Welcome to the winter edition of the Leicester Medical School Clinical Teachers’ Newsletter.

In this edition, we share with our readers, a number of key curriculum changes which lie ahead. Dr Adrian Stanley, Phase 2 Lead, talks about the impending curriculum re-design at Leicester. On page 2, Professor London sheds light on the decision to change the way we deliver primary care teaching, and on the back page Dr Margaret Barnes-Davies, Graduate Admissions Tutor, outlines why the Medical School will no longer offer a graduate entry programme.

In the words of Benjamin Disraelie:
“Change is inevitable. Change is constant.”

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Curriculum Re-Design at Leicester

The re-design of Leicester Medical School’s curriculum continues. Over the last 12 months, colleagues across the region as well as past and present students have been surveyed. This has been very informative.

There are many challenges. Expectations have been raised. But the design of any new curriculum has to be predicated on our ability to deliver the curriculum at the university and in our partner hospitals and general practices. Any new curriculum will need to reflect the financial reality of a publicly funded service.

A number of key decisions have been made. The current 2½ year phase 1 (pre-clinical) period will be shortened to 2 years, allowing 3 years of clinically-based activity. This will mean that there will be a greater emphasis on integrating clinical and pre-clinical studies throughout the course and minimising the traditional sense of boundary between the two.

There will be a longer period of ‘shadowing’ in the final year.

We will no longer offer a graduate-entry programme. We aim to maintain the diversity of our student body by recruiting a substantial number of graduates to the 5 year course.

The new curriculum will start with 1st year students in September 2016, with its first students graduating in 2021. This seems a lifetime away! But there will be evolution, not revolution and we have already started to see changes made to our current curriculum on the back of this activity, e.g. the changes to the primary care block and more integrated working between clinical and pre-clinical education leads. These and further changes will help as we move into a transition phase in the delivery of old and new curricula.

Dr Adrian Stanley & Dr Laura Mongan
**Professor London Talks about Changes to Primary Care Teaching**

The Medical School has decided to greatly augment the delivery of Primary Care and Community teaching in the curriculum. There are many reasons for this but perhaps the two most important are:

1. The recognition by the Medical School based on feedback from students, that whilst some secondary care teaching is excellent, there are other areas that are not satisfactory. The reasons for this include the fact that service demands in some areas of Secondary Care have become overwhelming and consultant staff are struggling to find time to teach.

2. The majority of the care of patients with common chronic diseases [e.g. diabetes, rheumatological diseases, dermatological diseases, COPD and asthma] now occurs in a Primary Care/Community setting.

At present, the Primary Care teaching takes place in the Clinical Methods block which consists of 2 days teaching at the Medical School and 2½ days based in a Primary Care setting. The focus of the Clinical Methods block has been to teach students the process of deductive diagnosis and clinical reasoning. Primary Care practitioners are particularly well placed to deliver such teaching because such skills form part of the core practice of Primary Care.

The Clinical Methods block has always received excellent feedback from students, this is because it is well structured, well delivered and the formative assessment at the end is constructive. These critical and core skills that are taught in the Clinical Methods block will be moved into the first two years of the new curriculum and during the clinical years, there will be much longer attachments to Primary Care. The General Practitioners working centrally in the Medical School are now collaborating with General Practices to develop the curriculum that will be delivered during these Primary Care attachments. Although not yet finalised, it is likely that within 2-3 years the Medical School will have established a number of Primary Care Academies, each of which will have links with a local hospital which will mean that a student attached to such an Academy will receive education in many areas of clinical medicine. I should stress that much of the clinical curriculum will still be delivered in a Secondary Care environment. The next article illustrates the type of facilities and education that Primary Care Academies could provide.

**New GP Teaching Programme for Medical Students at Lakeside Clinical Teaching Centre**

The Lakeside Clinical Teaching Centre, in Corby, is a Centre for mixed professional teaching. The Centre has 47,000 registered patients and 23 GP Partners. Next to the Centre is the Corby Urgent Care Centre that has on site X-ray imaging, near patient blood test analysis machines and 12 beds in the observation bay.

In September 2014, six students from Leicester Medical School joined the Teaching Centre, to pilot a new 7-week GP placement. Teaching Lead, Dr James Burden, shares his thoughts on how the new programme is progressing:

“The expanded medical student numbers has allowed us an opportunity to create a programme dedicated to the teaching needs of these students. Our size allows group teaching, group reflection and daily presentations of the surgery’s most interesting cases. All partners contribute to the teaching sessions and we utilise their expertise in ENT, Dermatology, Child Protection, Commissioning, Paediatrics, Orthopaedics and many more topics. We have developed new purpose built rooms to enable students to consult near their tutor and record the consultation, so that they can reflect upon it later using the IRIS Connect System. Students are also able to visit the Coroner’s court in Kettering and have a debrief with the Coroner after the sitting. Another development is that we have a skills expert who will work with the students to give individual personality assessments, so as to help improve student well-being now and in their future careers. The enthusiasm and energy in the Group creates a welcoming atmosphere in the coffee room and over lunch. Additionally, for me personally, it has been a joy to be part of the teaching team and work with the University that moulded me as a doctor. We hope to evolve the experience as the students guide us on the placement, but so far we have enjoyed having them, as much as they seem to be enjoying us!”
All You Need to Know About the Cardio-Respiratory Block

Dr Chandra Ohri, Consultant Respiratory Physician, Lead for Phase II Cardio-respiratory Block, Honorary Senior Lecturer in Medical Education

The Cardio-respiratory block is part of the Phase II junior rotation and offers students experience in Cardiology and Respiratory Medicine.

The block focuses on developing clinical skills and core knowledge as well as disease prevention, including smoking cessation. Students have a number of opportunities to gain clinical exposure including outpatient clinics, inpatients, procedure lists and admission unit attachments. As well as a 3-day Induction Programme, students attend seminars and also have the opportunity to develop problem solving skills with simulated patient (SIMS) sessions.

Students are encouraged to seek weekly constructive feedback from supervising clinicians and are eligible for Distinction Awards at the end of the block if they are nominated by their consultant tutor and do well in the end of block written assessment. There is a single Block Prize for the best performing student.

Overall the block aims to equip students with the ability to recognise and treat common cardio-respiratory diseases, as well as develop the necessary clinical and generic skills required to become a successful doctor. The block could not run effectively without the help and commitment of my colleagues and the exceptional organisational skills of Susie Sananes, block coordinator, to whom I am extremely grateful.

Q1. What does the block lead role entail?
I am responsible for ensuring that students complete the block and receive a good clinical grounding in cardiology and respiratory medicine irrespective of base hospital. This involves ongoing liaison with colleagues at Burton, Glenfield, Kettering and Northampton Hospitals, as well as the Clinical Skills Unit team at Leicester Royal Infirmary. I have also been able to develop further Medical School roles, such as collaboration with Phase I tutors.

Q2. What are the key challenges of the role?
One key challenge is covering all aspects of the cardio-respiratory curriculum within seven weeks. Time is short and I feel that colleagues are often stretched and unable to offer as much teaching time as they would like to.

Q3. What do you consider to be the main areas of good practice within the cardio-respiratory block?
As a result of developments to the block over the last 2 years, including an established Induction Programme, regular seminars, increased bedside teaching, SIMS development, refined workbooks and an end of block assessment, student and Medical School feedback has been good. I feel that close liaison with colleagues at all hospital sites has been beneficial, ensuring quality training no matter where students are based. The introduction of Prizes and Distinction Awards for high performing students has also been well received.

Clinical tutors are encouraged to provide regular constructive feedback to help students develop. Outstanding organisation from Susie Sananes ensures that students have a clear point of contact, that teaching delivery runs smoothly, and that tutors also receive good support.

Overall, one of the greatest rewards comes from seeing students that I have trained, qualify and, perform well as Foundation doctors and beyond.

The Medical School would like to wish all our clinical teachers and other health care professionals who teach our students, a Happy Christmas and a prosperous 2015!
End of 4yr Graduate Entry to Leicester MBChB

The 4 year graduate entry medicine (GEM) course at Leicester is based on the 5 year programme, with the belief that all parts of the curriculum are important and should be covered. Accelerated delivery is achieved by condensing phase 1 from 2.5 to 1.5 years, allowing all students equal time in phase 2, the clinical years.

The Medical School is redesigning the curriculum to produce graduates better prepared for the modern workplace. This will involve shortening phase 1 of the 5 year degree to 2 years giving more time in the clinical years. Because it was not feasible to design an accelerated phase 1 curriculum for a GEM course without the additional resources required to offer an entirely separate GEM course, the decision was taken to phase out the GEM course. The final entry will be September 2015.

Together stakeholders created a set of key principles, multi-professional training and education standards, a process for managing the visits, an annual assessment tool, a new style outcomes report and a balanced scorecard. Through a series of workshops, we explored strengths, good practice and innovation, acknowledging the importance of highlighting areas of concern early, so that education providers can manage them safely, quickly and effectively.

The involvement of the wide range of key stakeholders contributed to an energy and commitment to drive this agenda forward. By building a vision together, putting patients at the heart of the process and building on what currently works well, we created a process of change that everyone is positively engaged in and that will allow us to demonstrate the highest possible quality of education and training in the East Midlands.

Together with key partners within each Trust, we have gathered intelligence about where concerns have arisen and where there is a potential risk to the delivery of training and education programmes. We have also gathered intelligence on where education and training is working well and good outcomes are happening for learners across the medical, nursing and clinical professions. This has enabled us to effectively plan and conduct our visiting schedule.


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