

EDUCATION COMMITTEE

**REPORT OF THE VISIT TO THE SCHOOL OF MEDICINE AND
TO THE WESSEX DEANERY, UNIVERSITY OF SOUTHAMPTON**

7-8 DECEMBER 1999

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

Contents

	Page
Foreword	i-ii
Introduction.	1
Part 1: The undergraduate curriculum.	1
<i>Background information.</i>	1
<i>Form of the visit relating to undergraduate medicine.</i>	1
<i>The Southampton undergraduate curriculum.</i>	2
Curricular development	2
Structure and content of the curriculum	2
<i>The management of change (Principal Recommendation 13)</i>	3
Supervisory structures.....	3
The contribution of students.....	5
Staff development.....	5
The promotion of teaching as a valuable activity	5
<i>Aspects of the core curriculum (Principal Recommendations 1,2,5 and 7)</i>	6
Redefining the core curriculum	6
Reducing the burden of factual information.....	6
Integration.....	7
Learning through curiosity.....	8

<i>Special study modules (Principal Recommendation 6)</i>	9
<i>Delivery of the curriculum (Principal Recommendation 11)</i>	10
Teaching methods	10
Learning resources	11
<i>Changing patterns of health care (Principal Recommendation 10)</i>	11
<i>The goals of undergraduate education –attitudes, skills and knowledge</i>	12
Attitudes (Principal Recommendation 3)	12
Essential skills (Principal Recommendations 4 and 8)	13
IT skills	13
Communication skills	14
Clinical skills	14
<i>Aspects of the knowledge base</i>	15
Public health medicine (Principal Recommendation 9)	15
Legal and ethical issues	15
Medicine in a multicultural society	16
Complementary medicine	16
Basic and advanced life support	16
Infectious diseases and antibiotics	16
<i>Assessment of the process and the product (Principal Recommendation 12)</i>	17
The outcome of the course	17
The scheme of assessment	17
Fitness to practise	18
Preparation for the pre-registration year	18
<i>Other issues</i>	18
Student support	18
Feedback to students	20
Quality control	21
<i>Areas of good practice</i>	22
<i>Areas for further consideration</i>	23
<i>Conclusion</i>	24
Part 2: General clinical training	25
<i>Background information</i>	25
<i>Form of the visit relating to general clinical training</i>	25
<i>Organisation and management of the PRHO year</i>	25

Supervisory structures	25
The approval of posts	26
Communicating the aims and objectives of the PRHO year	26
The selection of PRHOs	27
Monitoring the quality of PRHO posts	28
<i>Components of a high quality PRHO post</i>	28
Induction	28
Educational opportunities	29
Educational supervision	30
Clinical training and supervision	31
Monitoring the progress of PRHOs	32
<i>Professional development and personal well-being</i>	32
Careers advice	32
Support for PRHOs	33
Accommodation, catering and personal safety	33
Contractual matters	34
<i>General clinical training in general practice</i>	34
<i>Areas of good practice</i>	34
<i>Areas for further consideration</i>	35
<i>Conclusion</i>	36
Annexes	
Diagram representing the structure and content of the curriculum A	Annex
Diagram representing the current organisational structure of the curriculum B	Annex
Overview of 'Teaching Tomorrow Doctors' staff development programme C	Annex
Description of the Special Study Module programme in Southampton D	Annex
Details of the TULIP computer-assisted learning programme E	Annex
List of core clinical skills and practical procedures F	Annex

Plans for future clinical skills training for students G	Annex
Draft report on public health medicine provision H	Annex
Report on the current resuscitation training programme and proposals for its expansion I	Annex
Diagrammatic representation of the curriculum and the assessment structure J	Annex
Criteria determining student progress throughout the curriculum K	Annex
Draft policy for ensuring the fitness for practise of students L	Annex
Assessment form for Year 3 clinical attachments M	Annex
Summary of general clinical training provision N	Annex
Summary of the recommendations of the PRHO Millennium Group O	Annex
PRHO evaluation questionnaire P	Annex
Summary of the Agreement for Postgraduate Medical and Dental Education Q	Annex
Programme for the 1999 PRHO Matching Scheme Fair R	Annex
Flow chart describing the stages and timescale of the PRHO matching scheme for August 2000 S	Annex
Checklist for review of PRHO/SHO posts T	Annex
Results of PRHO feedback 1998/99 U	Annex

Form for monitoring the Agreement for Postgraduate Medical
and Dental Education
V

Annex

Policy document on PRHOs in difficulty
W

Annex

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. Our visit had two purposes:

To review progress made by the School towards implementing the recommendations in *Tomorrow's Doctors* since our last visit in 1997, with a focus on the predominantly clinical years of the course.

To monitor progress towards implementing our guidance on the pre-registration year, as set out in *The New Doctor*.

2. Our team was led by Professor Graeme Catto, the Chairman of the Education Committee. The other members were Dr Joan Trowell, a member of the Education Committee, Professor Roger Green, a member of Council and former member of the Committee, and Mrs Angela Macpherson, a lay member of Council.

3. Our visit lasted two days, with the first day devoted to the undergraduate curriculum and the second day to the arrangements for 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. Our report is in two parts, reflecting the nature of our visit. In part one we look at the further progress made towards implementing the recommendations in *Tomorrow's Doctors* and discuss the School's plans for future development. In part two of our report we consider the arrangements for general clinical training in the light of our guidance in *The New Doctor*.

5. In both parts of our report we have identified areas of good practice and issues 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. The School also made available to the QAA copies of the questionnaire which it had compiled for us.

Form of the visit relating to undergraduate medicine

7. The day began with a meeting with senior members of the School to gain an overview of the curriculum and to discuss developments since our last visit. Later we had discussions with key staff involved in the day-to-day delivery of the undergraduate programme and with a group of students drawn from each year of the course.

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

9. During the day we were also able to view some of the excellent clinical skills teaching facilities and learning resources available to students. Throughout the visit the team had access to all the materials prepared by the School for the QAA visitors.

The Southampton undergraduate curriculum

Curricular development

10. Mindful of the major changes made by many medical schools following the publication of *Tomorrow's Doctors*, we commented in 1997 that the School might not have taken full advantage of this opportunity to review its own approach to curricular development.

11. Recently a number of modifications have been made to the curriculum to ensure that it reflects all aspects of *Tomorrow's Doctors*, and further changes are planned. Work is already well advanced in defining a core curriculum which aims to enhance the learning experience of students. Over the next three years the School intends to:

increase clinical contact in the early years of the curriculum by moving the Clinical Skills and Family Study course from Year 2 to Year 1 and some Primary Medical Care and other clinical sessions from Year 3 to Year 2

teach more basic science in Year 3 by relocating course material from the earlier years

develop further the teaching of communication skills

increase public health medicine teaching in Years 3 and 4

develop further the teaching and assessment of clinical skills

increase student exposure to community-based teaching in Year 3 by expanding courses in psychiatry, rehabilitation and child health

develop more opportunities for interprofessional learning.

12. We fully support the School in its plans for curricular change and look forward to learning how these are progressing.

Structure and content of the curriculum

13. A diagram representing the structure and content of the curriculum is at **Annex A**.

14. The early years of the course are designed to promote integration of the relevant scientific knowledge in a clinical context, providing the students with a framework for improved understanding of the scientific basis of medicine. A systems-based approach with combined teaching from clinicians and scientists is twinned with early patient contact, allowing students the opportunity to meet patients and their families in the first month of their studies on the Practice of Medicine course. The emphasis is on patients' experiences, feelings and perceptions with the objective of encouraging good communication and a patient-centred approach to practice.

15. The SSM programme, described in detail later in our report, commences in Year 2 when groups of students choose a topic of interest to explore throughout the year. They present their findings in a poster presentation and viva voce examination at the end of the year.

16. Students in Year 3 concentrate on the continuing development of their clinical skills, the reinforcement of the sciences acquired in Years 1 and 2 and their application to clinical disorders. The skills of integration are encouraged by the Scientific Basis of Medicine course. This comprises a series of clinico-pathological symposia which highlight the interrelationship between clinical practice, the sciences and laboratory-based disciplines. The course is described in further detail in paragraph 38 of our report. The Intermediate BM examination takes place at the end of Year 3 following clinical attachments in primary, community and secondary care settings, requiring students to demonstrate their ability to integrate basic and social sciences from the early years of the course in a clinical context.

17. The accent in Year 4 falls increasingly on student-centred learning. The clinical elective at the very start of the year affords students the opportunity to experience healthcare in a clinical placement overseas, while for much of the rest of the year students are undertaking their clinical attachments or are engaged in substantive research for the Study in Depth project. This project is designed to develop their skills in research methodology, literature-searching, written and oral communication and critical evaluation. The Department of Medical Statistics and Computing run a course on research methods to assist students in their work on the project. Students produce a written report of the results of their research which is assessed by two examiners. They also organise a conference at the end of Year 4 at which they present their findings to colleagues and staff.

18. Students on their clinical placements throughout the Wessex region in Year 5

have access to a wide range of clinical problems in primary care, community hospital and district hospital settings. Allocated to a specific clinician within the team, they receive teaching on an individual basis. They also have the opportunity to 'shadow' a pre-registration house officer (PRHO), enabling them to enhance their clinical skills and to perform simple practical procedures under close supervision.

The management of change (Principal Recommendation 13)

Supervisory structures

19. The diagram at **Annex B** describes the current organisational structure underpinning the undergraduate curriculum.

20. Reporting to the School Board for Medicine, the Education Management Committee (EMC) is responsible for strategic curriculum development, the establishment of teaching, learning and assessment policies and for ensuring that the overall aims and objectives of the curriculum are met.

21. The membership of the EMC comprises:

- the Head of School
- the Medical Education Co-ordinator
- the Postgraduate Dean
- the Clinical Sub-Dean
- the Head of Medical Education
- the Director of Education for Southampton University Hospital Trust (SUHT)
- the Year Co-ordinators.

22. The EMC regularly commissions audits of teaching and learning activities from working groups it has appointed. We were told that recently it had considered reports and recommendations from working groups on a review of Year 4 and about ways of increasing communication skills training and community-based teaching in the curriculum.

23. Each year of the undergraduate course is managed by a Steering Group, chaired by the Year Co-ordinator, apart from Years 1 and 2 which has a combined steering group. Students are well represented on these groups and are able to offer timely comment on how their courses are progressing. Each steering group produces an annual evaluative report for the Quality Assurance Committee.

24. The School has instituted a number of additional measures to ensure it retains control of the scope and quality of student learning. These include:

- regular meetings with the Director of Education from Southampton University Hospital trust (SUHT)

- the identification within each SUHT directorate of a lead consultant for undergraduate teaching who meets regularly with the School's Education

Co-ordinator and Clinical Sub-Dean

regular monitoring visits to all NHS hospital sites where teaching takes place.

25. In 1997 we noted that 'a large number of groups were involved in oversight of the curriculum and wondered whether there might not be scope for some rationalisation'. On our return we were encouraged to find that these groups had been significantly reduced in number, allowing the supervisory structure to be simplified and strengthened. In our view this streamlining has resulted in lines of responsibility and accountability being more explicitly defined.

The contribution of students

26. We were pleased to learn that, having a voice in all major educational committees of the School, students are able to influence curricular development. Student representatives meet regularly with course co-ordinators to discuss the organisation and content of the curriculum. As a result of these discussions the Scientific Basis of Medicine course has recently been modified and student exposure to teaching in general practice has been increased.

27. Course evaluation forms provide students with an additional means of registering their views on the curriculum. The student perception is that the School is responsive to criticism and proposals for change, and takes action where necessary.

Staff development

28. The School has introduced a number of measures to promote the development and training of its staff. These include:

'Teaching Tomorrow's Doctors' courses organised by the Medical Education Department. By the end of 1999 64 teachers had completed this five-day programme, first offered in 1997/98. An overview of the course is at **Annex C**.

Additional training sessions open to all involved in teaching medical students.

The introduction of peer observation of teaching, providing teachers with the opportunity to receive feedback on their performance and to observe and to comment on the teaching of their colleagues.

Separate training workshops specifically designed for both new and experienced teachers in general practice many of whom are geographically distant from the School of Medicine.

The provision of a staff development site on MEDIS, the School's Intranet, focusing primarily on the use of IT.

The establishment of a working party to co-ordinate staff development between the School and its local NHS trusts.

29. We were interested to hear about these developments and opportunities, most of which had occurred following our last visit in 1997.

The promotion of teaching as a valuable activity

30. The School has a policy of encouraging and rewarding teaching excellence and demonstrates this by including teaching ability among the key criteria to be met by staff seeking promotion. Amongst the other options it is actively considering are:

the redefinition of SIFT contracts to reflect teaching activity and quality

the appointment of valued NHS teachers to an honorary clinical senior lecturer grade.

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

Redefining the core curriculum

31. Early in 1999 the School embarked on the iterative process of redefining the core curriculum. Focusing on key areas of the curriculum, a number of small working groups, drawn from School and NHS staff, set out to consider what the newly-qualified doctor needs to be able to do in order to practise effectively. The key areas were:

- communication relating to patients
- professional integrity
- support and development
- management
- clinical skills.

32. Having modified the list of core competencies required by graduates following extensive consultation with teachers, students and employees, the next step was to define the science underpinning them. A small team of clinicians and scientists undertook this work, developing a directory of key clinical presentations and producing details of the relevant science relating to common clinical areas. The resulting draft core curriculum has recently been circulated for comment to course co-ordinators and undergraduate tutors.

33. The School hopes to introduce its new core curriculum at the end of the current consultation period though we understand that time spent mapping the new onto the old curriculum and considering ways of increasing opportunities for interprofessional learning may delay implementation. We strongly support the School's initiative in seeking to redefine its core curriculum. Whilst appreciating the need for consultation, we hope that implementation of the agreed changes can begin in time to meet the increase in students numbers in 2000/2001.

Reducing the burden of factual information

34. Recent years have seen a dramatic reduction in didactic learning. The table below shows the amount of time allocated to lectures, small group work and self-directed learning in each year of the course:

	Average hours of lectures per week	Average hours of small group work	Average hours of self-directed learning
Year 1 and 2	10 x 45 mins 21%	8 x 45mins in groups of 10-14 17%	18 hours 61%
In total 14 hours of contact time and 21 hours of private study in Years 1 & 2			
Year 3	3 x 45 mins 6%	Varies from one to one to one to eight in clinical areas. Seminar teaching can be with 10-40 students up to 7 hours 9%.	Varies from week to week
Year 4	2 x 45 mins at certain points of the year 4%	Clinical attachments are in groups of 2-12. During the Study in Depth students are supported by a supervisor with whom they meet regularly on a one to one basis. Additionally there are group meetings with other students every 2-3 weeks.	The Study in Depth is mainly self directed so the amount of time varies from week to week
Year 5	None	Mainly on an apprenticeship basis with one student shadowing a PRHO/SHO or one student with one general practitioner. Apart from ward rounds and outpatients clinics, students meet with their supervising consultant for an hour each week for teaching.	The students are expected at this stage of the course to direct their learning according to their needs.

35. We understand that the process of redefining the core curriculum is likely to result in a further reduction in the factual content of the undergraduate course. We support this approach, taking the view that any proposed curricular changes should be balanced against the need to constrain factual overload.

Integration

36. The School regards vertical integration of clinical teaching and basic science as a key element of its course. This was evident to us, particularly in the early years of the curriculum.

37. Teaching in Years 1 and 2 is based primarily around the major body systems, with contributions from both basic scientists and clinicians. Clinical problems are presented to students with particular reference to the pathology and pharmacology of each body system. Development of clinical skills and clinical work with patients is a feature of these years through the Early Patient Contact, the Practice of Medicine and the Clinical Skills and Family Study courses.

38. The Scientific Basis of Medicine course in Year 3 comprises two discrete strands. In one, a series of plenary clinico-pathological symposia, with contributions from a range of practitioners, stresses the links between different disciplines and between the sciences underpinning medicine and clinical practice. The second strand is provided by a booklet of case histories, designed to illustrate important basic science topics in a clinical setting. These are used for independent study and research by students and by tutors and students in small group sessions. During this year students are also required to prepare four clinical science essays, relating the science they have learned from the first two years of the course to a patient whom they have clerked. The essays must cover one of each of the following areas of basic science: pathophysiology and biochemistry; anatomy and pathology; pharmacology; psychology and sociology. Forty percent of the marks in the Intermediate Examination at the end of Year 3 are allocated to these four essays. We were impressed by the integration of basic medical science and clinical work in Year 3, and consider that the Intermediate Examination is well placed to assess students' ability to integrate scientific and clinical knowledge.

39. The School told us that it encourages students as they pass through each stage of the course to link their clinical experience with their learning in the basic sciences. We commend this approach which is clearly visible in Years 1 to 3 but less evident in Years 4 and 5. We hope that the School will consider ways of increasing the degree of vertical integration in the senior years of the curriculum.

40. In 1997 we noted that 'despite the School's best endeavours there was evidence that teaching remained discipline-focused'. We know that the School has worked hard to address the level of horizontal integration in the curriculum, particularly in the way it has co-ordinated topics in Years 1 and 2. Nevertheless, we noted a propensity by students to refer to teaching being delivered in those years in terms of specific disciplines. We would encourage the School to continue its work to enhance this aspect throughout the curriculum.

Learning through curiosity

41. One of the key educational aims laid down by the School is 'to encourage students to think critically and to develop the ability to learn independently'. The School sets out to achieve these objectives by using a variety of learning methods and approaches, including:

exposure to patients during the Practice of Medicine and the Clinical Skills and Family Study programmes in Years 1 and 2. Students confirmed that this experience helped to inform and to focus their learning at an early point in the course.

General interest essays in Year 1 and clinical science essays in Year 3 designed to promote wide-ranging and critical thinking.

Think Tank sessions. At the start of Year 2 students choose a topic of interest to them from a list drawn up by the School. Working in small groups of six to eight students, they research this topic in regular meetings before presenting their findings. Their end-of-year poster and viva presentation is assessed by a clinician and a scientist.

A series of SSMs undertaken one afternoon per week during medical, surgical and psychiatry attachments in Year 3.

A 9-week clinical elective at the start of Year 4.

The Study in Depth programme in Year 4. This 23-week SSM has been specifically designed to provide students with the opportunity to undertake a major self-directed learning project of their choice.

The 5-week Specialty module in Year 5 allows students to select clinical topics of particular interest to them from a list of options and to explore these in greater depth.

Lunchtime post-mortem demonstrations held regularly at Southampton General Hospital, open to students and other trainees.

42. The students whom we consulted were generally appreciative of the opportunities provided by the School to enable them to develop their intellectual curiosity, especially in the senior years of the course where the Study in Depth programme was singled out for particular praise.

Special Study Modules (Principal Recommendation 6)

43. The document at **Annex D** describes in detail the various components of the SSM programme in Southampton.

44. The amount of student time allocated to SSMs in each year of the course is

as follows:

Year 1	0%
Year 2	3%
Year 3	5%
Year 4	80%
Year 5	12.5%

45. Information about the options available in the Year 3 SSMs and in the Study in Depth programme is contained in student handbooks and is disseminated through a series of presentations given to the whole year by key members of the academic staff. In Year 3 students rank each of their options and these are allocated by means of an electronic matching system devised by the School. We were told that most students obtain one of their first three preferences. Students undertaking the Study in Depth programme in Year 4 meet individual supervisors for detailed discussion of the projects before making their final choice.

46. Students undertaking each element of the SSM programme from the Think Tank sessions in Year 2 to the Specialty module in Year 5 consider themselves well served in terms of academic and personal support. We subscribe to this view.

47. Completion of the SSM programme is mandatory for all students. With the exception of the modules in Year 3 it is a major determinant of student progression. Students must pass the Think Tank sessions in order to enter Year 3 whilst the submission of a satisfactory report on the Study in Depth project is a pre-requisite for admission to the final year of the course. We were told that although no overall gradings are awarded to students undertaking SSMs in Year 3, a degree of formative assessment is applied in the form of mini-quizzes or students being required to make oral representations about their subject of special study.

48. One of the concerns voiced by the student body during our 1997 visit was that the Study in Depth project in Year 4 limited their clinical contact with patients. This was not an issue for the current cohort of students who reassured us that they had successfully managed to combine their clinical and research commitments during the year. Indeed, they perceived the project to be an excellent means of undertaking substantive research into a topic which particularly interested them. We hope that the School will consider increasing the opportunities in the early years of the course for students to explore subjects which arouse their curiosity. One of the ways this could be achieved would be to establish a more extensive programme of SSMs in Years 1 to 3 and to review the current arrangements for the Think Tank sessions in Year 2 and the half-day SSMs in Year 3.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

49. Teaching is delivered and learning encouraged through a variety of methods, including:

lectures
tutorials and seminars
small group work
self-directed learning
laboratory practical sessions
clinical attachments in hospital and community settings
computer-assisted learning (CAL)
early clinical contact in the community
simulated clinical skills training
SSMs and project work
post-mortem demonstrations
work-shadowing of pre-registration house officers (PRHOs).

50. The School has developed learning portfolios to assist final year students in establishing their educational needs and to enable them to reflect their achievements and learning. These are currently being piloted with the expectation that they will be introduced for all Year 5 students in summer 2000, replacing the logbook presently in use.

51. Students valued the learning opportunities available to them throughout the course and were particularly appreciative of the high quality teaching delivered during their regional attachments in Year 5.

Learning resources

52. Students are fortunate to have access to a range of resources designed to assist their learning.

53. Medical students have access to approximately 800 computer workstations on campus designated for use by all students of the University. We were told that plans to increase these facilities at Southampton General Hospital were now well advanced. The students we consulted were generally satisfied with the number of PCs available though we noted that the School encourages those students who can afford to do so to buy their own computers as a means of improving access for their less economically privileged peers. It is estimated that by Year 4 more than 50% of students owned computers.

54. PCs with Internet links have been established in the nine general practices involved in the delivery of the Clinical Skills and Family Study course in Year 2 and in all thirteen regional centres used for clinical placements in Year 5.

55. Three major computer-assisted learning (CAL) projects have been developed: TULIP, an interactive learning package in psychiatry for Year 3 students; SCALPEL, a programme designed for teaching pathology practical sessions; and a computerised assessment package in human morphology. We saw impressive demonstrations of both TULIP and SCALPEL. Further information about the former can be found at **Annex E**.

56. We viewed the excellent facilities enjoyed by students at the Health Service

Library in Southampton General Hospital. They may also use the Biomedical Sciences Library at Boldrewood or any of the seven University Library branches. On their clinical placements students have access to local NHS libraries. The University Medical Librarian monitors the quality of this access by liaising regularly with NHS librarians.

57. We were told that five of the regional bases for final year clinical placements now have skills centres. The School arranged for us to see the clinical skills laboratory which has recently been developed at Southampton General Hospital. We are sure that this facility, the product of a combined enterprise involving the medical school, the nursing school and the local trust, will prove to be an excellent resource for students seeking to develop and practise their basic clinical skills.

Changing patterns of health care (Principal Recommendation 10)

58. The student perception is that the Southampton curriculum affords them ample experience in primary care and opportunities to follow up patients in the community.

59. During their Early Patient Contact and Practice of Medicine course in Year 1 students are able to follow patients at different stages of their care, including attendance at outpatient clinics and on home visits. Basic consultation skills are developed on the Clinical Skills and Family Study module in Year 2 when students are video-recorded whilst they interview patients. They review and reflect on their performance with their tutor. This module also involves four visits to the home of a mother and newly born baby in the company of the health visitor.

60. The Primary Medical Care course in Year 3 spans thirty mornings, comprising 23 visits to GP surgeries and 7 seminars during which students meet other members of the primary health care team. The mental health and geriatric medicine attachments allow students the opportunity to visit various units in the community and patients in their homes whilst they spend time at a nursery and a special school for children with disability on their child health attachment.

61. In Year 5 students are individually attached to a general practice in the Wessex region for three weeks, gaining particular experience of the managerial aspects of primary care. A pilot-based project had recently considered the efficacy of introducing a community-based attachment in Year 5. The evaluation of the pilot indicated that although students appreciated the supportive learning environment and valued the experience of working in a community hospital, they felt disadvantaged in not seeing so many patients with acute medical problems. As a result of the evaluation the School decided to discontinue the project, and to offer students the opportunity to gain community experience as a SSM in Year 5.

62. Following its successful bid for an expansion in students numbers to an intake of 200, the School plans to increase teaching in the community by expanding the mental health and community child health attachments in Year 3 and including a one week course in rehabilitation. The outcome will be a 3-month rotation, based predominantly in the community. To accommodate this initiative the

School intends to relocate the Clinical Skills and Family Study module in Year 1 and to move a significant proportion of clinical teaching, particularly in primary care, from Year 3 to Year 2. We fully support these proposals which we believe can only raise the profile of community-based education in Southampton.

The goals of undergraduate medical education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

63. Promotion of the attitudes and professional behaviour required for medical practice begins early and continues throughout the Southampton curriculum.

64. In the very first week of Term 1, small groups of students meet to discuss, agree and define the qualities required by a doctor for professional practice. Each group presents its findings to the rest of Year 1 and to members of staff. After the presentations students compare their conclusions with the principles set out in *Duties of a Doctor*.

65. This initial work is reinforced and referred to in the Early Patient Contact/ Practice of Medicine course, also in Term 1. Students are encouraged to explore patients' experience of their illness or disability and are introduced to the topics of confidentiality and consent.

66. During general practice attachments, we were told that teachers stress the importance of both the patient's attitudes and that of the doctor to the outcome of a consultation. The teaching of communication skills incorporates discussion of students' attitudes, which underpin their relationships with patients.

67. At the beginning of the third year, during preparation for more intensive work on the wards, students are given copies of *Duties of a Doctor*. This document is discussed in one of the Clinical Foundation course plenary sessions to remind students of the importance of developing attitudes of respect for patients and to promote awareness of the responsibilities attached to the doctor's role.

68. In Year 5 there is an introductory lecture on *Good Medical Practice* which includes a talk by representative from the GMC as well as a discussion on clinical governance with the Medical Director of SUHT. We were told that the fifth year portfolio will include the *Duties of a Doctor* card and will encourage students to reflect on attitudinal matters during their clinical attachments.

69. Students with attitudinal problems are quickly identified by their teachers and peers. In Year 2, 3 and 5 the School uses Objective Structured Clinical Examinations (OSCEs) to assess attitudes and behaviour.

70. During the primarily clinical years of the course students are taught by a wide range of teachers in a variety of settings. The students whom we met were aware of the importance of having good role models as teachers and clinicians and were confident of their ability to identify those whom they considered were not adequately fulfilling this responsibility. Teachers displaying inappropriate attitudes

or behaviour are removed from the teaching programme. We were told that this option is rarely used. Given the proportion of female students now entering medicine there will be benefit in having role models among the clinicians and academics with whom that group can specifically identify. We would ask Southampton, in common with other UK medical schools, to give thought to this.

71. We were interested to learn that the School has produced a booklet 'Making Links' for hospital-based teaching staff which specifically mentions the importance of the teacher as a role model. This message is reinforced in the Primary Care teachers' handbook and in staff development programmes.

72. It was clear to us that the School had taken great pains to define appropriate attitudes and to seek to inculcate these in its students. We were impressed by the explicit way in which the tenets of *Good Medical Practice* inform each stage of the curriculum.

Essential skills (Principal Recommendations 4 and 8)

IT skills

73. The development of effective IT skills is necessary from the very start of the course since the assessment at the end of the Foundation term is computer-based. This approach is evident throughout the rest of the curriculum where students are actively encouraged to communicate via email and are required to become proficient in the use of the School's Intranet. Additionally all essays must be word-processed.

74. Students are given library-based IT training in the use of biomedical and healthcare related databases and other web-based information resources. Advanced training sessions are available to students who wish to develop particular skills in search, retrieval, evaluation of information sources and the export of records.

Communication skills

75. In 1997 we invited the School 'to consider introducing a more coherent programme of communication skills training extending throughout the five years of the course, which would be managed in a more integrated way'.

76. The School has recently reviewed its communication skills training provision. A number of new initiatives have been introduced including:

the inclusion of communications learning objectives in all courses where appropriate, clarifying the specific areas to be developed for both students and teachers.

the appointment of two hospital consultants to provide communication skills teaching in Year 3. SIFT money has been used to fund one session per week. Both consultants have been charged with the task of developing a

communication skills programme integrated across the year.

Objective Structured Clinical Examinations (OSCEs) to assess competence in communication skills in the Clinical Skills and Family Study (CSFS) course in Year 2, the Primary Medical Care attachment in Year 3 and in the Final Examination at the end of Year 5. Nine of the sixteen stations in the Finals OSCE are specifically linked to communication skills assessment.

77. Communication skills teaching is integrated with other teaching in the Southampton curriculum, occurring predominantly in the Clinical Skills and Family Study in Year 2 and during the Clinical Foundation course and the Primary Medical Care attachment in Year 3. The School is keen to extend this teaching more widely throughout the course. We were told that it is currently seeking to appoint a communication skills facilitator who is not a doctor to take this work forward. We would support the School in its plans for expansion of this important area and encourage it to build on the progress which has already been made.

Clinical skills

78. The School's current list of core clinical skills and practical procedures is set out at **Annex F**. Students are expected to learn these skills as they progress through the course.

79. Students gain some initial exposure to history-taking and other specific clinical skills during their visits to general practices in Year 2 but it is the Clinical Foundation course at the start of Year 3 which provides their major introduction to clinical skills training. During this six-week course students develop basic clinical skills under the supervision of a consultant (and sometimes jointly with each other) supported by junior medical staff or a general practitioner. In 1997 we were told by students that, despite the opportunities provided by the School for early clinical contact, they felt ill-equipped to begin clerking patients in Year 3. This was not identified as a particular problem by the students whom we met in 1999 but some indicated that they had experienced difficulty in taking bloods when moving onto the wards in Year 3. Although they had been taught this procedure in Year 2, no formal assessment of their competence had been conducted by the School. In effect students decided themselves whether or not they were competent in basic clinical skills. We believe that the School should assess these skills and provide feedback to students on the level of their proficiency at each stage of their training.

80. Although the School has recently introduced an OSCE into the Final examination explicitly for the purpose of assessing competence in clinical and communication skills, it readily acknowledged that there is currently no mechanism for recording students' exposure to and acquisition of clinical skills. Work has now begun on the development of an electronic logbook for recording the attainment of clinical skills. Further information about this initiative and details of planned clinical skills teaching in the School can be found at **Annex G**. We strongly support the School in its plans for further development of the teaching and assessment of clinical skills. We note the recent opening of the clinical skills laboratory at

Southampton General Hospital and look forward to hearing how this develops.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

81. The draft report at **Annex H** includes information about the historical development of the public health medicine course in Southampton and details of the School's plans to introduce a new programme in public health medicine.

82. In our view and that of the students with whom we spoke, the teaching of public health medicine is currently well integrated into different parts of the Southampton curriculum. However, we welcome the School's proposals to increase both its extent and the degree of its integration in the later years of the course as suggested in our 1997 report.

Legal and ethical issues

83. Consideration of legal and ethical issues forms a vertical strand running through the predominantly clinical years of the undergraduate programme.

84. Ethical topics are discussed and explored during many of the clinical attachments in Year 3 and in the seminars on the Primary Medical Care course in the same year. The two-day Law and Ethics course in Year 4 provides students with dedicated time for consideration of legal and ethical issues, (for example, obtaining informed consent for treatment from a patient) and the opportunity to revisit the precepts of *Duties of a Doctor*. They also attend a series of lectures which relate to the ethical and legal obligations of a doctor to patients, colleagues and the public. In recent years these lectures have been given by a member of the University's Department of Law or by a spokesperson from a human rights organisation, such as Amnesty International.

85. Although the Law and Ethics course is not formally assessed, we were told that these important areas now form part of the Final examination where students must write an essay about ethical issues.

Medicine in a multicultural society

86. In 1997 we commented on the few opportunities available to students in Southampton to prepare themselves for medical practice in a multicultural society.

87. The School has responded positively to our comments. During the summer vacation at the end of Year 1 students are asked to prepare some written work using a distance learning health care package, Cultural and Religious Equality in Education (CARE). The issues raised by this work form the basis for discussion by students as they meet in multiprofessional groups in Year 2. A learning package 'Valuing Diversity' has been incorporated into the Primary Medical Care attachment in Year 3. We were pleased to discover that the School encourages students to reflect on their own cultural background and that of their patients as they move

through the entire course.

Complementary medicine

88. Students have the option of choosing a Think Tank project on complementary therapy in Year 2 and an SSM in complementary medicine in Year 3. During their palliative care attachment in Year 3 students are made aware of the various alternative therapies and techniques which may be used to provide pain relief for patients whilst a demonstration of the use of acupuncture is often a feature of their general practice attachments.

Basic and advanced life support

89. The report at **Annex I** provides details of the current resuscitation training programme in Southampton and describes the proposals for its expansion which we fully support.

90. In our discussions on general clinical training we noted that many trainees expressed a lack of confidence in the level of their practical skills at the beginning of the PRHO year. It is our view that the introduction of an Advanced Life Support (ALS) course in the later stages of the undergraduate curriculum or during the PRHO shadowing attachment would help to provide both the School and its trainees with the necessary reassurance in this respect. We invite the School to give further consideration to this proposal as part of its overall strategy for additional development of the teaching and assessment of clinical skills.

Infectious diseases and antibiotics

91. Students have opportunities to learn about antibiotic resistance and infectious diseases at various points in the course. Microbiology infection teaching occurs in Years 1 and 2 whilst plenary sessions on infection control and antibiotic resistance feature during the Scientific Basis of Medicine course in Year 3.

92. We were told that the School hopes to establish a Department of Infectious Diseases in the near future.

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

The outcome of the course

93. The School has based the aims and objectives of the course on those set out in *Tomorrow's Doctors*. The schedule of assessment is designed to enable students to demonstrate satisfactory progress towards establishing a sound knowledge base, appropriate attitude to patients and colleagues and the necessary clinical skills to practise as a doctor.

The scheme of assessment

94. At **Annex J** is a diagrammatic representation of the curriculum and the

assessment structure. The document at **Annex K** details the criteria for determining student progression through each year of the course.

95. We were told that the various methods used to assess student progress were specifically chosen to reflect the range of learning objectives in the course. For example OSCEs assess clinical and communication skills development in addition to students' attitudes to patients. Essay assignments evaluate students' ability to define a topic area, analyse and synthesise information and to write effectively. Group working skills can be assessed through project work and clinical skills through case presentations.

96. The School now has no single discipline-related examinations in the curriculum. Particular emphasis is placed on assessment methods which test the integration of basic and clinical science as in the BM Intermediate Examination at the end of Year 3. Students' understanding of the basic biomedical behavioural sciences, taught mainly in Years 1 and 2, is evaluated after they have completed a year of clinical attachments. We commend this approach, assessing student learning of fundamental disciplines within appropriate clinical contexts. We also welcome the inclusion of an integrated OSCE in the BM Final Examination, ensuring that students' knowledge, skills and attitudes are being tested.

97. The School's assessment arrangements are subject to continuous monitoring and review. This has resulted in a recent change to the format of the long case examination in Finals. From November 1999 it has been agreed that examiners will return with the candidate to the patient for demonstration of the physical signs. This will ensure direct observation of candidates' clinical skills.

98. The School has considered the suggestion we made on our last visit that the BM Primary Examination at the end of Year 1 might place undue pressure on students. It has decided to retain this examination on the grounds that it affords an early means of identifying students in difficulty. As the next summative assessment in the course does not occur until the end of Year 3, we can understand the reason for the School's decision.

99. It is of course appropriate that the School employs a variety of systems to assess its students but it seemed to us that too great a reliance was being placed on the use of essays for this purpose. For example students told us that they were required to complete two examination essays per term in Year 2 alone. We would encourage the School to explore additional ways of testing student knowledge.

Fitness to practise

100. The School is acutely aware of its responsibility for ensuring the fitness for practise of its students. With this in mind it has recently submitted proposals to the Faculty Board clarifying its procedures for monitoring this issue and for dealing with any problems which are identified. A copy of this paper is at **Annex L**. We commend these proposals and look forward to learning in due course whether they are to be implemented in full.

101. We were pleased to hear that effective channels of communication have been established between the medical school and the deanery for exchange of information about students and trainees who may be in difficulty. The Clinical Sub-Dean and Associate Postgraduate Dean meet to discuss students with potential problems before the PRHO matching scheme takes place each year.

Preparation for the pre-registration year

102. Students are currently expected to spend two weeks 'shadowing' a pre-registration house officer (PRHO) as part of their ten-week attachment to a clinical firm in Year 5. The feedback we received from PRHOs suggested that they found this integrated experience to be helpful grounding for their work as pre-registration house officers, though many considered this experience would have been more valuable if acquired in the unit where they would be employed following graduation.

103. The School has been active on this issue. The Year 5/6 Working Group is due to report shortly on a proposal to introduce a discrete shadowing attachment of one week's duration located after the BM Finals Examination.

Other issues

Student support

104. The School has worked extremely hard to create a caring and supportive environment for its students. This was clearly evident in the feedback we received from students who spoke positively of the range of support systems available to them.

105. For new students much of their first week is organised around induction. The Faculty stages an induction day for all health-related students, with an introduction by the Dean and contributions from the chaplaincy, computing, health and counselling services. After watching a video which identifies misconceptions about attending university and explains the roles of health care professionals in the healthcare team, students gather in mixed professional groups to discuss the reasons why they chose their respective courses. During this week new medical students meet their personal tutors and are introduced to the library, computing and other facilities in the University. They are also be inducted into the student family system organised by MEDSOC, the medical students society. Under this scheme first-year students are befriended and looked after by a 'mother' and a 'father' from the years above. Regular meetings of 'families' are timetabled in Years 1 and 2 but we were told that this system has been so successful that in many cases contact has been maintained throughout the course.

106. Students are well served in terms of both academic and personal support. We noted in particular that the following mechanisms had been put in place for this purpose:

Foundation Term tutorials. These weekly tutorials in Term 1 provide students

with a forum for discussing issues associated with working in a university setting and the opportunity to explore study skills and to develop increased responsibility for their own learning.

The Student Support and Development Sub-Committee comprising staff and students from each year of the course. This Sub-Committee, established in 1997, is active in making recommendations for the continuing development of the support system. It has produced guidance in handbooks for students and tutors.

Personal tutors are allocated to all new students. The School Office arranges specific appointments for meetings once a term during Year 1. Thereafter, it is the joint responsibility of tutor and tutee to organise regular meetings. Tutors are informed of student grades throughout the course and of any illness, absence or of any difficulties their tutee may experience, either academic or personal. They also act as an advocate for their tutees, representing their interests to the School of Medicine and writing references if required.

Pastoral tutor system. Three pastoral tutors have been appointed by the School to take an interest in the welfare and to monitor the progress of a particular cohort of students from their arrival through the first two years of the course. Pastoral and personal tutors may share information concerning students as appropriate and, with student consent, may liaise with other professionals, such as the University's student counsellors. The pastoral tutor interviews students who have failed an assessment to discover the strategies for study they used in preparation for the examination, to enquire why they thought they failed and to advise on remedial action. These students may be asked to see their pastoral tutor on a regular basis.

The Clinical Sub-Dean takes on responsibility for providing students in Years 3-5 with support and guidance. She meets regularly with the Education Co-ordinator and maintains close links with clinical course co-ordinators, undergraduate tutors in hospitals outside Southampton and the Postgraduate Dean. She will also act as an advocate for students during formal enquiries instituted under the School's fitness for practise procedures.

Undergraduate tutors perform a similar role to the pastoral tutors and the Clinical Sub-Dean but are located and work in the regional centres where the Year 5 attachments take place. They are responsible for the pastoral care of Southampton students attached to their hospital and for monitoring their progress. They also ensure that teaching sessions are organised and that student feedback is utilised.

University Health Service and Counselling Services.

A 'listening service' whereby students can discuss confidentially with a

retired doctor issues of concern to them.

107. The School ensures there is no sudden exposure to clinical work by introducing this gradually to new students in the early Patient Contact courses in Years 1 and 2 and the Clinical Skills and Family Study course in Year 2. During the Clinical Foundation course at the beginning of Year 3 students are attached in groups of three to a tutor who supports them through their early learning of history-taking and physical examination.

108. Students are reimbursed the cost of travel to centres outside Southampton. This is managed through contributions which they make individually to a travel fund each year, claiming back travel costs as required. We thought this was a sensible and fair system.

109. We were told that any student leaving medicine would be counselled by their personal or pastoral tutor, and offered assistance through the University Careers Service if they wished to transfer to another degree course in the University. Students who leave medicine after Year 3 and have met certain other academic criteria are eligible for the award of a Bachelor of Medical Science degree.

110. The School is to be commended for the efforts it has made to ensure that its students feel valued and supported.

Feedback to students

111. Following our 1997 visit we remarked that 'the quality of feedback to individual students was very variable. Written work was not always subject to the detailed comment that the students had expected and was sometimes slow to be returned.' On our return we were pleased to learn that the School had taken these comments to heart and had extended the range of mechanisms which allow students to assess and to analyse their progress throughout the course.

112. In Years 1 and 2 students are given their marks in the individual components of each end-of-term assessment so they can judge their respective strengths and weaknesses. They also receive written feedback on the essays that form part of the assessment. The introduction of video-recording of consultations with patients in the Clinical Skills and Family Study (CSFS) course in Year 2 has provided students with the opportunity to review their performance with their tutors and to receive feedback on their progress. This was perceived to be an instructive and educational experience by students.

113. Students in the predominantly clinical years of the course spoke positively of the level of feedback they received on their individual performance. Advice and guidance about their communication skills techniques are given following video work on the Clinical Foundation course or following their presentation of a patient. Recently a revised assessment form has been introduced to enable students to obtain more information about the outcome of their clinical attachments in Year 3. A copy of this form, which asks consultants and general practitioners to discuss the content of their assessments with individual students, is at **Annex M**. The School

recommends that all teachers observe this practice in the later clinical attachments in Years 4 and 5.

114. A new form has also been devised which encourages students to make a critical appraisal of their essays in Year 3 and to seek specific feedback from their markers. In Year 4 regular meetings with supervisors allow students to gauge their progress, whilst they receive independent feedback on their Study in Depth projects in the form of written comments from their supervisors.

115. Students considered they were kept well abreast of curricular developments and able to influence these if necessary through the return of evaluation questionnaires and their representation in all the key educational committees of the School.

116. We were impressed by the School's initiatives to improve both the quantity and quality of feedback throughout the course. Students appreciated the efforts that had been made on their behalf and welcomed the responsive approach of the School to their suggestions for change.

Quality control

117. Since our last visit in 1997 the School has restructured its quality reporting routes and has clarified its quality procedures. The Medical Education Committee has been replaced by a smaller Education Management Committee and an Examinations and Assessment Sub-Committee has been established. Annual monitoring of all courses has also been implemented.

118. The current organisation structure of the curriculum is described in the diagram at **Annex B**. Reporting to the Education Management Committee, the Quality Assurance Committee oversees the internal quality mechanisms of the School and is responsible for sending the Annual Quality Statement to the Faculty.

119. The quality of each course within the curriculum is monitored through the return of student questionnaires. Each year an evaluative report is compiled containing details of changes which have occurred in a particular course, the results of the analysis of the questionnaire, student and staff comments and, in some cases, a summary of the assessment results. The report concludes with a list of recommendations to be implemented when the course next runs. The Clinical Sub-Dean also visits all hospitals in the region where medical students are trained, producing an annual evaluation of each of these centres which is included in the Year 5 Steering Group Report.

120. The University undertakes a quinquennial review of each of its departments, including the School of Medicine. In this Assessment of Departmental Performance the review panel is chaired by a member of another Faculty and an external reviewer chosen by the School. After scrutiny of relevant documentation and discussions with staff and students, the panel produces a report containing recommendations for change or improvement. The report, and the School's response, are presented to Senate. In the following year, the School is required to

give an account of the action it has taken to meet the recommendations made by the review panel.

121. It seemed to us that the School had introduced sound mechanisms for ensuring the quality of teaching and learning.

Areas of good practice

122. *The contribution of students:* We were pleased to learn that, having a voice in all major educational committees of the School, students are able to influence curricular development (paragraph 26). The student perception is that the School is responsive to criticism and proposals for change, and takes action where necessary (paragraph 27).

123. *Study in Depth project:* The students whom we consulted were generally appreciative of the opportunities provided by the School to enable them to develop their intellectual curiosity, especially in the senior years of the course where the Study in Depth programme was singled out for particular praise (paragraph 42).

124. *Teaching in Year 5:* Students valued the learning opportunities available to them throughout the course and were particularly appreciative of the high quality teaching delivered during their regional attachments in Year 5 (paragraph 51).

125. *Attitudes:* It was clear to us that the School had taken great pains to define appropriate attitudes and to seek to inculcate these in its students. We were impressed by the explicit way in which the tenets of *Good Medical Practice* inform each stage of the curriculum (paragraph 72).

126. *The BM Intermediate Examination:* Students' understanding of the basic biomedical behavioural sciences, taught mainly in Years 1 and 2, is evaluated after they have completed a year of clinical attachments. We commend this approach, assessing student learning of fundamental disciplines within appropriate clinical contexts (paragraph 96).

127. *Fitness to practise:* The School is acutely aware of its responsibility for ensuring the fitness for practise of its students. With this in mind it has recently submitted draft proposals to the Faculty Board clarifying its procedures for monitoring this issue and for dealing with any problems which are identified. We commend the proposals and look forward to learning in due course whether they are to be implemented in full (paragraph 100).

128. *Student support:* The School has worked extremely hard to create a caring and supportive environment for its students. This was clearly evident in the feedback we received from students who spoke positively of the range of support systems available to them (paragraph 104).

129. *Feedback to students:* We were impressed by the School's initiatives to improve both the quantity and quality of feedback throughout the course. Students appreciated the efforts that had been made on their behalf and welcomed the

responsive approach of the School to their suggestions for change (paragraph 116).

Areas for further consideration

130. *Implementation of the new core curriculum:* We strongly support the School's initiative in seeking to redefine its core curriculum. Whilst appreciating the need for consultation, we hope that implementation of the agreed changes can begin in time to meet the increase in students numbers in 2000/2001 (paragraph 33).

131. *Integration:* The School told us that it encourages students as they pass through each stage of the course to link their clinical experience with their learning in the basic sciences. We commend this approach which is clearly visible in Years 1 to 3 but less evident in Years 4 and 5. We hope that the School will consider ways of increasing the degree of vertical integration in the senior years of the curriculum (paragraph 39).

132. In 1997 we noted that 'despite the School's best endeavours there was evidence that teaching remained discipline-focused'. We know that the School has worked hard to address the level of horizontal integration in the curriculum, particularly in the way it has co-ordinated topics in Years 1 and 2. Nevertheless, we noted a propensity by students to refer to teaching being delivered in those years in terms of specific disciplines. We would encourage the School to continue its work to enhance this aspect throughout the curriculum (paragraph 40).

133. *Special Study Module programme:* We hope that the School will consider increasing the opportunities in the early years of the course for students to explore subjects which arouse their curiosity. One of the ways this could be achieved would be to establish a more extensive programme of SSMs in Years 1 to 3 and to review the current arrangements for the Think Tank sessions in Year 2 and the half-day SSMs in Year 3 (paragraph 48).

134. *The teaching of communication skills:* In 1997 we invited the School 'to consider introducing a more coherent programme of communication skills training extending throughout the five years of the course, which would be managed in a more integrated way' (paragraph 75). The School is keen to extend this teaching more widely throughout the course. We were told that it is currently seeking to appoint a communication skills facilitator who is not a doctor to take this work forward. We would support the School in its plans for expansion of this important area and encourage it to build on the progress which has already been made (paragraph 77).

135. *Practical skills:* In our discussions on general clinical training we noted that many trainees expressed a lack of confidence in the level of their practical skills at the beginning of the PRHO year. It is our view that the introduction of an Advanced Life Support (ALS) course in the later stages of the undergraduate curriculum or during the PRHO shadowing attachment would help to provide both the School and its trainees with the necessary reassurance in this respect. We invite the School to give further consideration to this proposal as part of its overall strategy for

additional development of the teaching and assessment of clinical skills (paragraph 90) and to ensure that students are given feedback on their practical skills proficiency at each stage of their training.

136. *The use of essays as an assessment tool:* It is of course appropriate that the School employs a variety of systems to assess its students but it seemed to us that too great a reliance was being placed on the use of essays for this purpose. We would encourage the School to explore additional ways of testing student knowledge (paragraph 99).

Conclusion

137. We were impressed by the progress made in Southampton since our last visit. It was evident to us that the active involvement of both staff and students in curricular planning had been a key factor in ensuring the successful management of change.

138. We encourage the School to press ahead with its plans for further curricular development and look forward to receiving a report on progress in a year's time.

Part 2: General Clinical Training

Background information

139. Prior to the visit we were issued with helpful background information about the arrangements for general clinical training in the region. This included a summary, reproduced at **Annex N**, showing the extent to which the recommendations in *The New Doctor* have been implemented to date.

Form of the visit relating to general clinical training

140. The day began with an overview of general clinical training provided by senior staff from the School of Medicine and the Deanery. We then had discussions with the PRHO management team and with chief executives and medical directors from various trusts throughout the region. Over lunch we met a number of PRHOs from a variety of locations and specialties. After talking to a group of clinical tutors and educational supervisors from different hospitals and practices in Wessex, we reported back to the Deanery on our impressions of the day.

Organisation and management of the PRHO year

141. There are 19 NHS trusts in the Wessex region involved in the training of PRHOs.

Supervisory structures

142. The Postgraduate Dean has overall responsibility for the management of the pre-registration year. He is assisted in this task by the Associate Dean (PRHOs) and by a number of groups with particular roles to perform in relation to general clinical training.

143. These groups comprise:

PRHO Millennium Group. This working party was set up in December 1998 to identify important issues around the pre-registration year and the implementation of *The New Doctor* in Wessex. Many of its recommendations are now in place as the document reproduced at **Annex O** confirms. Its ongoing work programme includes implementing its framework for induction courses, developing a new PRHO portfolio, and revising the handbook for educational supervisors.

Year 5/6 Working Party which includes the Postgraduate Dean, the Associate Dean (PRHOs) and the Clinical Sub-Dean of the School of Medicine amongst its membership. Its remit is to examine how the Deanery can work together with the School of Medicine to develop a seamless transition from medical student to PRHO.

PRHO Committee. This currently consists of:

The Postgraduate Dean (Chairman)
Associate Dean (PRHOs)
Associate Dean (Medical Workforce)
University of Southampton representatives
Head of the Medical School
Clinical Sub-Dean
Deanery Contracts Manager
Matching Scheme Manager
Trainee Development Co-ordinator
The clinical tutor or educational supervisor representing PRHOs in each trust
Final year medical students and PRHOs

The role of the PRHO Committee is now primarily strategic, with detailed work being undertaken by either the PHRO Millennium Group or the Year 5/6 Working Party. The Committee meets once a year, providing a forum for stakeholders to discuss developments in general clinical training.

Clinical tutors who meet every 3 months with the Postgraduate Dean and Deanery staff.

The approval of posts

144. It falls to the Postgraduate Dean to approve and monitor the quality of PRHO posts in the region. All PRHO posts must meet the criteria set out in *The New Doctor*. This is stipulated in the Agreement for the Provision of Postgraduate Medical and Dental Education, a formal document setting out the minimum standards for the education and training of doctors in training. The Agreement is drawn up between each NHS trust which employs doctors in training and the Secretary of State for Health. This document is signed annually by the Chief Executive and the Clinical Tutor/Director of Medical Education for the Trust and by the Postgraduate Dean on behalf of the Secretary of State.

145. The opinions of trainees are sought by means of confidential questionnaires completed at the end of each post and through enquiries made by the Postgraduate Dean on his annual visits to trusts. A copy of the PRHO questionnaire is at **Annex P**. PRHOs are also encouraged to raise any concerns about the quality of their posts and the training which they are receiving during appraisal sessions with their educational supervisors or in direct communication with clinical tutors.

Communicating the aims and objectives of the PRHO year

146. We were impressed by the range of measures adopted by the deanery to ensure that the aims and objectives of general clinical training are known and understood by PRHOs, educational supervisors and clinical tutors.

147. The Postgraduate Dean and the Associate Dean (PRHOs) make a presentation to Year 4 medical students about the PRHO year at an annual half-day 'Introduction to the Fifth Year'. Copies of *The New Doctor* and two Deanery leaflets *The New Deal* and the *Summary of the Agreement for Postgraduate Medical and Dental Education* are distributed to students. A copy of this last leaflet is at **Annex Q**. Further information about the PRHO year in the form of presentations given by the Postgraduate Dean, Associate Dean (PRHOs), clinical tutors and Task Force representatives is a feature of the annual PRHO Matching Scheme Fair attended by all Year 5 students. Work is also well advanced on the development of a PRHO portfolio which will help trainees understand the aims and objectives of general clinical training. The intention is to pilot the portfolio in February 2000 with a view to introducing it for the entire PRHO cohort in August 2000.

148. Clinical tutors have responsibility in each trust for ensuring that educational supervisors are well versed in the goals of the PRHO year. To support this process both groups receive the following documentation:

The New Doctor

The Deanery leaflets, *The New Deal* and the *Summary of the Agreement for Postgraduate Medical and Dental Education*

The handbook for educational supervisors.

149. Clinical tutors from each trust involved in the training of PRHOs attend regular quarterly meetings with the Deanery to discuss a wide range of issues relating to the PRHO year. Similar opportunities arise on formal and informal visits to trusts and at the annual two-day Conference for Postgraduate Medical and Dental Education attended by Deanery staff, educational supervisors, general practice advisors and postgraduate centre managers.

The selection of PRHOs

150. The Wessex Deanery operates a matching scheme that guarantees a PRHO post in Wessex to every Southampton graduate. At present there are around 150 posts in the Wessex Matching Scheme with six rotations including general practice. A PRHO Fair is held each summer to which students about to start the fifth year are invited. The day consists of a series of presentations explaining how the matching scheme works and giving further information about the PRHO year. A copy of the programme for the 1999 event is attached at **Annex R**. Each trust taking PRHOs provides a stand manned by the clinical tutor, the postgraduate centre manager, education supervisors, PRHOs and medical personnel representatives. Throughout the day students have the opportunity to talk to consultants and staff from the trusts to help them to decide which posts interest them. We thought the idea of including a currently-serving PRHO on each of these stands, to enable students to receive a first-hand account of the nature of their prospective PRHO post, was commendable.

151. To apply under the matching scheme each student enters a series of

preferences on a standard form and a similar one is completed by educational supervisors in conjunction with clinical tutors and postgraduate centre managers. Data from the scheme is stored on a computer database but currently the matching itself is undertaken manually. Most matches are performed on a one-to-one basis, (i.e. students are matched for the post that they have placed first and with a consultant who has marked them first). Where a one-to-one match is not possible the student's preference is given priority; for example, students could be placed with their first choice of consultant even though that consultant has indicated them to be his/her second choice. The flow-chart at **Annex S** describes the various stages and the timescale of the matching scheme for students seeking their first PRHO post in August 2000.

152. The PRHOs with whom we spoke were satisfied with the selection process which they considered to be fair and offered them the best means of securing the post of their choice.

Monitoring the quality of PRHO posts

153. Each trust is required to provide annually detailed quality monitoring information covering all issues identified in the Agreement for the Provision of Postgraduate Medical and Dental Education. This takes the form of a response to a formal questionnaire issued by the Deanery. In addition the Deanery makes regular monitoring visits and an annual contract visit to each trust. Individual posts are reviewed on each monitoring visit, during which educational supervisors and PRHOs are interviewed in accordance with the checklist reproduced at **Annex T**.

154. Where deficiencies in a particular post are identified, these are brought to the attention of the trust chief executive with recommendations for improvement following discussion between the Postgraduate Dean and the clinical tutor and educational supervisor. To date approval has not been withdrawn from any PRHO posts in the region but we were told that this situation is likely to change in the near future as the Deanery launches a sustained drive for quality improvement.

155. The results of PRHO feedback on the quality of their posts in 1998/99 as expressed in the confidential questionnaires are at **Annex U**.

Components of a high quality PRHO post

Induction

156. All PRHOs attend an induction programme of at least one full day's duration in protected time and must all have a formal hand-over session from the outgoing PRHO or team SHO. Additionally, each general practice taking PRHOs provides a two to three-week induction tailored to the trainee's educational needs. PRHOs embarking on general practice rotations spend at least half a day with the outgoing trainee before each changeover. Arrangements are made for additional training if this is required.

157. PRHOs found the induction arrangements reasonably useful but some told

us that they still felt ill-equipped for their first full day on the wards, and would have welcomed more practical experience in certain areas such as writing up fluid charts and devising management plans for patients. Others informed us that there was a great variability in the time allocated for formal hand-over sessions; for itinerant PRHOs in Southampton we were informed that only 30 minutes was available. We invite the PRHO Millennium Group, which is currently reviewing the content of the induction period, to consider whether changes to the programme are required to ensure that it provides a practical and meaningful introduction to general clinical training for all trainees.

158. Paragraphs 102 and 103 of our report refer to the current arrangements for PRHO 'shadowing' and the form this might take in future. We encourage the School to press ahead with the proposal to introduce a discrete PRHO 'shadowing attachment', an initiative which drew unqualified support from trainees. An Advanced Life Support (ALS) course might form part of this attachment, an option which we have also invited the School to consider.

Educational opportunities

159. The Agreement for the Provision of Postgraduate Medical and Dental Education defines the Deanery's responsibilities for provision of formal educational sessions as follows:

"Formal education should be in accordance with paragraphs 18, 22, 23 and 24 of *The New Doctor*.

All PRHOs will attend a dedicated and structured core educational programme of at least one hour per week (or equivalent) in each six-month appointment. The sessions will be held in protected time during the normal working day, and be bleep free, and the PRHO must be released for attendance. Alternative arrangements must be made to cover the PRHO's work during these training sessions. A record of attendance should be kept and may be monitored. A system should be instituted to allow the PRHO to evaluate these training sessions.

All PRHOs should attend departmental education programmes appropriate to their needs including attendance at audit meetings. The total of education and training time should be a minimum of one session per week or its equivalent (4 hours) taking place during the normal working day."

160. The clinical tutor is responsible for organising PRHO core teaching and for ensuring that departmental programmes are available. The format of educational sessions varies according to the topic but the style is generally interactive. They may cover a diverse range of areas, for example communication, CPR and pain management. PRHOs have the opportunity to influence the choice of topics for future sessions through the comments they make on the evaluation forms. Most considered the quality of the sessions to be variable, from excellent to poor. One trainee told us that one of his educational sessions took advice about pension

arrangements as its theme. He was unable to understand how this would enhance his professional development. PRHOs are required to attend at least 70% of core-teaching sessions and currently they devise their own timetable to meet this objective, attending those sessions which most appeal. In order to develop a more structured approach to this learning experience for trainees, the PRHO Millennium Group has recommended that core teaching throughout the PRHO year be co-ordinated across the region to avoid duplication of topics during each post. We strongly support this initiative which we understand is in the process of being implemented.

161. The trainees with whom we spoke confirmed that they were all receiving protected teaching sessions each week and the bonus of a free lunch. Attendance at these sessions is good and is assisted by the arrangements made by the Deanery for ensuring that this is on a 'bleep-free' basis. These include:

- written or verbal reminders to trainees before the session;
- PRHOs depositing their bleeps in the postgraduate centre;
- informing switchboard that PRHOs are unavailable for the duration of the session.

We were told that this system works well, especially as those holding the bleeps take messages or help with calls, so these are not stacking up for PRHOs on their return. We heard of only one instance when a PRHO was unable to pass on her bleep. Attendance is formally monitored by clinical tutors who take a register at each session. Additionally, each PRHO is required to submit, with their Certificate of Satisfactory Service, a form (reproduced at **Annex V**) signed by their clinical tutors confirming that they have attended at least 70% of core-teaching sessions.

162. The consequences of poor attendance would be an investigation by the clinical tutor, including an interview with the PRHO concerned and a discussion with the educational supervisor. The Postgraduate Dean or the Associate Dean (PRHOs) would become personally involved in the event of a trainee failing to submit the signed form at **Annex V**.

163. PRHOs were generally appreciative of the steps taken by the Deanery to ensure that they did not routinely have to carry out inappropriate tasks but we were told that the level of support available to them was variable across the region. Trainees at centres such as Bournemouth and Portsmouth particularly welcomed the appointment of nurse practitioners who were on call out-of-hours to filter bleeps. We would urge the Deanery to introduce this resource at all centres taking trainees. PRHOs continued to encounter minor difficulties at most hospitals in obtaining the results of radiological investigations whilst the phlebotomy service was very variable across centres. We were told that at Salisbury trainees were fortunate to have a full phlebotomy service every morning, including Saturday whereas there had been no service whatsoever available to PRHOs in Swindon. We encourage the Deanery to continue to seek solutions to these difficulties with trust managers.

Educational supervision

164. Each PRHO is allocated an educational supervisor who is likely to be the consultant with whom the trainee is working. Clinical tutors are responsible at trust level for ensuring that each PRHO is clearly linked to an appropriate educational supervisor. The trainees with whom we spoke had all met their educational supervisors apart from one PRHO who told us that she had only learned that day who her educational supervisor was.

165. Under the terms of the Agreement for the Provision of Postgraduate Medical and Dental Education, educational supervisors are required to arrange an appraisal session with the PRHO within the first ten days of the post and thereafter at two to three-month intervals. Trainees undertaking four-month posts should meet their educational supervisor for three appraisal sessions. Apart from the PRHO alluded to in the previous paragraph, all trainees had received either verbal or written feedback on their performance, although not necessarily at the prescribed time. Educational supervisors themselves admitted that due to extreme pressure of work on some consultants the quality of appraisal was variable throughout the region. However, the PRHOs we met were generally satisfied with the level of feedback they received. It was their perception that many educational supervisors had taken into account the views of other staff, both medical and non-medical, when conducting an appraisal. We were told that the Deanery sends written reminders to both PRHOs and educational supervisors, alerting them to the need to schedule appraisal meetings.

166. In recent years the Deanery has arranged a number of educational and training programmes for its educational supervisors and clinical tutors. All general practice trainers in Wessex attend an initial five-day course on 'Teaching and Learning'. Those volunteering to supervise PRHOs participate in a workshop to prepare them specifically for this responsibility. They also receive support from the Associate Dean (PRHOs) who visits trainers and trainees in the practice. The Deanery is currently compiling a database of educational supervisor training so that it can assess provision and determine future strategy.

167. The performance of educational supervisors is monitored by clinical tutors. Both educational supervisors and clinical tutors are employed and are subject to appraisal by their local trust. The tenure of a clinical tutor appointment is initially three years with renewal conditional on formal review by the trust and the Postgraduate Dean. The progress of educational supervisors and clinical tutors is also evaluated by the Deanery on its regular monitoring visits and through the information it receives from trusts in response to its annual questionnaire.

Clinical training and supervision

168. The Deanery satisfies itself that core generic training, as defined in *The New Doctor*, is being delivered through its regular visits to trusts and feedback from its annual quality-monitoring questionnaire. Trainees were generally appreciative of the clinical opportunities available to them though many considered that their experience would have been enhanced if they had been able to follow through the treatment of patients they had admitted. All spoke enthusiastically about the high quality teaching which they received from their consultants and general practice

trainers.

169. Initially some trainees lacked confidence in their clinical proficiency. In paragraph 90 we have invited the Deanery to consider our suggestion for improving PRHO confidence in the level of their practical skills at the beginning of general clinical training.

170. Trainees were satisfied at the degree of clinical supervision to which they were subject, being particularly appreciative of the additional layer of support and experience provided by senior nurses. None of the PRHOs we asked had ever been placed in a position where they were unable to seek direct support or guidance from a senior colleague.

Monitoring the progress of PRHOs

171. All PRHOs are monitored by their educational supervisors with whom they have agreed a training plan and a schedule of educational appraisals. These are certified on the form reproduced at **Annex V**. Clinical tutors have the responsibility for overseeing this process in each trust.

172. If any deficiencies in performance are noted these are discussed with the PRHO by the educational supervisor and remedial action agreed in conjunction with the clinical tutor. Depending on the nature and severity of the deficiency, this may involve some retraining in a specific area. We were told that the Deanery has created a number of supernumerary posts to lend additional support to failing PRHOs. If no improvement is forthcoming or more serious problems, such as unsatisfactory clinical performance are identified, the trainee would be interviewed at an early stage by the Postgraduate Dean or the Associate Dean (PRHOs) and warned that unless these deficiencies are addressed the Deanery would refuse to 'sign up' the PRHO as being suitable for full registration. In the event of a trainee missing a substantial amount of training through ill health, the Associate Dean (PRHOs) would interview the PRHO and, after close consultation with clinical tutors and educational supervisors, would devise an appropriate action plan which takes account of the nature of the health problem and the performance of the trainee thus far.

173. We thought that the Deanery had developed a range of effective procedures for identifying and supporting poorly performing PRHOs and PRHOs with health-related problems. Underpinning their success are the robust communication links which have been established for exchange for information between the School of Medicine and the Deanery, which we have commended at paragraph 101 of our report. The Deanery has sought to strengthen these links still further in its new policy document on PRHOs in difficulty, reproduced at **Annex W**. This excellent paper sets out clearly the protocols to be followed when unsatisfactory progress is identified and details the roles and responsibilities of all interested parties.

Professional development and personal well-being

Careers advice

174. Early careers advice is provided to fifth-year students during the annual PRHO Fair.

175. Educational supervisors are encouraged to offer careers advice to trainees. Many PRHOs told us that they had a dedicated session with their educational supervisor every six months when they received general advice about future career options and were given guidance about planning their curriculum vitae. Clinical tutors also make themselves available during the year to provide careers information and to direct trainees seeking specialist guidance to the appropriate sources. We were told that detailed careers advice material from the BMA and Medical Forum can be easily accessed by PRHOs in the libraries and the postgraduate centre. The Postgraduate Dean or the Associate Dean (PRHOs) will make themselves available to see a PRHO requiring specific guidance while an Associate Dean has been appointed with particular responsibility for trainees seeking to undertake flexible training.

Support for PRHOs

176. The Deanery has established excellent outreach systems in all its trusts to support its PRHOs. For advice on the practical and educational aspects of the PRHO year, trainees are encouraged to approach their educational supervisors, clinical tutors or postgraduate centre managers. Each trust is required to provide occupational health services for all its employees.

177. In terms of providing specific support for its trainees, we were interested to learn that one centre had allocated an experienced nurse as a mentor to assist a PRHO who was experiencing some difficulty. We were told that this arrangement had worked well for the first six months but less so thereafter as the trainee in question did not feel a member of the ward-based team. One trust manager told us that in his view some trainees adopted a defensive attitude and he wondered if this was because they believed their work was undervalued by management. However, this was not borne out by the PRHOs whom we consulted who were satisfied with the tiers of support available to them throughout the region. They knew they could contact the Deanery team if they could not resolve issues locally. Indeed, some centres had already taken the initiative to ensure this did not happen by establishing a 'Junior Doctors Hour' when trainees met trust chief executives and medical directors over lunch each month to discuss matters of mutual interest in an open and informal manner. We commend this practice, which other centres throughout the Deanery might wish to adopt.

Accommodation, catering and personal safety

178. The Regional Task Force conducts yearly visits to each trust as part of the New Deal accreditation process. Included in its remit for these visits is an audit of the standards pertaining in accommodation, catering and personal security. Where these are found to be below par an action plan and a timescale for improvement

are agreed with each trust. The Deanery receives a summary of the Task Force's findings which it uses to inform its review of the educational contracts of trusts.

179. The PRHOs we met considered the standard of accommodation to be generally unsatisfactory and the quality of catering and its availability out of hours to be poor. Some exceptions were noted. Trainees at the new hospital in Dorchester had good accommodation and the benefit of a servery providing hot food throughout the night. We also heard that a group of PRHOs in Basingstoke secured improvements in the quality of their accommodation through an approach to trust management.

180. Personal safety was a live issue for most PRHOs as many residential blocks were located outwith hospital grounds. Porters were available in some hospitals to escort PRHOs in poorly-lit areas at night, but this did not appear to be common practice throughout the Deanery. We were dismayed to learn that security staff had not changed the locks of the trainee's accommodation at one hospital despite two recent burglaries.

181. We hope that the Deanery in conjunction with local trusts will take prompt action to resolve the particular difficulties identified by trainees and will continue to explore ways of improving their working conditions.

Contractual matters

182. Many of the PRHOs with whom we spoke were working longer hours than those for which they had been contracted. Trust managers acknowledged that they were experiencing difficulty in meeting the New Deal requirements on hours. This was borne out in the latest report we saw on Junior Doctors' Hours produced by the Regional Task Force. We were disappointed to learn that in September 1999 only 36% of PRHO posts in the Wessex region complied fully with the requirements of the New Deal. Whilst we recognise the difficulty of balancing service commitments with the educational needs of PRHOs, it remains the case that PRHOs are doctors in training whose educational objectives should be met. In this particular respect we encourage the Deanery to work closely with trusts to secure rapid implementation of New Deal targets on junior doctors' hours.

General clinical training in general practice

183. In August 1998 the Deanery introduced three new PRHO rotations, including four months in general practice, in Southampton, Portsmouth and Basingstoke. These rotations were an unqualified success, with the result that in August 1999 the scheme was expanded to cover six sites, totalling eighteen trainees in general practice.

184. We were particularly impressed by the enthusiasm and commitment of trainers and trainees. Trainers welcomed the opportunity to be an integral part of a positive learning experience while trainees spoke highly of the excellent teaching, feedback and support available to them.

Areas of good practice

185. *Communication:* We were impressed by the range of measures adopted by the deanery to ensure that the aims and objectives of general clinical training are known and understood by PRHOs, educational supervisors and clinical tutors. (paragraph 146).

186. *Selection of PRHOs:* The PRHOs with whom we spoke were satisfied with the selection process which they considered to be fair and offered them the best means of securing the post of their choice (paragraph 152). We thought the idea of including a currently-serving PRHO on each stand at the annual PRHO Matching Scheme Fair, to enable students to receive a first-hand account of the nature of their prospective PRHO post, was commendable (paragraph 150).

187. *Provision of educational sessions:* The Deanery is to be commended for ensuring that all trainees now receive protected teaching sessions each week. In order to develop a more structured approach to this learning experience for trainees, the PRHO Millennium Group has recommended that core teaching throughout the PRHO year be co-ordinated across the region to avoid duplication of topics during each post. We strongly support this initiative which we understand is in the process of being implemented (paragraph 160).

188. *Clinical teaching and supervision:* PRHOs spoke enthusiastically about the high quality teaching which they received from their consultants and general practice trainers (paragraph 168).

189. Trainees were satisfied at the degree of clinical supervision to which they were subject, being particularly appreciative of the additional layer of support and experience provided by senior nurses. None of the PRHOs we asked had ever been placed in a position where they were unable to seek direct support or guidance from a senior colleague (paragraph 170).

190. *Monitoring the progress of PRHOs:* We thought that the Deanery had developed a range of effective procedures for identifying and supporting poorly performing PRHOs and PRHOs with health-related problems. Underpinning their success are the robust communication links which have been established for exchange for information between the School of Medicine and the Deanery, which we have commended at paragraph 101 of our report. The Deanery has sought to strengthen these links still further in its new policy paper on PRHOs in difficulty, which sets out clearly the protocols to be followed when unsatisfactory progress is identified and details the roles and responsibilities of all interested parties (paragraph 173).

191. *Support for PRHOs:* The Deanery has established excellent outreach systems in all its trusts to support its PRHOs (paragraph 176). Some centres had already taken the initiative of establishing a 'Junior Doctors Hour' when trainees met trust chief executives and medical directors over lunch each month to discuss matters of mutual interest in an open and informal manner. We commend this practice, which other centres throughout the Deanery might wish to adopt

(paragraph 177).

192. *Posts in general practice:* The PRHO general practice rotations have been an unqualified success (paragraph 183). We were particularly impressed by the enthusiasm and commitment of trainers and trainees. Trainers welcomed the opportunity to be an integral part of a positive learning experience while trainees spoke highly of the excellent teaching, feedback and support available to them (paragraph 184).

Areas for further consideration

193. *Induction arrangements:* PRHOs found the induction arrangements reasonably useful but some told us that they still felt ill-equipped for their first full day on the wards, and would have welcomed more practical experience in certain areas such as writing up fluid charts and devising management plans for patients. We invite the PRHO Millennium Group, which is currently reviewing the content of the induction period, to consider whether changes to the programme are required to ensure that it provides a practical and meaningful introduction to general clinical training for all trainees (paragraph 157).

194. *Preparation for the PRHO year:* Paragraphs 102 and 103 of our report refer to the current arrangements for PRHO 'shadowing' and the form this might take in future. We encourage the School to press ahead with the proposal to introduce a discrete PRHO 'shadowing attachment', an initiative which drew unqualified support from trainees. An Advanced Life Support (ALS) course might form part of this attachment, an option which we have also invited the School to consider (paragraph 158).

195. *Inappropriate tasks:* PRHOs were generally appreciative of the steps taken by the Deanery to ensure that they did not routinely have to carry out inappropriate tasks but we were told that the level of support available to them was variable across the region. Trainees at centres such as Bournemouth and Portsmouth particularly welcomed the appointment of nurse practitioners who were on call out-of-hours to filter bleeps. We would urge the Deanery to introduce this resource at all centres taking trainees (paragraph 163).

196. *Clinical opportunities:* Trainees were generally appreciative of the clinical opportunities available to them though many considered that their experience would have been enhanced if they had been able to follow through the treatment of patients they had admitted (paragraph 168). We support this view.

197. *Practical skills:* Initially some trainees lacked confidence in their clinical proficiency. In paragraph 90 we have invited the Deanery to consider our suggestion for improving PRHO confidence in the level of their practical skills at the beginning of general clinical training (paragraph 169).

198. *Accommodation, catering and personal safety:* The PRHOs we met considered the standard of accommodation to be generally unsatisfactory and the quality of catering and its availability out of hours to be poor (paragraph 179).

Personal safety was a live issue for most PRHOs as many residential blocks were located outwith hospital grounds (paragraph 180). We hope that the Deanery in conjunction with local trusts will take prompt action to resolve the particular difficulties identified by trainees and will continue to explore ways of improving their working conditions (paragraph 181).

199. *Contractual matters:* Many of the PRHOs with whom we spoke were working longer hours than those for which they had been contracted. Whilst we recognise the difficulty of balancing service commitments with the educational needs of PRHOs, it remains the case that PRHOs are doctors in training whose educational objectives should be met. In this particular respect we encourage the Deanery to work closely with trusts to secure rapid implementation of New Deal targets on junior doctors' hours (paragraph 182).

Conclusion

200. Much has clearly been done since our last visit both to improve the educational experience of the PRHO year and to introduce rigorous systems for monitoring PRHO development, performance and fitness for practice. We congratulate those responsible for the considerable effort and imagination which they have undoubtedly invested in bringing about these changes.

201. We wish the Deanery well with its plans to address the areas requiring further consideration as identified in our report, and we look forward to hearing how these are developing.