

Summary of 2014 Medical Schools Annual Return

Introduction

UK medical schools submit a Medical School Annual Return (MSAR) to the GMC each year. This report summarises the key themes arising from the information provided by medical schools. In 2014 the MSAR focused on three broad areas:

- Questions exploring schools adherence to the standards for undergraduate medical education in *Tomorrow's Doctors (2009) (TD09)*.
- Progress update on any areas of non-compliance with TD09 reported in previous MSAR.
- Progress update on visit requirements and recommendations reported in 2013 MSAR.
- Schools also submitted data on:
 - Student numbers and demographic characteristics
 - Student progression and attrition rates
 - Student fitness to practise cases
 - Undergraduate clinical placements

Contents:

We have listed each section in the report to help you identify and locate question areas or domains which are of particular interest.

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Executive Summary

Domain 1: Patient safety

- Medical schools reported 127 issues in relation to clinical supervision. Most issues are being addressed appropriately by schools themselves. In a small number of cases (16) we have requested further information in order to determine if additional action is required. We will continue to monitor these issues with schools directly.

Domain 2: Quality assurance, review and evaluation

- Medical school quality management visits during 2013/14 have identified 150 non-confidential concerns and 422 non-confidential areas of good practice. We will be working with schools directly to develop a significant number of good practice areas into case studies which we will share with all schools. We have requested further information on 19 areas of concern in order to determine if any further action is required.
- The data suggested that medical schools' decisions are generally upheld when reviewed by ombudsman services. We hold regular meetings with higher education ombudsmen services around the UK and we will use the information schools have provided to identify issues to discuss with ombudsman services.

Domain 3: Equality and diversity

- Examples of data used by medical schools for equality and diversity monitoring purposes (as set out in Domain 3 of *TD09*) included admissions data, assessment data, Student Fitness to Practise data, as well as data on academic appeals.
- Most schools indicated that the GMC mental health guidance has had a positive impact, with examples of changes undertaken as a consequence - such as systems of wellbeing or additional tailored learning sessions. In addition, we noted areas that appear to be working well in particular schools, for example issuing a handbook aligned with the GMC guidance, providing an undergraduate psychiatric adviser and introducing a student absence authorisation card (for students to attend essential outpatient appointments or treatment).
- Fourteen schools gave examples of new reasonable adjustments, including physical, sensory, learning and mental health adjustments. Responses to this question showed some inconsistency in medical schools' views and practices concerning time-related reasonable adjustments for OSCEs. This information will be shared with the Medical Schools Council (MSC) for consideration. Most

schools reported that no reasonable adjustment requests has been turned down in the 2013/14 academic year, where they had we noted the requests tended to be for either OSCEs or written tests. All schools reported that no students were withdrawn from the course due to disability, on the grounds that they would be unable to meet the outcomes required for graduation. The responses to this question could reflect that medical schools are following the advice given in Gateways on selecting and offering places to disabled applicants.

Domain 5: Design and delivery of curriculum including assessment

- Twenty-seven medical schools reported requiring their final year students to take the Prescribing Safety Assessment (PSA); the majority of these used the PSA formatively. However, half of the schools using the PSA formatively indicated the possibility for this to change. We will use this feedback to inform our support for and policy on the PSA. Subject to its continued development and subsequent implementation, we hope and expect medical schools to use the PSA as a summative assessment and that UK graduates will have demonstrated their competence in prescribing through the use of this test. We will share our analysis with the MSC and the British Pharmacological Society that together established and run the PSA
- Schools overwhelmingly reported a positive experience of Common Content. A few difficulties were reported, with some schools raising issues on whether the project would be able to reach robust conclusions about the comparability of the standard required for new medical graduates.

Domain 9: Outcomes

- Most schools expressed support for the *TD09* outcomes for graduates. Additional outcomes were suggested, with the most frequent being environmental / sustainability outcomes, as well as kindness / compassion / human factors. A number of challenges were also reported, especially in terms of students having opportunities to perform certain procedures (e.g. taking blood, transfusions, catheterisation, IV infusions). We will be reviewing the outcomes and practical procedures listed on *TD09*. We will ensure the outcomes remain relevant and continue to describe the appropriate expectations of undergraduate medical education and training.
- Twenty-nine schools reported that there was explicit coverage of Health inequalities (lower socioeconomic backgrounds, LGBT, learning disabilities) in the curriculum. Socioeconomic issues were particularly well developed, with most schools reporting defined curricula in this area. LGBT issues were covered in the least detail of the three categories. Interesting initiatives reported in this area featured student, patient, or expert group involvement in the design of the curricular content. We have a planned review for the

outcomes listed in *TD09* in this area, to ensure they remain relevant and appropriate. We also hope to address issues around proving care for and dealing with diverse groups of patients.

- Undergraduate medical education comprises a mixed economy of theoretical and practically-based learning on End of Life Care. The review of the Liverpool Care Pathway (LCP) has led to changes in the delivery of education, and the establishment of a more intuitive approach to end of life care. Responses indicated that schools were placing considerable emphasis with end of life education on the elderly and frail. The clinical components of this focused on care planning, symptom and pain management. Professional and human-factor type skills included ethics, communication with patients and those closest to them, as well as multi-disciplinary approaches to care. There have been attempts to produce a consensus syllabus on end of life care for undergraduate education. We are exploring if this has influenced consistency across the schools or whether it has helped strengthen the effectiveness of that education.

Medical School Progression Data:

- Schools provided their responses to the Medical Schools Progression data we published in autumn 2014. It shows that this data adds value to the schools' quality management process. Schools stated it helped address the known difficulty of obtaining information on graduates' future performance; enabled them to confirm anecdotal trends; they also outlined plans for the data to inform curriculum reviews.

Analysis of student profiles and progression

In 2014, Medical Schools report 40,491 students on programmes in the UK leading to a UK primary medical qualification (PMQ) at the time of reporting (Quarter 4 2014).

Figures 1 - 3 illustrate the demographic breakdown of medical students by gender, ethnicity and their entry route into medical school.

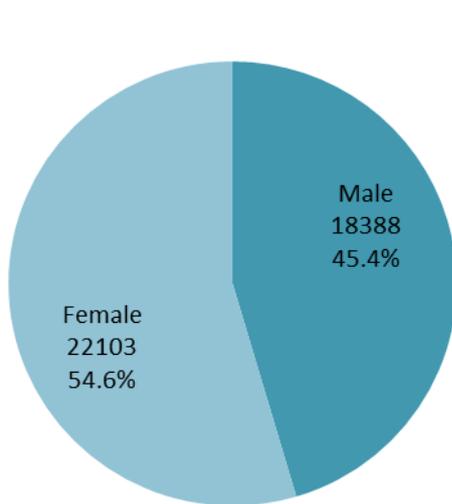


Figure 1 Total student population by Gender

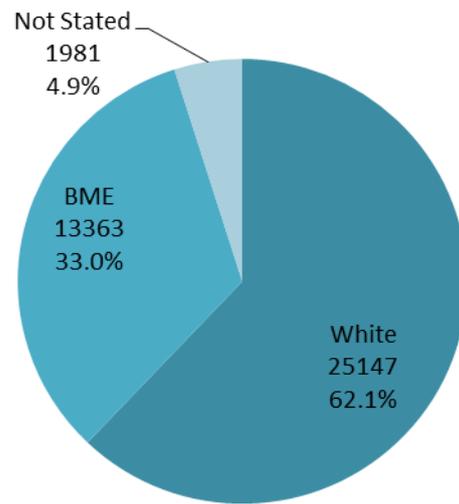


Figure 2 Total student population by Ethnicity

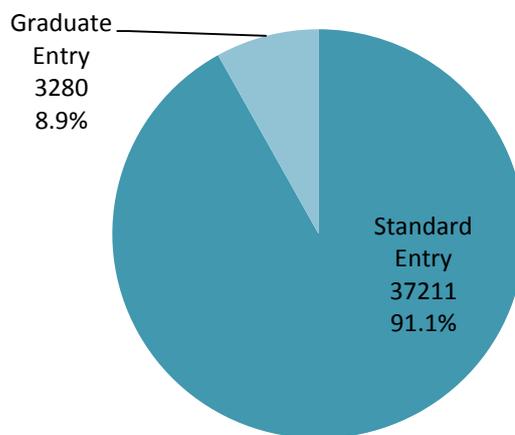


Figure 3 Total student population by route of entry into Medical School

In **figures 4 – 8** we compare the demographic breakdown of these two groups by gender, ethnicity and students with other characteristics.

By Gender:

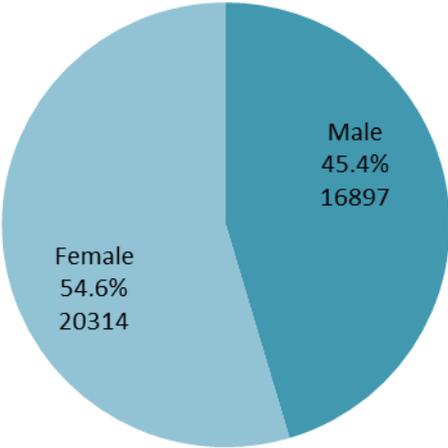


Figure 4 Standard Entry Method students by Gender

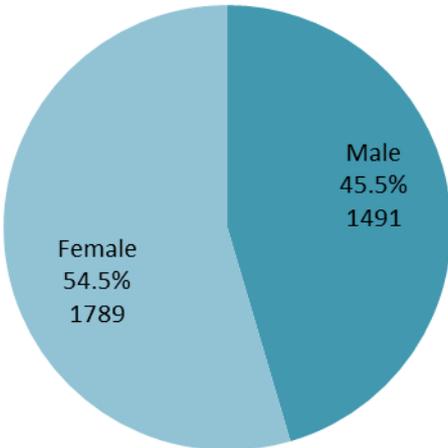


Figure 5 Graduate Entry Method students by Gender

By Ethnicity:

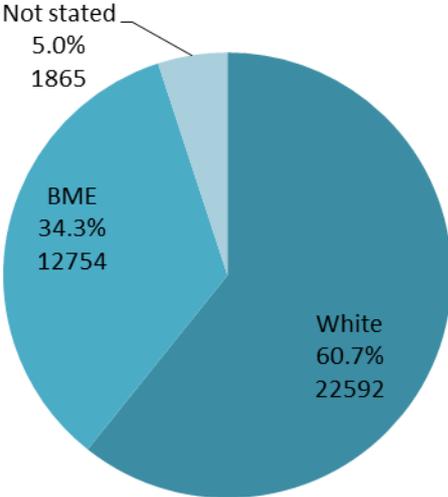


Figure 6 Standard Entry Method students by Ethnicity

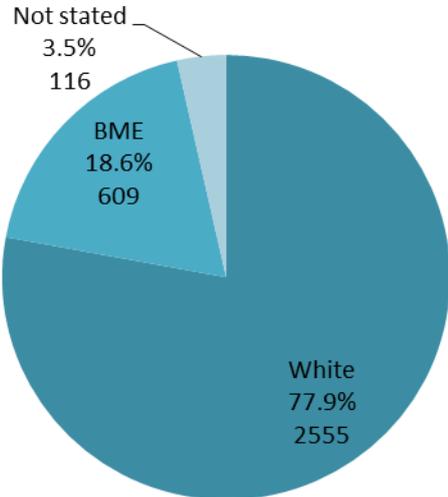


Figure 7 Graduate Entry Method students by Ethnicity

By other characteristic:

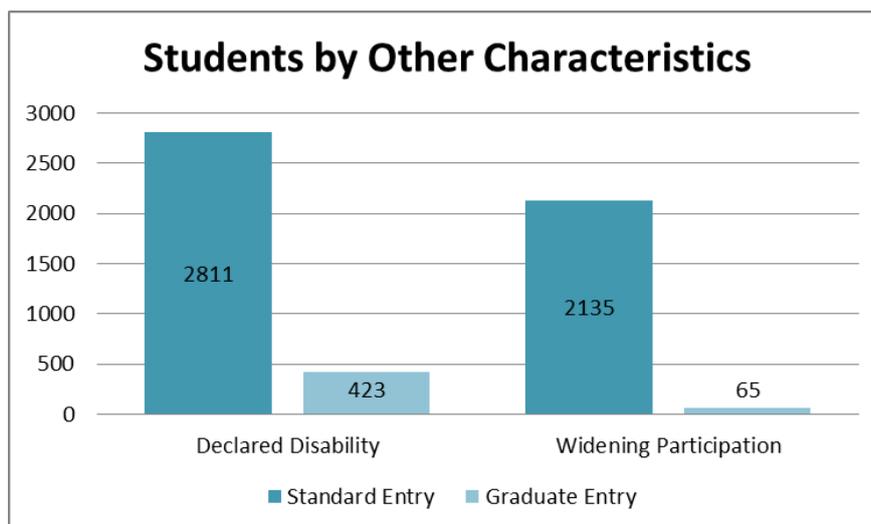


Figure 8 Students with Other Characteristics

Analysis of progression and attrition rates

Medical schools report the number of students who successfully progress to the next academic year as well as those who fail to progress to the next year of study for a variety of reasons including those to repeat a year of study.

Figure 9 illustrates the proportion of students who failed to progress to the next level of study and attrition rates (proportion of students who left programmes in medicine or who were not on programme at the time of reporting) split by year of study, gender and the route of entry to medical school:

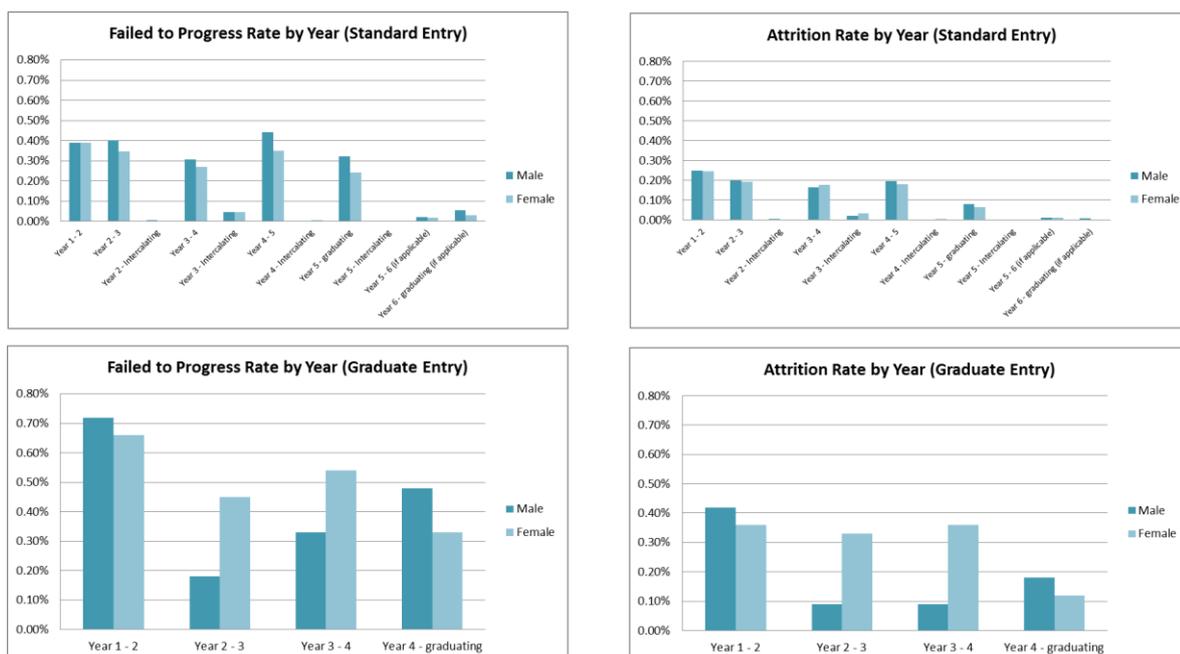


Figure 9 Failed to Progress and Attrition Rates by Year and Entry Method

Figure 10 breaks down information showing the different reasons students fail to progress by their route of entry to medical school:

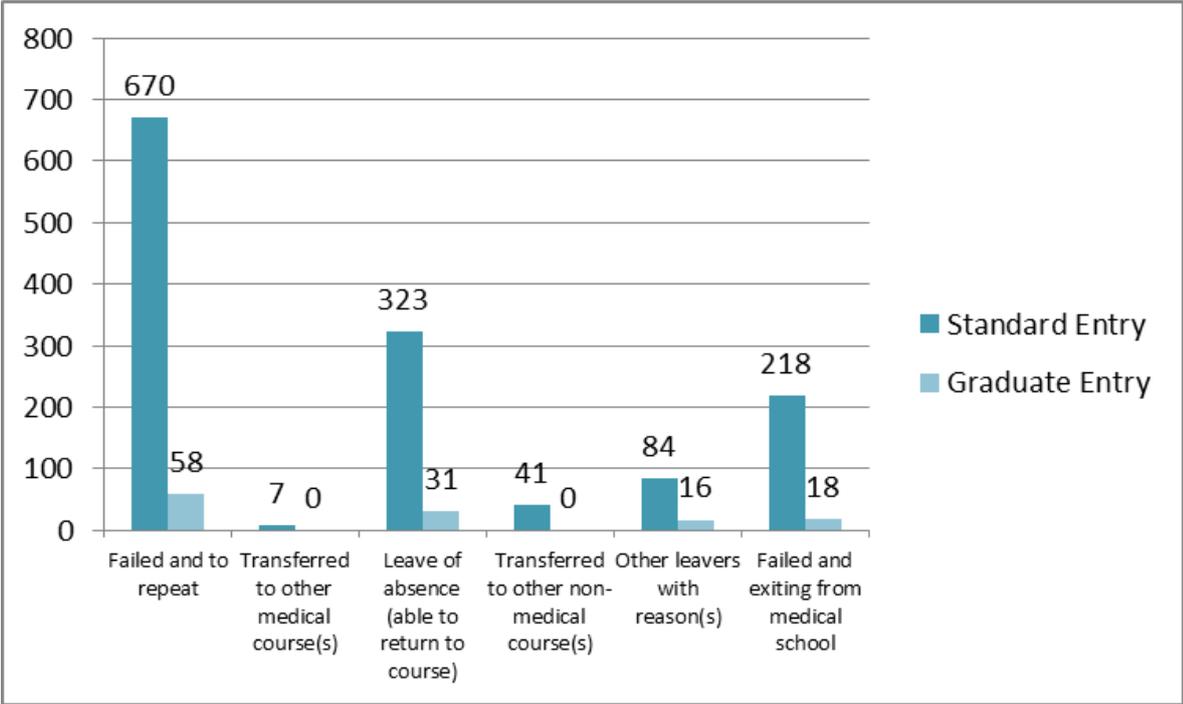


Figure 10 Failed to Progress and Attrition rates by Reason and route of entry to medical school

Medical schools responses to questions on GMC standards for undergraduate medical education

Domain 1: Patient safety

1. *Do you have a process in place for monitoring low level conduct or health concerns?*
 - All schools stated that they have systems in place to monitor concerns. Twenty schools have the same system in place for initial dealing with causes of concern that relate to both health and conduct.
 - Half also have a system that allows staff and students to raise professionalism or health concerns outside of formal placement feedback or assessment of professionalism on an ad hoc basis.
 - Following identification of a concern, twenty schools would arrange an individual interview between the student and a senior staff member. Thirteen schools refer students to a dedicated group or panel in the first instance.
 - Some schools stressed the primary purpose of any system for identifying and monitoring low level concerns was to provide timely and appropriate support to students.

2. *Have you identified, in the last academic year, any issues with clinical supervision (supervision by clinicians during clinical placements) within your Local Education Providers (LEPs) and if so what steps are you taking to resolve them?*
 - 127 issues have been reported across 24 schools. 122 of which were reported as concerns. The majority of issues have an appropriate action plan documented by schools. In sixteen cases we have requested further information on the action plan and will monitor these issues with the schools concerned.

Domain 2: Quality assurance, review and evaluation

3. *Paragraph 41 of TD09 states that medical schools will have systems to monitor the quality of teaching and facilities on placement. We would like to know:*
 - a *The list of quality management visits you have undertaken in the 2013/14 academic year?*

 - b *Details of any concerns or areas of good practice identified during these visits. Please also provide us with the actions which you have taken to address concerns or promote good practice?*

- We received 812 issues or areas of good practice on placement arising from their quality management visits during the 2013/14 academic year. Among these, there were 166 concerns reported.
 - Schools reported 456 examples of good practice on placement. We have selected 56 to share more widely.
 - Of the 40 items we identified as concerns following internal scrutiny, we have highlighted 19 which require further information.
4. *A small number of newly qualified doctors may undertake their F1 training in overseas posts. If any of your graduated students are in this situation - how do you ensure these doctors meet and are signed off as meeting the outcomes for the F1 year, in order to meet the requirements for full registration with the GMC? (This question applied to six schools – Barts, Cambridge, KCL, Imperial, Oxford and St George’s)*
- Five applicable schools submitted information on how they quality manage new graduates who have chosen to undertake F1 training in overseas posts. This situation is relatively unusual; some schools noted only a single graduated doctor overseas and one (KCL) has indicated that they no longer support these arrangements.
 - Each of the schools with graduates in overseas F1 posts must work closely with their local foundation school. The medical school must also get prospective approval from the GMC for any student planning to gain their F1 experience overseas. At the end of the year, the experience is normally reviewed jointly by the LETB and the medical school to ensure outcomes have been met. The doctor will require a certificate of experience to confirm this in order to secure full registration with the GMC.
5. *Please tell us about any innovations you are piloting or potential areas of good practice.*
- Schools reported 216 areas showcasing their strengths, 196 of which were clearly mapped against *TD09* outcomes or domains.
 - We have identified 49 areas of innovation at medical schools in response to this question that we will investigate further and may develop into case studies to share more widely with across schools.
6. *During 2013-14 was your medical school subject to investigations into student complaints by the Office of the Independent Adjudicator (OIA), the Scottish Public Services Ombudsman or Visitorial scheme in Northern Ireland?*
- Twenty-one schools stated that they had been subject to an ombudsmen service investigation or complaint over the past academic year.

- The level of detail in responses varied but the data suggested that medical school decisions are generally upheld when reviewed by ombudsman services.
- Appeals to ombudsman services across the four countries in 2014 can be categorised as:
 - decisions about academic progression (this includes challenges on mitigating circumstances and academic appeals)
 - appeals against the outcomes of fitness to practice processes
 - appeals concerning allocation to a placement
 - appeals concerning the payment of fees.
- Some schools raised issues such as
 - A number of schools excluded students who were then readmitted to the course following an appeal to the ombudsman services, but the school believed the student's future practice to be potentially unsafe.
 - Where universities and medical schools have different processes which interact, complications have arisen; some schools questioned the extent to which the OIA understands how the medical schools' processes interact with those of the parent university. This appears to be an area where there is a lack of clarity amongst medical schools about how the OIA considers both processes when making a decision.
 - Lack of clarity over how the ombudsman services determine their recommendations from a judgement, and how compensation recommendations are determined.
- The GMC hold regular meetings with higher education ombudsmen services around the UK in order to:
 - help us understand their involvement in the resolution of complaints around medical education and their perspective on the complaints they receive
 - raise issues that are important to us or medical schools.
 - The OIA has stressed to us that they rarely overturn a medical school/university decision unless the school/university has failed to follow (or have in place) a clear process for dealing with student appeals.

Domain 3: Equality, diversity and opportunity

7. *It is important for medical schools to meet the equality and diversity requirements set out within Domain 3 of TD09; therefore we would like you to:*

- a Tell us how in the academic year 2013/14 you used evidence to monitor how you are meeting the equality and diversity requirements set out in Domain 3 of TD09?*

- b Tell us the biggest challenges you face in promoting fairness and equality in medical education and training?*

Monitoring progress

- Seventeen schools reported that at least some staff attended equality and diversity (E&D) training.
- Seventeen schools reported systems to monitor progress across different groups of students.
- 25 schools told us that they monitor admissions data and a further two schools (Leicester and St Andrew's) told us that they plan to do so.
- Ten schools reported that they monitor assessment data and a further two schools (Keele and Swansea) plan to do so. Barts reported that there is no evidence of systematic differences.
- Eight schools reported that they monitor SFTP data and Plymouth told us that they have done an analysis of professionalism judgements for first year students. Three schools (Belfast, Swansea and Warwick) noted that numbers are very small which can make analysis difficult and may raise issues for anonymity.

Challenges in promoting fairness

- Belfast reported that there was a lack of meaningful data about equality and diversity for students going through Fitness to Practice processes because there are so few cases to report on. However, they noted that the group of students about whom they have low level concerns is larger and there is more diversity within it. The school has used this information to inform practices such as enhanced teaching in appropriate academic referencing to target plagiarism.
- Nine schools reported that they monitor data on academic appeals and a further school (Leicester) reported plans to follow.

- Six schools told us that they have an Athena SWAN gold or silver award. Two schools (KCL and Swansea) also reported involvement with the new Race Charter Mark scheme.

8. *Please provide a brief case study outlining the management and support of a student with a mental health condition. Please highlight any changes in the management of students as a consequence of implementation of the GMC guidance: Supporting medical students with mental health conditions.*

- Case studies highlighted a number of issues which will be considered during our review of GMC guidance *Medical Students: Professional values and fitness to practise*:
 - separation between academic and pastoral support
 - signposting/directing students to the appropriate support
 - frequent follow-up meetings and monitoring by the medical school welfare personnel
 - emphasis on confidentiality (and emphasis that this will only be breached in rare circumstances)
 - encouraging students to seek independent care from their GP and communication between GPs and health/welfare support at the medical school
 - management of support across localities when students undertake placements – including placement location adjustment to maximise continued access to healthcare advisors.
- Most schools indicated that the mental health guidance has had a positive impact. However, stigma associated with mental health issues has also been reported and may be a barrier for students seeking appropriate help.
- Two schools identified changes they had implemented as a consequence of the mental health guidance, systems for wellbeing were mentioned by two schools (Bristol and Brighton/Sussex). They both have introduced additional learning sessions tailored for year 3 students to address curriculum pressures caused by clinical placements and examinations. Glasgow reported routine referrals of students with mental health to disability services for reasonable adjustment consideration.
- In addition, we noted the following areas that appear to be working well:
 - Bristol’s extensive work on mental health prevention and support is notable. All students at this school have been issued a handbook aligned

with the GMC guidance which aims to dispel myths about mental health and direct them to local support. Additional support is also provided to 3 year students during their first placement.

- Edinburgh has an undergraduate psychiatric adviser to ensure effective and dynamic joint working by liaising between the medical school and clinical teams at placement sites.
- The introduction of a student absence authorisation card at Cambridge which is issued by a member of the postgraduate team allows students to be absent from the course to attend essential outpatient appointments or treatment. Students may take time away from clinical placements without having to disclose personal medical information to their supervisors and tutors.

9. *Please let us know how your students with disabilities can access the following and give brief details of what they consist of. Please include links to relevant information if helpful.*

a Careers advice.

b Occupational health services.

c Advice on reasonable adjustments and support in making sure they are implemented once agreed, including when on placements.

- These three areas were highlighted by our 2012-13 review of health and disability in medical education and training. We are aiming to build a picture of current arrangements for each and identify practice to share among all schools. We asked in particular to hear about instances where there is an identifiable individual who students can contact for advice.
- Responses to these questions provide us with an overview of the current situation. They also give us examples of innovation which may be shared more widely to enable other schools to provide the best service to medical students.

Careers advice:

- During our health and disability review, we heard from disabled students that the careers advice available to them was insufficient. We agreed that there should be clearly identifiable individuals or groups of people in each school who students can refer to for expert careers advice.
- Whilst there have been no changes to how disabled students access careers advice, six schools gave examples of innovative initiatives in careers advice including one to one support for disabled students.

Occupational health (OH) services

- The health and disability review showed us a perceived variability in the quality of assessments and support provided by OH services. We stressed the need of a consistently high quality of service, and that we would monitor quality assurance arrangements that promote good practice in this area.
- Exeter reported the rise in pre-admission declarations of a disability or pre-existing health condition. This has led to more students needing face-to-face pre-admission screening.
- We received examples of good practice in providing OH services from five other schools (Cardiff, Glasgow, Leicester, Nottingham and UCL), including allowing students to self-refer.

Advice on reasonable adjustments and support in implementation

- Throughout our health and disability review we heard from stakeholders that more work is needed to promote the provision of reasonable adjustments. We also noted that the level of access to reasonable adjustments appeared to vary across medical schools. We will continue to monitor the implementation of agreed reasonable adjustments as well as promote areas of good practice through our quality assurance activities.
- Two schools (Birmingham and Dundee) reported that they are following a good practice example in our mental health guidance. Both schools have implemented a system of recording approved reasonable adjustments on a card which the disabled students carry around with them.
- Three other schools (Birmingham, Leicester and Nottingham) gave examples of good practice in giving advice on reasonable adjustments, including referring all students with disability to disability services or mental health advisory service.

10. Please tell us about adjustments relating to the 2013/14 academic year only:

- a Any new reasonable adjustments you made which you had not made before.*
- b Any requests for reasonable adjustments that you turned down and why.*
- c Any cases where a student was withdrawn from the course on the grounds that they would be unable to meet the outcomes required for graduation due to disability.*
- During our 2012-13 health and disability review, we noted that we do not have data on reasonable adjustments made and turned down by medical schools. We agreed to continue collecting data on reasonable adjustments

made within the current reporting period and that we would reflect good practice and other learning back to medical schools.

New reasonable adjustments

- Responses to this question will help us build a picture of the types of reasonable adjustments currently being made by medical schools. They can also be included in our Gateways guidance as up to date examples of reasonable adjustments.
- Fourteen schools gave details of new reasonable adjustments made. A few examples were:
 - Physical: provision of an ergonomic chair.
 - Sensory: exams papers printed on A3 coloured paper.
 - Learning: provision of extra time for assessments (up to 25%).
 - Mental health: allowing candidates to sit their written examinations in a separate room.
- Four schools (Bristol, Cardiff, Cambridge and Exeter) reported that they had made time-related reasonable adjustments for disabled students in Objective Structured Clinical Exams (OSCEs) and assessments.

Requests for reasonable adjustments that were turned down

- As part of the health and disability review, we looked at information provided by medical schools on reasonable adjustments that had been refused for OSCEs. We compared this to feedback from disabled students.
- Responses to this question showed the types of reasonable adjustments currently being refused by medical schools. The inconsistency in medical schools' views and practices concerning time-related reasonable adjustments for OSCEs will be passed on to the MSC for further consideration.
- Whilst most schools reported that no reasonable adjustment requests had been turned down in the 2013/14 academic year, we noted that those requests for reasonable adjustments which were turned down by medical schools were for either OSCEs or written tests.
- There were mixed views on whether the timed OSCE stations reflect clinical practice time requirements; three schools (Keele, Leicester and Newcastle) stated that they refused requests for a time adjustment to OSCEs on the grounds that they are designed to replicate clinical practice. Four other

schools (Bristol, Cambridge, Cardiff and Exeter) had also refused requests for extra time in OSCEs, but these appeared to be on a case by case basis, as opposed to a blanket policy.

Students withdrawn from the course on the grounds of disability

- All schools reported that no students were withdrawn from the course on the grounds that they would be unable to meet the outcomes required for graduation due to a disability.
- The responses to this question could reflect that medical schools are following the advice given in *Gateways* on selecting and offering places to disabled applicants.

11. Please briefly describe the exit arrangements and awards you have in place for students who are unable to continue to study medicine. We are particularly interested in arrangements and awards for students who make it as far as:

a Year 3.

b Year 4.

c Year 5 (if applicable).

d Year 6 (If applicable).

- Some schools indicated that students who leave their undergraduate medical courses do so because of academic issues. Hull/York reported that smaller numbers leave for health or fitness to practise reasons.
- The majority of medical schools reported that they have established exit routes at bachelor level. The main route was BSc in medical sciences – across years 3, 4, and 5. Some schools also awarded honours. However, thresholds in eligibility for honours appeared to vary.
- Other bachelors routes included:
 - BSc in medical studies
 - BSc in human life sciences
 - BSc in applied medical sciences.
- Exit points varied due to structural differences between curricula.
 - Students who successfully complete their third pre-clinical year at two schools (Oxford and Cambridge) are awarded a BA degree, and they may leave the course at that stage.

- Exeter has a flexible combined honours system which leads to MSc in either environment and human health or applied health services research.
- St Andrew's' exit route included exists to other courses, including science, arts and divinity, reflecting the fact that St Andrew's only provides the first three year of medical studies and all its students move on to another university to complete their primary medical qualification.
- Barts offered a place on the intercalated degree programme to gain an academic award or an exit with grace award diploma in undergraduate studies if they have completed two academic years successfully.
- Other schools offered various options if students leave their courses early, for example, students at three schools (Hull/York, Liverpool and St Andrew's) may be offered a certificate or diploma of higher education.
- Although not specific to this question, it would be interesting to explore further the careers advice and personal support which students receive from their schools, including tutors, advisers and welfare teams.

Domain 4: Student selection

12. Each year we ask you to check and update the flow charts showing, at a high level, the admissions processes you use at your school. Please let us know of any changes to your process for student selection to any of your programmes.

- This data will be used to update the published anonymised data on the different admissions processes at medical schools nationally as part of our work on best practice in selection methodology.
- Being able to track changes to admissions processes will allow us to look at any impacts on the outcomes of undergraduate education.
- The MSC report *Selecting for Excellence* recommends that we build an evidence base around widening participation in medical education.

Domain 5: Design and delivery of curriculum including assessment

13. In order to develop a comprehensive and authoritative picture of implementation of and support for the Prescribing Safety Assessment (PSA), we would like the following information:

- a Does your medical school require that its final year medical students take the Prescribing Safety Assessment (PSA)?*
- b If so, is the PSA used formatively or is success required in order to graduate?*

c Please summarise the school's position and intentions with regard to the PSA.

- Twenty-seven medical schools reported requiring their final year students to take the PSA. Twenty-seven schools used the PSA formatively, six used it summatively and one did not confirm.
- Of those schools that used the PSA formatively, over half (14) of them indicated the possibility of changing their use of the PSA. Other schools referred more generally to developments, discussions or what other schools are doing. Notably, Cambridge reported that it will adopt the PSA as a summative test.
- Seven schools were looking for stronger evidence about the reliability or effectiveness of the assessment before they would consider changing their position. Four envisaged changes if there were requirements or recommendations from the GMC.
- We will use this information to inform our support for and policy on the PSA. Subject to its continued successful development and subsequent implementation, we hope and expect medical schools to use the PSA as a summative assessment so that UK graduates will have demonstrated their competence in prescribing through use of this test.
- We have indicated that we will take a particular interest in the arrangements for assessing prescribing at any schools that do not use the test summatively or that allow medical students to graduate who have not passed the test. We do not currently have the statutory authority to require universities to use a particular test or to impose a national examination.
- We will also use the responses to this question to inform our work on the possibility of establishing a national licensing examination (NLE). The context for this work includes the steps that are being taken to promote patient safety through a more consistent approach to undergraduate assessment, including the PSA. Should we pursue an NLE, we will need to consider whether and how it should cover prescribing and the implications for the PSA.
- We will share our analysis with the MSC and British Pharmacological Society that together established and run the PSA.

14. Is your medical school using Common Content in finals as part of the MSC Assessment Alliance project on equivalence? Please summarise the school's position and intentions with regard to Common Content.

- All but one medical school that awards a primary medical qualification confirmed that they are using Common Content in finals, although not necessarily in the final year examinations. The only exception was:
 - Glasgow who used Common Content in 2014/15 but did not in 2013/14
- Schools overwhelmingly reported a positive experience of and attitude to Common Content. There were some concerns about the quality of the questions used from the MSC Assessment Alliance (MSCAA) bank, although schools generally recognised improvement in recent years. We heard some suggestions for taking the Common Content project forward.
- A few schools reported difficulties in using Common Content or changes that were required to their approach to assessment. Some schools raised issues or doubts about whether the Common Content project would be able to reach robust conclusions about the comparability of the standard required of new medical graduates.
- This information is informing our work on the development of Common Content. In our supplementary advice on assessment we state *'where cross-school assessment arrangements are robust, medical schools should take advantage of them and take opportunities to contribute to their support, management and development'*.
- It will also feed into our work on the possibility of establishing a licencing examination. We would look at taking steps to promote patient safety through a more consistent approach to undergraduate assessment, including the development of Common Content.
- Should we pursue a licencing examination, we will need to consider the implications for Common Content in medical school final examinations. We will also share our findings with the MSCAA.

15. Paragraph 81 of TD09 states that the curriculum must be designed, delivered and assessed to ensure that graduates demonstrate all the outcomes for graduates.

Please inform us of any changes that you have made within the school regarding processes, curricula and assessment systems to comply with TD09 or address issues raised by postgraduate bodies or employers since the previous MSAR?

- In all, there were 198 changes reported in this year's MSAR. Some applied to more than one domain, and have been illustrated in **Figures 11 and 12**.
- The most frequent changes reported were to allow schools to comply with TD09 Domain 5. And within this domain, most changes related to assessment systems.

- There were a fairly consistent number of changes reported reflecting change to Outcomes 1, 2 and 3 to comply with TD09, with Outcome 3 having the highest total items submitted, followed by Outcomes 1 and 2.

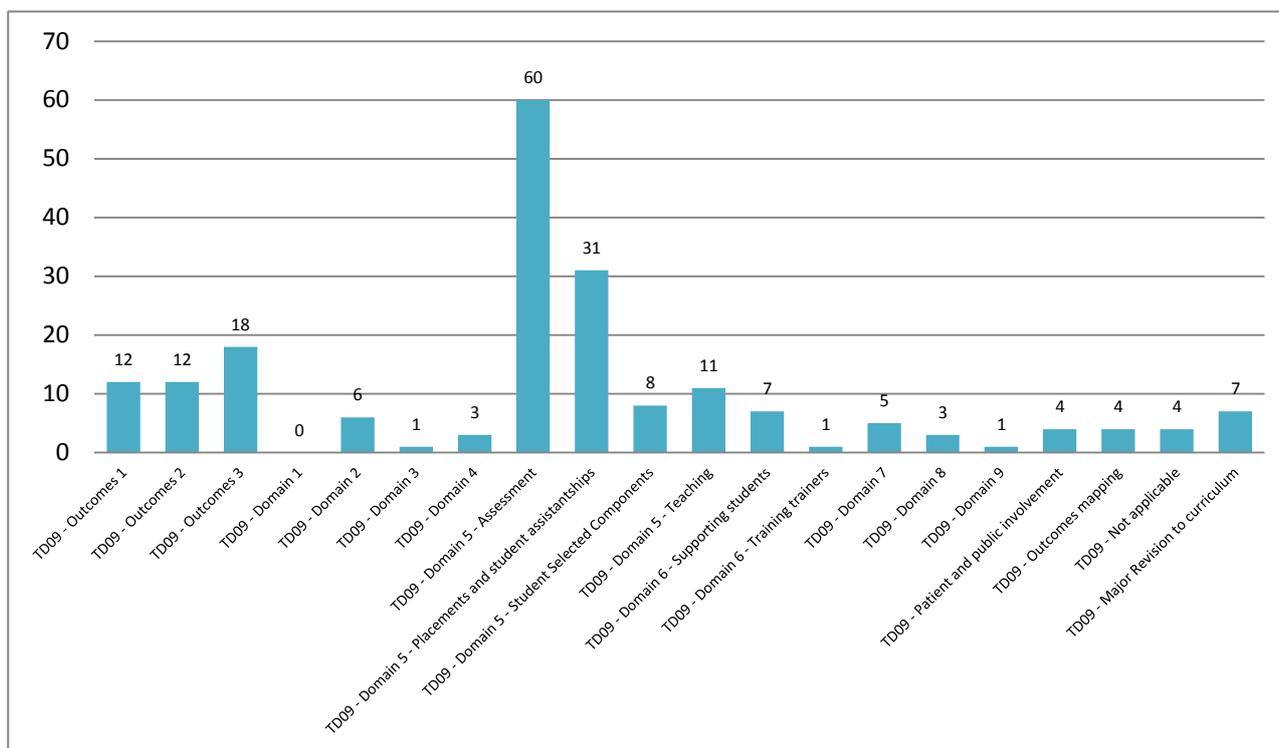


Figure 11 Number of changes required to comply with TD09 ($n=198$)

With regards to drivers for change:

- 65 items indicated the driver was from internal discussions or internally driven changes or external drivers not identified, which was the most frequently reported category.
- 38 items related to student feedback
- 30 items concerned TD09.

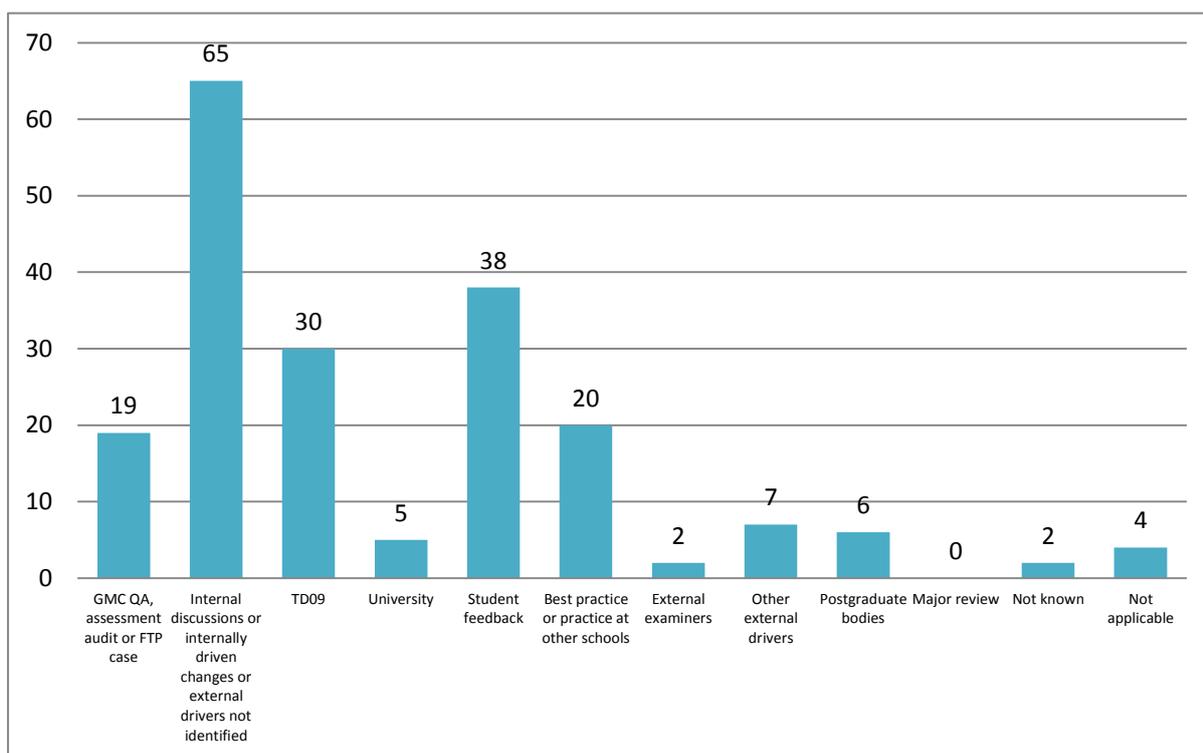


Figure 12 Drivers for changes to comply with TD09 (*n=198*)

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

16. How are students made aware of career opportunities across the full range of specialties including those with particular recruitment challenges?

- All medical schools provided career information sessions, and most indicated that these took place at several points in the course. Almost all reported that they supplemented these timetabled sessions with e-learning and/or web-based materials. Most schools also reported having dedicated careers advice services that students could access.
- Most schools told us that they either organised or supported careers fairs, and found these to be an effective way to provide medical students with careers information. Some schools required medical students to reflect on their future career choices in a formal discussion or as a part of portfolio work.
- We received initiatives in which medical students were able to access information about careers from recent graduates. Examples included formal sessions in two schools (Aberdeen and Bristol) and a mentoring programme in two schools (Exeter and Plymouth).

- Some schools also reported practices in highlighting competition ratios for speciality applications. However, relatively few schools indicated that they had included the workforce needs in planning either the careers information or the practical experience provided in their curricula.
- In addition, we received some notable initiatives:
 - Nottingham identified a difficulty in recruitment to general practice training in its region, and a relative lack of exposure to general practice in its curriculum. The school is currently reviewing its curriculum to increase exposure to practice in community settings.
 - Cardiff identified regional difficulties in recruitment to paediatrics and psychiatry. It gave specific focus to these specialities in timetabled small-group work to research specialty careers, and in web-based information.
 - Aberdeen described work to link students with graduates who were working locally, as well as participation in a Scottish initiative – the Strategy for Attracting and Retaining Trainees (StART).
- Many medical schools told us about how they provided information on academic careers. Many also told us that student societies provided helpful information on careers. In these cases, the information provided was often reflected by the students' own career interest.

Domain 7: Management of teaching, learning and assessment

17. We would like to know if you have risk assessment strategies for the introduction/implementation of new curricula and curricular change. It will be helpful if some practical examples are included in your response.

- Almost all schools reported having formal risk assessment strategies and processes for the introduction and implementation of new curricula as well as curricular change. Several schools described using risk assessment as part of a wider business planning structure.
- Most schools gave examples of curricular change and new curricula being piloted before full implementation as part of the risk management strategy. This included changes to assessment. Many of the reported examples described using student evaluation and feedback to identify and address risk and inform the curricular change.
- We received examples of practical application of risk registers. Themes in the type of risks identified included the following.
 - Preparing clinical teachers to deliver clinical placements following curricular change (two schools – Cardiff and Hull/York).

- Considering how changes to assessments affect student progression (four schools – Belfast, Glasgow, Hull/York and Nottingham).
- Technical issues following the introduction of new electronic systems (five schools – Edinburgh, Glasgow, Hull/York, Lancaster and UEA).
- Limited resources at local education providers (LEPs) impacting on education (four schools – Exeter, Hull/York, Nottingham and Plymouth).
- National Student Survey results following curricular changes (two schools – Hull/York and Nottingham).

Domain 9: Outcomes

18. Does the medical school have any concerns about, or suggestions for amendments to, the GMC's outcomes for graduates (TD09, paragraphs 7-23) or practical procedures (TD09, Appendix 1)?

- Schools gave a variety of responses to this question. Most expressed general support for the outcomes and practical procedures, but seven schools made suggestions for changes to the outcomes.
- Whilst all suggestions for changes to existing outcomes were requests for modification, some were specific requests for clarification. For example, Manchester suggested placing greater emphasis on organisation of healthcare services as well as patient safety within the context of existing outcomes. Newcastle suggested clarification on legislation where different legal approaches exist across the four UK countries.
- Schools also made suggestions in relation to additional outcomes. Environment and sustainability, and kindness/compassion/human factors in care were the most mentioned outcomes.
- We noted various suggestions.
 - Eight schools had a strong view that outcome 15 (pregnancy testing) should be removed.
 - Two schools (Swansea and Cardiff) also stated that dosage and administration of insulin using sliding scales (outcome 19) was considered outdated in some locations and should be removed.
 - Brighton/Sussex suggested that measurement of body temperature (outcome 1) was not required.

- Some further modifications were also suggested. For example, the terminology- parenteral in outcome 18 was reported as having a wider definition than that given in *TD09*.
- We also note the suggestion for further clarification on expectations of peak flow measurement in outcome 10.
- Many schools considered that students should be competent with arterial blood gas (ABG) measurement and nasogastric tubes (NGT) insertion as they were important skills for foundation doctors.
 - We noted that some school have already included them in the curriculum.
 - Two schools (Dundee and Swansea) also suggested defining the competency level at which these should be performed
 - KCL further suggested the need for aligning outcomes between undergraduate and Foundation Programme.
- Schools also reported a number of challenges.
 - Taking blood and performing transfusions at clinical placements due to local restrictions.
 - Ensuring student access to patient records including electronic records.
 - Ensuring the delivery of team working as part of the programme.
 - Providing of opportunities to perform catheterisation.
 - Ensuring consistency in IV infusion training as equipment differed across placement sites.
- Schools also raised the following issues for us to consider:
 - Procedures which students should not perform.
 - Clarification on status of the supporting documents referenced in *TD09*.
 - The risk of a national exam overshadowing the learning of practical procedures.
 - Limited opportunities to perform ABG as a practical procedure.
- This information will inform our review of the outcomes and practical procedures listed in *TD09* to ensure that the outcomes remain relevant and

continue to describe the outcomes that should be expected of undergraduate medical education and training.

19. How does the curriculum address providing appropriate healthcare and understanding health inequalities, particularly relating to people from lower socioeconomic backgrounds, lesbian gay bisexual or transgender (LGBT) people, and people with learning disabilities?

- Twenty-nine medical schools reported that there was explicit coverage of all these issues in the curriculum. Although not currently covered completely, two schools (Nottingham and Oxford) reported work underway to achieve full coverage.
- Some schools used part of their response to note particular philosophical approaches to the treatment of equality and diversity issues with the aim of encouraging students to develop generic skills for working with diverse patients. Learning outcomes were mapped to problem based learning (PBL) scenarios by many schools. For example, Manchester provided a clear list of learning outcomes and gave examples of scenarios in which they were delivered.
- LGBT issues were covered in the least detail of the three categories discussed.
 - Six schools drew attention to the difficulties of teaching LGBT issues outside the context of sexual health teaching
 - KCL noted that LGBT issues were seen as a lower priority in a survey of students' interests supporting a curricular session on access to healthcare, but had not yet had an opportunity to explore what factors had contributed to this prioritisation.
 - Learning difficulties were covered in the curricula of most schools; although the depth of the curricula appeared vary.
- Socioeconomic issues were notably well developed, with most schools reported defined curricular strands in this area. This was further supported by a wide variety of SSCs as well as innovative initiatives.
 - Some schools reported that these issues were viewed as unimportant or uninteresting by students.
 - Other schools reported innovative initiatives which may be helpful to others. For example, Warwick requires students to devise a presentation on socioeconomic differences in healthcare around a single primary care practice as part of their GP placement.

- We also consider the following initiatives as areas that are working well:
 - Expert patient or patient group involvement including in the design and delivery of curricular content (twelve schools).
 - Students or expert groups designing and/or delivering curricular content on LGBT issues (two schools – Newcastle and Oxford).
 - Student involvement in the delivery of learning around socioeconomic differences from students admitted under widening access routes (one school - UEA).
- Legislation and practices in this area had evolved considerably since the publication of TD09. We will be reviewing the outcomes listed in TD09 to ensure they remain relevant and appropriate.
- Part of the planned review will be looking at what outcomes should be set in relation to health inequality. We also hope to address issues around providing care for and dealing with diverse groups of patients.

20. How does your school teach students how to best handle the issue of the care of dying people?

- Medical schools' responses to this question showed that undergraduate medical education comprises a mixed economy of theoretical and practically-based learning on end of life care. The returns highlighted the complexity and integral nature of the clinical and professional skills required of doctors dealing with vulnerable patients and those closest to them.
- Many schools referred to the changes made in the delivery of education in light of the review of the Liverpool Care Pathway (LCP) and the systems wide response. This examination led to the establishment of a more intuitive approach to end of life through the five priorities for care in England*. Similar approaches have been adopted in Scotland, Wales and Northern Ireland.
- Across the board, schools appeared to be factoring in the key elements specified in our outcome requirements, in our ethical guidance and in the five priorities for care. Some schools reported that they actively explore with students why the LCP was withdrawn and the limitations of what was considered by the profession to be an otherwise helpful tool when deployed flexibly.

* GOV.UK. 2014. *One chance to get it right*.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

- In terms of themes across schools, responses indicated that schools are placing considerable emphasis with end of life education on the elderly and frail. Schools also reported many initiatives featuring as integrated elements of the curriculum such as:
 - providing practical experiential opportunities, including working within hospices
 - prescribing
 - case based discussion
 - role play – on communication and breaking bad news as well as e-learning.
- There was also reference to:
 - education focussing on the complexities associated with patients who wish to die in their own homes
 - the importance of interaction between professional groups, particularly in the community setting.
- In terms of the clinical components, education focuses on care planning, symptom and pain management, medication and drug charts and issues on resuscitation were also mentioned by schools.
- Exeter highlighted that in year 4, there is a focus on the care of patients with malignant and life-limiting disease. This includes placements and learning in oncology, haematology, as well as palliative and hospice care.
- In respect of the associated professional and human factors-type skills, we noted the coverage of ethics, communication with patients and those closest to them, and multi-disciplinary team approaches to care.
- Some schools highlighted coverage of the components of:
 - breaking bad news
 - understanding and responding to patients and relatives' grief
 - respecting different cultural and religious beliefs to death and bereavement.
- There were also schools that cited the practical instruction which students receive about the death certification process.

- Previously, there have been attempts to produce a consensus syllabus on end of life care for undergraduate education. We are exploring if this has influenced consistency across the schools or whether it has helped strengthen the effectiveness of that education.

Medical School Progression Data

21. In autumn 2014 we published reports around Medical School Progression Data and we have asked you to update us through the MSAR on how you have used this new information to improve your understanding of and make improvements to the quality of training?

- Responses were encouraging and schools indicated that the published data adds value to their quality management processes.
- We noted that schools have challenges in obtaining information on their graduates' future performance. Schools reported that the published data is particularly valuable in addressing this known difficulty.
- Schools indicated that the data enabled them to confirm trends or impacts which were previously only supported by anecdotal evidence. For example, Nottingham reported the use of variation of graduate preparedness between medical schools to examine the potential impact of its recent curricular changes. It considered that improvements in perceived preparedness of its graduates over the last two years could be attributed to the introduction of assistantship.
- Several schools also outlined plans to use the progression data to inform curriculum reviews. Liverpool stated its curriculum changes were in part informed by this new data. These included the introduction of earlier clinical immersion for all students. The school also introduced careers advice services as early as Year 1 to promote a better understanding of what they can expect from future years as both medical students and junior doctors.
- We have received useful feedback on how we can improve our presentation of the data. We have incorporated the feedback into the way we present our second phase of reports, which have been published recently. These reports focus on a different set of progression outcomes. These include performance of graduates in exams taken during specialty training and outcomes of foundation year 2 doctors applying to specialty training programmes.

22. Implementation of trainer recognition

This is the third time that we will use the MSAR to record progress against recognising trainers across the four countries.

By July 2014, 88% of the 34 medical schools polled indicated that they had met the milestone three criteria for recognition. This compares with 54% of medical schools reported in the last period.

Of those schools who answered positively to meeting the milestone:

- 24% were provisionally recognising trainers
- 38% were fully recognising trainers
- 38% were recognising both.

The evidence suggests that many medical schools have substantially developed processes for recognising and reporting on trainers, but that it is still a work in progress as schools work toward milestone four.