

EDUCATION COMMITTEE

**REPORT OF THE VISIT TO THE SCHOOL OF MEDICINE
AND THE DEPARTMENT OF POSTGRADUATE MEDICINE AND DENTISTRY,
THE UNIVERSITY OF MANCHESTER**

7 - 8 MARCH 2000

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

Contents

	Page
Foreword	i
Introduction	1
Part 1: The undergraduate curriculum	1
Background information.....	1
Form of the visit relating to undergraduate medicine.....	1
The undergraduate curriculum.....	2
Curricular development.....	2
The new curriculum.....	2
The management of change.....	4
Supervisory structures.....	4
The contribution of students.....	4
Staff development.....	4
Promoting teaching.....	6
Aspects of the core curriculum.....	6
Reducing the burden of factual information.....	6

Integration.....	7
Learning through curiosity.....	8
Special study modules.....	9
Delivery of the curriculum.....	11
Teaching methods.....	11
Learning resources.....	11
The changing patterns of health care.....	12
The goals of undergraduate education	
- attitudes, skills and knowledge.....	13
Attitudes.....	13
Essential skills.....	13
IT skills.....	14
Communication skills.....	14
Clinical skills.....	14

ALS skills.....	15
Teamworking.....	15
Aspects of the knowledge base.....	15
Public health medicine.....	15
Legal and ethical issues.....	16
Medicine in a multicultural society.....	16
Complementary and alternative medicine.....	17
Infectious diseases and antibiotics.....	17
Assessment of the process and product.....	17
The scheme of assessment.....	17
Academic performance.....	18
Fitness to practise.....	19
Preparation for the PRHO year.....	19
Other issues.....	20
Student selection.....	20
Increasing medical student numbers.....	20
Student support.....	21
Feedback to students.....	22
Quality control.....	22
Areas of good practice.....	23
Areas for further consideration.....	24
Conclusion.....	24
Part 2: General clinical training.....	25
Background information.....	25
Form of the visit relating to general clinical training.....	25
Organisation and management of the PRHO year.....	25
Supervisory structures.....	25
The approval of posts.....	26
Communicating the aims and objectives of the pre-registration year.....	26
The selection of PRHOs.....	27
Monitoring the quality of PRHO posts.....	28
The views of PRHOs.....	29
Components of a high quality PRHO post.....	29
Induction.....	29
Educational opportunities.....	29
Educational supervision.....	31
Clinical training and supervision.....	32

Professional development and personal well-being.....	33
Support for PRHOs.....	33
Careers advice.....	34
Accommodation, catering and personal safety.....	34
Contractual matters.....	.35
Other issues.....	35
New rotations.....	35
Areas of good practice.....	36
Areas for further consideration.....	36
Conclusion.....	37

Annexes

Diagram of the new curriculum.....	Annex A
Examples of the PBL trigger problems.....	Annex B
The School's supervisory structures.....	Annex C
The clinical skills expected of Manchester graduates.....	Annex D
Outline of the scheme of assessment.....	Annex E
Year 3 - 5 objectives.....	Annex F
Form for assessing students' attitudes.....	Annex G
Training programme for educational supervisors.....	Annex H
PRHO matching scheme timetable.....	Annex I
The views of PRHO: summary of 1999 questionnaires.....	Annex J
Model PRHO curriculum.....	Annex K
PRHO core competencies.....	Annex L
PRHO assessment form.....	Annex M
Record of in-training assessment (RITA) form.....	Annex N
Facilities questionnaire.....	Annex O

Foreword to the visit reports 1998-2001

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

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

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

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

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

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

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

Introduction

1. The purpose of the visit, which took place on 7 and 8 March 2000, was

twofold:

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

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

2. The visiting team was led by Professor Graeme Catto, Chairman of the Education Committee. The other members were Professor Ian Cameron and Professor Robert Stout, both medical members of the Committee.

3. The visit lasted two days. The first day was concerned with the undergraduate curriculum, and the second focused on general clinical training. On both days we worked in collaboration with a team from the Quality Assurance Agency (QAA) which was simultaneously conducting a review of medicine at the University. We have provided information about the nature of this collaborative working where this is pertinent.

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

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

Part 1: The undergraduate curriculum

Background information

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

Form of the visit relating to undergraduate medicine

7. Following an initial meeting with the Dean and senior members of staff we met members of the Committee for Medical Education to discuss curricular development and progress since our last visit. At lunchtime we had the opportunity to meet a group of students drawn from the first four years of the curriculum, including students who had joined the third year of the course from the University of St Andrews. In the afternoon we met representatives from the universities of St Andrews and Keele, to discuss their working relationships with the School. We also had the opportunity to discuss the School's special studies module (SSM) provision. We were joined for all these meetings by colleagues from the QAA review team.

8. We also had access to the materials which were provided for the QAA reviewers.

The undergraduate curriculum

Curricular development

9. In September 1994, the School began to introduce a new curriculum. Each year of the new course has been rolled out annually so that when we visited in April 1997, the first two years of the new course had been implemented and the School was half way through the implementation of the third year. On our return we were pleased to learn that the course had been fully implemented. The first group of students to complete the new course graduated in July 1999.

The new curriculum

10. The aim of the School is to ensure that graduates are well prepared to enter the pre-registration year and to manage their own future education and career. On successful completion of the course students will have gained and demonstrated the knowledge, skills and attitudes necessary for them to practise medicine competently in line with the recommendations set out in *Tomorrow's Doctors*.

11. The new curriculum, which was designed in consultation with clinicians and students, is based on 207 index clinical situations (ICSs). These are a mixture of clinical presentations, for example abdominal pain, and diagnoses, such as carcinoma of the colon. The ICSs are drawn together around a number of core modules, each of which has an overall integrating theme.

12. The curriculum is divided into the following phases:

Phase 1 – Years 1 and 2 (Laying the Foundations).

Phase 2 – Years 3 and 4 (Developing Clinical Competence).

Phase 3 – Year 5 (Preparation for Practice).

13. The course has been designed so that the knowledge, skills and attitudes introduced at each phase are revisited, reinforced, expanded and consolidated. Thus, Phase 1 provides a grounding in the basic medical sciences. Phase 2 draws on the areas addressed in the first phase and allows students to develop clinical skills in a variety of clinical settings including district general hospitals (DGHs), primary care and other community-based medical services. Phase 3 draws together all the elements of the course in preparation for the pre-registration year. A diagram of the new curriculum is at Annex A.

14. The School adopted a problem-based learning (PBL) approach because it believes this encourages students to develop the self-directed learning skills necessary for lifelong learning and competent practise. Small groups (PBL groups) of students use trigger problems, written by the School and based on the ICSs, to determine what to study through a process of discussion, individual study and the sharing of information. These problems address the relevant themes for each part of the course. PBL groups are facilitated by trained tutors whose role is to ensure that groups function effectively and all important learning objectives are

considered. Examples of the trigger problems, and linked ICSs, are at Annex B.

15. In Year 1 students are introduced to PBL and use small group sessions to consider trigger problems designed to stimulate learning around normal form and function as well as human behaviour. During Phase 1 there is emphasis on the development of key study skills. PBL group work is supported by large group interactive 'theatre events' which comprise lectures, practical sessions, discussions with patients or consideration of videos.

16. From Phase 2 students are located in one of three teaching sectors based around the three principal teaching hospitals in the region. The third year begins with the Basic Skills Course, which is designed to ensure that students have the requisite knowledge and skills prior to having the opportunity to gain experience in a clinical setting. During this phase the focus of learning is on abnormal function, disease and patient management.

17. The final year provides opportunities for extensive clinical experience, and is designed to ensure that students are clinically competent to become pre-registration house officers (PRHOs). There is a strong emphasis on learning through clinical apprenticeships, evidence-based practice and the consolidation of professional attitudes.

18. PBL groups provide students with opportunities to develop self-directed study skills and the ability to work in teams. However, the School also provides a number of specific opportunities to study areas of interest including a special study module (SSM) programme, which is described in more detail in paragraphs 56 - 61.

19. During the final year of the course students have the opportunity to shadow the PRHO post they will take over, and to work with the consultant who will become their educational supervisor during the pre-registration year. This part of the course is described in paragraphs 100 and 101.

20. A unique aspect of the programme in Manchester is that approximately 80 students join the course in the third year. These students come from the University of St Andrews having been awarded a BSc (Medical Science) degree by that university. The School's longstanding relationship with the University of St Andrews' School of Biomedical Sciences, and how it copes with this influx of students, is described in paragraphs 26 and 27, and 112 and 113.

21. The School uses a variety of assessment techniques to ensure that students have acquired the necessary knowledge, skills and attitudes. The scheme of assessment is discussed in paragraphs 89 - 93.

The management of change (Principal Recommendation 13)

Supervisory structures

22. The School is fortunate to enjoy excellent leadership from its senior staff. The supervisory structures are sound and lines of accountability and responsibility are well defined. A diagram of the supervisory structures is at Annex C.

23. The Board of the Faculty of Medicine, Dentistry & Nursing is ultimately responsible for the delivery and academic quality of the MBChB programme. Much of the delivery of Years 1 and 2 is devolved to the School of Biological Sciences. However, as the Committee for Medical Education (CME), which includes representatives from the School of Biological Sciences, is responsible for managing the course; this arrangement poses no difficulties for the School of Medicine.

24. As stated in paragraph 16, from Phase 2 (the third year) each student is located in a teaching sector based around one of the principal teaching hospitals¹ with which the School works. All DGH's in the region are then attached to one of these sectors. A hospital dean, jointly appointed by the University and the relevant trust, is responsible for the appropriate implementation of the curriculum within his or her sector. Hospital deans are members of the School's principal committees.

25. The Professor of Teaching Medicine in the Community is responsible for coordinating the delivery of the curriculum in the community-based part of the course. Like the hospital deans, this individual is a member of the School's principal committees.

26. The School's relationship with the School of Biomedical Sciences at the University of St Andrews was established during the 1970s. To ensure congruence between the two courses the schools have adopted the following strategies:

The Deans of each school sit on the other's principal curriculum committee.

The Associate Dean of Medical Undergraduate Studies (ADMUS) and the hospital deans visit St Andrews annually to discuss curricular matters with their counterparts.

The ADMUS runs staff development courses on PBL for colleagues in St Andrews.

The St Andrews School of Biomedical Sciences consults colleagues in Manchester about proposed changes to the St Andrews course.

Trigger problems from Manchester were introduced to the St Andrews course this year to familiarise students with the concepts and practice of PBL before they join the Manchester course.

27. It was clear to us that both schools have made commendable efforts to

ensure that students from St Andrews are well prepared, and have the necessary knowledge, skills and attitudes to join the course in Manchester. However, the relationship does impose some constraints on both parties. Thus, if the Manchester School of Medicine wished to introduce more extensive clinical teaching in Phase 1 of its course, this would have an impact on students joining from St Andrews. We were told that both schools are in fact keen to introduce opportunities for community-based teaching and learning in Years 1 and 2 of their respective programmes. We welcome this intention and would encourage the schools to continue to work closely together to ensure that these initiatives are taken forward successfully.

28. When we visited in 1997 we noted that the School had not been in a position to fund a medical education unit (MEU). Our return revealed that the absence of such a unit had not hindered the School's ability to implement the new curriculum. Nevertheless, we were pleased to learn that the CME was considering the establishment of such a unit. We look forward to hearing about progress in this respect.

The contribution of students

29. Students have been integrally involved in curricular reform and development. Student representatives sit on all the School's principal committees, except those which confirm examination results, where they play a full and active part in the management and evaluation of the course. Where problems with aspects of the course have been identified through evaluation, students are involved in developing solutions and implementing changes. A new Student-Staff Liaison Committee has been established to provide a more formal means of gathering the views of students and feeding back information about proposed changes.

30. The students we spoke to confirmed that the School takes every opportunity to involve them in curricular development, and is always willing to seek their views and make changes in the light of their comments. We were left in no doubt that an effective partnership exists between staff and students which has allowed the new curriculum to be introduced successfully and monitored effectively.

Staff development

31. When the new curriculum was being devised the School recognised that it would be introduced successfully only if a sufficiently large pool of staff, both University appointed academics and NHS clinicians, were trained in PBL techniques. Accordingly, a programme of staff development was put in place to train PBL tutors. We were told that to date 700 staff, including NHS clinicians and GPs, have received such training. We welcomed the recent appointment of a Staff Development Officer, who will help to manage and co-ordinate the training programme.

32. All University appointed teachers must undertake specific induction training provided by the University. However, for the purposes of the medical course the School makes no distinction between University appointees and NHS clinicians. All

are actively encouraged to develop their teaching skills. Academic staff and GPs who teach students are contractually obliged to undertake relevant training. Although this is not the case with NHS clinicians, we were told that trust chief executives were very supportive and that the vast majority of clinicians were themselves keen to develop the necessary skills.

33. The ADMUS confirmed that the School is seeking to co-ordinate its staff development programme with that offered by the region's postgraduate dean. Given that many NHS clinicians teach both students and PRHOs, and that common teaching skills are required, this seems to us entirely appropriate.

Promoting teaching

34. The School recognises that teaching is a valuable activity and wishes to ensure that all teachers, both academics and clinicians, regard this as an important and worthwhile duty. Promotion is used to recognise a valuable educational input, and staff would not be promoted if their contribution to teaching was considered insufficient.

35. The School is fortunate to have good working relationships with NHS trust chief executives in the region, who encourage teaching by clinicians. In future, the School hopes to use the service increment for training (SIFT) contracts to recognise the teaching contribution of clinicians and to provide additional support and resources for clinical departments with a large teaching commitment. The School is also discussing the use of merit awards to reward teaching excellence with its NHS partners. If the School believes that an individual trust, hospital or department is failing to fulfil its teaching commitment, the ultimate sanction is to withdraw students.

36. Student evaluation provides a check on the quality of teaching. Every semester students are asked to provide anonymous feedback about the teaching provided. This information is subsequently shared with teachers. In two of the hospital teaching sectors a system is being piloted which prevents students using their e-mail system unless they have filled out evaluation forms concerning their PBL tutors. The students that we spoke to confirmed that teaching at the School of Medicine was excellent.

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

Reducing the burden of factual information

37. The School is confident that definition of the core curriculum has given students a clearer understanding of what is expected of them in terms of the knowledge, skills and attitudes which they must acquire and demonstrate. These expectations are enshrined in the course objectives which are reiterated for each part of the course. Because summative examinations are designed to assess the core curriculum, students know what they will be examined upon and are likely to focus their efforts accordingly.

38. By using PBL the number of didactic large group teaching events has been drastically reduced. Thus, in Years 1 and 2 there is a maximum of five lectures per week, a figure which is further reduced in the clinical years of the course.

39. Clearly, in a PBL system in which students identify their own learning objectives, there is the potential for students to consider non-essential material. However, the students we spoke to confirmed that the trigger problems were so well written that it would be difficult to develop inappropriate learning objectives. In addition, PBL tutors were available to ensure that no individual or group carried out unnecessary work.

40. The demands on students are constantly monitored and student and staff feedback allows the School to identify any part of the course where unrealistic expectations are being imposed.

41. The students confirmed that the PBL method was challenging, but they did not feel that unreasonable demands were placed on them. They thought PBL was an excellent learning system which engendered self-directed learning, confidence, initiative and an enquiring approach. We agreed that the course made appropriate demands on students.

Integration

42. As we noted in 1997, the entire curriculum is system-based. The fact that the core was defined by multi-disciplinary groups, and that the overall supervisory structure itself involves a number of multi-disciplinary bodies, has helped to promote horizontal integration.

43. The School ensures that the problems which students consider are designed to act as triggers to the study of the underlying basic medical sciences. In Years 1 and 2 the clinical relevance of these problems is reinforced by clinical teachers who undertake teaching in interactive 'theatre events' and act as co-tutors for PBL groups. Year 3 and 4 modules revisit Phase 1 teaching and require the basic sciences to be reconsidered. Having analysed the learning objectives developed by PBL groups in Years 3 and 4, the School told us that the basic sciences were being addressed by students. Evidence from assessments also suggested that students' knowledge of the basic sciences continues to develop in the later years of the course.

44. During Years 1 and 2 students have little direct clinical teaching. Some of the 'theatre events' are led by clinicians who seek to demonstrate the clinical relevance of issues being covered in PBL tutorials. The ICSs around which the problems are developed are also rich in clinical context and link the basic sciences to clinical issues. During the second year of the course an SSM allows students to undertake a community-based project. However, students' first sustained experience of clinical contact is in Year 3. Given that Phase 1 of the course is designed to furnish students with the basic knowledge and conceptual tools for the rest of the course, this is understandable. However, as noted in paragraph 27, the admission of students from St Andrews into the third year of the course means that the

introduction of any sustained clinical experience in Phase 1 would have to be taken forward in parallel with developments at that university.

45. The students we spoke to did not think they were disadvantaged by not gaining earlier clinical experience. They argued that Phase 1 was a necessary building block which prepared them for the clinical attachments in Phases 2 and 3. It was suggested to us that if clinical experience were introduced too early then only token benefits would be achieved.

46. We accept that introducing clinical experience into the early years of the course would need to be carefully managed. However, we think this would enhance the course and strengthen student learning. We therefore welcome the School's intention to work with colleagues in St Andrews to introduce a community-based element into Years 1 and 2 (see paragraph 27).

Learning through curiosity

47. The new curriculum is designed to provide students with a range of learning opportunities and to engender self-directed and lifelong learning skills. PBL groups in Phases 1 and 2 encourage students to develop their study skills and to define their own learning objectives. In this they are supported by their peers and PBL tutors. In addition, a range of specific opportunities have been introduced to provide learning through curiosity.

48. At the end of Years 2, 3, or 4 students are able to take a one year intercalated Bachelor of Science (BSc) degree. There are 14 intercalated courses which students can take. Entry to these is competitive: there are limited places available. The School also has limited resources with which to fund students who are unable to secure their own funding. We were told that approximately 13% of students intercalate. Students that we spoke to confirmed that this programme was an excellent learning opportunity which had enhanced their research capabilities.

49. We were particularly interested to hear about the European Studies Option. This allows up to ten students in each year, who have an A or AS level in the relevant language, to study French or German and spend 6 months of the final year on a clinical attachment abroad. Students receive extra teaching in Years 1 to 4 and are externally examined in Year 4. To ensure that the clinical training provided is of a suitable standard the School has so far limited students to undertaking attachments in hospitals associated with its partner universities in Rennes, Saarland and Lausanne.

50. Students confirmed that this was a very popular option which was oversubscribed. We understand that students unable to gain a place have nevertheless attended teaching and act as reserves in case any successful applicants are unable to complete the programme. Students must fit the additional teaching and learning, estimated at 3 hours a week, around their medical studies. This is a very interesting development and we look forward to learning how the programme progresses.

51. The fourth year Research Project Option, which is taken by all students, is an opportunity to undertake 11 weeks of uninterrupted research which may be science-based, clinically-based or a combination. It involves the design of a project, the collection and analysis of data, a critical review of relevant literature and the production of a 5,000 – 10,000 word report. Students must also make a five minute presentation to staff and their peers. Students are graded on their presentation and the report. Those that reach a high standard may be awarded an honours point which contributes to the award of an honours degree.

52. During the final year students must undertake a series of clinical attachments in a teaching hospital, a DGH and in the community. Students are able to choose the location and specialty of the attachments they wish to undertake. They must produce a project report following their community placement. This is discussed in more detail in paragraph 67.

53. The elective period of study, which is an integral part of the final year, consists of an eight week block of study. The elective can serve a range of objectives including:

The exploration of an area of medical practice which:

interests a student
a student wishes to explore in more detail.

The exploration of medicine in an unfamiliar setting where the scientific, social, economic or cultural standards are different to those of the UK.

54. Students are required to produce a 3,500 word report which should include their aims and objectives, information about the context in which medicine was practised and studied, and an indication of the benefit derived from the experience. This is assessed and students may be awarded an honours point which counts to the award of an honours degree.

55. The School has introduced portfolio learning in the final year and will extend this gradually into Years 3 and 4. This is intended to give students greater control of their own learning. A 'Learning Planner' is given to students to enable them to make best use of the teaching and learning opportunities that are provided. By the end of the course students will have developed a portfolio of work which can be used to compile a curriculum vitae, and will also allow them and their teachers to reflect on their strengths and weaknesses. The students we spoke to thought this was a useful tool which helped them to organise and manage their learning. We agreed that this seemed to be an excellent method for fostering self-directed learning skills.

Special study modules (Principal Recommendation 6)

56. The School believes that its SSM programme provides students with a further important opportunity to take control of their learning and to study areas that interest them. The programme is as follows:

In Phase 1 students undertake two two week SSMs, one in each year. The first module is a literature review and students must produce a 2,000 – 4,000 word report. Students undertake an investigative module in the second year in which they seek to analyse ways in which the abilities or quality of life of a chosen individual could be maximised. A number of options are provided, but students may decide to design their own module. Thus, for example, a student may consider the training methods used by themselves or a friend in preparation for a particular sporting activity. Alternatively, they may choose to study a friend or family member who is mentally or physically disabled. They must make a 5 minute oral presentation to their peers and staff, and produce a 900 – 1,000 word report.

In Year 3 students spend four weeks on an SSM of their choice which should have some relevance to the core teaching. Thus, for example, following the Heart, Lung and Blood Module a student may do an SSM on paediatric cardiology or the prevention of heart disease. Students must produce a case report of up to 3,500 words.

In Year 4 students must complete two 3-week SSMs which, as in Year 3, should be related to core teaching. Students must produce a written case report.

57. The SSMs are seen as an important part of the course and students must complete them all. If an SSM is failed it must be retaken, normally in vacation time. SSMs are not used for remedial teaching and learning.

58. In Phase 1 SSMs are assessed by the SSM supervisor and a proportion are double-marked to ensure that consistent standards have been applied. In Phase 2 SSMs are marked by the supervisor and those graded 'fail' or 'honours' are double-marked to ensure consistency of standards. SSM marks in Phase 1 contribute to a student's marks in the semester in which the module is completed. Phase 2 modules contribute to the award of an honours degree.

59. In Phase 2 SSMs are organised and delivered in the three teaching sectors. Consistency is maintained through common overall objectives, double-marking of work and the sharing of examples of good practice through a joint working group. An excellent electronic system for selecting SSMs, which has been pioneered in Hope Hospital, will be extended to other sectors through this group. Although different options are offered in each of the sectors, a number of SSMs are made available in all sectors. We were also told that the sector system is sufficiently flexible to allow students based in one sector to take an SSM offered in another. We were therefore reassured that student choice is not comprised by this system.

60. Students expressed great enthusiasm for the SSM programme. They appreciated this further opportunity to exercise some choice over the subject studied, and the chance to guide their own learning. They also welcomed the inclusion on the School's website of information about the modules available. This seemed to us to be an excellent way of communicating with students.

61. We think that SSMs play a crucial role in the development of students and, in many respects, the SSM programme in Manchester, allied to the Year 4 Research Project Option and the extensive flexibility of the final year, seemed entirely appropriate to us. However, we identified the following weaknesses which we would like the School to address:

The Phase 2 modules appeared to be very closely linked to core teaching, thereby limiting students' freedom of choice. We think that this, together with the inability to choose a subject outside, although relevant to medicine, is a weakness of the current programme. We would therefore invite the School to reconsider this aspect of its provision with a mind to introducing greater flexibility and diversity.

Although the final year allows students to undertake a period of elective study and to exercise choice over what is studied during their clinical attachments, there are no SSMs in this part of the course. We think that the final year students, who are nearing the end of their programme of study, would benefit immensely from the opportunity to undertake SSMs and to study topics of their own choice in-depth. We would therefore invite the School to consider the possibility of making such an opportunity available in the final year of the course.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

62. The School uses a wide range of teaching methods to ensure that students develop the requisite knowledge, skills and attitudes. These include:

PBL groups in which trigger problems are discussed and learning objectives identified.

Theatre events which support PBL learning. These are large group events, often led by clinicians, which may comprise lectures, interactive sessions and practical demonstrations.

Computer assisted learning (CAL) packages which allow students to study areas in detail and self-assess their knowledge and understanding.

Role-plays with simulated patients which allow students to develop appropriate communication skills.

Learning resources

63. On our 1997 visit we commended the School's skills laboratories. We did not have the opportunity to visit any physical facilities during this visit, but were provided with detailed information about the library, IT and other resources made available to students. Students that we met spoke positively about the learning

resources provided.

64. During our visit we did however have the opportunity to explore the School's website. This provides detailed information about the course including updates on new developments, information for applicants, and the SSMs available. Students clearly appreciated the wealth of information available on the website and we thought this resource, which is linked to all principal teaching sites, was excellent.

The changing patterns of health care (Principal Recommendation 10)

65. The School has identified a number of features relating to the changing patterns of healthcare including:

Shortened patient stays in hospital.

An increased emphasis on care in the community.

An increased workload for hospital consultants.

66. However, it has been keen to take advantage of the opportunities presented by the new curriculum to provide students with greater clinical experience in a variety of settings. During Phase 2 core modules students spend one day a week in a GP practice. This allows them to observe the doctor-patient relationship and to see examples of conditions and illnesses relevant to the themes covered by core teaching. In the final year students have an eight week attachment to a GP practice. On this attachment students are expected to consolidate their clinical skills and to follow patients through hospital care and when they return to the community. These attachments provide opportunities to work with district nurses and health visitors, as well as with GPs. There are also opportunities to be attached to community paediatrics, obstetrics and psychiatric services.

67. At the end of the final year community attachment students must produce a 3,000 word report about a patient they have followed. The patient's anonymity must be maintained. This report, which is assessed by an independent tutor, should include:

A history of the patient's complaint or condition.

A management plan for the patient.

c. A narrative life sketch of the patient.

d. Details about the patient's family history.

e. A description of the patient's social network.

f. A description of the patient's living environment.

68. It seemed to us that the School had made great efforts to adapt its teaching

programme to the changing patterns of health care, and was keen to augment this aspect of the course. We welcome the plans to exploit teaching opportunities afforded by outpatient and day care surgery clinics. As stated in paragraphs 27 and 46, we also support the intention to expand community-based teaching into Phase 1 of the new course in consultation with colleagues in St Andrews.

The goals of undergraduate education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

69. Students we spoke to confirmed that the School stresses the importance of developing appropriate professional attitudes and conduct. Students receive copies of *Good Medical Practice* on the first day of the course. They are expected to explore the principles set out in this booklet in their PBL groups and through independent study. A number of problems have been devised to address issues relating to professional conduct. In addition, specific themes are identified throughout the course. For example, in the final year students are expected to demonstrate the ability to work in a team, recognise their own limitations and understand how their attitude to medical practice can affect their approach to patients and colleagues.

70. A number of objective structured clinical examination (OSCE) stations are designed to assess student conduct, behaviour and attitudes. Formative feedback from clinicians is also used to monitor student attitudes. We were pleased to be told that when they graduate students affirm their commitment to the principles set out in *Good Medical Practice*.

71. Students encounter a variety of clinicians and other staff who act as role models. Tutor handbooks reiterate the need to provide good role models, and the GMC's recently published document, *The Doctor as Teacher*, has proved useful in reminding teachers of the professional standards to which they must adhere. Students discuss issues relating to conduct in their PBL groups and are able to draw any concerns to the attention of the School. They told us that the majority of teachers provided excellent role models, but where they had any concerns these were taken very seriously by the School. We understand that one teacher has recently been removed from the teaching programme as a result of concerns about the behaviour and attitude of this individual.

Essential skills (Principal Recommendations 4 and 8)

72. In 1999 third year students were issued with a 'Skills Portfolio' designed to help them identify and address the key skills they are expected to acquire. The portfolio includes a checklist of the skills to be covered and guidance for self-assessment of competence. It provides an opportunity to reflect on experience and identify learning objectives. This document is purely formative and is for students' personal use. The skills identified in the portfolio are listed at Annex D.

73. Students that we spoke to told us that the portfolio provided helpful information about the generic and clinical skills they are expected to master. They

felt that this was a further opportunity for them to guide their own learning.

IT skills

74. In Phase 1 students receive formal IT teaching and have the opportunity to acquire word-processing skills, data handling skills and the ability to use statistical packages. SSM work and the Research Project Option also require them to use IT facilities to locate and retrieve information. Project and SSM written reports must all be word-processed. In Years 1 and 2 IT skills are assessed via a computer-based skills examination.

Communication skills

75. Communication skills are first assessed by the School during the student selection interview. Thereafter the development of these skills is totally integrated within the course. PBL groups address communication issues and enable students to develop specific skills. During Phase 1 students acquire information gathering and presentational skills. Later in the course role-plays, video recordings of consultations and work with simulated patients develop further skills. The third Year Basic Skills Course covers listening and generic history-taking skills, while in Year 4 there are sessions on a range of issues including breaking bad news and how to negotiate a patient management plan. In addition, we noted that a number of trigger problems have been designed to address issues relating to obtaining consent, a topic which is also considered in a number of theatre events. Students informed us that OSCE stations tested their ability to obtain informed consent from a patient.

76. The School has identified specific communication skills objectives for each year of the course. These are assessed summatively through formal examinations and formatively by clinicians during clinical attachments. In Years 3 and 4 OSCE stations assess students' communication skills, while an objective structured long examination record (OSLER) assesses students' ability to integrate a number of relevant skills. This examination is being revised and will, once amended, consist of a history-taking station followed by a presentation to an examiner of the student's findings, their interpretation of these and a proposed management plan. We understand that students may be observed while taking the history.

77. In 1997 we thought that the teaching of communication skills was a strength of the new curriculum. On our return we were told by students that the course allowed them to develop excellent skills. Those whom we met were very articulate and confident speakers. The School is to be commended for designing such an excellent programme for the development and assessment of these skills.

Clinical skills

78. The clinical skills which students are expected to acquire, and the level of competence they must demonstrate, are identified, along with a number of generic skills, in the skills portfolio which is described in paragraph 72. Some of these skills are taught and tested in Phase 1, for example taking blood pressure, and recording pulses. However, they are introduced mainly in the third year Basic Skills Course, which is designed to prepare students for clinically based teaching in the later years of the course. Students' expertise is expected to develop throughout Phases

2 and 3, and students should use the skills portfolio to plan and chart progress.

79. Students' clinical skills are formatively assessed by clinicians during clinical attachments. These skills are summatively assessed through a series of OSCEs in Years 3, 4 and 5. Whenever possible, real patients are used in OSCE stations so that examinations are as realistic as possible.

Advanced life support skills

80. Students receive cardiopulmonary resuscitation and basic life support training in the first year of the course. This training, which is supported by accident and emergency consultants and anaesthetists, is reinforced in every year of the course and, as portfolio learning is introduced, students will record their experiences in their skills portfolio. Currently, the School does not provide any formal advanced life (ALS) instruction, although all PRHOs receive this as part of their induction training. However, the School is running a pilot scheme to explore the possibility of providing such instruction during the consolidation period in the final year. In *Tomorrow's Doctors* we state that all students should have acquired and demonstrated proficiency in basic and advanced life support skills by the end of the undergraduate course. We would therefore urge the School to extend the ALS pilot to all students.

Teamworking

81. A large element of the course involves students working in small groups to consider trigger problems. Inevitably this requires them to develop teamworking skills to ensure that the groups work effectively and that appropriate learning objectives are identified. All students must take a turn at chairing and scribing for each group. We understand that the induction programme for next year's first year students will involve specific consideration of group roles. PBL groups are changed every semester to ensure that they remain fresh and stimulating. The School seeks to ensure that each group contains students from a range of ethnic and cultural backgrounds, and has an appropriate gender mix.

82. In Phases 1 and 2 the effectiveness of PBL groups is gauged by means of structured assessment forms. Each group makes an assessment of its abilities which is then discussed with the PBL tutor and a group mark is agreed. In Years 1 and 2 this work is moderated by an external assessor and the moderated mark is included in the semester assessment for each student. In Years 3 and 4 this information is used in a purely formative manner. We were told that the School is considering whether each student should be given an individual mark for their contribution to their group, and we look forward to learning of the outcome of this debate.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

83. When devising the new curriculum the School ensured that the themes set

out in the 'Health of the Nation' were addressed. Priority areas identified in 'Our Healthier Nation', such as the prevention of heart disease and strokes, are also covered. This subject is not taught as a separate discipline, but is integrated within the course. However, the School was able to identify for us a number of trigger problems that deal with public health medicine. We were told that the School is keen to bolster this part of the course and would shortly be interviewing for a Chair of Public Health Medicine and a medical sociologist. We think that this will help to ensure that public health medicine is regarded as an important element of the curriculum.

Legal and ethical issues

84. Like public health medicine, medico-legal and ethical issues are integrated within the course and addressed through the problems considered by students. Thus, for example, one problem involves the use of a patient's blood sample in a clinical trial although the patient's consent has not been obtained. As students progress through the course consideration of such issues is increasingly stressed so that when they undertake their final year clinical attachments they are encouraged to discuss patients who, in their opinion, present medico-legal or ethical problems. The School monitors the learning objectives developed by PBL groups to ensure that legal and ethical issues receive appropriate consideration.

85. We were told that the School is in discussion with the Institute of Medicine, Law and Bioethics about how this element of the course can be improved. We understand that PBL tutors are likely to receive additional training and advice on medico-legal and ethical issues so that these can be covered more comprehensively.

Medicine in a multicultural society

86. The School recognises the importance of ensuring that students have experience of dealing with individuals from a wide range of ethnic, cultural and social backgrounds. The region contains a very diverse population which allows students to gain such experience opportunistically. In addition, the following specific strategies have been devised:

The School attempts to ensure that each PBL group is balanced in terms of the gender, ethnicity and culture of the participating students.

A number of trigger problems address relevant issues. Thus, there is consideration of how infertility affects different cultural and ethnic groups, different cultural responses to ethical issues such as euthanasia and illnesses that affect certain groups, for example sickle cell anaemia.

As mentioned in paragraph 81, the School ensures that PBL groups have an ethnic, gender and cultural balance so that individuals can contribute their knowledge, expertise and perspectives to group discussions.

GP practices which conduct consultations in languages other than English

have been identified. Students with knowledge of the relevant languages have been made aware of these and given the opportunity to observe such sessions.

Complementary and alternative medicine

87. There is no formal teaching about the range of complementary and alternative therapies that are available. However, students have an opportunity to gain experience of such therapies in pain relief clinics and when they consider patients with musculo-skeletal problems. Students can also investigate complementary medicine through the SSM programme or during their elective period of study. Nevertheless, we thought that all students should have the opportunity to become familiar with the range of therapies available, so that on graduation they would have a knowledge base upon which to draw when a patient seeks information and guidance about alternative therapies. We therefore hope that this feature of the course will be reviewed by the School with the intention of ensuring that all students have an awareness of the therapies available, and an understanding of their applications and limitations.

Infectious diseases and antibiotics

88. Antibiotic resistance is dealt with in PBL group work, most noticeably in the third year Nutrition, Metabolism and Excretion Module, but also in other years. In addition, students are expected to observe and discuss cases of antibiotic resistance and the use of antibiotics during clinical attachments in Phases 2 and 3.

Assessment of the process and product (Principal Recommendation 12)

The scheme of assessment

89. The School uses a variety of techniques to guarantee that students' knowledge, skills and attitudes are assessed in a valid and reliable manner. The current scheme of assessment is outlined at Annex E.

90. The scheme involves a number of interesting features including:

Seen and unseen question papers in Phase 1 which test students' ability to handle the process of learning. Seen papers test students' ability to answer a series of questions on a problem or case issued to them at the beginning of the examination period. Unseen papers require students to consider a case and to demonstrate the ability to reason, to link information and to develop a strategy for gathering further information.

A Year 1 and 2 publication-based paper which uses a published one-page article that students are expected to summarise in scientific language and write up as an article for a popular magazine with a lay readership.

Progress tests in Years 3 to 5 consisting of 250 true or false items. The questions relate to the core curriculum and are linked to the ICSs. The same paper is presented to all three years so that the School can measure year on year progress.

91. All examinations are linked to the core curriculum and OSCEs and the

OSLER address the skills identified in the skills portfolio. It therefore follows that assessments are integrated and do not focus on individual subjects or disciplines.

92. The assessment techniques are continually reviewed to ensure that they remain appropriate. Planned changes include:

The inclusion of new questions in the progress tests and the publication of test papers once they have been sat.

The introduction of criterion referencing for OSCEs, to ensure that competency has been demonstrated satisfactorily. This system has been piloted in the Year 3 formative OSCE and will be extended to replace the norm referenced scheme currently employed in all other such examinations.

The inclusion of more patients in the final year OSCE to make this examination as close to reality as possible.

The modification of the final year OSLER to make it more focused and to integrate it with the OSCE. (Proposed changes are outlined in paragraph 76.)

The inclusion of student representatives on the group which oversees OSCEs. It is hoped that students will help to improve the examinations by providing feedback on them and evaluating proposed changes.

93. We thought that the scheme of assessment was both excellent and innovative.

Academic performance

94. At each stage of the course students are told the aims and objectives against which their performance will be judged. A series of 'essential guides' are produced which provide information about assessments. The objectives for Years 3 to 5 of the course are at Annex F.

95. Students must obtain at least an overall mean mark of 50% or more to pass the Phase 1 end of semester examinations. However, if they are awarded a mark of 40-49% in only two components of the examination, or a mark of less than 36-39% in one component, they can take a viva voce examination to satisfy the examiners that they should be allowed to proceed.

96. During Phases 2 and 3 a Progress Committee reviews the case of any student who is having difficulty with the course. Students who have failed one of the summative assessments will normally be allowed to resit the assessment at the next opportunity. The Progress Committee discusses any student who has failed more than one summative assessment in any academic year. Such students may be advised to leave the course, resit an entire year, or continue their studies but retake the relevant assessments at the next opportunity.

97. Students who have successfully completed Year 3 of the course, but who will not continue to pursue a career in medicine, can be awarded a Bachelor of Medical Sciences degree.

98. Students who perform well in summative assessments and SSMs may be awarded honours points in recognition of the high standards they have achieved. Students who have been awarded 8 such points throughout Years 1 to 5 of the course graduate with honours. However, to graduate with honours at least one of the honours points must have been awarded for performance in the Year 5 final examinations. No honours points are awarded for performance in resit examinations

Fitness to practise

99. In the past, when the School had concerns about a student's fitness to practise, such cases were dealt with on an ad hoc basis. However, we were pleased to learn that the School and Deanery are in the process of establishing a committee that will consider the cases of students and PRHOs about whom there is some concern, for example on the basis of poor health or inappropriate conduct. We understand that the precise nature of an individual's right to appeal against any decision reached by this body has yet to be determined. We commend the School and Deanery for working together in this matter, and look forward to learning how the system is developed and implemented.

Preparation for the pre-registration year

100. In the final year of the course students have an eight week consolidation period which is used to ease their transition into the pre-registration year. This period consists of three weeks for revision prior to the final examination, one week of examinations, and four weeks shadowing the PRHO post they intend to take up on graduation.

101. As mentioned in paragraph 55, students are given a Learning Planner which helps them to plan their clinical experience, identify learning objectives and develop a portfolio of work. During the four week shadowing period students are expected to continue to use their Learning Planner and to develop a Record of Professional Development. This latter document is designed to help a student to chart a career path and to provide prospective employers with information about that individual's skills, achievements and interests. The School and Deanery hope that when they become PRHOs, graduates will continue to use the Learning Planner to develop their learning plan and objectives for the pre-registration year.

102. On the second day of our visit we spoke to a number of recent graduates, educational supervisors and NHS trust managers. All agreed that the four week shadowing period had been very beneficial and had allowed students to become familiar with the hospital, unit and colleagues with whom they would be working.

103. We think that the consolidation period plays an important part in preparing students for their first PRHO post. As stated in paragraph 80, we think it would be

enhanced if the ALS pilot scheme were to become a central component of this part of the course.

Other issues

Student selection

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

105. We were told that the School receives approximately 3,000 applications each year, of which 900 are invited for an interview. Details about entry requirements are included on the School's website.

106. The School has a rigorous and transparent process which involves trained interviewers and structured interviews which test applicants' commitment to medicine and their ability to cope with a PBL course. To date the interviews have not involved lay individuals or students, but this is an area which the School is actively pursuing. All interviewers are provided with detailed information on the conduct of interviews in line with the University's equal opportunities policy and procedures.

107. The School encourages applicants from a variety of backgrounds. Graduates with an insufficient science knowledge base can enter a one year premedical programme, and alternative criteria are used to judge applications from mature students. Approximately 20 students are admitted to the premedical programme each year. This provides students with the knowledge and understanding of biology, chemistry, physics and mathematics required to join Year 1 of the medical course. PBL teaching and learning methods have been introduced to the programme to ensure that students develop the learning skills necessary to commence the MB ChB course. Students to whom we spoke confirmed that the premedical course is an excellent preparation for the MB ChB programme.

Increasing medical student numbers

108. The Medical Workforce Standing Advisory Committee recommended that the number of UK medical students should be increased and this recommendations was accepted by the government. In collaboration with the University of Keele, the School made a successful bid for an extra 80 students, starting with an additional 50 students in September 2000.

109. We were told that the additional students will follow the Manchester curriculum, and that all students, irrespective of where they have studied, will receive a University of Manchester degree. However, from the third year onwards 50 of them will be located at North Staffordshire Hospital and 30 at the Preston Acute Hospitals NHS Trust. North Staffordshire will become a fourth hospital sector with its own hospital dean, while students in Preston will be absorbed within one of

the current sectors.

110. Students at North Staffordshire will follow the Manchester course, but will be taught by University of Keele appointed academics, although we understand that joint appointments are being discussed. The University of Keele will provide access to IT library facilities and organise the Year 4 Research Project Option for students. However, the University of Manchester School of Medicine will be responsible for entry to the course, for fitness to practise and for examining students. The School will also retain overall control of the curriculum and responsibility for quality assurance.

Student support

111. At the beginning of the course there is a one week period of induction. This has been modified in the light of student feedback and includes consideration of a trigger problem. Students to whom we spoke had found this very helpful.

112. A number of students that we met had joined the third year of the course from the University of St Andrews. We understand that such students were provided with information about the Manchester course while still at St Andrews and, as mentioned in paragraph 26, Manchester trigger problems have been introduced to the St Andrews course. The third year Basic Skills Course also provides a helpful introduction to the programme.

113. To help ease St Andrews students in to the course the Manchester Medical Students Representative Committee (MSRC) has organised an induction event for them. This provides opportunities to:

Stay with, and socialise with, Manchester students they will be joining on the course.

Visit clinical teaching sites and become familiar with different teaching and clinical locations, and the individuals they will encounter.

114. All the students we spoke to confirmed that St Andrews graduates were successfully integrated into the course and in no way placed at a disadvantage. Such students were seen as a new learning resource by their Manchester peers, who in turn helped them to come to terms with PBL. It seemed to us that the needs of students from St Andrews were addressed.

115. Students and staff told us that PBL groups provided an excellent system for academic and pastoral support. Students were often able to help their peers and warn the School if one of their colleagues was experiencing difficulties.

116. Although the School does not have a 'personal tutor' system, students were confident that the necessary support was available from a variety of sources including:

a. Their peers.

- b. PBL tutors.
- c. GP teachers during primary care attachments.
- d. Educational supervisors who support students during clinical attachments.
- e. Phase 2 and 3 hospital deans.

117. Students also have access to a confidential counselling scheme and a MSRC organised “mummy and daddy” scheme in which senior students support new students.

118. Students confirmed that the School was approachable and supportive and took great pains to help students with problems. They appreciated that although an extensive support network had been put in place, it was not too formalised. This allowed them to seek guidance, advice and support from the individual they felt most confident to approach. It seemed to us that the School has set in place sufficiently sound support systems.

Feedback to students

119. Throughout the course students receive formative feedback from PBL tutors, their peers and clinicians. Students’ attitudes are assessed during clinical attachments using the form at Annex G. In addition, during the final year students have an educational supervisor whom they meet regularly to agree objectives for each clinical attachment, to monitor progress and review experience. Although one of the students we spoke to felt there could be more formative feedback, the great majority of students felt that the level of such feedback was appropriate. They pointed out that PBL encouraged self and peer appraisal, and felt that teachers were very helpful. They also thought that the Skills Portfolio and Learning Planner were useful instruments that helped them to gauge their own progress.

120. As well as formative feedback students receive feedback about their performance in summative assessments. The School tries to make this as detailed and helpful as possible, to the extent of telling students about performance at individual OSCE stations. The School is conscious of the need to provide such feedback swiftly and seeks to make provisional results available within two and a half weeks of an examination.

Quality control

121. It seemed to us that appropriate mechanisms are in place to ensure the quality of the teaching and learning opportunities provided by the MBChB programme. These include:

The Student-Staff Liaison Committee which provides a formal forum for student comments about the course.

Regular questionnaires that allow students to comment on the course and the quality of the teaching encountered.

An annual and a five yearly review of the course, which are conducted by an independent Faculty Teaching Standards Committee. We understand that the five yearly review involves an external expert.

Each summative examination involves an external examiner who is required to ensure that the examination is fair and carried out in accordance with set procedures. External examiners comment on draft question papers, or OSCE proposals, observe assessments, perform viva voce examinations and sit on the bodies which confirm examination results. They also produce reports on the assessments they were involved with, including recommendations for changes, which are considered by the School.

122. These quality assurance procedures have allowed the School to monitor each year of the course as it has been rolled out. As a result, parts of the course have been amended to ensure that they function as intended. A number of trigger problems have, for example, been revised to ensure that students will identify appropriate learning objectives.

Areas of good practice

123. *The contribution of students:* Our discussions with students and staff left us in no doubt that students have been integrally involved in curricular change. The School has drawn heavily upon students' experience and knowledge in the development of the new course. The effective relationship between students and staff has helped to ensure that high quality undergraduate medical education is provided in Manchester.

124. *Learning through curiosity:* The new curriculum affords students a number of opportunities to study areas that are of particular interest to them. The European Studies Options, which allows a small number of students to study a European language and undertake clinical attachments abroad, is a particularly interesting innovation. We look forward to hearing how this progresses.

125. *Learning resources:* Students in Manchester are fortunate to enjoy excellent facilities. The School's website, which is linked with partner trusts, is excellent. This provides students and staff with a wide range of learning and teaching materials.

126. *Fitness to practise:* Given medical schools' pivotal role in providing access to a career in medicine, we welcome the intention to establish a committee to consider the cases of students giving cause for concern other than about their academic performance. We think such bodies are vital if professional standards are to be maintained. We look forward to hearing how this new process is developed and implemented.

127. *Student support:* The School has made great efforts to ensure that students

have a range of support systems which can be used if necessary. PBL groups provide ongoing peer support which is supplemented by other more formal structures. The students to whom we spoke confirmed that the School is tremendously supportive of any student who experiences difficulties.

128. *Preparation for the pre-registration year:* The School and Deanery are to be commended for working together to develop a system which allows students to shadow the PRHO post that they will take over. Like the staff and students we spoke to, we have no doubt that this will ease considerably the transition from student to PRHO.

Areas for further consideration

129. *Clinical experience:* We appreciate that the School's links with the University of St Andrews necessarily place some constraints upon its ability to introduce earlier clinical experience into the curriculum. However, we were pleased to note that plans are in hand to work with colleagues in St Andrews to allow an increased element of community-based medical teaching in Years 1 and 2. We would encourage the School and its partners to take this initiative forward.

130. *SSM programme:* The new curriculum provides students with a number of opportunities to study areas of interest, of which the SSM programme is one important element. It seemed to us that the modules in Years 3 and 4 were very closely linked to core teaching and might therefore inhibit student choice. We also thought that students would benefit from the opportunity to undertake SSMs in Year 5. We therefore wish the School to reconsider this aspect of the programme with a view to including SSMs in the final year, and introducing greater flexibility and diversity in Years 3 and 4, for example by allowing students the option of choosing modules that are not directly related to medicine.

131. *Advanced life support training:* We think that all students should have received instruction in, and demonstrated proficiency in, ALS skills by the end of the undergraduate medical course. We welcome the pilot scheme that the School is running as part of the consolidation period in Year 5, and would encourage the expansion of this scheme to all students.

132. *Complementary and alternative medicine:* We think it important that all students are familiar with the applications and limitations of the alternative therapies available to the public, so that they can discuss such therapies in a considered manner with patients seeking treatment. We would therefore wish the School to identify further opportunities for students to address such issues as part of the core curriculum.

Conclusion

133. Although we have identified a number of areas for further consideration we were very impressed with the undergraduate medical education offered in Manchester. The excellent relationship between students and staff has undoubtedly enabled the School to develop its programme so rapidly. The School

has successfully implemented a new and innovative course and all those involved, staff and students, deserve praise for what has been achieved. We look forward to hearing about further progress in a year's time.

Part 2: General clinical training

Background information

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

135. There are posts for 298 PRHOs within the region. The Postgraduate Dean confirmed that the Deanery is a net exporter of graduates.

Form of the visit relating to general clinical training

136. The day began with an overview of general clinical training from the Postgraduate Dean and the Deputy Postgraduate Dean. We then met members of the Pre-Registration Year Committee (PYC). This was followed by a meeting with a group of educational supervisors and clinical tutors from a variety of hospitals and trusts. In the afternoon we met PRHOs from a range of locations and specialties, and had the opportunity to have discussions with medical directors and chief executives from NHS trusts within the region.

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

Organisation and management of the PRHO year

Supervisory structures

138. The PYC, which meets twice a year, is responsible for overseeing general clinical training in the region. Members include the Dean of the School of Medicine, the Director of Postgraduate General Practice Education, the undergraduate hospital deans, clinical tutors from the teaching hospitals and DGHs, two PRHOs and two student representatives. We noted that no lay people are involved. The Postgraduate Dean agreed that this was a possibility that should be pursued. She was keen to ensure that any such members should be able to play an active role and not be a token presence.

139. The following two sub-groups report to the PYC:

A Standards Working Group which is responsible for defining the standards required at sites which have, or wish to have, PRHOs.

A Logbook Group which is responsible for overseeing the logbook which PRHOs use to chart their progress. (The PRHO logbook is described detail in paragraph 184.)

140. The Deanery hopes to establish a further sub-group to the PYC, a Review Panel, which will consider poorly performing PRHOs and determine the appropriate course of action to be taken in each case. As discussed in the first part of this report, the Deanery also intends to establish a Fitness to Practise Committee

in collaboration with the School of Medicine. This body will consider the case of any PRHO giving cause for concern other than about their academic performance.

141. The Deputy Postgraduate Dean has specific responsibility for the pre-registration year. This individual chairs the PYC and its sub-groups, and is responsible for co-ordinating the Deanery's work relating to PRHOs.

142. It seemed to us that the Deanery has established sound supervisory structures for managing the pre-registration year. Its plans for establishing a Review Panel and a Fitness to Practise Committee are to be commended.

The approval of posts

143. The PYC is responsible for approving PRHO posts in the region. In this it is guided by *The New Doctor* and recommendations from the Deputy Postgraduate Dean. The Deanery's criteria for the approval of posts are set out in the document 'Criteria for PRHO Placements'. This provides trusts with detailed information and guidance about what is expected of them. An equivalent document is provided for GP practices wishing to have PRHO posts in primary care.

144. The Deanery has removed approval for posts which did not fulfil its criteria. However, this is seen as a last resort as the Deanery is keen to work with trusts to raise standards by reorganising and restructuring training posts.

145. The Deanery is aware that the University of Manchester School Of Medicine will be increasing its intake of medical students from September 2000. Consequently, it is hoping to increase the number of PRHO posts within the region to accommodate this expansion, and is currently in the process of identifying new educational opportunities and posts. We understand that the intention is to increase the number of three by four-month rotations through this process.

Communicating the aims and objectives of the pre-registration year

146. A number of mechanisms have been put in place to ensure that PRHOs, educational supervisors, clinical tutors and NHS managers are aware of, and understand, the objectives of this period of training. These include:

A PRHO logbook which incorporates and explains the objectives of general clinical training.

The widespread circulation of *The New Doctor* to individuals involved in PRHO training.

The inclusion and explanation of the objectives for PRHO training in the Criteria for PRHO Placements sent to all trusts in the regions.

Annual review visits which are designed to monitor and maintain the quality of the training and education provided for PRHOs.

147. We were pleased to learn that staff development is recognised as an important method for improving education and training of PRHOs. By April 2000 all consultants who wish to be educational supervisors must have received training which the Deanery deems appropriate. We were told that all but eight out of the 324 designated educational supervisors in the region had already received such training and the remainder would be trained by the specified date.

148. The Deanery has developed a modular four-day programme to develop the skills required to educate PRHOs. This programme covers:

The identification of learning needs and the development of learning objectives.

The development of sound teaching skills.

The principles of good assessment and appraisal.

The management of under-performing PRHOs.

149. The programme for this training course is at Annex H.

150. The Deanery is to be commended for the steps taken to ensure that the objectives of PHRO training are known throughout the region. As mentioned in paragraph 33, we understand the Deanery is in discussion with the School of Medicine about how to coordinate the training programmes offered for those involved in training medical students and PRHOs. This seems entirely appropriate to us. However, it was not evident to us that there is a mechanism for disseminating examples of good practice within the region. During our discussions with PRHOs, educational supervisors, clinical tutors and NHS managers, we identified many examples of good practice which did not appear to have been shared with colleagues in the rest of the region. We would wish to encourage the Deanery to explore the development of a means by which good practice could be shared.

The selection of PRHOs

151. The Deanery runs a 'Hospital Fair' annually. This allows fourth year students to meet trust representatives and discuss the PRHO posts which are available. The Deanery's website includes information about all the trusts and PRHO posts within the region. In addition, this year the Deanery ran two 'Making the Right Choice' evening sessions which were designed to help final year students consider employment opportunities and identify the PRHO post that would be most suitable for them.

152. The Deanery runs a matching scheme which is open to all medical graduates. This scheme is advertised nationally to ensure that the requirements of equal opportunities legislation are met. There are approximately 500 applicants each year for the 298 posts available.

153. The scheme allows trainees to identify posts in which they are interested, and

consultants to select trainees via an interview or the structured curriculum vitae which each student provides. Consultants and trainees rank their selections which are then matched by computer. A 'clearing house' system operates for individuals and posts which are not matched in the first instance. The timetable for August 2000 and February 2001 is at Annex I.

154. The Deanery is already a net exporter and is aware that pressure will increase as the School of Medicine's intake rises. Individuals who wish to undertake training outwith the region, or have failed to secure a post via the matching scheme, are interviewed by the Deputy Postgraduate Dean and provided with advice and guidance about posts in other regions.

155. The Deanery is keen to ensure that PRHO posts are allocated in order to meet the educational needs of trainees, as well as their preferences. Information is shared between the School of Medicine and the Deanery about students' performance and needs and, wherever possible, students with particular training requirements are channelled into posts that will provide the specific support and training they need.

156. Posts outwith the region are approved for individuals only once the Deanery is satisfied that they offer appropriate education and training, and meet the standards of assessment that are required of posts within the region.

Monitoring the quality of PRHO posts

157. All trusts with PRHO posts within the region are visited annually. The visiting teams usually comprise the Deputy Postgraduate Dean, an associate postgraduate dean and an administrator. Visits are arranged three months in advance. Prior to a visit the following material is collated:

- a. Feedback from PRHOs via Deanery questionnaires about the quality of their posts.
- b. Feedback from the New Deal Task Force about the posts.
- c. Information about accredited facilities.
- d. Issues identified in previous visits.

158. During the visits PRHOs are interviewed in two groups, medicine and surgery, as are consultants. If problems relating to accommodation or catering are identified these facilities are visited and assessed. The visit concludes with feedback to the trust's chief executive, medical director and clinical tutor. All trusts receive a written report which includes recommendations and highlights action that is required. Trusts are expected to respond to these reports and indicate the remedial action that will be taken. The Deanery monitors the implementation of changes to ensure that appropriate action is taken within an acceptable time-scale.

159. GP practices with PRHOs are visited regularly by the Deanery's advisers in

general practice to ensure that appropriate training and support are being provided. Each practice is formally visited every three years through the normal process by which a training practice is approved. There is very close liaison between the Deputy Postgraduate Dean and the Director of Postgraduate General Practice Education to ensure that appropriate standards are maintained.

The views of PRHOs

160. The Deanery recognises the important contribution that PRHOs can make to the maintenance and development of high quality general clinical training. Accordingly:

Two PRHO representatives are members of the PYC.

The views of all PRHOs are gathered annually using a questionnaire. A summary of the findings from the 1999 questionnaires is at Annex J.

PRHOs are interviewed separately during annual trust visits so that their true opinions and views can be obtained.

PRHOs have direct telephone access to the Deputy Postgraduate Dean should they have any concerns about their post.

161. We thought that the Deanery had established a robust and thorough system for monitoring PRHO posts.

Components of a high quality PRHO post

Induction

162. As mentioned in part one of the report, the consolidation period in the final year of the undergraduate course is designed to ease the transition from student to PRHO. The trainees and consultants that we spoke to agreed that shadowing a PRHO had helped to prepare graduates for their first post, and helped induct them to the pre-registration year. Shadowing was considered particularly helpful in allowing graduates to become acquainted with the other members staff with whom they would be working, the layout of the unit or department in which they would be located and the working practices of the employing trust.

163. Trusts organise and arrange their own induction training. However, the Deanery has identified the following elements which should be covered:

Orientation to the trust and trust policy, including an introduction to the clinical tutor.

Distribution of an up to date trust handbook outlining trust protocols and how to obtain common procedures.

An introduction to the unit or department where a PRHO will be working. This

should occur during a trainee's first week.

An introduction to their educational supervisor by the clinical tutor. This should occur in the first week in post.

Cardio-pulmonary resuscitation training, which should be undertaken within five working days of the trainee taking up post.

164. In addition, the Deanery provides written materials for certain areas of induction training. Thus, there is guidance about time management skills and how to use the PRHO logbook.

165. We noted that the trusts arrange a wide variety of induction activities over and above what is required. One example of good practice, which other trusts should be made aware of, operates at the Royal Oldham Hospital. Here trust board members have lunch with each new set of house officers when they take up their posts and when they leave. We thought this an excellent practice, which allows trust board members to learn about the work carried out by trainees and also demonstrates to trainees the importance attached to them and their work by the trust members.

166. The trainees that we spoke to confirmed that induction was generally well planned and helpful. All were confident that they were well prepared to undertake their first post.

Educational opportunities

167. The Deanery's contracts with trusts specify that PRHOs should have four hours of bleep-free training each week. The 'Criteria for PRHO Placements' identifies the topics that should be covered. Clinical tutors are required to organise and plan teaching sessions and to monitor attendance. A model PRHO curriculum, which is at Annex K, has been produced to ensure that essential areas are covered in all posts.

168. The NHS managers that we spoke to recognised the importance of providing high quality education and training. One chief executive pointed out that it was in a trust's own interest to treat PRHOs well as this would help with the recruitment and retention of high quality medical staff. While believing that major advances had been made in the provision of training, managers confirmed that balancing service commitments and educational needs was a constant struggle.

169. Trainees said that educational opportunities were made available in all posts and, when they were able to attend them, these were generally helpful. The opportunity to suggest subjects and issues to be covered was much appreciated. However, PRHOs were critical of poor bleep filtering systems that undermined the benefit they received from training. Some told us that they only had one hour of bleep-free training a week, while others had up to five hours. Trafford General Hospital was identified as having an excellent bleep filtering system. We think that this is another example of good practice that should be more widespread within the region.

170. GP trainees were particularly complimentary about the educational opportunities and the teaching provided by primary care posts. The chance to observe consultations and receive one to one training was much appreciated. The Day Release Course, which has been introduced for PRHOs in general practice, was also thought an excellent educational opportunity. We were impressed with this scheme which allows all GP PRHOs to meet fortnightly to discuss common concerns and make case presentations to their peers and staff. One beneficial by-product of this course is that PRHOs, who might feel isolated working in a GP practice, are provided with a supportive peer group. The Deanery is to be commended for establishing this course.

171. Trainees generally did not feel that they were spending many hours on duties or tasks of little educational value. Where available, nurse practitioners were much appreciated and those at the Manchester Royal Infirmary were considered excellent. However, support for routine tasks at weekends was considered poor by trainees in most trusts.

172. Trainees were also critical of partial shift systems, which disrupted continuity of patient care and thereby reduced the educational opportunities in some posts. We understand that the Deanery is working with trusts to develop imaginative and innovative schemes for reducing the detrimental impact of partial shifts on continuity of care. Although provided with limited information about these schemes they seemed to be a helpful response to a common cause of concern. We would like the Deanery to provide us with more written details about these initiatives.

173. Some trainees were concerned about the number of wards and patients they had to cover when on-call. Being responsible for over a hundred patients was not uncommon, and resulted in PRHOs becoming task rather than patient focussed. Problems with excessive demands while on-call were exacerbated in many trusts by poor bleep filtering systems. Thus, PRHOs were often bleeped for tasks which were not an emergency and even if a senior nurse was supposed to filter calls this did not always happen. Trainees thought that some nurses, particularly juniors, failed to appreciate the long hours PRHOs worked and the pressures they were under.

174. It seemed to us that the Deanery and trusts have set in place a sound structure that could provide trainees with the education and training they require. At present, however, PRHOs at many trusts are unable to take full advantage of the educational opportunities on offer. The Deanery will wish to address this matter with its NHS partners to ensure that examples of best practice are shared and all trainees derive the maximum educational benefit from their posts. Thus, for example, a review of the bleep filtering policies operating in trusts within the region, and the adoption of the most efficient systems, would clearly help to improve the educational experience of many PRHOs.

Educational supervision

175. The Deanery is aware that educational supervisors have a strong influence

on what is learnt during PRHO posts and on the standards of conduct and behaviour that are considered appropriate. Hence, emphasis is placed upon providing all supervisors with information and training that will assist them to undertake their role. The Deanery has made clear to supervisors what is expected of them, through the 'Criteria for PRHO Placements'. Thus, all PRHOs should:

Have a named educational supervisor.

Be assessed using national documents that allow their learning needs to be identified and monitored.

Have regular informal meetings for feedback about performance.

Have three formal meetings at which performance can be reviewed and recorded.

176. Historically, educational supervisors have been identified locally on the basis of ability and willingness. However, following the publication of *The New Doctor* the Deanery is keen to formalise the appointments process and to ensure that supervisors' performance is monitored more closely. This seemed appropriate to us.

177. The educational supervisors that we spoke to found the Deanery very supportive, and thought the PRHO logbook, described in paragraph 184, very helpful. They thought that the training which they had received was sound, but those not involved in teaching medical students would have appreciated more training and guidance about the new PBL undergraduate course introduced in Manchester. We thought this a helpful suggestion that the Deanery would wish to take forward.

178. All the PRHOs that we spoke to knew their educational supervisor, and most found them helpful and supportive.

Clinical training and supervision

179. The Deanery has identified a list of core competencies which must be addressed. This is at Annex L.

180. PRHOs and their supervisors are expected to use the Record of PRHO Training, described in paragraph 183, to help identify opportunities for gaining clinical experience and developing the appropriate skills.

181. The PRHOs to whom we spoke said that they received excellent clinical training and supervision. This was particularly so for PRHOs in general practice and the pilot posts in Accident and Emergency medicine. All said that they enjoyed appropriate clinical supervision and guidance. Furthermore, we were pleased to note that they were never placed in a situation where they were unable to seek direct support or guidance from a senior colleague.

Monitoring the progress of PRHOs

182. Educational supervisors are expected to meet trainees at the start, mid-point and end of a post to monitor and review progress. At the first meeting the trainee and supervisor are expected to sign a learning agreement and develop a learning plan. The Deanery is hoping that the Learning Planner, which has been introduced into the undergraduate course, will form the basis for the development of the learning plan.

183. To assist PRHOs in monitoring and recording their performance the Deanery has introduced a Record of PRHO Training. This allows them to record training experiences and provides evidence of the training which they have completed. Although intended for use by the PRHO, the Deanery stresses that the record can be helpful to supervisors when they review progress with a trainee.

184. The PRHO logbook has been introduced to ensure that PRHOs and educational supervisors have a shared understanding of the evidence and decisions upon which completion of the PRHO record of in-training assessment (RITA) is based. Supervisors and PRHOs are expected to use the forms at Annex M to evaluate performance, so that the RITA form at Annex N can be completed at the end of each PRHO post. A PRHO cannot be signed off by the clinical tutor as having completed this period of training satisfactorily unless all these forms have been filled in appropriately.

185. The Deanery expects PRHOs who fail to perform satisfactorily to be discussed with the clinical tutor in the first instance, to see if the problem can be solved locally. If a problem persists, this should be drawn to the attention of the Deputy Postgraduate Dean so that remedial steps, for example extending the period of training, can be taken. Historically, such cases have been dealt with on an ad hoc basis; however, as stated in paragraph 140, the Deanery intends to establish a Review Panel to consider all such cases in a more formal manner.

186. The majority of the PRHOs that we spoke to had had formal appraisal meetings as required. These were found to be very helpful, although in a number of instances they were not as detailed and extensive as expected, some such meetings lasting no more than ten minutes. A minority of the trainees we met had had no such meeting. This is clearly unacceptable and something that the Deanery will wish to pursue with educational supervisors.

187. Educational supervisors and PRHOs generally found the Record of PRHO Training and the PRHO Logbook useful. They thought these helped to formalise the appraisal process and ensured that all parties knew what was expected of them. However, some PRHOs thought them cumbersome documents which included too much educational jargon that meant little to them or their supervisors.

188. We thought the Record of Training and Logbook were excellent innovations. Feedback from users will no doubt cause these to develop and change, but they have laid the foundations for a more objective and rigorous appraisal system.

Professional development and personal well-being

Support for PRHOs

189. The Deanery is working with its NHS partners to create an effective learning environment within all trusts in the region. The NHS managers that we spoke to said they were aware of the vital role that PRHOs play in patient care, and were committed to providing them with the necessary support and facilities.

190. Clinical tutors and educational supervisors, who have been trained in appraisal and counselling skills, are required to provide academic and pastoral support. All PRHOs are encouraged to register with a GP, and trusts are expected to provide confidential counselling services and access to appropriate occupational health services.

Careers advice

191. Clinical tutors are expected to provide advice about career plans, and should meet trainees at least once in the year, or during a placement, to discuss their intentions. In February 2000, a clinical tutors' 'away day' provided training in careers counselling. PRHOs ready to apply for SHO posts should receive advice about the preparation of a curriculum vitae.

192. A careers fair is held annually, and each specialty has a stall at which trainees can seek information about training and prospects. Booklets about each specialty are available from the Deanery on request, and events and additional information is provided on the Deanery's website.

193. PRHOs thought that the provision of careers advice was good. However, they thought it would be helpful to have anonymous, objective information about training and opportunities in each specialty via the internet.

Accommodation, catering and personal security

194. To date accommodation, catering and security have been monitored in three ways:

Through annual PRHO visits.

Through routine SHO monitoring visits by the Postgraduate Dean or relevant medical royal college.

Through inspection by the regional New Deal Task Force medical officer.

195. Where facilities have been found inadequate this has been discussed with the trust concerned and an action plan for implementing improvement identified.

196. The Deanery has recently commissioned a management trainee to undertake a project accrediting the facilities for catering and accommodation within

the region. A copy of the facilities questionnaire is at Annex O. The Deanery anticipates requests from trusts for additional resources to improve facilities in the light of this project.

197. The PRHOs to whom we spoke thought that catering and accommodation was generally very good, and at some trusts, for example Tameside General Hospital, excellent. The Deanery, Task Force and trusts are to be commended for this. PRHOs' only concerns related to security on wards, which was thought a problem in a few trusts where security guards could take some time to respond to a call. However, no trainees had ever been assaulted and safety was considered a greater problem for nursing staff.

Contractual matters

198. The region's New Deal Task Force is responsible for monitoring the hours worked by trainees and work intensity. NHS managers confirmed that all trusts have systems for monitoring the hours worked by trainees.

199. Most PRHOs that we spoke to said they worked longer hours than they were contracted for, although they did not think this necessarily meant that their posts were poor. NHS managers with whom we raised this confirmed that it was an issue. Evidence from the New Deal Task Force suggested that the problem had been increasing recently. We understand that all trusts with PRHO posts that do not meet 'New Deal' requirements have been written to and given three months to address this matter.

200. We appreciate the difficulty of matching service commitments and educational needs. However, we hope the Deanery will continue to work with its NHS partners to ensure that all posts meet the nationally agreed standards.

Other issues

New rotations

201. The Deanery has introduced 11 three by four month rotations providing experience in primary care, two such rotations involving accident and emergency medicine (A and E) and two including posts in paediatrics.

202. All these rotations were welcomed by the trainers and PRHOs to whom we spoke. As mentioned in paragraph 181, PRHOs in primary care posts have enjoyed excellent educational opportunities and supervision. We have already commended the Day Release Course for GP PRHOs. The paediatrics rotations were also highly thought of by the trainees whom we met.

203. We were told that the two rotations involving A and E, which started in August 1999, were very popular. The A and E posts are supernumerary and involve close supervision by senior colleagues. The PRHOs with experience of these posts confirmed that they provided experience of a vast range of clinical problems, the opportunity to develop and apply a variety of practical skills and a wealth of

educational opportunities.

204. We were impressed with the new rotations which the Deanery has introduced. These have clearly helped to improve general clinical training provision within the region. We hope that such rotations will form the model for any expansion of PRHO posts that may occur to cope with increasing student numbers.

Areas of good practice

205. *Supervisory structures:* We were pleased that PRHOs play a very active role in the Pre-Registration Year Committee. The Deanery has clearly benefited from their involvement. The close links which have been forged with the School of Medicine have also helped to ensure a seamless transition between undergraduate medical education and general clinical training within the region.

206. *Fitness to practise:* The Deanery is to be commended for working with the School of Medicine to establish a fitness to practise committee that will consider PRHOs who do not maintain the high professional standards expected of doctors.

207. *Staff development:* The Deanery has placed great emphasis on establishing a sound staff development programme for educational supervisors. By ensuring that all educational supervisors will have received appropriate training by April 2000, the Deanery has signalled the importance that it attaches to providing high quality education and training for PRHOs.

208. *GP Day Release Course:* PRHOs that had undertaken posts in primary care had found these a very worthwhile educational experience. The Day Release Course, which provides trainees with peer group support and the opportunity to discuss relevant matters, is a particularly noteworthy.

209. *Clinical training and support:* All the PRHOs we met confirmed that they received excellent support and guidance from the doctors with whom they worked. We were pleased to be told that clinical teams made a great effort to make sure that all PRHOs felt valued members of the team.

210. *New rotations:* Trainees and staff were very enthusiastic about the new three by four month rotations which the Deanery has introduced. The rotations which include experience in accident and emergency medicine, and paediatrics were particularly well thought of. We welcome these new posts and hope that they will act as the template for any new PRHO posts that might be introduced.

Areas for further consideration

211. *Disseminating good practice:* It was not evident to us that there is an effective mechanism for disseminating examples of good practice within the region. We think the Deanery should explore ways of ensuring that best practice is more widely shared among its NHS partner.

212. *Educational opportunities:* Although educational opportunities are made available to all PRHOs, they were not always able to take advantage of these due to working practices or service demands. We were told that the quality of bleep filtering is variable and that covering a large number of beds while on-call made it difficult to make best use of the educational opportunities afforded by posts. The Deanery will wish to work with its NHS partners to ensure that all PRHOs can benefit from the training that is available.

213. *Educational supervision:* Educational supervisors appreciated the staff development programme which the Deanery has set in place. However, those not intimately familiar with the Manchester undergraduate PBL course indicated that they would find more information about the philosophy and practice behind PBL helpful. This seemed a sensible request to us.

214. Most PRHOs had had appraisal meetings with their educational supervisors, and such meetings were generally helpful. However, the Deanery will wish to explore with educational supervisors the shortcomings we have identified at paragraph 194, to ensure that the appraisal system is rigorous and worthwhile for all trainees.

215. *Partial shifts:* Some trainees complained about the detrimental impact that partial shifts had on continuity of patient care. This is not a problem for the North West Region alone and we were told that the Deanery is working with its NHS partners to come up with some innovative schemes that would ameliorate the impact of partial shifts. We would be grateful for further details about these schemes.

216. *Contractual matters:* While we appreciate the difficulty of meeting service demands, we were concerned to learn that many PRHOs were working beyond their contracted hours and not taking all the rest time to which they were entitled. The Deanery and its NHS partners are clearly aware of this problem, but efforts must be made to ensure that nationally agreed standards are met.

Conclusion

217. We were pleased to find that the Deanery has set in place the infrastructure necessary for providing high quality PRHO education and training, including a rigorous system of evaluation and appraisal. However, the Deanery and its NHS partners will wish to work together to ensure that working practices do not prevent PRHOs from deriving the maximum benefit from their posts. We look forward to hearing about the further progress made in a year's time.