2017/18 Medical Schools Annual Return (MSAR)

Section A – Questions around the GMC standards and guidance

There are six thematic areas in this section. These are:

- our work programme on health and disability (Q1)
- end of life care teaching (Q2)
- clinical placements (Q3-4)
- our guidance on consent (Q5)
- student fitness to practice guidance (Q6)
- and guidance on personal beliefs (Q7)

Question 1:

Since 2015, schools have provided information on how the teaching of end of life care has evolved in response to the Leadership Alliance and reports on the care of dying people.

> What challenges does your school currently face in providing learning and teaching in relation to end of life care, including challenges around providing direct experience in placements?

There continues to be difficulty in the number of patients available to cover the number of medical students. The small number of patients may not be a representative of the overall patient population in the hospice i.e. although the selected patients have palliative care needs requiring inpatient care, these needs tend not to be as complex as those of patients excluded from the clinical session. This usually results in the same patients speaking to different students, within different year groups, over multiple days.

It is also difficult to incorporate valuable contributions from other colleagues within the multidisciplinary team due to the limited time of a placement (currently 3 days for Year 5 and 1 day for Year 6).

Question 2:

We are currently undertaking a work programme on health and disability, revising our guidance in this area (*Gateways to the professions*) and looking at what support is available for students with long-term health conditions and disabilities.

Last year we asked your thoughts on the implementation of the existing *Gateways* guidance. We will be engaging with you in many ways to hear your suggestions for our ongoing work programme, including a public consultation in 2018. But here it will be helpful to get more information on:

In what ways do you think you can change or improve the support for students with long-term health conditions and disabilities? This can include physical conditions, mental health conditions and learning disabilities.

The University of Edinburgh has developed a trained named contact outside the current Personal Tutor system to mentor individual students with autism and ADHD. While these conditions are uncommon within the medical school we believe that this model could be built upon to target trained mentors outside the PT system for students with long-term health conditions and disabilities. We believe that this could complement our current robust approach and highly regarded student support network.

We continue to meet annually with the University Disability Service to discuss reasonable adjustments and plan to introduce this type of meeting with Occupational Health to ensure there is a consistent approach in dealing with on going student health issues.

Question 3:

In 2010, we issued guidance in four areas to help schools implement some of the standards of *Tomorrow's doctors 2009*. Since then, *Tomorrow's doctors* has been replaced by the standards in *Promoting excellence*, but the guidance has been retained on our website as we understand it is still useful.

We are now considering whether it would be helpful to provide an update to the placements and assistantships document.

a) Please describe any challenges or impacts on the management of your clinical placements you have identified resulting from the requirements in *Promoting excellence* around clinical placements and assistantships. We would be interested specifically to know if there are impacts resulting from the new requirements that placements should enable students to follow patients' care pathways (R5.3c) and gain experience of out of hours working (R5.3h), but also about any other impacts from the requirements relating to placements in *Promoting excellence*. The full wording of the paragraphs cited is in the Appendix.

The requirement to enable students to follow patients' care pathways has had a significant impact in terms of training and access to the electronic patient records system (TRAK). Particularly with the move towards write access. We have worked to address these issues with NHS Lothian and believe we now have streamlined processes in place for all students requiring access. To ensure that we have clear records of all access requests within the team, and to make processes as clear as possible for students, we have created an online form where staff and students can follow the progress of access requests at any given

time which is working very well.

Out of ours working has had a limited impact as we had already timetabled our senior students to experience a full variety of shift types, including evenings, weekends and Hospital at Night (HAN) working. We are working to increase this type of experience and enhance the consistency, quality and equality of exposure.

b) What criteria do you set for the quality of your placements and assistantships, and how are these measured and monitored?

We have written clear criteria, issued to all Module Organisers which outlines what we require from a clinical placement. It covers areas such as Learning Outcomes and objectives, how this information should to presented to students on the virtual learning environment (VLE) and will include key knowledge and skills and core content as well as relevant programme themes. We ask for Induction and a detailed timetable to be provided with at least two weeks' notice. Students will be met at the beginning of each module by the Module Organiser, local lead or designated deputy. Information provided includes:

a. explanation of geography of hospital area

b. overview of the timetable, teaching, clinical experience and feedback opportunities.

c. identification of clinical tutor, how to contact them and the nature of supervision during the attachment.

d. outline of what they can be expected to do, their role in the multidisciplinary team and what they should gain from the module.

e. outline key work-place policies and guidelines e.g. dress code, infection control etc

f. description of what will be required to successfully complete the module, including academic and professionalism assessments.

g. Provide contact for when problems arise including need for additional support, cancelled teaching sessions, student absences etc

The design of each module starts with outlining the direct contact between tutors and students. The module should outline what can be expected from all learning opportunities e.g. ward rounds, out-patients, GP surgeries, theatre sessions, MDT meetings, interaction with allied healthcare professionals, clinical skills or simulation sessions, lectures, tutorials and workshops etc.

We measure and monitor these actions by a number of quality management

routes, such as student feedback via national and local ACT surveys, quality management reports and ask that each module reviews their arrangements annually against the Medical School template, ensuring that all members of the wider team are aware of expectations. A rolling programme of teaching quality improvement visits are used to recommend further developments within the modules.

Question 4:

Our standards require that clinical placements allow students to become members of the multidisciplinary team, provide practical experience relevant to the learning outcomes of the programme and opportunities to work alongside health and social care professionals (*Promoting excellence* 5.4a, e-f). The framework for students' access to information can be found in paragraphs 4-6 of our guidance.

We understand that students sometimes have difficulty accessing the information they require in their placements. We would like to understand what issues there are in students' access to information in the course of placements.

> Has your school encountered any difficulties in securing appropriate access for students to information in their placements? If so, please can you describe the issue and any actions taken to address them.

As mentioned in question 3a, there have been some issues agreeing processes with NHS Lothian regarding access to the various systems required for students during their placements (NHS Logins, Sunray Cards, Trak). We have worked to address these issues with NHS Lothian, and believe we now have streamlined processes in place for all students requiring access.

The expiry of student access remains an ongoing issue, with numerous requests from students for their NHS accounts be reactivated. We remind students of the need to regularly login to the their Trak accounts throughout their placements to reduce the risk of expiry, but there is little we can do when students are out with NHS Lothian on other placements and their access expires during this time.

Due to the timing of the start of Year 4 coinciding with the start of Foundation Year, NHS Lothian Directory Services have been unable to create accounts promptly during this time due to capacity issues, and there is a risk that if this is not managed correctly this will disadvantage students on their first NHS Lothian placement. We are working with NHS Lothian to ensure that they have all the Year 4 student data they require in good time.

Students on peripheral placements have not reported any issues with access to systems, as access requests on other NHS sites is integrated into student inductions.

Question 5:

We are updating our guidance on Consent to make sure that it is clear, helpful, and easy to use in practice. We will consult on a draft in spring 2018. We want to know how you use the guidance and what we can do to support your practice.

> Is there anything that you think is missing from the current guidance, or anything that we could improve? Do you have ideas for resources on consent and shared decision-making that we could produce which would be helpful for you and your students?

We believe that the GMC's guidance covers all the issues regarding consent very well. The Montgomery Ruling is dealt with formally within our modules.

Question 6:

Our revised guidance on Student Fitness to Practise, developed with the Medical Schools Council (MSC), came into effect on 1 September 2016. The guidance includes two documents: *Professional behaviour and fitness to practise*, primarily addressed to medical school staff, and *Achieving good medical practice*, addressed to medical students.

Last year you told us about changes you have made to your rules or processes in order to comply with the new guidance, any aspects you were unable to meet, and steps you had taken to ensure your students were aware of the guidance.

> What (if any) challenges remain in managing student fitness to practise, that are not addressed by the guidance? Is there anything the GMC and MSC (as co-authors) can do to help you address these?

As mentioned last year, the medical school welcomed the guidance from the GMC on Professional behaviour and fitness to practise. The only on-going issue would be the need for clarification on fixed penalty notices in relation to Scottish Law but we understand that this is being addressed in conjunction with the Medical Schools Council.

The monitoring of low-level concerns across the medicine programme has resulted in a large amount of administration. It would be helpful if there was an online system for recording low-level issues, similar to the MSC database for excluded students, rather than all medical schools needing to develop their own bespoke systems. That being said, our updated regulations and monitoring of low-level concerns is working well and we will continue to monitor and enhance this in line with best practice across the sector.

Question 7:

As medical schools will know, the GMC published guidance on personal beliefs and medical practice http://www.gmc-uk.org/static/documents/content/Personal_beliefs-web.pdf . This guidance explains how the principles in *Good medical practice* apply for doctors to ensure they treat patients fairly and with respect, whatever their life choices and beliefs. It also provides a set of guidelines for doctors who may have a conscientious objection to a particular procedure.

We are exploring whether there may be scope for producing additional guidance with specific reference to education and training, and how the personal beliefs of medical students and doctors in training can be accommodated within the clinical and learning environment.

Please let us have your ideas on the areas you think additional guidance from the GMC should cover, highlighting particular issues that have presented challenges for your school and any local policies and guidance you have produced.

We introduce the topic of conscientious objection early in the programme (semester 1 of Year 1) although we address this as an issue in clinical practice rather than an issue that might permeate the student experience. We do point out that the right to conscientiously object (in clinic) extends to students.

We have included a new session early into the curriculum on lesbian, gay, bisexual and trans (LGBT) and health and we plan to develop this further, recognising gender fluidity issues as an area of changing social attitude and therefore subject to conflict with some traditional values.

We are also considering embedding sessions which explore the issue of respect and challenges to this in the context of education as well as clinical practice, encouraging students to critically explore the ideas in the GMC guidance including the practice of conscientious objection. We will continue to improve teaching methods which help our students develop as tolerant, respectful doctors.

Appendix

Please see below for the text of the requirements cited in Question 2, from our standards for medical education and training (*Promoting excellence*).

R5.3 Medical school curricula must give medical students:

a early contact with patients that increases in duration and responsibility as students progress through the programme

b experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor

c the opportunity to support and follow patients through their care pathway

d the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics

e learning opportunities that integrate basic and clinical science, enabling them to link theory and practice

f the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates

g learning opportunities enabling them to develop generic professional capabilities

h at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.