Report of the visit to the University of Leicester

11 - 12 May 1999

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

Introduction

1. The purpose of the visit, which took place on 11 and 12 May 1999, was twofold:

    a. To monitor progress made towards implementing *Tomorrow's Doctors.*
    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 Andrew Elkington and Dr Anthony Toft, both medical members of the Education Committee; and Mr Gareth Wardell, a lay member of the Committee.

3. The visit lasted two days. The first day was concerned with the undergraduate curriculum, and the second focused on general clinical training. Both days involved us in collaborative working with a QAA team that was simultaneously conducting a review of medicine at the University. Further details about the nature of this collaboration are provided in the relevant sections of the report.

4. This report is therefore in two parts. In the first we consider developments in undergraduate education since our last visit in July 1995. 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 Faculty provided us with helpful background material including the Self-Assessment Document prepared for the QAA reviewers. Members of the QAA team received copies of the completed GMC questionnaire produced for our visit.

Form of the visit relating to undergraduate medicine

7. The day began with a meeting with senior staff to gain an overview of the curriculum and to discuss developments since our last visit. Later we met members of the Educational Policy Committee (EPC), the body responsible for overseeing the curriculum. In the afternoon we had the opportunity to meet a group of students drawn from each year of the curriculum.

8. 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.

9. Members of the team were able to visit the Resource Centre, which provides a study area and access to a large number of medical journals. One member also had the opportunity to visit the library facilities. During the visit the team had access to all the materials made available for the QAA team.

The Leicester undergraduate curriculum

Curricular development

10. At the time of our last visit we noted that the Faculty planned to roll out the new course year by year, starting with Year 1 in October 1994. Thus we saw a recently introduced new first year, and were able to discuss the Faculty's plans for the future. On our return we were pleased to learn that Phase II of the new curriculum had been fully implemented. Students were due to graduate from the new course for the first time in July 1999.

11. We were told that as each new year had been introduced the preceding years had been revisited to ensure the internal consistency of the curriculum. Consequently, the Phase II competencies have been imbedded in Phase I teaching via a number of case studies, which help to prepare students for the increased clinical exposure they will experience.

The new curriculum

12. The aim of the Faculty is:

"That new graduates should have the clinical competence to work as Pre-registration House Officers combined with the potential to develop along the continuum of medical education into humane and rational doctors. They should have the understanding, intellectual skills, attitudes to practise and habit of lifelong learning necessary for a career of constant development in the Health Services of the future."

13. The new curriculum has been designed to meet this aim. The competencies which are expected of all Leicester graduates are listed at Annex A.

14. Although described here, and in the Faculty's own course documentation, as two phases, the curriculum is designed as a single vertically and horizontally integrated course. While the level of clinical exposure increases as students move through the course, they should not experience the phases as separate and distinct entities. The general structure of each phase is at Annex B.

15. Phase I is a modular course, which runs over five semesters. During this phase students take six modules concurrently during each semester. Core modules, which are systems or topic-based, cover the medical sciences, including social and behavioural medicine, and are taught by inter-disciplinary teams.

16. In addition to the core modules students must take three special studies modules (SSMs). The SSM programme is described in more detail at paragraphs 46 to 51. Students are also provided with opportunities to experience clinical work in a variety of contexts, and start to develop their clinical skills. These opportunities are discussed in more detail in paragraphs 33 and 66.

17. Phase II is wholly clinical and involves a number of eight-week attachments in a variety of clinical settings. Each student undertakes 12 attachments divided into two blocks, the Junior and Senior Rotations. The Junior Rotation covers Year 3 and part of Year 4, the Senior Rotation spans the remainder of Year 4 and most of Year 5.

18. During these rotations student learning is guided by a course document containing the curricular objectives, which have been defined for specific clinical contexts. Students must also collate a portfolio of patient studies. Further details about the portfolio are provided at paragraphs 80 to 82.

19. Following the new Final Professional Examination, held in April, all students undertake a period of Additional Clinical Practice (ACP). This is designed to prepare them for their first pre-registration house officer (PRHO) post. This training is described in paragraphs 85 to 87.

The management of change (Principal Recommendation 13)

Supervisory structures

20. The Faculty is fortunate to enjoy excellent leadership from its senior staff. The supervisory structures are sound, and lines of accountability and responsibility well defined.

21. The merging of the Faculty of Medicine and the School of Biological Sciences in August 1998 left management of the medical curriculum unaffected. Thus, the EPC retains responsibility for setting the broad policy relating to curricular development. The delivery of Phase I remains the responsibility of module leaders, whose work is co-ordinated through the Phase I Module Leaders Group.

22. As Phase II has been developed and implemented, so a supervisory structure has been established to manage and monitor this part of the course. The Board of Clinical Studies, which reports to the EPC, co-ordinates the provision of Phase II clinical education. This body is chaired by the Director of Clinical Studies, and links the Faculty to representatives of clinical teachers from the University and the NHS trusts.

The contribution of students

23. In 1995 we were pleased to learn that students had been playing an active role in defining the content of the new curriculum. On our return we were informed that students continue to participate in curricular developments through membership of the EPC. A Staff-Student Committee provides a further opportunity for students to comment on and influence each aspect of the course. Formal evaluation questionnaires for each Phase I module and each Phase II clinical attachment provide another avenue for eliciting their views.

24. Students with whom we spoke confirmed that the Faculty takes every opportunity to seek their views, and is willing to implement changes as a result of student feedback. We were left in little doubt that an effective partnership exists between staff and students to ensure the maintenance of a high quality medical curriculum.

Staff development

25. We were pleased to lean that the Faculty has taken up the suggestion we made in 1995 to consider ways of keeping NHS clinicians informed of curricular changes. The following methods having been used to keep clinicians abreast of developments:

a. Regular briefing sessions at which senior members of the Faculty have explained the new curriculum to clinical teachers.
b. The production of a newsletter which details changes that are being introduced.
c. The provision of detailed written guidance for clinicians concerning curricular innovations.
d. The provision of training opportunities to enhance the skills necessary to teach and assess those enrolled on the new curriculum.

26. The University has a clear policy relating to staff development and the Faculty has established a Staff Development Group to manage staff development relevant to undergraduate medical education. This body co-ordinates the provision which departments have hitherto been offering independently. Main features of the staff development programme are as follows:

a. All new members of Phase I teaching staff are supported by a mentor.
b. The University has established a Postgraduate Certificate of Higher Education that will be taken by all new academic staff.
c. Over 200 teachers have attended 'teaching the teacher' courses.
d. Seventy hospital consultants have attended training that focuses on teaching and assessing students' consultation skills. A further 40 are awaiting this training.
e. Peer review of teaching has been piloted in the teaching of communication skills, and is likely to be extended across the curriculum in line with University policy.

27. Teaching is regarded as a valuable activity and, as such, is recognised at times of promotion and consideration for additional salary. We were assured that a number of promotions were based primarily upon the individual's contribution to the development, management and delivery of the curriculum.

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

Defining the core

28. Initial identification of curricular content, including the core, was carried out by a number of working groups involving students, junior doctors and NHS clinicians. Ultimate responsibility for approving content rested with the EPC. In Phase I the core is contained within 20 systems and topic-based modules. The Phase II the core curriculum is defined by the competency-based objectives listed at Annex C.

29. The Faculty is aware that, having defined the core, there remains the potential for additional content to be added, thereby imposing unrealistic demands on students. Accordingly, an annual review considers each area of the course on a rolling programme to ensure that 'curricular drift' does not occur. This process is described more fully at paragraph 94. Written guidance also ensures that teachers are aware of the latitude they have for introducing changes to their modules or teaching without seeking the permission of the EPC.

Reducing the burden of factual information

30. The Faculty is confident that the demands on students have been reduced as a result of introducing the new curriculum. Each Phase I core module has 36 hours of scheduled teaching time, which is divided into 12 three hour slots. Scheduled teaching fills only half of students' time, thereby ensuring a mixture of teaching and learning opportunities. We were told that Phase I students have an average of 15 hours of formal teaching a week. Definition of the Phase II objectives means that students understand what is expected of them during that part of the course, which should reduce the amount of unnecessary learning.

31. The students confirmed that the course was demanding, but did not consider the demands unrealistic. We concurred with that view.

32. However, there was a student perception that, in Phase I, the theoretical content relating to the social and behavioural sciences was too large. Particular concern was expressed about aspects of the Health Psychology Module. Students did not question the importance of such subjects, but found them more interesting when their relevance to clinical problems was identified. The Faculty may wish to consider whether the balance of the coverage of social and behavioural sciences between Phases 1 and 2 is correct.

Integration

33. Students have opportunities to experience clinical work and develop clinical skills from the beginning of the course. In Year 1 the Clinical Skills component enables them to develop communication skills, through work with simulated patients, and physical examination skills. A Family Attachment provides experiential learning with real patients. In Year 2 the hospital-based Introductory Clinical Course sees small groups of students allocated to clinical teachers. A workbook, which is structured around systems of the body, guides the development of their clinical skills and helps them to relate their learning in core modules to their clinical experiences. Year 3 provides students with the chance to undertake community-based clinical experience, which is described in more detail in paragraph 59.

34. A Clinical Applications SSM, described in more detail at paragraph 49, requires students to integrate their learning across the core modules by focusing upon a number of clinical conditions.

35. During Phase II coverage of the basic medical sciences is assured through the patient portfolio students are expected to produce in consultation with their teachers. As part of this process they are expected to refer to relevant basic medical sciences. This element of the course is discussed in more detail at paragraphs 80 to 82.

36. A series of Academic Half Days runs in the second phase of the course. These sessions address topics chosen by a panel of senior students and junior doctors. They involve whole-group discussion and small-group work, and provide an opportunity for students to revisit basic medical sciences relevant to the topic under consideration.

37. It seemed to us that the Faculty has achieved a high degree of vertical integration within the curriculum. This has been facilitated by the involvement of basic scientists and clinicians in the development and delivery of each phase of the course. Students confirmed that they were continually expected to link their understanding of the basic sciences with their ongoing clinical experience.

Learning through curiosity

38. Leicester graduates are expected to continue their own professional development through self-directed learning (SDL), with an approach based on curiosity and the exploration of knowledge. To assist students in the attainment of this objective teaching and learning opportunities are designed to guide them from directed self-learning (DSL) in Phase I, to SDL in Phase II.

39. Teaching and learning is initially structured in Phase I, so that the skills of DSL can be gradually developed and mastered. Students are taught how to translate objectives into learning outcomes, and how to organise their study to meet these. Modules include extension work which students are expected to undertake in their own time. They also participate in supervised problem-solving tasks intended to reinforce the skills required by an active learner.

40. In Phase II students are given scope to deploy SDL in order to attain the stated course objectives. They are encouraged and expected to organise their educational and clinical experience. Thus they arrange attendance at additional clinical sessions to bolster their knowledge, understanding and skills within a particular clinical context. The period of ACP, which is described in paragraphs 85 to 87, also provides students with an opportunity to undertake a clinical attachment in an area of their choice in preparation for the PRHO year.

41. An eight-week elective block in Phase II is an opportunity for students to exercise choice. The elective aims to allow students to develop:

a. Greater ownership of the learning process.
b. Attitudes appropriate to the practice of medicine.

42. Students are required to produce a word-processed elective report, of no more than 3,000 words. Students must complete the elective satisfactorily in order to pass Phase II of the course and proceed to graduation.

43. Students confirmed that teaching was well structured and gradually gave them greater responsibility for their own learning. Most felt that by the second year they had become confident self-directed learners. We understand it is quite common for Phase II students to amend their clinical timetables, in consultation with their teachers, in order to gain further experience in an area that concerned them, or in which they had a particular interest.

44. The Faculty is to be commended for establishing a strategy that facilitates the development of such an approach. However, although there appeared to be ample scope for students to determine how best to meet the overall course objectives, the scope for studying in-depth areas of interest to them was less evident, particularly in Phase II.

The intercalated year

45. Students who achieve a satisfactory level of performance are able to undertake an additional one year intercalated BSc honours degree at any time between the second and fifth years of study. This programme allows students to develop the skills of scientific research, whilst under the guidance of scientists and clinicians. We understand approximately 10% of students undertake such a degree annually.

Special Study Modules (Principal Recommendation 6)

46. The Faculty believes that SSMs offer an important opportunity for students to take control of their own learning and development. In Leicester, SSMs are intended primarily to provide students with further freedom to organise their own learning to meet the overall objectives of the course. However, the SSM programme also allows them to exercise some choice over what is studied.

47. During Semesters 4 and 5 of Phase I, students have the opportunity to take two double modules from a list of options, which is at Annex D. These modules were originally designed to allow students to study an area of their choice, and thereby develop an understanding of the scientific process. The nature and content of modules vary as do the teaching and assessment methods. However, these modules are considered an important aspect of the course, and external examiners participate in their assessment to ensure that appropriate standards are maintained.

48. Formerly these modules were called Science Skills SSMs. However, for some time students have been able to study within a broader context, and modules in foreign languages, the history of medicine and disabilities and the arts have been offered. Consequently these modules will be retitled SSMs.

49. During Phase I students also undertake a Clinical Applications SSM. This is designed to enable them to integrate their knowledge and understanding across core modules through the study of a number of clinical conditions selected from the list at Annex E. There is no timetabled formal teaching for this module, but a mentor assists students to fulfil the aims of this part of the course. The module is summatively assessed by a written dissertation and a viva voce examination in Year 3. Initial failure requires students to revise the dissertation and take a second viva voce examination. A second failure could result in the termination of a student's course of study.

50. Students expressed great enthusiasm for the SSM programme. They appreciated the opportunity to exercise some choice over content, and welcomed the chance to exercise greater control over the learning process.

51. We believe that SSMs play a crucial role in the development of students and, in many respects, the opportunities offered by the SSM programme in Leicester seemed entirely appropriate to us. However, notwithstanding the flexibility offered by the elective and the period of ACP, it appeared that students' ability to exercise choice in Phase II was limited. We would ask the Faculty to consider whether there is any scope for extending the SSM programme into this part of the course.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

52. The Faculty uses a number of innovative methods to assist the development of students. Self-study time in Phase I is guided by student workbooks which contain objectives and suggestions for further work on specific topics. As noted in 1995, small-group rooms provide facilities for videotaping consultations with simulated patients for analysis and consideration at a later time.

53. We were particularly impressed with the practice of allocating students to two consultants, one a

generalist and one a specialist, during the Phase II clinical attachments. Students are guided by a clinical timetable, based on their clinical teachers' work patterns, which optimises their opportunities to enjoy a range of clinical work. Experience and development is focused and recorded by means of the patient portfolio described at paragraphs 80 to 82.

Learning resources

54. Students are fortunate to enjoy facilities, which include:

a. Well equipped teaching accommodation.
b. Excellent libraries.
c. Good IT facilities including multi-media computers.
d. Extensive exposure to patients.
e. Close supervision and teaching from clinicians.

55. The curriculum is designed so that teaching and learning materials, for example interactive case studies and self-assessment packages, can be accessed from a central website. SIFT funding has been used to ensure appropriate IT and library facilities are available on all teaching sites. Provision is reviewed annually to ensure that appropriate resources are available.

The changing patterns of health care (Principal Recommendation 10)

56. The Faculty is keen to take advantage of the changing patterns of health care and provide students with clinical experience in a variety of settings.

57. A Family Attachment, during the Phase I Clinical Skills Course, provides an early opportunity to visit patients and gather information. Students develop an understanding of the impact medical care has on an individual and their family. The Clinical Applications SSM programme enables students to observe the chosen clinical conditions in many different settings such as hospices, community hospitals, or to spend time with a district nurse or health visitor. In addition, the Phase 2 Clinical Method rotation is based partly in a general practice and an acute hospital. This provides students with the opportunity to develop basic consultation skills and to appreciate the special circumstances of primary care.

58. The increased through-put of patients, and shorter stays in hospitals, has tended to reduce student contact with patients. Attaching students to pairs of consultants, as described in paragraph 53, has given them greater scope for obtaining the necessary clinical experience. The Faculty is increasingly using outpatient clinics for teaching, and has been impressed with the teaching opportunities provided. To date there has been no systematic exploitation of day care units for teaching, but we understand that this is an area the Faculty is seeking to develop.

59. We thought highly of the opportunities for community-based education to be derived from the Phase I Prince Philip House Attachment and the Phase II attachment to a community hospital. These allow students to follow individual patients and interview staff from the agencies involved in their care. Working in economically and socially deprived areas has given students exposure to a wide range of medical and social problems, including living with a chronic disability; and to the agencies, such as the police, social services and GPs, involved with patients.

The goals of undergraduate education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

60. The Faculty stresses the importance of developing and displaying appropriate attitudes to patients and colleagues. *Good Medical Practice* and *Duties of a Doctor* are given to all students at the start of the course and discussed by the Dean in an introductory address. The induction week allows students to discuss and become familiar with the principles outlined in GMC publications, and makes them aware

of their responsibilities to patients. Role plays and work with simulated patients during communication skills training provides further opportunities for students to consider the behaviour and attitudes they display when interacting with others. By the end of Phase I students are expected to have a clear view of sound professional conduct and to be able to recognise appropriate role models. During Phase II they have the opportunity to work closely with clinicians and observe how they interact with patients.

61. The importance of sound attitudes is reflected in the scheme of assessment. The Phase I Introductory Clinical Course involves an assessment of students' attitudes to patients. During Phase II clinical attachments students' attitudes are formatively assessed by supervising clinicians, and students' performance is graded at the end of each attachment. This area is also addressed during the summative assessments, and we understand that a student can fail the Final Professional Examination by displaying inappropriate attitudes.

62. The students with whom we spoke confirmed that standards of professional conduct and appropriate attitudes are emphasised throughout the course. They were clearly able to recognise good role models, and willing to criticise those teachers whose conduct they felt inappropriate. The students were confident that the Faculty would take account of any concerns about the conduct of teachers and would investigate these.

Essential skills (Principal Recommendations 4 and 8)

IT skills

63. The ability to use IT facilities and the Internet are central to the course. Specific IT objectives are addressed during the first year Clinical Skills Course, which is designed to ensure a basic level of competency. Students are also expected to carry out a literature search on the Internet. There is an informatics SSM for students who wish to develop their capabilities to a higher level. All coursework and the patient portfolio must be word-processed.

Communication skills

64. Phase I includes objectives concerning the development of sound communication skills. Students are given the opportunity to develop these skills, for instance by forming a relationship with a family through the Family Attachment, and practising history-taking skills with simulated patients. At the end of the second year the first clinical examination assesses their ability to take a history and perform a focused physical examination.

65. Experiential bedside learning during Phase II offers further scope for students, under supervision, to develop and hone their communication skills. The large ethnic population also provides opportunities to interact with patients for whom English is not their first language, and to work with translators. Communication skills are formatively assessed during each clinical attachment, and summatively assessed in the Phase II clinical examinations.

Clinical skills

66. The opportunities students have to develop their basic clinical skills in Phase I are described in paragraph 33. These include the Family Attachment, the hospital-based Introductory Clinical Course and community-based attachments. The first phase is designed to develop students who have the basic skills to interact with patients and begin to undertake clinical problem-solving.

67. Phase II clinical experience is guaranteed by the clinical attachments and the necessary skills which are outlined in the learning objectives. The Phase II clinical examinations are designed to ensure that, on graduation, all students can demonstrate the specified competencies.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

68. We were pleased to note that public health medicine has a high profile within the curriculum. Phase I provides a thorough grounding in the principles relating to health promotion and the causes of illness. This aspect is delivered mainly through the modules Health and Disease in Populations, The Human Lifespan, and Health Service Policy, Provision and Evaluation. The clinical conditions forming the basis of the Clinical Applications SSM were taken from conditions identified in *Our Healthier Nation*. During clinical attachments consideration is given to relevant issues, for example the causes of illness in infancy and childhood. The objectives of the patient portfolio also require students to address relevant social and environmental factors relating to the cases under consideration.

Legal and ethical issues

69. The ethical basis of medical decision making is introduced in Phase I and revisited in Phase II within the context of the patient portfolio. The objectives of the portfolio require students to consider relevant ethical issues. A final year programme is designed to ensure that students are aware of the legal framework within which they will practice as registered doctors. The written papers of the Final Professional Examination (FPE) include questions relating to ethics and law as they apply to the study and practice of medicine.

70. Following graduation the period of ACP provides further detailed medico-legal knowledge and practical information that they will need to be familiar with as a PRHO. For example there are sessions relating to the prescribing of drugs, and the issuing of death and cremation certificates.

Transcultural medicine

71. Throughout the course students are taught to respect individuals from different ethnic, cultural and social backgrounds, and to display appropriate attitudes to patients and colleagues at all times. The Phase I module, Human Diversity, introduces students to a variety of subjects including equal opportunities, racial and cultural awareness and diversity of faith. The multicultural local population ensures that students interact with individuals from a variety of backgrounds, and have the opportunity to work with translators where communication is problematic. Attitudes and relationships with patients are formatively and summatively assessed throughout Phase II.

Complementary and alternative medicine

72. The Faculty considers it important that all students should have a good working knowledge of certain complementary and alternative therapies. Accordingly, during Phase I they are familiarised with statutorily controlled practices such as osteopathy and chiropractic, and those therapies practised by registered therapists such as acupuncture and hypnotherapy. In the Medical Sociology module consideration is given to the social, cultural and psychological factors which may influence an individual to seek assistance outwith the orthodox medical profession.

Infectious diseases and antibiotics

73. Students have opportunities to learn about antibiotic resistance and the use of antibiotics. The Phase I module, Infection and Immunity, considers the mechanisms by which micro-organisms evade host defences and antimicrobial agents, and the use of different classes of antibiotics.

Assessment of the process and product (Principal Recommendation 12)

The scheme of assessment

74. The scheme of assessment uses a variety of techniques to guarantee that students' competencies and knowledge are assessed in a valid and reliable manner.

75. The assessment of Phase I, which is described in Annex F, is as observed during our last visit. However, whilst developing patient management problems for the Phase II FPE, the Faculty decided that these would be an ideal vehicle for integrated assessment of the Phase I core modules. It is therefore reviewing the Phase I scheme of assessment with the intention of introducing end of semester cross-module examinations consistent with the FPE written papers.

76. Phase II assessment, which is described in Annex G, consists of a combination of formative and summative instruments. All assessments are based on the competency-based objectives, which are given at Annex C.

77. Phase II includes two summative examinations, the Intermediate Clinical Examination (ICE) and the FPE. We understand that the ICE is intended to identify students who are unable to interact positively with patients, and who may therefore be unsuited to a career in medicine.

78. The clinical elements of both examinations involve the observation of students' clinical practice by examiners. Both examinations are in two stages. All students must take Stage 1, and students about whom there is any doubt must also take Stage 2. Thus, students must take Stage 2 of the FPE if:

a. They have failed to complete the necessary number of patient portfolio cases.
b. Their performance in any of the formative assessments was unsatisfactory.
c. There is uncertainty about the level of their performance in Stage 1 of the examination.
d. The ACP has recommended that they take the extended part of the examination.

79. We understand that this year 25% of all students had to sit the extended element of the FPE. However, as assessments are criterion referenced against the stated competencies, this proportion will vary annually.

The patient portfolio

80. This is an innovative technique for recording and tracking student development in Phase II. Student are expected to compile a total of 50 patient cases from a list of specified conditions. They are required to consider the cases of relevant patients, discuss these with their teachers, and to write up the cases in a standardised format. Teachers are expected to comment upon the cases and give feedback. This is an integral part of the course and failure to complete the appropriate number of cases at any stage may prevent a student from progressing and could lead to the termination of their studies.

81. The portfolio fulfils a number of roles. It provides a focus for students' clinical work during the second phase of the course. It helps students and teachers gauge development and progress, and provides students with a detailed summary of a number of presenting conditions by the end of the course.

82. We were impressed with the thought and effort that has gone into designing the assessments for Phase II. The extended elements of the clinical examinations are very innovative and should ensure that all candidates who graduate have the requisite competencies and attitudes. The portfolio is potentially an excellent vehicle for guiding student development. However, given the large number of clinical teachers involved, it was unclear how the Faculty could ensure their consistent and appropriate involvement. There appeared to be no central mechanism designed to ensure that students were taking account of teachers' comments when writing up cases for their portfolio. The Faculty may wish to consider establishing a process that would confirm that this vehicle was being appropriately deployed by students and teachers.

Poorly performing students

83. The grade descriptions used for the Phase II clinical examinations are reproduced at Annex H.

84. Students whose academic performance causes concern at any stage of Phase II will normally be seen by the Director of Clinical Studies. If necessary, a written warning will be issued, which indicates that unless performance improves the student will be required to appear before the Academic Progress Committee (APC). If performance does not improve a student is referred to the APC for consideration. In exceptional circumstances the Committee may recommend to the Board of the Faculty of Medicine and Biological Sciences that a student's studies should be terminated.

Preparation for the PRHO year

85. As stated in paragraph 19, following graduation students undertake a period of Additional Clinical Practice. This is designed to prepare them for their first PRHO post, and consists of the following components:

a. Four weeks shadowing the PRHO whom they will succeed. This period also includes a mandatory two-day course on Drug Prescribing and Administration and Cardiopulmonary Resuscitation.
b. A four week period which allows students to choose to study a topic or specialty that is of particular interest to them, or in which they have little or no experience.
c. Additional Clinical Practice is mandatory for all graduates. Supervising clinicians will be required to confirm the attendance of students.

87. Former Leicester students and NHS clinicians, with whom we spoke during the second day of our visit, confirmed the importance of shadowing a PRHO before undertaking this role for the first time. Shadowing is excellent preparation for the PRHO year and we commend this as an example of good practice.

Other issues

Student support

88. The Faculty has put in place the following support systems:

a. Detailed course books that outline what is expected of students.

b. A pre-sessional induction week for first year students, which introduces them to the University, the Faculty and the course of study. Much of the induction week involves students working together in small groups. These groups are retained for small-group teaching during Phase I, thereby providing students with a peer support.

c. Pastoral tutors who are available for appointments most days. There is a 24 hour telephone duty tutor service.

d. Undergraduate co-ordinators in clinical teaching sites who monitor the provision of support provided by clinicians.

89. Students also have access to a range of other support services, which are organised by the University, the Faculty, or the Medical Students Society. These services include:

a. A confidential counselling service dedicated to medical students.

b. The student Health Service.

c. A 'parent' system arranged by the Medical Students Society, in which senior students provide support to new students.

90. The BMA students' guide to medical schools describes Leicester as a friendly and caring Faculty. Our discussions with staff and students confirmed that this was so. Students were content with the level and nature of the support provided, and those with whom we spoke said they would recommend

Leicester as an enjoyable place to study medicine. The Faculty is to be commended for the efforts it has made to make students feel welcomed and supported.

Feedback to students

91. Our discussions with staff and students revealed that feedback from formal examinations, for example the Phase I module tests and the Phase II clinical examinations, was both swift and helpful. Students told us that it was always possible to discuss examination performance with teachers and receive further insights about their progress.

92. The identification of learning objectives and performance criteria in Phase II has allowed students and staff to monitor progress against the specified course outcomes. Being aware of the level of achievement expected has reduced the pressure on students and allowed them to concentrate on meeting the defined objectives.

93. Phase II students are responsible for ensuring that formative assessments of their clinical attachments are completed and lodged with the Faculty. If the appropriate forms are not received by the Faculty a student is not considered to have completed the relevant attachment satisfactorily. This process encourages students to take control of their own learning, which is something they considered important in their development as self-directed learners.

Quality control

94. It seemed to us that the Faculty has put in place sound mechanisms for ensuring the quality of teaching and learning experiences. These include:

a. Structured questionnaires allowing students to comment on Phase I modules.

b. A rolling programme of reviews for Phase I modules. These consider the structure, effectiveness and clinical relevance of the modules, and are carried out by independent teams of senior and junior doctors who report to the Educational Policy Committee.

c. Questionnaires allowing students to comment on the teaching and learning opportunities afforded by the Phase II clinical attachments. The findings of these questionnaires are collated and reported to senior trust managers, including the chief executive and medial director, at an annual quality review meeting.

95. The only area in which we had any concerns related to the production of the patient portfolio during Phase II. As stated in paragraph 82, we believe that the Faculty should monitor this aspect of the course centrally, to ensure it is being utilised appropriately by staff and students.

Areas of good practice

96. *Supervisory structures*: Excellent supervisory structures have been put in place at Leicester. We believe that the Faculty has been able to implement its new curriculum so effectively because of the dynamic leadership it enjoys, the clear lines of responsibility and accountability that have been established, and the good relations that have been fostered with students and NHS colleagues.

97. *Good Medical Practice*: The Faculty is commended for placing *Good Medical Practice* and the *Duties of a Doctor* at the heart of the teaching in Leicester. An introductory address from the Dean, and the induction week for new students, ensures that students are made aware of the high professional standards that will be expected of them from day one of the course. It was clear that students understood their professional obligations and the need to develop appropriate attitudes to patients, their relatives and colleagues.

98. *Public health medicine*: We were pleased to see that public health medicine has a high profile in

the Leicester curriculum. Modules in Phase I provide a sound grounding in this subject, which is built upon by the Clinical Applications SSM and clinical attachments.

99. *Community-based education:* Students at Leicester enjoy excellent opportunities for community-based education. The Phase I Prince Philip House Attachment and the Phase II attachment to a community hospital are particularly impressive. These allow students to work with economically and socially deprived individuals and to see the impact that economic and social factors can have on health.

100. *Clinical experience:* The practice of attaching clinical students to two consultants, one a specialist and the other a generalist, allows them to experience a wide range of clinical situations. Students at Leicester are fortunate to enjoy such close working relationships with consultants.

101. The period of Additional Clinical Practice provides students with an excellent introduction to their first PRHO post. All the students with whom we spoke felt that the opportunity to shadow the PRHO they were to succeed would be an invaluable experience.

102. *Assessment*: We commend the development of a scheme of assessment that reflects the inter-disciplinary nature of the curriculum, addresses the objectives of the course and provides students with feedback on their performance. The new clinical examinations, which involve extension assessments for any students whose academic performance is in question, are both interesting and innovative.

Areas for further consideration

103. *Social and Behavioural sciences:* These aspects of the basic medical sciences are given appropriate prominence in the course. However, a number of students suggested that the emphasis placed upon the theoretical aspects of these sciences in Phase I was onerous. We would ask the Faculty to consider whether the balance of coverage between Phases 1 and 2 is appropriate.

104. *SSMs*: There are a number of commendable features to the SSM programme which has been developed at Leicester, including the opportunity to undertake modules in subjects such as a modern foreign language during Phase I. However, we did feel that students have insufficient opportunity to study areas of interest to them in the second phase of the course, and would ask the Faculty to consider developing an SSM programme in Phase II.

105. *Patient portfolio*: This instrument provides a potentially excellent means of coordinating, focussing and recording students' clinical experiences during the second phase of the course. The portfolios we considered indicated that much sound work is resulting from this part of the course. Nevertheless, the Faculty should consider developing a system which demonstrates that portfolios are being completed properly.

Conclusion

106. On our return to Leicester we were pleased to learn that the Faculty has successfully implemented its new curriculum. All those that have been involved in the development and implementation of the new course deserve praise for having completed this task.

107. While we have identified some areas that the Faculty will need to consider, we would not wish to give the impression that we were other than very impressed with what has been accomplished. Our discussions with staff and students left us in no doubt that undergraduate medical education in Leicester is of the highest quality. We look forward to hearing about further progress in a year's time.

Part 2: General clinical training

Background information

108. Prior to the visit we were provided with helpful background information about general clinical

training within the Trent region for Leicester graduates.

Form of the visit relating to general clinical training

109. The day began with an overview of general clinical training from the Postgraduate Dean and members of the Pre-registration Executive Committee (PEC). We then met a group of educational supervisors and clinical tutors from a variety of hospitals and trusts, and had the opportunity to have discussions with medical directors and chief executives from several NHS trusts within the region. In the afternoon we also met a number of PRHOs from a number of locations and specialties.

110. We were joined for some of these meetings by colleagues from the QAA team.

Organisation and management of the PRHO year

Supervisory structures

111. The PEC, which meets twice a year, is responsible for overseeing all aspects of PRHO education and training. Members include the Dean of Medicine and Biological Sciences and NHS representatives.

112. The PEC's overall objective is to ensure that all Leicester PRHOs receive high quality training which conforms to the recommendations in *The New Doctor*.

113. We were informed by the Postgraduate Dean that the PEC was taking a proactive stance in order to improve the quality of the pre-registration year. Thus a number of initiatives, including the provision training for consultants and the formalisation of educational supervision and appraisal procedures, were being put in place.

The approval of posts

114. Requests for new PRHO posts are considered initially by the Postgraduate Dean, the Associate Postgraduate Dean (PRHOs) and the deanery's Business Manager. Approval must be given by the PEC.

115. Posts must comply with guidelines set down by the Postgraduate Dean. These are reproduced at Annex I.

Communicating the aims and objectives of the pre-registration year

116. 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:

a. Annual Education Contract Review meetings at which the Postgraduate Dean and the Associate Postgraduate Dean (PRHOs) meet senior NHS managers, clinical tutors and PRHOs.

b. Informal visits and correspondence from the Associate Postgraduate Dean (PRHOs) to publicise changes required to meet the recommendations set out in *The New Doctor*.

c. Production of detailed guidance for PRHOs, for example the Professional Development Handbook, which will be used for the first time from August 1999. This introduces the PRHO year to trainees and explains what they should expect.

d. The period of Additional Clinical Practice, already mentioned in Part 1 of this report, which will prepare graduates for their first PRHO post.

117. We were pleased to learn that staff development is seen as a means for improving the quality of education and training. Educational supervisors are recognised as the clinical tutors and medical directors of the future. The deanery hopes that as they are trained and develop their expertise, they will influence and improve PRHO training within the region.

118. A mandatory training programme has been established for clinical tutors and educational supervisors. This covers:

a. An introduction to PRHO education.

b. Use of documentation developed to monitor PRHO performance.

c. Assessment and appraisal methods.

d. Mentoring and counselling.

119. We understand that all educational supervisors will have attended one day of training before the August 1999 intake of PRHOs. A database of those who have been trained will be maintained, and attendance at a refresher course will be required at least every three years.

The selection of PRHOs

120. Within the region a PRHO matching scheme operates. Students are provided with details of all the posts available and told to contact relevant consultants for further details about any posts that interest them. They are required to identify and rank three posts for which they wish to apply. Consultants may interview any students and must themselves identify and rank three candidates for their posts. The preferences of students and consultants are then considered and posts filled. Examples of the forms completed by students and consultants are at Annex J.

121. The Postgraduate Dean was well aware of the concerns expressed about the fairness and legality of matching schemes. However, until national guidelines on the selection of PRHOs are provided by the NHSE, the deanery intends to make no changes to its selection process.

122. Historically the region has not been a net exporter of graduates. All Leicester graduates have therefore ultimately been found posts through the deanery's matching scheme. However, from August 1999 there is expected to be a surplus of approximately 15 graduates. The deanery proposes to support these individuals by:

a. Informing them of the database of unfilled PRHO posts provided on the Internet by the North Thames Deanery.

b. Providing contact details of all other deaneries in the country.

c. Advising them to consider advertisements for posts in journals such as the British Medical Journal.

Monitoring the quality of PRHO posts

123. The principal method for maintaining the quality of PHRO posts has been annual Education Contract Reviews. These have involved the Postgraduate Dean, or the Associate Postgraduate Dean (PRHOs) visiting all trusts on an annual basis to talk to PRHOs about the quality of their posts. The comments of trainees are considered at a meeting with senior trust management including the chief executive, director of human resources and the clinical tutor. Such meetings are minuted and trusts are expected to address any areas of concern that have been identified.

124. In February 1997, the PEC removed approval for four posts in orthopaedic surgery because they involved little or no formal education, provided inadequate educational and clinical supervision, and trainees were expected to perform inappropriate medical and non-medical tasks. We understand these posts were reallocated within the region. It therefore seemed to us that a sufficiently rigorous monitoring mechanism was in place.

125. From August 1999, the Associate Postgraduate Dean (PRHOs) will undertake additional bi-annual

visits to trusts. These will allow the deanery to gain further feedback from trainees, clinical tutors and educational supervisors about the quality of education and training. It is intended that meetings with PRHOs will be scheduled as part of the formal educational programmes of their posts.

126. The new procedures to be introduced from August 1999 will include a learning agreement for PRHOs. It is hoped that this will empower trainees to insist on the quality of education and training to which they are entitled.

The views of PRHOs

127. As mentioned in paragraph 123, the annual Education Contract Review visits allow trainees to give their views about posts. Any concerns or issues raised are pursued by the deanery with the NHS trust concerned. The additional visits by the Associate Postgraduate Dean (PRHOs), due to commence from August 1999, will provide a further opportunity to collect the views of the PRHOs.

128. Historically there has been no formal procedure for seeking PRHOs' views at the end of posts. Trainees have been encouraged to comment on their training and to raise any issues of concern. However, an exit questionnaire for PRHOs will be introduced in July 1999. A copy of the proposed questionnaire is at Annex K.

129. We welcome the introduction of a formal questionnaire, which we believe will provide further invaluable information to both the deanery and trusts. We hope the information collected will be used to inform the Education Contract Review visits, and those made by the Associate Postgraduate Dean (PRHOs), thereby strengthening the monitoring process.

Components of a high quality PRHO post

Induction

130. The period of Additional Clinical Practice has already been mentioned in Part 1 of this report. The trainees with whom we spoke confirmed that shadowing had been an excellent preparation for their first PRHO post.

131. In addition to ACP the following elements assist new PRHOs to come to terms with their new jobs.

a. All incoming trainees in August overlap with their predecessors by 24 hours. This provides an opportunity for an effective hand-over of responsibility to be undertaken.

b. All trusts organise a compulsory, one day, bleep-free induction session. This may take a variety of forms, but all proposals are considered by the deanery to ensure some consistency of provision across trusts.

132. We were pleased to learn that chief executives and senior trust managers participate in the induction arranged at many trusts. We believe it is important that trainees meet senior managers, and that trust manages acknowledge the vital role PRHOs play in providing health care.

133. The PRHOs whom we met confirmed that induction training was both informative and helpful.

Educational opportunities

134. Clinical tutors are expected to arrange formal educational sessions for the PRHOs at their trust. These programmes usually involve weekly meetings and address issues and topics identified as relevant by previous trainees. A variety of methods, ranging from mini lectures, workshops, case presentations and discussions, are employed. It is left to the discretion of teachers to determine the most appropriate format for these sessions.

135. It was apparent from our discussions with trainees and trust managers that education was being given a higher priority than in the past. Trainees were clearly appreciative of the educational programmes that were arranged, and welcomed the opportunity to influence the topics which these covered. Trust managers recognised the importance of high quality education as a means to enhance patient care and increase staff morale. One chief executive pointed out that it was in his trust's interests to provide good education and training, as this was a powerful means of improving its ability to recruit and retain the best medical staff.

136. During induction trainees are informed that attendance at formal educational sessions is mandatory. Clinical tutors maintain a record of attendance and are expected to identify and rectify any problems that may inhibit attendance. We were told that failure to attend at least 80% of such sessions could result in a trainee not being signed up as having completed the post satisfactorily. We were therefore concerned to learn that a trainee at one trust had been able to attend just one formal session in 13 weeks, because meetings were on another site and occurred during a ward round. The deanery will wish to assist the relevant clinical tutor to resolve this unacceptable situation.

Educational supervision

137. Historically educational supervision has been organised in a relatively informal manner. Thus:

a. Educational supervisors were appointed according to local wisdom about who was willing and able to undertake the role.

b. Little formal training or support was available to educational supervisors or clinical tutors.

c. Limited guidance was issued about educational supervision and what was expected of the various parties.

138. As a result of this the deanery has had little evidence that PRHOs and supervisors were identifying learning objectives, or that progress and development was being monitored rigorously.

139. However, publication of *The New Doctor* has encouraged the deanery to reconsider the strategies it deploys, and to set in train a series of innovations designed to improve the quality of educational supervision. These innovations include:

a. Formalising the process for appointing educational supervisors. In future these will be proposed by clinical tutors, approved by the Postgraduate Dean and ratified by the PEC.

b. Introducing mandatory training for educational supervisors and clinical tutors. This is described at paragraph 118.

c. Developing more detailed procedures and documentation to help educational supervisors to oversee PRHO training. These will be introduced from August 1999 and include guidance concerning the respective roles and duties of PRHOs, educational supervisors, clinical tutors and the Postgraduate Dean.

140. Our discussions with trainees and educational supervisors revealed that the present systems appeared to be working adequately. Supervisors understood their role and felt supported by the deanery. All the trainees with whom we spoke knew who their educational supervisor was, and all but one had received helpful feedback about their performance. There was no evidence that PRHOs were being treated inappropriately by senior members of staff, or that they were routinely expected to undertake tasks of little or no educational value.

141. While there was no evidence that the current system was failing, it was clear that the systems that will be set in place from August 1999 should improve the rigour and objectivity of educational supervision within the region.

Clinical training and supervision

142. Currently there is no core of generic clinical training for PRHOs in the region. Clinical training and supervision is organised locally and the deanery is only informed if difficulties arise.

143. The trainees with whom we spoke confirmed that the level of supervision and support was generally excellent. However, it appeared that there were some problems concerning the on-call cover available in one renal unit. We were told the unit has no SHO, and that the PRHOs on-call cover is a specialist registrar who could be contacted at home by telephone. We were assured that in other respects the team is most supportive, and the consultants were praised for their efforts to supervise and assist the trainee. However, the Postgraduate Dean may wish to consider introducing an SHO post to the unit to ensure that PRHOs have sufficient support.

144. From August 1999 PRHOs and teachers will have a clear list of the core skills and competencies to be addressed in the Personal Training Record (PTR). A copy of the Case Presentation Record Sheet from the PTR, outlining the criteria against which students' competencies will be judged, is at Annex L. We believe trainees and trainers will derive enormous benefit from having this clear statement of the deanery's expectations.

Monitoring the progress of PRHOs

145. Currently educational supervisors are expected to meet trainees at least three times during a six month post to monitor progress and provide feedback on development. Towards the end of a post the supervisor is expected to complete an assessment form which summarises performance. Educational supervisors should identify poorly performing PRHOs as soon as possible so that the deanery can be alerted to any potential difficulties.

146. Members of the PEC with whom we spoke accepted that the tracking of problems and sharing of information between the deanery and trusts could be improved. However, we were encouraged to learn that in the few cases where remedial training and support had been necessary, the trainees had ultimately proved themselves deserving of full registration.

147. The deanery deals sensitively with any trainee who has missed a substantial amount of a post through ill health. Reports are requested from relevant educational supervisors and the clinical tutor, and the trainee in question may be interviewed. Evidence of performance in other posts will be taken into account, but any PRHO who has had more than four weeks of sick leave in a four month post is unlikely to be considered as having satisfactorily completed the post. The decision to extend the period of training will be taken on an individual basis according to the relevant facts and information.

148. While there was no evidence from trainees or trainers that the current processes do not work, the deanery is instituting new procedures from August 1999, which are designed to provide more objective and detailed evidence about trainees' progress. These will include:

a. Guidance about the number and nature of meetings educational upervisors are expected to have with trainees.

b. Introduction of the PTR, which will contain:

- A portfolio of written up patient cases.
- Records of meetings with the educational supervisor.
- Records of formal training and educational inputs.
- A Personal Development Plan and the identification of educational objectives for each post.

c. The introduction of end of post records of assessment which will be completed by educational supervisors. These will be used as the basis upon which the Postgraduate Dean will sign Certificates of

Experience.

149. The deanery's new procedures will clearly improve the rigour of the monitoring process and we look forward to learning how their implementation proceeds.

Professional development and personal well-being

Support for PRHOs

150. Clinical tutors and educational supervisors are expected to provide PRHOs with academic and pastoral support. They have been assisted in this role by the training on mentoring and counselling offered by the deanery. Trusts also provide helpful handbooks which include useful information concerning trust protocols, local procedures and services, and occupational health services.

151. Senior trust managers with whom we spoke believed that PRHOs represented the future of the NHS and should be nurtured and supported accordingly. We were therefore pleased to learn of the following measures designed to support PRHOs.

a. The employment by a number of trusts of phlebotomists and health care assistants to carry out venepunctures and electro-cardiograms (ECGs).

b. Investment in clinical skills centres at two trusts, which were accessible to trainees and other grades of staff.

c. The development of teleconferencing facilities at two peripheral sites, which allowed trainees to participate in educational and appraisal sessions without having to travel long distances.

152. The trainees with whom we spoke were content with the level of support provided by the deanery and trusts.

Careers advice

153. The Postgraduate Dean organises an annual careers fair for final year students in conjunction with the BMA. Educational supervisors and clinical tutors are also expected to provide appropriate careers advice. Our discussions with trainers revealed that careers advice often consisted of directing a trainee to the relevant college tutor, or effecting an introduction to a consultant colleague who could explain the career path and opportunities in a particular specialty.

154. Trainees did not feel that careers advice was offered in a proactive way, although they were confident that if they invested a little time and effort they would secure the necessary guidance and information. Trainees were particularly impressed when they were told about the additional advice offered by a medical staffing officer at the Leicester Royal Infirmary. We understand this advice consisted of:

a. Guidance on the preparation of application forms and producing CVs.

b. Guidance on interview technique.

c. Information about short-listing and the appointments process.

155. The response from trainees who had not benefited from such advice suggested that this is an example of good practice that could be disseminated throughout the region.

Accommodation, catering and personal safety

156. The suitability of accommodation, catering and security is monitored by the regional New Deal Task Force. The Postgraduate Dean is the chairman of the South Trent Task Force and the Associate Postgraduate Dean (PRHOs) receives a copy of Task Force reports for each trust in the region.

157. In any instance where facilities or accommodation are found to be inappropriate the trusts concerned are expected to take remedial action. Approval of posts may be withdrawn or withheld if appropriate action is not taken by relevant trusts.

158. Trust chief executives and medical directors reiterated the importance they attached to PRHOs, and this was reflected in the resources that some trusts were investing in facilities. Thus we learned that:

a. Walsgrave Hospital has funded a common room, which includes a TV and computer terminal, specifically for PRHOs. We understand this has helped improve the morale of trainees.

b. A number of trusts have installed closed circuit televisions and cameras, provided personal alarms and improved lighting. These initiatives had helped to make staff feel safer.

c. The Leicester Royal Infirmary has arranged a police presence in the accident and emergency department on Friday and Saturday evenings, which are the most difficult times for staff.

d. The Leicester Royal Infirmary also has plans to upgrade the accommodation provided for trainees.

159. Trainees' concerns about out of hours catering were noted. However, discussions with trust managers suggested that most trusts were endeavouring to ask trainees what catering facilities they would like. There was some frustration amongst managers that, as each set of PRHOs changes, so the expectations and wishes change. It was therefore considered impossible to completely satisfy trainees' expectations. Nevertheless, it was accepted that systems should be put in place to keep trainees informed of trusts' plans, and to allow their views and opinions to be sought and considered.

Contractual matters

160. The South Trent Task Force collects evidence from PRHOs about the hours worked and the intensity of on-call work. Approval and funding will be withdrawn for posts which do not conform to the *New Deal*.

161. The trainees with whom we spoke did not consider the hours they worked to be an issue of particular concern.

162. However, trainees at two trusts expressed some concern about their involvement in the treatment of private patients and work to reduce waiting lists. Although their experiences varied, it appeared that some were expected to undertake such duties with no corresponding additional payments. The deanery will wish to ensure that both PRHOs and consultants have a clear understanding of the appropriate involvement of trainees in work of this type.

Areas of good practice

163. *Management of the PRHO year*: Since the publication of *The New Doctor* the deanery has been reviewing its procedures for general clinical training and intends to implement a number of changes to improve the quality of this period of training. We welcome the more proactive stance which has been adopted.

164. *Staff development*: The deanery clearly regards staff development as a mechanism for developing and improving the quality of PRHO training. By introducing mandatory training for educational supervisors and clinical tutors, and rationalising the process for appointing educational supervisors, a clear signal is being sent to the consultant body about the importance attached to general clinical training.

165. *The views of PRHOs*: We think the intention to introduce a formal PRHO questionnaire, and for the Associate Postgraduate Dean (PRHOs) to undertake informal visits to trusts, should help elicit

further information from trainees about the quality of training. If this information can be used to inform the formal visits the whole process will be strengthened considerably.

166. *Feedback to NHS colleagues*: We thought the annual Education Contract Review meetings, at which senior trust management is given feedback on the quality of its PRHO posts, were excellent. It was clear that the trusts found this feedback helpful, and the process contributed to the development of close working relationships between the deanery and the NHS.

Areas for further consideration

167. *Educational opportunities*: It was evident that educational programmes were being arranged for trainees and that these were generally appreciated. However, there did seem to be an issue concerning attendance at such programmes at one trust. The deanery will wish to help the appropriate clinical tutor to resolve this unsatisfactory situation.

168. *Clinical supervision*: The level of support and supervision experienced by the vast majority of trainees with whom we spoke was considered excellent. However, there was some concern about the level of on-call support provided in one renal unit. The Postgraduate Dean will wish to consider this case and ensure that PRHOs in this unit are not put in a position whereby they are unable to seek advice and support from a senior colleague within the hospital.

169. I*nappropriate tasks*: A number of PRHOs expressed some uncertainty and concern about their involvement in work for private patients and to reduce waiting lists. The deanery will wish to explore this matter with trainees and trusts.

170. *Careers advice*: The trainees with whom we spoke were confident that if they invested a little time and effort they would be able to find the advice and guidance required. However, the provision of advice and training similar to that offered by a medical staffing officer at the Leicester Royal Infirmary is something that all trainees would welcome.

171. *Catering*: Our discussions with trainees and senior trust managers revealed that there remain some concerns about the quality of out of hours catering. However, it was evident that trusts did take note of the views of PRHOs, and were endeavouring to meet their needs. The deanery may wish to encourage trusts to develop systems that would keep PRHOs informed of trust initiatives, and would allow them contribute to trust plans.

Conclusion

172. We were impressed with the plans which the deanery has set in place to ensure a more rigorous process for monitoring PRHO development and performance. The deanery is to be commended for the proactive stance it has taken to ensure that PRHO posts are of an appropriate quality. The implementation of the new procedures and the Personal Training Record will be a great advance, and we look forward to hearing about this in the future.