

# Undergraduate Quality Assurance Visit

## Report on Birmingham School of Medicine

2011/12

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## Executive Summary

1. The 2011 visit occurred during a time of change for Birmingham Medical School (the School). The School has recently amended both its governance structures, in response to changes to the University college structure, and its administrative systems following a School review. The School was also in the middle of major reviews of its curriculum and assessment systems at the time of the visit.
2. Overall the School appears to be making positive progress, although the pace of change has been slow. We understood that the restructure required by the University has been a factor in this and may still be impeding the rate of progress. The School indicated that it wanted to increase the speed of change and we agree that this is necessary. It was also evident there have already been improvements in this area, with a considerable amount of work being undertaken in the last 18 months.
3. Where the team identified issues, the School was generally already aware of these and reported that work was planned or underway to address them. The School was also committed to ensuring that the changes to its management and committee structures would allow it to be more responsive in the future and enable continuous improvement of the programme.
4. We were impressed by the students we met with at the School and on the site visits. Students were generally happy with the training they received, and would recommend their medical school to others. Foundation programme trainees and their trainers reported that Birmingham graduates were well prepared for their role and of a good standard. Staff we met at the local education providers (LEPs) all appeared eager to engage with education and training and committed to the continuous improvement of training programmes.

### *Quality management*

5. Both the overall management structure of the School and the academy structure for LEPs were relatively new at the time of the visit, so the team were not able to determine the effectiveness of these structures or their impact. We found that the School's current quality management structures do not provide the required comprehensive oversight of programmes. We acknowledge that the School's quality management processes are required to align with those of the University and that this, in conjunction with the resourcing of the quality team, presents challenges to the School in achieving a coordinated view of the quality of its programmes. We considered this an area of risk to be addressed as a priority by the School (see requirement 1).
6. The School has clearly given consideration to future proofing its structures in the face of wider uncertainty within the NHS and had introduced the academy structure as a result. The new structure devolves quality control to LEP level and allows individual academies to adapt the programmes based on their circumstances, such as service reconfiguration. However the quality management systems of the

School do not appear to currently be adequately monitoring and resolving issues with the quality of teaching in LEP placements (see requirement 2).

### *Curriculum and Assessment*

7. The School was three years into a six year curriculum review, at the time of the visit. The strategic objectives of the curriculum review include ensuring compliance with *Tomorrows' Doctors* 2009 (TD09) reducing anonymity, improving feedback and the integration of clinical and basic sciences. We noted that the 2004 GMC visit report identified similar issues regarding integration, and while we acknowledge the improvements made to date we consider that the rate of progress has been slow. We were pleased to note however that the pace of change had quickened, with a considerable amount of work being undertaken in the last 18 months, and encourage the School to continue its progress in this area (see requirement 4).

8. The School was also partway through a review of its assessments at the time of the visit, and its draft assessment strategy demonstrated recent developments. The School has some further work to complete before this strategy can be finalised and we encourage them to complete this work as soon as possible. We also identified some specific issues with the reliability and validity of some of the School's assessments which it must address (see requirement 3).

### *Student support*

9. The School demonstrated a strong commitment to student support, both of individual students and of the student population as a whole. The School undertook an analysis of the results of the National Student Survey (NSS) which led it to identify a feeling of anonymity amongst its large student cohort. The School's subsequent changes to its administrative processes demonstrated its responsiveness to identified issues concerning student support.

10. Student support services were universally commended by students and staff, and the availability and effectiveness of support was evident. We found that staff responsible for student support were enthusiastic and dedicated to providing a high quality service, and that this was being delivered (see good practice 1).

### *Relationship with stakeholders*

11. The School's introduction of the academy structure for LEPs builds on previous structures that were in place. The full impact of the academy structure was not yet evident, although the regular heads of academy forum at the School was acknowledged by those involved as an effective way of sharing concerns and good practice. We encourage the School to continue its development of the academy structure, with a particular focus on communication and engagement on changes with LEPs, as this remained a challenge.

12. The School has a good relationship with the NHS West Midlands Workforce Deanery, and arrangements are in place to transfer information and share fitness to practise concerns relating to Birmingham graduates.

## *Visits to LEPs*

13. The School delivers teaching across 13 trusts (16 hospitals), and around 100 general practices. We were impressed by the commitment and enthusiasm of the clinical teachers we met at the two LEPs visited, and students reported that teaching was mostly of high quality. Students particularly highlighted their appreciation of the experience they gained in community based medicine.

### Heart of England NHS Foundation Trust (HEFT)

14. HEFT serves over a million people throughout north and east Birmingham, Solihull, Sutton Coldfield, Tamworth, Burntwood and the surrounding areas. We visited Heartlands Hospital, which is one of four hospitals within the Trust. The Hollier simulation centre is situated within the Trust at Good Hope Hospital, and this is used by all students within the School.

15. The senior management team were engaged with education and training, however the reconfiguration of services presents a challenge to the Trust and this has impacted on the delivery of timetabled undergraduate teaching. Academy staff are working to address this, but we consider that the Trust would benefit from increased engagement from the School in addressing these challenges.

### University Hospitals Birmingham NHS Foundation Trust (UHB)

16. We visited the new Queen Elizabeth Hospital site, which was nearly complete following a large reconfiguration of services and sites, and which replaces the previous Selly Oak and Queen Elizabeth sites. The Trust is the regional centre for a number of services (including cancer, trauma, and burns and plastics) and provides adult services to more than half a million patients each year.

17. Student experience at UHB was generally positive. There were some issues about the timetabling of teaching following service reconfiguration, and LEP staff were working to correct these issues. The senior management team were engaged with education and training and had a good working relationship with the School, which is situated on the same site.

## Key findings

### Good Practice

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| 1. | <i>Tomorrow's Doctors</i> (TD) Domain 6 (TD 124 and 131) | The School's Student Support Unit was widely acknowledged to be accessible and of excellent quality with universal commendations from both students and staff (see paragraph 66).   |
| 2. | Domain 6 (TD 122)  | The School's innovative commendations processes for students who have made a significant contribution at any stage during the programme (see paragraph 65).   |
| 3. | TD Outcome 17  | The quality of the School's prescribing licence teaching and assessment (see paragraph 33).   |
| 4. | Domain 5 (TD 103 and 106)                                | The well organised community-based medicine placements, and the opportunity this provides to students to link clinical and basic sciences at an early stage of the programme (see paragraph 34).  |
| 5. | Domain 8 (TD162, 166)                                    | The roles of Educational Fellow and Clinical Tutor were recognised by students and staff as making a major contribution to teaching quality and developments in the programme as well as playing an important role in student support (see paragraph 64). |

### Requirements

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|----|--|---|
| 1. | Domain 2 (TD 38, 39, 40, 49, 51 and 53)  | The School must ensure that its quality management processes are appropriately documented and resourced to plan, monitor, and identify and resolve problems for all areas of the programme, including; admissions; the learning experience, including induction, teaching, supervision, placements and curriculum; appraisal of, and feedback to, students; pastoral and academic support; assessment; educational resources and capacity (see paragraphs 10-14, 42 and 74) |
| 2. | Domain 2 (TD 38, 40, 41, 44, 48, 49, 50, 51 and 53)<br>Domain 7 (TD 151 and 152) | The School must share with the GMC an evaluation of the effectiveness of the academy structure to demonstrate that the School is monitoring the delivery of its curriculum by LEPs in a consistent, effective and formal way. This must also include specific examples of how the School uses the evidence it collects from the LEPs to resolve issues and further enhance training, and how this activity is   |

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|    |   | communicated to students and staff (see paragraphs 75-78)   |
| 3. | Domain 5  | <p>The School must provide evidence that its final assessment strategy fully reflects the mechanisms by which it oversees and coordinates assessments across the whole curriculum, and that these mechanisms have enabled the School to implement required changes to assessments, including to:</p> <ul style="list-style-type: none"> <li>• integrate learning about basic medical and clinical sciences, and the reinforcing of learning through re-visiting topics at different stages, for assessments in Phase 1 (see paragraphs 31, 43, 47-49, and 77)</li> <li>• Improve the reliability of the Phase 2 OSCE by increasing the number of stations (see paragraph 51)</li> <li>• Use evidence from research into best practice to improve the planning and organisation of the final year (Phase 4 OSCE) (see paragraphs 52-54)</li> <li>• Update assessment blueprints for each individual assessment following changes (see paragraph 46)</li> <li>• Ensure all examiners apply the School's assessment criteria consistently, particularly for the final examinations (see paragraphs 53, 56-57)</li> <li>• Ensure that end of block formative assessments are delivered in a fair and consistent way (see paragraph 44)</li> </ul> |
| 4. | <p>Domain 5 (TD 101)</p> <p>Domain 7 (TD 152 and 156)</p> | <p>The School must accelerate the curriculum review and must provide a clear programme of implementation demonstrating that the review of the curriculum will be complete, and the majority of changes to all years in place, by the start of the 2014/15 academic year. The School must continue to monitor and evaluate the progress of the review and ensure that the revised curriculum meets the requirements set by <i>Tomorrow's Doctors</i>, in particular that the teaching of basic medical and clinical sciences is properly integrated from the beginning of the course. Changes to the penultimate year must be finalised through effective communication with Local Education Providers (see paragraphs 31, 36 and 78)</p>  |

## Recommendations

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|----|-----------------------------|--|
| 1. | Domain 1 (TD 30)            | The School should ensure that those supervising students are fully aware of the learning requirements of these individuals at each particular stage of their training (see paragraphs 8 and 37)  |
| 2. | Domain 3 (TD 60 and 61)     | The School should consider identifying a lead with responsibility for ensuring that School's policies and procedures are based on principles of equity and fairness (see paragraphs 21-22).  |
| 3. | Domain 5 (TD 106)           | The School should work to improve the consistency of scheduled formal teaching between modules and trainers across a range of sites (see paragraphs 37-40).  |
| 4. | Domain 6 (TD 128)           | The School should improve communication about the reporting process for concerns with regards to students' behaviour, so that students and LEP staff are clear about its purpose and to ensure the process is applied consistently (see paragraphs 69-70). |
| 5. | Domain 5 (TD 84, Outcome 8) | The School should monitor the impact and effectiveness of changes to anatomy teaching, and report back to the GMC on its effectiveness in ensuring students meet the relevant outcomes of <i>Tomorrow's Doctors</i> (see paragraph 32).                    |
| 6. | Domain 9 (TD 43c, 169, 172) | The School should develop its tracking of graduate progression and outcomes to enhance the quality of its programme and collect feedback from employers about the preparedness of its graduates (see paragraph 81).  |

18. The School's right of reply and initial action plan against the requirements and recommendations are appended to this report. The School will provide an update on progress against these requirements and recommendations in their next scheduled Medical School Annual Return in 2012.

## Visit overview

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|-------------------------|--|
| School                  | Birmingham School of Medicine  |
| Dates of visits         | 18-19 October, 9, 23, 30 November 2011, 1 December 2012  |
| Programmes investigated | Bachelor of Medicine and Surgery (MBChB) and MBChB Graduate Entry Course   |
| Areas for exploration   | Organisational structure of the School; Quality management processes of the School, and how the School works with LEPs at a quality control level; Delivery of, and changes to, the curriculum; Assessment processes and strategy of the School; Student support and the student experience; Fitness to practise procedures; Transition to the foundation programme; Training of trainers; Patient and public involvement. |

### *Risk based visiting*

19. The QIF recognises that quality management (QM) within schools and deaneries has matured and that quality control (QC) within local education providers (LEPs) requires further development. Previous visits have investigated all standards in all schools. This is no longer proportionate and we have committed to focusing our visits on areas of risk and areas that are new in the 2009 version of *Tomorrow's Doctors*. We are also committed to sharing good practice encountered through visits.

### *Concerns raised during the visit*

20. We have a policy which sets out the process for responding to serious patient safety or educational concerns that may be raised during a scheduled quality assurance visit. Concerns raised via this process will require immediate action and if necessary will then be referred to our response to concerns process:

<http://www.gmc-uk.org/education/process.asp>.

|  |  |
|--|--|
| Were any Patient Safety concerns identified during the visit?                                  |  |
| Yes <input type="checkbox"/> (include paragraph reference/s)                                   | No <input checked="" type="checkbox"/> |
| Were any significant educational concerns identified?  |  |
| Yes <input type="checkbox"/> (include paragraph reference/s)                                   | No <input checked="" type="checkbox"/> |
| Has further regulatory action been requested via the responses to concerns element of the QIF? |  |
| Yes <input type="checkbox"/>   | No <input checked="" type="checkbox"/> |

## The report

1. This is a report on the quality assurance programme for Birmingham Medical School (the School) for 2011/12.
2. Birmingham Medical School is the one of the largest medical schools in the UK, with approximately 2000 students, and a cohort of around 385 students a year. The School offers two programmes, a five year MBChB (Bachelor of Medicine and Surgery) programme and a four year MBChB graduate entry programme.
3. The University of Birmingham is split into five colleges; with the head of each college also acting as Pro-Vice Chancellor and representing the college on the University Executive Board. The two MBChB programmes sit within the College of Medical and Dental Sciences. The Dean of Medicine reports to the Head of the College, but in regard to issues of students' fitness to practise (FtP) or relating to the General Medical Council the Dean reports directly to the Vice Chancellor. The School is required to comply with the University reporting structure, although this at times represents a duplication of reporting or does not match the reporting structures of the School organisational structure.
4. The School is currently part way through a curriculum review process. The review began in 2008 and all of the amendments to the curricula and assessment systems will be implemented by 2014, although the review is a phased approach with changes to different parts of the course being made at different stages. The School is moving from a pre-clinical/clinical split between Phase 1 (Years 1 and 2) and Phases 2 – 4 (Years 3-5), to a more integrated programme, with a spiral curriculum. Phase 1 of the standard entry programme is modular and systems based, whilst Phase 1 of the graduate entry programme is structured around problem-based learning. Students from both programmes share clinical placements and lectures from Phases 2 – 4 and the programmes are then run in a broadly similar fashion.
5. The School was last reviewed by the GMC during the 2003/4 (quality assurance of basic medical education) cycle, and the amount of time since the last visit introduced an additional element of risk, and required the team to consider a wide range of issues. The 2004 report focused on the work the School was undertaking to develop the integration and co-ordination of its curriculum and assessment systems. The report noted that the School was required to comply with the University's modular structure for courses, and that this was constraining integration of learning. We acknowledge that the School has been working with the University to address these issues, although progress has been slow.

## Domain 1: Patient safety

*26. The safety of patients and their care must not be put at risk by students' duties, access to patients and supervision on placements or by the performance, health or conduct of any individual student.*

*27. To ensure the future safety and care of patients, students who do not meet the outcomes set out in Tomorrow's Doctors or are otherwise not fit to practise must not be allowed to graduate with a medical degree.*

### *Clinical supervision*

6. The School has developed a risk register that identifies both the 'risk of students being assigned inappropriate tasks to carry out for which they are not sufficiently qualified' and the risk of 'insufficiently skilled teaching staff leading to poorly trained students'. The School assigns a low probability of occurrence for both risks, and provides evidence for this.

7. We found that students were not being asked to work beyond their current competence without appropriate supervision. Students all knew who their clinical supervisor was, and always had access to support and advice.

8. However we met with students from across a range of years and sites who indicated that their supervisors were not always aware of their requirements and what tasks they were able to undertake, and that this also varied between consultants, nurses and foundation programme trainees. Some teachers indicated that they were sent this information by the School, whilst others indicated that they asked the students for their handbooks when they started their post to check if there had been any changes. The School should ensure that those supervising students are fully aware of the learning requirements of these individuals at each particular stage of their training.

9. The School has recently produced a draft whistle-blowing policy to inform students and those supervising them of how to raise concerns if they identify risks to patient safety. Comments on this are being gathered from students before the policy is considered and finalised by the School.

## Domain 2: Quality assurance, review and evaluation

*38. The quality of medical education programmes will be monitored, reviewed and evaluated in a systematic way.*

### *Quality management*

10. The School has a quality management structure, but it does not cover all areas of the programme. The quality team undertake monitoring visits to LEPs, arrange external examiners, review the NSS and manage the School's risk register. Assessment and curriculum evaluation, review of student support effectiveness and

review of admissions are undertaken by different groups within the College looking at medicine and dentistry together.

11. The quality management of the programme is fragmented as different committees and groups are responsible for their different areas, and some areas for example curriculum and assessment report directly to over-arching College groups and do not interact with the School's internal QM processes. There is also a separate Student Welfare and Development Advisory Group, and Medical Quality Assurance and Enhancement Committee (MQAEC) within the School that report into separate College (medical and dental) committees rather than being responsible to the senior management team at the medical school.

12. While systems are in place they are not clearly documented for students and staff, and we found that the fragmented responsibilities for QM resulted in a lack of coordination across the medical school programmes. For example the risk register does not cover issues relating to student fitness to practise, assessment or curriculum development. In addition some of the issues identified when we visited in 2004, for example the integration of basic medical and clinical sciences and the mapping of assessment to the curriculum, have not been resolved.

13. We understand that the design of the School's quality management structure is aligned to the University's processes however this prevents a holistic view of the quality of the programmes. The quality management of School programmes could be improved by central coordination and leadership for quality issues, risks, action and evaluation.

14. We remain concerned about the lack of an overarching strategy for the planning and monitoring of the MBChB programmes (see also paragraphs 37-39, 42, 74-78). The School must ensure that its quality management processes are appropriately documented and resourced to plan, monitor, and identify and resolve problems for all areas of the programme, including; admissions; the learning experience, including induction, teaching, supervision, placements and curriculum; appraisal of, and feedback to, students; pastoral and academic support; assessment; educational resources and capacity.

15. We did however see evidence that in the areas for which the School was responsible for quality management improvements had been made. For example in response to student feedback the School reviewed and amended its 2011 'Welcome Week' induction, and the new programme has received positive evaluation from students, which was supported by the views of the students we spoke to.

#### *Agreements with providers*

16. The School has agreements in place with its academies and there is a system of annual reporting against the agreements, which includes performance metrics, such as students' attendance at formal teaching sessions, who delivered the teaching, and instances where teaching was rescheduled. Twice a year the School reviews the academies' reports against student evaluation and meets with the heads of academy to discuss the results.

17. We saw evidence of issues being raised through these meetings. This positive process could be further enhanced by central monitoring of the actions agreed and evaluation of effectiveness of actions taken.

18. The School facilitates a Heads of Academy Forum which both promotes the sharing of experience between the academies and allows the views, issues and good practice from the academies to be communicated to the School. The forum was valued by the heads of academy we spoke to and we heard examples of good practice that had been shared for example following the success of the Russell Hall teaching clinic which made use of department space that had been closed, other LEPs have reallocated unused clinic space for teaching.

19. We saw evidence that the School has a strong relationship with the NHS West Midlands Workforce Deanery which supported a coordinated approach to the management of relationships with LEPs. In addition to the twice yearly meetings between the heads of academy and the School, the quality team undertake monitoring visits which include a representative from the deanery. This tripartite discussion of funding for training ensures a joint approach between the medical school and the deanery.

#### *Patient and public involvement*

20. We noted that the School has a number of initiatives in place to involve patients and the public, which is a challenging area for medical schools across the UK. Patients are involved as gynaecology teaching assistants to teach examination techniques in conjunction communication and interpersonal skills, and they participate in role-plays on psychiatry placements and give feedback to students. Additionally, in preparation for the curriculum review, the School ran a focus group with representatives of a patient group to identify the most important patient requirements for students and their role as future doctors

### **Domain 3: Equality, diversity and opportunity**

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| 56. Undergraduate medical education must be fair and based on principles of equality. |
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#### *Policies and data collection*

21. The School collates a significant amount of equality and diversity data for the various elements of its programmes, however that there is no overarching group with responsibility for equality and diversity to ensure that data are analysed and concerns identified. The MQAEC analyses information on equality and diversity for work it directly undertakes, such as the monitoring of student evaluations, but does not consider this in the context of equality and diversity data for other areas such as student progression.

22. The School should consider identifying a lead with responsibility for ensuring that School's policies and procedures are based on principles of equity and fairness.

## *Support for students*

23. The University structure within which the School works means that the disability advisers within the University indicate reasonable adjustments for individual students in writing, and these may not necessarily be applicable to a clinical programme with a professional regulatory body. The School said that direct communication between the University disability advisers and the Student Support Unit would be beneficial in the sharing of issues and good practice.

24. We were pleased to note that in 2011 the University funded a member of the QA team to visit to other medical schools to explore how they helped to accommodate students with disabilities. The School will use the research from this investigation to make further improvements to its approach to dealing with students with disabilities.

25. The School has a number of support groups for students including a Religious and Cultural Beliefs Forum and a Lesbian Gay Bisexual and Transgender group. The lead for the Religious and Cultural Beliefs Forum also sits on the MQAEC, and feeds any relevant issue into this group. Some of the Muslim and Jewish students from within the Religious and Cultural Beliefs Forum have worked with the School to develop guidance which has been considered by a number of other medical schools.

26. Support for students with a disability is provided centrally by the University and locally by the School. The School indicated that the proportion of individuals with a disability in the School is on a par with that of other Schools. The School advised there are students with mobility issues within the current cohort and were able to provide examples of how it has made reasonable adjustments for students on placements at LEPs. The School is currently not wheelchair accessible, but has not yet had a student with these requirements and advised it will review this if the need arises.

## **Domain 4: Student selection**

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| <i>71. Processes for student selection will be open, objective and fair.</i> |
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### *Selection*

27. The School participates in a number of initiatives to widen access for underrepresented groups. Some of the initiatives, such as the Access to Birmingham (A2B) Scheme are led by the University, but the Admissions Tutor ensures active engagement on behalf of the School. The A2B scheme involves visits to a number of local schools and colleges to promote the Medical School, and to highlight the availability of bursaries from the University for students accepted under the scheme. The School tracks A2B students' progression through their first year on the programme, to facilitate early identification of academic difficulties, but to date no issues had been identified.

28. The School also supports 'Birmingham Widening Access to Medicine', which is a student led initiative in which medical students go to local schools to encourage

interest in studying medicine. In addition some local trusts have their own initiatives to bring local pupils interested in medicine into the trust for a day to gain experience of working within a clinical environment.

29. During the recent review of the School's selection processes the School self-identified a need to include lay representation on their selection panels. We would encourage the School in its plans to incorporate lay representation to support the objectivity of its selection processes.

## **Domain 5: Design and delivery of the curriculum, including assessment**

*81. The curriculum must be designed, delivered and assessed to ensure that graduates demonstrate all the 'outcomes for graduates' specified in Tomorrow's Doctors.*

### *Curriculum design and structure*

30. The School is three years into a six year curriculum review, Curriculum 2014 (see paragraph 4). The strategic objectives of the curriculum review included work to ensure compliance with *Tomorrows' Doctors* 2009 (TD09). We found that the curriculum mapped to the outcomes of TD09.

31. Another objective of the School's curriculum review is to improve the integration of basic medical and clinical sciences. Students we met agreed that the integration of basic medical and clinical sciences had been limited, and that that re-visiting the knowledge, skills and behaviours developed at earlier stages of training would have helped to reinforce their learning. The School stated that it has begun to adopt a spiral curriculum philosophy, but that so far work has mainly been focused on amending the clinical years of the programme, phases 2, 3 and 4. Work on the pre-clinical years (Phase 1) has not started yet. The School must accelerate the curriculum review and must provide a clear programme of implementation demonstrating that the review of the curriculum will be complete, and the majority of changes to all years in place, by the start of the 2014/15 academic year. The School must continue to monitor and evaluate the progress of the review and ensure that the revised curriculum meets the requirements set by TD09, in particular that the teaching of basic medical and clinical sciences is properly integrated from the beginning of the course.

32. The School has made some recent amendments in response to students' evaluation of their anatomy teaching. However Year 2 students we met still expressed considerable dissatisfaction over the organisation and resourcing of anatomy teaching they received, particularly with regards to access to the prosectorium, and indicated that this was of variable quality and relied upon a disproportionate amount of time for self-directed learning. Although we acknowledge that the changes to anatomy teaching are recent, and that the full impact may not yet be evident, the School should monitor the impact and effectiveness of changes to anatomy teaching, and report back to the GMC on its effectiveness in ensuring students meet the relevant outcomes of TD09.

### *Prescribing Licence Assessment*

33. We note that the School's Prescribing Licence Assessment has helped to inform the development of the national Prescribing Skills Assessment. The training course and associated assessment had been in place for 15 years, and the School submitted this for consideration for use as the national assessment tool. Students in Year 5 mentioned this as a particular strength of the course and indicated that they found it to be helpful preparation for practise. We commend the quality of the School's prescribing licence teaching and assessment as an area of good practice.

### *Clinical placements and experience*

34. Students at all stages of training were extremely positive about their experience within community based medicine (CBM), and the ability to link clinical and basic sciences at an early stage. Students were particularly positive about this as it provided their only opportunity for clinical exposure in the early years of the course. Additionally students felt that the placements were well organised and that the continuity of teachers allowed them to develop good relationships with their CBM trainers. We commend the well organised community-based medicine placements, and the opportunity this provides to students to link clinical and basic sciences at an early stage of the programme as an area of good practice.

35. Prior to the introduction of the academies, students visited most of the 16 teaching hospitals used by the School over the course of the programme. The School has extended the duration and reduced the number of placements in Phase 2 to reduce students' feelings of anonymity within their cohort and address students' perception that their training was disjointed. The School is planning to implement similar changes to phases 3 and 4.

36. Staff at the LEPs were concerned as to how the revised curriculum for Year 4 could be delivered due to resource constraints, and did not feel that the School was fully cognisant of these difficulties. LEPs were concerned that the final plans for the reorganisation of students' placements in Year 4 had not yet been confirmed by the School, and staff at Heartlands Hospital were particularly concerned as to how the new curriculum could be implemented. Changes to the penultimate year must be finalised through effective communication with Local Education Providers

37. Students in phases 2, 3 and 4 raised concerns about the consistency of scheduled formal teaching between modules/specialties and trainers across a range of sites. This appeared to be a particular issue at Heartlands Hospital, although variation in consultant engagement and teaching between departments was also identified by students at HEFT and UHB. Teachers we met with confirmed that there was variability in the engagement of supervisors in teaching, and highlighted that in most departments all consultants are expected to have a training role, regardless of their personal skill or interest in teaching. Teachers' and supervisors' awareness of students' learning objectives was also variable (see paragraph 8), as was the range and amount of experience in specialties students encountered.

38. Access to formal surgical training was described as an issue by students at both UHB and HEFT, following service reconfigurations and the combination of

medical and surgical teaching into one combined block. At UHB staff had tried to address the issues raised through student feedback at a local level, but teachers indicated that this had been limited by the uncertainty surrounding the curriculum changes for Year 4 in 2012. In addition, the concerns at HEFT were revealed to be more widespread than indicated by previous feedback, with all students describing extreme variation in the teaching received between specialties, and all students reporting some experience of placements where formal training had been minimal or non-existent. Students based at Solihull Hospital indicated that they split their time between this site and Heartlands Hospital, but that they do not get formal teaching when at Heartlands, as they are not attached to a firm there. Some consultants at Good Hope Hospital have also offered to let their students spend some of their time at Heartlands Hospital due to the limited number of clinics and specialties provided at Good Hope, but this is not formally in the timetables of students.

39. Students reported not being able to find the location of clinics they were scheduled to attend, and the merger of services and sites resulting in the cancellation of clinics without this being reflected in student's timetables. This was particularly an issue at HEFT, with students reporting that teachers were not always aware that they were scheduled to provide teaching, and in some cases the nominated consultant had left the organisation. We noted that some of these issues had previously been raised through student evaluation of their placements (see paragraph 75).

40. We acknowledge the impact that service reconfiguration has had on the delivery of teaching, however the School should work to improve the consistency of scheduled formal teaching between modules and trainers across a range of sites

#### *Assessment*

41. An assessment review is being undertaken alongside the curriculum review by the School. The review aims to ensure that the assessment system is fit for the purposes of the amended curriculum, that standards are being maintained, and that final year assessments ensure graduates are prepared for Year 1 of the foundation programme. The Assessment Group manages the entire assessment system and assessment processes, and reports to both the College Curriculum Committee (for medicine and dentistry) and the College's Medical School Management Board. The deputy phase leads have a direct responsibility for assessment for their respective phases, and all sit on the Assessment Group.

42. A draft assessment strategy has recently been produced by the School and is still in development, along with the assessment systems and processes. The administration of assessment is not yet fully formalised and codified, for example the assessment strategy does not yet describe how the Assessment Group works and where the responsibilities for setting exam questions and blueprinting sit. The School must provide evidence that its final assessment strategy fully reflects the mechanisms by which it oversees and coordinates assessments across the whole curriculum.

43. We were pleased to note that the University has now granted the School an exemption from their rules on the modular structure of assessments for Phases 2, 3

and 4 of the MBChB programmes. Now that these restrictions have been removed the School has been able to reduce the number of assessments students have to undertake, which is generally seen positively by students. Phase 1 is still required to comply with the University's modular structure and this poses a challenge to the School in allowing them to adapt their assessments to reflect the integrated approach to learning required by TD09. We encourage the School to continue to work with the University to ensure that the structure of assessments in Phase 1 is appropriate for the integrated curriculum.

### *Validity and reliability*

44. Students reported an issue in the variability across sites of some formative end of block assessments. Students stated that for some of the end of block assessments the rigour with which the module was assessed was dependant upon the approach of staff at that site. Teachers indicated that some formative end of block assessments are still in place, but that there is no mark provided for this, and the students must simply be deemed as satisfactory. The School must ensure that end of block formative assessments are delivered in a fair and consistent way.

45. We were pleased to note that the School has now adopted standard-setting procedures for both programmes and all years of training. The School is moving to the use of a modified version of the Cohen method for written examinations in Years 1, 2 and 3 of the five year programme, with the final two years of the five year programme and the graduate entry programme using the Angoff method for written examinations. The School uses the borderline group method for its objective structured clinical examinations.

46. The School is in the process of producing formalised blueprints for all assessments. We saw the blueprint for the Year 5 examinations. This focused on mapping the subjects against TD09 outcomes, but did not provide evidence that the clinical assessments are being systematically planned to test the learning outcomes of the curriculum. We acknowledge the progress that the School has made so far on blueprinting. The School must continue to develop their blueprints for all assessments, and ensure these are of sufficient quality and reflect the planning of valid examinations.

### *Examinations*

47. We reviewed copies of the previous years' (2010/11) examination papers. The papers were appropriate, mainly comprising an extended matching question (EMQ) format. The re-sit papers also used an EMQ format, but some questions were asked in a single best answer format. The papers were split into separate sections for each subject.

48. Year 1 and 2 papers are developed and marked at module level; although for practical reasons are combined across up to three modules within a single examination session. If students fail one of the modular sections within the examination therefore, they only need to re-sit that module. Short answer questions are used in addition to MCQ/EMQ.

49. Integration of assessment is not currently in place for Phase 1, as each module is effectively assessed separately. This is not the case in assessment for the later years of the programme. The School confirmed that this format is historical and that the School intends to continue moving towards further integration of teaching and assessment, with work on phase 1 still to be undertaken. The School must integrate learning about basic medical and clinical sciences, and the reinforcing of learning through re-visiting topics at different stages, for assessments in Phase 1.

50. Some students said that there was a lack of focus on clinical skills in Year 4, with the majority of teaching taking place in outpatient clinics and therefore providing limited opportunity for practicing history taking, communication, clinical examination or procedures. Clinical skills are assessed in Phase 3 in the form of the Clinical Skills Passport, however some students indicated that they would appreciate further focus on clinical skills (see also paragraph 31). It was highlighted by students that if they chose to intercalate after Year 3, then there may be a period of nearly three years in which students do not undertake an objective structured clinical examination (OSCE). We were pleased to note that the School has plans to introduce a Phase 3 OSCE in 2012/13 in response to students' concerns.

51. The Year 3 OSCE has six stations, and the School acknowledged that the reliability co-efficient was lower for this assessment than for the Year 5 OSCE. We consider six stations a low number for use within an OSCE, and that this may lead to low reliability. The School must improve the reliability of the Phase 2 OSCE by increasing the number of stations.

52. The School's final year OSCE consists of 18 stations and is split into two parts of nine stations each, with students undertaking one part of the assessment in November, and the other the following April. To pass the OSCE students must score at least 50% overall in the OSCE, and must pass 12 out of 18 stations. We noted that the nature of the stations used was limited, and the School could expand its use of scenarios and the range of clinical skills tested. For example there was no testing of clinical skills in obstetrics and gynaecology through this exam, with both stations instead taking the form of a case based discussion. We note that a similar issue regarding the unstructured nature of examinations was raised in the 2004 GMC visit report.

53. The OSCE marking schedules for examiners lacked structure which allowed significant variation both in individual examiner performance and between examiners. Trigger questions were few in number and examiners supplemented these with their own questions allowing significant variation between students within a circuit, and between different circuits.

54. The School must use evidence from research into best practice to improve the planning and organisation of the final year (Phase 4) OSCE.

### *Examiners and assessors*

55. The School informed us that it has trained around 450 examiners, and this training is based on the training designed by the Royal College of Physicians, as well as using student videos in training. The School undertakes analysis of the

performance of the examiners to determine whether an examiner generally marks above or below the average. The School stated that sanctions are not generally applied based on this data, but that the data is monitored from year to year and that action would be undertaken if necessary.

56. The examiner briefings before the exam varied between sites in quality and content, and there was little guidance on the standard expected of students in the different stations. Aside from the generic briefing at each site, there were no mechanisms in place to allow those examining the same station across different circuits or sites to discuss their approach and the calibration of marks.

57. We acknowledge the School's work in analysing data on the performance of examiners, however we are concerned about possible inconsistent application of assessment criteria arising from unstructured marking schedules, variation in examiner briefings and a lack of meetings between examiners to ensure consistency. The School must ensure all examiners apply the School's assessment criteria consistently, particularly for the final examinations.

58. We are concerned that the feedback from external examiners did not identify these issues with the OSCE process. We were not able to meet with any external examiners during the visits, but noted the involvement of an external examiner at the Examination Board. The School may wish to review their external examiner process to ensure that this is adding value.

59. We were satisfied that all students received timely and accurate guidance about assessments. All students we met were aware of the assessments for their year of training, and had received an assessment booklet and explanation of the assessments at the start of each year. The School explained that the details of the full range of assessments across the five years of the programme were not provided to students due to the review and resulting changes to assessments that are ongoing, and students appeared to be aware of this reason.

#### *Feedback to students on their performance*

60. We were satisfied that students received regular feedback on their performance. Some students, however, considered that more detailed feedback would assist their learning. The School has addressed this in Phase 1 by giving students feedback with their summative end of year examination marks, including the distribution of marks for the rest of the students and some general feedback from examiners on the average mark of each question and subject area. Students who failed were also offered individual face to face feedback. The School highlighted that this method of feedback has been recognised by the University as good practice and as something that other colleges should consider. The School is also piloting different types of feedback to students on the phase 4 OSCE.

#### *Transitions*

61. The School works well with the local postgraduate deanery to ensure the effective transfer of information, particularly in relation to students and trainees with concerns. The deanery informs the School of any foundation programme trainees

who are Birmingham graduates who are referred to GMC with fitness to practise (FtP) issues. The School has added a section to the transfer of information form that asks students to confirm where they will be undertaking their foundation programme training. Trainees with FtP or diligence concerns, or who may require support due to personal issues at the point of graduation, are discussed by a group of staff at the School. This group then decides what information on the individual should be passed on.

62. The Clinical Skills Passport records students' successful completion of clinical procedures, and facilitates teachers sharing concerns relating to students' clinical skills. The Clinical Skills Passport is a joint venture with the postgraduate deanery and with other medical schools in the region to assist the transfer of information from undergraduate to postgraduate training. The students and heads of academy confirmed that this was an effective tool and is in use across all academies.

## **Domain 6: Support and development of students, teachers and local faculty**

*122. Students must receive both academic and general guidance and support, including when they are not progressing well or otherwise causing concern. Everyone teaching or supporting students must themselves be supported, trained and appraised.*

### *Academic support*

63. The School identified some concerns with the organisation and management of the course and has initiated the Reviewing and Enhancing Administration for Medical Students project to review and enhance its administrative systems. The University has funded the purchase of a new electronic administration system, and has relocated their administrative staff into one central office. The School expects to complete the reorganisation of administrative systems in November 2011, and plans to use student evaluation and the results of next year's NSS evaluate the effectiveness of these changes.

64. We found that the academy system provided good mechanisms for student support at LEP level. Each academy is supported by an undergraduate coordinator and students said that this provided valuable administrative support for their placements. Students reported that the roles of educational fellow and clinical tutor were particularly beneficial to the provision of teaching. Educational fellows facilitate the movement of students from non-clinical to clinical learning, and clinical tutors play an important mentoring role. We commend the introduction of educational fellows and clinical tutors as an area of good practice.

65. We found the School's commendations process to be a positive initiative. The scheme is a way of commending students for exemplary performance. Many of these are presented to students who are good with patients, or who excel academically. A commendation form can be submitted by anyone, and these forms are considered by the School Support Unit. Commendation letters are signed by the student's year tutor and the Dean, and the commendations are published in the School newsletter. Students we met spoke positively about this initiative, and some

reported having received commendations from the School. Not all clinical teachers were aware of this initiative, although they all considered it a positive development by the School and were eager to engage with it. We commend the School's innovative commendations processes for students who have made a significant contribution at any stage during the programme as an area of good practice.

### *Student Support*

66. We were impressed by the School's provision of pastoral support through its Student Support Unit. Students and staff at HEFT and UHB were all aware of the support provided by the School's Student Support Unit, and this was widely acknowledged by everyone we met to be accessible and of very good quality. Students also have access to the University counselling and support service and to occupational health resources. Support systems are flagged to students at the start of each year, with a different presentation from the Support Unit forming a part of the students' induction each year. We commend the School's Student Support Unit's accessible and high quality service as an area of good practice.

67. The School directs students to the Student Support Unit as a central point of access, but there are a range of supportive roles in place, including year tutors, undergraduate organisers, student "mums and dads", and personal mentor groups. Students we met all knew about the different support systems available, and all had access to a variety of mentors across their different stages of training.

68. The School also has a good professional support unit which assists students with fitness to practise concerns, both during and after concerns are identified, and supports them in a number of ways to help remediate issues of professionalism.

### *Student fitness to practise (FtP)*

69. The School reported it was the first to introduce a yellow card process for reporting concerns relating to the professional behaviour of students. The form can be submitted to the School by anyone including trainers, other health professionals, patients and other students. The purpose of the yellow card process is to pick up issues relating to student welfare, to enable the School to pick up professionalism issues early, and to allow year tutors to monitor patterns of behaviour, such as poor attendance and sickness absence as potential indicators to follow up.

70. We found that the intended purpose of the yellow card system was not consistently understood or applied by LEPs, trainers or students. Students we met perceived the yellow card process to be purely punitive and were confused about the threshold between low level professional behaviour concerns raised through the yellow card process, and what might constitute an FtP issue. The School is aware of this misinterpretation by students and is working to educate and communicate with and educate students on this. The School should improve communication about the reporting process for concerns with regards to students' behaviour, so that students and LEP staff are clear about its purpose and to ensure the process is applied consistently.

71. There have been recent instances of Birmingham graduates not being able to gain provisional registration with the GMC due to outstanding undertakings set by a School FtP hearing. The School acknowledged that these instances had highlighted some process weaknesses, and that it had introduced new processes to address this deficiency. The School is now monitoring FtP undertakings to ensure they are resolved, and the effectiveness of its new processes will be demonstrable by the end of the 2011/12 academic year.

#### *Support for Educators*

72. The School has high levels of completion of teacher training for CBM teachers (190 out of 200). GP tutors reported good communication with the School, and all reported awareness of the curriculum requirements and learning outcomes for which they were responsible. Records on the training of existing trainers are held by the LEPs, and responsibility for monitoring this information has now been devolved to the heads of academy. Virtually all teachers we met had completed training, and the training of teachers is explored during the School's monitoring visits.

73. The School recognised that there is variation between LEPs in the provision of time for teaching in consultant job plans and that allocation for teaching did not always account for the amount of educational work undertaken by individuals. Some time for teaching had been allocated through the new academy structure but this was limited, and the School indicated that consultants who are new to their LEP will have teaching defined within their job plan, and that appraisal of this part of their role will be required. In addition there was variation in the designated time for supporting professional activities for academy staff.

### **Domain 7: Management of teaching, learning and assessment**

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| <p><i>150. Education must be planned and managed using processes which show who is responsible for each process or stage.</i></p> |
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#### *Management Structures*

74. The management and development of the MBChB programme is led by the Medical School Management Board. Sub-groups, such as the Assessment Group, lead on QM of their respective areas. These groups then report, directly or indirectly, to both the relevant College-wide committee and to the Medical School Management Board which draws together all issues relating to medicine. The overall management structure of the School is new, so we were not able to assess the effectiveness of this structure in ensuring a co-ordinated approach to the management and development of the programme.

75. We found that the School's quality management systems do not appear to adequately monitor and resolve issues with the quality of teaching in LEP placements. The heads of academy we met described their reporting as being less robust and frequent than was reported by the School and advised that LEPs had not received a formal response from the School on their action plans regarding concerns identified in students' evaluation of placements. They also described their own use

and triangulation of student evaluation data and other information sources to make improvements to placements locally, separate from the School QM processes.

### *LEP input into curriculum management*

76. The governance structure for curriculum development was also changed in 2011, not only to accommodate the curriculum review, but also to ensure that the structures allow for better continuous improvement in the future. Phase management committees manage all issues related to course delivery and assessment within their remit and to contribute to the overall course strategy, reporting to both the Medical School Management Board and the College Learning and Teaching Committee.

77. The School has also created curriculum integration groups to further assist in the integration of teaching across the different phases of training. These groups allow the School to provide a comprehensive review of any specific subject across all stages of training (see paragraph 32), and ensure that it is adequately sampled at various levels of training. Many teachers we met felt they were not consulted on the structure of training within their specialty (see paragraph 37) but we note that the curriculum integration groups are still a recent development and that School has plans to roll these out further.

78. The School communicates with LEP staff through the heads of academy and has an NHS liaison who works with the heads of academy to address any issues. LEP staff still considered that there was limited engagement from the School in dealing with issues or change, citing LEP reporting and the curriculum review as two examples. Most perceived that the academy structure introduced by the School has not yet created significant change, but acknowledged that it is still a new system and were aware that the academy heads are able to contribute to curriculum design. The School must share with the GMC an evaluation of the effectiveness of the academy structure to demonstrate that the School is monitoring the delivery of its curriculum by LEPs in a consistent, effective and formal way. This must also include specific examples of how the School uses the evidence it collects from the LEPs to resolve issues and further enhance training, and how this activity is communicated to students and staff.

## **Domain 8: Educational resources and capacity**

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| <p><i>159. The educational facilities and infrastructure must be appropriate to deliver the curriculum.</i></p> |
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79. The logistics and choreography of the OSCE circuits were generally well managed, and the assessments ran smoothly at all sites observed. The OSCE at The Barberry Hospital included two circuits which were run in the same room, and we noted that students and examiners struggled to hear each other at times.

80. The heads of academy of both LEPs that we visited commented on the allocation of Service Increment for Teaching (SIFT) funding. Both LEPs were eager to maintain a full capacity of medical students within their trust in order to maximise their SIFT allocation. There is a lack of transparency around the historical allocation of SIFT funding to different departments. This is a challenge for the School and

heads of academy in adjusting the SIFT allocation from a departmental to an individual level, in order to fund time in consultants' job plans for teaching. The School and some heads of academy also raised the issue that the allocation of SIFT funding was not entirely commensurate with student numbers, so some LEPs received funding disproportionate to their student numbers. This is a potential cause for friction between academies and we encourage the School to continue to review the SIFT arrangements.

## **Domain 9: Outcomes**

*168. The outcomes for graduates of undergraduate medical education in the UK are set out in Tomorrow's Doctors. All medical students will demonstrate these outcomes before graduating from medical school.*

*169. The medical schools must track the impact of the outcomes for graduates and the standards for delivery as set out in Tomorrow's Doctors against the knowledge, skills and behaviour of students and graduates.*

81. We note that the School works well with the NHS West Midlands Workforce Deanery on issues of foundation programme trainee fitness to practise and academic progression involving Birmingham graduates. The School is actively involved in cases where graduates who stay within the local area to complete foundation programme training are not progressing appropriately. The School struggles to gain information from deaneries outside the region on the progress of its graduates. We recognise that this is a challenging area for medical schools and deaneries nationally, but the School should develop its tracking of graduate progression and outcomes to enhance the quality of its programme and collect feedback from employers about the preparedness of its graduates.

## **Acknowledgement**

82. The GMC would like to thank the School and all those we met during the visits for their co-operation and willingness to share their learning and experiences.

## Annex 1: Context

### The GMC's role in medical education

1. The GMC protects the public by ensuring proper standards in the practise of medicine. We do this by setting and regulating professional standards for qualified doctors' practise and also for undergraduate and postgraduate medical education and training. Our powers in this area are determined by the Medical Act 1983 and subsequent amendments to the act.
2. The General Medical Council (GMC) sets and monitors standards in medical education. The standards and outcomes for undergraduate medical education are contained in Tomorrow's Doctors (TD09) while the standards for postgraduate medical education are set out in the publication The Trainee Doctor. The GMC visits medical schools and deaneries to share good practice, review management of concerns and investigate any other areas of risk indicated by the information held by the GMC.
3. When the evidence collected indicates that specific standards are not being met we will set requirements with deadlines in the visit report so that schools and deaneries can adjust their programmes to ensure they meet all of our standards. We may also make recommendations when schools or deaneries are meeting the standards but there are opportunities to improve the way medical education is managed or delivered. The visit reports will highlight good practice identified in the review.
4. The Quality Improvement Framework (QIF) sets out how the GMC will quality assure medical education and training in the UK from 2011-2012, and how we will work with other organisations working in this area such as medical schools and postgraduate deaneries. Visits will be targeted towards areas of risk identified through the GMC's evidence base and coordinated across all stages of medical education and training within a region of the UK.

## Annex 2: Sources of evidence

|  |                            |
|--|----------------------------|
| Visit team   |                            |
| Team Leader  | Professor Stewart Petersen |
| Deputy Team Leader   | Professor Steve Heys       |
| Visitor  | Dr Tim Lancaster           |
| Visitor  | Dr Suzanne Shale           |
| Visitor  | Professor Maurice Savage   |
| Visitor  | Katie Kemp                 |
| GMC Staff  | Sarah Beattie              |
| <p><b>Quality Assurance Activity</b></p> <p>Meetings with:</p> <ul style="list-style-type: none"> <li>• members of the School responsible for: <ul style="list-style-type: none"> <li>○ quality management;</li> <li>○ curriculum development;</li> <li>○ assessment;</li> <li>○ student support;</li> <li>○ Fitness to Practise (FtP).</li> </ul> </li> <li>• GP tutors.</li> <li>• students from Years 1 to 5, including graduate entry students.</li> <li>• clinical teachers</li> <li>• staff responsible for quality control and curriculum and assessment delivery within the School's local education providers (LEPs)</li> </ul>   |                            |
| <p><b>Evidence base</b></p> <ul style="list-style-type: none"> <li>• GMC evidence base (previous QABME reports, 2009/10 and 2010/11 Enhanced Annual Returns, GMC trainee survey data by Primary Medical Qualification (PMQ), United Kingdom Foundation Programme Office data by PMQ, Quality Assurance Agency report, National Student Survey results)</li> <li>• Birmingham introductory report, contextual document and supporting documentation covering: <ul style="list-style-type: none"> <li>○ Organograms</li> <li>○ College of Medical and Dental Sciences Quality Assurance and Enhancement systems</li> <li>○ External Examiner feedback</li> <li>○ Trust and GP monitoring visits</li> <li>○ LEP plans and inductions</li> <li>○ MBChB programme annual review</li> <li>○ Admissions</li> <li>○ Standard setting</li> <li>○ Assessment summaries and student handbooks (Years 1-5)</li> <li>○ Committee structures and terms of reference</li> <li>○ Results of student evaluation</li> <li>○ Curriculum development</li> <li>○ Student development and support</li> <li>○ Learning resources, including virtual learning</li> </ul> </li> </ul> |                            |

## Annex 3: Glossary

|        |  |
|--------|--|
| A2B    | Access to Birmingham   |
| BIQAES | Birmingham Integrated Quality Assurance and Enhancement System |
| CBM    | Community based medicine                                       |
| EMQ    | Extended matching question                                     |
| FtP    | Fitness to practise  |
| GMC    | General Medical Council  |
| GP     | General practice/practitioner                                  |
| HEFT   | Heart of England NHS Foundation Trust                          |
| LEP    | Local education provider                                       |
| MBCChB | Bachelor of Medicine and Surgery                               |
| MQAEC  | Medical Quality Assurance and Enhancement Committee            |
| NSS    | National Student Survey  |
| NHS    | National Health Service  |
| OSCE   | Objective structured clinical examination                      |
| PMQ    | Primary medical qualification                                  |
| QA     | Quality assurance  |
| QABME  | Quality assurance of basic medical education                   |
| QC     | Quality control  |
| QIF    | Quality Improvement Framework                                  |
| QM     | Quality management   |
| SIFT   | Service increment for teaching                                 |
| TD09   | <i>Tomorrow's Doctors</i> 2009                                 |
| UHB    | University Hospitals Birmingham NHS Foundation Trust           |

Right of Reply to GMC QIF Visit Process  
General Medical Council  
Regents Place  
350 Euston Road  
London  
NW1 3JN

**Re: University of Birmingham Medical School's Quality Improvement Framework Report for 2011/12**

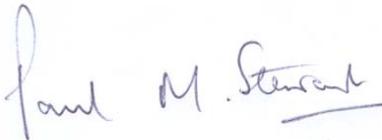
I would like to thank the Quality Improvement Framework visit team for their Final Report on the 2011/12 visit to the School of Medicine at Birmingham and for the opportunity to respond to this report. The Medical School is pleased with the positive outcome of the process and that the visiting team was able to commend us across a range of areas of good practice.

The staff and students are pleased with the largely positive outcome and I include our action plan for dealing with the required and recommended changes to our practice. We intend to use the report to our advantage as a driver for change.

I would like to reiterate comments made at the final session in respect of the constructive and positive nature of the QIF process which I am sure will further enhance the quality of education we provide to our medical students.

Kind regards.

Yours sincerely

A handwritten signature in blue ink that reads "Paul M. Stewart". The signature is written in a cursive style with a horizontal line under the name.

Professor Paul Stewart, MD FRCP FMedSci  
Dean of Medicine



| Summary | Action | Owner | Steps to be taken and deadline for each step.  | Full implementation by:  |
|---------|--------|-------|--|--|
|         |        |       | <p>3. In the light of 1 and 2 above, review of QAE office resource to be undertaken, with, if necessary, increased resource to ensure all quality management requirements can be met. To be started in April 2012 when QAE Manager returns from maternity leave. Implementation, should there be substantive change, to be from new academic session.</p> <p>4. Once the above three steps have been completed, agreeing and documenting of all quality management processes will begin. To be reviewed on annual basis to ensure implementation.</p> <ul style="list-style-type: none"> <li>• As part of the wider review and documenting of QM processes, MQAEC and Assessment Group to agree and publish criteria and review timetable for QA of individual assessments (currently in draft form), based on: content validity, reliability, fairness and question quality by August 2012. Reports based on these criteria (including actions to be taken as identified by the module lead and agreed by the Assessment Group) to be sent to MQAEC according to review timetable.</li> <li>• MQAEC will review the overall content validity using course-wide blueprinting results.</li> </ul> | <p>Sept 2012</p> <p>Dec 2012</p> <p>From 2012/13 academic year</p> <p>Summer 2012 for current blueprint, end of Dec 2012 following review of Phases 2-4 and following review of Phases 1 and 2 (2013/14)</p> |

| Summary   | Action   | Owner   | Steps to be taken and deadline for each step.   | Full implementation by:  |
|---|--|---|---|--|
|   |  |   |   |  |
| <p>2. Domain 2<br/>(TD38,40,41,44,48,49,50,51 and 53) and Domain 7 (TD 151 and 152)</p> | <p>The School must share with the GMC an evaluation of the effectiveness of the academy structure to demonstrate that the School is monitoring the delivery of its curriculum by LEPs in a consistent, effective and formal way. This should also include specific examples of how the School uses the evidence it collects from the LEPs to resolve issues and further enhance training, and how this activity is communicated to students and staff.</p> | <p>Professor Michael Gammage, Vice Dean for Education, Professor Paul Stewart, Dean of Medicine</p> | <ul style="list-style-type: none"> <li>• Post GMC visit we have completed a re-structuring of the leadership of the Medical School to a 3-phase approach. Dr Prem Kumar will have a greater input and oversight of Years 1 and 2 (Phase 1), Dr Jamie Coleman Year 3 (Phase 2) and Professor Michael Gammage Years 4 and 5 (Phase 3). All 3 Phases will still report through the Curriculum Committee (chaired by Professor Gammage) to the Medical School Management Board (chaired by the Dean of Medicine). This will, however, provide Professor Gammage with greater time to oversee, manage and monitor the delivery of the curriculum in the LEP's, providing all necessary quality assurance of standards across LEP's.</li> <li>• A programme of termly interactions with our 16 NHS Teaching Academies has been implemented with immediate effect. Each interaction is lead by Professor Gammage and involves a whole day meeting comprising interactions across Medical School Academies, NHS Academy Leads, Clinical Tutors and students. Lunchtime student led grand rounds followed by feedback sessions with staff and students address curriculum content, quality of teaching and an appraisal of the SIFT education allocation to each partner. Feedback across the Academies to ensure optimal practice is co-ordinated through existing bi-monthly NHS Academy Lead meetings.</li> </ul> | <p><b>Completed March 2012</b></p> <p><b>Initiated in March 2012</b></p> |

| Summary    | Action  | Owner  | Steps to be taken and deadline for each step.   | Full implementation by:   |
|------------|---|--|---|---|
|            |   |  | This enhanced Medical School- NHS Teaching Academy Programme will be augmented by the existing comprehensive QA site visits to each partner NHS Trust led by Professor John Skelton every 2-3 Years   |   |
| 3.Domain 5 | <p>The School must provide evidence that its final assessment strategy fully reflects the mechanisms by which it oversees and coordinates assessments across the whole curriculum, and that these mechanisms have enabled the School to implement required changes to assessments, including to:</p> <ul style="list-style-type: none"> <li>• integrate learning about basic medical and clinical sciences, and the reinforcing of learning through re-visiting topics at different stages, for assessments in Phase 1</li> <li>• Improve the reliability of the Phase 2 OSCE by increasing the number of stations</li> </ul> | Professor Michael Gammage and Dr Celia Taylor, Senior Lecturer, Assessment | <ul style="list-style-type: none"> <li>• The assessment strategy will be updated with: <ol style="list-style-type: none"> <li>1. The agreed remit of the assessment group and reporting lines.</li> <li>2. A Phase-specific summary of the assessment setting and review process, including development of specification, question selection, scrutiny and post-exam evaluation.</li> <li>3. A brief rationale for the choice of assessment types.</li> <li>4. A year-specific summary of summative assessments and feedback on assessments (as in the current Assessment Summaries).</li> </ol> </li> <li>• The assessment strategy will be approved by MCC and published to staff and students.</li> <li>• The Phase 1 assessments will be reviewed alongside the curriculum review, which will lead to a revised Year 1 in 2013/14 and Year 2 in 2014/15. This review will include the assessment structure and a quality review of individual exam questions (including blueprinting)</li> <li>• The CC2 committee will agree the revised structure of the OSCE, which will include more stations and will integrate across CC2. The planning stage will be complete by September 2012 in order to run for the first time in April 2013. An evaluation of the revised format will be undertaken which may result</li> </ul> | <p>October 2012</p> <p>October 2014/15</p> <p>First iteration of the revised OSCE to be implemented in 2012/13, to be evaluated and reviewed by</p> |

| Summary | Action  | Owner | Steps to be taken and deadline for each step.  | Full implementation by:                     |
|---------|---|-------|--|---|
|         | <ul style="list-style-type: none"> <li>Use evidence from research into best practice to improve the planning and organisation of the final year (Phase 4 OSCE)</li> </ul> |       | <p>in further improvements being made for 2013/14</p> <ul style="list-style-type: none"> <li>The CC2 committee will produce a blueprint for the new OSCE by September 2012.</li> <li>OSCE mark sheets will be reviewed by Jan 2013 to ensure that there are a sufficient number of separate and structured tasks.</li> <li>The content of acute stations (Med, Surg, A&amp;E and AIP) will be more integrated from 2012/13.</li> <li>One (or both) O&amp;G portfolio-based station will be replaced by a case management discussion from 2012/13.</li> <li>All station mark sheets will be reviewed to ensure that there are a sufficient number of separate tasks and all questions used by examiners will be reviewed to ensure they are sufficiently structured. This will be done initially by the Assessments Group and results passed to the Year 5 CC for amendment by September 2012.</li> <li>A revised OSCE specification will be developed together with that for Phase 3 and used for station selection from 2013/14 onwards.</li> <li>Revised information to be included in the Assessment Strategy summary for Phase 4, so students are informed of the changes by June 2012.</li> </ul> | <p>2013/14</p> <p>New Phase 4 in 203/14</p> |

| Summary | Action   | Owner | Steps to be taken and deadline for each step.   | Full implementation by:  |
|---------|--|-------|---|--|
|         | <ul style="list-style-type: none"> <li data-bbox="447 345 743 459">• Update assessment blueprints for each individual assessment following changes</li> <br/> <li data-bbox="447 911 758 1076">• Ensure all examiners apply the School's assessment criteria consistently, particularly for the final examinations.</li> </ul> |       | <ul style="list-style-type: none"> <li data-bbox="1102 342 1717 537">• Exam specifications for the Phase 3 &amp; 4 written exams will be updated following the review of the curriculum and used to select exam questions from 2012/13, from which exam blueprints will be constructed (exam specifications will be available in September 2012 and exam blueprints in December 2012).</li> <li data-bbox="1102 545 1703 626">• A blueprint for the Phase 3 &amp; 4 OSCEs in 2012/13 will be produced in October 2012, following a station-selection meeting.</li> <li data-bbox="1102 634 1717 773">• An exam specification for the written CC2 exam will be produced by January 2013. CC2 questions will be reviewed and blueprinted by January 2013 so that a blueprint for the 2012/13 exam can be produced.</li> <li data-bbox="1102 781 1703 862">• Phase 1 and GEC questions will be blueprinted as part of the question review process from 2013/14 and exam specifications developed accordingly.</li> <br/> <li data-bbox="1102 894 1703 976">• Training for examiners in Phases 2 &amp; 3 to start in 2012/13 (training for Phase 4 examiners already in place and will continue).</li> <li data-bbox="1102 984 1717 1154">• An on-line 'refresher' package will be developed and examiners will be required to complete this three years following their initial training or earlier if there is a significant change in the curriculum/assessments in a Phase. On-line training will start in 2012/13.</li> <li data-bbox="1102 1162 1717 1268">• Scores given by different examiners will be monitored and feedback given following completion of the OSCEs in Phases 2-4, based on the format already used in Phase 4.</li> <li data-bbox="1102 1276 1703 1357">• The Assessment Group will agree a process to be followed by module leads on all written assessments which are marked by more than one</li> </ul> | <p data-bbox="1745 342 1839 367">2014/15</p><br><p data-bbox="1745 886 1860 911">July 2013</p> |

| Summary   | Action  | Owner  | Steps to be taken and deadline for each step.  | Full implementation by:   |
|---|---|--|--|---|
|   | <ul style="list-style-type: none"> <li>Ensure that end of block formative assessments are delivered in a fair and consistent way</li> </ul>   |  | <p>person.</p> <ul style="list-style-type: none"> <li>Formative assessments provided on WebCT for Phase 1 students will be reviewed as the curriculum is reviewed from 2013/14. Guidance will be provided to module leads to help ensure consistency and quality.</li> <li>Formative assessments in clinical years will be considered by the Assessments Group and suitable training via Heads of Academy</li> </ul>   | <p>October 2012</p> <p>2014/15</p>  |
| <p>4.Domain 5<br/>(TD 101)</p> <p>Domain 7<br/>(TD 152 and 156)</p> | <p>The School must accelerate the curriculum review and must provide a clear programme of implementation demonstrating that the review of the curriculum will be complete, and the majority of changes to all years in place, by the start of the 2014/15 academic year. The School must continue to monitor and evaluate the progress of the review and ensure that the revised curriculum meets the requirements set by <i>Tomorrow's Doctors</i>, in particular that the teaching of basic medical and clinical sciences is properly</p> | <p>Professor Michael Gammage, Professor Paul Stewart</p> | <ul style="list-style-type: none"> <li>The New Year 4 and 5 programme structure was formally agreed at the Medical School Management Board on 14<sup>th</sup> March 2012. Year 4 placements will commence in June 2012 and placements finalised with each NHS Trust partner by end of April 2012, once the School is satisfied that core competencies can be delivered through proposed NHS Teaching Academy timetables.</li> <li>Dr Prem Kumar has already commenced a review of all Year 1 and Year 2 modules based upon QA feedback. The Dean has met with him and all Phase 1 Module Leads- a strategy for greater integration of clinical and basic science in every module, together with a process for updating each module on an annual basis will be presented to the Management Board in April 2012 for implementation in the next academic year 2012/13</li> <li>The emphasis of Anatomy as a core underpinning discipline will be endorsed through a 'summative' exit prosectorium spotter assessment and MCQ exam at the end of Year 2 (from 2012/13) and the provision of greater access to Anatomy resources</li> </ul> | <p><b>Agreed 14<sup>th</sup> March</b></p> <p>April 2012</p> <p><b>Initiated March 2013</b></p> <p>September 2013</p> <p>September 2013</p> |

| Summary | Action  | Owner | Steps to be taken and deadline for each step.   | Full implementation by: |
|---------|---|-------|---|-------------------------|
|         | integrated from the beginning of the course. Changes to the penultimate year must be finalised through effective communication with Local Education Providers |       | including the recently acquired Acland Anatomy, now available on WebCT 24/7 for all 3 Phases. |                         |

#### Recommendations:

| Summary                      | Action  | Owner   | Steps to be taken and deadline for each step.   | Full implementation by:   |
|------------------------------|---|---|---|---|
| 1.Domain 1<br>(TD 30)        | The School should ensure that those supervising students are fully aware of the learning requirements of these individuals at each particular stage of their training | Professor Michael Gammage, Professor Kate Thomas, Vice Dean Student Welfare | <ul style="list-style-type: none"> <li>A manual of learning requirements will be produced for each Phase of the programme for staff supervising students. This will be used in induction of all new staff teaching on the MBChB programme and in ongoing training in the Academies, the Medical School and with Personal Mentors</li> </ul>   | December 2012   |
| 2.Domain 3<br>(TD 60 and 61) | The School should consider identifying a lead with responsibility for ensuring that School's policies and procedures are based on principles of equity and fairness   | Professor Paul Stewart, Dean of Medicine, Dr Jayne Sayers                   | <ul style="list-style-type: none"> <li>An interim Reasonable Adjustment Contact (RAC) has now been nominated</li> <li>The appointment of a College Reasonable Adjustment Lead (RAL) for 2012/2013 academic year</li> <li>The RAC/RAL to ensure policies and procedures are based on equity and fairness through implementation of the MBChB quality management systems (see Point1 Requirements)</li> </ul> | <p><b>Completed March 2012</b></p> <p>September 2012</p> <p><b>Completed March 2012</b></p> |

| Summary                        | Action   | Owner   | Steps to be taken and deadline for each step.   | Full implementation by:         |
|--------------------------------|--|---|---|---------------------------------|
| 3.Domain 5<br>(TD 106)         | The School should work to improve the consistency of scheduled formal teaching between modules and trainers across a range of sites  | Professor Michael Gammage   | <ul style="list-style-type: none"> <li>This will be a focus of the new structures proposed across Phases 1 and 3 (see above)</li> </ul>   | September 2013                  |
| 4.Domain 6<br>(TD 128)         | The School should improve communication about the reporting process for concerns with regards to students' behaviour, so that students and LEP staff are clear about its purpose and to ensure the process is applied consistently | Professor Kate Thomas,  | <ul style="list-style-type: none"> <li><b>Students:</b> to develop the annual presentation to each year on the purpose of the Concern Form and processes related to its use by using data from a study we have undertaken and the use of fictional cases based on real examples. To engage with student representatives on improving their understanding of the Concern form.</li> <li><b>LEP Staff:</b> as part of the regular visits to Academies by Senior Staff we will present data above in the context of the work of the Student Development and Support Office. In addition to a presentation, we will use scenarios based on real cases for LEP staff to work through and discuss as a group how they might handle the issue. As part of the regular visits to establish with administrative and academic staff, such that they feel able to access help from the student support team</li> </ul> | November 2012<br><br>March 2013 |
| 5.Domain 5<br>(TD 84, Outcome) | The School should monitor the impact and effectiveness of changes to anatomy teaching, and report back to the GMC on its effectiveness in ensuring students meet the relevant outcomes of <i>Tomorrow's Doctors</i>                | Professor Michael Gammage, Dr Prem Kumar, Professor Joanne Wilton | <ul style="list-style-type: none"> <li>A complete review of all Phase 1 teaching is currently underway and the outcomes will be reported in a two part formal report (in December 2012 and December 2013). The process will investigate mean marks in the variety of assessment methods used throughout the course and compare these, year on year to look for change.</li> </ul>   | December 2013                   |

| Summary                          | Action  | Owner  | Steps to be taken and deadline for each step.   | Full implementation by:   |
|----------------------------------|---|--|---|---|
|                                  |   |  | As discussed above, there will be additional changes to Anatomy teaching across Years 1 and 2 and this will also involve a prosectorim test. The 2013 report will therefore be the best measure of how well anatomy teaching at Birmingham prepares students for their hospital-based teaching in years 3 – 5.  | Sept 2013   |
| 6.Domain 9<br>(TD 43c, 169, 172) | The School should develop its tracking of graduate progression and outcomes to enhance the quality of its programme and collect feedback from employers about the preparedness of its graduates | Professor Kate Thomas, Dr Celia Taylor, Professor Michael Gammage, | <ul style="list-style-type: none"> <li>• With the co-operation of West Midlands Deanery, we will continue to monitor FY1 performance based on the analysis of our 2010 graduates which has been undertaken. This will be undertaken annually.</li> <li>• A research proposal to track graduates who work in the West Midlands Deanery up to the end of F2 has been drafted. We hope to collect data on the 2010 graduates in May-Sept 2012, but this will require ethical approval. Liaison with the Deanery and application for ethical approval by end of May 2012.</li> <li>• To perform a survey of educational supervisors to ask about preparedness of graduates.</li> <li>• To work with the West Midlands Deanery to propose to the Medical Schools Council and CoPMed the establishment of a routine reporting process through which Foundation Schools feed back to Medical Schools.</li> </ul> | <ul style="list-style-type: none"> <li>• Annual report from 2011/12 onwards.</li> <li>• Data collection to be completed Sept 2012; analysis by end of Dec 2012.</li> <li>• October 2012</li> <li>• November 2012 to give paper to MSC and CoPMed</li> </ul> |