details for each source. The student centre handbook provides details of the services available at the centre and externally. We note that there is no formal support provision at outlying sites, but links are in place to ensure support can be provided where needed. Students demonstrated awareness of these services during our visits and felt able to seek help if required both on-site and on placements.

101. All students transferring into the course have a one week orientation period and the student centre coordinates the transfer of overseas students. Student comments confirmed that the support provided was very good.

102. The personal tutor system is signposted to students in introductory lectures in Year 1 and the T year. The system aims to provide a point of contact for students throughout the course and to give advice on academic and non-academic matters and refer students to others for help. Students are allocated their PBL or CBL tutor as their personal tutor at the start of the four and five year stream respectively. Students can request to change their tutors if they wish.

103. Students and F1 doctors of the pre-2007 courses advised that the personal tutor system was reactive, with the onus on them to make appointments if required. We heard examples of tutors leaving the School and students not being notified of their new tutors. We note that, for MBBS 2007, students are required to meet with their tutors twice each year for the first two years only. We encourage the School to continue developing its personal tutor system to ensure that students have continued longitudinal support throughout the course.

104. Students are encouraged to look after their own health and register with a general practitioner, with information on local GPs provided in the student centre handbook. Information on the Occupational Health and counselling services, available five days a week, is provided in the handbook. There are three counsellors who get curriculum time with students to promote the importance of maintaining health and wellbeing. The service is self-referring and confidential. The School is trialling having a psychiatrist based in the student centre for a half day a week to support counsellors in assessing whether a student needs further referral. Our impression concurred with the views of students and F1 doctors that the counselling services were effective.

105. Guidance on the structure of the core curriculum, SSCs, learning objectives and assessment, including the key contacts for the course, is provided in the student handbooks along with the School's policy on cheating. Students were satisfied with the information available and demonstrated awareness of these during visits. Information on the new T year has been conveyed to students through student forums in March and May 2009 and the T year handbooks will be finalised by mid-August 2009. We note that the School plans to make the learning objectives available online in a searchable format, and encourage the School to continue this development.

106. Students on MBBS 2007 receive information about their development and progress through the personal tutor system. Students are required to complete a post-examination reflective document and a personal development plan, and are required to reflect on their academic performance in advance of meetings with their tutor.

107. Feedback on assessments is provided on a group and individual basis and includes the general performance of the cohort. Failing OSCE students go through their mark sheets in detail with their tutors, and all students can request copies of their OSCE mark sheets. All tutors and assessors for projects and SSCs are encouraged to give feedback to students to justify the grade given. Visiting examiners have previously commented that there was no feedback given to students on the SSCs, but the School advised that this has now changed.

108. Students maintain a portfolio during the entire course. We reviewed a sample of these and found detailed feedback is given on examination performance to include individual OSCE station marks and students' rank within the cohort. However feedback on the students' reflections within their portfolio was variable. We encourage the School to ensure that comprehensive portfolio feedback is provided.

Assessing student performance and competence

The principles of assessment

109. We reviewed the detailed curriculum maps, assessment outlines and blueprints and final year examination papers, and are satisfied that the schemes of assessment support the curricula and allow students to demonstrate the breadth and

depth of their knowledge. Professional attitudes and behaviour are assessed through the longitudinal professional assessment strand in all years of the MBBS 2007. We see this as an area of developing strength.

110. The schemes of assessment and the student handbooks for all courses show that student performance in the core and student selected parts of the curriculum contribute to the overall results. For the new five year stream, all SSCs except the Year 1 SSC contribute to the overall result for that year.

111. We are satisfied that the wide range of assessment techniques used to test the curricular outcomes are valid and reliable. These include appropriate written, clinical, communication and practical skills assessments blueprinted against the curriculum outcomes with clear criteria and marking schemes. We are content that processes are in place for setting standards; the School uses recognised standard setting methods to set the pass marks. The processes for making decisions about a student's performance are detailed in the schemes of assessment.

112. We reviewed detailed psychometric analysis of assessments, the 2007/08 Examination Review Report and statistical data on final year OSCE performance and found these to be of a high standard. We commend the School's overall assessment strategy, including the assessment methods, processes, materials, scripts, training and compliance of examiners, and detailed evaluation of assessment systems.

113. We are satisfied that students' knowledge, skills, attitudes and behaviour are thoroughly assessed. We observed the final year OSCEs which tested a range of competences and reviewed the final written examination papers taken in the penultimate year of the courses. We found that these satisfactorily tested the breadth and depth of knowledge.

Assessment procedures

114. The School's scheme of assessment for each year of each course describes how students will be assessed against the curricular outcomes. This details how individual assessments contribute to the overall strategy.

115. Information about assessment is available on the School's web pages and given to students in handbooks, the schemes of assessment document, and lectures for students on the new course. In addition, students receive briefings before examinations. The majority of students we spoke to understood how they would be assessed in their year, but some considered advice on examination technique for each format would be beneficial. We observed student briefings for the 2009 final OSCEs and found this to be clear and consistent, and observed that students had understood instructions for each OSCE station.

116. The GP tutors we spoke to advised that there is no formal training on assessment within GP placements, but guidance is given in the GP handbooks. We heard examples of past issues with subjectivity and double marking of student essays. We note the School's response has been to change the mode of assessment to clinical summaries.

117. All OSCE examiners are required to undertake formal training and attend the examiner briefings for each session. Detailed instructions were given to examiners about how to apply the marking criteria and the effectiveness of this process was apparent in our observation of the 2009 final year OSCEs. We commend the training provided to OSCE examiners in carrying out their role and applying the School's assessment criteria consistently.

118. We observed the briefing for simulated patients used at the final year OSCEs. The School explained the format of the OSCEs and how the marking scheme for the simulated patient score should be applied. Simulated patients for the same station met in advance to practise their roles and had specific briefings from the responsible examiner for the station to ensure understanding of their role. We found this to be an area of good practice and observed consistency in performance within and across circuits.

119. We reviewed the marking sheets for the final year OSCEs, which consisted of a global rating and a checklist of pre-set criteria individual to each station, covering history, examination and investigation, explanation and management and other professional behaviours. The examiner briefings explained how to apply the marking guidelines and we observed this to be followed appropriately. We share external examiners' views that the examiners are well trained.

120. We found the systems in place to determine the pass mark to be appropriate and to follow best practice in assessment. We reviewed the records of attendance and specialties at standard setting meetings and an example of how the pass mark was set for a particular assessment, and found this to be appropriate.

121. We observed the Final Board of Examiners discussing students with a borderline performance and found that the approach taken did not have a clear structure. The School must specify the framework for exercising discretion about such students to ensure fairness and consistency in decision making. The framework should be compatible with good practice, ensure adequate safeguards to protect patients and be readily accessible to students.

122. We reviewed information in the School's Quality Manual on how external visiting examiners (VEs) are appointed, the VE job description, induction course material and VE reports procedures. VEs are invited to attend annual induction days covering the course design and assessment strategy. We consider VEs are appropriately involved in all stages of the assessment process from selection of methods through to student progress decisions.

123. We reviewed all the final year VE reports for the existing courses for the last three years and the 2007/08 reports for Years 1 and 2 of the new five year stream. We share concerns around subjectivity in decision making of borderline candidates and the policies and practice for double marking. We observed VEs at the final OSCEs and Final Board of Examiners in 2009. We are satisfied that the VEs are employed appropriately and give constructive feedback to the School to ensure that standards are met.

Appraisal

124. For the new MBBS 2007, tutors are expected to meet with their tutees once a term during the Clinical Science years to discuss academic progress. During the Clinical Practice years for all courses, feedback is provided to students at the end of each clinical attachment. Students reported that this feedback is variable.

125. We note the introduction of the Progress Test in 2010 will provide longitudinal feedback.

126. Students and graduates confirmed that the School provides detailed feedback to students who have failed an assessment or are a cause for concern on placements. Remedial support is provided to these students. The students stated that they would like more detailed feedback on their performance.

127. We reviewed a sample of a range of portfolios and noted that students were scored by percentile, and that professional attitudes and conduct were marked on a designated scale. We note the detailed breakdown of marks for summative assessments which include results by theme, marks for each examination, the students' band within the year and classification, class results and a percentage mark by subject feedback area.

128. We found the feedback given to students on areas for further development was satisfactory and noted significant improvement in SSC reports that had originally failed and were resubmitted. We found the formative feedback given to students on their reflective writing to be variable and encourage the School to develop criteria for judging this work to support consistency.

Student progress

129. We are satisfied with the provisions in place for students who have made the wrong career choice. Information for students is available through a number of sources and signposted to students. The recognised credit system allows students to transfer to another course within the Faculty to be awarded a Diploma, Bachelor of Science (BSc), or BSc (Hons) in Medical Studies or a BSc (Hons) in Biomedical Sciences.

130. We are satisfied with the careers advice provided to students. This includes access to a University of London Careers Advisor on-site once a week, an annual careers fair and specific support for application to the Foundation Programme through talks, lectures and workshops. Where appropriate, careers advice is given to students who do not meet the requirements for the MBBS.

131. The School has a Student Progress and Monitoring Committee which allows it to track any students causing concerns. The committee meets once a term or at short notice if there is an urgent issue to decide whether an issue can be dealt with informally or referred to a Fitness to Practise (FtP) Panel.

132. The School updated its FtP procedures to reflect the joint guidance by the GMC and Medical Schools Council (MSC): *Medical Students: professional values and fitness to practise* in July 2008. The procedures include informal and formal processes.

133. Under the formal FtP procedures, an Investigating Officer is appointed to review initial evidence and decide whether to refer the case to a Hearing Committee to deliberate on whether the student is fit to practise and to impose any necessary sanctions. Students may apply to the Chair of the School's Council to review the case and establish an Appeal Committee. We are satisfied that the procedures in place are fair and there are no conflicts of interest in the membership of the Hearing Committee.

134. Information about the FtP procedures is signposted to students through introductory lectures to all first year students, distribution of the GMC and MSC guidance by hard copy and on Moodle, and reminders in the final year as part of the GMC registration and Foundation Programme application process.

Student health and conduct

135. We are satisfied with the support available at the School for students with health and conduct issues.

136. We note concerns from clinicians that there is no agreed procedure for disclosing information to them on students with concerns when they are on placements. The School liaises with the student to reach agreement on sharing of information. Given these concerns, we encourage the School to review this area in discussion with clinical sub-deans and in keeping with GMC guidance on confidentiality and patient safety.

Acknowledgement

137. The GMC would like to thank St George's Medical School and all those they met during the visits for their co-operation and willingness to share their learning and experiences.

Response to the QABME Report on St George's University of London

1. We wish to thank the GMC, its QABME staff and the members of the visiting team for their work in undertaking this review and producing the report. We are grateful to the QABME team for the open, constructive and professional manner in which the visits were conducted.
2. We consider the report to be a fair and balanced analysis of the MBBS courses that we offer currently. In our view the report represents a positive endorsement of those courses, but also offers us helpful guidance in improving various aspects.
3. We are gratified by the positive comments in the report including the four areas of innovation and good practice selected for specific commendation. These are the teaching and assessment of communication skills; the embedding of ethics and law in the curriculum and an innovative approach to teaching in ethics; the AHO placements in preparing students for practice; and, notably, the development and implementation of a comprehensive assessment strategy.
4. We are pleased with a number of other comments and statements in the report that highlight areas of strength. These include handbooks for the Good Medical Practice clinical attachments (Paragraph 44); the teaching in disability and rehabilitation; (Paragraph 59); Moodle, our virtual learning environment (Paragraph 70); the well resourced dissecting room, pathology museum, library and PC rooms and very high quality PBL rooms (Paragraph 91); support arrangements for transfer students (Paragraph 101); the training available to OSCE examiners (Paragraph 117); and the preparation of simulated patients (Paragraph 118).
5. The report includes three requirements for us to address and a single recommendation. We undertake to respond to these, and our proposed action plan is attached to this paper. It is our intention to respond carefully to each requirement and recommendation and to the other constructive comments and suggestions that appear throughout the report.
6. We have commenced a review of our SSC programme to ensure that our students have genuine choice during their studies. We have noted the concerns about the consideration of borderline candidates in the Final Assessment and steps are being taken to ensure that our decision-making is fair, valid and reliable. We recognise that the quality monitoring systems that apply to our NHS partners could be

strengthened and we are looking carefully at ways in which this can be achieved. In the coming years, we will be rolling out the T, P and F years of our new curriculum and phasing out the current 4 year and 5 year courses. In this context, the team's report contains much that will be of value to us.

7. We will seek to enhance the quality and maintain the standards of our MBBS provision in a continuing dialogue with the GMC through the QABME process.

Professor Sean Hilton
Deputy Principal

St George's University of London: QABME report action plan

Requirements	Actions	Lead responsibilities	Timeline
Evaluate the continued implementation of MBBS 2007. In the 2010/11 GMC Annual Return, the School must provide a detailed report on the implementation of the T year and the further development of the plans for the P and F years	<ol style="list-style-type: none"> 1. Monitoring report for clinical science years to be submitted to UMBEC. 2. Progress report on introduction of T year and development plans for P and F years to be submitted to Course Committee. 3. Detailed reports to be included in 2010-2011 Annual Return as required by team. 	Course Director/ Course Committee/UMBEC	October 2009 November 2009 March 2010 (enhanced return) and 2011
Increase substantive choice in the student selected components (SSCs)	<ol style="list-style-type: none"> 1. Current SSC blocks to be reviewed and core material reassigned elsewhere. 2. Student views on the type of choice they would welcome to be canvassed. 3. Introduce the additional five week SSC block early in the Final year, rather than in the P year originally proposed to GMC. This will allow students a wider range of choice from any specialty, rather than limit them to the P year specialties. 	Academic Lead for Student Selected Programme /SSC Development Committee	March 2010 January 2010 March 2010
Specify the framework for exercising discretion about students with a borderline performance in the final examinations	<ol style="list-style-type: none"> 1. Schemes of Assessment for MBBS 2007 (including for the Final Assessment) will not identify borderline candidates. 2. For the existing programmes, the practice of discussing borderline candidates in the Part Four Examination will be discontinued. Extending this approach for remaining sittings of the current Final Assessment will be explored. 	Chief Examiner/ Associate Dean/Medicine Assessment Committee	October 2009 February 2010

Recommendation	Actions	Lead responsibilities	Timeline
To enhance the quality of the courses, we advise the School to review the reporting and monitoring systems with NHS partners, including in general practice	<ol style="list-style-type: none"> 1. Develop more formal involvement of SGUL in appointment and appraisal of clinical sub deans at partner NHS Trusts. 2. Introduction of standardized evaluation forms for students to complete. 3. Aim for 100% completion rate by asking students to confirm that that they have completed evaluation forms when they hand in attachment certificates. 4. Development of a formalised system of annual reporting and monitoring of delivery and quality of teaching by Partner Trusts, and of facilities, including site visits. 5. Development of a programme of repeat visits for GP practices. 	Course Director/ Course Committee/UMBEC	Nov 2009 Dec 2009 Ongoing March 2010 March 2010 March 2010

R:\Academic Registrar\GMC\SGUL Response to Final Report - confirmed.doc