

EDUCATION COMMITTEE

**REPORT OF THE VISIT TO THE UNIVERSITY OF BRISTOL SCHOOL OF
MEDICINE AND THE SOUTH WEST DEANERY**

18 - 19 JANUARY 2000

We should like to express our thanks to the Director of Medical Education, the Clinical Dean, the Postgraduate Dean, and all those who spent time organising the visit programme and discussing the undergraduate curriculum and the pre-registration year with us.

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Foreword to the visit reports 1998-2001

The Education Committee is accountable for ensuring that its recommendations on basic medical education are implemented by every medical school in the UK. When our latest guidance on undergraduate education, *Tomorrow's Doctors*, was published in December 1993 we made it clear that we intended to monitor the

progress of curricular change, through both written enquiries and on-site visits. We are taking a similar approach towards implementation of our recommendations about the pre-registration year, published in *The New Doctor* in April 1997.

The first round of visits, to 25 medical schools, took place between 1995 and the spring of 1998. A second round of visits began in the autumn of 1998. These are focusing on the rolling out of the 13 principal recommendations in *Tomorrow's Doctors* during the primarily clinical years of the undergraduate course, as well as the introduction of improved arrangements for the training of pre-registration house officers.

The Quality Assurance Agency also began its review of medicine in the autumn of 1998 and at the request of the medical schools concerned a number of our visits have been synchronised with those of the QAA. This has enabled both bodies to minimise the burden which would otherwise have been imposed on the schools as a result of two separate visits within a relatively short space of time. We have, for example, been able to share documentation, and hold some joint meetings with medical school staff, students and recent graduates. Where collaborative working with the QAA has taken place, we state this in our reports.

The purpose of the QAA reviews is described in detail in their own documentation, including the reports of visits their teams have undertaken. The visits we ourselves are presently making are informal and are designed to be facilitative and supportive of curricular change, rather than judgmental. For this reason they contain no graded assessments of the quality of the provision available, or the quality of the student experience. They do, however, point up areas which we believe to be in need of further consideration. We will be pursuing progress with regard to these issues through written enquiries of the medical schools 12 months after each report has been published.

As well as informing us in some detail about the extent to which each school has succeeded in introducing a curriculum consonant with our guidance, and in enhancing the clinical experience of its new graduates along the lines advocated in *The New Doctor*, the visits provide us with opportunities to identify examples of good practice which we can share with other medical schools. These too are detailed in our reports.

The reports of individual visits will normally be available on our website (www.gmc-uk.org) one month after these have been sent to the schools concerned.

In addition, we will be publishing a summary of our findings at the conclusion of the current round of visits in 2001.

Introduction

1. The purpose of the visit, which took place on 18 and 19 January 2000, was twofold:

To monitor progress made towards implementing *Tomorrow's Doctors*.

To consider progress towards implementation of the recommendations contained in *The New Doctor*.

2. The visiting team was led by Professor Graeme Catto, Chairman of the Education Committee. The other members were Professor James Drife, a medical member of the Education Committee; Ms Susan Leggate, a lay member of Council; and Professor Stewart Petersen, Head of Medical Education at the University of Leicester.

3. The visit lasted two days. The first day was concerned with the undergraduate curriculum, and the second focused on general clinical training.

4. This report is therefore in two parts. In the first we consider developments in undergraduate education since our last visit in January 1997. In the second half of the report we consider compliance with the recommendations in *The New Doctor*, and plans for developing general clinical training provision within the region.

5. In both parts of the report we have identified areas of good practice, as well as those where further progress is required.

Part 1: The undergraduate curriculum

Background information

6. Prior to the visit the School provided us with helpful background material including the Self-Assessment Document prepared for the QAA reviewers who visited in November 1999.

Form of the visit relating to undergraduate medicine

7. Following a private meeting we met members of the Curriculum Development and Coordination Group and Year 4 and 5 course organisers to discuss curricular development and progress since our last visit. In the afternoon we had the opportunity to meet a group of students drawn from each year of the curriculum.

8. Members of the team were also able to see a number of facilities including the Clinical Simulator, the Clinical Skills Centre, and the Medical Library and

Comparative Morphology Centre. In addition, the team had access to the background documents prepared for the QAA subject review in November 1999.

The undergraduate curriculum

Curricular development

9. When we visited in January 1997 the School was in the process of introducing a new curriculum, the first year having been introduced in 1995. On our return in January 2000 we were pleased to learn that the School had successfully implemented its new curriculum in full. The first group of students to complete the new course were due to graduate in July 2000.

10. We were told that as each year of the new curriculum had been introduced, the course had been reviewed to monitor internal consistency and to ensure that changes were successfully implemented.

The new curriculum

11. The new curriculum, which was designed to meet the aims and learning objectives at Annex A, is divided into the following phases:

Phase 1 (terms one and two of the first year)

Phase 2 (third term of Year 1 to the end of Year 3)

Phase 3 (Years 4 and 5)

12. Each phase is divided into a number of units, which in turn consist of a number of elements. A diagrammatic representation of the course and details of each unit and element are at Annex B.

13. The following vertical themes run throughout the five years of the MB ChB programme:

Ethics and medico-legal issues.

b. Communication skills.

c. Evidence-based medicine.

d. Disability and rehabilitation.

e. Psychosomatic medicine.

14. These allow important topics and issues to be revised, and student understanding to be consolidated and enhanced throughout the course. More complex teaching and learning activities are introduced as students gain experience and become more reflective about their knowledge, skills and attitudes.

15. Phase 1 is designed to ensure that all students have a common knowledge and understanding of the basic medical sciences, the structure and function of the

human body and the place of the individual in society.

16. Phase 2 builds on the Phase 1 knowledge base and introduces students to clinical work through attachments in medicine and surgery, and clinical specialties. During this phase students have the first opportunity to select a special study module, and can undertake a one year intercalated degree.

17. Phase 3 consolidates the knowledge, skills and attitudes learned to date, and allows students to further develop their personal and cognitive skills. By the end of this phase students should be fully prepared for the pre-registration year.

18. The introduction of the new curriculum has enabled the School to provide students with an early opportunity to gain experience in clinical contexts and to meet patients. For example, in the first term of Year 1 groups of students spend one half day a week in a general practice observing consultations and attending home visits. This allows them to see the range of conditions encountered in primary care, observe GPs communicating with patients and develop an understanding of the importance of the doctor-patient professional relationship.

19. The new curriculum has also allowed the School to review the assessment techniques used. The scheme of assessment is discussed in more detail at paragraphs 89 to 92.

The management of change (Principal Recommendation 13)

Supervisory structures

20. The School of Medicine is one of four schools which make up the Faculty of Medicine. The others being the School of Dentistry, the School of Veterinary Science and the School of Medical Sciences.

21. Following a restructuring in July 1998, responsibility for the overall management of the curriculum rests with the Medical Education Committee (MEC), which reports to the Faculty Board via the Board of Medical Studies. The Curriculum Development and Co-ordination Group (CDCG) oversees curricular developments. Each year has a group that oversees the programme for that year. All Year Group Chairmen are members of the CDCG, which assists this body to coordinate curricular changes. Unit and element organisers are responsible for the implementation of the curriculum and the day to day monitoring of the course and the teaching provided.

22. A diagram of the committee structure for the MB ChB programme is at Annex C.

23. It seemed to us that the School has moved rapidly to implement changes in a number of areas. However, we feel that further refinement of the assessment techniques used (see paragraph 92), and enhancement of the SSM programme (see paragraph 51), would be assisted if a medical education unit were established. Units of this type have provided an invaluable source of support and

innovation at other medical schools, and we think the School should consider establishing such a body.

The contribution of students

24. Student representatives, elected by the medical students association, 'Galenicals', are members of the MEC and all its subgroups. The School informed us that students played an active role in curricular development and in reviewing change. The students with whom we spoke confirmed that Galenicals had an excellent working relationship with the MEC. We were told that their views were constantly sought by the School and they were encouraged to suggest changes and participate in new initiatives.

25. We were very impressed with the prominent role which students play in curricular design and development in Bristol. We were left in no doubt that an effective partnership has been developed between staff and students to ensure the maintenance of high quality undergraduate medical course.

Staff development

26. In 1997 we were very impressed with the extensive programme of staff development that had been put in place to support the introduction of the new curriculum. The School was commended for ensuring that as many staff as possible, both academics and NHS clinicians, took advantage of the opportunities provided.

27. On our return in January 2000, we were pleased to find that the MEC continues to place great importance on providing appropriate staff development programmes for both teachers and those involved in curricular design and development. Initiatives taken by the MEC include:

Staff 'away-days', which consider relevant issues such as assessment policies and procedures, IT initiatives and the production of course handbooks.

Training days for clinical teachers, which have been organised by unit and element organisers.

The development of regular teacher workshops to discuss issues and problems. These are currently being pioneered in primary care.

The provision of training in objective structured clinical examinations (OSCEs) to increase the pool of expert examiners upon which to draw.

28. In addition to the above, we noted that:

As part of the University's teaching and learning programme all new academic staff must attend a programme which is run by the School of Education. NHS clinicians are encouraged to participate in this programme.

Students nominate 'teachers of the year' who are given a reward in recognition of teaching excellence.

29. The School is aware that while NHS clinicians have a responsibility to teach students, they also have large service commitments that must be met. In order to promote teaching excellence the School

Is working with its NHS partners to ensure that teaching is considered during annual performance reviews of NHS clinicians.

c. Intends to circulate the GMC's guidance, *The Doctor as Teacher*, to all teachers as a reminder of their obligations.

Aspects of the core curriculum (Principal Recommendations 1, 2, 5, and 7)

Defining the core

30. The MEC was responsible for overseeing development of the new curriculum, and for ensuring that the decisions of groups which established the core for each unit were coordinated. Core content was defined at a unit level by multi-disciplinary teams. In drawing up the new course consideration was given to the views of students and the content of the traditional curriculum.

Reducing the burden of factual information

31. Development of the new course provided the School with an opportunity to reduce the burden of factual information on students. The MEC determined this aspect of the curriculum by:

Considering the demands made on students in other medical schools and in other courses at the University of Bristol.

Limiting the amount of time allocated to each part of the new course.

Requiring the groups defining the core for each unit to remove unnecessary factual information.

Defining overall learning objectives more clearly so that students and staff would know what was expected in each part of the course.

32. We were told that in the first two years of the course students have, on average, nine lectures a week, two practical sessions and a number of small group sessions.

33. Phase 1 includes over 140 lectures in the first two terms of the course, and we thought that this was didactic. The School accepted that there were not many small group sessions in this part of the course, but pointed out that it acted as an important transition between the didactic teaching students would have

experienced at school, and the more self-directed learning that was engendered on the new medical course. We were told by members of staff that students valued this part of course. This was confirmed by those students to whom we spoke.

34. Unit organisers are required to monitor units to ensure that additional content is not included. In addition, the Annual Review of the Programme, which is discussed at paragraph 112, provides a further check on unauthorised extensions of the core content.

35. The students we spoke to thought the course was challenging but that the demands were appropriate. We shared this view.

Integration

36. Years 1 and 2 of the new curriculum are system-based. Clinicians and basic scientists were involved in designing these elements and both categories of staff are involved in the teaching programme. The School has ensured that the MEC and its various sub-groups are multidisciplinary, which has helped to break down departmental barriers and promote horizontal integration throughout the curriculum.

37. Clinical experience is provided from the first term of the new curriculum, through a primary care attachment, and then threaded throughout the five years of the course. Students' 'First Clinical Attachment' is in the second term of Year 2. This allows students to develop basic clinical skills. The 'Second Clinical Attachment', in the first term of Year 3, extends students' experience and skills.

38. In addition to providing earlier clinical experience than hitherto, the School has sought to embed consideration of basic medical sciences in the later years of the course. Thus, in Year 4 it has introduced units in Applied Clinical Sciences and Clinical Specialisms which address the sciences underpinning medical practice. The SSM programme, discussed in paragraphs 46 to 51, provides students with a further opportunity to revisit the basic sciences in the later years of the course.

39. The curricular themes, identified in paragraph 13, provide further scope for vertical integration. These allow relevant knowledge, skills and attitudes to be revisited and progressively enhanced. The themes are greatly valued by the students and the teaching and learning opportunities they provide seemed to us to be a particular strength of the new curriculum.

Learning through curiosity

40. As students progress through the course they are expected to develop skills that will prepare them for lifelong learning. The School has sought to assist this process by:

- a. Providing advice about study skills in the Year 1 Handbook.
- b. Introducing personal advisers to facilitate the development of lifelong

learning skills.

c. Providing more small group teaching sessions and increased time for self-directed learning in the later years of the course.

41. Intercalation occurs at the end of Year 2 or Year 3, when students can undertake a Bachelor of Science (BSc) honours degree in a range of subjects covering medical science and bioethics. The programme allows students to undertake a research project in a chosen subject.

42. The students that we spoke to found the intercalated programme to be immensely beneficial. The new intercalated programme, 'Ethics in Medicine', was particularly welcomed, and we understand the number of places available on this programme will be expanded.

43. During the final year students also undertake an elective period of study which allows them to gain clinical experience in an area of medicine which interests them. Many students take this opportunity to obtain experience overseas in a different cultural and clinical environment. Students must produce a written elective report that is assessed and included in the SSM portfolio. The SSM portfolio, which is described at paragraph 48, contributes to the award of an honours degree.

44. Through the European Credit Transfer Scheme (Erasmus/Socrates), the School has a well-developed scheme for allowing students to learn about other cultures by studying in Europe. At present students can study the following core elements in the universities of Strasbourg and Vienna:

Care of the Elderly (Year 3)
Musculoskeletal Disorders (Year 3)

45. Students return to Bristol to be assessed on these elements. They can also take advantage of the School's links with 13 other medical schools in Europe to arrange SSMs and electives overseas.

Special study modules (Principal Recommendation 6)

46. The SSM programme in Bristol is overseen by the SSM Committee on behalf of the MEC. The programme is still developing and the School does not expect it to reach its final form until at least one year after the first cohort has graduated from the new course.

47. At present, students have the following opportunities to undertake SSMs:

Year 1

Students undertake a module in the form of directed self-learning during the Cardiovascular System. This comprises three half day sessions and contributes 10% of the marks to the end of year assessment for this system.

In Year 2

Students undertake two modules which are each equivalent to 16 half days. They can choose a module from over 200 options, including a foreign language. Category A modules allow students to study an aspect of the core in more detail. Category B modules allow students to study outside the core. The form of the modules varies but each contribute 16% of the end of year marks.

Year 3

Six weeks are allocated to SSMs. This time is divided into three weeks before and three weeks after the end of year examinations. Students can carry out one six week module or two three week modules. Students must develop a project and identify a supervisor to assist them in this process. The School has a database of all the projects students have ever undertaken. The mark for each module, weighted according to time spent on a project, is entered into the SSM portfolio for the whole course.

Year 4

Students are expected to make a 10 or 15 minute presentation on one of the modules that they carried out in Year 3. Students are assessed formatively by their peers on their ability to produce an abstract, make a presentation and contribute to discussion.

Year 5

Four weeks are allocated to SSMs. Students may choose to do a module from a range of options offered to them, or they may decide to offer a project based on their own experiences and contacts. Marks for each module, like those for Year 3, are entered into the SSM portfolio for the whole course.

48. Although SSM marks only contribute to end of year marks in Years 1 and 2, modules in Years 3 to 5 must be completed satisfactorily in order to progress to the next part of the course and, subsequently, to graduation. In addition, performance in SSMs will contribute towards the award of an honours degree. Consequently, the SSM portfolios (SSM work and marks) of students who have performed sufficiently well on the core curriculum will be reassessed by a panel of examiners. The marks awarded by this panel will contribute to the award of an honours degree.

49. The staff and students that we spoke to agreed that the SSM programme was a welcome innovation. Students found the opportunity to study areas of interest both stimulating and challenging. Staff confirmed that there were many examples of outstanding performance among the modules completed by students. However, the School was aware of the following issues that need to be addressed:

Although generic objectives are provided for SSMs, students and supervisors develop specific objectives for individual projects. The School believes that it must refine the programme to ensure that the stated overall objectives for the programme are met by every student for each module .

The School believes that the number of modules available will need to be

expanded as the programme matures.

At present there is no mechanism for monitoring the combination of modules carried out by individual students.

The School relies on module supervisors to oversee modules and assess projects against the set objectives. As yet the School is unable to guarantee that the standards set by different supervisors are consistent.

50. We agree that these areas need to be addressed, and wonder if the establishment of a medical education unit would be particularly beneficial in this respect. Such a unit could assist the School to monitor, develop and enhance this aspect of the new curriculum.

51. We were concerned that students who fail the end of Year 3 examination use the three weeks following the examination for remedial teaching and learning to ensure that they reach an adequate standard on the core of the curriculum. Because the School believes that performance on the core curriculum is of overriding importance, the SSM programme for such students is inevitably diminished. We appreciate the School's desire to ensure that students perform adequately on the core curriculum. However, if SSMs are to be considered an important part of the medical curriculum we feel that all students must be able to derive equal benefit from this aspect of the course. Given that the SSM programme in Bristol, which equates to approximately 10% of the overall teaching time, falls well short of the 30% we envisaged for SSMs, time allocated to the programme is particularly precious. We would invite the School to reconsider this aspect of the SSM programme, and also to seek to increase the overall proportion of time set aside for SSMs.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

52. Although the number of lectures has been reduced, they still play an important part in providing a knowledge base, particularly in Phases 1 and 2. However, the School has sought to introduce a number of innovative teaching methods including:

Role plays and the use of simulated patients in realistic clinical scenarios to teach communication skills.

Early exposure to clinical experience through GP teachers.

A patient simulator in the Medical Simulation Centre which is used in the teaching of anaesthesia in the Applied Clinical Sciences Unit. This is the only such simulator available to UK medical students.

Opportunities for final year students to work with nurse trainees and thereby develop a better understanding of the role of nurses.

Learning resources

53. Students at Bristol are fortunate to enjoy the following facilities:

Excellent libraries.

Well equipped teaching accommodation.

Sound IT facilities.

A Medical Simulation Centre, which allows students to practice clinical procedures in a realistic setting.

An Open Learning Centre, which provides self-learning resources such as computer-based tutorials, videotapes and CD ROMS.

54. The School has developed its own website, 'Medici', which provides a range of information, resources and useful links to students and staff. Medici is accessible to the general public. However, we understand that as this resource is enhanced, password protected pages will be developed that will give staff and students access to learning resources and more detailed curricular information. We welcomed the School's intention to develop this facility.

The changing patterns of health care (Principal Recommendation 10)

55. As noted in 1997, the School has taken advantage of the introduction of the new curriculum to provide students with greater exposure to primary care. There are a number of opportunities to gain experience in this area throughout the course. These include:

Groups of students spending a number of half days at a GP practice during the first year. This allows them to observe consultations and participate in visits to patients' homes.

Small groups of students, which meet in the second term of Year 1 to consider issues relating to the interface between GPs and hospitals. These groups are facilitated by a hospital consultant and a GP and may involve patients.

The First Clinical Attachment in Year 2, which enables students to develop basic clinical skills under the supervision of a GP teacher.

The Second Clinical Attachment, which provides an opportunity to practise basic history-taking and examination skills, to develop diagnostic formulation and to produce a patient management plan under the supervision of a GP.

A four week attachment in primary care during Year 4, which offers the opportunity to learn in detail about primary care as a medical specialty.

Students spend two weeks in a city practice in Bristol and two weeks in a regional practice.

GPs who act as tutor-facilitators for the PRHO Course in the final year.

56. As well as increased experience in primary care, a larger proportion of teaching now takes place in the community to reflect the changing patterns of health care. Opportunities for community-based teaching involve:

The two week Community Paediatrics Attachment in Year 4.

Exposure to community-based services during the Year 3 Care of the Elderly Attachment.

Experience of community-based psychiatric services in the Year 3 Psychiatry Attachment.

One day with a community midwife visiting a mother and new-born baby at home.

57. Although the organisation of medical education in a community setting is more complex, the School intends to increase the proportion of community-based teaching in the next two to three years. We would support the suggestion from the workshop held to discuss teaching on the First and Second Clinical Attachments that more teaching could be carried out in outpatient clinics and pre-operative assessment clinics.

58. We were particularly impressed with the Community Orientated Medical Practice (COMP) Course which occurs in the fourth year. This 16 week programme comprises teaching and learning in:

Primary care
Public health medicine
Community child health.

59. The programme is designed to allow students to develop the intellectual and clinical skills required for the practice of medicine in the community and involves a combination of lectures and clinical placements in GP practices, hospitals and community settings. As well as teaching and learning within the separate disciplines, a number of teaching sessions provide the opportunity to integrate learning from the different areas of the COMP Course. Fifteen percent of the marks for the course are derived through self-assessment, and the remaining 85% are via a 2½ hour written paper which uses multiple choice questions (MCQs) to assess knowledge and a 3 hour OSCE to assess clinical skills.

60. We agreed with students and staff that the COMP Course is a strength of the Bristol medical course.

The goals of undergraduate education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

61. We were pleased to learn that the School stresses the importance of developing and displaying appropriate attitudes to patients and colleagues. Students are given *Duties of a Doctor* during the introductory week in Year 1. The MB ChB Programme Handbook also includes the GMC's statement about the duties of a doctor. Ethics and medico-legal issues is one of the vertical themes which permeates the course. Formal exploration and teaching on the professional standards set out in *Good Medical Practice* occurs in Years 1, 3, and 5.

62. The students that we spoke to were very aware of the fact that they were being trained to become doctors and should therefore develop appropriate attitudes and conduct. We were interested to note that students have been involved in an innovative scheme which is intended to allow their conduct and behaviour to be assessed. Details of this scheme, which involves students being judged against a series of headings, are at Annex D.

63. The scheme has been piloted in the Second Clinical Attachment, and the School intends to roll it out into all clinical attachments. This is a very interesting development which, when fully implemented, should provide the School with a comprehensive profile of each student's conduct and behaviour. We look forward to hearing about the implementation and development of this scheme.

64. Students have a number of opportunities to discuss issues relating to obtaining a patient's consent. Thus,

Prior to the Second Clinical Attachment there are teaching sessions which consider issues relating to consent and confidentiality.

The COMP Course includes a module that addresses how to gain consent by proxy for children, including cases in which parental consent is withheld.

The final year includes teaching on ethical issues including consent and other medico legal issues.

65. The students we met had a clear understanding of appropriate professional conduct and were therefore able to distinguish between good and poor role models. We were pleased to be told that clinical teachers were generally considered excellent. However, students made it clear that they would not hesitate to draw the School's attention to clinicians that they thought were poor role models. Students were confident of receiving the full backing and support of the School if such an occasion were to arise. We thought this was a further positive indication of the sound staff-student relationship that has been engendered in Bristol.

Essential skills (Principal Recommendations 4 and 8)

IT skills

66. As each new cohort has entered the medical course the School has found increased levels of competence and proficiency. Nevertheless, a significant minority of students still require some assistance to develop their IT skills to the requisite level. For such students there is small group teaching in which they are taken through a series of exercises to demonstrate a wide range of computer packages. Student competence in IT is reinforced throughout the course particularly through the requirement for coursework and SSM reports to be word processed. Presentation of SSM projects in Year 4 is usually via PowerPoint.

Communication skills

67. We were impressed with opportunities which students have to develop, consolidate and augment their communication skills. These are addressed in one of the vertical themes threaded throughout the course. The discussion paper on which teaching for this theme is based is at Annex E.

68. A variety of techniques and contexts are used to develop communication skills. These include:

The use of simulated patients in realistic clinical scenarios.

Interactive presentations with video or live demonstrations.

Audio taping and self-assessment of consultations.

Small group discussion of relevant issues.

69. Communication skills are assessed both formatively, by teachers, and summatively, through OSCEs.

70. The students that we met confirmed that the teaching of communication skills was one of the most enjoyable and beneficial aspects of the course. They felt that their skills were highly developed and that they were well prepared for difficult occasions such as breaking bad news and asking for intimate information from patients.

Clinical skills

71. The curriculum is designed to allow students to develop their clinical skills progressively. Clinical experience is introduced from Year 1 and basic skills are assessed in Year 3. These skills are reinforced and developed through clinical placements in the final years of the course. A final year OSCE, which will be introduced in 2000, will focus on the skills required by a PRHO, specifically:

Taking a full medical history.

Performing a physical and mental state examination.

Formulating a list of differential diagnoses.

Interpreting clinical data.

Prescribing medication and understanding the potential for drug interactions.

Performing clinical procedures including venesection, inserting venous cannulae and introducing a urethral catheter.

72. We were pleased to learn that there is extensive training in life support skills. The principles of life support are introduced in the Cardiovascular System in Year 1. During Year 2 there is basic life support training and the final year of the course involves an advanced life support course, which is organised by accredited trainers.

73. Following each of the First and Second Clinical Attachments a clinical skills assessment is carried out to monitor progress and formative feedback is provided. Such feedback is regarded as an integral part of the educational programme.

74. Although the students we spoke to generally felt that the clinical training provided was very good, there were some concerns about variable teaching and inadequate feedback from NHS clinicians. It was not evident to us that the School had a central mechanism for monitoring the quality and extent of clinical teaching and that this might be another area in which the School could derive benefit from establishing a medical education unit. Such a unit could coordinate and focus the School's efforts to:

Emphasise the importance of teaching to clinicians.

Ensure that more NHS clinicians take advantage of staff development opportunities.

Develop a more consistent method for providing feedback about students' clinical skills, perhaps akin to the scheme piloted for professional conduct and behaviour.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

75. We were pleased to note that public health medicine has a high profile within the curriculum. In Year 1 students are introduced to epidemiology and biostatistics in the Human Basis of Medicine Unit. However, the majority of teaching about this aspect of medicine is within the Year 4 COMP Course, which is described in paragraphs 58 to 60. Through a combination of lectures and small group sessions this course:

Extends students' understanding of epidemiology and biostatistics and demonstrates how these disciplines can be applied to the evaluation of health care and the management of clinical problems.

Allows students to learn about health economics and health promotion.

Helps students to appreciate the context within which medicine is practised, both in terms of the organisation of health care and the common causes of ill health, in the UK and elsewhere in the world.

76. During the course there are teaching and learning sessions about the history of the NHS, UK health strategy and rationing. A session about rationing involves consideration of topical issues such as the prescribing of Viagra, and introduces students to new government initiatives such as the National Institute for Clinical Excellence (NICE).

77. Students' knowledge of public health medicine, and their ability to apply this, is assessed in the following ways:

A one-hour written paper in which students must answer three out of five questions.

OSCE stations that are designed to assess students' knowledge and skills in this discipline.

A written report and oral presentation on a critical appraisal project ran by the departments of Public Health, Primary Care and Paediatrics.

78. The students that we spoke to thought this was a worthwhile and interesting component of the course.

Legal and ethical issues

79. The School has ensured that consideration of ethical and medico-legal issues permeates the full five years of the MB ChB. One of the vertical curricular themes provides students with extensive opportunities to develop their knowledge and understanding in this area.

80. Students receive experiential and clinical teaching in the ethical aspects of medical practice and how to be a good medical practitioner. In Year 1 all students take the Ethics and Medicine Element. This involves lectures and tutorials on a range of subjects including patients' values, professional obligations and medicine and human rights. Students are assessed through a 2,000 word essay and must answer one essay question on ethics in the Human Basis of Medicine examination.

81. From Year 2 ethics teaching takes place in the context of specific systems courses or within clinical placements. Thus, for example:

In the Respiratory System Course in Year 2 issues relating to genetic screening are discussed and explored. Prior to the First Clinical Attachment there is an ethics briefing session.

In Year 3 ethical teaching in the early years of the course is consolidated in the Integrated Systems Teaching Block.

During clinical placements in Years 3 to 5 consideration is given to relevant ethical and legal issues. During Palliative Care the topic of euthanasia is addressed while the ethics of clinical trials is considered during the fourth year Medicine and Surgery Rotations.

82. Relevant medico-legal and ethical issues are addressed in the Preparation for Day One Course for final year students. This includes sessions on GMC and BMA guidance, risk management and dealing with death.

83. Along with communication skills, and the other vertical themes, this is a positive feature of the Bristol medical course. The students that we met greatly appreciated the training and education they received in this aspect of medical practice.

Medicine in a multicultural society

84. Throughout the course students are taught to value the views of patients and their relatives, and to appreciate that they may have different views about health care and illness. During the Human Basis of Medicine in Year 1 students are introduced to different cultural perspectives and values. During the COMP Course there is consideration of ethnicity and health, and international aspects of health.

85. Students are encouraged to interact with patients and colleagues from different cultural and ethnic backgrounds. Exposure to clinical practice in central Bristol offers many opportunities to gain clinical experience of patients from a wide range of ethnic minorities. Students are encouraged to study overseas via the Erasmus/Socrates scheme and many choose to undertake their final year elective study outside the UK.

Complementary and alternative medicine

86. There are few timetabled opportunities for students to gain experience of complementary and alternative medicine. Where appropriate, consideration is given to relevant therapies in teaching and learning sessions relating to the core curriculum. The SSM programme provides opportunities for students to study this area in depth. Popular topics have included hypnosis, homeopathy and acupuncture.

87. Members of staff that we spoke to were confident that sufficient opportunities were provided for students to develop an understanding of the range of alternative therapies offered. We were told that students had contact with patients seeking complementary treatment and complementary practitioners during primary care attachments and experience.

Infectious diseases and antibiotics

88. Students have opportunities to learn about good prescribing practice and about the use of antibiotics and antibiotic resistance. In Year 1 the Infection and Immunity element considers the mechanisms of action of the major antimicrobial agents and the acquisition of resistance to antimicrobial agents. The appropriate use of antibiotics is addressed in the COMP Course and during the final year in preparation for the pre-registration year.

Assessment of the process and product (Principal Recommendation 12)

The scheme of assessment

89. When we visited Bristol in 1997 we noted that the School was reviewing the scheme of assessment and hoping to develop a system which would reflect the aims and objectives of the new curriculum. On our return we were pleased to note that new assessments techniques, which more adequately assess students knowledge, understanding, skills and attitudes have been introduced. These include:

A system for assessing professional conduct and behaviour which has been piloted before being more fully implemented. (For further details see paragraphs 62 and 63.)

A new OSCE examination designed to assess clinical skills at the end of the Second Clinical Attachment in Year 3.

A new integrated examination which has been introduced at the end of the third year to test scientific knowledge and clinical understanding.

90. In addition to these developments, a new OSCE will be held for the first time in June 2000. This will assess the clinical skills that students are expected to be competent in as well as the skills necessary for the PRHO year.

91. We were impressed with the progress that has been made, and noted that a range of techniques, including MCQs, OSCEs, and recorded consultations, are used to assess the competencies of students. An outline of the principal assessments is at Annex F.

92. However, it was not clear to us that the changes so far made had been informed by an overall assessment strategy. We were told that the School had recognised this and recently produced a code of practice for assessment in the MB ChB programme. We welcome this development, and the School's acceptance that it requires expert assistance to take forward further changes to the scheme of assessment. We believe that this is another instance where the School could derive benefit from establishing a medical education unit, which could focus and coordinate its approach to assessment. The recruitment of staff with particular expertise in assessment would undoubtedly strengthen the School's teaching base.

Academic performance

93. Achievement in summative assessments is recorded by the School and the performance of individual students is reviewed if concerns are expressed. Where necessary, feedback and remedial teaching is provided for such students.

94. Students have the opportunity to resit summative assessments and are only asked to leave the course as a last resort. An unclassified Bachelor of Science

(BSc) degree can be awarded to students who leave the course having achieved an appropriate level of performance in the end of Year 3 examination. The students that we spoke to confirmed that the School is very supportive and in all cases attempted to assist students to overcome any difficulties that they were experiencing.

95. An honours degree is awarded on the basis of performance in the core curriculum and the SSM portfolio. We were told that historically approximately 1% of the cohort received an honours degree, but that the School hopes to increase this figure as students SSM portfolios are considered.

Fitness to practise

96. The School is keen to ensure that students develop appropriate attitudes and that they conduct themselves in a professional manner. To address the cases of students who exhibit behaviour inconsistent with progression to medical qualification a Fitness to Practise Committee (FPC) has been established. The FPC considers the cases of individuals about whom serious concerns have been identified and, as an ultimate sanction, can recommend to the Dean of the Faculty of Medicine that a student should leave the course. We were told that the University fully supports the FPC and would not overturn any of its decisions unless procedures had not been followed or new evidence was presented.

97. We were pleased to learn of the creation of such a body, which we think is vital if appropriate professional standards are to be maintained and developed in medicine. The University and School are to be congratulated on having taken such a proactive stance on this issue. To date we understand that few cases have been considered. However, we would ask the School to keep us informed of how this new system is functioning.

Preparation for the PRHO year

98. The School has worked closely with its colleagues in the South West Deanery to ensure that students are well prepared for life as a PRHO. As mentioned in paragraph 90, the new final year OSCE is designed to ensure competence in the skills required by PRHOs. In addition, the following initiatives have been included in the final year of the MB ChB programme.

A one week Preparation for Day One Course.

A two week PRHO Course.

99. The one week course is designed to cover key areas and issues including medico-legal issues relating to consent, confidentiality, dealing with coroners and how to deal with sick or incompetent colleagues. There are also sessions on clinical pharmacology and an Infectious Disease Symposium which covers the management of common infections that are likely to present, for example HIV and tropical diseases. The week closes with a session covering details about PRHO posts and information about the PRHO course.

100. The two week PRHO course is designed to prepare students for the transition to PRHO and to consolidate the knowledge, skills and attitudes that they will require. The course is divided into the following parts:

Two days of preparatory sessions at the Medical School, which includes an explanation of what is expected of students when they shadow a PRHO. It also covers:

- The role of the PRHO.
- Case management.
- When and how to look for help.
- Managing paper work.
- Surviving shadowing.
- Working with nurses.

One week shadowing the PRHO posts students will be undertaking. Participants are provided with a diary in which they must record critical incidents and lessons derived from these. Students are also given a 'Good Start Guide' which sets them a series of tasks to undertake so that shadowing is not merely a passive experience.

Three days back at the Medical School in which students reflect on their experiences and identify learning needs.

101. Staff from the School and Deanery believe that PRHO shadowing will be beneficial to the students and the staff responsible for training PRHOs. We understand that the School and Deanery hope that by identifying learning needs with the assistance of their future colleagues, training during the pre-registration year will be tailored to the needs of individuals.

102. The students we met thought that these courses would greatly enhance their ability to operate effectively when they become PRHOs. The School and Deanery are to be commended for the development of this programme for final year students.

Other issues

Student selection

103. Although student selection is not directly within our remit, we have an interest in ensuring that only those who are fit to become doctors are admitted to Medical School. We therefore sought information about this aspect of the School's procedures.

104. The Admissions Committee oversees the selection process for the MEC. We understand that the School receives approximately 2000 applicants each year, of which 500 are invited for interview. Members of the Admissions Committee screen applicants and carry out interviews. Training, which addresses interview technique

and equal opportunities, was introduced last year for all members of the Committee.

105. The students we spoke to confirmed that, although not involved in the interviewing process, students meet applicants and show them around the School. We understand that Galenicals had been approached by the School about a more formal involvement in interviews, but did not feel this would be appropriate. The students we met confirmed that their visits to Bristol and interviews were positive and enjoyable experiences.

Student support

106. The School has put in place excellent systems for ensuring that all students receive appropriate academic support. These include:

Detailed course handbooks which outline what is expected of students.

Tutors for Year 1 and 2 system-based teaching who monitor student performance and progress.

Formative assessments which allow staff and students to gauge progression.

Opportunities to discuss problems with Pre-Clinical and Clinical Deans.

107. In addition, pastoral support is provided by:

Personal Advisers.

The Students' Health and Counselling Services.

Undergraduate Teaching Co-ordinators (Sub-Deans in some cases) at each trust who have pastoral and welfare responsibilities.

The Galenicals Society through its programme of leisure activities and a student family system in which senior students provide guidance and support to newer students.

108. The students that we spoke to confirmed that the School was very helpful and made great efforts to ensure that all students enjoyed the MB ChB programme. Staff were commended by the students for the supportive and sensitive manner in which they dealt with students' difficulties and concerns.

Feedback to students

109. Our discussions with staff and students revealed that feedback from summative and formative examinations was very helpful. Students in Years 1 and 2 also felt that feedback from tutors on their performance was extremely helpful.

110. However, students in the later years of the course were concerned about the

feedback provided by some NHS clinicians. We were told that this was inconsistent, and that the level of detail provided varied greatly. We would like the School to consider this issue, together with students' concerns about variable teaching by NHS clinicians, which are discussed at paragraph 74. It seemed to us that the system for providing feedback on students' conduct, which is being piloted, may provide a useful model that could be adapted for more general feedback about performance.

Quality control

111. The University's Teaching and Learning Strategy Guidelines provide a framework for quality assurance and enhancement. Within the Faculty of Medicine the Faculty Quality Assurance Team (FQAT) is responsible for overseeing quality arrangements. The MEC, supported by its Quality Management and Enhancement Group, is accountable to FQAT for the MB ChB programme. Systems set in place to monitor the MB ChB programme include:

Requests for formal feedback about the course from students.

The involvement of external examiners in the assessment process to ensure that appropriate standards are set and maintained.

Consideration of external examiners' reports about assessments.

Meetings of course organisers, teachers and Year Groups to consider quality issues.

Consideration of major issues by the CDCG.

The introduction of an Annual Review of the Programme by the MEC.

112. This last mechanism, which was introduced recently, seems to us to be an excellent development. It involves consideration by the MEC and student representatives of the following:

Annual FQAT report on the course.

External examiners' report.

An analysis of student feedback.

113. It was evident that student concerns about the variability of teaching and feedback from NHS clinicians were no surprise to the School. We hope that the quality assurance procedures are sufficiently robust to address these.

Areas of good practice

114. *The contribution of students:* The School has encouraged students to play an active role in curricular development and has drawn extensively upon their

experiences in the development of the new curriculum.

115. *Curricular themes:* The vertical themes are a powerful tool for vertical integration and allow knowledge, skills and attitudes to be revisited and enhanced at various parts of the course. The communication skills and ethics and medico-legal themes are particular strengths of the Bristol MB ChB programme.

116. *Learning resources:* Students are fortunate to enjoy a range of excellent facilities. The School's website, Medici, is an interesting development that should help students and teachers to access teaching and learning materials.

117. *The changing patterns of health care:* The School has provided students with extensive opportunities for gaining experience in primary care and other community based medical services. The COMP Course is an excellent programme, drawing as it does upon inputs from a range of disciplines, which will help to prepare students for medical practice in the modern NHS.

118. *Professional attitudes and conduct:* We were very impressed with the initiative that has been taken to develop a system for assessing students' attitudes and behaviour. The involvement of students in the creation of this scheme is to be welcomed. We look forward to hearing about how this scheme is developed.

119. *Fitness to practise:* The School and University are to be congratulated upon the introduction of a system to deal with students about whom there is concern, other than upon academic grounds. Clearly the system is still new, and as yet little used. However, we would welcome being kept up to date about how this evolves.

Areas for further consideration

120. *Supervisory structures:* As we indicated in 1997, we believe that the School would benefit from establishing a medical education unit. We think that this would be particularly beneficial to the School's efforts to enhance its SSM programme and further develop the scheme of assessment.

121. *The SSM programme:* We appreciate the School's belief that the core curriculum is of central importance. However, we do not think that the time set aside for SSMs in Year 3 should be devoted to remedial study for those that have fared badly in examinations. Given the small proportion of time allocated to SSMs, we consider that the SSM programme should not be further reduced in this way. We hope the School will review its approach to this issue.

122. *Teaching in the clinical years:* The teaching and learning opportunities in the early years of the course were considered excellent by the students to whom we spoke. However, there was concern about the variability of teaching in the predominantly clinical years. The School will wish to ensure that teaching by NHS clinicians is more consistent.

123. *Feedback to students:* Feedback to students in the clinical years of the course was thought to be inconsistent by the students to whom we spoke. Given the

model for assessing students' attitudes and behaviour which the School is piloting, it should be possible to develop a scheme for providing consistent feedback about students' clinical competence and skills.

Conclusion

124. Although we have identified some areas for further consideration, this should not detract from the progress that has been made in Bristol since our last visit. All those involved in developing and implementing the new curriculum deserve praise for what has been achieved.

125. While there remain areas that need to be addressed, the School's excellent relationship with students should ensure that these challenges are met successfully. We look forward to hearing about further progress in a year's time.

Part 2: General clinical training

Background information

126. Prior to the visit we were provided with helpful background information about general clinical training within the region.

Form of the visit relating to general clinical training

127. The day began with a meeting with PRHOs from a number of locations and specialties. We then met the Postgraduate Dean and PRHO Committee for an overview of general clinical training within the region. In the afternoon we met a group of educational supervisors and clinical tutors from hospitals and trusts, including a GP teacher. We also had the opportunity to have discussions with medical directors and one chief executive from NHS trusts within the region.

Organisation and management of the PRHO year

Supervisory structures

128. The PRHO Committee, which meets at least three times a year, is responsible for overseeing the provision of general clinical training within the region. Members include representatives from the School of Medicine, a junior doctor representative and the president of the students' medical society, Galenicals.

129. The Postgraduate Dean pointed out that the geography of the region, with the large distances involved, made co-ordinating and managing posts difficult. As a result of this, the Deanery has started to establish a number of 'one year in one place' PRHO posts in order to rationalise PRHO training and allow for better co-ordination and supervision of this period of training. The feedback that we received from NHS teachers and trainees indicated that these 12 month rotations, which provide opportunities to gain experience in general practice, peri-operative care, paediatrics, and palliative care and oncology as well as general medicine and general surgery, were extremely successful.

The approval of posts

130. Requests for new posts are considered by the Associate Postgraduate Dean (PRHOs). All posts must comply with the standards set out in *The New Doctor*, these requirements being reiterated in the Educational Agreement between the Deanery and trusts. A condition of acceptance is that all new posts are for an initial period of two years only. During this period such posts are monitored and continued approval depends on a satisfactory evaluation of the education and training provided.

131. Approval of new posts is reported to and ratified by the PRHO Committee.

Communicating the aims and objectives of the pre-registration year

132. A number of mechanisms have been put in place to ensure that the aims and objectives of the pre-registration year are understood by NHS managers, teachers and the PRHOs themselves. These include:

PRHO shadowing and preparation courses for final year Bristol students.

Clear and unambiguous references to *The New Doctor* and the standards expected for PRHO posts in the Deanery's Educational Agreement with the NHS trusts.

The involvement of NHS staff on the PRHO Committee.

Regular meetings between the Deanery and clinical tutors.

The production and dissemination of an excellent handbook for educational supervisors, which outlines what is expected of individuals who undertake this role.

The production of a regular newsletter, 'Update', which is circulated to all medical directors, clinical tutors and educational supervisors within the region.

The circulation of PRHO Committee minutes to clinical tutors and GP teachers.

133. We were pleased to learn that staff development has been identified by the Deanery as an important way of improving the quality of the education and training provided for PRHOs. Further details about staff development are provided in paragraph 159.

134. The trainees we met believed that the opportunity to shadow a PRHO in the final year of the undergraduate medical course would be of immense benefit to the next set of PRHOs. They felt somewhat disadvantaged by not having a similar opportunity themselves. Nevertheless, they felt that they had been well prepared for general clinical training and had been given a clear understanding of the expectations for this period of training as set out in *The New Doctor*.

The selection of PRHOs

135. The Deanery operates a matching scheme to fill posts within the region. This scheme allows trainees to apply both for individual posts and for the 12 month rotations that have been introduced.

136. Trainees are provided with information about the available posts, and NHS trust managers are given guidance concerning the details that must be provided for applicants. Applicants for posts are interviewed by a panel using a set of standard questions. All interviewers must be trained in interview technique and be aware of

equal opportunities legislation. Interviewing panels grade each interviewee and posts are allocated according to trainees' preferences and those of interviewing panels.

137. Our discussions with trainees and staff indicated that this scheme was an effective means of filling PRHO posts within the region. We understand that the scheme will be modified slightly in 2000/01, to accommodate the final year of the new Bristol MB ChB programme, which will include the opportunity for students to shadow their forthcoming PRHO post. However, as the changes mainly relate to fitting interviews around students' final year clinical experience, they should not affect the functioning of the scheme.

Monitoring the quality of PRHO posts

138. The quality of PRHO posts within the region is monitored by annual joint visits by the Deanery and the regional New Deal Task Force. Prior to each visit PRHOs are asked to fill in a questionnaire concerning the quality of the education and training which they have received. A copy of this questionnaire is at Annex G. The PRHOs' responses are used to inform visiting teams of issues which may need exploring.

139. During a visit outstanding issues from previous visits are considered to ensure that appropriate action has been taken. PRHOs, teachers and NHS managers are interviewed, and feedback is given to senior trust managers about the findings of the team. Following each visit trusts receive a written report that includes action points to be addressed. We understand that if significant issues are identified additional visits to a particular trust are arranged to ensure that any shortcomings are rectified.

140. As mentioned in paragraph 130, new posts are monitored for an initial period of two years. Trusts receive detailed feedback about such posts in order to maintain appropriate standards.

141. We were told that approval has been removed from six posts in the last 18 months. It therefore seemed to us that the Deanery has established an appropriate mechanism for monitoring the quality of PRHO posts.

The views of PRHOs

142. PRHO feedback about posts is recognised by the Deanery as an important source of information. Accordingly, their views are sought as follows:

Through an annual questionnaire which asks all PRHOs about their experiences during the pre-registration year. A copy of this is at Annex H.

Via interviews during annual visits. A copy of the standard PRHO checklist for visits is at Annex I.

By encouraging them to give ongoing feedback to their teachers and

advisors and, if necessary, to contact the Deanery if they wish to discuss matters outside of the trust in which they work.

Components of a high quality PRHO post

Induction

143. The Deanery's Educational Agreements with NHS trusts specify that PRHOs should be provided with at least 1 day of induction in protected time. Trusts are told that as a minimum this induction should include:

A pack providing basic information about the trust.

An introduction to the NHS for non-UK trainees.

An induction to the department or unit in which a trainee will work.

A formal handover with the outgoing PRHO or the team SHO.

144. The Deanery's handbook for educational supervisors identifies the following three components of induction training:

Information about a hospital or trust.

Information about the team or unit.

c. Information about the individual post. We understand all trusts have been asked to institute more extensive team/firm-specific induction programmes.

145. An example of an induction programme is at Annex J.

146. The trainees that we spoke to had all received induction and had generally found it helpful. Trust handbooks which included trust guidelines and protocols were considered particularly helpful. However, some trainees thought there was a tendency for induction sessions to be factually overloaded which meant that important information was sometimes missed. We would ask the Deanery to encourage trusts to reduce content to the essential information and, where possible, to spread induction over a number of days.

Educational opportunities

147. The Deanery's Educational Agreements specify that all PRHOs should attend a dedicated and structured educational programme of at least one hour each week. Such sessions should be in protected time and should be bleep free.

148. Our discussions with PRHOs, clinical tutors and educational supervisors revealed that all trusts made such educational opportunities available to trainees. In most instances the programme of events was determined by feedback from

previous house officers. However, where trainees had the chance to suggest topics and issues which they wished to address this was much appreciated. The educational opportunities offered by GP posts were clearly well thought out and trainees welcomed the training available.

149. Although formal educational sessions were made available to all trainees, one PRHO had been unable to attend the sessions arranged at his trust for three months. We were told that the post in question had been very busy due to an increased take during the winter period. As the educational sessions occurred during a ward round the trainee had felt unable to attend. We were disappointed to be told that although this issue had been raised by the trainee, the onus for ensuring attendance had remained with the PRHO. We would ask the Deanery to explore this issue with the trust concerned to ensure that educational sessions are given due importance and that this matter is resolved.

150. The trainees that we met expressed considerable frustration about the way in which hospital/trust procedures undermined their educational opportunities and filled their day with routine tasks. Familiar complaints included:

Difficulties in requesting X-rays from radiology departments.

Poor or inconsistent phlebotomy services.

Refusal by trained nurses to undertake IVA and cannulation.

151. Allied with the amount of time they had to dedicate to such tasks, trainees were unhappy about the way in which they were treated by nurses. It was evident that relations with nursing staff were poor in some trusts, and this resulted in inappropriate bleeping and a generally unhelpful working environment.

152. Some trainees were also concerned about partial shifts and the effect this had on the continuity of patient care. Feedback from PRHOs indicated that it was not unusual for them to admit a patient, but then have no way of knowing how that individual was subsequently dealt with. Trainees felt that this lack of continuity deprived them of an excellent learning opportunity. In contrast, trainees based at Gloucester and Barnstaple said that the ward-based systems in operation at these trusts provided excellent continuity of patient care and experience.

153. It seemed to us that while all trusts had set in place formal educational opportunities, trust procedures and systems sometimes undermined the effectiveness of the education offered. It was not apparent that trainees were aware of any mechanisms by which their concerns and difficulties could be discussed with senior colleagues and shared with management.

154. We were told that all trusts had liaison committees that allowed trainees' views to be discussed with management. However, the comments of trainees indicated that these bodies were not functioning effectively. The Deanery and its NHS partners should consider how to ensure that trainees are aware of, and use, systems designed to assist them to secure a high quality education and training.

155. The NHS trust managers that we spoke to acknowledged their responsibilities to PRHOs. While mindful of service commitments, a number of them were considering ways of re-organising service provision in order to both improve patient care and the education afforded to PRHOs. Thus, for example, the University of Bristol Healthcare Trust was considering creating multidisciplinary teams and the Frenchay Hospital was considering ward-based teams. It was hoped that such changes would provide greater continuity of care.

156. We appreciate that NHS trusts have service commitments which must be met, as well as an obligation to train junior doctors. Trusts are clearly seeking ways of balancing service and education and we welcome such initiatives. However, it seemed to us that a number of the trainees' concerns related to managerial and administrative problems which could be addressed quite easily. We wish the Deanery to pursue the inappropriate use of PRHOs' time and expertise with its NHS partners, and to discuss the provision of appropriate levels of support, such as phlebotomy services and IT based requests for investigations.

Educational supervision

157. The Deanery requires all trainees to be allocated an educational supervisor. PRHOs should be told who their supervisor is on their first day in post. Educational supervisors must meet new trainees within the first 10 days of appointment, and thereafter at regular intervals to monitor their progress.

158. The Deanery recognises that clinical tutors and educational supervisors play a vital role in the provision of general clinical training. Individuals who undertake these roles are identified locally, and the Deanery seeks to provide them with guidance and support through:

The excellent handbook for educational supervisors.

Opportunities to undertake training and education.

Funding individuals to undertake masters degrees in medical education.

Arranging conferences and meetings to discuss relevant issues such as implementing *The New Doctor*, assessment and training the trainers.

159. Staff development has been identified as a means of improving the training provided for PRHOs. The Deanery has made funds available to tutors to undertake training at a local level, and has an Education Group to coordinate and monitor the provision of such staff development opportunities.

160. We thought the handbook for educational supervisors was an excellent document which provided much sound advice and guidance. The educational supervisors we spoke to clearly appreciated such support. We thought that an equivalent handbook for trainees might be helpful, an impression that was strengthened when we were told that some trusts provide PRHOs with an

abbreviated version of the handbook.

161. All the trainees we spoke to knew who their educational supervisor was and had met them on at least one occasion. The majority also confirmed that they were given ongoing guidance and advice, and having regular formal meetings. Trainees at the Bristol Royal Infirmary thought that the support which they received was excellent.

162. However, trainees from Frenchay Hospital expressed some concerns about the supervision they received. We were told that one educational supervisor had been on leave when PRHOs had taken up post and, as a result, these trainees had been uncertain about what was expected of them until the supervisor had returned from leave.

163. The Deanery will wish to remind NHS managers and clinicians about the importance of educational supervision. We were told by the Deanery that if supervision and guidance were inadequate, posts would be removed from a trust.

Clinical training and supervision

164. The Deanery has identified a core of generic clinical training for all PRHOs which is based on *The New Doctor*. The procedures that trainees are expected to be competent in are outlined in the PRHO assessment form at Annex M.

165. The trainees that we spoke to confirmed that the level of clinical supervision and support was excellent. All thought that SHOs, specialist registrars and consultants strove to integrate them into firms and be as supportive as possible. In one instance it was suggested that SHOs should have guidance about training PRHOs, and that all medical staff should be reminded that PRHOs would require additional support in the first few weeks of a new job. However, trainees thought the quality of clinical supervision was a strength of the posts in the region. We shared this view.

Monitoring the progress of PRHOs

166. Educational supervisors are required to meet trainees at the beginning of a post to produce a written learning agreement and then every two to three months to monitor progress. We were told that the Deanery had initially intended learning agreements to be developed at a local level. However, this having failed to work consistently, the Deanery intends to impose a centralised system. Examples of the learning agreement and personal development plans which will be developed are at Annexes K and L respectively.

167. The Deanery has encouraged trusts to provide trainees with some form of monitoring incidents, clinical experience, practical procedures undertaken, training needs and the outcomes of review meetings. However, it has not sought to impose a centralised model for this purpose.

168. At the end of each post the educational supervisor is required to assess the

PRHO's personal attitudes and development, and their clinical skills, using the form at Annex M. The educational supervisor must confirm that the post has been completed satisfactorily, and the form must be countersigned by the clinical tutor and sent to the Deanery.

169. As a net importer of trainees the Deanery is keen to ensure that medical schools outside the region provide it with details that are pertinent to the training programme that should be devised for the individual concerned. It was evident that trusts managers felt that serious problems that had been identified earlier in an individual's medical career should be communicated to them. We thought it appropriate that, with a trainee's permission, relevant information should be shared. We pointed out the overriding importance of patient safety and the need to report information if a trainee was considered to represent a potential risk to patients.

170. We were pleased to learn that the School of Medicine is working closely with the Deanery to ensure an appropriate flow of information. We particularly welcome the suggestion that the Postgraduate Dean may be offered a place on the School's Medical Education Committee. We have no doubt that this will further strengthen an already close relationship.

171. The Deanery has been very keen to address concerns about PRHOs who have experienced difficulties. Where performance is causing concern a special assessment form, Annex N, is completed. This takes account of the views of other members of the health care team so that a wide range of views are sought.

172. We were particularly impressed with the thought that has been given to devising remedial training programmes in those few cases where a PHRO has had difficulties. The Deanery is currently developing a process to deal with such cases in a more considered and rigorous manner than has hitherto been the case. We welcome this initiative.

Professional development and personal well-being

Support for PRHOs

173. PRHOs are able to seek guidance and advice about general clinical training from educational supervisors, clinical tutors and the Associate Dean for PRHOs. Other support services to which trainees have access including a counselling service and an occupational health service.

174. As noted in paragraph 150, trainees felt that they were spending too much time on ancillary activities such as requesting investigations and X-rays, and taking blood. While support at some trusts was considered excellent, for example the IT facilities at Southmead Hospital and the filtering of on-call bleeps at Frenchay Hospital, trainees felt that more could be done to provide assistance and cover that would allow them to devote time to core clinical and educational activities. We shared this view.

Careers advice

175. The Deanery's Educational Agreement requires trusts to provide trainees with careers advice and guidance. The Postgraduate Dean, associate postgraduate deans and clinical tutors are all available to provide trainees with guidance and support.

176. The trainees that we spoke to did not think that careers advice was offered in a proactive manner, but they were confident that with a little effort they could find the information and guidance required. However, if general careers information could be provided in a more objective manner, using IT facilities for example, that would be appreciated.

Accommodation, catering and personal safety

177. We were pleased to be told that personal security was not an issue for any of the trainees that we met. However, there were some concerns about the quality of accommodation on some sites, and the availability of food while on-call. Accommodation at the Bristol Royal Infirmary, Barnstaple Hospital and Gloucester Hospital was considered excellent, while accommodation at Frenchay Hospital was poor.

178. It was clear that access to a hot meal when on-call was a problem at many trusts. Typically there was a very small time window when such meals were available, with many canteens closing quite early in the evening. At the Bristol Royal Infirmary we were told that there was no private canteen for staff, or preferential rates. We feel that all medical staff should have access to a private canteen where they can eat in a relaxed atmosphere. Nevertheless, some trusts offered excellent services, for example one provides frozen meals and a microwave, while the canteen in Plymouth NHS trust is open until 2.00 am.

179. The standard of accommodation and catering is monitored during annual visits and the representative from the Regional Task Force that we met was aware of trainees' concerns. Senior trust managers also recognised that appropriate services should be provided.

180. Better communication between PRHOs and managers could swiftly address a number of the concerns raised with us. We believe that if trainees' channels of communications with trust managers were publicised more effectively, this would strengthen them and help to ensure a better dialogue between PRHOs and trusts. We would like the Deanery to work with its NHS partners to strengthen this aspect of the current system.

Contractual matters

181. The trainees that we spoke to indicated that their major concern was the length of their working day and insufficient rest time. All thought that they were working in excess of their contracted hours. Again, it seemed trusts procedures acted to lengthen the working day. Thus in some trusts it was impossible to move

patients out of wards until the early evening, when transport became available, which meant that trainees had to stay late to clerk the new admissions. It was clear that trainees did not wish to go off duty and leave their colleagues to cope with service demands.

182. It was evident that the Deanery was aware of, and shared, trainees' concerns. The regional Task Force representative that we met accepted that many trainees were working beyond their contracted hours. We were told that the Deanery and Task Force were keen to address this issue and saw the reduction of working hours as a priority for the next round of visits to trusts.

183. The Postgraduate Dean told us that part of the problem was the mismatch between trainee numbers and service demands in the region. However, he accepted that trust organisation and systems sometimes contributed to the excessive hours worked. We were told that the Deanery was hoping to provide resources that would allow acute care within the region to be re-organised in a more rational manner, which it was hoped would lead to a diminution of the demands on all medical staff, including PRHOs.

184. The senior NHS staff that we spoke to acknowledged the difficulties experienced by trainees and other staff when dealing with service demands. However, they believed that a change in attitude by senior doctors to trainees was also required. They thought such doctors should ensure that trainees worked appropriate hours and took the rest that they were due.

185. Balancing the well-being of trainees and other staff with service commitments is clearly a challenge for NHS trusts. However, it was apparent to us that some trainees were working too long, with insufficient rest, which undermined their ability to provide sound patient care. We were heartened by the concern shown by the Deanery and its NHS partners concerning this issue, and welcome the intention to address this matter as a top priority in the next round of visits to trusts.

Areas of good practice

186. *New posts:* The Deanery is to be commended for introducing a number of 12 month rotations which offer experience in primary care, peri-operative care, paediatrics, and palliative care and oncology. The staff and trainees that we met spoke highly of the education and training afforded by these posts.

187. *Educational supervision:* The Deanery and trusts have set in place a framework to provide trainees with the educational supervision they require. We were particularly impressed with the handbook for educational supervision, which we considered an excellent document.

188. *Clinical training and supervision:* The PRHOs that we spoke to confirmed that they received excellent clinical training and supervision from the consultants and other doctors that they worked with. It was clear that firms had made great efforts to ensure that PRHOs felt like valued team members.

189. *Remedial training:* The Deanery has worked closely with its NHS partners to develop strategies for dealing with poorly performing PRHOs. This is an area of great importance and we look forward to hearing how the Deanery's initiatives are developing.

Areas for further consideration

190. *Disseminating good practice:* It struck us that there were many examples of good practice in PRHO training, and the facilities provided, in a number of trusts within the region. We think the Deanery should explore ways of ensuring that these examples are widely disseminated so that best practice predominates.

191. *Working practices:* The PRHOs that we spoke to appreciated the educational opportunities that were made available, but felt that these were often undermined by poor working practices and procedures. Inefficient bleep filtering, difficulties in arranging investigations and poor relations with nurses meant that they spent too much time undertaking tasks of little educational value. The Deanery will wish to work with its NHS partners to overcome these problems.

192. There was some concern amongst PRHOs about partial shift systems and the detrimental effect these have on continuity of patient care. The Deanery and trusts are clearly aware of these difficulties and we would appreciate being kept informed of the various initiatives that are being put in place to tackle this issue.

193. *Contractual matters:* We were concerned to hear that most PRHOs were working beyond their contracted hours and having insufficient rest periods. While we appreciate the difficulty of balancing service commitments with educational needs, the Deanery must ensure that posts conform to the requirements of *The New Deal*. We understand that this will be a priority for the next round of PRHO inspection visits, and look forward to hearing about progress.

194. *Communication between PRHOs and managers:* While our discussions with PRHOs revealed a number of concerns about working practices and facilities, we felt a large proportion of these could be dealt with swiftly if management was aware of the problems. Although we were told that all trusts in the region have liaison committees through which PRHOs can express their views to managers, it was not evident that these were functioning well. The Deanery should encourage trusts to publicise the existence of these committees and thereby promote a closer working relationship between PRHOs and NHS managers.

Conclusion

195. The Deanery has clearly put in place excellent systems for providing PRHOs with the educational opportunities and the supervision which they deserve. The new 12 month rotations seemed to us to be working particularly well. All the PRHOs that we spoke to confirmed that they were enjoying this stage of their medical training. This is something of which the Deanery can be justifiably proud.

196. Clearly the Deanery, in cooperation with its NHS partners, will want to ensure

that PRHOs work within national guidelines, and that the working practices of trusts support the education and training that is provided. We look forward to hearing about progress in a year's time.