
Undergraduate Board

To consider

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

Issue

1. To consider Warwick Medical School for accreditation in 2007.

Recommendations

2. The Undergraduate Board are invited to agree:
 - a. That Warwick Medical School is approved for accreditation subject to meeting the requirements in paragraphs 17 a to 18 d.

Further information

3.

Coreen Beckford	020 7189 5397	cbeckford@gmc-uk.org
Cara Talbot	020 7189 5284	ctalbot@gmc-uk.org

Introduction

4. This is the final report to the Education Committee on the quality assurance programme for the Warwick Medical School for 2006.

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

Professor Sam Leinster (Team Leader)

Dr Nick Bishop

Dr Roger Bloor

Dr Gina Radford

Dr Martin Rowan-Robinson

Ms Jessie Sohal-Burnside

Professor Julius Weinberg

Dr Olwyn Westwood

Mrs Barbara Wright

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

Our programme of visits in 2005/6

7. The GMC visiting team attended the School on 7 occasions: 9 February 2006, 21 February 2006, 7 March 2006, 16 May 2006, 23 May 2006, 19 June 2006 and 22 June 2006.

8. The following field work was undertaken:

- a. Meetings with a variety of members of the School.
- b. Observation of the Examination of Clinical Skills.
- c. Module and/or Phase Examination or other Board meeting observation.
- d. Site assessment(s): NHS Trusts.
- e. Observation of Clinical Teaching.
- f. Discussions with General Practitioners.
- g. Discussions with Students and F1 doctors.
- h. Discussions with Teachers.
- i. Discussions with the NHS and other service providers.

9. This was a complex review due to the current Leicester Warwick Medical School partnership arrangements, and Warwick Medical School's application for independence from 2007.

History

10. In 1965 the first students entered into the University of Warwick. The School of Postgraduate Medical Education was founded at Warwick in 1980. In response to the Medical Workforce Standing Advisory Committee third report in 1997 a proposal was developed for a new joint medical school between Universities of Warwick and Leicester, with Warwick providing placements for a Graduate Entry Programme (GEP) in undergraduate medicine. In 2004 the first 65 Warwick based students graduated from the Leicester Warwick Medical Schools.

11. At present the current Academic Progress, Curriculum, Fitness to Practise, Termination of Registration and Executive Committees are jointly managed and run with Leicester Medical School. Each School separately manages all the other committees.

12. Warwick Medical School has grown rapidly over the past five years and now has three key institutes:

- a. Institute of Clinical Education
- b. Clinical Sciences Research Institute
- c. Health Sciences Research Institute

13. Warwick Medical School has three key sites: the Medical Teaching Centre, Medical School Building and Clinical Sciences Research Institute. In addition to this a new Bio Med Learning grid, based in the Medical School building, opened in February 2006.

Summary of key findings

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

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

16. The School recognised that the GMC would make its recommendation for accreditation to the Privy Council based on this 2005/06 report.

Requirements

17. Warwick is required to:
 - a. Provide an update in their 2007 annual report as to whether it has increased the current provision of Student Selected Components (SSCs). Although it has demonstrated that students had opportunity to seek individual areas of interests, Warwick Medical School recognised that it needed to increase its current provision of Student Selected Components (SSCs) and was already taking steps to address this issue (paragraph 39).
 - b. Be followed up by a visitor observation for the first run of the revised assessments. It was noted that the School proposed to revise their assessment framework for Phase 1, with minor changes in Phase 2. Approval for the changes would be sought from the Undergraduate Board (paragraphs 89 to 90, 100, 102, 104 to 105).
 - c. Produce a formal arrangement outlining and guaranteeing the provision for anatomy training at Leicester for Warwick medical students. This should be drawn up between Leicester and Warwick Medical School prior to Warwick going independent in 2007. This should include details of the provision and access for Warwick students to educational facilities at Leicester (paragraphs 69 and 70).
18. It was recognised that new regulatory structures were being put in place. In order to enable graduates to be registered in a timely manner for the new award, it would not be possible to observe their effectiveness before accreditation. Therefore, the following visit activities would be conducted after accreditation in 2007:
 - a. Observation of the Final Professional Exam
 - b. Observation of the final Examination Board meeting
 - c. Observation of the final Academic Progress Committee meeting
 - d. Formal review of the relevant University of Warwick and Warwick Medical School supervisory structures as soon as was reasonably possible post accreditation.

Suggestions for quality enhancement

19. The team have highlighted the following suggested areas for quality enhancement that should be considered by the School, Warwick:
 - a. Even though details of the revised Fitness to Practise procedure appeared signposted in a number of areas, further steps should be taken to make students more aware of the system (paragraphs 117 to 123).
 - b. Warwick should consider expanding the community-based components of the curriculum to ensure that clinical opportunities more accurately reflect

disease prevalence, disease management and delivery of care in the community (paragraphs 40 to 42).

c. The new cascading system of utilising Personal Tutors and Clinical Education Supervisors to support students that has been piloted should be fully implemented to provide a robust appraisal system for the students (paragraphs 45, 75, 80 and 108).

d. In its assessment review Warwick should follow current best practise to ensure that all the assessment components are valid and reliable, including the use of appropriate assessment formats and the development of clear and appropriate grade descriptors for all examinations (paragraphs 92 to 94).

Areas of innovation and good practice

20. The visiting team would like to commend the School on the following:

a. The newly developed web-based Inter-professional learning pathway in which medical students from Warwick, and students from other health and social work professions from Coventry University, worked together on case based scenarios (paragraph 127).

b. The use of various technological media at the Learning Grid and Medical Teaching Centre to provide 24-hour access to students enabling self-organised group sessions as well as resources for independent study and the Virtual Learning Environment as a learning aid (paragraphs 65 and 66).

c. The University/User Teaching and Research Action Partnership (UNTRAP), which involved a large number of patient and carer representatives to support the involvement of service users and carers in teaching and research (paragraph 126).

d. The training of examiners for clinical examinations and in particular the standardised approach of examiner feedback to students during the clinical assessments (paragraph 84 and 101).

e. The recently introduced system whereby senior students acted as mentors to junior students undertaking the Clinical Applications Special Study Module (paragraph 30).

f. The 'Additional Clinical Practice' course at the end of students' shadowing period (paragraph 98).

Main Body of the Report

2005/06 Update

21. There were no significant concerns arising from the previous review of Leicester Medical School in 1999, which predated the formation of the Warwick School in 2000. The key developments that had occurred at Warwick Medical School since 2000 have been:

- a. Warwick Medical School had undergone a number of statutory and regulatory audits in 2006. The School felt they had effectively utilised the recommendations from the audits to improve their infrastructure.
- b. The School invested heavily to enhance their teaching and learning process. £37,500 was planned for distribution in the academic years of 2005/06 from the Education Innovation Fund to appoint a teaching and learning specialist to assist with Faculty development for clinical teaching colleagues.

Curricular outcomes

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

Curriculum content, structure and delivery

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

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

Content

25. Warwick delivers a 4-year graduate programme consisting of two Phases with a heavy emphasis in Phase 1 on sociological issues as well as biomedical science. Students are taught to base their decisions on values as well as facts. Phase 1 students had taught sessions and guided group-learning sessions. Phase 2 was made up of junior and senior rotations.

26. The visiting team reported that Public Health, Mental Health, Complementary Medicine and the strong focus on social sciences were featured appropriately within the curriculum.

27. The visiting team was satisfied that chronic conditions and the management of disease were represented vertically in the curriculum, although this was not clearly specified in the outcomes for the course.

28. Some students reported they were unclear about the learning outcomes they were supposed to meet in Pharmacology. Students suggested this could be improved if the teaching of Clinical Pharmacology was more integrated into the medical course as a whole. Students in Years 2 and 3 agreed that the delivery of Pharmacology teaching had improved from their first year.

29. Warwick reported that its curriculum review was being undertaken in increments that would eventually provide a holistic review of the course. Student feedback collected by the School reported that some students felt lost and unsupported on Phase 2 components of the curriculum. The School addressed this by making changes that would involve students at all levels of development. As a result small groups were looking at different aspects of the curriculum and an important contribution had been made by the student body to develop and implement major changes. The School stated that the levers for curriculum change were similar to those for quality enhancement. The visiting team and the School were impressed with the proactive nature of the students and their involvement in the curriculum content.

30. Clinical Applications Special Study Modules (CASSMs) had undergone a module review that resulted in the development of a new format whereby Phase 2 students would educate and mentor Phase 1 students. This would commence in induction week and enable students to acquire teaching experience. Warwick reported that in Semester Three of Phase 1 a specific week was set aside for study relating to CASSMs, and included skills such as report writing. The visiting team commended this as an innovative idea particularly as it involved senior students as teachers.

31. Phase 2 Portfolios were used for formative assessments and helped students direct and monitor their learning. Portfolios incorporated core cases, which helped students to maximise learning in clinical settings and ensured that important core presentations were not neglected. Portfolios were also used to identify students where there was concern about progress. Students expressed concern that the perceived level of quality and therefore the time spent on portfolio completion was steadily increasing. This had resulted in students losing sight of the original objective of portfolios and disliking them. The visiting team welcomed the idea of the School revising portfolios to make them more useful.

32. The visiting team suggested that the School further clarify to students the expectations of portfolios and provide better guidelines as to how they should be approached.

Structure

33. Phase 1 students received didactic sessions and guided group-learning sessions. These enabled students to learn from others in a group setting and share experiences from placements in different environments. Students commended the teaching of basic clinical and communication skills via the Introductory Clinical Skills Course at the end of Phase 1. It was compulsory for students to attend this course in order to progress.

34. Phase 2 offered greater emphasis on self-directed learning and two students were based with two consultants during their eight-week blocks in what was termed a 'Partnership'. This resulted in apprenticeship-style learning with consultants. There were some concerns that a 'dysfunctional partnership' might disadvantage a student, however it was clear that the School had arrangements in place to prevent this happening, and could intervene in a timely way if it did occur.

35. Phase 2 was divided between Junior and Senior rotations. Within a rotation students were split into streams. The stream a Phase 2 student was allocated to would determine the order in which they carried out their block rotations. Within this structure all students completed all blocks (or modules) within Phase 2.

36. In the Phase 2 Junior Rotation, the Clinical Methods course occurred at different times for different students. The visiting team was concerned that this might disadvantage certain groups. For example those groups who completed the Clinical Methods course at the end of the rotation might have been less able to utilise their clinical learning opportunities on earlier placements. The visiting team reviewed this issue with both students and staff and found no evidence of significant disadvantage for any particular group.

37. Although Phase 2 student handbooks were not focused on specialties, students worked in placements with specialists covering many specialties. The curriculum allowed for students to be attached with clinical specialists across timetabled sessions and understand key areas that needed to be covered.

38. Students were assigned to placements in relation to their travelling distances from home. There was an agreement with the neighbouring Medical Schools not to encroach on each other's territory whilst ensuring that students were not placed too remotely.

39. The visiting team noted the low quantity of SSCs, which stood at just under 20%¹ across both Phase 1 and 2. The School has recognised this and aimed to increase the provision of SSCs by allowing for more curriculum allocation and creating a larger portfolio of SSCs during the academic year. The visiting team considered the plans for increasing SSCs to be appropriate.

Primary Care

40. Phase 1 exposure to primary care comprises of a Health in the Community module and a Developing Interviewing Skills in the Consultation (DISC) course

¹ Please see important note at the end of this report.

taught and organised by General Practitioners. Phase 2 students had placements in Primary Care during their Clinical Methods Course. The focus of the Clinical Methods course was on interviewing, relationship building and problem solving skills. Students agreed that the Clinical Methods Course provided a rounded view with exposure to different cases. GPs interviewed were familiar with the Warwick curriculum.

41. The GP Tutors suggested that Primary Care could be improved by ensuring better continuity throughout the course. Warwick students did not have a substantive community based placement within the senior rotation of Phase 2. The Tutors envisaged developments of more teaching out in the community and a move towards more general integration.

42. Teachers reported that in the delivery of Child Health teaching, the School deliberately rotated students through various community settings. Students learnt about the management of chronic conditions in outpatients and health care of the elderly. Increasingly these conditions were being managed in a Primary Care setting. These changing models of health care delivery meant the populations in outpatients were becoming less representative of the spectrum of disease future practitioners would be required to deal with.

Delivering the curriculum

Supervisory structures

43. The visiting team noted that progress had been made by the School towards developing the restructuring of committees upon being accredited in 2007. The visiting team were satisfied that the plans for supervisory structures met appropriately the requirements of *Tomorrow's Doctors*.

44. Phase 1 students reported feeling encouraged to provide student feedback that was fed into the Phase 1 Management Group for review. Students understood that should a teacher receive a bad review, they would not be invited into the next teaching rotation.

45. As a result of Phase 2 student feedback, Clinical Education Supervisors had been introduced to act as interpreters of the clinical environment for students. They were chosen from the Trusts and General Practices involved in Warwick's Phase 2 teaching.

46. Students confirmed they had opportunity to feedback on the course and that their feedback was taken seriously. Students across the years were able to supply examples to the visiting team where their feedback had resulted in changes at the School. Students within hospital placements reported there to be ample opportunity to provide feedback.

47. The Trusts were committed to establishing clinical academic units with Warwick Medical School. The cost and complexity of doing this was evident but the Trusts were keen to further this development in partnership with the School. Future developments and significant investment was planned to bring facilities up to a high

standard. The visiting team noted that the Service Increment for Teaching (SIFT) Steering Group, containing representatives from the Medical School and Trusts was specifically assigned to look at the allocation of SIFT. They commended the strong relationship that was evident between the School and neighbouring NHS Trusts and the transparency of the SIFT arrangements.

Quality Assurance

48. The University of Warwick carried out a periodic internal review every five years. The School has set up a new Quality Assessment and Enhancement Group (QAEG) had been formed to focus on quality issues within the School. QAEG had the responsibility of analysing reports from the level of module leaders to external examiners to find solutions to issues raised.

49. The visiting team concluded that the supervisory systems in place were appropriate and effective.

Teaching and learning

50. The School aimed to appoint their first learning and teaching advisors who would initially be based in Warwick. The advisors would be sent to Trusts in an effort to improve feedback and develop the teaching skills of the clinicians. Overall, teachers reported to the visiting team that they felt well supported by the School.

51. Students reported the quality of clinical teaching to be excellent. The visiting team was informed that many students were able to negotiate their way into observing various clinical opportunities and procedures whilst on clinical placements. The consultant body was generally positive about providing teaching. Whilst recognising issues about capacity and sustainability, the visiting team felt that the teaching delivered by General Practitioners was of a high quality.

52. Students commended the approach of receiving clinical experience early on in the course. Students commended Warwick for instilling confidence that what they were learning was relevant. The visiting team welcomed the use of simulated patients in the Clinical Methods Course for teaching students how to break bad news.

53. Under the student pairs to Consultant Partnerships, the School reported that eighty-five percent of the student-to-student pairings were self-chosen. Operationally there was formal opportunity to shift partners between Junior and Senior rotations but Warwick worked to avoid breaking up good relationships if possible.

54. The School had since introduced the use of trio arrangements for junior surgery in order to cope with capacity and recruitment issues. It was hoped the original student-pair partnerships would return within a few years, as capacity and resource issues were resolved.

55. The sample of seminars and ward-based teaching observed, were considered to be of a high standard. The visiting team felt that the clinical teaching of outpatients

and ward-based patients appropriately delivered the outcomes of *Tomorrow's Doctors*.

56. The visiting team felt that the nurses and midwives spoken with at Trusts demonstrated how they were involved in the teaching of medical students. Nurses helped deliver the teaching for admin skills, insertion of nasogastric tubes, resuscitation and venepuncture. Nurses described themselves as acting as clinical trainers although they were not official assessors.

57. The School commented that the current system of peer learning was now more difficult to deliver under the EU directives. The School planned to enhance peer learning by allowing students to learn with Specialist Registrars as a means of broadening their learning experience.

Staff appraisal

58. Associate Clinical Directors reported that a newly introduced appraisal system for staff was in place. The appraisal system was intended to allow weaknesses to be highlighted and addressed.

59. In order to develop high quality teaching, the School reported that they only recruited consultants for clinical education supervision from amongst those who showed a high level of interest.

60. GP Tutors received Peer Reviews throughout their induction and ongoing teaching. Phase Coordinators reviewed student comments about their teachers. Additionally students had the opportunity to log complaints about teachers via the School's website that were automatically emailed to the Phase Coordinators for action.

Teacher Training

61. Associate Clinical Directors in hospitals were responsible for teacher training being delivered to the appropriate standard. In the event that any issue arose with the standard of teaching, the matter would be taken up for review. The School reported that the percentage of teaching time varied from Consultant to Consultant.

62. The School held faculty development days to reinforce teacher training. All new teachers were required to obtain their formal teaching certificate. Teacher training for DISC included a validated L-Pass package to be gained on qualification. Teacher training for the Clinical Methods course involved practices 'peer' observing one another.

63. GPs are offered the opportunity to attend a four-day workshop run approximately 3 to 4 times a year. The workshops covered teaching skills and how to build upon feedback and learning. A refresher course had been implemented (four days annually), primarily for the established members of staff to ensure there was no drift in teaching methods.

64. The School reported that it had instituted the recommendations of the Follett Report. The visiting team reviewed the details of how the system worked and was satisfied with this comprehensive approach.

Learning resources and facilities

65. The visiting team received a tour of the School's Learning Grid and Medical Teaching Centre. The former was an outpost of the University Learning Grid, which opened in September 2004 and offered a 24-hour study facility of 10,000 textbooks within an electronic library. The visiting team noted that smart boards and plasma screen stations were available for self-organised student sessions. All furniture and equipment were on wheels to allow students to configure their learning space to their purpose. There were trained resource staff on hand to help with the technology and teaching aids on offer. The visiting team commended this facility as an example of good practice.

66. The visiting team was given an e-learning demonstration of a newly built Virtual Learning Environment (VLE) constructed around case-based learning. It connected to the library facilities and incorporated assessment strategies and learning outcomes as highlighted in the accompanying student handbooks. Extensive information was provided for each module and student forums were available for discussion.

67. There were a suitable number of computers to cater for the medical students in a separate dedicated IT suite. Students reported that in response to feedback they were given extended opening hours at the library over Christmas and the School had been accommodating to their needs.

68. The George Elliot Hospital Trust would own a new clinical skills unit from September 2006. This would be a training ward using elective patients. Nurses would work alongside medical students helping with clerking and other activities. The visiting team considered the Warwick Hospital Trust to have well set out and spacious facilities. Members of the visiting team were impressed with the Dermatology outpatient facilities and resources designated specifically for teaching.

69. Under the current Leicester Warwick arrangement, anatomy teaching was delivered at Leicester Medical School by Warwick academic staff. Leicester confirmed it had the capacity to continue to accommodate Warwick students and agreed to continue current arrangements. The cost for this service had yet to be finalised. Warwick offered a free coach service for students to travel to Leicester for each anatomy session.

70. Leicester and Warwick worked closely together to ensure that anatomy timetables were scheduled a year in advance to mitigate any conflicts. Warwick reported that beyond the letter of intent there was no further formal agreement of the arrangement as yet. The visiting team felt that the Warwick and Leicester anatomy arrangements would work and suggested that a formal agreement would be beneficial for clarifying arrangements in the future. Warwick should also ensure that monitoring mechanisms are in place to ensure that anatomy facilities are maintained to sufficient standards and are appropriate for the student numbers travelling across to the Leicester campus.

Student selection

71. The School had steadily increased its student numbers by over 27% since 2001, including the addition of a small number of international students onto the course. The visiting team was satisfied that the proportion of black minority and ethnic students selected for Warwick was proportional to the numbers applying for that region.

72. Warwick reported that it was using a new admissions system involving a selection centre in association with Queen Mary's School of Medicine. Students were required to pass the MSAT that included an admissions test on insight into the feelings, motivation and behaviour of other people, and into issues related to helping or working with others as part of the process. Currently the School only accepted biological science graduates.

73. Warwick reported that they did not actively exclude people with Hepatitis B or C from entry to the course. The visiting team suggested that the School needed to amend its documentation as the current text on policy for the contraction of Hepatitis could be misinterpreted.

Student support, guidance and feedback

Student support

74. Warwick reported that it was working independently from Leicester with regards to student support systems. The Warwick Medical School board monitored academic difficulties and identified students deemed to be at risk.

75. Phase 2 students demonstrated that they understood the channels to use when asking for support. Students reported that the staff at Warwick were approachable and the Clinical Educational Supervisors recently brought in as part of a pilot were useful and helpful. Both the administration and pastoral support staff were considered supportive.

76. Students reported that they were aware of at least one disabled student enrolled at the School. Students reported that the School was implementing British Medical Association policies on Dyslexia into Warwick's University policy. The visiting team was satisfied with the School's support mechanisms for dyslexic students.

77. The visiting team was informed that a group of learning facilitators had set up drop in sessions as a form of revision that students had the option of attending.

78. The School reported that it was not uncommon for students to require counselling. Medical students could be self-referred to the counselling service for psychiatric support. Warwick confirmed that students had access to an independent psychiatrist in Birmingham.

79. Student funding advisors reported that they advised students on tuition fees and day-to-day living expenses. The advisors helped create payment plans and organise hardship funds. Financial help was offered to support students with

childcare or disabilities. Additionally the Warwick Student Union had its own student welfare unit with qualified staff.

80. Warwick reported that the new Personal Tutor system was a work in progress. The School reported that at present Personal Tutors remained with their students from Phase 1 to Phase 2. The School planned to integrate the tutoring system into the curriculum by using a cascade system of Personal Tutors and Clinical Education Supervisors to deal with personal issues. Personal Tutors and Clinical Education Supervisors would be assigned an average of ten students each.

Guidance

81. The visiting team considered the course objectives in the handbooks to be a helpful guide for offering direction on the course modules to students.

82. Career guidance was reported to be student led. Students agreed that this was of benefit because the older students reliably informed others about the pros and cons of certain medical areas. Each academic year had two representatives to deliver information.

83. Warwick reported that students were offered careers advice from the start of their induction week. The School organised a series of expert lectures where professionals talked to students about their specialities. Warwick reported that a new careers advisor had been appointed. The appointee would offer generic careers advice as the West Midlands Deanery already provided advice about specific careers routes. Warwick reported that students had organised careers meetings and their own publications. A number of students had visited the Chaplain to ask for vocational advice so that they received non-specialist guidance and could discuss ethical careers.

Student feedback

84. Examiners are required to write down areas of strengths and weaknesses as a form of feedback for students on assessments. The visiting team noted this as an area of good practice.

Assessing student performance and competence

85. The visiting team has concluded that the Schools arrangements for assessing student performance and competence meets the requirements of *Tomorrow's Doctors*¹ (Sections 62 through 73) in accordance with Section 5(3) of the Medical Act 1983.

86. Phase 1 of the course saw students completing written Integrated Medical Sciences Assessments (IMSAs) covering all of their modules. If students failed to do well they received a 'best efforts' warning and moved into an end of year qualifying examination. At the end of Phase 1 students completed the Phase 1 IMSA and Introductory Clinical Course (ICC) Examination of observed clinical practice, to satisfy the requirements to progress to Phase 2. On completion of the Junior rotation

of Phase 2, students sit the Intermediate Clinical Examination (ICE). This examination is in two parts. Students who did not receive satisfactory marks in the first part were examined on further cases in the extended part of the examination. At the end of Phase 2 students completed the Final Professional Examination. Prior to graduation students were required to take an Additional Clinical Practice course, which provided refresher training in practical aspects of Foundation Years.

The principles of assessment

87. In Phase 2 there were five categories of competence for clinical assessments:
- a. History taking
 - b. Clinical examination
 - c. Problem solving
 - d. Relationships with patients
 - e. Patient management (finals only).

88. Warwick indicated that it wished to revise its examinations after accreditation, as it was unable to change its assessment layout before the official separation from Leicester. Warwick planned to reduce the assessment burden and use more integrated assessments within Phase 1. This would include end of semester OSCEs, more structure to the final exam and restructuring of the grading system. The School wished to improve the competency framework and produce performance-tested assessments. Approval would be sought from the Undergraduate Board, and followed up by a visitor observation of the first run of the assessment. The visiting team supported the School's plans.

Assessment procedures

89. Students reported an imbalance of assessment with the majority of it occurring in Phase 1. Additionally students would like to have received more feedback on their individual performance throughout Phase 2 components of the course. The School had proposed changes to address these areas, which were likely to take effect once Warwick gained independence.

90. The School was aware that it needed to improve the comparability in the assessments across SSCs. To help address these issues, the School appointed an SSC Coordinator in April 2006 to review SSCs both in their range and assessments. The resulting report proposed a revised programme model and establishment of a SSC curriculum group. The group had planned to develop new SSC proposals and assess the potential value of differently configured SSCs.

91. Students felt that the marking of their Phase 2 Portfolios was variable. Students felt that four levels of marking was too broad in relation to the subjectivity of the portfolios and would have liked more formative type feedback on this work. There was concern about standard drift in the portfolios often driven by the students

wishing to do well. Individual consultants marked the Portfolios. Moderators or double markers were not involved. The School was concerned that changes to the assessment process for the portfolios would alter students' approach to learning from this component. The visiting team thought the Portfolios offered good potential for learning opportunities and encouraged the school to develop this area further.

Standards Setting

92. The School had blueprinted Phase 1 modular and overarching exams by relating question design to modular learning outcomes. In addition the sampling matrix and blueprint of the recent Phase 1 overarching assessment demonstrated how the IMSA related to modular learning outcomes.

93. The visiting team was satisfied with the School's standard setting methods. Large consultative groups at the School were involved in setting and marking papers and model answers were developed. An initial standard would be set and the group reviewed this after the first papers were marked. A second examiner marked borderline papers and a recommendation was then made to the external examiners.

Marking Criteria

94. The grading for students in the clinical examinations was based on the level of competence expected of doctors at different stages of their careers with for example C+ equating to foundation level. Phase 2 students were expected to achieve this level in a broader range of competencies than a Phase 1 student. The visiting team felt that the grading was too subjective and was concerned that there could be significant variation between examiners. The visiting team felt that examiners were drawn towards giving a safe C+ mark.

95. The marking system for clinical examinations was such that the examiners were unable to use the full range of marks. The School used two examiners per station marking independently. The School explained that incorporating a multiple observations approach generated consistent patterns and it was rare for there to be a discrepancy of more than one grade between observers. The School reported it was unable to change grade descriptors due to restrictions under current arrangements with Leicester.

96. The visiting team commented that the School should ensure it followed current best practice in assessment including the development of clear grade descriptors for all examinations. The visiting team was reassured of the School's plans to review the descriptors as part of their overall review of assessment, post accreditation.

Assessments

97. The School's additional summative assessments in Phase 1 included a three-hour written paper of Short Answer Questions (SAQs) with fifteen clinical scenarios given at the end of the year. Students who had received one or more unsatisfactory marks moved to the Qualifying Examination, which was another three-hour

assessment. There was a seven-week period between the end of Year 1 summative examinations and the Qualifying Examination to give students sufficient time for remedial learning. The process is repeated at the end of Phase 1.

98. The visiting team queried how the practical clinical skills component was assessed, as they were not covered in the clinical examinations. The School explained this was by direct observation of students performing a procedure on the 'Additional Clinical Practice' (ACP) course. At the end of the shadowing period for the Final Year, students completed the three-day ACP where competencies in all of the common clinical practical procedures were revisited in order to be formally 'signed off'. The visiting team observed part of this course, which began three years ago, and found it to be impressive. It acted as a confidence builder for students and confirmation for the School and employers that students had attained a safe standard in the competencies needed as a Foundation Year 1 doctor. F1 trainees reported that ACP had added to their confidence. The visiting team noted ACP as good practice.

99. The School reported that students were provided with logbooks as a focused reminder of the specific requirements of *Tomorrow's Doctors* to help them record completion of specific tasks.

Qualifying Exam

100. If students failed the Qualifying Examination, the Phase 1 assessment group recommended students to take a viva with the results presented to the examinations board for review. Both the visiting team and the School agreed there were weaknesses in the viva method. The visiting team was reassured to note that the interim assessment group had reviewed this issue and would be removing the viva component in 2007.

Examiner training

101. Warwick reported that they conducted a training day where examiners performed exercises based on marking criteria and observed videos to reach marking agreements. Examiners were required to re-train every three years. The visiting team felt the arrangements were more than sufficient and commended the examiner training as an example of good practice.

Observation of clinical exams

Phase 1

102. The visiting team doubted the reliability of the Observed Clinical Practice Examination at the end of Phase 1 in its current format. In particular the communication to the patient might have been better addressed with specific communications stations in an OSCE format. The School reported that at the end of Year 1 there was an OSCE. In the new Code of Practice there would be an OSCE at the end of each semester.

103. The visiting team agreed the resources for the clinical assessments layout were excellent. Appropriate facilities had been made available to teachers and students.

Phase 2

104. For the Phase 2 Final Professional Examination the visiting team noted and commended the use of real patients but observed some variation in the amount of information patients gave to students during their examination. Additionally some variation was observed in the examiners instruction to students over what should be examined. The visiting team agreed that examiners should ensure that all candidates examined the same or part system of the patients to ensure consistency and reliability of the assessment. A quality assurance check was needed on the use of real patients, as variability in the instruction from the examiners was the issue.

105. The visiting team noted considerable inter-examiner variability in the second part of the examination where students presented and were questioned on their case findings. There was no clear structure to this component, which the team felt to be more of a viva, than a structured component. The visiting team was unclear how judgements in this component related to the mark sheets. The visiting team noted that the School had proposed new assessment procedures upon accreditation in 2007.

External Examiner Reports

106. Warwick reported that the findings of its external examiner reports were read by the Deputy Vice-Chancellor and then forwarded for action to senior staff. The School provided a response for the Examination Committee of the Undergraduate Board, which was then placed online alongside the actual report as a means of closing the loop. The School reported that the secretariat and the Deputy Vice-Chancellor were responsible for ensuring that action was taken in relation to external examiner reports.

Appraisal

107. The School was confident it was able to identify students who were not covering all areas adequately or were struggling through the course. Various channels were available such as reports received whilst students were on attachments, elective reports, assessments in examination and reports on assessments. Additionally Phase Coordinators and the Phase 2 Pastoral Care Co-ordinator reviewed student comments about their peers and the School reported that rapid action was taken when negative peer feedback was received.

108. The School had piloted a new requirement of educational supervisors to conduct a learning needs assessment on students before they made their choices for SSCs although this was not yet in place within the current curriculum. This method would allow the students to receive constructive advice to aid them with their progress.

Student progress

109. A student would only progress if they demonstrated a basic level of competence across a broad range of competencies through the Phase 1 written exams.

110. Students could fail the clinical component in Phase 1 and still progress to Phase 2 if everything else was satisfactory. Specific remedial teaching would be arranged for students in this situation.

111. Borderline students on clinical placements or whose performance on a previous assessment was poor would be required take the extended Final Professional exam. This is where students would be assessed over eight stations instead of four.

112. If a student missed any substantial components of an attachment, they would be referred to the Academic Progress Committee. This Committee would determine if there was a satisfactory way of making up for lost time, although usually any substantial time lost on any block would require the student to extend their course and defer assessment to the following year.

Exam Board

113. Two members from the Warwick QABME team and two members from the Leicester team observed the Phase 2 Board of Examiners meeting to ratify the results of both Leicester and Warwick students. All students had sat the same assessment.

114. The Exam Board was well attended by senior examiners, exam coordinators from both Medical Schools and three External Examiners. It was conducted in accordance with the Schools' joint Code of Practice on Assessment. The visiting team was able to observe and review the processes involved in setting and marking the Phase 2 written and clinical examinations.

115. The visiting team found there to be no issues with the exam board process although it was considered to be somewhat complicated.

Student health and conduct

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

117. The School had various methods for reporting a concern:

- a. Phase 1 students had close supervision and contact with relevant members of staff. All the module staff and personal tutors were aware of the mechanisms covered in the student handbook.

¹ GMC (London); *Tomorrow's Doctors*, February 2003

- b. In Phase 2 issues were brought before the Phase 2 coordinator for review.
- c. The coordinators and tutors considered information collectively.

118. The teachers reported to the visiting team that they understood the escalation channels for whom to talk to if they had any issues of a pastoral or clinical nature.

119. Warwick explained that staff had access to a Notification of Concern Form, which they could use to raise issues and act as a backup mechanism to handle concerns. The School aimed to handle concerns at an informal level through rapid information sharing and intervention. The School stated that Personal Tutors and Clinical Education Supervisors supported this system well as they were able to quickly identify concerns.

120. The School reported that it had a low threshold for addressing fitness to practise matters at an early stage and was encouraged to deal with minor issues on clinical placements. In addition, clinicians were required to assess students on attendance and attitude and make regular reports to the Medical School. The School regarded these reports as good indicators of the students' fitness to practise because of the close contact between the clinicians, staff and students.

121. The Leicester Warwick Fitness to Practise committee had a broad remit, which extended to GMC Fitness to Practise procedures and included attitudinal aspects that were normally outside of the current University standards. The new Fitness to Practise system in development for the School post accreditation would also cover these aspects.

122. Issues were first informally reviewed by the School before formal referral for consideration to the Leicester Warwick Committees. An investigating officer gathered information to aid the committee's decision. The School reported that students were aware of this process, although students that met with members of the visiting team were unaware of being formally taught about aspects of Fitness to Practise other than that it was briefly discussed during lessons on ethics and clinical law. Year 4 students had had no medico-legal talks as yet.

123. The School gave good examples of how cases had progressed to the Fitness to Practise Committee. The visiting team noted that personal tutors could be heavily involved with cases if needed. The visiting team was satisfied that the Fitness to Practise policy was working appropriately although suggest that the School might consider how to improve the students' awareness of their policy.

Whistle blowing

124. The School reported that they presented the issue of whistle-blowing to students during induction week. This was a common policy held in partnership with the Trusts. Emphasis was placed on staff training to ensure they understood the importance of teaching this principle to students. The students met with by the visiting team demonstrated an understanding of this issue.

Reflecting Contemporary Society

125. Warwick was planning a joint appointment with Coventry Teaching Primary Care Trust to recruit an advisor with the aim of extending learning within General Practice. Currently students interviewed patients at home in groups of four during community placements in 'Health in the Community' and 'Learning from Lives' modules. The Community Tutor visited all patients at home where the module was explained and written consent was obtained. Patients were given the option of having a Community Tutor present at the student interview. During the Health and the Community module students were supervised prior to visit and immediately following.

126. The visiting team was informed of the University/User Teaching and Research Action Partnership (UNTRAP) between users of health services and the Universities of Warwick and Coventry and the NHS. This was a diverse group with over 80 plus members with various experiences and expertise. The objective of the group was to support the involvement of service users and carers in teaching and research so that they would have a direct influence on the skills and knowledge of professionals in training.

Inter-Professional Education (IPE) Developments and Research

127. The School was developing innovative programmes of IPE in particular using on-line methods. There was an Inter-professional learning pathway that linked Coventry and Warwick students to 'The Ocean'. 'The Ocean' was an open forum for students, student nurses, physiotherapists and social workers. Students were made aware of the importance of team working and the roles of other parts of the healthcare team from an early stage. The School was engaged in working with the Primary Care Trusts and other Higher Education Institutions (HEIs) in the further development of IPE. The visiting team reported this as an area of good practice.

Widening Access

128. The School reported that it was associated with the National Association of Gifted and Talented Youth. Warwick students were part of a scheme where they visited local Schools to encourage interest in the medical profession. In the future Warwick will hold at least one open day for young people up to the age of fourteen who would like to consider a medical career.

129. Warwick reported that it participated in the 'Aim Higher' programme that operated across all Universities. The programme enabled students from local Schools to observe aspects of medical student life. The visiting team commended this altruistic approach of the School and the students, as they did not have an active interest in recruiting students.

130. Warwick was currently creating literature to go out to all science graduates highlighting the School's admissions system. Warwick planned to widen access incrementally. They would begin by asking for a wider diversity of students from various science degrees.

131. The School stated that for the last four years there has been an annual three-day event that promoted medicine to interested applicants. Warwick also ran annual graduate fairs.

Recommendation: That Warwick Medical School is approved for accreditation subject to meeting the requirements in paragraphs 17 a to 18 d.

Conclusion

132. The GMC and visiting team would like to thank Warwick Medical School for their cooperation and openness from all those they came into contact with during the course of the review.

Important note:

133. Since the review, on 04 October 2006 the Education Committee met and considered whether it was acceptable for Student Selected Components (SSCs) to constitute less than 25% of Graduate Entry Programmes (GEPs).

134. The Committee agreed that it was acceptable for Student Selected Components to constitute less than 25% of Graduate Entry Programmes but that Quality Assurance of Basic Medical Education Visitors should require robust justification for GEPs in which SSCs fall significantly below 20% of the course.

received 18/12/06

Warwick Medical School

Professor Peter Rubin
General Medical Council
2nd Floor
Regents Place
350 Euston Road
London
NW1 3JN

14 December 2006

Dear Peter

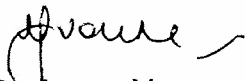
**Re: Response to the General Medical Council
QABME: Warwick Medical School, the University of Warwick Report for
2005/2006**

Further to your letter and enclosures of 13 October 2006 and Cara Talbot's further email and attachment of 23 November 2006, please find attached the formal response to the GMC from Warwick Medical School to the QABME report.

We found the content of the report helpful and the process as a whole to be thorough and constructive at this formative stage in the School's development.

Kind regards

Yours sincerely



Professor Yvonne H Carter OBE MD FRCGP FMedSci
Dean

Enc

Warwick Medical School

Medical School Building
The University of Warwick
Coventry CV4 7AL United Kingdom
Tel: +44 (0)24 7657 3080
Fax: +44 (0)24 7657 5343
Email: Yvonne.Carter@warwick.ac.uk

Re: Response to the General Medical Council
QABME: Warwick Medical School, the University of Warwick Report for 2005/06

Warwick Medical School found the QABME report helpful and the process as a whole to be thorough and constructive at this formative stage in the School's development. There follows a brief response to the major points in the final report.

REQUIREMENTS

The School is confident that we can meet the outstanding requirements of the Education Committee, as for the most part these represent 'work-in-progress' on the path to autonomy. Much of this work could not be progressed further until the QABME visit had taken place, and the School given a 'green light' to proceed further independently.

The 2007 Annual Report updates on the provision of student selected components (SSCs). The School notes the most recent guidance of the Education Committee, and in 2007 will be offering SSCs which constitute in excess of 20% of the GEP curriculum content.

The planned revisions to the assessment framework for both Phase I and Phase II have been made (with student input), and have passed through the University regulatory process. The new assessment framework for Phase 1 is in place for the 2006 student cohort, who will sit the End of Semester Assessment (ESA 1) written papers and Clinical and Practical Assessments in January 2007. At the time of the QABME team revisits, we will be able to report on the conduct of these Phase 1 assessments.

A formal 3-year contract to guarantee the provision for anatomy training at Leicester Medical School for Warwick Medical students has been agreed and will shortly be signed off.

The required revisions to the ordinances and regulations have been to the appropriate University of Warwick Committees and have been approved. All arrangements are therefore in place for awarding Warwick Medical School degrees from July 2007 following Privy Council approval in June 2007.

RECOMMENDATIONS

Further steps to make students more aware of the Fitness to Practise (FtP) system include a new page on the web site within Student Support pages "The Zone" explaining more about FtP including an explanation of FtP Committee processes and practices with explicit references to safeguards within processes. A 'whistle-blowing procedure' is displayed on the front page of the MB ChB website. A case study on FtP issues is being included in the Introductory Clinical Skills Module in Phase I, and a 360 degree evaluation of behaviours and attitudes is included in the Phase II Student Appraisals, with explicit discussion of FtP now part of individual clinical education supervision.

The community-based components of the curriculum will be expanded with particular emphasis on the 8 week Clinical Methods Course in the junior rotation of Phase II. This will be renamed the "General Practice Attachment". For the year 2007/8, sessions taught in community settings by undergraduate teachers in general practice will rise from 63 to 70, and for the year 2008/9 all 80 sessions will be focussing on the identification and management of common chronic conditions in primary care and taught in the community. Students will conduct "Student Surgeries", in the final week of the 8 week GP attachment.

The pilot Personal Tutor and Educational Supervisor system to support students is now fully implemented across all years of the MB ChB. The philosophy is that the professional attitudes and behaviours and skills needed after graduation are discussed and learned during Phase I, practised during Phase II and used in Foundation years. All Phase 2 students now have regular meetings with their individual Clinical Educational Supervisor and are encouraged to identify objectives and plan their learning to make the most of their clinical partnership teaching.

In developing our assessment system to use a more integrated criterion-referenced approach, we are following current best practice selecting assessment methods with established validity and reliability and adapting previously used assessment formats. Our assessment blueprint process maps directly our learning outcomes, to ensure that our question design and selection reflects appropriately the balance of our curriculum and the balance of issues to be faced by doctors on qualification. Warwick Medical School is an active member of the Universities Medical Assessment Partnership. The creation of our new question database enables tracking of use of examination items and monitoring of item performance. Previous grade descriptors are retained. Examiners will be given explicit guidance on the use of different grades and their consistency will be monitored.

COMMENDATIONS

We welcome the commendations for innovation and good practice and we continue to build on these.

Learning objects are being developed for the web based inter professional learning pathway to enhance the e-learning environment and to promote discussion between the student groups.

WMS created a new academic post, Associate Professor (Reader) in Medical Education in September 2006 to consolidate existing good practice in the use of e-learning and to bring new strength in this area to the MB ChB. This post coupled with a new medical librarian will further strengthen the links between physical and virtual learning spaces.

We continue to develop the involvement of patient and carer representatives through the University/User Teaching and Research Action Partnership (UNTRAP).

The commended training of examiners for clinical examinations and the standardised approach of examiner feedback to students during the clinical assessments will be further enhanced by the use of specially made DVDs for examiner briefing and revision sessions.

Peer mentoring is proving successful in the Clinical Applications Special Study Module and is being extended within MB ChB. A generic model for mentoring has been developed and is being used to inform more specific applications.

The commended 'Additional Clinical Practice' course at the end of students' shadowing period is being further developed in response to student feedback.

In summary, Warwick Medical School was deeply appreciative of the constructive approach adopted by the QABME visiting team, assisting the development of the independent Medical School, and we look forward to demonstrating our progress during their visits in 2007.

Professor Yvonne H.Carter OBE MD FRCGP FMedSci
Dean
Warwick Medical School
University of Warwick
Coventry
CV4 7AL

December 2006