Report of the visit to the University of Leeds

24-25 November 1998

We should like to express our thanks to the Dean of the School of Medicine, 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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Introduction

1. The purpose of the visit was twofold:

   a To monitor progress made towards implementing *Tomorrow's Doctors* since our last visit in 1997.

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

2. The visiting team was led by Professor Sir Charles George, Chairman of the Education Committee. The other members were Professor Roger Green, a member of the Education Committee, and Professor Robert Stout, a member of Council and former member of the Committee.

3. The visit lasted two days. The first day was concerned with the undergraduate curriculum, and involved us in collaborative working with a Quality Assurance Agency (QAA) team that was simultaneously conducting a review of medicine at the University. The second day focused on the provision made for general clinical training.

4. Like our visits, this report is in two parts. In the first part we consider developments in the undergraduate curriculum since our last visit, and the School's plans for further curricular change. In the second we consider compliance with the recommendations in *The New Doctor*.

5. Both for undergraduate education and general clinical training, we have identified areas of good practice, as well as those where further progress is required.

Part I: The undergraduate curriculum

Background information

6. Prior to the visit the School provided us with background material including the Self Assessment Document prepared for QAA visitors. Members of the QAA team were supplied with copies of the completed GMC questionnaire that the School had produced for our visit.

Form of the visit relating to undergraduate medicine

7. The day began with a meeting with senior staff from the School to gain an overview of the current curriculum, and to discuss progress since our last visit. This was followed by a meeting with representatives of the Undergraduate Medical Education Committee (UMEC), the body responsible for overseeing the curriculum.

8. Members of the team were able to visit facilities at the principal teaching hospitals, including clinical skills centres, as well as the School's library and computing facilities. We also had the opportunity to meet a group of students representing each year of the curriculum.

9. We were joined for a number of these meetings by members of the QAA team, who wished to pursue issues relevant to their consideration of undergraduate medical education.

The Leeds undergraduate curriculum

Curricular development

10. At the time of our last visit we noted that the School had adopted an evolutionary approach to curricular development. An internal review starting in 1989, prior to the publication of *Tomorrow's Doctors*, had led to the phased introduction of a revised curriculum for Years 1 to 3 between 1992 and 1995.

11. In 1997 we saw a traditional, discipline-based curriculum, with little vertical integration and in which a pre-clinical and clinical divide was still clearly evident. At that time the School recognised the need to develop a curriculum in line with our recommendations on undergraduate medical education. However, it had decided to concentrate on re-designing the later years of the course before re-visiting Years 1 to 3.

12. Our findings in 1997, as set out in our previous report at Annex A, made us anxious to see progress on our return. However, although plans for curricular reform are in hand, the general structure remains largely unchanged. There have been two significant developments since our last visit:

> a. The introduction into the third year of an integrated medical and surgical 12 week course, 'Introduction to Clinical Practice'.
>
> b. Completion of the revision of Year 4. This year now includes a number of special study modules (SSMs), and an integrated medical and surgical specialties clinical attachment.

13. As the current curriculum is essentially still the same as in 1997, this report focuses on the School's plans for curricular development, including new courses and initiatives that have been piloted in advance of implementation.

14. Diagrams of the current curriculum and associated assessments are at Annexes B and C of this report respectively.

Planning the new curriculum

15. The School has defined the general objectives upon which the new curriculum will be based. These are at Annex D of this report.

16. The proposed new curriculum is outlined at Annex E of this report. It will comprise the following phases:

- Phase 1 (Years 1 to 3) Fundamentals for Clinical Practice
- Phase 2 (Year 4) Clinical Practice in Context
- Phase 3 (Years 5/6) Becoming a Doctor

17. Five themes will run throughout the new curriculum:

- Communication skills
- Ethics
- Health and Prevention of Disease
- Community-based medicine
- Medical information management.

18. Phase 1 will comprise seven integrated course units (ICUs). Students will also have opportunities to undertake SSMs during this phase.

19. In its revised form Year 4 will form Phase 2 of the new curriculum. Students rotate through a series of eight week clinical attachments in obstetrics and gynaecology, paediatrics and child health, psychiatry, and general practice and public health medicine. They then undertake the new medical and surgical specialties 16 week attachment mentioned in paragraph 12b.

20. Core teaching, which takes account of the aims and objectives of the new curriculum, has been identified for each specialty. In addition students must undertake a two week SSM for each eight week clinical attachment, and an eight week SSM during the medical and surgical specialties attachment.

21. Phase 3 will comprise the final year of the degree programme and the pre-registration house officer (PRHO) year. It will build upon earlier training, and help students to develop the skills necessary for practice as a doctor. When revised, Year 5 will include an introductory week designed to:

a. Provide students with information about the teaching, learning and assessments they will encounter during the phase.

b. Introduce the training portfolio that will be used to review their progress.

c. Allow students to refine their clinical skills and revise their history taking skills.

d. Provide information about the PRHO matching scheme and the Job Fair.

22. This will be followed by a series of four week clinical attachments, that will provide general, as well as specific, medical practice. There will then be a period of assessment followed by an opportunity to shadow a house officer and two short courses concerning peri-operative and emergency/trauma medicine.

Timetable for curricular changes

23. Only the revised fourth year has so far been put in place. The timetable for implementation of the remaining curricular changes is as follows:

a. In 1999/2000 the new Year 1 curriculum will be introduced. The School also hopes that the revised Year 5 course will begin.

b. 2000/01 will see the start of the new Year 2 course, together with changes to the PRHO year.

c. In 2001/02 Year 3 of the new course will be put in place.

24. We understand that proposals for some Phase 1 ICUs have already been considered twice by the Core Curriculum Sub-Committee. However, given the intended date for introduction of the first year of the new curriculum, we were concerned that the content and assessment of all the ICUs had not yet been finalised. Little time remains for the production of supporting guidance documents, appropriate assessment instruments and literature for students joining the degree programme next year. If the School is to forge ahead with the necessary curricular development, decisions about the content, delivery and assessment of Phase 1, particularly the first year, must be made swiftly.

25. The implementation timetable indicates that the School plans to introduce a revised Year 5 course in 1998/99. However, our discussions with current fourth year students revealed uncertainty about whether this would be so. We learned from our discussions with staff that there were some problems concerning the range of clinical attachments to be made available. Given the pressing need to introduce Phase 1 of the revised curriculum, we suggest that implementation of Year 5 should be delayed by a year to allow design problems to be resolved. This would enable the School to concentrate upon finalising and implementing Years 1 and 2 of the new curriculum.

The management of change (Principal Recommendation 13)

Supervisory structures

26. The Undergraduate Medical Education Committee (UMEC) is the body responsible for overseeing the undergraduate curriculum, including monitoring the current course and curricular development. A number of groups report to UMEC including:

a. The Core Curriculum Sub-Committee, which advises UMEC on the core content of the curriculum.

b. The Curriculum Implementation Group (CIG), which is overseeing the development of Phase 1 of the new curriculum.

c. A Phase 3 Planning Group, which is overseeing development of the final phase of the new course. This body is jointly chaired by the Postgraduate Dean's assistant for the PRHO year and a senior member of staff from the School.

d. Theme co-ordinating teams, which have been established to identify learning objectives for each of the identified themes, and to co-ordinate their delivery.

e. The Task Force on Examinations and Assessments, which is considering assessment of students following the revised curriculum.

f. The SSM Steering Group, which advises UMEC on the development, delivery and assessment of this aspect of the course.

g. Course management teams, which oversee the day to day running of courses.

h. The Course Review Committee, which monitors the quality of the School's teaching provision.

27. A diagram of the current management structure is at Annex F.

28. We feel that the very complexity of the structure, and the large number of bodies involved, fragments leadership and ultimately undermines UMEC's authority. We appreciate that the School

currently has parallel structures for overseeing the existing curriculum and developing the new curriculum. However, we feel the structure would be greatly strengthened if it were simplified, the number of groups reduced, and lines of responsibility and accountability more explicitly defined. UMEC must exercise the responsibility and authority for implementing curricular change.

29. The role and responsibilities of the School's Medical Education Unit (MEU) were unclear to us. This unit employs a number of experienced members of staff with considerable expertise in the theory and practice of education and assessment. It was not evident that this potentially formidable resource was being harnessed and used to its full potential. At present the MEU offers guidance and advice on the development of teaching, learning and assessment systems. However, we believe the MEU should lead such initiatives and therefore be at the very heart of curricular development.

The contribution of students

30. Students are represented on UMEC and all its sub-committees. We understand they have also been invited to participate in course management teams. The group of students we met confirmed that UMEC actively sought their views and, more importantly, that their comments were acted upon.

31. We were told that the Medical Students Representative Committee (MSRC) is very active in Leeds. We understand the MSRC funds classes in conversational Urdhu and Hindi for students working in areas with high proportions of patients from these ethnic groups, and is considering publishing an accompanying phrase book.

Staff development

32. The School recognises the crucial role staff training can play in the implementation of curricular change and the improvement of teaching. A policy is being established whereby all teachers, including NHS clinicians with teaching responsibilities, must attend at least one approved course on teaching, learning or assessment within a three year period. We understand the School is discussing with its NHS partners how to implement this policy with respect to NHS teachers.

33. A range of training courses have been run since our last visit. Some of these have been aimed at developing the new curriculum, and others at developing clinical teachers into more effective educational facilitators. Examples of such courses include 'How to Teach Better', 'Teaching Small Groups in Clinical Settings', 'Designing Integrated Courses' and 'Integrated Assessment'.

34. Staff are also encouraged to participate in externally run courses, and are provided with a list of such opportunities to facilitate their involvement. A database has been developed to monitor the training received by members of staff. We understand that to date approximately 300 members of staff have received some form of training.

35. A further component of the staff development policy has been the introduction, since 1997/98, of a system of peer review. This involves the observation of teaching by colleagues, the provision of feedback to teachers and the collection of data to place student opinion and feedback in context. The intention is that each member of staff will be reviewed twice within a three period, and that all members of staff should act as reviewers.

36. The MEU has taken responsibility for training peer reviewers, who are expected to offer their expertise to divisions and teaching groups within the School. Training courses for reviewers are run four to six times a year.

The promotion of teaching

37. The School recognises the importance of high quality teaching and aims to:

a. Raise the profile of teaching within the School and University.

b. Establish a culture in which teaching is valued.

c. Provide appropriate staff development opportunities.

d. Ensure that those who teach have the time and resources to do so effectively.

38. We were told that the School believes this project will take between three and five years to implement. It is currently discussing this matter with the University.

39. The School plans to:

a. Define excellence in teaching.

b. Identify the evidence required for making judgements about teaching quality.

c. Discuss with the University changes to its promotion criteria to include a greater emphasis on teaching.

d. Require all new staff employed by the School to undergo teacher training.

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

Reducing the factual burden

40. The current teaching timetable is very demanding, and we saw few opportunities for self-directed learning (SDL). We understand the School shares this concern and intends to reduce the burden of factual knowledge in the new curriculum. The ICU teams drafting the new course units are asked to work to the following principle:- 'The curriculum will give students a grounding in the basic sciences sufficient to understand the principles of normal function and disease processes, but will minimise the details not relevant to clinical practice'.

41. During the planning process a number of measures have been put in place with the intention of keeping the factual content of the core course to a minimum, and to ensure consistency between the ICUs developed. Thus:

a. ICU teams have been provided with core clinical conditions on which to base core scientific principles.

b. The Core Curriculum Sub-Committee is reviewing the draft aims and objectives for all units to ensure that appropriate demands are made of students.

c. The amount of time allotted to formal teaching is to be limited. Each ICU team is expected to identify time for SDL and SSMs.

42. The School has allocated 16 weeks to SSMs in the revised fourth year. To accommodate the introduction of SSMs course management teams were required to redefine core content, reduce the burden of factual information, and to take account of the aims and objectives of the new curriculum.

43. Despite these measures, our discussions with current fourth year students revealed concerns about the demands of the revised course. They felt that the core teaching for this year was still very demanding, and had failed to take account of the introduction of SSMs. We hope the sub-committee overseeing this part of the course will review its expectations of students to ensure that these are kept within acceptable limits.

Defining the clinical core curriculum

44. Medical and surgical core clinical curricula have now been developed for Years 3 and 5. However, on the basis of the documentation with which we were provided, we thought these were predominantly

concerned with factual information that students should know of or about. Less emphasis was placed on the practical skills and attitudes that should be demonstrated. This appeared to be contrary to the spirit and principles intended to inform development of the School's new curriculum.

45. We were told by senior staff that the medical and surgical core courses for Years 3 and 5 were developed by separate course management teams. However, the teams in each year have now been combined with the intention of achieving integration. We would question the logic of this process, which is inefficient, time consuming and does not readily promote the desired outcome.

Integration of clinical training and basic science

46. In 1997 we were concerned that the course was still divided into pre-clinical and clinical phases. This remains the case, although the School plans to address this issue when it develops the four remaining years of the new curriculum.

47. We welcome the change to Year 3 which occurred in 1997/98. As mentioned at paragraph 12a, this year now begins with an introductory 12 week systems-based course. One day a week is spent in classroom-based activities including teaching sessions, small-group tutorials to practise history taking and examination skills, and a range of clinical case presentations and problem solving exercises. During the remainder of the week clinical teachers re-inforce the systems teaching and students are provided with a clinical workbook, which guides students' work and offers exercises that can be used to focus tutorial sessions.

48. Early patient contact will be a feature of the new curriculum. A new programme, 'Becoming a doctor - the first step', has just been piloted. This will allow students to visit various community-based settings, for example patients' homes and health centres, within the first month of starting the degree course. This programme is described in more detail in paragraph 66.

49. In the new first phase students will also learn about medical interviewing techniques and clinical skills relevant to the systems under consideration. The School plans to integrate clinical skills teaching and clinical science into one course that will run throughout the second half of Phase 1. We understand that the ICU teams are expected to identify the clinical skills and basic science which underpin the course units they are developing.

Learning through curiosity

50. Although not immediately evident from the teaching timetable, we were assured by students and staff that there were considerable opportunities for students to study areas of interest to them. These opportunities include a ten week elective period in Year 5, and an intercalated Bachelor of Science (BSc) degree. The students with whom we spoke were particularly enthusiastic about the Year 2 Literature Review, and the opportunities afforded in Year 3 to acquire, develop and refine their clinical skills.

51. In addition a new course, Molecular Medicine, was provided for the first time in 1998/99 by one of the School's divisions. This has increased the School's contribution to the intercalated degree programme. In order to encourage more students to take intercalated courses run by divisions of the School, a number of bursaries are offered to students who choose to follow one of these.

Special study modules (Principal Recommendation 6)

52. The introduction of SSMs into the current curriculum has been implemented as follows:

- In 1995 a five week SSM was included at the end of Year 3. This has given students the opportunity to undertake an individual or group project on a subject of their choice.
- In 1996/97 project-based SSMs were introduced in Year 4. Students must carry out a project for each of their four clinical attachments.

- In 1997/98 an eight week clinically based SSM was introduced alongside the new Year 4 integrated medical and surgical specialties attachment.

53. We understand SSMs have proved an invaluable means of identifying students whose attitudes are bordering on the unacceptable, or whose communication and teamwork skills are in need of further development. In such instances the School provides remedial training and support to ensure that students are able to progress appropriately.

54. However, as mentioned in paragraph 43, fourth year students believe the introduction of SSMs has placed too great a burden on them. They were particularly concerned about the impact of the short, two week modules. This is an area of concern which the School will wish to review.

55. We understand a substantial amount of time will be allocated to SSMs in the new curriculum (see paragraphs 18, 20, 42 and 43). ICU teams will be expected to bid for SSM time so that modules can be introduced alongside the new course units in Years 1-3. The precise nature and number of modules is still under discussion, but they will include a range from research to taught programmes, and will all include a literature review. The plans for Year 5 are still being considered by the Phase 3 Planning Group.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

56. In 1998 a new clinical skills learning centre was opened at the Leeds General Infirmary (LGI). This complements the one at St James's University Hospital (SJUH). These centres are staffed by teachers with nursing experience, who also have educational experience and qualifications, and are under the direction of the MEU. Year 3 students attend the centres for a series of taught workshops on the following topics:

- Visit to the operating theatres (scrub and gown)
- Basic life support
- Intravenous cannulation; blood pressure recording
- Retinal fundoscopy
- Injections and bedside blood sampling
- Introduction to computer based learning
- Catheterisation
- Breast examination
- Focused history taking
- Revision of practical skills.

57. Students can attend the centres for individual learning at their own request. A wide range of mannequins are provided for practice and instruction. There are also videos on clinical examination, history taking and a number of clinical procedures.

58. We were particularly pleased to note the introduction of a bedside teaching scheme which was piloted by the Division of Medicine at SJUH in 1997. A ward-based teacher, in this case a person with nursing experience, was given the task of assisting students to develop their clinical skills. This teacher was expected to provide students with opportunities to practise their history taking skills, to supervise their physical examination of patients and their acquisition of practical skills, and to help them to work through the systems-based Year 3 workbook. The teacher also co-ordinated input and support from nursing and paramedical staff.

59. Students with whom we spoke confirmed that this scheme had helped them to develop their clinical skills and, crucially, had increased their confidence when undertaking clinical work. We understand that, as a result of evaluation and positive student feedback, this scheme has now been

expanded with the recruitment of a further three teachers. We believe this is a positive development, and one which is clearly appreciated by the students who have had the opportunity to participate in it.

Learning resources

60. Since our last visit the learning resources available to students have been increased, and we welcome the following initiatives:

> a. Thirty new computer workstations became available in autumn 1998 with the opening of a new computing cluster at SJUH. Additional workstations have also been made available at LGI, and SIFT funding has allowed workstations to be installed in a number of district general hospitals (DGHs).
>
> b. A medical teaching centre consisting of 20 seminar rooms was opened during the 1997/98 academic year.
>
> c. The new clinical skills centre recently opened at the LGI.
>
> d. The School has entered into a partnership with the University of Bradford, which it hopes will provide greater scope for teaching and learning within the region.

61. In addition, an expanded medical and dental library should be in place for the first year of the new course in 1999/2000. We understand this will be able to accommodate 600 students.

62. Although the resources we were shown were excellent, the School's intention to bid for an increased intake has concerned current students. Those with whom we spoke did not believe the School had the capacity to absorb additional student numbers. For example we learned that some lecture theatres could not accommodate the existing intake. This had necessitated the setting up of rooms with video links to lecture theatres for those unable to join the main lecture. The School must consider very carefully how it might cope with expanded student numbers in a way that would not be educationally detrimental.

The changing patterns of health care (Principal Recommendation 10)

63. On our last visit we noted that students' greatest opportunity to experience primary care arose in the Year 4 general practice attachment. However, in 1996/97 the School piloted a scheme that allowed some Year 3 students to spend four days at a general practice. Students were able to meet patients at the surgery and also be involved in home visits. We understand that this pilot was very successful and has been extended to all Year 3 students.

64. In order to provide students with greater experience in primary care the School is piloting a Year 3 community firm in 1998/99. This involves one group of students completing their junior firm in a general practice rather than in a hospital setting. The intention is to introduce such a firm for all students in Phase 1 of the new curriculum.

65. Fourth year attachments give students the opportunity to undertake home visits and meet community-based professionals in a variety of settings. During the psychiatry attachment, for example, students have contact with a community mental health team. As part of their paediatrics attachment students spend a week in community paediatrics and have specific community-oriented learning objectives. These attachments, which include a home visit, also allow students to follow the progress of a mother and infant through birth and early development.

66. The School recognises that at present the majority of students are otherwise afforded little opportunity to experience community-based medicine outside primary care. We noted that the School and Leeds Community Mental Health Trust have jointly appointed a Community Education Liaison Officer, who is developing the 'Becoming a doctor - first step' programme mentioned in paragraph 48.

This involves bringing people from the community, for example patients, health professionals and representatives from voluntary agencies, into the School, and allowing students to go out into the community. At present both methods are employed, albeit on a small scale. The School hopes that the development of primary care groups in response to the Government's White Paper will allow it to improve the use of community settings for training and education.

67. Students have the opportunity to carry out a community-based SSM in Year 3. Examples of SSM reports by students include 'Drug Use in Prisoners', and 'Work, Health and Illness in the context of Policing'.

68. We understand community-based experience will be included during the clinical attachments planned for Phase 3 of the new curriculum. However, because the range of attachments to be made available is still under discussion, we were not able to gain any further details about this aspect of the new curriculum.

The goals of undergraduate education - attitudes, skill and knowledge

Attitudes (Principal Recommendation 3)

69. In 1997 we recommended that students should be introduced to the concepts outlined in *Duties of a Doctor* earlier in the course, and given more assistance in appreciating their application. We were pleased to note that 'maintaining trust' is a topic that is addressed in a newly introduced Year 2 communication skills course. The introduction of visits to a general practice during the third year, when the focus is on patient-centred history taking, has also augmented this process.

70. Students told us that the Year 3 OSCE was an excellent opportunity to demonstrate appropriate skills and attitudes, and that feedback from the counselling station was particularly helpful.

71. In-course assessment during the Year 4 paediatrics and child health attachment includes consideration of 'attitudinal development'. This requires appraisal of students' team-working and communication skills.

72. Plans to improve the teaching and learning opportunities relating to attitudes in the new curriculum include:

a. The new first year programme 'Becoming a doctor - the first step', which is mentioned in paragraphs 48 and 66. This will address G*ood Medical Practice,* and encourage students to explore attitudes towards patients, colleagues and society.

b. Two new ICUs (Personal and Professional Development (PPD) and Lifestyles and Populations) will run for the first two years of the new degree programme. These will share a focus on *Good Medical Practice,* and will encourage students to explore attitudes towards patients, colleagues and society.

Essential skills (Principal Recommendations 4 and 8)

73. The students with whom we spoke were uncertain about the essential skills they were expected to acquire, develop and master by the time of graduation. This seemed a major shortcoming to us. The revised curriculum must include a clear and unambiguous statement of the essential skills to be acquired and demonstrated prior to graduation.

Study skills

74. Students currently receive a one hour lecture on study skills at the start of Year 1, plus a study skills booklet. An SSM booklet also introduces the concept of SDL. We were told that the new PPD ICU will include a strand that addresses study skills.

IT skills

75. This has been identified as one of the five key themes that will run throughout the new curriculum, and already features prominently in the existing curriculum. Students with whom we spoke were complimentary about the Year 1 foundation course in computing.

Communication skills

76. The following general aims have been identified for the development of communication skills in the new curriculum:

- Phase 1

  Reinforcing or developing respect for and understanding of patient and others without medical expertise. Reinforcing or developing pleasure in communicating.

- Phase 2

  Teaching the general skills required for medical interviews and basic counselling. Developing advanced skills such as dealing with distressed individuals and preventing stress from damaging communication.

- Phase 3

  Developing advanced interviewing skills. Providing further teaching on counselling and stress limitation. Supervising practice in the use of skills and concepts taught earlier. Exposure to good role models.

Clinical skills

77. The Core Clinical Competencies in Medicine Project, which has been co-ordinated in Leeds, has identified a number of core clinical skills that have been taken into account in the development of the new curriculum. For example advanced life support skills were not initially included in the School's plans, but will now be part of an Emergency Medicine course in Phase 3.

78. In the new curriculum vertical integration of clinical skills will start at an early stage and gradually expand throughout the course. The general intention is as follows:

- Phase 1

  Interviewing and clinical skills relevant to systems-based core addressed will be developed. Later in the phase students will spend two days a week practising introductory clinical skills before experiencing their first intensive clinical block.

- Phase 2

  Basic clinical skills will be developed in more specialised contexts such as mental health, sexual and reproductive health and disease, paediatrics and child health, primary care, public health, medical and surgical specialties. A variety of OSCEs, logbooks, and records of achievement will monitor the development of students' clinical skills.

- Phase 3

  Students will be provided with opportunities to refine their clinical skills in preparation for the PRHO year.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

79. The new Health and Disease Prevention theme is intended to ensure that students gain a sound understanding of the factors that contribute to health and disease, and the extent to which the health service can influence them. The principles outlined in *The Health of the Nation* and *Our Healthier Nation* will be taken into account. The inter-disciplinary team developing this theme includes representatives from public health medicine, general practice, health promotion, medical statistics and a student.

80. Teaching and learning will be integrated vertically and horizontally across the curriculum. In the earlier years specific teaching will be included in the ICUs, while in the later years the SSM programme will afford a vehicle for this theme. A variety of teaching and learning opportunities including lectures, small-group work, problem-based learning exercises and visits to external locations will be provided. However, emphasis will be placed upon the importance of self-directed and independent learning.

Legal and ethical issues

81. The School has provided an ethics course for four years. The experience gained from this has been used to develop ethics and law as a vertical theme in the new curriculum. A team composed of clinicians, medical ethicists and medical lawyers is leading this work. The team has identified aims which include enabling students to:

a. Think critically about ethical issues in medicine.

b. Demonstrate an understanding of, and an ability to analyse, critically evaluate and debate the ethical values and principles which underpin sound medical practice.

c. Understand ethical views which they do not share, and be able to reason constructively about disagreements.

82. The intention is that teaching and learning opportunities for this theme should begin as early as possible in the new curriculum, and continue to be evident through the five years of the course. The School plans to allocate ten days a year to this theme in Years 1 to 3. Teaching and learning opportunities will be integrated within clinical attachments in the last two years of the degree programme.

Complementary and alternative medicine

83. The School has developed a computer assisted learning (CAL) package on alternative therapies that will shortly become available. The package provides an introduction to a variety of alternative therapies ranging from herbalism and acupuncture to crystal healing. Self-assessment questions are included so that students can test their knowledge and understanding of these therapies.

84. The SSM Co-ordinator told us that demand from students for SSMs in alternative and complementary medicine had allowed the School to establish links with a range of institutions and organisations involved in this aspect of health care. Hence contacts have been developed with the Centre for the Study of Traditional Chinese Medicine and The North of England Teaching Centre for the FM Alexander Technique. Titles of SSMs undertaken by students include 'Reflexology and Health Care Today', 'Homeopathy - Principles and Practice' and 'Traditional Chinese Medicine - The Back Shu Points'.

85. We understand the new Health and Illness in Individuals and Populations ICU will include specific formal teaching on complementary medicine.

Infectious diseases and antibiotics

86. Students currently have the opportunity to learn about infectious diseases and the use of antibiotics. Teaching and learning on these subjects occurs principally in the Year 2 Pharmacology course, and in the Year 3 Laboratory and Scientific Medicine course.

Assessment of the process and product (Principal Recommendation 12)

The outcome of the course

87. The philosophy underpinning the new curriculum is expressed in the intended characteristics of the Leeds graduates, which UMEC has adopted. These are listed at Annex G.

88. The School is determined to ensure that its graduates are fit to be provisionally registered as doctors. The new curriculum and associated assessments will allow the necessary knowledge, understanding, skills and attitudes to be developed and accurately assessed.

89. We commend the change to the degree regulations which requires students to satisfy the Faculty that, in respect of their health and conduct, they are fit to be registered as medical practitioners. We were also pleased to note the addition of a new regulation which states:

> 'Candidates for whom fitness to practise is called into question on non-academic grounds will be considered by the Professional Progress Sub-Committee, a sub-committee of the Committee on Referred Students (Medicine), to which any recommendation for termination of studies will be submitted.'

The scheme of assessment

90. The aims and objectives of the current curriculum are consonant with the recommendations set out in *Tomorrow's Doctors,* and give due emphasis to the development of appropriate skills, attitudes and a sound knowledge base.

91. However, the nature of the assessment techniques currently employed, particularly in the earlier years of the course, are more appropriate to the assessment of knowledge and understanding than to monitoring the development of appropriate attitudes and clinical skills. Essay papers, short-answer questions and multiple choice questions (MCQs) predominate.

92. The School accepts that this is so, but we were told UMEC has had little success in encouraging course management teams to use a wider range of assessment techniques. Although we were informed that decisions about the assessment techniques to be used do not rest with UMEC, we subsequently learned that this is in fact UMEC's responsibility. Nevertheles, it seemed to us that the implementation of change had been undermined by the perceived lack of central control by UMEC.

93. As well as concerns about the range of assessment techniques used, we felt that students were subjected to too many formal assessments. There are currently 14 degree level examinations, which we believe places too high a burden on students. However, we understand UMEC intends to reduce the number of degree examinations when the new Phase 1 curriculum is introduced.

94. We were told that UMEC has decided to leave the current assessment structure in place until the new curriculum is introduced, to avoid the need to amend University regulations.

95. Since our last visit the Task Force on Examinations and Assessments has:

a. Begun to review the planning documentation for ICUs in Phase 1, with a view to considering proposed assessments against the GMC guidelines on assessment.

b. Reviewed plans for the new Year 4 examination in general practice and public health medicine.

c. Started to develop ideas for a portfolio of learning that will embrace the five years of the curriculum and the PRHO year.

96. We were assured that the new assessment structure will incorporate a wider range of techniques

to assess the identified knowledge, skills and attitudes appropriately. However, given UMEC's failure to encourage course management teams to use a wider range of assessment techniques in the current curriculum, it was unclear how this would be achieved.

97. The School intends to reduce the overall burden of assessment by introducing integrated examinations. The integrated examination for general practice and public health medicine, which is being piloted this year, may provide a model that can be used in the future for the design of new assessments.

Threshold standards

98. We understand that model answers, which indicate the expected level of performance, are produced to help examiners mark students' work consistently.

99. It was not clear whether the School provided students with information about standards expected of them. In our discussions with them, students indicated that the best way of discovering the expected standard was to ask students who had already taken the relevant assessment.

100. Students with whom we spoke were particularly concerned about the grades awarded for their third year clinical attachments. We were told that clinical teachers applied the grading scale inconsistently. Thus, some teachers interpreted grade C as good performance by a Year 3 student, and considered grade A to be the level expected of a PRHO. However, other teachers believed that grade A signified a good level of performance by a third year student. Such discrepancies are clearly a major flaw which could disadvantage some students. Unambiguous guidance should be provided for all those responsible for supervising students during these clinical attachments.

Other issues

Student selection

101. The School makes its selection criteria available to applicants. These provide applicants with information about the number of places available, the academic requirements, health requirements, the personal qualities which the School considers desirable for future doctors, how the School seeks to combat discrimination, and details about the admissions process. We believe applicants will find this information most helpful.

102. We understand that on average 3000 applications are received each year, and that in region of 30% of applicants are interviewed for 200 places (185 for home students and 15 for overseas students).

103. Interviewers are trained in interviewing techniques, given guidance notes about the process, including information about equal opportunities legislation, and provided with a list of mandatory questions that must be asked in each interview.

104. We understand that the proportion of females on the course is increasing and is currently close to 75% for admissions in 1997. Entrants from the ethnic minorities constitute approximately 20% of the student population.

Student support

105. When we last visited Leeds we noted students' concerns about the level of pastoral care provided. In 1997/98 a new personal tutor scheme was introduced, and there are currently around 180 voluntary tutors in the scheme. This scheme is overseen and monitored by the Dean of Students. Unfortunately this individual was ill at the time of our visit and we were unable to discuss the scheme with him.

106. Each tutor is responsible for a group of five or six students, which includes students from all years of the course. These tutorial groups are expected to meet at least once a term, but students are also encouraged to contact their tutors as and when the need arises. Tutors are expected to offer support to students with academic and personal problems. The School provides tutors with guidance about how to fulfil their role, and monitors the amount of contact between students and tutors by means of a questionnaire completed by tutors.

107. Although the staff with whom we spoke gave us the impression that this scheme was working well, the students were less convinced of its effectiveness. We were told that while the scheme was very good for some students, for others contact and support had been minimal. We understand students have made the School aware of the problems, and that action will be taken if further feedback indicates the system is still failing some students.

108. In 1997 we noted students' concerns about becoming isolated when studying for the intercalated Bachelor of Science (BSci) degree. The School has sought to retain contact with such students through the new personal tutor scheme, and reports from the Academic Sub-Dean responsible for this year.

109. The support provided for students declines as they move from Year 1 to Year 5. We accept that students should take more responsibility for their learning and education as they mature. However, our visits to other medical schools have revealed that students in the predominantly clinical part of a course require substantial support to help them come to terms with the new environment in which they are working and learning, and to cope with the different demands placed upon them. The School should ensure that students in the predominantly hospital-based years of the course receive appropriate levels of support.

Feedback to students

110. In 1997 we suggested that students required more feedback about their academic progress. The new personal tutor scheme, discussed in paragraphs 105 to 107, is clearly intended to provide feedback to students about their progress and performance. However, the comments of students lead us to question the extent to which the current scheme is fulfilling its intended role.

111. Additional feedback and support is now provided for third year students. This area was identified as a particular concern by students in 1997. Following each clinical attachment students receive a grade from the relevant firm's co-ordinating teacher. Any student receiving a grade C or below is interviewed and counselled by one of the School's two professors of clinical education.

112. This system is intended to ensure that students are aware of any weaknesses that may need rectifying, well in advance of the Year 3 OSCE which summatively assesses their progress. While welcoming this additional support, concerns expressed by students about the inconsistency of grading, which are mentioned in paragraph 100, suggest that the support provided may not always be appropriately targeted.

113. Nevertheless, students told us that, notwithstanding our concerns about over-assessment, one advantage of having so many formal assessments was that they received regular feedback about their progress and development.

Careers advice

114. The School and the Postgraduate Dean jointly arrange a series of events designed to provide students with careers advice and information about the PRHO year. These include:

a. A meeting for third year students where the Postgraduate Dean explains the role of the Deanery, and encourages them to begin considering their career options.

b. A meeting for fourth year students where the Postgraduate Dean provides more formal careers advice, and suggests that students contact college tutors to discuss career prospects in specialties which interest them.

c. A careers day where final year students are prompted to consider their personal strengths and weaknesses, attributes and priorities. They are then encouraged to consider careers that may best meet their personal and professional aspirations.

Quality control

115. The quality of teaching and learning provision is monitored by the School's Course Review Committee (CRC), which reports to UMEC. We were told that since our last visit the CRC has become increasingly proactive, and has produced guidance for course organisers about good practice.

116. We received a copy of the CRC's most recently published annual report, which indicated that areas of concern were being identified, monitored and changes implemented. This suggested the CRC was becoming an effective means for monitoring the quality of the provision.

117. We were informed that external examiners are also considered to be an invaluable resource. They help to maintain and improve the quality of provision, and to ensure that national standards are being applied in the formal examinations. External examiners' reports about assessments are considered by UMEC, and course management teams are expected to make relevant changes in the light of these.

118. Course management teams also invite external examiners to contribute to course developments. To facilitate this, course management teams are expected to inform them of any proposed changes to course content, organisation or assessment, and to provide them with copies of the minutes of all course management team meetings.

Areas of good practice

119. *The contribution of students:* the students whom we met were very articulate and made it clear to us that the School seeks their views and takes their comments into account. We were particularly impressed with the Medical Students Representatives Committee (MSRC), which funds classes for students to learn to speak Hindi and Urdu in a clinical setting.

120. *Staff development:* the School is making a great effort to ensure that all teachers, including NHS clinicians, receive training that will help them to implement the new curriculum, and improve the general quality of teaching and assessment. We were pleased to note that a database has been established to keep a record of the training undertaken to date. This is clearly an area which the School takes most seriously.

121. *Learning resources:* A clinical skills centre has now been opened at the LGI. This supplements the SJUH centre that has been open for four years. The students that we spoke to confirmed that these centres provided an excellent environment in which to practice and enhance their clinical skills.

122. *Teaching methods:* the use of bedside teachers in SJUH is an interesting and innovative development. The School's evaluation of the process, and feedback from students, indicates that this is an effective method for helping students to develop their clinical competency. We look forward to hearing in due course how this initiative is progressing.

123. *Complementary and alternative medicine*: the School has devised an excellent CAL package to help students become familiar with a range of complementary and alternative therapies. The School is also to be commended for giving students opportunities to explore complementary and alternative therapies through the SSM programme. We understand that this has allowed the School to develop a number of productive working relationships with alternative therapists based in the region.

124. *Fitness for purpose:* The School is keen to ensure that only those students who have proved themselves fit to be registered as a medical practitioner should be allowed to graduate. The amendment of the degree regulations to take account of a student's health and conduct, and consideration by the Professional Progress Sub-Committee of students whose practice has been called into question on non-academic grounds, are examples of good practice which we welcome.

125. *Student selection:* We were pleased to note that the School makes its selection criteria available to applicants. The information provided will be of enormous help to those considering an application to Leeds.

Areas for further consideration

126. *The management of change:* we believe that the complexity of the current supervisory structures has hindered the planning and implementation of curricular change. The large number of bodies reporting to UMEC make it difficult for this body to wield effective control over the process. The School needs to consider streamlining the management structure to ensure implementation of curricular changes in line with the proposed timetable.

127. It is clear that there have been some difficulties in finalising the content of the final year of the new curriculum. We would therefore urge the School to delay the implementation of this part of the course for a further year, and concentrate on driving through the changes to Years 1 to 3.

128. The role and responsibilities of the Medical Education Unit need to be given further consideration. This is a potentially formidable resource which could be harnessed to effect curricular change. However, at present UMEC does not appear to make full use of the expertise at its disposal.

129. *Definition of clinical cores:* the definition of separate medical and surgery cores in Years 3 and 5 has clearly been problematic. However, we hope that bringing course management teams together will promote integration.

130. *SSMs:* students generally appreciated the opportunities which the SSM programme offers to study areas of interest to them. However, the introduction of SSMs in Year 4 has resulted in students feeling over burdened. The School will wish to consider whether appropriate demands are being imposed on students in this part of the new curriculum.

131. *Community-based medicine:* the School recognises that, to date, opportunities for community-based experience, other than primary care, have been limited. We hope and understand that plans for the new curriculum will address this concern.

132. *The essential skills:* we were concerned that the students we met had no clear understanding of the skills that graduates from the Medical School should possess. It is imperative that the new curriculum includes clear guidance about the skills in which students will be expected to be competent by the time of graduation.

133. *Assessment:* third year students were worried about inconsistent grading during their clinical attachments. The School should ensure that students and teachers have a common understanding of the standards that are to be applied in this part of the course.

134. The current scheme of assessment, which includes 14 degree level examinations, is very heavy. Assessment techniques such as MCQs and short-answer questions predominate, particularly in the early years of the course. The assessment of the new curriculum should be designed to ease the burden of assessment on students, and to encourage the use of techniques more suited to assessing clinical competence and communication skills, and probing the development of appropriate professional attitudes and values.

135. *Student support:* It was evident from our discussions with students that the level of support provided in the later years of the course was not always sufficient. We understand that the School is monitoring the personal tutor scheme, and we hope that the necessary level of support will be forthcoming.

Conclusion

136. There are a number of areas of good practice in the current curriculum. The use of clinical skills centres and bed-side teachers to assist students to develop their clinical skills is praiseworthy. We were also impressed by the student body, a view clearly shared by the NHS managers we met on the second day of our visit.

137. However, little has changed since our last visit. The current curriculum exhibits a paucity of vertical and horizontal integration, and the pre-clinical and clinical phases are still clearly discernible. While plans for revising the curriculum are being developed little has been achieved, and a major effort is required to ensure that the changes proposed will be implemented in line with the intended timetable.

138. The School needs to consider whether its supervisory structures are appropriate for implementing change. Staff are clearly making great efforts to develop plans for the new curriculum, and it is vital that effective mechanisms are in place to secure the desired outcome. We look forward to hearing how implementation of the new curriculum is progressing in a year's time.

Part 2: General Clinical Training

Background information

139. Prior to the visit we were provided with helpful background information about the provision of general clinical training within the region. This included a table summarising the extent to which the recommendations in *The New Doctor* have been implemented. This summary is at Annex H.

Form of the visit relating to general clinical training

140. The day began with an overview of general clinical training within the region from the Postgraduate Dean and her assistant. We then met medical directors and chief executives from several NHS trusts, and had a discussion with a group of educational supervisors and clinical tutors from a variety of hospitals and trusts. Following lunch we also met a number of PRHOs from a range of locations and specialties.

141. We were joined for a number of these meetings by colleagues from the QAA team.

Organisation and management of the PRHO year

Supervisory Structures

142. The Yorkshire Deanery has overall responsibility for the management of general clinical training in the region. The Deanery comprises: the Postgraduate Dean, the Postgraduate Dean's Assistant for the PRHO Year, the Director of Postgraduate General Practice Education, the Educational Advisor and an administrative assistant.

143. The main responsibilities of the Deanery are:

- Overseeing the management of general clinical training
- Organising the PRHO matching scheme
- Organising and running meetings with medical students
- Inspecting PRHO posts

- Meeting with clinical tutors
- Liaising with clinical tutors
- Providing education programmes for those involved with PRHO education and training.

144. Management of the PRHO year is co-ordinated by the Postgraduate Dean and her assistant.

145. Clinical tutors are responsible for overseeing the provision of education and training within their trust, and for ensuring that Deanery standards are met. All clinical tutors meet at the Deanery at least once a year to discuss issues relating to general clinical training. Clinical tutors also arrange their own meetings, and many attend programmes arranged by the National Association of Clinical Tutors (NACT).

Communicating the aims and objectives of the pre-registration year

146. The Deanery uses the following methods to ensure that trusts, teachers, students and trainees are aware of the aims and objectives of general clinical training:

a. Educational and training contracts with NHS trusts set out the requirements for PRHO posts.

b. Annual meetings with clinical tutors allow Deanery staff to outline the aims and objectives of PRHO training.

c. Clinical tutors inform and support the educational supervisors who oversee PRHO training.

d. Educational and training programmes are arranged by the Deanery for those involved in teaching PRHOs. These programmes re-inforce and clarify the purpose of PRHO training.

e. A newly introduced appraisal process for clinical tutors ensures that clear objectives are set for post holders. This scheme is discussed in more detail in paragraph 177.

f. A logbook training record for use by educational supervisors and trainees outlines the areas to be covered during this period of training. This record is discussed in more detail in paragraph 182.

g. The Careers events organised for students are described in paragraph 114. In addition the Postgraduate Dean holds a preparation day for final year students to provide them with information about the PRHO year. A series of presentations give an insight to this period of training. The titles of such presentations include 'What I expect of my PRHO' and 'How to survive as a PRHO'.

h. Deanery staff meet new graduates on the morning of their first PRHO post to provide an introduction to general clinical training.

147. The trainees with whom we spoke felt they were generally well prepared for their first PRHO post. However, they felt that more opportunity to shadow a PRHO in their final year would have provided an invaluable insight to life as a PRHO. As stated in paragraph 22, the new undergraduate curriculum will provide such an opportunity.

148. We were pleased to note that representatives of trusts with whom we spoke, including chief executives, medical directors and educational supervisors, were very complimentary about the quality of Leeds graduates. They were generally considered intelligent, enthusiastic and willing to learn.

149. We were particularly pleased to note positive comments about the introduction of SSMs in the undergraduate course. Clinical tutors indicated that it was enjoyable to work with students carrying out SSM projects because they were so willing and enthusiastic. Having committed students to teach was a

stimulating and challenging experience.

150. Leeds graduates were felt to have a sound knowledge base. However, there were some concerns about their understanding of the NHS and general health care provision, and a perceived lack of anatomical knowledge. There were also some doubts expressed over their clinical skills, for instance some trusts felt it necessary to teach venesection. Nevertheless, the increasingly proactive stance being taken by both the Medical School and the Deanery, to ensure that the service needs of their NHS partners were met, was praised.

The selection of PRHOs

151. The region is currently a net importer of PRHOs.

152. The Deanery runs a matching scheme for PRHO posts. Graduates of other medical schools are invited to participate in this scheme.

153. Students are provided with guidance about the matching scheme. This information includes a timetable for the submission of applications, details of the interview period and when results are published. Any students who have failed to secure a post may apply for any post on the list of vacancies provided by the Deanery.

154. We were told that approximately 90% of applicants are appointed to their first or second choice post. The trainees with whom we spoke confirmed that the selection process was clear and worked well. However, we understand the number of applicants from other medical schools is increasing, and therefore it is possible that in the future Leeds graduates may fail to secure a post in the region.

The approval of posts

155. Approval of PRHO posts rests with the Postgraduate Dean, who is accountable to the Dean of the School of Medicine, the Vice Chancellor and ultimately the GMC. However, much of the responsibility has been delegated to the Assistant Postgraduate Dean for the PRHO year.

156. The criteria for the approval of PRHO posts are based on the principles set out in *The New Doctor*. These criteria are included in the checklist used during PRHO post inspection visits, reproduced at Annex I.

Monitoring the quality of PRHO posts

157. Annual PRHO inspections of each trust are carried out by the Postgraduate Dean's assistant. During these visits PRHOs have the opportunity to discuss their posts in confidence. Clinical tutors and educational supervisors are also able to give their views about the posts within their hospital or trust.

158. Following an inspection visit a trust is provided with a report. This includes an action plan, together with a timetable for the implementation of any changes deemed necessary.

159. If shortcomings in posts are identified more regular visits will be made to monitor progress and ensure that changes are implemented. Temporary approval may be granted on the understanding that changes will be implemented within an agreed timescale.

160. We understand that approval for posts has been removed as a result of poor educational and clinical supervision, or excessive hours. In such cases the removal of posts is negotiated with the trust concerned to ensure that alternative service arrangements can be made and that patient care does not suffer.

161. Examples of good practice, identified through the programme of inspection visits, are disseminated at meetings with clinical tutors.

162. In addition to the inspection visits clinical tutors are required to inform the Deanery of any changes to service arrangements which may effect PRHO posts. Failure to notify the Deanery of such changes has led to clinical tutors not being re-appointed.

The views of PRHOs

163. The Deanery does not use evaluation questionnaires to elicit PRHO views on each post. However, in the past it has carried out surveys to gauge stress levels among PRHOs in the region. The Deanery also operates an 'open door' policy whereby trainees are encouraged to come forward with particular concerns which have not been raised or dealt with locally. Such concerns are investigated with the trust or hospital concerned.

164. Trainees with whom we spoke were confident that any queries, concerns or complaints they raised were considered objectively and dealt with appropriately.

Components of a high quality PRHO post

Induction

165. Although induction is organised locally by each trust, the Deanery has provided clinical tutors with guidance and advice to ensure greater consistency in the content of induction programmes.

166. A variety of approaches are employed to provide new PRHOs with the requisite information. Some trusts hold a series of lunchtime sessions, and one trust includes presentations from its chief executive and leading clinicians.

167. Students are currently able to spend one day with the PRHO they are replacing on the first Tuesday in August.

Educational opportunities

168. The Postgraduate Dean's educational and training contracts with trusts requires them to provide protected time for formal education sessions. We understand that the Deanery expects trusts to set aside one hour a week for this purpose.

169. Our discussions with trainees, educational supervisors and clinical tutors confirmed that formal educational programmes are arranged. These are generally organised by the clinical tutor, although trainees are given the opportunity to influence the content and approach. A variety of teaching formats are used, including lectures, small-group teaching and case presentations. Many trusts provide trainees with the opportunity to practice their clinical skills on mannequins. In onecase a hospital chaplain had given presentations on ethics and care of the terminally ill.

170. The trainees with whom we spoke were generally very positive about the formal educational programmes made available to them. However, we noted that at one trust such sessions were not bleep-free, causing some trainees to miss these important learning opportunities. The Deanery will wish to remind all trusts of the importance of these programmes to trainees.

171. Attendance sheets for formal training are maintained locally. If participation is poor educational supervisors are expected to discuss this with the trainee, and to address the matter during formal appraisal sessions. If service commitments or other organisational issues prevent attendance, the clinical tutor is expected to bring this to the attention of the trust, and to ensure that the matter is resolved.

172. We were concerned to note that introduction of partial shift system has prevented some trainees from taking advantage of all the educational sessions arranged for them. The Deanery may wish to raise this issue with clinical tutors to ensure that trainees are given appropriate support and advice.

Educational supervision

173. Historically, all consultants in the region were designated educational supervisors. However, since her appointment, the Postgraduate Dean has stressed that only consultants willing to carry out the role as defined by the Deanery will be appointed.

174. The Deanery encourages clinical tutors to appoint a single educational supervisor for all PRHOs within a unit or department. This ensures there is one contact point for the clinical tutor and trainees alike, and should guarantee greater consistency of supervision within each unit or department.

175. Sound training is considered of vital importance in maintaining and improving the quality of educational supervision. Clinical tutors must therefore attend NACT training programmes, and consultants cannot be appointed as an educational supervisor unless they have received training considered appropriate by the Deanery.

176. Trust-based training opportunities provided by the Deanery include:

a. A six hour programme 'Teaching & Training', which is funded by the NHSE and designed for educational supervisors. This has been attended by over 200 supervisors to date.

b. A two day course 'The Skills of Effective Teaching', which has been run for the last three years.

c. A two day programme 'Appraisal and Assessment', which is offered four times a year. Approximately 300 consultants have attended this course.

177. The Deanery is also introducing an appraisal system for clinical tutors. This scheme is run jointly by the Deanery and NHS trusts, and involves appraisal at the end of the first and third years as a tutor. The aims and objectives for tutors are set jointly by the NHS Trust chief executive, the medical directors and the Postgraduate Dean. The Postgraduate Dean hopes this scheme will further enhance the quality of the education and training for PRHOs in the region.

178. The Deanery has made great efforts to ensure that all PRHOs enjoy appropriate educational supervision. The trainees that we met confirmed that they were content with the level and quality of educational supervision they were receiving.

Clinical training and supervision

179. Clinical training and supervision is organised locally, and the Deanery expects to be notified of any problems.

180. The trainees with whom we spoke agreed that the level of training and supervision was generally very good. Most trainees felt that senior house officers (SHOs) and specialist registrars were very supportive, and that consultants tried to make them feel part of the team. However, there were some concerns about the level of on-call support in elderly medicine at one trust. We were told that although SHOs were available, they did not consider elderly medicine a priority, and therefore were not always willing to respond swiftly to PRHOs' requests for help.

Monitoring the progress of PRHOs

181. Appraisal of PRHO performance should occur at the beginning, mid-point and end of each post. We understand that clinical tutors are expected to ensure that supervisors meet their trainees regularly, and the inspection visits also provide trainees with the opportunity to comment on the level of supervision. All the trainees to whom we spoke had met their supervisor, and had received helpful feedback and advice.

182. The Deanery has developed a logbook training record to help educational supervisors to monitor the progress of trainees. This record has been used for four years and has been revised to take account of comments and problems raised in earlier years. The logbook outlines the aims and objectives of PRHO training and sets out general clinical competencies to be achieved prior to full registration.

183. The educational supervisors with whom we spoke confirmed that training provided by the Deanery had helped them to undertake appraisal with greater confidence. The Postgraduate Dean also informed us that educational supervisors' comments on appraisal sheets had become increasingly clear and helpful.

184. We were pleased to note the development of the training record. This is clearly a comprehensive document, which educational supervisors and trainees find most helpful. The specific requirement to consult nursing staff, and other health care professionals, about a trainee's progress and development is particularly commendable.

185. Poor performance is expected to be dealt with by educational supervisors and their clinical tutor. However, if the issues are not satisfactorily resolved locally, the Postgraduate Dean will offer guidance and support.

186. In August 1998, the Deanery met medical staffing officers to discuss the management of trainee doctors in difficulty. We understand this meeting was very productive and resulted in a Deanery policy for all medical grades. In future such cases will be handled under one of the following headings:

- Personal misconduct
- Professional misconduct
- Clinical incompetence
- Health related problem

187. Clinical tutors will be expected to inform the Deanery of any trainee whose performance is unacceptable. If necessary, additional remedial training and support will be provided, and the period of training extended.

188. We were told the Deanery is willing to allow PRHOs to take up to two weeks of sick leave in a six month period. Longer absences are investigated and detailed reports from the supervising consultant required. If a trainee is absent for more than one month during a six month attachment the period of training is extended to ensure that the trainee is fit for full registration.

Professional development and personal well-being

Support for PRHOs

189. Clinical tutors and educational supervisors are required to provide PRHOs with academic and pastoral support. In addition all trusts provided helpful handbooks which include useful information concerning trust protocols, local procedures and services, and occupational health services.

190. The trust managers we spoke to were aware of their obligation to help trainees. We were pleased to note the following initiatives at individual trusts:

- The appointment of a co-ordinator to ensure that all trainees receive appropriate support and guidance.
- The provision of a counselling service for female trainees, which allows them to seek advice from female consultants on a range of professional and personal issues.
- The introduction of a mentoring system whereby a more experienced trainee is able to offer advice and guidance.
- The provision of counselling that helps PRHOs to cope with the stress associated with training.

191. We understand that PRHOs are encouraged to register with a local GP, and that the Deanery is currently seeking advice as to whether this can be made a condition of employment. We were also told the Deanery is developing a business plan for the provision of confidential primary care and psychotherapy services.

192. The trainees with whom we spoke were happy with the level of support provided by the Deanery and trusts.

Careers advice

193. Clinical tutors are required to meet PRHOs to discuss their career plans, and in some trusts assistance is provided in the preparation of curricula vitae for applications to SHO posts.

194. The trainees with whom we spoke felt that the support provided by the Deanery when they were Leeds students, and outlined in paragraph 114, had been most helpful in encouraging them to consider their career options. All were confident that appropriate information, advice, and counselling was available on request.

Accommodation, catering and personal safety

195. The suitability of accommodation, catering and security is monitored by the regional New Deal Task Force. This body is based in the Deanery's premises and is accountable to the Postgraduate Dean.

196. The work of the Task Force is being taken forward by a consultant who has been appointed by the Postgraduate Dean on secondment. A junior doctor is also attached to this body to ensure that the views of trainees are taken into account.

197. The Task Force monitors provision through:

a. Bi-annual visits to trusts, which involve meetings with management and trainees.

b. Seeking the views of trainees about the services provided.

c. Requiring trusts to send six monthly returns detailing provision. These include a detailed questionnaire about the facilities available to trainees.

198. In addition clinical tutors are expected to inform the Task Force of any relevant problems within their hospital or trust.

199. The trainees with whom we spoke were generally content with the services provided. Accommodation was mostly adequate, and at two Trusts (York and Huddersfield) considered excellent. However, there were concerns about personal security at one location, where the lighting in a carpark was poor.

200. The major concern of trainees related to the provision of out of hours catering. For example we were told that the canteen at one trust closed at 5 pm at the weekend. It was therefore virtually impossible for doctors working there to have a warm meal in the evening.

201. The trust managers whom we met were aware of problems relating to catering, and they outlined strategies being used to improve the service. Thus, one trust pays for a professional take-away service, while another provides frozen ready made meals and a microwave. While we were pleased to note such initiatives, the Deanery will wish to work with trusts to ensure that adequate catering is available in all trusts where PRHOs are trained.

Contractual matters

202. The New Deal Task Force monitors working hours and work intensity through its six monthly

returns, which are spot-checked by the junior doctor attached to the Task Force, and its bi-annual visits. PRHO inspection visits also gather information about the hours worked. In addition trusts are expected to monitor this aspect of their working practices and to provide information about how this monitoring is carried out.

203. As already noted in paragraph 160, approval for posts has been removed in the past when service commitments were considered too great.

204. We were pleased to learn from trainees that a number of trusts had made efforts to ensure that PRHOs have protected time for sleeping when on-call. For example, at one trust a night co-ordinator filters bleeps after midnight so that PRHOs are only disturbed for matters which are sufficiently urgent to require immediate attention. The employment of nurse practitioners has also been beneficial as this has freed trainees from a number of minor or routine tasks, and allowed them to concentrate on more pressing medical issues.

Plans for further development

205. The Deanery is working with the Medical School to revise the final phase of the undergraduate curriculum. The intention is to develop a portfolio of SSMs, assessments and a personal development programme that will also embrace the PRHO year. This should help to ease the transition from student to PRHO.

206. Subject to funding, the Deanery hopes to introduce a further 16 PRHO posts from August 1999. We understand that this will include four additional general practice rotations.

Areas of good practice

207. *Careers guidance:* The Deanery clearly takes its responsibility for providing careers advice to students and PRHOs very seriously. Our discussions with trainees indicated that the advice and guidance provided were excellent.

208. *The views of PRHOs:* the trainees with whom we spoke made it clear that they have ample opportunity to raise concerns about training and facilities. We were left in no doubt that the views of trainees are sought and taken into account.

209. *Staff development:* the Deanery has recognised the importance of training in improving the quality of education and the clinical experience of PRHOs. A number of excellent in-house training programmes are offered, and the Deanery actively encourages all consultants to take advantage of training opportunities.

210. The appraisal system for clinical tutors, which is jointly administered with NHS trusts, is another example of the Deanery's commitment to providing high quality education and training within the region.

211. *Monitoring the progress of trainees:* we understand the logbook training record devised by the Deanery has proved most helpful to educational supervisors and trainees. Outlining the aims and objectives of the PRHO year, and defining the necessary patterns of experience, has provided a further guarantee of high quality education and training.

212. We were also pleased to note that the Deanery has spoken to its NHS partners about the process for identifying and helping poorly performing trainees. We have no doubt that this will prove beneficial to the small number of PRHOs who require additional assistance to complete this part of their training satisfactorily.

Areas for further consideration:

213. *Educational opportunities:* although formal educational programmes are available to all trainees, we were concerned that in some trusts such sessions do not occur in protected time. The Deanery will wish to remind trusts that protected time should be set aside for formal education.

214. We share the concerns of those trainees who have missed formal educational sessions as a result of the introduction of partial shift systems. The Deanery should discuss this issue with trusts to ensure that working practices do not have a detrimental effect upon the training and education of PRHOs.

215. *Catering:* The Deanery will wish to work with its NHS partners to ensure that adequate meals are available to trainees. This was a particular problem for some trainees at the weekends and when they were on-call.

216. *Security:* Trainees were generally complimentary about the steps taken by trusts to ensure their safety and security. However, lighting in the carpark of one trust was very poor, leading to some concerns about PRHOs' personal safety. The Deanery may wish to remind trusts of the need to ensure the safety of their staff.

Conclusion

217. We were very impressed with the standard of general clinical training in the region. The Deanery and New Deal Task Force have made a great effort to ensure that high quality education, training and facilities are in place. We congratulate them on what has been achieved and look forward to hearing about further developments in due course.