

Quality Assurance of Basic Medical Education

Report on School of Medicine,
University of Southampton

December 2008

**General
Medical
Council**

Regulating doctors
Ensuring good medical practice

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The GMC's role in medical education

1. The Education Committee of the General Medical Council (GMC) sets and monitors standards in medical education. The standards for undergraduate medical education are set out in the publication *Tomorrow's Doctors*.
2. In order to ensure that UK medical schools maintain these standards the GMC runs a quality assurance programme, which involves regular assessments and visits to schools. This programme is called Quality Assurance of Basic Medical Education (QABME) and is carried out on behalf of the GMC Education Committee by a team of medical and educational professionals, student representatives and lay members.
3. The team makes determinations as to whether these schools are meeting the standards in *Tomorrow's Doctors* after analysing extensive School documentation and completing a range of quality assurance activities at the School and partner institutions. The determinations in this report have been endorsed by the GMC Education Committee.

Introduction

4. This is the 2007/08 quality assurance report to the GMC Education Committee on the medical school at Southampton (the School).
5. The last GMC review of Southampton Medical School was in December 1999, prior to the establishment of the Quality Assurance of Basic Medical Education (QABME) programme.
6. There are currently over 1200 medical students on the three Bachelor of Medicine (BM) programmes. The School admits 246 students annually into either:
 - a. BM4 Programme – This is a four year graduate entry programme which has been running since October 2004. The first cohort will be graduating from the programme at the end of the academic year 2007/08.
 - b. BM5 Programme – This is the standard five year undergraduate programme which has been running since 1971.
 - c. BM6 Programme – This is a six year widening access programme, where students undertake a specially designed Year 0 course before joining the students on the BM5 programme. This was piloted in 2002 and has grown substantially with 30 places available on the programme each year, with the first cohort graduating from the programme at the end of the academic year 2007/08.
7. The School revised its BM5 programme curriculum in 1999, 2002 and most recently in 2006, with a focus on the basic sciences. In 2006, a Curriculum Project Group undertook a curriculum review of Years 1, 2 and the final year of the BM5/BM6 programmes. The plans for the changes were finalised and validated for the BM4, BM5 and BM6 programmes in March 2007 and are being implemented from October 2007 for Year 1 and 2008/09 for Year 2. The changes in the early years include the reinforcement of the spiral nature of the curriculum and the introduction of a more extensive case based approach to contextualise learning.
8. The changes in the final year include the introduction of a six week Medicine in Practice course at the beginning of the year. This provides a transition for BM5 students who will have completed their Year 4 study-in-depth to bring them up to speed with their BM4 counterparts before they start a common final year. The aims and outcomes of the other final year courses were reviewed by the School to ensure consistency with the Foundation Programme.
9. In 2004/05 changes were made to the final clinical exam. The School introduced the mini-clinical evaluation examination (mini-CEX) as an assessment tool as there was dissatisfaction and concern over the previously used Long Case. The School consider that the advantages of the mini-CEX are that it is a multiple repeated experience which drives learning and students are given immediate feedback. This is used in addition to the 16 station Objective Structured Clinical Examinations (OSCE) to test the clinical skills in the final year.

The QABME team

10. The visiting team members appointed by the GMC Education Committee to undertake the quality assurance visits were:

Professor Reg Jordan (Team Leader)
Professor Trudie Roberts (Deputy Team Leader)
Professor Trevor Beedham
Mr Philip Brown
Professor Tim Cooke
Mr Chris Hands
Mrs Susan Hobbs
Professor Philip Milner
Dr Matt Shale

11. Miss My Phan (GMC Education Quality Officer) supported the QABME team.

Our programme of visits in 2007/08

12. The team conducted five quality assurance visits on: 15 November 2007, 6-7 February 2008, 15 May 2008, 17-18 June 2008 and 22 July 2008.

13. The findings of the team have been reached by reviewing documentary evidence submitted by the School and undertaking the following activities:

- a. Meetings with a variety of members of the School.
- b. Observation of teaching sessions in GP practices and both the main university teaching hospital and district general hospitals.
- c. Observation of a demonstration of e-learning resources.
- d. Site visits to various NHS Trusts.
- e. Site visits to various GP practices.
- f. Discussions with students.
- g. Discussions with teachers, including general practitioners and clinical consultants.
- h. Discussions with Foundation Year 1 (F1) doctors and their supervisors.
- i. Observation of the examination of clinical skills.
- j. Observation of the final Examination Board.

The report

Summary of our key findings

14. Subject to the requirements in paragraphs 17 -18, the School's BM programmes meets the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983.
15. We are pleased that most areas identified for further attention have been identified by the School and some steps are already being taken to address these.
16. Where there are requirements, the School is requested to respond to the requirements with timelines for action within the 28 day right of reply to the report.

Requirements

17. The School is required to:
 - a. Review the approach to the delivery of the interprofessional learning (IPL) component of the medical curriculum to ensure that it meets the needs of medical students (see paragraphs 49-50).
 - b. Revise the OSCEs to ensure objectivity, reliability and validity so that the School can demonstrate the robustness of the assessment of overall clinical competence (see paragraphs 72-73, 75-77).
18. The University is required to review and revise the application of its Fitness to Practise procedures for medical students, including the appeals process (see paragraph 82).

Recommendations

19. To enhance the quality of the programme we recommend that the School:
 - a. Review the use of the time allocated for the Year 4 Study in Depth project (see paragraphs 34-35).
 - b. Take further steps to ensure the compliance of all named mini-CEX assessors with the School's requirements for the mini-CEX assessment (see paragraphs 69-71, 75 - 77).

Areas of innovation and good practice

20. We commend the School on the following areas of innovation and good practice:

- a. The overall approach to staff development and appraisal which has fostered a culture of enthusiastic engagement by NHS partners, hospital clinicians and general practitioners (see paragraphs 43-45).
- b. The development and use of e-learning tools in supporting the delivery of the curriculum (see paragraph 53).
- c. The effectiveness of pastoral student support (see paragraph 58).

Curricular outcomes

Outcomes

21. We are content with the School's overall aims and learning outcomes in the curriculum which are matched closely to *Tomorrow's Doctors*.
22. The curriculum is made up of three key components: themes, subjects and courses which overlap and build upon each other. The four themes which underpin and run through all three BM programmes are Communication, Diversity, Teamwork and Leadership and Ethics and Law. Core areas of important study such as the health of the public are covered within the subject component of the course.
23. The aims and learning outcomes for each year are signposted in the medical curriculum booklets given to students for the individual BM programmes. Students demonstrated awareness of these curricular outcomes on our visits.
24. Trainees were generally very positive about how their undergraduate training at Southampton Medical School prepared them for the first year of the Foundation Programme.

Curricular content, structure and delivery

Content

25. The School is in the process of implementing the outcomes of the curriculum review of 2006. The revised programme will be fully implemented in the academic year 2008/09. We will monitor the progress of the delivery of the new BM5 Year 2 in 2008/09 in the School's next annual update to the GMC.

The scientific basis of practice

26. The 2006 curriculum revision was introduced to improve the integration and spiral nature of the programmes. From the analysis of the documentation, meetings with students, graduates and supervisors, we are satisfied so far that the basic sciences are appropriately introduced and reinforced. We sampled the teaching of cardiovascular and renal systems within the curriculum and are satisfied that these topics are revisited each year at increasing levels of complexity and build upon previous learning.

Clinical and practical skills

27. We are content that clinical and practical skills are taught satisfactorily and meet the requirements of *Tomorrow's Doctors*. F1 doctors praised the final year clinical ward attachments which provided good experience in preparation for their foundation training.

Communication Skills

28. Students and F1 doctors advised that communication skills are incorporated throughout the curriculum to include coping in difficult situations and breaking bad news. Opportunities are available to learn sign language and other languages during the course as part of the student selected components.

General skills

29. General skills such as time management, prioritising tasks and self-reflection, are taught and assessed within the curriculum.

The working environment

30. F1 doctors said they thought the shadowing period should be made more relevant to the actual F1 post they are appointed to and wanted to learn more about the current developments in the NHS. We acknowledge the concerns from the School and of the Director of the Wessex Foundation School that students have different shadowing experiences which vary between deaneries.

The health of the public

31. We found the input of social and behavioural sciences to the curriculum to be appropriate overall.

32. A working group has been set up to improve public health teaching and engage with the local NHS organisations. The School has introduced a final year public health student selected option. We encourage the School to continue exploring ways to integrate public health into the curriculum, particularly for the topics of assessing the health needs of a population and health promotion. The settings for teaching public health could be expanded to include Primary Care Trusts, health authorities, NHS Trusts, local authorities, the voluntary sector, and local communities.

Structure

33. Over 25% of the standard BM5 programme consists of student selected components (SSCs) through student selected units (SSUs) in Years 1 to 3, a clinical elective and study in depth project in Year 4 and clinical SSUs in the final year. This satisfies the requirements of *Tomorrow's Doctors*.

34. We recognise that the Year 4 study in depth project is a feature of the Southampton programme and note that this preceded the SSC requirement in *Tomorrow's Doctors*. Students manage a six month project from a choice of 280 existing or new projects across 40 different disciplines. Student views regarding the project were mixed. Some students and F1 doctors expressed concern over the length of the project which takes time out of clinical practice. This view was supported by a number of clinical teachers on our visits. Students also had varied experiences depending on whether they got their first choice of project and a minority had problems with obtaining ethical approval in time.

35. This year the School introduced a new six week Medicine in Practice 3 course at the beginning of the final year to refresh students' clinical skills. Final year students found this useful, but still thought that it would be beneficial to shorten the project. We consider that the curriculum may have now evolved around the Year 4 study in depth project and recommend that the School review its time and place within the curriculum and the broader implications it will have on the rest of the curriculum including clinical teaching.

36. Students stated that they enjoyed the choice of SSUs available and thought they were very good at enriching their experiences. The Southampton graduates commented in particular that they found the final year Clinical SSUs useful as a career taster or to enhance their knowledge in areas not really covered in the core curriculum.

Delivering the curriculum

Supervisory structures

37. We are satisfied that clear lines of authority and responsibility are set out through the University and School supervisory structures. The various committees allow the School to plan, implement and review curricula and associated assessments.

38. We are impressed with the School's relationship with its partner institutions, evidenced by, for example, cross-representation on committees, joint appraisal arrangements, and the level of NHS clinicians' commitment to teaching and assessing the programmes.

Teaching and learning

39. The School works with over 20 partner institutions as well as general practices to provide clinical attachments across the Southern region in Dorchester, Poole, Bournemouth, Salisbury, Winchester, Southampton, Isle of Wight, Gosport, Portsmouth, Basingstoke, Chichester, Frimley, Wexham, Guildford and Crawley.

40. We observed a wide range of teaching, including clinical teaching in primary and secondary care settings and were satisfied with the quality of teaching. We noted the quality of the teaching, and the enthusiasm and experience of the clinical teachers who demonstrated knowledge of the School's curriculum and their role within it. We saw a number of examples of excellent teaching from general practitioners, clinicians and a specialist nurse delivering mental health teaching to medical students. These observations are consistent with the experience reported by students.

41. Students and F1 doctors were generally enthusiastic and satisfied with the standard of teaching and learning at the School. Both groups commented positively on the early clinical exposure in general practice and the wide range of student selected components available.

42. We are satisfied with the systems that are in place to monitor the quality of teaching at the NHS partner sites. We note that formal visits to major NHS partner trusts are undertaken and reported on every three years. We also note the use of coordinators based in Southampton for every attachment in the curriculum. These central coordinators liaise with the coordinators of the same attachment on each site and hold annual meetings or visit the partner institutions to discuss educational developments, share good practice and ensure cohesion. We consider that some improvements could be made in the communication links to ensure consistency in teaching.

43. We commend the School's proactive approach to staff development and appraisal which has fostered a culture of enthusiastic engagement by clinical teachers. We consider that the School's two-pronged approach to deliver staff development is appropriate. The generic approach offers all staff the opportunity to go on general training courses. The tailored approach offers training relevant to the course that staff are teaching and assessing. In addition, staff members with a role in the BM programmes wishing to undertake certificates of medical education, Masters programmes and other qualifications are supported by the School.

44. All partner institutions are informed of available training courses and annual events by the School's Medical Education Development Unit. The events provide opportunities to share good practice, address specific areas of concern and general needs. Staff development information is also available on the School's Medicine Information Systems website, MEDIS. We also note the development of a web-based staff development site to support teachers who are unable to attend organised courses.

45. There are joint appraisals between the School and NHS trusts for NHS teachers with a major role in undergraduate education. The School rewards quality of teaching through annual teacher prizes and a Vice Chancellor's teaching award.

46. We are satisfied that the BM programmes provide a balance of different teaching and learning opportunities through lectures, tutorials, small group collaborative working, e-learning, clinical symposia, clinical skills experience and opportunities for self directed learning.

Interprofessional Learning

47. We note the School's commitment to developing a model of IPL and teaching for all health care professionals in partnership with key stakeholders. A nationally funded New Generation Project was established in 1999 and has since expanded and evolved to become a partnership between the University of Southampton, the University of Portsmouth and the South Central Strategic Health Authority. The Partnership reaches across fourteen professional programmes; four faculties; two universities and the health and social care organisations that support student learning in practice.

48. IPL is incorporated within the curriculum through the Teamwork and Leadership theme through three compulsory units: IPL1 in Year 1, IPL2 in Year 2

and IPL3 in the final year with an optional SSU in Year 3 and a study in depth option in Year 4. Students work in groups of 10 with five different professions.

49. While we are pleased with the School's commitment to IPL, we are concerned about the dissonance between the views of students and those responsible for the IPL programme. We reviewed student evaluation of the IPL units over the last three years and noted a high proportion of negative views of the IPL experience. On our visits we heard many critical comments from students and some clinical staff. Students understood the aims of the IPL programme but felt that the content and timetabling did not enable them to meet these aims. They felt that the consequence may be that professional stereotyping is reinforced rather than reduced. Students suggested different ways of structuring IPL, such as the very successful shadowing of other healthcare professionals undertaken by Year 0 BM6 students. In view of the strength of student feeling we consider that the School should look at whether a different approach to the IPL programme is needed.

50. We have taken note of the June 2008 report on the Periodic Thematic Review of Interprofessional Learning. Given the student evaluation and opinions expressed to us, we are concerned about the small number of students consulted in the review. We do not consider that the needs of medical students at Southampton have been fully considered or being appropriately met. We require the School to demonstrate that the delivery of IPL within the medical curriculum meets the needs of medical students.

Learning resources and facilities

51. We are satisfied that students have access to appropriate learning resources and facilities and mechanisms are in place for students to provide feedback on these. This view was supported by the feedback from students on our visits.

52. We are content with the progress of the development of the new Institute for Life Sciences due for completion in 2010 and new Centre for Learning Anatomical Sciences which will be completed in 2009. Both sites will replace the existing Biomedical Science Building at the Boldrewood site. We will monitor the progress of this in the School's annual return to the GMC.

53. We found that students made effective use of MEDIS which provides access to existing course material and stand alone interactive e-learning packages. These include SCALPEL used to teach pathology practicals, TULIP used to simulate mental health interviews and a new Virtual Patients resource designed to help students think about diseases in the context of a clinical consultation. We reviewed these resources and considered these to be well designed and easy to use. We commend the development of e-learning resources which students considered to be useful, and note the additional funding secured by the School to expand these.

Student selection

54. We are satisfied that the selection procedures are valid, open, objective and fair. The School's Selection Procedure and Policy document is published on its

website, in a brochure and the Prospectus, and via UCAS. This document outlines the criteria for entry to each programme and is reviewed annually by an established Medical Selection Committee (MSC).

55. All applications are considered by two independent selectors of the MSC. All new selectors receive training which includes equal opportunities. Any updates to relevant legislation are provided to selectors in regular meetings during the selection cycle and in the annual Away Day. The Admissions and Recruitment Manager is responsible for ensuring all applicants are considered fairly through the School of Medicine's Admission Office which monitors all selectors' decisions.

56. We note that the recent BM4 and BM6 programmes were specifically designed to widen participation in the medical profession. The BM4 programme is intended for graduates from any discipline, who can also apply for the BM5 programme. The BM6 programme is aimed at applicants from previously under-represented groups who have the potential to study medicine. In addition to these programmes, the School more generally encourages applications to its medical programmes from a wide range of socio-economic groups.

Student support, guidance and feedback

57. We found that the student support, guidance and feedback procedures and processes are robust. We observed teachers providing effective feedback to students during the course of our visits.

58. Southampton makes use of a multi-level system of student support which ensures accessibility for all students. Students and F1 doctors gave positive feedback on the formal and informal support which was readily available to them from both academic and non-academic staff during the course. Pastoral tutors are made available every day of the week in the Student Support Office to provide help if required. Both groups felt able to seek support if needed and considered staff to be approachable, friendly and always willing to help. The support systems are well signposted and examples were given of students who received excellent support through the service. We commend the effectiveness of pastoral student support.

59. Guidance is provided to students about the core curriculum, student selected components and how performance is assessed during the course. Students stated that they understood this guidance and in addition had all been made aware of the policies on fitness to practise, cheating and whistle-blowing and knew where to find them if required.

60. Some students commented on the variability of feedback received for written assessments which had general grade descriptors, but did not always include additional specific comments. However, students valued the feedback received on each clinical attachment through the mini-CEX.

61. Careers advice is provided in the student handbooks and on MEDIS which includes: the Careers Handbook, the School's Careers website, Career Impact - interactive fortnightly lunchtime sessions on different specialties, Sci 45 - a computerised Specialty Inventory tool and the Students Careers Advisory Group.

Assessing student performance and competence

The principles of assessment

62. We are content that the schemes of assessment in the programmes are appropriate and support the curriculum. These include assignments, essays, reports, spotters, multiple choice examinations, problem solving papers, reports and clinical assessment. We note the use of formative assessment in the mini-CEXs during the final year clinical attachments which provide valuable student and teacher interaction.

63. We are satisfied that student performance in the SSCs is assessed appropriately and contributes to the earlier parts of the programme. Students must pass each SSC in order to progress to the final year.

64. The BM Final Examination is integrated and tests students' knowledge, skills, attitudes and behaviour to determine their fitness to practise as a F1 doctor through the following four equally weighted components:

a. Two written multiple choice examinations (One Best Answer paper and Extended Matching Items paper).

b. Three equally weighted essay papers on (1) an ethical problem, (2) writing a GP referral or hospital discharge letter and (3) a critical appraisal of a published clinical research paper.

c. 17 mini-clinical evaluation exercise (mini-CEX) undertaken throughout the year. Students take three mini-CEXs in each attachment in medicine, surgery, obstetrics and gynaecology, psychiatry and child health, and two for primary care. Exemption from a further mini-CEX assessment in the BM Final Examination is dependant on the number of below expectation or borderline scores that the students achieve in each group of mini-CEX assessments.

d. 16 Objective Structured Clinical Examination (OSCE) stations lasting five minutes with a one minute changeover between each and one rest station. The examination covers a range of clinical areas: history, communication, examination, explanation, procedures, interpretation and management.

65. Students must satisfactorily complete their clinical attachments prior to sitting the final examination, be certified competent in resuscitation, pass all four components of the BM Final examination at a bare pass grade D or above to be eligible for the award of the BM degree. Students are also required to undertake pre-F1 shadowing.

66. Aside from the concerns expressed in paragraphs 70 - 72, we are satisfied with the assessment strategy for the final year. However, we consider that a number of improvements need to be made to its implementation.

Assessment procedures

67. The schemes of assessment are mapped against the curriculum outcomes and the standards in *Tomorrow's Doctors* in a document which clearly shows how individual assessments and examinations contribute to the overall assessment of the curricular outcomes.

68. We consider the guidance given to students in their handbooks on what is expected of them in all examinations and assessments to be clear. We also found the student briefing before the final year OSCEs to be comprehensive. Students stated that they understood how the individual assessments contribute to the overall assessment of the course.

Mini-CEX

69. We recognise the positive contribution of the Mini-CEXs to enable students to be assessed in the workplace.

70. We are, however, concerned about the reliability of the in-course mini-CEX, which is delivered across many sites, as the majority of clinical skills are assessed through this tool. We observed variation in approach between different assessors. Students also reported that they perceived the in-course mini-CEX assessment to be very subjective and they gave examples where the assessment had not been carried out appropriately.

71. The School reported that all sites have named assessors who should be the only people carrying out the assessment. However students reported that the named assessors were not available at some sites and they needed to find alternative examiners themselves. We observed variability in marking of this assessment on a visit to three different sites sampling six mini-CEXs. The mini-CEXs are a component of the final examination and therefore we recommend that the School takes further steps to ensure the compliance of all named mini-CEX assessors with the School's requirements for mini-CEX assessment.

OSCEs

72. We observed the final year OSCE examination which comprised seven circuits across the Southampton General Hospital site. 13 circuits were run throughout the day. While we recognise and note the hard work and commitment of all staff, patients (real and simulated), helpers and the acute trust in delivering the final year OSCE in one day and on one site, we have some concerns about the OSCE examination. We observed examiner briefings which included a statement that if a student was to fail more than three stations this would mean failing the OSCE and repeating the final year. Using the present marking system this could potentially bias examiner judgement. Given the unproven reliability of the in-course mini-CEX the OSCE must serve as a robust final assessment of a students' clinical competence. We therefore considered that this OSCE had too few physical examination stations and that the duration of some stations was too short. We also observed higher noise contamination in four of the seven circuits because of their

location and variation in examiner interpretation of the briefing both for the conduct and marking of the stations.

73. We require the School to revise the OSCEs to ensure objectivity, reliability and validity so that the School can demonstrate that the assessment of overall clinical competence is robust.

Examiner training

74. We are satisfied with the training provided to examiners in the earlier years of the course which include attendance at Universities Medical Assessment Partnership question writing workshops and internal sessions on standard setting.

75. We are concerned about training provided to examiners carrying out clinical assessments. We note the use of OSCE champions at each site for the Intermediate OSCE, training videos for the final year mini-CEX and OSCE, and shadowing for new OSCE examiners.

76. We recognise the practical difficulties in training over 300 mini-CEX examiners and more than 100 OSCE examiners across multiple sites. However we are concerned that there is no obligation for examiners to attend training that is offered and that the School is reliant on the 30 minute examiner briefing in advance of the final clinical exams, which contained inappropriate information.

77. We encourage the use of training videos, but consider that the mini-CEX training video and examiner briefings did not fully address the needs of the examiners.

78. We consider that the formal meeting between the external examiners and the students following the final clinical exams provides a useful forum for student evaluation of the programme.

79. We interviewed external examiners and noted that while they can observe the in-course mini-CEX component they rarely do, even though it is part of the final exam. We are therefore concerned that the external examiner system is not working as effectively as it should. Nevertheless, we noted that the external examiners reports contained similar concerns to ours in relation to the OSCE.

Appraisal

80. Students receive feedback on their progress and performance in every year of all programmes. Feedback on written in-course assignments is provided in the earlier years of the course. Supervisors for the Year 4 study in depth project carry out at least three formal appraisals of progress. Educational supervisors provide feedback on clinical skills, attitudes and behaviours during clinical attachments in the final year. Individual feedback is provided to students who fail assessments to discuss strategies to improve their performance.

Student progress

81. We are satisfied that the School has robust and fair policies and procedures in place for student progress decisions which are well signposted to students.

82. We note the update to the School's policy on fitness to practise (FtP) following the new guidance published by the GMC in September 2007. We consider the terms of reference of the appeal process for the student FtP at faculty level to be appropriate. However we note that all reported instances of appeals against the FtP Panel appeared to have been upheld and we are concerned that there may be a dissonance between the Faculty's and the School's approach to fitness to practise issues. We require the University to review and revise the application of its fitness to practise procedures for medical students, including the appeals process.

Student health and conduct

83. We are satisfied with the mechanisms in place to support students with personal health problems which are described in the student handbook and on MEDIS. This is considered accessible and effective by students who had used them.

Acknowledgement

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

Kirsty White
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16th October 2008

Dear Kirsty

GMC QABME Report School of Medicine University of Southampton

Thank you for your recent letter enclosing the QABME report on the BM programmes at the School of Medicine, University of Southampton. The School of Medicine welcomes the report confirming that we meet the requirements set out in *Tomorrow's Doctors*. We are very pleased to see some of our strengths acknowledged.

To address the specific comments:

Requirements:

Paragraphs 49 and 50 -The review of the delivery of the interprofessional learning was underway prior to the GMC QABME visit. Major changes in the interprofessional learning units are planned for 2009. Interprofessional Learning takes place across two Universities and involves thirteen different health care professions. We will continue to work constructively and in collaboration with the interprofessional educational team to ensure that IPL meets the needs of all healthcare students, including medical students. We will update the GMC on our progress.

Paragraphs 72 and 73 - A working group as been set up to review the OSCE which will report in February 2009.

Paragraph 82 -The Faculty Associate Dean for Education has established a working group to review the appeals regulations for Fitness *to Practise* procedures for all healthcare students, including the appeals process.

Recommendations:

Paragraphs 34 and 35- a working group was set up in October 2006 to review the Study-in-Depth and has identified and planned changes, including shortening the research component and strengthening the research methods and statistics teaching. These changes will be implemented in 2010 when the award of a Bachelor of Medical Science degree for successfully completing the 4th Year will be introduced. In October 2008 we increased the clinical component of the fourth year.

Please reply to:

Office of the School of Medicine

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Paragraphs 69 to 71- We were pleased that the GMC acknowledged the School's innovation in introducing and evaluating work based assessments across the Final Year. We will continue to work with our clinical assessors to ensure they comply with our requirements for the mini-CEX assessment.

Innovation and good practice:

We were delighted that the GMC identified staff development, pastoral student support and the blended curriculum using e learning as areas of innovation and good practice. We are also pleased that team noted that the University is investing in a new Centre for Learning Anatomical Sciences on the hospital site. (Para 52.) We were pleased that the GMC team:

- reported that Trainees praised the final year clinical attachments on the wards which provided good experience in preparation for their foundation training;
- were impressed with the School's relationship with its partner institutions;
- found that the quality of the teaching, and the enthusiasm and experience of the clinical teachers who demonstrated knowledge of the School's curriculum.
- saw a number of examples of excellent teaching from general practitioners, clinicians and a specialist nurse delivering mental health teaching to medical students.
- found that students and Foundation Year 1 trainees were generally enthusiastic and satisfied with the standard of teaching and learning at the School. Both groups commented positively on the early clinical exposure in the course in general practice and the wide range of student selected components available.

We are proud of the two major innovative programmes which we have planned, developed and implemented since your last visit in 1999 as well as the reviews and developments in BM 5. The BM 4 graduate entry programme which commenced in 2004 and the BM 6 programme are both designed to widen access and their first cohorts graduate in 2008. The BM6 programme has been identified as an example of good practice in widening participation in reports by Universities UK and the Department of Health.

We look forward to working with the GMC to demonstrate that we have addressed the concerns identified in the report, and are maintaining and enhancing our strengths.

Yours sincerely



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