EDUCATION COMMITTEE

REPORT OF THE VISIT TO IMPERIAL COLLEGE SCHOOL OF MEDICINE AND THE NORTH THAMES DEANERY, THE UNIVERSITY OF LONDON

22 - 23 FEBRUARY 2000

We thank the Principal, the Vice Principals, the Dean Director of Postgraduate Medical & Dental Education and all those who spent time organising the visit programme and discussing the undergraduate curriculum and the pre-registration year with us.

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Foreword to the visit reports 1998-2001

The Education Committee is accountable for ensuring that its recommendations on basic medical education are implemented by every medical school in the UK.

When our latest guidance on undergraduate education, *Tomorrow's Doctors,* was published in December 1993 we made it clear that we intended to monitor the progress of curricular change, through both written enquiries and on-site visits. We are taking a similar approach towards implementation of our recommendations about the pre-registration year, published in *The New Doctor* in April 1997.

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

The Quality Assurance Agency also began its review of medicine in the autumn of 1998 and at the request of the medical schools concerned a number of our visits have been synchronised with those of the QAA. This has minimised the burden imposed on the schools. We have, for example, been able to share documentation, and hold some joint meetings with medical school staff, students and recent graduates. Where collaborative working with the QAA has taken place, we state this in our reports.

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

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

The reports of individual visits are normally available on our website (www.gmc-uk.org) one month after these have been sent to the schools concerned. We will be publishing a summary of our findings at the conclusion of the current round of visits in 2001.

Introduction

1. The purpose of the visit, which took place on 22 and 23 February 2000, was

twofold:

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

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

2. The visiting team was led by Professor Graeme Catto, Chairman of the Education Committee. The other members were Dr Steven Atherton, Medical Director of St Helen's and Knowsley NHS Trust; Professor Sir Kenneth Calman, Vice Chancellor and Warden of the University of Durham; Professor Brian Jolly, Professor of Medical Education at the University of Sheffield; and Professor Steve Tomlinson, Professor of Medicine at the University of Manchester.

3. The visit lasted two days. The first part of this report considers the provision of undergraduate education at Imperial College School of Medicine which we reviewed on the first day of our visit. The second half of the report considers compliance with the recommendations in *The New Doctor*, and plans for developing general clinical training provision.

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

Part 1: The undergraduate curriculum

5. The School provided us with a completed questionnaire and extensive documents in advance of the visit.

Creation of Imperial College School of Medicine (ICSM)

6. ICSM was established in 1995 when the Imperial College School of Science, Technology and Medicine and its existing medical School at St Mary's Hospital were joined by the National Heart and Lung Institute. In 1997 the Charing Cross and Westminster Medical School and the Royal Postgraduate Medical School merged with the College to form the current School of Medicine.

Changes to the curriculum

7. The mergers of the Schools coincided with two major changes to the curriculum in October 1998. First, students from St Mary's and Charing Cross who had successfully completed the second year traditional pre-clinical courses joined a modified clinical course. The modified course, in addition to merging the curriculums of the two medical schools, was also designed to bridge the gap between the traditional medical course and the new integrated curriculum.

8. Second, the School introduced a completely new curriculum for new students.

8. The main effects of these changes, which are illustrated at **Annex A**, were that at the time of our visit students in years one and two were following the new curriculum; students in years three and four were on the modified curriculum; and students in year five were still following the traditional Charing Cross or St Mary's final year course.

BSc degrees

10. Students at the Schools now integrated in ICSM have had the option to take an intercalated BSc or B.Clin.Sci degree. Under the new curriculum, all students take the BSc degree course, which is modular and fully integrated into the medical course.

The scale of change

11. The scale of the organisational and curricular changes undertaken at ICSM is amongst the most challenging that we have come across in a medical school. Quite apart from the examples of excellent practice which we describe later in the report, the achievement of establishing the School from its component parts, across four campuses, while continuing to deliver a complex curriculum, is remarkable.

The management of change (Principal Recommendation 3*)*

Supervisory structures

12. Responsibility for undergraduate medical education in ICSM is delegated to the Vice-Principal for Undergraduate Medicine. The detailed committee structures are at **Annex B**. The key features of the organisational structure are as follows:

> a. Four assistant Vice-Principals for Undergraduate Medicine, one on each campus, assist the Vice-Principal and are responsible for the delivery of the curriculum on each site.
>
> b. Each of the eight ICSM Divisions has a Deputy Head of Division (Teaching) (DHT) who is responsible for his/her Division's delivery of relevant aspects of the undergraduate course.

c. Course Co-ordinators (over 40 of them) are responsible for planning, implementing and examining different sections of the course, and report to the Year Co-ordinators (see below).

d. Year Co-ordinators have overall responsibility for a particular year/phase of the course.

e. Each hospital associated with ICSM has a Director of Clinical Studies (DCS) who is responsible for the delivery of undergraduate teaching on that site. There are also DCSs for general practice and mental health.

f. There is a new scheme of course review under which comments from students and staff are reviewed, and then fed back to course organisers for action. The scheme started in 1998/1999, in relation to the new curriculum, but we understand it has now been extended to cover both the modified and the new courses.

The contribution of students

13. Students are involved in all the undergraduate committees, and it was clear from our visit both that their contributions were valued by the School, and that they in turn appreciated the opportunity to make a real contribution to the development of the course.

Staff development

14. Development for ICSM staff is led by a Senior Lecturer in Medical Education who was appointed in 1997. Additionally, Imperial College has established a Centre for Educational Development to improve consistency in staff training and development across the college as a whole.

15. Appraisal for academic staff has recently been introduced, and the School is exploring ways in which teachers' training needs may be better identified. This should help to ensure that teaching is seen to be a fully valued activity.

16. In total, some 1,500 staff are involved in teaching during the undergraduate medical course. Some 50% of these have now been on courses run by the Senior Lecturer in Medical Education. The DCSs consider the suitability of clinical teachers on each site, and the General Practice Division insists upon video assessment of GP teachers. At the end of clinical attachments, students complete evaluations on each of their teachers, and there is a system for dropping teachers who are found to be unsatisfactory.

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

Defining the core

17. The School has stated that 'there will be an expectation by many that the unique assembly of resources available to ICSM should produce graduates who demonstrate a higher standard of medical skills and understanding of medicine than that found in the average student from other UK medical schools'.

18. The new ICSM curriculum was developed between 1994 and 1998, in advance of the merger, and continues to be reviewed. Key features of the curriculum are:

A six-year course leading to an MB BS and BSc qualification.

Three core elements to the MB BS course: systems and topics (knowledge

base), doctor and patient (personal and professional development and skills), and clinical experience.

15 science modules in the BSc course, taken between years two and five, to make full use of the scientific facilities available at ICSM.

The use of problem-based learning (PBL).

A diagram showing the timetabling of the undergraduate course is at **Annex C**.

19. The intention behind the new curriculum was to accommodate the requirements set out in *Tomorrow's Doctors*. The structure of the course is consistent with that aim.

20. Course guides define the core curriculum for each year of the course, although – because the new curriculum is currently only in its third year – the core for the later years of the course is as yet not completely defined.

Reducing the burden of factual information

21. The School is determined to keep the burden of factual information to a minimum and to promote learning through curiosity. They recognise that there is still some way to go in order to achieve this, and in particular to make explicit the amount of private study time available to students in the early years of the course.

22. Student self-directed study is being promoted through elements of problem-based learning, and the first class library and IT facilities at ICSM support students in this area. The opportunities for in-depth study in the science modules of the course, and the special study modules, also provide opportunities for self-directed work.

Special study modules (Principal Recommendation 6)

23. The SSMs at ICSM meet two purposes. 15 of the modules, as described above, are science modules which form the BSc element of the course. In addition, in the final year of the course students will have the opportunity to undertake three modules from a range of 60 in the areas of exploring career options, academic medicine, cancer medicine, and community medicine and complementary therapies.

24. Students on the modified course will be allowed to undertake one of these new modules from this year onwards.

25. Although the SSMs do not contribute to the final grade and assessment, students are required to complete the SSM programme satisfactorily before being allowed to graduate. In addition to the SSMs, in the final year students will also undertake elective clinical attachments, usually overseas.

26. When we discussed these modules with the School, considerable interest was expressed in offering the widest range of choices – including modules focusing upon the humanities. However, because the SSMs in the final year may – particularly in relation to students on the modified course – have to be used to make up ground not covered elsewhere, the opportunity for a free choice of subjects in SSMs may be constrained. We hope that the School will address this issue.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

27. ICSM uses a wide variety of teaching methods including lectures, tutorials, practicals, small group teaching, and clinical attachments.

28. The computer network on all the major teaching sites, the computer assisted learning packages available, and the clinical skills facilities are all impressive. The School has developed IT links to enable groups on different sites to take part in lectures. The School is also developing IT links with other sites where students undertake learning.

Changing patterns of healthcare (Principal Recommendation 10)

29. Students at ICSM have extensive opportunities to gain experience of primary care. In the new curriculum, students obtain experience of primary care throughout the course. In phase one, as part of the patient contact course, students visit general practices and hospitals to meet and interview patients, and to observe clinical care. In phase three of the course, students will attend GP surgeries for half a day a week to learn basic clinical skills, as well as undertaking some work in community paediatrics. There will be substantial attachments to general practice in years four and six of the course. Additionally, some students will undertake in depth study of general practice as part of their BSc options.

30. The School is working with one of the local health authorities to improve students' understanding of local environmental issues.

31. Students also have opportunities to experience other community medical services. These include one session a week in community antenatal clinics and domicillary antenatal visits, domicillary visits to the elderly, and attendance at GU clinics.

32. The School is well aware of the impact of changes in patient management and hospital stay patterns, which have tended to mean that students have less extended contact with patients on hospital wards. For that reason, some teaching has been moved into primary and community care. TV links between sites, and clinical skills laboratories, have also been used to improve students' learning opportunities. The School plans to develop facilities to teach students in the fields of minimally invasive surgery, anaesthetics, and day case surgery.

The goals of undergraduate education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

33. The School recognises the importance of training in attitudes, and believes that the new course has improved the teaching in this area.

34. The ICSM has a values and attitude statement based on the concepts of *Good Medical Practice*; students receive copies of GMC publications at the start of the course, and the course is designed to cover good communication, confidentiality and team working. Attachments provide opportunities to learn about, and put into practice, attitudinal skills.

Essential skills (Principal Recommendations 4 and 8)

Study skills

35. Students have an introductory session on study skills, and a further session on revision and examination techniques during phase one of the course.

IT skills

36. All students are given an IT workbook to help them check that their IT skills are sufficient and, if not, to address any deficiencies. Impressive facilities and support are available to ICSM students to ensure that they have the necessary skills.

Communication skills

37. During phases one and two of the new course there are 11 sessions on communication skills, which include large and small group work and videoing. Communication skills are assessed at the end of phase one, and students have to re-sit if they do not reach an adequate standard.

38. Sessions on consultation, history taking, and dealing with difficult situations are included in the later years of the course.

Clinical skills

39. The clinical skills laboratories at ICSM are excellent. In phase one of the new course the focus is upon laboratory skills and patient contact skills, in the context of learning about blood circulation; in phase two the focus is on skills based on understanding the anatomical organisation of the various body regions and includes linking anatomical understanding to physical examination skills.

40. In year three/phase three there is a focus on history taking and physical examinations, and students have logbooks for their third and fourth year attachments which list the skills in which they are expected to be proficient. An example of a logbook is at **Annex D**.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

41. Six three-hour sessions on public health are planned for the final year of students currently on the modified course. In the new curriculum, phase one of the course includes public health elements, and in phase two there is a core epidemiology and public health course covering, amongst other things, strategies for disease prevention, public health in practice, and cancer epidemiology. A public health module as part of the BSc course is also planned.

42. Further public health elements are planned for later stages of the new course. There is a recognition that, as at other medical schools, there is still some way to go in integrating public health into the new curriculum.

Legal and ethical issues

43. In phases one and two of the new curriculum lectures, PBL scenarios and teaching sessions on legal and ethical issues are included. There is also an optional BSc module on controversies and ethical dilemmas in medicine. Year three of the modified curriculum has a three-hour session on ethical issues, and in years four and five it is planned to have an entire optional BSc module on medical ethics and law. In the final year of the new course, further PBL modules are contemplated.

44. ICSM has been involved in an EC project involving the use of open learning materials on ethics and law, in which third to fifth year students will learn about ethics as part of their clinical attachments. This should help to address a problem identified by the School which is that there is a shortage of medical ethicist teachers, and that it has been difficult to integrate the teaching of medical ethics with clinical attachments.

45. We are pleased to see that the School is addressing legal and ethical issues well in the new curriculum. It is very important to ensure that students are equipped to tackle ethical and legal issues. We shall be interested to see how the School

progresses.

Medicine in a multicultural society

46. As part of the doctor and patient course, multicultural health care is addressed as a main theme, and this is supported by teaching and learning within the systems and topics course as appropriate. In the first two weeks of phase one students have foundation teaching in multicultural health care, and the PBL course includes cases relating to the provision of health care to patients of different cultures, patterns of health and disease in different cultures, and other issues.

47. The communications skills course includes sessions dealing with differences in cultural beliefs and languages. Students are exposed to a wide variety of clinical situations with patients from many different ethnic groups during their attachments.

48. Modules on ethnicity and health care are included in the mandatory BSc programme.

Complementary medicine

49. The School does not teach its students about complementary medicine as part of the main course. A special study module on homeopathy and acupuncture is however planned. We consider that the School should ensure that students are equipped to meet the needs of patients who wish to discuss complementary medicine with their doctors.

Assessment of the process and the product (Principal Recommendation 12)

50. The assessment strategy for the MBBS is still being developed. In phase one there is a formative assessment in the spring, followed by a summative assessment in June. In phase two there are summative assessments at the mid and end points. In phase three there are in-course assessments during attachments and summative assessments involving objective structured clinical examinations, multiple choice questions, and a project. In phase four, there is a mixture of formative and summative assessment, and in the final phase it is planned that there will be two summative assessments, a written assessment and a clinical skills assessment held at the end of the phase. Details of the examination formats are at **Annex E**.

51. The School is looking closely at the pattern of assessments as the new course develops, with the help of external advisers. It recognises that the assessments do not entirely conform with the main aims of the curriculum. As vertical integration of the curriculum improves, we would expect the assessment programme to be revised.

Other issues

Student support

52. It is clear from our discussions with both staff and students that ICSM has invested a lot of effort in student support. As with other areas of the course, ICSM has had to merge different systems from the old medical schools.

53. Each student is allocated to a senior student on arrival at ICSM. The introductory course lasts three weeks and is designed amongst other things to ensure that students are aware of welfare provision.

54. Each student has a Personal Tutor who provides pastoral support. There was, however, some variation between tutors in the regularity with which they saw their students. Because students work in small groups (particularly in PBL, where students are assigned to a tutor for a year at a time) other tutors develop rapport with the students, and act as an alternative source of support and counselling. There is also a Student Welfare Tutor who, in addition to co-ordinating the personal tutoring system, can provide support in complex cases.

55. In the later years of the course, Clinical Welfare Tutors provide pastoral care on clinical sites, as do the DCSs.

56. The Undergraduate Medical Office, and the Student Progress Committee provide backup in problem cases.

57. The Student Progress Committee is designed to identify students who are developing serious difficulties, though it is acknowledged that this work might be developed further.

58. Despite the efforts made to publicise the welfare system, it is complex, and for that reason is not fully understood by many students.

59. At the time of our visit, ICSM had recently produced a position statement on student support, reviewing the progress being made, and identifying the need for further refinement of the system, particularly to ensure clarity. We welcome this initiative.

Other student issues

60. The students were enthusiastic about the course, considered the faculty to be forward-looking, and were complimentary about the range of activities available. They had concerns, however, about the anonymity of the new campus (in comparison with the smaller old medical schools).

61. Students reported to us their concerns about the very high travel and living costs from which they suffered. The School is engaged in London-wide negotiations to try to deal with this problem. There is no easy solution, but it is clear

that this problem must be tackled if ICSM – and other London medical schools – are to continue to attract high calibre students.

Feedback to students

62. Students receive copies of the results of all their assessments. It was clear to us, however, from speaking to students that there was some confusion about the way in which assessments fed into their final results, particularly the assessments resulting from attachments. There was a view, which was acknowledged by the staff, that the gradings by individual clinical firms were inconsistent, and there was no clear appeal structure.

63. Arrangements for telling students about their results vary from course from course and phase to phase. This tends to create uncertainty, and we believe that it should be addressed.

Quality control

64. ICSM has a quality group responsible for developing, implementing and overseeing quality management. Student and teacher questionnaires are used to assist the annual review of each course, and the committee structure (at **Annex B**) ensures regular monitoring.

65. The curriculum groups which have staff and student representatives undertake regular reviews of quality, using assessment results, student and teacher questionnaires, and other methods. DCSs have responsibility on clinical sites for teaching quality.

66. External examiners are used, both to report directly to the Rector, and to help in the development of courses by curriculum groups.

67. Academic staff are subject to bi-annual appraisal, and there is a staff training programme for both academic and NHS undergraduate teachers. The college ILT staff accreditation scheme is expected to provide further quality assurance.

Fitness to practise

68. In our discussions, the staff were interested in considering the establishment of a fitness to practise committee to deal with students whose suitability to proceed to registration was in question – and in particular able students who are not suited to the practice of medicine.

69. The School has a system of ‘red alerts’ to pick up problems of attitudes, fitness for practise and academic progression. These are designed to put right problems so that graduating students are fit to practise, and those students who are not suited for medicine are directed to alternative career paths.

Preparation for the PRHO year

70. During their final year, ICSM students undertake a course called *Introduction to Graduate Medical Practice*. The aim of the course is ‘to provide students with the confidence and competence to practise in the PRHO year and beyond’. The course is still being developed, and will become the final phase of the doctor and patient course of the new curriculum. We shall be interested to see how this course develops.

Student selection

71. ICSM requires two Bs and an A at A-level before an application will be considered. Panels of selectors then consider applications on the basis of the student’s perceived commitment, understanding and interest: if two assessors agree, an interview is offered.

72. Most interviewers have now had training, including equal opportunities training, and the aim is that all interviewers will in due course be trained. Interviews are structured, and include a lay observer and a student. School teachers are permitted to see interviews in action as a means of understanding the process, and we commend this initiative. The selection processes are being audited with the help of the Commission for Racial Equality.

73. The change from a five to a compulsory six-year course to incorporate the BSc has not affected the levels of applications. The School has deliberately operated an academically conservative selection policy for the initial years of the new course, but is now looking to broaden the intake. Links are being developed with deprived areas. The School is discussing with the Open University how access to the course might be widened, possibly through the use of foundation courses.

Areas of good practice

74. The establishment of the ICSM from its component parts, while retaining the commitment and enthusiasm of staff and students, is a major achievement.

75. The involvement of teachers from local schools in the admissions interviews is an innovative development.

76. Students spoke warmly of the friendliness of the staff and they appreciated the way in which the School had responded rapidly to their concerns over aspects of the curriculum. They had been attracted by the six-year course and the diversity of the clinical experience available at ICSM.

77. The computer network across the major teaching sites, the CAL packages available and the development of the clinical skills facilities are all impressive.

78. ICSM is to be congratulated on how it is tackling the difficult problem of staff development involving NHS as well as academic colleagues.

Areas for further consideration

79. As explained above, the introduction of this new course has coincided with both organisational upheaval and the introduction of the modified course for students in the middle of their undergraduate training. It is therefore not surprising that the new course, which was only half way into its second year when we visited, had experienced some problems. In particular:

There was a lack of clarity amongst both staff and students about the totality of the course. While considerable care had been devoted to designing the first two years of the course (and the two years of the modified course), planning for the remaining years had not been finalised.

The Divisional Structure of ICSM, coupled with the introduction of radical changes to the undergraduate medical course, has meant that integration of the different elements of the course is far from complete. The co-ordination and coherence of clinical teaching needs to be improved. The concept of the core curriculum had not yet been fully translated into practice.

There seemed to be some confusion about the role of PBL in the course. PBL was well established in the doctor and patient element, but had not been fully introduced into the system and topics part of the curriculum. The School plans to introduce centrally co-ordinated PBL into attachments in year 4 of the course: making sure that PBL is understood and properly used during attachments as well as in centrally delivered teaching will be important.

There was also some confusion about the role of special study modules (SSMs): some students expressed concern that, because of a lack of clarity about the structure of the final years of the course, they were uncertain about whether they could safely elect to do unusual topics for their SSMs.

Students are unclear about how some elements of the course will be assessed.

The need to ensure that students are equipped to deal with patients wishing to discuss complementary medicine.

80. The School was well aware of these problems: they provided us with a very thorough and candid analysis of the strengths and weaknesses of the course, and are committed to a review of the whole curriculum at the end of the academic year (when the first two years of the new curriculum will have been completed). At this point, the School will be able to see how the vertical integration of the curriculum can best be achieved. As at other medical schools, introducing a new curriculum inevitably identifies areas which require adjustment, and we were impressed by the way in which the School had already proved itself capable of responding promptly where changes were needed. For example, duplication in the course has already

been identified, and aspects merged to avoid it.

81. We support the School's wish to undertake a fundamental review of the 1998 curriculum. We believe it would now be helpful to reassess the philosophy and framework of the core curriculum and SSMs to be delivered over the entire five/six years, recognising the needs of school-leavers, Oxbridge and other graduates. A single document, describing the core curriculum, would be valuable.

82. While we recognise the considerable logistical problems involved, we hope that further vertical integration will be achieved and the role of PBL, currently used in only one part of the course, clarified. It will be important to allow sufficient time for reflection and ensure that the burden of factual information is reduced appropriately, with adequate provision for private study time.

83. The assessment arrangements are currently not fully understood by students who expressed concerns about consistency or approach across the clinical firms. We anticipate that the curriculum review will include appropriate changes to the examination system.

84. The way in which the SSMs are currently organised may constrain choice and not help the process of learning through curiosity in the way intended. We hope that the curriculum review will allow a greater diversity of provision throughout the course.

85. We agree with the Faculty that the student support systems are complex, do not perform uniformly well and should be revised to meet the needs of students in the different locations.

Conclusion

86. The establishment of the ICSM from its component parts, while retaining the commitment and enthusiasm of staff and students, is a major achievement for which all concerned should be congratulated.

87. Although we have identified a number of areas which deserve attention – and most of which were already receiving attention before our visit – it is clear to us that ICSM has high calibre teaching staff and students, who are committed to the success of the School.

88. We look forward to learning about progress in the identified areas when we follow up our report in a year's time.

Part 2: General Clinical Training

Background information

89. Before our visit ICSM provided us with helpful background information about general clinical training during the pre-registration year.

Form of the visit relating to general clinical training

90. During our visit we discussed general clinical training with the Vice-Principal and his team, and the Dean Director for North Thames and her team. We had further sessions with Clinical Tutors, with PRHOs, with Chief Executives and Medical Directors from NHS Trusts in the Deanery.

Organisation and management of the PRHO year

91. The relationships between medical schools, the University, and Deanery are different in London from other parts of the UK. A chart and details of the functions of the University, the School of Medicine, and the North Thames Deanery are at **Annex F**.

Supervisory structures

92. The University's Postgraduate Committee has overall responsibility for the pre-registration year and for general clinical training within the University's five medical schools.

93. Within ICSM, a Pre-registration House Officer Committee – which meets each term – is responsible for policy and allocating PRHOs to posts. The membership of the ICSM PRHO Committee is shown at **Annex G**.

94. The North Thames Deanery (which is part of Thames Postgraduate Medical & Dental Education (TPMDE)) is responsible to the University committee for ensuring that pre-registration posts in its area meet the educational requirements of the University.

The approval of posts

95. We were impressed by the rigour of the Deanery's approach to the approval of posts. The University has clear criteria for the approval of posts, and the Deanery and School of Medicine are committed to moving from a culture in which all consultants have PRHOs to a culture in which some consultants are considered suitable to be house officer trainers. On two recent occasions, swift action has been taken to terminate unsatisfactory posts. Every post is evaluated at least every two years.

96. In response to concerns about the quality of surgical PRHO posts, the Deanery recently threatened to withdraw approval from all surgical posts in two

trusts: as a result, swift improvements were made.

97. The Deanery has undertaken extensive research into the factors which make PRHO posts satisfactory, including one to one interviews with over 1,600 PRHOs between 1995 and 1999. This has shown that opportunities for hands on experience, and good consultant supervision, are the two most important factors in PRHO satisfaction.

98. The PRHOs whom we met reported very good experiences in general practice posts. There were, however, some complaints about low grade work, and insufficient work, in surgical posts, particularly at teaching hospitals. Other concerns reported by the PRHOs included:

Being on duty on a ward with no senior medical backup, particularly where there was no SHO in the firm.

Confusion about whom to turn to for support and advice.

Variations in the amount of feedback from supervising consultants.

99. Positive comments were made about:

Consultants taking PRHOs on post-take rounds.

The fact that most PRHOs were not overworked.

The matching scheme.

The use of logbooks to try to ensure that PRHOs obtained the necessary experience during their placements (although some commented that at the teaching hospitals they were not always exposed to the full range of experience prescribed in the logbooks).

100. Overall, satisfaction levels seemed to be high: in a survey, about 90% of PRHOs described their recent posts as at least adequate (and 70% classified them as good or excellent). This may reflect the efforts made by the Deanery and ICSM to ensure that PRHOs are no longer asked to undertake inappropriate duties.

101. The Deanery and ICSM, were at the time of our visit, in the process of ensuring that PRHOs no longer worked after midnight: this was on the grounds that, when they did work after midnight, the PRHOs were often asked to undertake inappropriate tasks, or to shoulder responsibilities for which they were not yet ready. The Chief Executives and Medical Directors of Trusts expressed some concerns about the practical effect of the introduction of this new policy, but we are in no doubt that the policy is both in the interests of patients and of PRHOs.

Communicating the aims and objectives of the pre-registration year

102. Our guidance *The New Doctor* is introduced to undergraduates about one year before they graduate, when they have a course on the aims and objectives of the pre-registration year. *The New Doctor* is also given to all Clinical Tutors, Educational Supervisors and Consultants, and the PRHOs' logbook refers to *The New Doctor*.

103. The Deanery makes considerable efforts to maintain a dialogue with Educational Supervisors and Clinical Tutors for which all concerned should be congratulated. However, not many of the Clinical Tutors have had educational training, and the Deanery would like to empower Clinical Tutors more than is currently the case.

104. We were pleased to note the close co-operation between ICSM and the Deanery in the delivery of the objectives of general clinical training.

105. In our discussions with the Chief Executives and Medical Directors of trusts, there was considerable enthusiasm for integrating PRHOs more into the clinical governance structures, and in allowing more flexibility in PRHO posts to improve the training content. There remained, however, a lack of clarity about how this would be achieved in practice.

The selection of PRHOs

106. ICSM has a matching scheme for its graduates. The PRHO Committee has final responsibility for approving allocations to posts.

107. The details of the scheme are at **Annex H**, but the key features are that:

Each applicant ranks posts in order of preference.

Each Consultant with posts on the scheme ranks applicants in priority order.

Where the applicant's first choice and the Consultant's first choice match (in practice in over 50% of cases) the allocation is made.

Having allocated first preferences, applicants and posts are matched as closely as possible, student choice taking priority over consultant preference.

108. Occasionally if no suitable posts are available through the matching scheme, posts are found outside the scheme, sometimes with trusts elsewhere in the country.

109. The scheme enjoyed the confidence of the PRHOs whom we met. The School is satisfied that it conforms with equal opportunities principles.

Monitoring the quality of PRHO posts

110. Each PRHO post is approved for a maximum of two years – if serious problems are identified, a shorter period of approval is granted.

111. When a post is reviewed, the PRHO post-holder is seen individually, having completed a questionnaire. The evaluating team includes the Associate Postgraduate Dean, the Clinical Tutor or Consultant Supervisor from another trust, and others. PRHOs are given an opportunity to speak confidentially. The findings are then discussed with the consultants, clinical tutors, senior nurses and senior management, following which a formal report is prepared.

112. Where approval for a post has been withdrawn, arrangements are made to ensure that the PRHO is re-allocated to a suitable post.

Components of a high quality PRHO post

Induction

113. The medical schools which have merged into ICSM have had different systems for induction training. The schools have all had some form of shadowing arrangements under which final year students are attached to PRHOs. From July 2000 all ICSM final year students will do two shadow attachments (not necessarily shadowing the PRHO whom they are to succeed), one in a main base hospital and one in a district general hospital, and will have the opportunity to undertake student assistantships if they wish.

114. PRHOs taking up their first appointments have one or two-day induction programmes organised by the Clinical Tutor. On some sites, the new PRHO has a day's hand-over with the old PRHO to encourage continuity.

115. The Deanery have some concerns that the shadow attachments are too far in advance of the first PRHO post, and can inculcate bad habits as well as good. They are considering the possibility of arranging induction training immediately before the start of the first posting.

Educational opportunities

116. The policy is that all PRHOs working in North Thames should have at least one hour per week of focused formal education in protected time during rostered hours, in addition to other more informal educational opportunities (for example meetings, grand rounds). This appeared to be delivered in almost all cases.

117. The PRHOs to whom we spoke commented favourably upon the education given to them during ward rounds.

118. Both Clinical Tutors and students commented that, although filling in the PRHO logbook could be a chore, it did provide a useful means of enabling both the PRHO and Consultant or tutor to check that progress was being made in the

PRHO's education.

119. Favourable comments were made about giving PRHOs protected time with nurse practitioners, post-take rounds with physicians on teaching wards, PRHOs attending out-patient clinics, and a twice weekly morning report at Charing Cross at which PRHOs could discuss the previous night's take.

120. Although one PRHO complained that in a surgical post they were largely doing clerical work, in general it appeared that the policy of ensuring that PRHOs were not exploited for inappropriate tasks was being followed.

Educational supervision

121. Clinical Tutors are appointed by the Deanery. Educational Supervisors are employed by the trusts and have a contract which includes a requirement to be responsible for the education of doctors in training.

122. Clinical Tutors are responsible for ensuring that Educational Supervisors meet their PRHOs on a regular basis, and review the PRHOs progress against the aims and objectives set out in the logbook.

123. Not all of those responsible for PRHOs' training have been trained, although the Deanery offers training on appraisal and assessment skills to all Consultant staff who are involved.

124. The Deanery has introduced annual appraisal for Clinical Tutors. Educational Supervisors are the responsibility of the trusts.

125. Several trusts have recently implemented a nurse mentor scheme for PRHOs, and this has been extremely popular.

126. PRHOs reported to us that the feedback they received on their performance was very variable, ranging from the excellent to the very poor. In general, PRHO posts in general practice were seen to offer better educational opportunities than others.

Monitoring the progress of PRHOs

127. The University has recently produced a new framework for a formal system of education training supervision and service for PRHOs, which has been piloted in North and South Thames. This is designed to provide a more robust framework for educational supervisors and PRHOs to plan learning objectives, to ensure feedback, and to deal with poor performance. An example of the framework, for use in House Physician posts, is at **Annex I**.

128. The Vice-Principal of Postgraduate Medicine is involved where serious problems arise, and works with supervisors and tutors to produce a plan of action. Where a PRHO decides to leave medicine, careers counselling is offered. If

necessary, a post may be extended to allow remedial measures to be taken.

129. At the end of each post, the supervising consultant is required either to award or withhold a certificate of satisfactory service. The new framework (see above) identifies the characteristics of both satisfactory and unsatisfactory service, to enable PRHOs and their supervisors to monitor progress.

130. The clinical tutors commented that information about PRHOs' problems was sometimes not properly communicated when a PRHO took up a post. There had been examples of clinical tutors not being informed of important information about a PRHO's history.

131. The Deanery hoped to prepare guidance for supervising consultants on signing or not signing up PRHOs at the end of their posts, and on remedial measures for PRHOs who run into difficulties. There was also an objective to improve the 'red alert' system for dealing with failing PRHOs. We encourage these initiatives.

Professional development and personal wellbeing

132. In addition to advice from Educational Supervisors and Clinical Tutors, PRHOs have access to occupational health services in their employing trusts, there is a student counselling service at Imperial College, and a confidential service at the Tavistock Clinic for doctors in need of psychological help.

133. There seemed to be some confusion amongst PRHOs about the systems available to support them.

134. Careers fairs were held in 1999 and 2000 and a formal careers panel is being set up to help PRHOs. Courses in careers counselling for Clinical Tutors and Educational Supervisors are available.

135. The view of the PRHOs was that the provision of careers advice was not currently very systematic, although materials were supplied.

Accommodation, catering and personal safety

136. The PRHOs did not consider that personal safety was an issue. They reported some shabby accommodation on one site, and expensive catering, or catering unavailable after 8 o'clock at night.

137. The educational contract between the Deanery and trusts sets out standards which are monitored with posts. The new deal task force also monitors these matters.

Contractual matters

138. Ensuring that hours of work fall within the Government's new deal is a matter which is monitored by the new deal task force. As explained above, a new policy, under which PRHOs will not be expected to work after midnight, is being introduced.

Areas of good practice

139. We were impressed by the strategic direction and commitment shown by the staff of North Thames Deanery and the VP PG Medicine, and hope that they will continue to gain the commitment of clinical colleagues during this time of considerable change in West London.

140. We support the aim of changing the culture from one in which all consultants have a house officer to one in which some consultants are recognised as PRHO trainers. The concept of identifying senior nurses as mentors for PRHOs seemed to us a welcome innovation.

141. We encourage ICSM to develop further the concept of making the PRHO post the final year of the medical course ensuring appropriate linkage with the educational opportunities associated with the Deanery.

142. The PRHOs appreciated the progress that had been made in reducing the need for them to undertake routine tasks of no educational value.

143. We were impressed to learn of the ways the Deanery was able to identify and then meet the educational requirements of individual PRHOs.

Areas for further consideration

144. We were concerned that some PRHOs were continuing to seek patients' consent for major procedures against explicit advice from the Pre-registration Committee of the University of London.

145. PRHOs and some of the other staff with whom we spoke seemed uncertain of how they would deal with issues relating to performance – both personal and professional. Not all appeared familiar with the principles of *Good Medical Practice*.

146. We hope that the clinical and educational experience to be gained from some PRHO posts will now be re-evaluated in the light of changing clinical workload patterns. We learned, for example, that in some posts only a small number of patients were admitted on take while the changing patterns of healthcare have diminished the educational opportunities available in some, predominantly surgical, posts. We welcome the approach being taken locally to achieve greater flexibility in the provision of clinical and educational experience.

147. We encourage ICSM to forge close links with local trusts and seek their

feedback on undergraduate and PRHO education.

Conclusion

148. The Vice-Principal for Postgraduate Medicine and the Deanery have been working hard to improve the provision of education in the PRHO year. Their initiatives to improve links with Clinical Tutors and Educational Supervisors, to systematise the monitoring and assessment of PRHOs, and to take a rigorous approach to the approval of posts, are to be commended.

149. We look forward to hearing further news of progress in all these areas.