

1 September 2006

General  
Medical  
Council

Regulating doctors  
Ensuring good medical practice

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## Undergraduate Board

*To consider*

QABME: the School of Medicine, University of Leicester for 2005/06

### Issue

1. Review of the assessment of Leicester Medical School in the academic year 2005 to 2006.

### Recommendations

2. The Undergraduate Board are invited to agree:
- a. In the academic year 2005/06, the School of medicine, University of Leicester met appropriately for that stage the standards of Tomorrow's Doctors, subject to meeting the requirements in paragraphs 15 a to c.

### Further Information

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## Introduction

4. This is the final report to the Education Committee on the quality assurance programme for the School of Medicine, University of Leicester for 2006.

5. The visiting team appointed by the Education Committee to undertake the quality assurance visits included the following individuals. Throughout the rest of this report the GMC visiting team is referred to as the visiting team:

Professor Reg Jordan (team leader)

Mr Philip Brown

Dr Jennie Ciechan

Mrs Susan Hobbs

Professor Peter McCrorie

Dr Philip Milner

Professor Trudie Roberts

Dr Bruno Rushforth

Dr Martin Talbot

6. Miss Coreen Beckford and Ms Cara Talbot supported the visiting team.

### *Our programme of visits in 2005/06*

7. The GMC visiting team attended the School on 6 occasions: 14 February 2006, 2 March 2006, 18 May 2006, 23 May 2006, 14 June 2006 and 21 June 2006.

8. The following field work was undertaken:

- a. Meetings with various members of the School.
- b. Observation of the clinical examinations.
- c. Observation of the Final Exam Board Meeting
- d. Site assessment(s): NHS Trusts.
- e. Site assessment(s): GP Practices.
- f. Discussions with students.
- g. Discussions with teachers.
- h. Discussions with the NHS and other service providers.
- i. Meetings with F1 Trainees and Educational Supervisors.

## *History*

9. Leicester Medical School had been operational since the 1970s. It provided two routes to an MBChB primary medical qualification: the five-year curriculum for applicants with A-Levels or equivalent, and a four-year accelerated curriculum for graduates with a Health Science background.

10. Leicester partnered with the University of Warwick in 2000 to form the Leicester Warwick Medical School. This added a four-year accelerated graduate entry programme (GEP) for graduates of Biological Sciences to be delivered at the Warwick site. Warwick Medical School has since applied for separate accreditation from 2007.

11. Leicester Medical School had 219 students enrolled in 2005/06 on the first year of its five-year programme and 64 students enrolled on the first year of its graduate entry programme. In 2004 the School appointed clinical education leads to all their teaching hospitals with the majority based at the main teaching trust, University Hospitals of Leicester NHS Trust.

12. The Dean of the School had confirmed that necessary funding was in place for the new educational facilities. These would include a multi-professional education and training centre to be completed by 2009 in order to accommodate expanding student numbers.

## **Summary of key findings**

13. In 2005 the Education Committee sought to clarify where a school was required to introduce mandatory changes (requirements) in order to meet the standards of *Tomorrow's Doctors*.

14. Although the visiting team has suggested some areas requiring additional consideration by the School, (recommendations) these suggestions are not mandatory and should be read in the context of the overall findings.

## *Requirements*

15. Leicester is required to:

a. Improve the structure and organisation of Phase II clinical attachments so that:

i. The timetabling and organisation of attachments is enhanced to maximise the number of clinical learning opportunities for students so that they may cover the core experience necessary to support them in preparation for their F1 posts (paragraphs 25, 29, 33 and 37).

ii. A clear management plan is produced for the preparation and support of staff development and training to ensure that the clinical curriculum is delivered as intended (paragraphs 46, 52 and 75).

- iii. There is transparency on what content contributes to the Phase II core curriculum, and what is genuinely a Phase II SSC (paragraphs 36 to 38).
- b. Provide a learning resources strategy that improves the quality and increases facilities to cope with expansion in student numbers. The School is required to improve the clinical skills centre at Leicester Royal Infirmary or provide new clinical skills facilities at University Hospitals of Leicester NHS Trust (paragraphs 41, 62 and 63).
- c. Redesign Phase II assessments to ensure summative assessment of common practical procedures so that the School can be assured that graduates meet the requirements for entering F1 (paragraphs 25 and 95).

### *Suggestions for quality enhancement*

16. The team have highlighted the following suggested areas for quality enhancement that should be considered by the School, Leicester:

- a. The visiting team recommends that the School review the design, delivery and process of the Phase I curriculum for the Graduate Entry Programme (GEP) students. This is to ensure it is tailored more to the needs and prior experience of these students, and addresses issues of the sequencing of learning and assessments, and of student workload (paragraphs 30 to 33 and 93).
- b. That the School review SSCs across both Phase I and II to ensure they are branded consistently to remove any confusion over what is core and what is student-selected choice. The School should increase the total amount of student time spent on true SSCs for both Phases (paragraphs 36 and 37).
- c. The School should enhance and review where necessary its examiner training and take-up rates, to ensure a more consistent approach is adopted to allay issues about variability in assessor performance (paragraph 97 to 104).
- d. While the visiting team was pleased to note that Leicester acknowledged the need for change, they recommended the School strengthen its supervisory and management structures to ensure they are sufficiently robust, transparent and integrated in the period following separation from Warwick (paragraph 39 and 40).

### *Areas of innovation and good practice*

17. The visiting team would like to commend the School on the following as areas of good practice:

- a. Specific areas of teaching such as the acute coronary syndrome course (paragraph 49).
- b. Student support systems such as the 'Looking After You' guidance booklet and the 24-hour duty tutor service (paragraph 73).
- c. Comprehensive feedback and follow up for students who failed assessments (paragraph 78 and 92).
- e. The excellent study guides used in Phase I and the overall course documentation (paragraph 47).
- f. GP Attachments, which were particularly well delivered and organised (paragraph 50).
- g. The Phase 1 OSCPE where basic science had been integrated with clinical methods (paragraph 91).

## **Main body of the report**

### *2005/06 Update*

18. There were no significant issues arising from the previous review of Leicester Medical School in 1999. Overall students during the 2005/06 QABME assessment reported that they were happy with their experience at Leicester Medical School. The key developments that occurred at the School since the last visit in 1999 were:

- a. Leicester Warwick Medical School accepted their first biological sciences graduates in 2000 onto the Graduate Entry Programme (GEP) at Warwick.
- b. A significant restructuring of the local NHS Trusts associated with Leicester Medical School in 2001.
- c. Leicester's Graduate Entry Programme for healthcare graduates expanded to 64 students in 2003.

## **Curricular outcomes**

19. Following the work undertaken in the visiting programme for 2005/06, the team has concluded that the curricular outcomes for the School's MBChB programme meet the requirements of *Tomorrow's Doctors* (Section 1 through 10) in accordance with section 5(3) of the Medical Act 1983.

## Curriculum content, structure and delivery

20. Content and Delivery: The visiting team concluded that the curriculum content and delivery of the School's MBChB programme meets the requirements of *Tomorrow's Doctors* (Sections 11 through 37 and 42 through 53) in accordance with Section 5(3) of the Medical Act 1983.

21. Curriculum Structure: The visiting team has concluded that some aspects of the curriculum structure of the School's MBChB programme does not meet the requirements of *Tomorrow's Doctors* (Section 38) in accordance with Section 5(3) of the Medical Act 1983.

### *Content*

22. The School's curriculum incorporated a structured progression from Phase I to Phase II. Phase I was directed student-learning whereas Phase II was predominantly student-directed learning. The modules in Phase I had a strong clinical focus. Phase II had a broader approach to bring together the application of knowledge, skills and attitudes learnt in Phase I. The visiting team was satisfied that clinical teaching within the curriculum had been vertically integrated.

23. The visiting team reported that community and public health, mental health, and complementary medicine featured appropriately within the curriculum. Ethical content was spread throughout the five years of the course. F1 Trainees reported the School was good at preparing students for medical ethics scenarios and had equipped them well with the necessary communication skills to deal with patients.

24. Students across the year groups and F1 trainees commented on the good balance between the didactic teaching received and their own student-directed learning. In particular the Phase II specialist blocks were reported to be well organised especially the clinical methods, psychiatry, obstetrics & gynaecology and child health blocks.

25. F1 trainees indicated that their ability to deal with new situations was largely dependent on whether they had received exposure to the relevant experience during the undergraduate course. Some trainees reported feeling unprepared before their F1 posts due to some gaps in training in the undergraduate course and students suggested that there was a weighting imbalance of the core subjects in Phase II. Whilst anxiety about the comprehensiveness of their preparation was normal, the trainees had the perception that the Phase II attachments did not provide the required breadth of clinical experience necessary to prepare for finals. The visiting team felt unsure about whether clinical teachers taught fundamental core aspects of the curriculum or whether they focused on their own specialties. The visiting team required the School to review the design and organisation of Phase II attachments.

26. Final Year students and F1 trainees felt that the one-month shadowing aspect had been very good in preparing them for their foundation posts.

27. Educational supervisors were enthusiastic about the Leicester graduates and felt the undergraduate course had equipped them well to undertake F1 duties although they did note a few knowledge gaps. The supervisors commented that generally trainees had a poorer understanding of clinical pharmacology and therapeutics than expected and therefore had difficulty in applying this knowledge within a clinical setting.

### *Structure*

28. The Phase I curriculum was structured to make students study different module topics simultaneously. The School had taken this approach as they felt it allowed time for reflection across the different modules. Students commented favourably on the emphasis of clinical teaching throughout the course. One such example was the setting of the People and Disease course in general practice where students had the opportunity to see a number of patient conditions and strengthen their problem-solving skills. The structure of Phase I was commended by students.

29. The Phase II curriculum structure was designed to ensure students met an appropriate range of patients and encountered disease cases through several general clinical education attachments with a pair of consultants.

30. The visiting team had remaining issues about the integration and synthesis of knowledge with regards to the GEP. Phase II of the five-year and four-year course were the same but for Phase I the GEP was covered over 3 rather than 5 semesters, as for the 5-year course. The consequence was that graduate students did not take two choice-based SSCs, did not receive an integrative course module and had little time for extracurricular activities. Graduate students expressed concern about this and felt that the content of Phase I could be tailored more to their experience as health science graduates.

31. The intercalated students of the 5-year course emphasised that their year was a key opportunity to stand back and reflect on learning from a new perspective. Year 3 and 4 GEP students reported that no allowances had been made in the curriculum for their previous degree experience. The School reported that there was no evidence that the specific prior learning of students was conferring advantage to particular parts of the course. Progression statistics showed that the graduate entry students performed better, with more distinctions and no more failures than 5-year students.

32. The visiting team found clear differences in the pressures reported by the GEP and 5-year programme students. Both the School and students reported that one of the reasons for this was due to creating the 4-year GEP out of the existing 5-year programme, rather than designing a programme specifically tailored for graduates. The School reported that the benefit of both courses was that they allocated substantial time for clinical learning in Phase II but the disadvantage was that some GEP students felt over-burdened in Phase I.

33. The Leicester student satisfaction survey highlighted that GEP students felt there was insufficient time for reflection and they were under constant pressure to meet course deadlines. Leicester reported that within a forty-hour week students on

the five-year course had four half-day sessions for free study time. Students on the GEP had two half-day sessions, and sometimes less for free study time. The visiting team felt that the School appeared to have a curriculum organisation problem with regards to the GEP timetable. The structure at present failed to encompass an appropriate philosophy of graduate entry.

34. Phase II students commented that the transition from Phase I to Phase II had felt like a dramatic change from the pre-clinical to the clinical years. Many reported that it took most of their first eight-week placement to adjust. The School reported that initially placements were highly structured to help ease this transition for students. The School gave examples of their support methods for students unable to deal with the transition. These included:

- a. Pairing students with consultants and providing verbal and written guidance.
- b. Briefing students on reviewing how much they were getting out of all the resources available in order to broaden and gain an appropriate breadth of learning experience.

35. The visiting team felt that the transition was manageable since students reported that early patient contact had helped eased the Phase I and II transition. The visiting team recognised that the School was starting to address the curriculum organisation of Phase II but made it a requirement for the School to clarify what constituted core and what was student choice within the curriculum.

#### Student Selected Components (SSCs)

36. The visiting team was satisfied that the School offered a wide range of SSC topics for Phase I and the majority of students received either their first or second choice in a science and non-science topic. Students did not, however, identify the module 'people and disease' as a genuine SSC and it appeared to cover mainly core outcomes and involved limited student choice.

37. The Phase II SSC clinical block was perceived as a general education block where students had opportunity to make up for missed core experience rather than explore a clinical specialty in more depth. Students expressed confusion over some of the components of the course that the School labelled as SSCs that students had assumed were core. The visiting team recommended that the School review all SSCs to ensure that they were branded consistently enabling students to be clear where there was student selection within the curriculum. The School responded that the Phase II SSC blocks were intended to be as generic as possible. Students had the tendency to label each area of their learning and then search for learning areas they had not yet come across. The School addressed this by planning to introduce specifically named blocks so that emphasis was removed from the general education block. The School was saddened that this had been necessary, as it ran contrary to the overall ethos of the programme, which was based largely around students seeking out and using all the opportunities offered in each block to independently further their own learning.

38. Although the School provided guidance to students for selecting their SSCs, the visiting team was concerned that the variety of assessment methods could influence students to make tactical choices so as to undertake SSCs that were easier to pass rather than ones that better met their development needs. However students assured the visiting team that this was not the case.

### *Delivering the curriculum*

#### Supervisory structures

39. The visiting team discussed the committee structures, supporting quality assurance measures and reviewed the terms of reference and minutes of various key committees. The visiting team was satisfied with the quality assurance procedures surrounding the modules and agreed it was evident the School had mechanisms in place to monitor the quality of teaching. However it was less clear how the quality loop was closed in systematic fashion.

40. Once Warwick gained independence, the joint Curriculum Committee would formally end and Leicester had already set up a Shadow Curriculum Committee. The Shadow Committee would use a broad representation of academic and medical staff to have an overarching responsibility for the medical curriculum.

41. Leicester reported that the School's executive group was responsible for areas such as the resources strategy, funding and the general running of the School. Plans for the expansion of resources had been primary on the agenda for this group for the past few of years.

42. Leicester reported they monitored their processes semester by semester to collect feedback from students on a continuous basis. A detailed questionnaire was administered to encourage written opinions. The response rate for semester feedback was around 80% and the students reported confidence in the School's ability to follow up on changes although the visiting team remained unclear about the action the School took in response to student feedback. The School informed the visiting team that the formal monitoring by questionnaire was supplemented with staff-student committees. Students reported that these committees offered the opportunity to feedback student views to relevant staff members.

43. The School reported that student feedback in relation to the new clinical education leads already in place had been positive, and demonstrated that the leads were highly valued. One example was cited where a problem was highlighted and dealt with very quickly. Trusts monitored the clinical education leads through the medical education unit and fed back to the School through ongoing evaluations. A sub group of the clinical education leads met regularly to review their progress.

44. The School reported their web-based learning environment was a useful source of electronic feedback. Students with issues about their consultants were able to give anonymous electronic feedback via this channel. Additionally the School reported that the Phase II coordinator was available to answer suggestions or

complaints via the School's web discussion board. Both Phase I and II students had been active in asking questions via this channel.

45. For the quality assurance of General Practices, the School reviewed student feedback before signing up to the practice for additional academic years. Students are given guidance on how to provide anonymous feedback.

#### Teaching and learning

46. Year 1 and 2 students reported they liked the variety of the course, and found it helped them to link and integrate different areas. Year 3 and 4 students spoke of varied clinical opportunities, and reported that being attached to a team-working ward was better than being assigned to pairs of consultants. Students also commented on the variability within the attachments across Phase II. For example some F1 trainees indicated that they had been observed at each of their placements while others stated they had been observed only a handful of times. This led the visiting team to conclude that there were inconsistencies in the teaching and signing off of students whilst on placements. The visiting team made it a requirement for the School to review its staff development procedures as part of reviewing Phase II.

47. Students across the years reported the learning objectives and modular handbooks to be good mechanisms for directing their learning.

48. The visiting team observed a range of teaching sessions across various sites including at Burton and Kettering hospitals. Teaching was found to be of a good standard with committed staff and a supportive atmosphere. The teachers observed demonstrated excellent supportive and probing approaches. The observed sessions were judged to provide a good educational experience for learners.

49. The visiting team observed a simulated session on acute coronary syndromes. All undergraduates attached to Burton Hospital were required to attend this four-day course, which visitors commended as good practice. This course included two days to prepare the students for their simulation day, then a team-working day of practicing various cardiac clinical events skills all concluded by a reflective practice day.

50. The visiting team observed general practice locality teaching where students reviewed videotapes of their consultation sessions and was satisfied that students had enough exposure to general practice. The students displayed a good level of discussion about one another's performances and their management and diagnoses were impressive. The GP tutors facilitated the sessions well and provided student-led opportunities. The idea of student-led surgeries was considered excellent. The GP-based attachments in Phase 2 as part of the clinical methods block were considered to be good. Students reported that the GP placements were the most enjoyable and learner-focused parts of the course.

51. The clinical sessions observed by the visiting team demonstrated good integration of knowledge with practical, communication and team working skills. Teachers made good use of the technology available to further enhance the learning experience.

52. The visiting team felt that the consistency of teaching delivery between the remote sites and those on the main campus was satisfactory. Many consultant pairs were felt to deliver good teaching opportunities and encourage a variety of learning, but there was considerable variation. Students reported that on occasions the general clinical education attachments were not delivered as intended, with consultants focusing on teaching their specialty rather than providing the broad range of clinical learning opportunities.

53. Students reported that the new clinical education leads had been appointed by the School to help ensure that the clinical curriculum was consistently delivered as intended. Clinical education leads provided guidance for students on placements in adapting to the student-directed learning approach of Phase II.

### Staff Development

54. New teachers at Leicester were required to take a post-graduate certificate course accredited by the Higher Education Academy. The School trained clinical teachers on how to give effective feedback and how to provide analysis on clinical performance. NHS teaching consultants were appraised within the NHS annually and their role as University Teacher was considered during this appraisal. Clinical demonstrators had a structured induction process, including an introduction to teaching methods, and the School was working with the Postgraduate Dean to formalise this process further. Leicester reported they kept track of which teachers had undertaken which training courses.

55. The School explained that their 360-degree appraisal system for staff was a recent innovation. An electronic system would be used to complete appraisals through the trusts and directors of clinical education. Phase I and II appraisals would run parallel with each other as a multi-layered system and the School felt they had the staff in place to administer it. The visiting team welcomed this development as it could start incrementally and consist of appraisal from all staff other than consultants.

56. Seconded NHS staff from hospitals and general practices began teaching after their induction period. The Phase II coordinator monitored this. There was no such system for NHS consultants undertaking clinical teaching of university students on NHS premises.

57. In Trusts, the School reported the appointment of senior education executives represented at director level. The visiting team welcomed this particularly as it could influence strategic direction. The visiting team welcomed the appointment of the new clinical education leads responsible for the provision of clinical education on clinical sites.

### Learning Resources and Facilities

58. The visiting team observed a sample of clinical teaching and facilities at various sites across the School, GP practices and hospital placements. These

ranged from extremely good to barely adequate. Leicester had a range of suitable library suites including the Leicester Royal Infirmary medical library, which offered appropriate IT facilities and 24-hour access.

59. The visiting team considered the virtual learning environment (VLE) to be a good feature as students and teachers could gain access from distant sites. The learning environment was considered effective for reinforcing key information from lectures, as students were able to access past lectures that had been audio streamed. Year 1 and 2 students reported that they liked the VLE and the availability of having the lecture notes to hand.

60. Overall facilities were considered to be suitable and offered an excellent learning environment. In particular the visiting team considered the facilities at the clinical education centre at Burton Hospital to be excellent. The visiting team was informed that undergraduate medical students used these facilities extensively. There was a simulation suite that allowed for live video feed to adjacent rooms and a control room where facilitators could monitor and dictate the course of events, which offered a realistic environment for the learners. The visiting team also visited a commendable clinical skills lab at the Kettering site, which was used by medical and nursing students.

61. The School confirmed there would be a three-way partnership with the NHS, De Montfort and Leicester Universities for the purpose of sharing a new Multi-Professional Education and Training Centre to accommodate the School's administration and teaching facilities. Anatomy facilities are not included in this three-way partnership and are provided exclusively by Leicester Medical School.

62. The clinical skills lab on the Leicester Royal Infirmary site was considered inadequate. Lecture theatres were deemed barely adequate for the size of the current cohort and the visiting team felt this posed a risk to student numbers, which were expected to increase in the near future. The School reported that student numbers in the school were not projected to rise further, as they were at a steady state from the last allocations. The School reported that tutorial space was due to be expanded. In addition, once Warwick Medical School gained independence, Warwick's anatomy teaching would continue to be delivered at the Leicester site using Leicester's facilities. The visiting team have made it a requirement that Leicester Medical School give further consideration to the expansion of its learning resources and improve the quality of some of the existing facilities.

63. The School, in partnership with Leicester Trusts, entered into a Private Finance Initiative (PFI) and reported that their successful bid would be used to build a multi-professional education and training centre. The School had a contingency plan in place to deal with building extensions directly within the School in case the 2009 plan did not proceed, which provided reassurance to the visiting team. The plan included building a library extension, a large lecture theatre and refurbishing the existing lecture theatres.

#### Student Selection

64. The GEP applicants came from Health Science graduates including Nurses, Optometrists, Physiotherapists and Psychologists. The School had requested

graduates to have a minimum of a year's work experience so that the rationale behind early patient contact and behavioural issues would have already been covered.

65. The visiting team reviewed the admissions policy and student selection procedures and considered them to be valid, objective and fair. The visiting team was satisfied that there was a sufficient mix of applicants through the current admissions system. Information on admissions and student selection was well sign-posted to prospective students.

66. Leicester reported that traditionally it had not admitted students with Hepatitis B disease but this policy was now under national review.

### *Student support, guidance and feedback*

#### Student support

67. Students had access to a multi-layered support network, which could refer them to appropriate help channels through a web of tutors, clinical education leads and peer parenting systems. The School reported that students regularly met with their tutors as each module offered a drop-in 'health clinic' where students could receive direct help if required.

68. The School operated a one-stop shop approach where students could drop-in to discuss any personal or academic issues they may be facing. The student welfare team reported that they worked closely with staff and external contacts to offer support for stress or issues over exam results. The welfare team offered professional advice to students and assured confidentiality unless the student presented a health issue that could affect their fitness to practise.

69. Students were positive about obtaining access to senior staff. Leicester reported that it was not uncommon for students to require counselling and they would refer themselves to the counselling service for pastoral support. Disabled students were able to use an 'Access-ability Centre' that provided them with tailored resources and a range of expert advice in addition to the standard range of services.

70. The School recognised a need to appoint more clinical tutors as personal development tutors for Phase I to ensure good support for the Personal and Professional Development Programme in Phase 2. Leicester confirmed that all students would have the same personal development tutor throughout their clinical years. Overall the visiting team was satisfied that Phase I students received adequate support.

#### Guidance

71. The visiting team commended Leicester's Personal and Professional Development Programme (PPDP) that guided students on taking responsibility for their well-being and future career development. The visiting team was concerned

that while the younger cohorts had full exposure to this programme, which included career support and advice, the later years had only been introduced to key elements.

72. Leicester reported that when the PPDP was in the process of being rolled out to all years. Phase II students would have access to personal tutors when in need of guidance. The personal tutors would be either a School tutor or one of the consultants to whom students were assigned.

73. The School disseminated a booklet in hardcopy and electronically titled 'Looking after you'. It outlined where to seek help and provided useful support information and contacts. A more tailored version of 'Looking After You' was produced for students beginning Phase II, both to remind them of systems and address specific issues relating to full time clinical work. The School's 'Looking After You' document and 24-hour duty tutor service were considered areas of good practice.

74. Learners and F1 trainees reported that more guidance on learning expectations and teaching outcomes would have been useful at the beginning of Phase II including encouraging students to seek out clinics to complete any gaps in learning experience.

75. Some students gave examples of some clinical teachers who, at the end of eight-week attachments, did not even know their students by name. The School reported they did not feel this to be a predominant problem and continually stressed to students the importance of feeding back these types of issues. The School felt that guidance was available and expected Phase II students to take more responsibility to self-declare issues as and when they arose. The visiting team recognised that unless students self-declared issues then they would be difficult to identify.

#### Career Guidance

76. In addition to the PPDP, Leicester held career fairs that had recently expanded in association with other Medical Schools. The School reported that the career management module was being integrated into the curriculum. The visiting team was pleased to hear it would be taught to students from Year 1 through the PPDP and would be available to other years shortly.

#### Feedback (to students)

77. Phase II students reported that feedback received from consultants on their performance varied. The School required consultants to inform the School on the strengths and weaknesses of students. Mechanisms were in place that allowed for monitoring of students and encouraged student feedback on their learning experience. F1 trainees reported that there was an inconsistent approach from clinical teachers giving feedback at the end of each block. Some consultants actively gave feedback while others did not.

78. Leicester ensured that students who failed their final assessments were seen by staff immediately post-exam and accompanied home. A formal feedback session would be arranged over the following days. These students would receive a personal, comprehensive feedback letter within one week of their results. The visiting team noted this as an example of good practice. In contrast, high performing students and those just over the borderline did not receive any feedback after their assessments. F1 Trainees reported that more detailed feedback post-assessments would have been useful in guiding their learning instead of the current system where examination feedback was given only to students that fail.

### **Assessing student performance and competence**

79. The visiting team concluded that the School's arrangements for assessing student performance and competence broadly meets the requirements of *Tomorrow's Doctors* (Sections 62 through 73) in accordance with Section 5(3) of the Medical Act 1983.

#### *The principles of assessment*

80. The School's principles of assessment were based on the Leicester Assessment Package (LAP) which included a list of competencies based on those described in *Tomorrow's Doctors*. Students were required to complete these by the point of graduation and were assessed on the complete category of competencies in the LAP in the finals.

81. An Intermediate Clinical Exam (ICE) occurred in Phase II between the junior and senior rotation. The School reported that the main objective of the exam was to identify poorly performing students and provide formative feedback. The ICE tested the students' ability to consult with real patients by taking a history and gathering information in a patient-centred way. The visiting team felt that the ICE failed to test students on their ability to problem solve. Many of the patient's conditions had been largely resolved by the assessment date, which made it difficult for examiners to decide clinical questions with the lack of symptoms being exhibited. This in turn made it difficult for the candidates to formulate and discuss with the patient a management plan based upon new evidence. The school reported that patient management was explicitly excluded from the ICE exam and problem solving is an explicit category of competence carrying 25% of the overall weighting of the judgement about a student.

#### *Standard Setting*

82. The School reported that there was an assessment committee for each phase of the course. All modules were scrutinised to mitigate the risk of assessments becoming too independent, and therefore inconsistent with each other. The exam board had the opportunity to turn back a draft exam paper several times before it was approved.

83. The School had a number of different assessment grading ranges across the exams. This was explained as different grading systems for formative and summative clinical assessments. Leicester reported that students had become confused as a result of the different grading systems. The grading systems have now been harmonised to two, one for written exams and one for clinical.

84. Regulations permitted the Phase II Examination Board to set the pass level for those taking extended examinations although the process for setting this level was unclear. This standard meant that out of the 80 rated marks, a candidate could perform sub-optimally (C-) on half of them and only just fail.

85. To address the above issue the visiting team noted that the School put in place a borderline group review process to check the appropriateness of the pass mark at the final professional examination. Success in this examination depended upon passing a certain number of questions, rather than compensating overall marks.

86. The standard-setting process for determining pass marks for written exams is a specified number of questions. Standards have always been set by the Angoff process.

### *Marking Criteria*

87. Merits and distinctions were awarded for the written examination, based upon the 10 core marks and the 5 extended marks available within each question. These marks did not contribute to the pass/fail decision, and this system thus ensured that outstanding students were allowed to demonstrate their understanding of more complex issues (beyond core) while leaving threshold competence decisions based upon core knowledge. The visiting team commended this method.

### *Assessments*

88. Phase I was examined by frequent summative assessments linked clearly to each module. The School reported that not all Phase 1 exams were modular, some tested integration and clinical application. Phase II end-of-block assessments were formative but if a certain number were failed then the student would have to sit an extended exam. Those students for whom doubts were raised about their abilities were required to undergo further assessments.

89. The Phase II Final Professional Exam (FPE) used real patients and was conducted in the same format as the ICE. The visiting team considered the Phase II FPE to be a robust and well-organised assessment fit for the purpose of assessing final year students' competence to graduate. The External Examiners at the Examination Board commented that the examination was well run and the range of patients was appropriate.

90. The visiting team felt that the use of real patients in the FPE and in particular the relatively un-structured viva-like middle section of the exam, could compromise reliability. Review of the first five 'real patient' cases on a cut base decision

demonstrated a reliability of around 0.68, which the School felt to be sufficiently reliable. The visiting team felt that real patients were important for increasing the validity of the exam but were concerned that the assessment of only four cases was insufficient to overcome the generalisability and sampling issues inherent in this kind of assessment. The School responded that any student about which there is doubt takes eight cases.

91. The visiting team considered the Year 1 End of Year Observed Structured Clinical Practical Examination (OSCPE) to be well run within a calm and efficient environment. The venue and facilities were appropriate. Likewise the range of stations was appropriate, and the time allowed for each station adequate. The visiting team was impressed by the approach of integrating basic sciences into clinical scenarios at this stage. The exam covered a lot of material and visitors were impressed with the performance of the students.

92. Students reported that they liked the Integrated Medical Sciences Assessments (IMSA) as they helped to identify weaknesses. Students who failed their IMSAs were invited to meet with their tutors to discuss a summary of the results. Students that failed a certain number of IMSAs, module assessments and any student who was unsatisfactory in more than one assessment would be automatically entered into a qualifying exam at the end of the year.

93. Graduate students reported that the integrative assessments, module exams and OSCEs all amounted to a heavy assessment load although they were aware that the School was anxious to preserve clinical time in Phase II. Graduate students also raised issues about the scheduling of exams. Previously students spoke of being examined on material not yet covered in modules, although the School confirmed that this procedure had now changed. The visiting team felt that it was reasonable for the GEP to have a large quantity of assessments due to the shorter length of the course.

94. Leicester reported that it would be phasing out the use of vivas for modular exams and borderline students. At present they are still in use for cohorts not yet on the new system. Students now only performed a viva if they were considered for a merit or distinction. The visiting team were pleased to note that vivas were being phased out.

95. The visiting team made it a requirement for the School to revise its Phase II assessments to ensure that student abilities in performing the common core practical procedures were properly assessed. The School reported that plans were in progress to allow the entire penultimate year of the course to have skills workshops with team working sessions and some assessments, which all students would have to get signed off before they could graduate. Additionally the School informed the visiting team that a new skills OSCE would be put in place in upcoming years to test the clinical procedures as outlined in *Tomorrow's Doctor's*. This later assessment of clinical skills would be completed in the Phase II attachments and had already been incorporated into the School's regulations. The visiting team recognised that this issue had already been acknowledged by the School as requiring further attention.

96. The visiting team noted that the real patients used for both the ICE and FPE were suffering from chronic conditions, with some showing few signs, complex

histories and well-established management plans. This made it awkward for candidates to formulate and explore the patient's conditions. The visiting team commended the inclusion of simulated mental health patients.

## Examiner Training

97. The visiting team considered the pre-examination briefing given to examiners of the clinical assessments observed to be variable in impact, in that not all examiners attended it, and felt that examiner consistency could benefit from more rigorous central training.

98. Inconsistencies and variability between examiners at observed assessments were evident across the four sites and two exams observed the ICE and final professional exam).

99. The examination experiences observed varied between visitors. Overall examiners understood the process and conducted the examination appropriately. Examiners followed the marking protocol by marking separately and without collusion. Timekeeping was generally good.

100. In a small number of cases, no opening statement was given, resulting in some students receiving no guidance on which area to focus on with complex patients exhibiting multiple symptoms. Similarly some patients were poorly briefed as to the aim of the examination leading to some confusion during the history taking. The visiting team noted inconsistencies within the examiner groups with regards to their use of marking. A short amount of time was given for examiners to prepare and decide on the clinical features students would be tested upon. The visiting team noted that some examiners seemed unfamiliar with the paperwork of the exams.

101. Other inconsistencies observed during the exams included the act of hand washing and offering remaining time warnings. Both the visiting team and external examiners suggested that these aspects should be standardised.

102. Whilst many of these inconsistencies may have been reduced over the eight cases approach (for the borderline students), the visiting team suggested that variability could be improved by better examiner training. The School reported that examiner consistency was an issue and felt that it affected only a small minority of examiners.

103. Leicester reported that a large number of consultant and GP teachers had attended examiner workshops. Consultants could not act as examiners unless they had completed the School's examiner training. Some of the topics covered included extensive instruction on how to analyse the clinical performance of students and how to provide structured feedback.

104. Examiner training was initially provided entirely by GPs but the courses were now run locally by the School in all areas including Kettering. The School had made recent changes so that it was working closely with the Deaneries to produce an examiner training group, reflecting the introduction of the Foundation programme. The training group was only run where there was demand.

## Final Exam Board

105. The visiting team observed the Final Exam Board for 2006 and reported that it was conducted in accordance with the Schools' joint Code of Practice on Assessment.

## External Examiners

106. The visiting team felt the external examiner system worked well as a QA mechanism, since both the School and the examiners regularly engaged in feedback. When a report was produced within a few weeks, the School responded to this and implemented approved changes promptly.

## *Student progress*

107. The visiting team was satisfied with Leicester's student progression statistics and considered it was in line with the national average.

108. The School stated that it was possible for students to fail the course and not progress if they persistently displayed poor attitudes and were incapable of relating to patients.

109. Leicester reported that it was considering an information sharing process between the undergraduate and foundation phases. This would enable the Postgraduate Dean to follow progression on all students with their consent and awareness.

## **Student Health and Conduct**

110. The visiting team has concluded that student health and conduct aspects of the School's MBChB programme met the requirements of *Tomorrow's Doctors*<sup>1</sup> (Sections 74 through 85) in accordance with Section 5(3) of the Medical Act 1983.

111. Clinical Teachers understood the escalation channels for whom to talk to if they had any issues about a student of a pastoral or health-related nature. The consultants would report to the School any issues they had about a student's team behaviour or attitude.

112. Educational Supervisors reported that Leicester graduates had a good knowledge of health and conduct issues.

113. The School reported that they had a formally constituted Fitness to Practice Committee with a lay chair. The Fitness to Practise Committee reviewed concerns from any person or persons having contact with a student to ascertain that they were fit for purpose. Additionally clinical tutors were regularly asked whether they had

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<sup>1</sup> GMC (London); *Tomorrow's Doctors*, February 2003

such concerns about students. Health or conduct issues were first referred for consideration to the Leicester Warwick Committees. The new fitness to practise system in development would cover attitudinal aspects. Over the past two years the School had used the University Fitness to Practice Committee and considered that a robust system was in place. The School was able to demonstrate strong examples of cases that had reached the Fitness to Practice Committee.

114. If a student matter could not be dealt with on site then it was entered into the formal Fitness to Practise system. If a concern were raised, an investigating officer would be appointed to establish whether there is a prima facie case, and if so the student is referred to the committee for a decision. Any appeal against a Fitness to Practice decision will enter into alternative University systems. The School reported that students were aware of this process. Students spoken with were unaware of being formally taught about aspects of Fitness to Practise but reported that it had been discussed during lessons on ethics and clinical law. Year 4 students reported that they had not had any medico-legal talks as yet.

115. The School reported that students were expected to demonstrate aspects of professionalism within assessments. Outside of assessments, students were signed off at the end of each module and their professionalism taken into consideration. Students reported to have poor professional attitudes were in the first instance referred to the pastoral support systems.

### **Reflecting Contemporary Society**

116. The School have introduced new developments such as

- a. A newly formed inter-professional clinical team for mental health that would be look to design a relevant team-working event.
- b. The clinical Cancer care teams that already had regionally acknowledged team working for post-qualified staff.

117. The regional inter-professional education (IPE) strategy was an evolving endorsed agreement between the healthcare region's three Higher Education Institutions (HEI's), The University of Leicester with De Montfort University and University College Northampton. Collectively these HEI's would prepare over 3,500 learners each year for the professions of medicine, nursing and midwifery, speech and language therapy, podiatry and others.

118. The School taught equality and diversity through the Health in the Community module. Here students interview a range of patients chosen to reflect socio-economic disadvantage. Patients reflected the range of diversity typical of a multi-cultural City.

**Recommendation:** That Leicester Medical School meets the requirements set out in *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983, subject to meeting the requirements in paragraph 15 a to c.

## Acknowledgment

119. The GMC and visiting team would like to thank Leicester Medical School for its cooperation in which all individuals met with the team during the course of the 2005/06 review.

## **Leicester Medical School - response to report of GMC visitation 2005-2006**

Leicester Medical School is pleased to receive the report of the team which visited us under the QABME process during 2005-2006. We thank the visitors and their support team for the enormous effort involved in the assimilation of massive amounts of information from such a wide variety of sources.

QABME was, at least initially, presented by the GMC as a developmental process aimed at helping medical schools enhance the quality of education through constructive dialogue with an expert visiting team. We are sad that we did not find it thus. The tone and conduct of the process was clearly that of a formal inspection, frequently confrontational. It would have been helpful to the school to have known of this apparent change in policy in advance, as it would have influenced both our decision about when to ask for a visit, and the preparation for and conduct of it. The GMC, as the accrediting body clearly has the right to inspect provision in whatever way it chooses, but it would have been good to have been clearer about the intended character of the process.

We do not however seek to challenge the outcomes. We are very pleased to see so many of our strengths acknowledged, and that the balance of the report favours strengths over weaknesses. We accept that most of the weaknesses identified were present at the time of inspection, but are disappointed that it has not been well acknowledged that many were already being actively addressed with, for some solutions already largely in place. We chose to ask for a visitation in 2005-2006 in part so that the final stages of intended reforms could be refined with the guidance of our visitors. In many cases visitors accepted critical comments about how things had been (which are problems acknowledged openly in the documentation provided) without being able to take account of improvements that have already happened and those that are planned. It is difficult to see how the process can be developmental, so long as the evidence requirements are entirely retrospective, and visitors unable to make quality judgements about direction of travel.

To address specifically the weaknesses identified.

Para 15a: A major requirement is that we redesign phase 2 (the final two and a half years) of the curricula. Ten years ago we chose a radical approach to clinical education, which was welcomed by both the GMC and QAA in 1999. A key feature of the approach is that students should have a very high degree of personal responsibility for seeking out appropriate clinical experience to meet the educational outcomes specified. Clinical attachments were designed to maximise the opportunity to hunt for clinical experience, not as a systematic exposure to a set of specialties. Good students have always gained great benefit from this approach. We had realised, however that increases in student numbers and changes in the working patterns of NHS consultants were increasingly compromising the system. We had already put in place a clinical education infrastructure to enable us to change to a much more systematic, thematic approach. Some of these curricular changes were just in place in 2005-2006, and the full, new system will come into operation in March 2007. Meeting this requirement will not be a problem for us, but it would have been good to see some acknowledgement of the progress already made.

The report does acknowledge our sadness that the processes of regulation are increasingly driving responsibility for learning back away from the student to the medical school, but we do accept this as an inevitable reality. The 1993 dream of the truly self-motivated learner - 'Tomorrows doctor'- clearly cannot easily be realised in our 21st century, intensively regulated world.

Para 15b. We have found the second requirement to produce a strategy for learning resources extremely helpful, as it has unlocked a planning blight consequent upon delays in local NHS developments, and we are thankful to the team for their support in this regard.

Para 15c. Our third requirement concerning clinical skills assessment has already been met, as virtually all elements were already in place last year. We acknowledge that they were not then complete, but they are now, and we welcome the endorsement of our direction of travel.

The report also makes a number of suggestions for quality enhancement which we are, of course considering very actively.

Para 16a. We acknowledge concerns about the intensive nature of phase 1 of our accelerated course, and have already made changes. We do, however, challenge the assertion that the course does not have an appropriate graduate ethos. Around the UK there are many models of accelerated provision and most have not yet been fully evaluated, so there is no established definitive approach.

Para 16b. We are very pleased to review student selected components in the courses, but look forward to the next edition of 'Tomorrow's Doctors' for more guidance on just what SSCs actually are. We have always contended that major elements of our course both involve student choice and are designed specifically to address the objectives specified in para 40 of 'Tomorrow's Doctors', but that seems not to be enough, so more specific, official guidance is clearly required.

Para 16c. We acknowledge that we have had difficulties in ensuring absolute consistency of assessor performance, and we will continue to address this issue vigorously.

Para 16d The School was inspected in the final stages of separation from Warwick Medical School, during the disassembly of joint supervisory structures established in the Leicester Warwick Medical Schools. The report acknowledges that we were completing the reconstruction of entirely Leicester supervisory structures, and that process is now complete.

Overall, we acknowledge how hard it is for visitors to make sense of complex provision in such a short time, and thank them for managing it so well. We look forward to working with the GMC to demonstrate that we have addressed all the concerns identified in the report, and are maintaining and enhancing our strengths.