MBChB

Code of Practice for Assessment

2015-16
## MBChB Assessment 2015/6

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Assessment Strategy</td>
<td>3</td>
</tr>
<tr>
<td>Summary Tables</td>
<td>7</td>
</tr>
<tr>
<td>Standard Setting</td>
<td>9</td>
</tr>
<tr>
<td>Written Assessments</td>
<td>15</td>
</tr>
<tr>
<td>Clinical Assessments</td>
<td>17</td>
</tr>
<tr>
<td>Year 1 Examinations</td>
<td>18</td>
</tr>
<tr>
<td>Year 2 Examinations (for 5-year cohort)</td>
<td>19</td>
</tr>
<tr>
<td>Primary Professional Examination</td>
<td>20</td>
</tr>
<tr>
<td>Intermediate Professional Examination</td>
<td>21</td>
</tr>
<tr>
<td>Final Professional Examination</td>
<td>26</td>
</tr>
<tr>
<td>Assessment of Student Selected Components</td>
<td>33</td>
</tr>
<tr>
<td>Assessment of People &amp; Disease Student Selected Component</td>
<td>34</td>
</tr>
<tr>
<td>Feedback to students after assessments</td>
<td>35</td>
</tr>
<tr>
<td>Merit and Distinction awards</td>
<td>38</td>
</tr>
<tr>
<td>Award of Honours</td>
<td>39</td>
</tr>
<tr>
<td>Calculation of Medical School Performance for the Educational Performance Measure (EPM)</td>
<td>40</td>
</tr>
<tr>
<td>Assessment of Clinical Placements</td>
<td>41</td>
</tr>
<tr>
<td>Responsible Bodies</td>
<td>43</td>
</tr>
<tr>
<td>Mitigating Circumstances Panel</td>
<td>43</td>
</tr>
<tr>
<td>Board and Panel of Examiners</td>
<td>45</td>
</tr>
<tr>
<td>Phase 1 and Phase 2 Assessment Groups</td>
<td>49</td>
</tr>
<tr>
<td>External Examiners</td>
<td>53</td>
</tr>
<tr>
<td>Plagiarism and cheating</td>
<td>55</td>
</tr>
<tr>
<td>Absence from an examination</td>
<td>56</td>
</tr>
<tr>
<td>Prizes</td>
<td>57</td>
</tr>
<tr>
<td>Appendix A: Outcomes of the MBChB course</td>
<td>58</td>
</tr>
</tbody>
</table>

September 2015 (updated June 2016)
1. Introduction

This document prescribes the conduct of the assessment of students in the MB ChB programme at Leicester Medical School, building on the general guidance of the University of Leicester regulations.

Assessment processes in the Medical School are continually reviewed in the light of experience and guidance from the General Medical Council and other bodies. The code of Practise for Assessment will therefore be reviewed and updated on an annual basis. The annual revised version will apply to all students on the course at the time they are published, which will be at least 1 month before the first assessment of the Academic Year. Any changes will be explained to the students at least 1 month prior to an assessment so that ample time is provided for students to be aware of the assessment strategy that applies to them.

The regulations for progression from one year to the next and for graduation are described separately.

2. Assessment Strategy

Overview of Assessment

The aim of the University of Leicester Medical School is to provide an excellent standard of education and assessment which mirror the specifications of the GMC’s document, Promoting Excellence (2015)


R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.

R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.

R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.

R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student’s performance and being able to justify their decision.

The primary purpose of assessment of the core curriculum is to ensure that all students develop cumulative and integrated knowledge and skills so that they are competent to practice and have an appropriate foundation for lifelong learning. Furthermore, the Medical School is required to demonstrate that students are able to practise as safe future doctors. It is for this reason that all students must demonstrate that they have achieved the minimum safe standard for their stage of the course. Assessments are therefore designed to identify those students who are not ready to progress from one year of the course to the next as well as those students who are progressing exceptionally well.
The key feature of assessment is that in terms of content, assessments are cumulative. The style of examination is also intended to test the application of this progressive competence to clinical problems, to encourage breadth of learning, and to discourage as strongly as possible the adoption of selective, focussed learning strategies.

The MB ChB programme is not a modular programme. The programme is taught in an integrated manner and all summative assessments are integrated. In addition, there will be no compensation between major elements of the assessment package.

The assessment package (including summative and formative assessments) is intended to ensure students meet the GMC outcomes described within:

- The doctor as a scholar and a scientist
- The doctor as a practitioner
- The doctor as a professional

The Medical School has put in place a uniform pattern of assessments with common principles for each year of the course.

Within every year of the MB ChB programme there will be:

- A **summative assessment**
  This will normally consist of a written assessment and a clinical assessment (except for year 2 of the 5-year cohort who will only have a written assessment).
- Any student who is unsatisfactory in the end of year examination will have the opportunity to take a **re-sit examination**. The whole re-sit examination is always taken, regardless of whether failure to reach the minimum standard occurred in the written, clinical or both examinations and irrespective of the nature of the weaknesses which make a student liable for resitting it. The exception to this is the first year re-sit for the academic year 2015/2016 only, where in line with the current curriculum, students will only be required to re-sit the element in which they failed to reach the minimum standard. Thereafter both components of the year 1 exam will need to be passed independently or the student will be required to re-sit both elements.

The following pattern of **summative** assessments will be followed:

**WRITTEN ASSESSMENTS**

The written assessment will consist of one paper of ‘short answer’ questions (SAQ) and one paper of ‘single best answer’ questions (SBA). Short answer questions have been used in Leicester for many years and provide a good test of understanding and the ability to apply knowledge to solve a clinical problem. Single best answer questions are now widely used in most postgraduate and national examinations and help to ensure the assessment covers an appropriate breadth of knowledge.

**Five year course**

In Year 1 there will be a written assessment at the end of Semester 1 (ESA 1) and again at the end of Semester 2 (ESA 2). The marks from both papers will be combined to award a single mark that is used to determine if a student has reached the minimum safe standard. The benefit of this approach is that if a student’s performance is unsatisfactory by a relatively small margin in the ESA 1 examination they have the opportunity to gain feedback and improve their learning strategy and performance in ESA 2. Providing their overall mark demonstrates that they have reached the minimum safe standard, they are not required to take the re-sit examination.
In Year 2, the same pattern of written assessments will be followed as in Year 1. There will be a written assessment at the end of Semester 3 and Semester 4, with the marks combined to provide an overall mark to determine if a student has reached the minimum safe standard.

In Year 3 there will be a written assessment at the end of Semester 5 (the Primary Professional Examination), prior to entry into Phase 2.

In Year 4 there will be a written assessment at the end of the junior rotation (the Intermediate Professional Examination).

In Year 5 there will be a written assessment at the end of the senior rotation (the Final Professional Examination).

Four year course
For students on the 4-year graduate entry course, the assessments will match that of Years 1, 3, 4 and 5 of the five year course.

Clinical assessments will be run as modified Objective Structured Clinical Examinations (OSCE). The skills and competencies will build progressively from Year 1 through to the final year.

Five year course
Year 1: OSCE at the end of Semester 2 forming part of the second End of Semester Assessment.
Year 3: OSCE forming part of the Primary Professional Examination.
Year 4: OSCE forming part of the Intermediate Professional Examination.
Year 5: OSCE forming part of the Final Professional Examination.

Four year course
For students on the 4-year graduate entry course, the clinical assessments will be in Years 1, 2, 3 and 4.

Note: For the 2015 intake only, in Year 1, the OSCE and the Written element will be considered separately For this year group, students who are unsatisfactory in either examination will only be required to re-sit the component in which they were unsatisfactory. In future years (2016 intake onwards) the year 1 examinations will need to be passed independently and failure in either component will result in having to re-sit both examinations.

In all other years where there is both a written and a clinical examination, the re-sit will require the student to be satisfactory in both components and failure in either written or clinical examination will result in both written and clinical examinations having to be retaken.
STUDENT SELECTED COMPONENTS
The primary purpose of assessment of Student Selected Components is to stimulate students to follow their interests, to study topics in depth, and to strive for excellence. Each element is therefore assessed separately using a mix of assessment methods appropriate to its aims and outcomes. Students may choose to focus upon topics of their choice and be assessed on their depth of understanding and capacity for evaluation.
### 3. Summary Tables

#### SUMMARY ASSESSMENT STRATEGY FOR 2016

**FIVE YEAR COURSE**

| Year 1 | Written:  
| ESA 1  minimum 12 Short Answer Questions (SAQ); minimum 60 Single Best Answer (SBA) questions  
| ESA 2 – minimum 12 Short answer; minimum 60 SBA  
| To give a single overall satisfactory/unsatisfactory grade  
| OSCE – 12 to 15 stations of 5 to 10 minutes each.  
| Written and OSCE currently regarded as separate exams, and students only re-sit the component that they failed in the academic year 2015/2016. Thereafter failure in either written or OSCE examinations will result in re-sitting both.  
| Year 1 re-sit Examination  
| Written: minimum 15 SAQ; minimum 120 SBA  
| Re-sit OSCE: 12 to 15 stations of 5 to 10 minutes each. |
| Year 2 | Written:  
| ESA 3 - minimum 12 SAQ; minimum 60 SBA  
| ESA 2 - minimum 12 SAQ; minimum 60 SBA  
| To give a single overall satisfactory/unsatisfactory grade  
| Year 2 re-sit Examination  
| Written: 15 Short answer; 120 SBA |
| Year 3 | Primary Professional Examination (PPE)  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items  
| Required to pass both independently  
| SSCs and People and Disease dissertation  
| Re-sit PPE  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items  
| Required to pass both independently |
| Year 4 | Intermediate Professional Examination (IPE)  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: Minimum of 2 hours examination time. To generate 22 separate items  
| Re-sit IPE  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: Minimum of 2 hours examination time. To generate 22 separate items |
| Year 5 | Final Professional Examination (FPE)  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: Minimum of 2 hours, 20 minutes examination time. To generate 28 separate item  
| Re-sit Finals  
| Written: minimum 15 SAQ; minimum 120 SBA  
| OSCE: Minimum of 2 hours, 20 minutes of examination time. To generate 28 separate items |
### Year 1
**Written:**
- ESA 1 - 12 Short Answer Questions (SAQ); minimum 60 Single Best Answer (SBA) questions
- ESA 2 - 12 SAQ; minimum 60 SBA

To give a single overall satisfactory/unsatisfactory grade

**OSCE** – 12 to 15 stations of 5 to 10 minutes each.
Written and OSCE currently regarded as separate exams, and students only re-sit the component that they failed in the academic year 2015/2016. Thereafter failure in either written or OSCE examinations will result in re-sitting both.

**Year 1 re-sit Examination**
- Written: 15 SAQ; minimum 120 SBA
- Re-sit OSCE: 12 to 15 stations of 5 to 10 minutes each.

### Year 2
**Primary Professional Examination (PPE)**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items

Required to pass both independently

**Patient Centred Clinical Practice**

**Re-sit PPE**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items

Required to pass both independently

### Year 3
**Intermediate Professional Examination (IPE)**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items

**Re-sit IPE**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: 8 x 10 minute stations (or equivalent). To generate 16 separate items

### Year 4
**Final Professional Examination (FPE)**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: Minimum of 2 hours examination time. To generate 22 separate items

**Re-sit Finals**
- Written: 15 SAQ; minimum 120 SBA
- OSCE: Minimum of 2 hours, 20 minutes examination time. To generate 28 separate items
4. Standard Setting

STANDARD SETTING FOR PROGRESSION ASSESSMENTS

DEFINITION OF A STANDARD

A standard is a single assessment score that serves to define the boundary between differing qualitative student performances following an assessment. The standard for all assessments within the MB ChB programme is the attainment of the minimum safe standard in knowledge and clinical skills appropriate for the stage of the course. Throughout the MB ChB assessment programme the ‘primary’ standard will be a single unique score defining the boundary between satisfactory (pass) and unsatisfactory (fail). Students who score above this primary standard will be deemed as at least satisfactory, whilst those who score below this standard will be deemed unsatisfactory. ‘Secondary’ standards will define the secondary boundaries in student performance namely the boundaries between satisfactory and merit, and merit and distinction respectively. The secondary standards will normally be directly derived from the primary standard.

THE USE OF ABSOLUTE STANDARDS TO DETERMINE PROGRESSION

Only absolute standards will be used to classify student performances throughout the MB ChB assessment programme. Absolute standards are solely expressed in terms of the performance of students against an assessment and not on the comparative performance of the students. Hence, if the primary absolute standard is, for example, 60% then the performance of any student achieving 60% or more of the available marks will be deemed as at least satisfactory. It is not the case that the performance of a defined proportion of students will ‘always’ be deemed unsatisfactory; using an absolute standard all students have equal opportunity to gain a satisfactory outcome and the entire cohort may achieve this. This is appropriate as the MB ChB programme assessments are designed to determine whether a student has accrued the necessary knowledge, skills and attitudes, to a sufficient level, to progress in the MB ChB programme and ultimately to graduate as safe Foundation doctors.

As absolute standards are derived directly from an assessment, each standard is unique and only applicable to the assessment from which it was derived. It therefore follows that the primary standard will vary from assessment to assessment depending on, for example, the relative difficulty and importance of the items (content) within that assessment. The primary standard will therefore not be fixed (i.e. the primary standard will not always be 60%), though due to the manner in which assessments in the MBChB assessment programme are constructed the absolute primary standard would not be expected to be below 50% or above 75% of the available marks. When a progression decision is based on the performance of students in more than one assessment AND the separate assessments are deemed to examine the same construct the primary absolute standards may be summed and compared to the total score a student achieves across those assessments in order to determine the assessment outcome and inform the progression decision. In this manner compensation is possible between assessments (e.g. End of Semester Assessments 1 and 2 together determine progression from Year 1 to Year 2). However a student must make a bona fide attempt at each assessment for each assessment attempt to be deemed valid and contribute towards

September 2015 (updated June 2016)
attainment of the primary standard. This will normally be determined by a student reaching a standard (not greater than the primary standard) across the domains examined by an assessment.

**METHODS FOR DETERMINING THE PRIMARY ABSOLUTE STANDARD**

The following methods will be used to determine the primary absolute standard throughout the MB ChB assessment programme. The method applied will be determined by the type of assessment instrument employed. These methods are used to ensure that the set primary standard is credible and fair and that decisions regarding the standard are based on expert judgement, demonstrate due diligence and are supported by research.

**STANDARD SETTING FOR WRITTEN PROGRESSION ASSESSMENTS: SINGLE BEST ANSWER (SBA) AND SHORT ANSWER QUESTION (SAQ) INSTRUMENTS**

The Angoff Method will be used to set the primary standard for all SBA and SAQ assessments employed during the MB ChB assessment programme. This method will therefore be applied to the following assessments:

- All End of Semester (ESA 1, 2, 3 and 4) written papers (SBA and SAQ)
- The Year 1 and Year 2 re-sit examinations
- The written components (SBA and SAQ) of the Primary Professional Examination (PPE)
- The written components (SBA and SAQ) of the Primary Professional Examination (PPE) re-sit
- The written components (SBA and SAQ) of the Intermediate Professional Examination (IPE)
- The written components (SBA and SAQ) of the IPE re-sit
- The written components (SBA and SAQ) of the Final Professional Examination (FPE)
- The written components (SBA and SAQ) of the FPE re-sit

The Angoff method will be applied to the assessment after the assessment has been constructed, edited and finalised but before implementation to avoid performance bias. The Angoff primary standard will be determined during a formal Standard Setting Meeting of the relevant standard setting group which will comprise a minimum of seven ‘standard setters’ to increase standard reproducibility and ameliorate assessor-teacher conflict. The standard setters will be academic and/or clinical staff, who understand the purpose of the assessment, are familiar with the assessment content and the curriculum to which it relates and are familiar with the students and the expected level of competence. Therefore the standard setting group will appropriately change from assessment to assessment dependent on the component(s) of the MB ChB programme being assessed. The standard setters will have received training in the Angoff method and review the assessment instrument in detail. Performance feedback and ongoing training will also be provided to standard setters.

The standard Angoff method will be used, however the following modifications may be applied in specific situations:

1. The assessment instrument may be reviewed by the standard setters independently of one another and Angoff proportions recorded electronically before the Standard Setting Meeting where items will then be discussed, outliers reviewed and the opportunity provided for
standard setters to review their estimates. This modification will only be implemented when the standard setters are experienced and the borderline student has been discussed and defined beforehand.

2. The Angoff method may be applied to an SAQ instrument by means of determining the Angoff proportion for each of the marks available for an item.

Following the Standard Setting Meeting a primary standard will have been determined which will be applied following post-examination analysis. Normally the primary standard applied will be the sum of the averaged Angoff proportions obtained at standard setting.

STANDARD SETTING FOR OBSERVED STRUCTURED CLINICAL EXAMINATIONS (OSCEs)

The Borderline Group Regression (BGR) method will be used to set the primary standard for all OSCEs in the MB ChB assessment programme. This method will therefore be applied to the following assessments:

- Year One OSCE
- Year One resit OSCE
- The OSCE of the PPE
- The OSCE of the PPE resit
- The OSCE of the IPE
- The OSCE of the IPE resit
- The OSCE of the FPE
- The OSCE of the FPE resit

The BGR method uses a global rating of a student’s performance provided by the OSCE station examiner(s). The student will be rated at each OSCE station assessed by an examiner. The data from which the primary standard for the OSCE is derived is therefore collected during the OSCE. The student’s performance will be rated by the examiner on a five point global rating scale attracting the following scores:

1. Clear fail = -2 demerit points
2. Borderline = -1 demerit point
3. Clear pass = score neutral
4. Good = 1 merit point
5. Excellent = 2 merit points

The OSCE primary standard is therefore based on the expert judgements of the examiners and therefore all individuals who make these performance judgements will receive on-going training in order to ensure reproducibility of standards and maximise examiner homogeneity. Following the OSCE, the global ratings will be used to determine the primary standard for each OSCE station and the overall primary standard by the BGR method.

Each student will have their merit and demerit points summed separately (i.e. a merit score and a demerit score).

Once the standard setting using the BGR method has been completed, a decision on whether a student’s performance is satisfactory or unsatisfactory will be based on the following two criteria:
• A student must achieve the overall pass mark for the OCSE (this ensures a sufficiently high standard)
• A student must not exceed a maximum number of demerit marks (this ensures breadth of competence and limits compensation). The exact number of demerit marks will be agreed by the Board of Examiners with the advice of the Assessment Group.

A student must meet both criteria in order to be graded as Satisfactory for the OSCE.

METHOD FOR DETERMINING SECONDARY STANDARDS
The secondary standards will be used for determining the award of merit and distinction. These standards are derived from the primary standard and will therefore, as for the primary standard, vary between assessments. Normally the secondary standards will be the primary standard plus a factor determined by the standard deviation of the cohort raw scores for the assessment. The secondary standards will therefore be derived following post-examination analysis and are dependent upon the content of the assessment (primarily difficulty). Z-scores will also be calculated and used to finalise the award of merit and distinction.

The recommendation for merit and distinction will be made by the Assessment Group and confirmed by the Panel and Board of Examiners, who have the power to modify the recommendation.

POST EXAMINATION ANALYSIS
Definition and purpose
Post-examination analysis is a collection of processes involved in analysing and evaluating the results of objective assessments. This analysis aims to minimise errors influencing the observed scores of an assessment, determine and ensure assessment accuracy, validity and reliability, ensure the credibility of the primary standard, provide quality evidence and deliver a means to evaluate and improve assessment items for use in future assessment instruments. The data from this analysis also feeds into curriculum development and outcome specification. The analysis performed will vary between the types of assessment instruments.

These analyses will be performed before and considered at the relevant Assessment Group meeting in order that the validity and reliability of the assessment(s) are determined, monitored and discussed and any problem items and outlying scores considered. The primary standard will then be applied to the total scores, in the context of the standard error of measurement (SEM). The secondary standards will be determined and applied. All of this data will form part of quality assurance and inform recommendations of assessment outcome to be considered by the relevant Panel and ultimately the Board of Examiners.

Post examination analysis of SBA instruments
After optical marking of the SBA instrument the following will be performed:

• A primary distractor analysis in order to validate the answer key and optical mark recognition scoring
• The frequency distribution of total scores will be inspected and mean, mode and median calculated to determine skewness of the score distribution
• Student Z-scores and decile ranking will be calculated
• Item analysis will be performed to calculate:
  o The Item-difficulty index (P_i) and item-difficulty index corrected for the effects of guessing (P_{Di})
  o The item-discrimination index (d) by point bi-serial correlation
  o The statistical significance of each item
  o The reliability of the SBA instrument by Cronbach’s co-efficient alpha (α)
  o The reliability of the SBA instrument by Cronbach’s co-efficient alpha (α) with each item removed
  o The standard error of measurement (SEM)
• Cohort-independent item difficulties will be determined by Rasch analysis to allow and inform item banking and aid in future assessment instrument construction.

Post examination analysis of SAQ instruments
Following marking of the SAQ instrument the following will be performed:

• The frequency distribution of total scores will be inspected and mean, mode and median calculated to determine skewness of the score distribution
• Student Z-scores and decile ranking will be calculated
• Item analysis will be performed to calculate:
  o The Item-difficulty index (P_i)
  o The item-discrimination (d) index (by Pearson correlation coefficients)
  o The statistical significance of each item
  o The reliability of the SAQ instrument by Cronbach’s co-efficient alpha (α)
  o The reliability of the SAQ instrument by Cronbach’s co-efficient alpha (α) with each item removed
  o The standard error of measurement (SEM)

Once the SEM has been calculated, moderation will occur in order to monitor and reduced inter-rater variability, ensure marking quality and the credibility of the primary standard and maintain fair standards. Moderation will involve the anonymous double marking of the following student scripts during a Moderation Meeting:

1. The scripts of students whose total scores fall within 2 marks above and 5 marks below the primary standard.
2. A further 5% scripts will be randomly selected from across the range of marks for moderation.

Post examination analysis of OSCE instruments
Following implementation of the OSCE instrument the following will be performed:

• The primary standard for each OSCE station will be determined by analysing the global rating scores using the BGR method
• The frequency distribution of total scores will be inspected and mean, mode and median calculated to determine skewness of the score distribution
• Student Z-scores and decile ranking will be calculated
• Item analysis will be performed to calculate:
- The Item-difficulty index ($P_i$)
- The item-correlations (by Pearson’s correlation coefficients)
- The statistical significance of each item
- The inter-station reliability of the OSCE by Kuder-Richardson 20 (KR-20)
- The standard error of measurement (SEM)

- Post-hoc analysis of stations and circuits will be performed to ensure equivalence.
5. Written Assessments

Each Year’s summative assessment includes a paper of short answer questions (SAQ) and a paper of single best answer questions (SBA).

All assessments will include questions on the entire core curriculum to date.

In Phase 1 of the course, this will include specific questions on material from units in the immediately preceding semester, and questions incorporating material from all previous semesters. The proportion of these components will be determined by the Phase 1 Assessment Group according to approximate guidelines.

In Phase 2 of the course this will include specific questions from the blocks in the preceding year as well as material from all previous years. There is an expectation that relevant Phase 1 material will be included in the examination, especially where a knowledge and understanding of basic science is required for the diagnosis and management of patients.

All questions in all end-of-semester assessments or end of year assessments will be compulsory. Students will be graded on the papers as a whole. For all written assessments students will be identified by student number only, so that marking is anonymous.

FORMAT OF WRITTEN PAPER QUESTIONS

Short answer questions

All short answer questions in the written papers will comprise an initial statement, usually describing briefly a clinical scenario, followed by a series of sub-questions (normally between 3 and 7 sub-questions) relating to that scenario drawn from one or more parts of the course across one or more units or blocks. The sub-questions will require a constructed response, where students have to write a short answer, annotate a diagram, complete a table or a similar variation of this principle. Students are expected to demonstrate knowledge and clinical reasoning in clearly written, short statements.

The marks allocated for each sub-question will be indicated and each question will have 10 marks overall. It must be clear from the examination instructions that, where examinees write more than the specified number of answers to a sub question, the first answers will be marked and the remainder will be ignored, even if they are correct and the preceding answers incorrect or irrelevant.

Model answers are written for all questions with a marking scheme including main and possible alternate answers. Scripts team marked against these model answers (see over).
Single best answer questions (SBAs)

Single Best Answer questions require the student to select the most appropriate answer from a list of answers (the ‘option list’) presented to them.

Each single best answer question will be worth one mark.

Each single best answer question will be set according to the guidelines adopted by the Medical Schools’ Council-Assessment Alliance (MSC-AA) in the UK.

SBAs may be drawn from the national question bank maintained by the MSC-AA.

In the final written examination, standardised questions from the MSC-AA will be incorporated into the examination in common with other medical schools in the United Kingdom.

BLUEPRINTING OF WRITTEN ASSESSMENTS

All questions in all written assessments will be blueprinted to the ‘outcomes for graduates’ prescribed by the General Medical Council in its document ‘Tomorrow’s Doctors’ (2009). Across individual assessments and the whole pattern of assessments for a cohort there will be systematic sampling of key presentations and index cases, linked to learning outcomes for the curriculum as a whole defined by the General Medical Council in its document ‘Tomorrow’s Doctors’ (2009) (see Appendix A).

MARKING OF WRITTEN PAPERS

All constructed response (short answer) questions in written assessments will be team-marked according to pre-defined model answers which may be modified in the light of actual student responses according to a standard protocol. Scripts will be identified by student number only throughout the marking and standard setting processes.

All scripts for each question in each paper will be marked by a marking team working together. The membership of the group and of the teams shall be chosen to reflect a wide range of disciplines and specialties.

Exam papers will be divided into individual questions for scoring. A single team will mark all the exam papers for any particular question.

Each member of the team will mark a small number of scripts, then the team as a whole will review the model answers in the light of student responses, and modify it if necessary. All scripts will then be marked by the same team, reviewing the first marked scripts if necessary. The agreed schedule is then applied rigidly to all scripts, including the initial papers used in the above process.

Data from all scoring teams will be entered to a central database.
6. Clinical Assessments

All clinical assessments will be in the Objective Structured Clinical Examination (OSCE) format or a modification of that format. This consists of a series of ‘stations’ which candidates rotate around. At each station the candidates will perform a defined task or set of tasks, which may be part or all of a clinical consultation, a clinical procedural skill, physical examination skill, assessment of images or data interpretation, explanation to a patient or health practitioner or a short, structured clinical discussion. In year 1, cadaveric prosections may be used.

There will be an Objective Structured Clinical Examination taken by all students at the end of the first year of the four and five year course, the Primary Professional Examination, the Intermediate Professional Examination and the Final Professional Examination.

The standard setting for the OSCE examination is described under the heading of ‘Standard Setting’.

The summary of the OSCE for each year examination is described in the information provided for each year.
7. Year 1 Examinations: ESA 1 and 2

The Year 1 examinations will be taken by all students on the 5-year and 4-year programmes.

Semester 1:
Written Paper: All students will take an End of Semester 1 Assessment (ESA 1) consisting of two papers.
Paper 1: minimum 12 short answer (SAQ) questions
Paper 2: minimum 60 single best answer (SBA) questions.

Semester 2:
Written Paper: All students will take an End of Semester 2 Assessment consisting of two papers.
Paper 1: minimum 12 SAQ questions
Paper 2: minimum 60 SBA questions.

As described previously, the ESA 1 and ESA 2 written assessments will be combined to give a single end of Year result.

OSCE: All students will take an OSCE examination at the end of Semester 2. The OSCE will consist of between 12 to 15 stations of 5 to 10 minutes each. The material used within the stations will represent the practical work performed within the Units, the communication skills training and the procedural skills covered in Year 1. The composition of the OSCE will be determined by the Assessment Group and outlined to the students well in advance of the examination.

For the 2015 intake, students who are unsatisfactory in either the Year written assessments or the OSCE examination will be required to take the resit that element alone (written or OSCE). From the 2016 intake onwards, students will be required to re-sit both written and OSCE examinations regardless of whether they fail either or both examinations.

THE RESIT EXAMINATION

Written Paper:
Paper 1: minimum 15 SAQ questions
Paper 2: minimum 120 SBA questions

OSCE:
The OSCE will consist of between 12 to 15 stations of 5 to 10 minutes each.

Students who are unsatisfactory in the Year 1 resit examination will be graded as Unsatisfactory for the Year.
8. Year 2 Examinations: ESA 3 and 4

The Year 2 examinations are taken by the 5-year students (the 4-year graduate entry students do not take these assessments).

Semester 3:
Written Paper: All students will take an End of Semester 3 Assessment consisting of two papers.
Paper 1: minimum 12 SAQ questions
Paper 2: minimum 60 SBA questions.

Semester 4:
Written Paper: All students will take an End of Semester 4 Assessment consisting of two papers.
Paper 1: minimum 12 SAQ questions
Paper 2: minimum 60 SBA questions.

As described previously the ESA3 and ESA4 written assessments will be combined to give a single end of Year result.

Students who are unsatisfactory in the Year written assessment will be required to take the Year 2 resit examination.

THE RE-SIT EXAMINATION

Written Paper:
Paper 1: minimum 15 SAQ questions
Paper 2: minimum 120 SBA questions

Students who are unsatisfactory in the Year 2 resit examination will be graded as Unsatisfactory for the Year.
9. Primary Professional Examination: PPE

The Primary Professional Examination (PPE) is taken by all students (both L5 and L4 cohorts). The 5-year students will sit this at the end of Semester 5 and the 4-year students at the end of Semester 3. The examination consists of a written examination and an OSCE examination.

WRITTEN PAPERS:
Each student will sit two written papers:
- Paper 1: minimum 15 short answer questions (SAQ)
- Paper 2: minimum 120 single best answer questions (SBA)

OSCE:
The OSCE will consist of eight stations each of 10 minutes. The examination will generate 16 separate items to be awarded a mark or grade.

Station content: The content of the stations will be taken from the following:
- Practical elements of all Units
- Communication Skills Course
- Consultation Skills Foundation Course
- Procedural skills completed to date

The composition of the OSCE will be determined by the Assessment Group and outlined to the students well in advance of the examination.

Marking of each station may be by direct observation by an examiner or patient (simulated or real), or via a computer or paper-based response. Marking shall be according to pre-defined schedules. For stations which involve elements of clinical consultations, scoring will follow standardised checklist which define the competencies required and link to the teaching delivered.

Students whose performance is unsatisfactory in either the PPE written assessment or the OSCE examination will be required to take the PPE re-sit examination.

THE RE-SIT EXAMINATION

Written Paper:
- Paper 1: minimum 15 Short answer questions
- Paper 2: minimum 120 SBA questions

OSCE:
The OSCE will consist of eight stations each of 10 minutes.
The examination will generate 16 separate items to be awarded a mark or grade. The resit OSCE will be structured in an equivalent manner to the main PPE OSCE.

A Student whose performance is graded as unsatisfactory for either the PPE resit written or OSCE examination will be graded as Unsatisfactory for the Year.
10. Intermediate Professional Examination: IPE

The Intermediate Professional Examination (IPE) must be taken by all students at the end of the junior rotation of Phase II. Students must normally have attended all blocks in the rotation to be eligible to take the examination. It will be scheduled in February or March of Year 4 for 5-year students and Year 3 for 4-year students. The Intermediate Professional Examination consists of a written examination and a clinical examination. Students who fail to satisfy the examiners in either or both parts of the Intermediate Professional Examination must re-sit both parts of the examination. The resit examination is held either in late May or early June.

WRITTEN PAPERS

Each student will sit two written papers:

Paper 1: minimum 15 short answer questions
Paper 2: minimum 120 single best answer questions

The Phase 2 Assessment Group is responsible for the preparation of written papers. Over the paper the questions must test a broad range of curriculum objectives. It is the responsibility of the Phase 2 Assessment Group, advised by the external examiners, to ensure appropriate spread of subject content across the papers to blueprint to the curriculum outcomes as effectively as possible.

Standard setting will follow the guidance previously outlined.

For each examination, the Assessment Group will appoint a ‘Scoring Group’ to mark all papers in that examination. The scoring group will follow the guidance previously outlined.

THE CLINICAL EXAM

Clinical assessment is by a structured clinical examination consisting of a series of stations. The precise configuration of the examination will be decided year by year to be consistent with the following guidelines.

Structure of the assessment

Each student will be examined at a series of stations made up from the components described below. Components may be combined together to make longer stations testing integration of competencies:

- Observed History Taking and Examination
- Interpretation of Investigations
- Developing a Management Plan
- Procedural Skills
- Prescribing
- Problem solving
- Patient safety
- Professionalism
- Communication skills

All stations will have at least one examiner present.
Observed history taking and examination: two 25 minute stations
At each station the student will be observed by an examiner taking a history from and examining a real patient. One of the observed consultation stations will comprise a patient with a medical problem. The other station will comprise a patient with a surgical problem.
For each circuit there will be parallel versions of each station. The patients in each version will be drawn from the same category and, although comparable, will not be identical. For each patient selected a written brief will be constructed including:

- a written version of the salient points of the patient’s history
- an agreed view of the most appropriate physical examination and a list of the abnormal signs (if present) which examinees are expected to detect
- an agreed view on the likely underlying mechanisms for the patient’s problems
- an introductory statement for the student to read before entering the room.

The stations will follow a standard protocol:
1. On arrival the student will read an introductory statement introducing the patient and the nature of the patient’s condition.
2. The student will then enter the room and the examiner will observe the student taking a focused history.
3. The examiner will ask what is the most appropriate examination to perform and why. If the student replies correctly they will be invited to perform that examination. If the reply is incorrect, the student will be directed to the most appropriate examination.
4. At the end of the examination, the student will be asked to summarise their examination findings.
5. The examiner will complete the station by asking a pre-determined set of questions relating to the patient’s condition to test problem-solving.

Each Observed History Taking and Examination station will receive four grades.

Investigation stations: two ten minute stations
At each of these stations, students will be presented with a clinical scenario involving the interpretation of investigations. Students will be given the results of investigations, including, but not limited to, plain X-ray, contrast X-ray, cross-sectional imaging, ECGs, lung function tests, blood gasses, serum biochemistry, serum haematology, urinalysis and microbiology results. They will be asked to identify abnormalities and suggest possible explanations for the results based on the clinical context presented. They will then be questioned about the case to assess their understanding of underlying pathophysiology, further investigations and management etc.

Students will receive two grades for each investigation station.

Mental health / primary care station. one 20 minute station
Students will be presented with a scenario involving a simulated patient with a mental health problem. They will be given an introductory statement and instructions about how to proceed with the station.
The first 15 minutes will involve data gathering from at least some of the following domains:
- Obtaining a current mental health history
• Obtaining a past mental health history
• Obtaining a focused medical history
• Making a mental health assessment of the patient
• Constructing a management plan

The last five minutes of the station will be spent answering questions to explore deeper understanding of issues relating to the case

Each Mental Health / primary care station will receive four sets of marks in total.

**Information giving stations:** one stations lasting 10 minutes (with 5-minute reading time beforehand)

Students will be given a clinical scenario and then asked to perform specific tasks related to patient management. It will include components related to safe prescribing. There will be a simulated patient and an examiner present for this station.

This can involve a number of the following components:

• Identification and communication of key issues
• Discussion of immediate management issues
• Important points to handover
• Consideration of longer-term management strategies
• Discussion about starting medications with patient
• Discussion about treatment side effects with patient
• Discussion with patient about management options / plans

Each Management station will receive two grades.

**Procedural skills:** one station lasting 20 minutes

The clinical skill will be set within a clinical context and will involve responses beyond simple performance of the skill.

The station will involve four elements. One element will be the performance of a given clinical skill. The other elements will be tasks associated to the case.

Examples of associated tasks include but are not limited to:

• Initial assessment of a case
• Interpretation of results, diagnosis and management
• writing up a prescription
• writing up a fluid balance chart
• interpreting a patient’s bedside charts
• Communicate information

The procedural skill itself will include elements from some or all of: communication skill, safety, infection prevention, procedural skill and team working

Each procedural skill stations will receive four grades.
**Scoring of student performance**
Each student will be scored for each competence or element of the OSCE assessment using a standardised mark sheet together with a global rating as outlined in the section on threshold setting.

The overall examination will be set to yield a total of 22 grades from an appropriate combination of stations. Descriptors will be produced so that four separate sets of marks are awarded for a twenty or twenty five minute station and two for a ten minute station. The combination of different types of station, but not the precise nature of each, will be published to students before the assessment. Grades are used to calculate the merit and demerit scores.

In addition, each grade is accompanied by a checklist score (out of 20). Therefore the maximum checklist score will be 440 marks. The overall pass mark will relate to a passing threshold from the checklist score.

In order to be graded as satisfactory a student must:
- Achieve the overall pass mark
- Must not exceed a maximum number of demerit marks which is likely to be between 7 and 11; and will be decided by the Panel or Board of Examiners.

**Reporting of exam irregularities**

It is anticipated that the OSCE examinations will proceed without incident. However if there are any perceived examination irregularities noted by students, patients, simulated patients or examiners, these should be reported on the day of the examination to a senior member of staff.

Students will be asked to sign a form at the end of the OSCE examination and before leaving the examination building to confirm that no irregularities occurred during their assessment.
THE IPE RE-SIT EXAMINATION

Written Paper:
Paper 1: minimum 15 Short answer questions
Paper 2: minimum 120 SBA questions

OSCE:
The resit OSCE will have the same format as the main Intermediate Professional Examination. The examination will generate 22 separate grades.

Students who are graded as unsatisfactory for either the IPE resit written or OSCE examination will be graded as Unsatisfactory for the Year.

Reporting of exam irregularities

It is anticipated that the OSCE examinations will proceed without incident. However if there are any perceived examination irregularities noted by students, patients, simulated patients or examiners, these should be reported on the day of the examination to a senior member of staff.

Students will be asked to sign a form at the end of the OSCE examination and before leaving the examination building to confirm that no irregularities occurred during their assessment.
11. Final Professional Examination: FPE

The Final Professional Examination must be taken by all students after the final block of Phase II, but before the elective period and preparation for Professional Practice. Students must normally have attended all blocks in the rotation to be eligible to take the examination at first sit. This is normally in March or April of year five for 5-year students and year four for 4-year students. The examination is in two parts, first a written examination, second, a clinical examination. Students must satisfy the examiners in both parts. No compensation between them is allowed.

WRITTEN PAPERS

Each student will sit two written papers:

Paper 1: minimum 15 short answer questions
Paper 2: minimum 120 single best answer questions

The Phase 2 Assessment Group is responsible for the preparation of written papers. Over the paper the questions must test a broad range of curriculum objectives. It is the responsibility of the Phase 2 Assessment Group, advised by the external examiners, to ensure appropriate spread of subject content across the papers to blueprint to the curriculum outcomes as effectively as possible.

The standard guidance for written papers will be followed.

Standard setting will follow the guidance previously outlined.

For each examination, the Assessment Group will appoint a ‘Scoring Group’ to mark all papers in that examination. The scoring group will follow the guidance previously outlined.

THE CLINICAL EXAM

Clinical assessment is by a structured clinical examination consisting of a series of stations, each scored according to standard criteria.

Structure of the assessment

Each student will be examined at a series of stations made up from the components described below. Components may be combined together to make longer stations testing integration of competencies:

- Observed History Taking and Examination
- Interpretation of Investigations
- Diagnosis
- Developing a management plan
- Procedural skills
- Prescribing
- Problem Solving
- Patient safety
Professionalism
Communication Skills

**Observed history taking and examination: two 25 minute stations**

At each station the student will be observed by an examiner taking a history from and examining a real patient. One of the observed consultation stations will comprise a patient with a chronic illness. The other station will comprise a patient with cancer or cancer related presentation.

For each circuit there will be parallel versions of each station. The patients in each version will be drawn from the same category, and, although comparable, will not be identical. For each patient selected a written brief will be constructed including:

- a written version of the salient points of the patient’s history.
- an agreed view of the most appropriate physical examination and a list of the abnormal signs which examinees are expected to detect.
- an agreed view on the likely underlying mechanisms for the patient’s problems.
- an introductory statement for the students to read before entering the room

The stations will follow a standard protocol:

1. on arrival the student will read an introductory statement introducing the patient and the nature of the patient’s condition.
2. the student will then enter the room and the examiner will then observe the student taking a focused history.
3. the examiner then asks what is the most appropriate examination to perform and why. If the student replies correctly they will be invited to perform that examination. If the reply is incorrect the student will be directed to the most appropriate examination.
4. At the end of the examination, the student will be asked to summarise their examination findings.
5. The examiner will complete the station by asking a pre-determined set of questions relating to the patient’s condition to test problem-solving

Each Observed History Taking and Examination station will receive four grades.

**Modified Observation Consultation**

**Ophthalmology station - 12 minutes**

Real patients will be used for this station. For each circuit there will be parallel versions of each station. The student will be required to read a short history before conducting a clinical examination and answering questions pertaining to the case. For each real patient selected a written brief will be constructed including:

- a written version of the salient points of the patient’s history.
- an agreed view of the most appropriate physical examination and a list of the abnormal signs which examinees are expected to detect.
- an agreed view on the likely underlying mechanisms for the patient’s problems.
- an introductory statement for the students to read before entering the room
The stations will follow a standard protocol

1. On arrival the student will read an introductory statement including a brief history
2. The student will then enter the room and the examiner will ask the student to perform an examination based on the history
3. The examiner will complete the station by asking a pre-determined set of questions relating to the patient’s condition to test problem solving

Each ophthalmology station will receive two grades

**ENT Scenario – 12 minutes**

Students will be presented with a scenario involving a simulated patient with an ENT problem. They will be given a scenario to read prior to entering the station with instructions to carry out the tasks as instructed by the examiner

This will involve at least some of the following

- Examination of an ear, nose, throat or neck
- Interpretation of clinical pictures or investigations
- Answering a set of pre-determined questions relating to the presentation to test problem solving skills
- Explanation to the simulator
- Developing a management plan
- Communication skills
- Prescribing

Each ENT station will receive two grades

**Acute Care Scenario – 20 minutes**

Students will be presented with a scenario involving a simulated patient with an acute problem. They will be given a scenario to read prior to entering the station with instructions to carry out the tasks as instructed by the examiner

This will involve at least some of the following

- Initial assessment of the patient using a standard ABCDE approach
- Requesting investigations and starting initial treatment
- Performing a procedural skill
- Interpretation of results
- Diagnosis and risk stratification
- Developing a further management plan
- Referral to another speciality
- Communication skills
• Prescribing

Each Acute Care station will receive four grades

**Chronic Care Scenario – 20 minutes**
Students will be presented with a scenario involving a simulated patient with a chronic illness. They will be given a scenario to read prior to entering the station and will be expected to run a 20 min consultation. The scenario will include the reason for attendance and can include investigation results or a discharge letter. The setting will either be within a GP practice or an outpatient setting in secondary care.

The station will involve at least some of the following
• Obtaining a history
• Performing an appropriate examination
• Interpretation of investigations
• Diagnosis
• Explanation to the simulator
• Developing a management plan
• Communication skills
• Prescribing
• Writing a referral letter

Each Chronic Care station will receive four grades

**Obstetrics and Gynaecology scenario – 10 minutes**
Students will be presented with a scenario involving a simulated patient with an obstetric or gynaecology problem. They will be given a scenario to read prior to entering the station with instructions to carry out the tasks as instructed by the examiner.

This will involve at least some of the following
• Obtaining a history
• Performing an appropriate examination
• Performing a procedural skill
• Diagnosis
• Interpretation of results
• Explanation to the simulator
• Developing a management plan
• Communication skills
• Prescribing
• Writing a referral letter

Each obstetrics and gynaecology station will receive two grades
Child Health scenario – 10 minutes
Students will be presented with a scenario involving a simulated patient who will be the relative of the child presenting with a problem. They will be given a scenario to read prior to entering the station with instructions to carry out the tasks as instructed by the examiner.
This will involve at least some of the following:
- Obtaining a history
- Diagnosis
- Interpretation of results including growth charts
- Explanation to the simulator
- Developing a management plan
- Communication skills
- Prescribing
- Writing a referral letter

Each child health station will receive two grades.

Professionalism scenario – two 10 minute stations
Professionalism will be testing in two stations, each 10 minutes in length. One will focus on communication skills and the other ethical and legal issues.
Students will be given a scenario to read prior to entering the station with instructions on how to proceed. The issues will be based around scenarios that they may encounter in during the Foundation Programme.
The stations will involve at least some of the following:
- Obtaining information
- Explanation to the simulator
- Communication skills
- Demonstration of working within an ethical and legal framework

Each professionalism station will receive two grades.

Scoring of student performance
Each student will be scored for each competence or element of the OSCE assessment using a standardised mark sheet together with a global rating as outlined in the section on threshold setting.

The overall examination will be set to yield a total of 28 sets of marks from an appropriate combination of stations. Descriptors will be produced so that four separate sets of marks are awarded for a twenty or twenty five minute station and two for a ten minute station. The combination of different types of station, but not the precise nature of each, will be published to students before the assessment. Grades are used to calculate the merit and demerit scores.
In addition, each grade is accompanied by a checklist score (out of 20). Therefore the maximum checklist score will be 560 marks. The overall pass mark will relate to a passing threshold from the checklist score.

In order to be graded as satisfactory a student must:
• Achieve the overall pass mark
• Must not exceed a maximum number of demerit marks which is likely to be between 8 and 14 and will be decided by the Panel or Board of Examiners.

Reporting of exam irregularities

It is anticipated that the OSCE examinations will proceed without incident. However if there are any perceived examination irregularities noted by students, patients, simulated patients or examiners, these should be reported on the day of the examination to a senior member of staff.

Students will be asked to sign a form at the end of the OSCE examination and before leaving the examination building to confirm that no irregularities occurred during their assessment.
THE FPE RE-SIT EXAMINATION

Two Written Papers:
Paper 1: minimum 15 Short answer questions
Paper 2: minimum 120 SBA questions

OSCE:
The resit OSCE will have the same format as the main Final Professional Examination.
The examination will generate 28 grades.

Students who are graded as unsatisfactory for either the FPE re-sit written examination or OSCE examination will be graded as Unsatisfactory for the Year.

Reporting of exam irregularities

It is anticipated that the OSCE examinations will proceed without incident. However if there are any perceived examination irregularities noted by students, patients, simulated patients or examiners, these should be reported on the day of the examination to a senior member of staff.

Students will be asked to sign a form at the end of the OSCE examination and before leaving the examination building to confirm that no irregularities occurred during their assessment.
12. **Student Selected Components (SSC)**

In Phase 1 of the course the following will apply:

Assessment of Student Selected Components (SSC) shall be the responsibility of the SSC lead, reporting to the Panel or Board of Examiners. The pattern of assessment may vary from module to module, and may include course work, dissertation, written examinations, practical examinations or *viva voce* examination.

**Grading of Student Selected Component**

The SSC lead should make recommendations to the Board of Examiners, placing each student in one of three categories, Excellent, Satisfactory, or Unsatisfactory.

Students classed as Unsatisfactory in an SSC will be offered the opportunity of one re-sit, held in the summer following second semester modules (5-year course), and in the spring following first semester modules (4- and 5-year courses). The performance in that re-sit shall replace all previous performance by students in that module. A student may not exceed a grade of satisfactory after a re-sit attempt. The SSC lead shall report to the Board of Examiners those students who remain unsatisfactory after resit.

The Board of Examiners will consider the results of all Student Selected Components when considering the outcomes of the Primary Professional Examination.
13. Assessment of Living with Long-term Conditions Selected Component: (Five year course only)

Assessment of the Living with Long-term Conditions component will be by:

- Submission of an essay at the end of the first year to demonstrate the ability to think and write in a reflective manner. If the essay is graded as satisfactory the student will progress. If the tutor awards an unsatisfactory grade the student will be asked to revise the essay and submit it for remarking.
- Presentation of a dissertation. Dissertations will be marked by module tutors, who have not acted as a tutor for the student whose dissertation they are marking. The dissertation will be marked against 10 criteria drawn from the learning outcomes of the student selected component.
- Students deemed Unsatisfactory will be permitted to revise their dissertation and re-submit it on one single occasion only.
- The mitigating circumstances process will apply to the submission of dissertations.
14. Feedback to students after assessments

The Medical School’s policies on feedback for students after assessments are based on the University’s policies. These policies are available at
http://www2.le.ac.uk/offices/sas2/quality/student-feedback/return-of-marked-work
http://www2.le.ac.uk/offices/sas2/quality/student-feedback/examinations

1. The provision of feedback following a summative assessment is part of a wider process of feedback linked to learning and the delivery of the curriculum. Feedback is commonly included within teaching events, some in a formal manner and others informally. To support learning, formative assessments are provided, with a key objective being to provide feedback to help students identify both strengths and weaknesses and to allow opportunities for reflection and review. Feedback related to summative assessments is to be seen in this context.

2. The University has set out five schemes for feedback after examinations. With regard to summative assessments outlined in this document, the Medical School will follow Scheme 5 (a bespoke model of feedback), since the process described below includes elements of both Scheme 2 and 4 and has additional features.

3. The final mark agreed by a Panel or Board of Examiners is not negotiable.

4. Students will not be allowed to see their examination scripts. This is in accordance with Schedule 7.9 of the Data Protection Act 1998.

5. The Medical School will arrange for feedback on examination performance to be provided to all students. This will be provided irrespective of whether a student has passed or failed an assessment. The exception to this will be students who fail a re-sit examination and have their course terminated as a result of this (see point 8).

6. WRITTEN ASSESSMENT FEEDBACK:

   Phase 1: Students in Phase I of the course will receive feedback for the ESA and Primary Professional Examination and re-sit examinations that will include the following information:
   • SAQ mark, SBA mark, Total mark and Overall %
   • Pass mark for the combined written papers
   • Student individual Z score and class Z score range
   • A breakdown of their SAQ and SBA marks related to individual Units of teaching and to key domains. The domains include basic sciences such as anatomy, biochemistry, physiology, pharmacology, sociology, scientific methodology etc. and skills relevant to Phase 1 of the course e.g. diagnosis, prescribing decisions, patient safety.

   Each student will have an opportunity to review the feedback with their Personal Tutor. Their Personal Tutor may refer a student to the various support pathways available through the University and/or may refer the student to the Medical School Academic Support Unit.

   All students graded as unsatisfactory are invited to attend the Academic Support Unit. Any student can self-refer to the Academic Support Unit.
Phase 2: Students in Phase 2 of the course will receive feedback for the Intermediate Professional Examination and the Final Professional Examination and the re-sit examinations. The feedback will include the following information:

- SAQ mark, SBA mark, Total mark and Overall %
- Pass mark for the combined written papers.
- Student individual Z score and class Z score range.
- A breakdown of their SAQ and SBA marks related to individual Clinical Placements and to key domains. The domains will include Basic Science, Diagnosis, Investigations, Management, Patient Safety, Population Health, Prescribing and Professionalism.

Students who fail either the IPE or FPE examination are invited to see a member of the Academic Support Unit immediately after the examination for remediation before the re-sit examination. Any student may also self-refer to the Academic Support Unit if they have concerns about their progress. All students are additionally invited to have a review of their progress with a senior member of staff in the summer following the IPE examination.

7. CLINICAL EXAMINATION (OSCE) FEEDBACK:

All students will be provided with feedback following a summative OSCE. This includes the Year 1 OSCE, the Primary Professional Examination, the Intermediate Professional Examination and the Final Professional Examination. Each student will receive a report with:

- Examiner grade (fail, borderline, pass, good, excellent) for each individual section for each station.
- Number of merit and de-merit scores
- Percentage mark
- Pass mark for the assessment in terms of total mark and maximum permitted de-merit points.

Examiner comments: For the Year 1 OSCE, the PPE OSCE and the IPE OSCE, each student will receive a report with the examiner comments transcribed from the examination sheet. Any concern related to patient safety will be flagged and feed back and the professionalism support group will follow up any students about whom professionalism concerns have been raised.

8. Students who are course terminated after failing a re-sit examination are not routinely provided with feedback. They can be provided with generic feedback at their request but this will only detail the overall elements of the assessment in which they were unsuccessful (written / OSCE / both). Students who are course terminated for other reasons will not be provided with any additional feedback. If a student is permitted to repeat a year due to their mitigating circumstances or after appealing course termination, then such a student will receive the same feedback as students who have failed a first sit examination.
9. Note: The process for provision of feedback related to summative assessments continues to evolve and develop. A number of initiatives linked to the use of appropriate software are currently being evaluated.
15. Merit and Distinction awards

MERIT AND DISTINCTION OF THE CORE CURRICULUM IN PHASE 1

The awards of merit and distinction for assessment in phase 1 is under review (as of November 2015). A separate document will be circulated and added to this document once this process has been completed (anticipated in January 2016).

MERIT AND DISTINCTION IN THE INTERMEDIATE PROFESSIONAL EXAM and FINAL PROFESSIONAL EXAM

Normally, in written examinations students will be considered for the award of merit if their mark is at least 1 standard deviation above the pass threshold for the award of merit and more than 1.5 standard deviations above the pass threshold for distinction. However these boundaries are reviewed in light of the performance of the assessment as a whole (and not that of individual students). The awards of merit and distinction for OSCE examinations is determined by the number of merit marks accumulated during the examination circuit. Again the boundaries for these awards are determined following psychometric analysis of the examination.

The Board of Examiners, with the advice of external examiners, decides finally on the threshold score for merit and distinction and may vary the thresholds indicated above.
16. Award of Honours

The degrees of MB ChB may be awarded with honours at the discretion of the Board of Examiners. Honours are decided on the basis of accumulated merits and distinctions across the whole medical course.

The awards of honours is under review (as of November 2015). A separate document will be circulated and added to this document once this process has been completed (anticipated in January 2016)
17. Calculation of the Medical School Performance for the Educational Performance Measure (EPM)

All applicants for the United Kingdom Foundation Training Programme are assessed and ranked on their performance at medical school in relation to their graduating cohort up to the point of application to the Foundation Programme. Applicants are 'competition ranked' into the top 10%, top 20% etc of their cohort and allocated into the appropriate deciles. Decile scores are determined by individual medical schools.

The calculation of the medical school performance score at the University of Leicester is currently under review (as of November 2015). A separate document will be circulated and added to this document once this process has been completed (anticipated in January 2016)
18. Assessment of Clinical Placements

Clinical Placements are a central component of the medical course.

At the end of each clinical placement a report will be prepared by the placement tutor (or block team) for each student, evaluating performance in each of the categories described below. The primary purpose of the block report is to ensure that each student receives timely and appropriate information on their performance.

The following elements will be reported for all clinical placements:

**Attendance**

Students must follow the guidance in the “Attendance and Absence Procedures” document.

**Professionalism**

Students in whom there is no concern will be graded as satisfactory. Students who exemplify good practice will receive additional comments of commendation.

If a professionalism issue is identified this will be discussed directly with the student by the Site Lead or Block Lead. Depending on the nature of the concern the student can be referred to the Professionalism Support Unit. An option exists to discuss the issue with the Year Lead or the Lead for Clinical Education. Any significant issue that impacts on patient safety will be discussed at the time it occurs and notified to the Medical School.

**Completion of specified course work**

All clinical placements or blocks have workbooks containing a variety of specified tasks for students to complete. The nature of these tasks varies widely. The Tutor or Block Lead will review the completed workbook to confirm that the student has engaged satisfactorily with the learning material and opportunities.

**Placement Formative Assessments.**

Each placement will include a formative assessment. This will vary and include either a single best answer (SBA) or short answer question (SAQ) paper and/or a clinical assessment.

- **Clinical assessment.** The placement report will include an outcome grade reflecting the clinical performance of the student. This will vary depending on the placement. In some cases this will reflect an overview of the student clinical interactions throughout the placement. In some placements there will be structured assessment of clinical competence and the student will be graded accordingly.

- **Academic / Written assessment.** The placement report will include an outcome grade for written assessment.
Formative Feedback and Support:

Note: The purpose of the clinical placement assessment is to provide formative feedback. Students who are identified as being below a satisfactory standard are encouraged to meet with the Placement Lead or Tutor to review their learning and consider strategies for subsequent placements. Any student is allowed to refer themselves to the Academic Support Unit where they will meet a member of staff to review their performance and develop a learning action plan.

The placement reports will be considered formally by the Medical School after six months of the Junior Rotation and after six months of the Senior Rotation. A student who is identified as struggling will be offered support as appropriate. This may include the following options depending on individual circumstances: Academic Support Unit, Pastoral Support Unit and Professionalism Support Unit. It may be necessary for the student to meet initially with the Year Lead to review the most appropriate channel of support.

Certification of procedural skills

All students are required to demonstrate competence at a defined list of clinical skills, specified by the General Medical Council in ‘Tomorrow’s Doctors’ (2009), to be recorded as the course progresses. The Board of Examiners may require students to complete certain elements of clinical skills training in order to progress from Phase 1 to Phase 2 or the junior to senior rotations.

Students are required to have completed all parts of the clinical skills training by the end of the course in order to graduate. Any student who does not demonstrate competence in all specified skills by the end of the course will be recommended for course termination, irrespective of performance in summative examinations, and their case considered by the Board of Examiners.
Responsible Bodies

19. Mitigating Circumstances Panel

The University recognises that students may suffer from an illness or other serious and unforeseen event or set of circumstances which may mean that they cannot attend an assessment or if they do attend the assessment that their performance may be suboptimal. In such cases the mitigating circumstances regulations and procedures may be applied. These regulations are designed to ensure the fair and consistent treatment of all students.

The regulations on mitigating circumstances procedures are part of Senate Regulation 7: Regulations Governing the Assessment of Taught Programmes and can be found in the Senate Regulations.

The University guidance applies to medical students. There are some additional points that are specific to the MB ChB programme. These are provided in the document entitled: “Mitigating Circumstances Guide” and are available on the Medical School website.

The Boards of Examiners will establish a Mitigating Circumstances Panel to consider submissions. Membership of Panels will be determined by Heads of Department and will be drawn from the internal examiners.

The Mitigating Circumstances Panel will consist of the following:

- Chair of the Mitigating Circumstances Panel (who will normally be a clinician with consultant status, but not involved in the assessment process)
- Named Deputy Chair (to ensure consistency and appropriate cover)
- Two or three members drawn from the Panel of Examiners
- One member appointed at the discretion of the Head of the Department. This may be a lay member.
- Secretary to the Mitigating Circumstances

Mitigating Circumstances Panels will meet prior to Board of Examiners or Panel of Examiners. Mitigating Circumstances Panels will consider cases on the basis of documentary evidence and will operate under delegated powers from the Board of Examiners.

Mitigating Circumstances Panels will be responsible for determining whether sufficient grounds have been established and for making recommendations to the Board of Examiners on whether mitigation should be applied to the outcomes of specific pieces of students’ assessment. Mitigating Circumstances Panels will do so without evidence of the student’s performance for that particular assessment.

NOTE: The recommendations made by the Panel will take into account the nature of the MB ChB Programme and the expectation that students are required to work as safe future doctors.

Departments shall keep a formal record of the discussions and recommendations of Mitigating Circumstances Panels.
Mitigating Circumstances Panels make one of the following recommendations to the Board/Panel of Examiners:

- Mitigation considered and accepted.
- Mitigation considered and not accepted.

Where mitigating circumstances are accepted by a Mitigating Circumstances Panel, Mitigating Circumstances Panels shall not make a judgement about the extent to which accepted mitigating circumstances have affected a student’s performance; marks will not be adjusted and there will be no tariff.

At the Board of Examiners meeting for the relevant assessment, the Board will only consider the report from the Mitigating Circumstances Committee in respect of those students who have failed the assessment. In the case of those students whose mitigation has been considered and not accepted, the Board will make its progress decisions in the usual way. In the case of students whose mitigation has been considered and accepted, the Board will take into account the fact that mitigation has been accepted and this may affect the student’s progress decision providing that the decision falls within the University regulations for the MB ChB programme.

The examination marks and progress decisions released following the meeting of the Board of Examiners should clearly identify results where mitigation has been considered and applied. Boards of Examiners will accept the recommendations of Mitigating Circumstances Panels but will not be expected to receive evidence. Boards of Examiners will determine the outcome of an assessment for an individual student in the light of the Mitigating Circumstances Panel’s recommendation.

NOTE: Mitigation will not affect marks, grades or whether or not a student passes an assessment or examination. It cannot permit a student to progress into a subsequent year (or to graduate) if the examination performance would otherwise prevent this. Mitigation only affects how the School deals with a student who has failed an assessment. If the Panel agrees that mitigating circumstances should be accepted as affecting an assessment/examination it will ask the Board of Examiners to take this into account when it makes a decision.

Note: The criteria used by the Mitigating Circumstances Panel and additional information is described in the “Mitigating Circumstances Guide”.

September 2015 (updated June 2016)
20. Board of Examiners and Panel of Examiners

The information contained in this section is based on the University Regulations for Taught Programmes [http://www2.le.ac.uk/offices/sas2/regulations/general-regulations-for-taught-programmes](http://www2.le.ac.uk/offices/sas2/regulations/general-regulations-for-taught-programmes). Some points have been clarified with regard to the MB ChB programme. Decisions on outcomes of summative assessments and progression on the programme are made by the Panel of Examiners and the Board of Examiners. The sections below outline the working of these respective groups.

**BOARD OF EXAMINERS**

A Board of Examiners shall be convened for the MB ChB programme, to consider the performance of students which contributes to an award of the University.

A Board of Examiners shall also consider the progression of students from one stage of a programme to the next.

The function of a Board of Examiners is to:

- confirm the recommended examination outcomes received from one or more Panels of Examiners;
- consider the academic performance of individual students as it relates to progression or award decisions;
- agree progression, and awards.

A Board of Examiners shall consist of:

- The Chair, which will normally be the Head of Department. In exceptional circumstances and with the agreement of the Academic Registrar, the Head of Department may nominate a member of staff of the department to act as Chair for a meeting of the Board of Examiners.
- Two members of each Panel of Examiners contributing assessment outcomes to the Board, one of whom shall normally be the Chair of the Panel of Examiners.
- Such other members of the academic staff, including unit leads or clinical block leads, as are necessary to make informed progression and award decisions.
- External Examiners for each of the assessments included in the remit of the Board.

The members of a Board of Examiners shall be agreed annually.

Attendance at a meeting of a Board of Examiners should consist of at least 75% of the membership and must include the Chair. Where an individual external examiner is unable to attend a meeting of the Board of Examiners, s/he shall normally be required to submit written comments on the outcomes of modules, and the performance of candidates so that these views may be taken into account during the meeting.

At least one external examiner, from a team of examiners, shall be present at a meeting of a Board of Examiners, in person or via a means of electronic conferencing, where awards are being made to students. On occasions when the Board of Examiners is expecting to consider progression decisions only, external examiners are not required to attend.
A representative of the Academic Registrar, normally a senior member of the administrative staff of the University, shall attend each meeting of a Board of Examiners where awards to students are under consideration to ensure that the proceedings of the Board are carried out in accordance with the regulations.

The business of the Board may not be transacted in the absence of the Academic Registrar’s Representative.

**PANEL OF EXAMINERS**

The function of a Panel of Examiners is to:

- consider patterns of student achievement for individual summative assessments, confirming the standards of achievement in the assessment, and ensuring that marking standards are sufficiently reliable to ensure that outcomes appropriately reflect student achievement against the written criteria;
- recommend summative assessment outcomes to one or more Board of Examiners;
- agree the release of provisional semester outcomes to students.
- consider patterns of student achievement for individual clinical rotations (i.e. junior rotation or senior rotation) via the Intermediate Professional Examination and the Final Professional Examination, confirming the standards of achievement in the rotation and that marking standards are sufficiently reliable to ensure that outcomes appropriately reflect student achievement against the written criteria;
- recommend rotation and assessment outcomes to one or more Board of Examiners;
- agree the release of provisional rotation and assessment outcomes to students.

A Panel of Examiners shall consist of:

- Chair of the Panel of Examiners. This will normally be the Assessment Lead. The Head of Department may nominate a member of staff of the department to act as Chair for a meeting of the Panel of Examiners.
- Such other members of the academic staff as are necessary to make informed progression decisions.

**Conduct of business**

There shall be a standard formal agenda for meetings of Panels and Boards of Examiners. The business of Panels and Boards remains confidential to the membership.

Panels and Boards shall make decisions on the basis of evidence of student achievement. Each Panel and each Board will be provided with a standard data set to include the outcomes of each unit of assessment being considered by the Panel; and the profile of each student for whom a progression or award decision is to be made by the Board.

Semester and component marks presented to a Panel or Board of Examiners will have been carefully considered by the markers who will have made informed academic judgments such that the overall outcomes fairly reflect the levels of attainment of the students. This should be done by carefully assessing the students’ work against written criteria.
Scaling, or norm referencing, of assessment outcomes may take place only in exceptional circumstances or where this has previously been agreed by a Programme Approval Panel for the purposes of professional accreditation. Scaling should not be used, for example to adjust for variations in student achievement across semesters or academic years. Any scaling shall be justified to the Panel of the Examiners and subsequently to the Board of Examiners. Once component marks have been confirmed by a Panel of Examiners they may not be adjusted for individual students.

Boards of Examiners shall not adjust component marks to elevate candidates across a classification boundary.

All members of the Board are equal; no particular weight shall be given to the views of the external examiner(s). An external examiner has no veto in relation to decisions in relation to individual students. If a vote in any particular case is necessary, the Chair shall have the casting vote.

A Panel or a Board may defer a decision in relation to an individual student if insufficient information about the performance of the student is available.

All recommendations for an award shall be recorded by the Academic Registrar’s Representative; this shall constitute the definitive record against which results are entered into the SITS student record and notified to students, and shall be held by the Registry, according to the University’s retention schedule.

The Academic Registrar’s Representative shall ensure that the lists of recommended awards is signed by the Chair and those external examiners present at the meeting.

The department shall provide a secretary to the Board, who shall take notes which shall include an account of any discussion in relation to difficult cases.

The Chair of a Board may make decisions on behalf of the Board, where a decision in relation to an individual student has been deferred. This will include making recommendations for intermediate awards, where appropriate.

The Board may make recommendations for the award of prizes to students.

Mitigating circumstances
Panels and Boards of Examiners will accept the recommendations of Mitigating Circumstances Panels but will not be expected to receive evidence. Boards of Examiners will determine the outcome of an assessment for an individual student in the light of the Mitigating Circumstances Panel’s recommendation.

The examination marks and progress decisions released following the meeting of the Board of Examiners should clearly identify results where mitigation has been considered and applied.
**Progression decisions**

A student’s progress will be reviewed at each progression point to determine whether s/he has met the requirements to progress to the next stage of the programme. In each case where a student has failed to meet the requirements to progress it will be determined whether the Board of Examiners makes a recommendation that s/he be withdrawn from the programme. The Board of Examiners shall consider whether any intermediate award may be made based on the student’s academic achievement.
21. Phase 1 and Phase 2 Assessment Groups

PHASE 1 ASSESSMENT GROUP

The group, chaired by the Phase 1 Assessment Lead, is responsible for the oversight of all aspects of assessment in Phase 1, and the management of assessment of the core curriculum.

Membership

The Phase 1 Assessment Lead (Chair)
The Programme Lead for Assessment
The Quality Lead for Assessment
One module leader from each of semesters 1 to 3 of the four and five year curricula
One module leader from each of semesters 4 and 5 of the five year curriculum
At least one medically qualified member of staff
The Assessment Manager
Assessment administrator (Secretary)

The group is responsible for:

1. Coordination of all core assessments in Phase 1
2. Maintenance of question banks for written core assessments
3. Construction of appropriate Phase 1 assessments and re-sit examinations for the four and five year curricula, including:
   - Blue printing to curriculum outcomes
   - Appropriate balance of unit specific and integrated questions
   - Appropriate balance of question difficulty and diversity
4. Oversight of administration of all core assessments in Phase 1 including:
   - Liaison with administrative staff to ensure appropriate room bookings
   - Identification of need for invigilators to be nominated under service level agreements with medical school departments
   - Preparation of scripts for marking
5. Administration of marking of Phase 1 assessments and qualifying examinations including:
   - Identification of staff requirements for marking teams to be nominated under service level agreements with medical school departments
   - Oversight of data entry and processing, and production of spread sheets for standard setting
6. Oversight of clinical assessments including OSCEs
7. Oversight of the assessment of student selected components in Phase 1 to ensure that:
   - The model(s) of assessment chosen for each is appropriate to the module aims and learning outcomes
   - The demands made upon students are comparable across student selected components
Semester Assessment Groups

The end of semester assessments for each of semester, semesters 1-4 of the five year course, and 1-2 of the four year course, will each be coordinated by Semester Assessment Groups, which are sub-groups of the Phase 1 Assessment Group.

The membership of each Semester Assessment Group shall comprise:

The Phase 1 Assessment Lead
All module leaders of modules in that semester for both four and five year courses
One other member of the Semester Assessment Group, preferably a module leader from an earlier semester
In the case of Semester 2, the individual responsible for the Objective Structured Clinical Examination
Assessment Administrator

The Semester Assessment Group will be responsible for:

1. The preparation of appropriate written end of semester assessments
2. Submission of the papers for approval by the Phase 1 Assessment Group and External Examiners
3. Administration of all core assessments in the relevant semester
4. Marking and moderating short answer question scripts
5. Working with the Phase 1 Assessment Group to maintain and develop the bank of question to be used across all assessments
6. Quality control and monitoring of assessments in the relevant semester
**PHASE 2 ASSESSMENT GROUP**

The group, chaired by the Phase 2 Assessment Lead is responsible for the coordination of all aspects of assessment in Phase 2, and the management of assessment of the core curriculum.

**Membership**

The Programme Lead for Assessment (Chair)
The Quality Lead for Assessment
The Clinical Lead for Assessment
The Director of Undergraduate Medical Education
Representatives of phase 2 blocks who constitute the phase 2 assessment group
The Phase 1 Assessment Lead
The Assessment Manager
Assessment administrator (Secretary)

The group is responsible for:

**Coordination of all core assessments in Phase 2**

1. Oversight of assessments within clinical blocks, including:
   - Approval of the pattern of assessments within each block to ensure:
     - Assessment methods are appropriate for the outcomes to be tested
     - The assessment load is comparable across blocks

2. Written assessments at the Intermediate and Final Professional Examinations, including:
   - Maintenance of question banks
   - Construction of appropriate papers including:
     - Blue printing to curriculum outcomes
     - Appropriate balance of question difficulty and diversity
   - Oversight of administration of the assessments including:
     - Liaison with administrative staff to ensure appropriate room bookings
     - Identification of need for invigilators to be nominated under service level agreements with medical school departments
     - Preparation of scripts for marking
   - Administration of marking including:
     - Identification of staff requirements for marking teams and recruitment of suitable staff from the medical school and NHS
     - Oversight of data entry and processing, and production of spreadsheets for standard setting
   - Conduct of appropriate standard setting procedures

3. Clinical assessments at the Intermediate and Final Professional Examinations, including:
   - Ensuring that:
     - Appropriate facilities are available for clinical examinations
     - Sufficient, appropriately trained examiners are available for each clinical examination
Examiners are briefed in a consistent way for each examination session at every site.
An appropriate mix of patients, including where appropriate simulated patients are available for all examinations.
Examinations are conducted in accordance with the code of practice for assessment in phase 2.

- **Collation and analysis of marks to:**
  - Ratify and ensure the assessments are fair, valid, reliable and generalisable.
  - Prepare lists of failing students and, where appropriate, those awarded merit and distinctions to be considered by the Phase 2 Board of examiners.

- **Standard setting by appropriate methods**

- **Quality control of clinical assessments, including:**
  - On-going monitoring of the conduct of assessments, and identification of strategies to improve assessment practice.
  - Monitoring of appropriate psychometric analyses of assessment outcome.

4. Oversight of the assessment of student selected components in Phase 2, including the elective period to ensure that:
   - The model(s) of assessment chosen for each is appropriate to the aims and learning outcomes.
   - The demands made upon students are comparable across student selected components.
22. External Examiners

The Medical School will follow the University Regulations with regard to External Examiners. See: Senate Regulation 7: Regulations governing the assessment of taught programmes [http://www2.le.ac.uk/offices/sas2/regulations/documents/senatereg7-assessment.pdf](http://www2.le.ac.uk/offices/sas2/regulations/documents/senatereg7-assessment.pdf) and the Assessment Regulations Handbook: [http://www2.le.ac.uk/offices/sas2/quality/committees/academic-policy-committee/implementation/assessment-regulations/documents/assessment-regulations-handbook](http://www2.le.ac.uk/offices/sas2/quality/committees/academic-policy-committee/implementation/assessment-regulations/documents/assessment-regulations-handbook)

The appointment and role of external examiners is detailed in the University External Examiner Handbook: [http://www2.le.ac.uk/offices/sas2/assessments/external/externalexamining](http://www2.le.ac.uk/offices/sas2/assessments/external/externalexamining)

Appointment of External Examiners

The Medical School will recommend the appointment of no more than 12 external examiners with a range of interest and expertise, particularly of assessing students within curricula of similar structure, sufficient to deal with all material covered in the core and Student selected components of the MB ChB.

The Department will have regard to the following:

- Only persons of seniority and experience who are able to command authority should be recommended for appointment. In order to have sufficient time for proper performance of their duties, individuals should not normally be expected to hold more than two external examiner-ships at first degree level. The Department will check how many examiner-ships a prospective examiner holds before recommending an appointment.
- Former members of staff or individuals who have been closely associated with the institution should not be invited to become external examiners unless a period of five years has elapsed and all students taught by or with the external examiner have completed their programme.

Period of Service

External examiners are normally invited to hold office for four consecutive years, and may, exceptionally be appointed for a fifth and final year.

Briefing of External Examiners

On appointment each external examiner will be sent:

- a copy of the most recent curriculum documents, which include information about the philosophy, educational principles, structure and detailed aims and learning outcomes of the curriculum
- a written description of the role of external examiners within the MB ChB course
- a copy of the code of practice for assessment of students
- in addition, a briefing meeting will be held in advance of the main summative examinations

Participation of External Examiners in the Summative Assessments

External examiners have the right to scrutinise all assessments taking place within the curriculum.
Specifically:

1) Setting of Assessments
   - All question papers used in summative examinations including re-sit examinations shall be sent to external examiners for approval.
   - All in-course assessments and student selected components should be available to external examiners for scrutiny if they wish.

2) Assessment Results
   - External examiners are able to inspect a sample of scripts from the end of year and re-sit examinations, after they have been double marked internally, at the end of each academic year.
   - A sample of students' work from in-course assessment will be available to external examiners for scrutiny if they so wish.
   - A sample of scripts from candidates in each student selected component may be scrutinised by an appropriate external examiner.
   - External examiners may at their discretion scrutinise a sample of student dissertations produced in the Living with Long-term Conditions Special Study Module.

3) Boards of Examiners
   - External examiners have the right to be present at all examiners’ meetings at which significant decisions are to be taken. An external examiner should be present, or available for telephone consultation, at meetings which make award decisions.

4) Comments and Advice
   - External examiners will be encouraged to comment on the assessment process, and they will be consulted about any changes to the assessment procedure.
   - Senior members of the Department will discuss with external examiners the structure and content of course. Comments or suggestions from the external examiners will be considered by the Board of Studies, and explicit decisions made about whether or not to make changes.

5) Written Reports
   - External examiners are required to make written reports to the Quality Office at the end of each academic year.
   - The reporting system will follow that outlined in the Assessment Regulations Handbook and the External Examiner Handbook
23. Plagiarism and cheating

All assessments will be subject to the University of Leicester Senate Regulation regarding Discipline:

http://www2.le.ac.uk/offices/sas2/regulations/documents/Senatereg11-discipline.pdf

Student advice regarding plagiarism can be found at:

http://www2.le.ac.uk/offices/ld/resources/study/avoiding-plagiarism

Plagiarism detection software will be used on submitted assessments.

If a candidate is suspected of plagiarism or cheating in any assessment or examination, this will be investigated. If proven, the investigating committee will determine the penalty. It is likely that the penalty would be an ‘Unsatisfactory’ grade in the assessment at least, but could be more severe. Penalties applied in relation to plagiarism or cheating in assessments will be recorded on the student’s official transcript and a record of the offence will be held. Also, the Fitness to Practice Committee will be informed of the offence. Cases of dishonesty may, where relevant, be reported to professional bodies.
24. Absence from an examination

All summative assessments are compulsory.

If a student fails to attend a summative assessment then, regardless of the reason, the student will be managed in exactly the same way as a student who has taken the assessment and failed. This means that such a student will be required to take the Resit Examination and will be assessed at the Resit Examination in exactly the same way as students who attended the examination and are resitting because of a previous failure. Students who fail to attend an assessment can submit a mitigating circumstances form.

Furthermore, all students are expected to make a bona fide attempt at each assessment they sit. If a student does not complete a written examination, they will be marked for the components they have completed but there will be no alteration of the pass mark to account for the proportion of the examination which has not been completed. If a student does not complete a clinical examination, they will receive a ‘fail’ for each element they have not attempted and there will also be no alteration in the overall pass mark to account for the proportion of the examination which has not been completed. The overall pass mark, both in terms of absolute mark and demerit score will be the same as if the whole examination had been completed.

If a student is absent due to ill-health or any other reason they may submit a mitigating circumstances form which will be considered by the Mitigating Circumstances Panel. The outcome of the Mitigating Circumstances Panel will then be considered by the Board of Examiners.

The Board of Examiners will follow the ‘Regulations for the Progression and Award of the degrees of Bachelor of Surgery and Bachelor of Medicine’.
25. Prizes

A large number of prizes are available to students throughout the course.

Phase 1 Prizes

- Phase 1 Prize
- Sir Robert Kilpatrick Prize
- BMA Prize
- Tresidder Prize
- Ballantine Prize
- Amir Gulamhusein Prize

Phase 2 Prizes

- Philip Hammersley Gold Medal
- BMA Prize for Clinical Excellence
- Prize for Academic Excellence
- GlaxoSmithKline Child Health Prize
- Arthur Watts Prize in Clinical Methods
- The Reverend Derek Hole Prize in Cardiovascular Medicine
- John MacVicar Prize
- Keeler Prize
- Sydney Brandon Prize
- John and Hilary Hearnshaw Diabetes Prize
- Frank Harris Prize
- Elective Prizes (three)

All students

- Noel Everson Surgical Prize
- Peter Bell Surgical Prize
- Arthritis Research UK Medical Student Prize

Note: The list of prizes and the criteria for the award of the prize is presently under review. Students will be informed of relevant prizes they can apply for and those linked to performance on the course. A separate document will be published in due course.
APPENDIX A

Outcomes of the MBChB Course

The doctor as a scholar and a scientist

*The graduate will be able to apply to medical practice biomedical scientific principles, method and knowledge relating to: anatomy, biochemistry, cell biology, genetics, immunology, microbiology, molecular biology, nutrition, pathology, pharmacology and physiology. The graduate will be able to:*

a) Explain normal human structure and functions.
b) Explain the scientific bases for common disease presentations.
c) Justify the selection of appropriate investigations for common clinical cases.
d) Explain the fundamental principles underlying such investigative techniques.
e) Select appropriate forms of management for common diseases, and ways of preventing common diseases, and explain their modes of action and their risks from first principles.
f) Demonstrate knowledge of drug actions: therapeutics and pharmacokinetics; drug side effects and interactions, including for multiple treatments, long-term conditions and non-prescribed medication; and also including effects on the population, such as the spread of antibiotic resistance.
g) Make accurate observations of clinical phenomena and appropriate critical analysis of clinical data.

*Apply psychological principles, method and knowledge to medical practice.*

a) Explain normal human behaviour at an individual level.
b) Discuss psychological concepts of health, illness and disease.
c) Apply theoretical frameworks of psychology to explain the varied responses of individuals, groups and societies to disease.
d) Explain psychological factors that contribute to illness, the course of the disease and the success of treatment.
e) Discuss psychological aspects of behavioural change and treatment compliance.
f) Discuss adaptation to major life changes, such as bereavement; comparing and contrasting the abnormal adjustments that might occur in these situations.
g) Identify appropriate strategies for managing patients with dependence issues and other demonstrations of self-harm.

*Apply social science principles, method and knowledge to medical practice.*

a) Explain normal human behaviour at a societal level.
b) Discuss sociological concepts of health, illness and disease.
c) Apply theoretical frameworks of sociology to explain the varied responses of individuals, groups and societies to disease.
d) Explain sociological factors that contribute to illness, the course of the disease and the success of treatment – including issues relating to health inequalities, the links between occupation and health and the effects of poverty and affluence.
e) Discuss sociological aspects of behavioural change and treatment compliance.

*Apply to medical practice the principles, method and knowledge of population health and the improvement of health and healthcare.*

a) Discuss basic principles of health improvement, including the wider determinants of health, health inequalities, health risks and disease surveillance.
b) Assess how health behaviours and outcomes are affected by the diversity of the patient population.
c) Describe measurement methods relevant to the improvement of clinical effectiveness and care.
d) Discuss the principles underlying the development of health and health service policy, including issues relating to health economics and equity, and clinical guidelines.

e) Explain and apply the basic principles of communicable disease control in hospital and community settings.

f) Evaluate and apply epidemiological data in managing healthcare for the individual and the community.

g) Recognise the role of environmental and occupational hazards in ill-health and discuss ways to mitigate their effects.

h) Discuss the role of nutrition in health.

i) Discuss the principles and application of primary, secondary and tertiary prevention of disease.

j) Discuss from a global perspective the determinants of health and disease and variations in healthcare delivery and medical practice.

Apply scientific method and approaches to medical research.

a) Critically appraise the results of relevant diagnostic, prognostic and treatment trials and other qualitative and quantitative studies as reported in the medical and scientific literature.

b) Formulate simple relevant research questions in biomedical science, psychosocial science or population science, and design appropriate studies or experiments to address the questions.

c) Apply findings from the literature to answer questions raised by specific clinical problems.

d) Understand the ethical and governance issues involved in medical research.

The doctor as a practitioner

The graduate will be able to carry out a consultation with a patient:

a) Take and record a patient's medical history, including family and social history, talking to relatives or other carers where appropriate.

b) Elicit patients' questions, their understanding of their condition and treatment options, and their views, concerns, values and preferences.

c) Perform a full physical examination.

d) Perform a mental-state examination.

e) Assess a patient's capacity to make a particular decision in accordance with legal requirements and the GMC's guidance.

f) Determine the extent to which patients want to be involved in decision-making about their care and treatment.

g) Provide explanation, advice, reassurance and support.

Diagnose and manage clinical presentations.

a) Interpret findings from the history, physical examination and mental-state examination, appreciating the importance of clinical, psychological, spiritual, religious, social and cultural factors.

b) Make an initial assessment of a patient's problems and a differential diagnosis. Understand the processes by which doctors make and test a differential diagnosis.

c) Formulate a plan of investigation in partnership with the patient, obtaining informed consent as an essential part of this process.

d) Interpret the results of investigations, including growth charts, x-rays and the results of the diagnostic procedures in Appendix 1.

e) Synthesise a full assessment of the patient's problems and define the likely diagnosis or diagnoses.

f) Make clinical judgements and decisions, based on the available evidence, in conjunction with colleagues and as appropriate for the graduate's level of training and experience. This may include situations of uncertainty.

g) Formulate a plan for treatment, management and discharge, according to established principles and best evidence, in partnership with the patient, their carers, and other health professionals as appropriate. Respond to patients' concerns and preferences, obtain informed consent, and respect
the rights of patients to reach decisions with their doctor about their treatment and care and to refuse or limit treatment.

h) Support patients in caring for themselves.

i) Identify the signs that suggest children or other vulnerable people may be suffering from abuse or neglect and know what action to take to safeguard their welfare.

j) Contribute to the care of patients and their families at the end of life, including management of symptoms, practical issues of law and certification, and effective communication and team-working.

Communicate effectively with patients and colleagues in a medical context.

a) Communicate clearly, sensitively and effectively with patients, their relatives or other carers, and colleagues from the medical and other professions, by listening, sharing and responding.

b) Communicate clearly, sensitively and effectively with individuals and groups regardless of their age, social, cultural or ethnic backgrounds or their disabilities, including when English is not the patient’s first language.

c) Communicate by spoken, written and electronic methods (including medical records), and be aware of other methods of communication used by patients. The graduate should appreciate the significance of non-verbal communication in the medical consultation.

d) Communicate appropriately in difficult circumstances, such as when breaking bad news, and when discussing sensitive issues, such as alcohol consumption, smoking or obesity.

e) Communicate appropriately with difficult or violent patients.

f) Communicate appropriately with people with mental illness.

g) Communicate appropriately with vulnerable patients.

h) Communicate effectively in various roles, for example, as patient advocate, teacher, manager or improvement leader.

Provide immediate care in medical emergencies.

a) Assess and recognise the severity of a clinical presentation and a need for immediate emergency care.

b) Diagnose and manage acute medical emergencies.

c) Provide basic first aid.

d) Provide immediate life support.

e) Provide cardio-pulmonary resuscitation or direct other team members to carry out resuscitation.

Prescribe drugs safely, effectively and economically.

a) Establish an accurate drug history, covering both prescribed and other medication.

b) Plan appropriate drug therapy for common indications, including pain and distress.

c) Provide a safe and legal prescription.

d) Calculate appropriate drug doses and record the outcome accurately.

e) Provide patients with appropriate information about their medicines.

f) Access reliable information about medicines.

g) Detect and report adverse drug reactions.

h) Demonstrate awareness that many patients use complementary and alternative therapies, and awareness of the existence and range of these therapies, why patients use them, and how this might affect other types of treatment that patients are receiving.

Carry out practical procedures safely and effectively.

a) Be able to perform a range of diagnostic procedures, as listed in Appendix 1 and measure and record the findings.

b) Be able to perform a range of therapeutic procedures, as listed in Appendix 1.

c) Be able to demonstrate correct practice in general aspects of practical procedures, as listed in Appendix 1.
Use information effectively in a medical context.

a) Keep accurate, legible and complete clinical records.
b) Make effective use of computers and other information systems, including storing and retrieving information.
c) Keep to the requirements of confidentiality and data protection legislation and codes of practice in all dealings with information.
d) Access information sources and use the information in relation to patient care, health promotion, giving advice and information to patients, and research and education.
e) Apply the principles, method and knowledge of health informatics to medical practice.

The doctor as a professional

The graduate will be able to behave according to ethical and legal principles. The graduate will be able to:

a) Know about and keep to the GMC’s ethical guidance and standards including Good Medical Practice, the ‘Duties of a doctor registered with the GMC’ and supplementary ethical guidance which describe what is expected of all doctors registered with the GMC.
b) Demonstrate awareness of the clinical responsibilities and role of the doctor, making the care of the patient the first concern. Recognise the principles of patient-centred care, including self care, and deal with patients’ healthcare needs in consultation with them and, where appropriate, their relatives or carers.
c) Be polite, considerate, trustworthy and honest, act with integrity, maintain confidentiality, respect patients’ dignity and privacy, and understand the importance of appropriate consent.
d) Respect all patients, colleagues and others regardless of their age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status. Graduates will respect patients’ right to hold religious or other beliefs, and take these into account when relevant to treatment options.
e) Recognise the rights and the equal value of all people and how opportunities for some people may be restricted by others’ perceptions.
f) Understand and accept the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their dependants and the public – including vulnerable groups such as children, older people, people with learning disabilities and people with mental illnesses.
g) Demonstrate knowledge of laws, and systems of professional regulation through the GMC and others, relevant to medical practice, including the ability to complete relevant certificates and legal documents and liaise with the coroner or procurator fiscal where appropriate.

Reflect, learn and teach others.

a) Acquire, assess, apply and integrate new knowledge, learn to adapt to changing circumstances and ensure that patients receive the highest level of professional care.
b) Establish the foundations for lifelong learning and continuing professional development, including a professional development portfolio containing reflections, achievements and learning needs.
c) Continually and systematically reflect on practice and, whenever necessary, translate that reflection into action, using improvement techniques and audit appropriately – for example, by critically appraising the prescribing of others.
d) Manage time and prioritise tasks, and work autonomously when necessary and appropriate.
e) Recognise own personal and professional limits and seek help from colleagues and supervisors when necessary.
f) Function effectively as a mentor and teacher including contributing to the appraisal, assessment and review of colleagues, giving effective feedback, and taking advantage of opportunities to develop these skills.
Learn and work effectively within a multi-professional team.

a) Understand and respect the roles and expertise of health and social care professionals in the context of working and learning as a multi-professional team.
b) Understand the contribution that effective interdisciplinary team-working makes to the delivery of safe and high-quality care.
c) Work with colleagues in ways that best serve the interests of patients, passing on information and handing over care, demonstrating flexibility, adaptability and a problem-solving approach.
d) Demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others.

Protect patients and improve care.

a) Place patients’ needs and safety at the centre of the care process.
b) Deal effectively with uncertainty and change.
c) Understand the framework in which medicine is practised in the UK, including: the organisation, management and regulation of healthcare provision; the structures, functions and priorities of the NHS; and the roles of, and relationships between, the agencies and services involved in protecting and promoting individual and population health.
d) Promote, monitor and maintain health and safety in the clinical setting, understanding how errors can happen in practice, applying the principles of quality assurance, clinical governance and risk management to medical practice, and understanding responsibilities within the current systems for raising concerns about safety and quality.
e) Understand and have experience of the principles and methods of improvement, including audit, adverse incident reporting and quality improvement, and how to use the results of audit to improve practice.
f) Respond constructively to the outcomes of appraisals, performance reviews and assessments.
g) Demonstrate awareness of the role of doctors as managers, including seeking ways to continually improve the use and prioritisation of resources.
h) Understand the importance of, and the need to keep to, measures to prevent the spread of infection, and apply the principles of infection prevention and control.
i) Recognise own personal health needs, consult and follow the advice of a suitably qualified professional, and protect patients from any risk posed by own health.
j) Recognise the duty to take action if a colleague’s health, performance or conduct is putting patients at risk.

Practical procedures for graduates

Diagnostic procedures

1. Measuring body temperature. - Using an appropriate recording device
2. Measuring pulse rate and blood pressure. - Using manual techniques and automatic electronic devices
3. Trans-cutaneous monitoring of oxygen saturation. - Applying and talking readings from an electronic device which measures the amount of oxygen in a patient’s blood
4. Venepuncture. - Inserting a needle into a patient’s vein to take a sample of blood for testing or to give an injection into the vein.
5. Managing blood samples correctly. - Making sure that blood samples are placed in the correct containers, and that these are labelled correctly and sent to the laboratory promptly and in the correct way. Taking measures to prevent spilling and contamination.
6. Taking blood cultures. - Taking samples of venous blood to test for the growth of infectious organisms in the blood. Requires special blood containers and laboratory procedures.
7. Measuring blood glucose. - Measuring the concentration of glucose in the patient's blood at the bedside, using appropriate equipment and interpreting the results.
8. Managing an electrocardiograph (ECG) monitor. - Setting up a continuous recording of the electrical activity of the heart. Ensuring the recorder is functioning correctly, and interpreting the tracing.
9. Performing and interpreting a 12-lead electrocardiograph. - Recording a full, detailed tracing of the electrical activity of the heart, using a (ECG) machine recorder (electrocardiograph). Interpreting the recording for signs of heart disease.
10. Basic respiratory function tests. - Carrying out basic tests to see how well the patient's lungs are working (for example, how much air they can breathe out in one second).
11. Urinalysis using Multistix. - Testing a sample of urine for abnormal contents, such as blood or protein. The urine is applied to a plastic strip with chemicals which change colour in response to specific abnormalities.
12. Advising patients on how to collect a mid-stream urine specimen. - Obtaining a sample of urine from a patient, usually to check for the presence of infection, using a method which reduces the risk of contamination by skin bacteria.
13. Taking nose, throat and skin swabs. - Using the correct technique to apply sterile swabs to the nose, throat and skin.
14. Nutritional assessment. - Making an assessment of the patient's state of nutrition. This includes an evaluation of their diet; their general physical condition; and measurement of height, weight and body mass index.
15. Pregnancy testing. - Performing a test of the urine to detect hormones which indicate that the patient is pregnant.

Therapeutic procedures
16. Administering oxygen. - Allowing the patient to breathe a higher concentration of oxygen than normal, via a face mask or other equipment.
17. Establishing peripheral intravenous access and setting up an infusion; use of infusion devices. - Puncturing a patient's vein in order to insert an indwelling plastic tube (known as a 'cannula'), to allow fluids to be infused into the vein (a 'drip'). Connecting the tube to a source of fluid. Appropriate choice of fluids and their doses. Correct use of electronic devices which drive and regulate the rate of fluid administration.
18. Making up drugs for parenteral administration. - Preparing medicines in a form suitable for injection into the patient's vein. May involve adding the drug to a volume of fluid to make up the correct concentration for injection.
19. Dosage and administration of insulin and use of sliding scales. - Calculating how many units of insulin a patient requires, what strength of insulin solution to use, and how it should be given (for example, into the skin, or into a vein). Use of a 'sliding scale' which links the number of units to the patient’s blood glucose measurement at the time.
20. Subcutaneous and intramuscular injections. - Giving injections beneath the skin and into muscle.
21. Blood transfusion. - Following the correct procedures to give a transfusion of blood into the vein of a patient (including correct identification of the patient and checking blood groups). Observation for possible reactions to the transfusion, and actions if they occur.
22. Male and female urinary catheterisation. - Passing a tube into the urinary bladder to permit drainage of urine, in male and female patients.
23. Instructing patients in the use of devices for inhaled medication. - Providing instructions for patients about how to use inhalers correctly, for example, to treat asthma.
24. Use of local anaesthetics. - Using drugs which produce numbness and prevent pain, either applied directly to the skin or injected into skin or body tissues.
25. Skin suturing. - Repairing defects in the skin by inserting stitches (normally includes use of local anaesthetic).
26. Wound care and basic wound dressing. - Providing basic care of surgical or traumatic wounds and applying dressings appropriately.
27. Correct techniques for 'moving and handling' including patients. - Using, or directing other team members to use, approved methods for moving, lifting and handling people or objects, in the context of clinical care, using methods that avoid injury to patients, colleagues, or oneself.
General aspects of practical procedures

28. Giving information about the procedure, obtaining and recording consent, and ensuring appropriate aftercare. - Making sure that the patient is fully informed, agrees to the procedure being performed, and is cared for and watched appropriately after the procedure.

29. Hand washing (including surgical ‘scrubbing up’). - Following approved processes for cleaning hands before procedures or surgical operations.

30. Use of personal protective equipment (gloves, gowns, masks). - Making correct use of equipment designed to prevent the spread of body fluids or cross-infection between the operator and the patient.

31. Infection control in relation to procedures. - Taking all steps necessary to prevent the spread of infection before, during or after a procedure.

32. Safe disposal of clinical waste, needles and other ‘sharps’. - Ensuring that these materials are handled carefully and placed in a suitable container for disposal.