

A photograph of a man and a woman in professional attire sitting at a table. The man, on the right, has curly brown hair, wears glasses, a white shirt, a dark vest, and a patterned tie. He is looking down at a document on the table. The woman, on the left, has long blonde hair and is also looking at the document. The background is a plain, light-colored wall.

Supported from the start;
ready for the future;
The Postgraduate Medical
Foundation Programme Review

Developing people
for health and
healthcare

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Foreword

The review of the foundation programme in England is one of the core threads of HEE's programme to reform medical education. We started this journey with partners in the Spring of 2018. Our conclusions and recommendations within this report provide an important and timely contribution to delivering the aspirations for medicine set out in the NHS Long Term Plan and subsequent Interim NHS People Plan.

Foundation training is a momentous stage in the education of our future doctors. It forms the bridge between their learning as undergraduate students in medical school and the transition into serving patients at the frontline of our NHS. The vast majority of foundation doctors have an enriching experience during their foundation training. However, there is more the NHS must do to support them through this crucial phase of their development by ensuring they receive the highest quality educational support and supervision as well as the protected time they need to consolidate their progression.

In particular, those who find their undergraduate studies in medicine more difficult than others deserve to be better supported. For example, by enabling them to train closer to their support networks or in locations of their choice, we can better realise the potential of these doctors early in their careers. The 'special circumstances' process aims to provide this for some graduates. However,

there is variation in its application often through lack of awareness or scarcity of opportunity, particularly in large foundation schools. We will therefore consult on how we can better apply the principles of special circumstances processes in order to make it accessible to a broader range of students.

I am passionate about widening participation into medicine. Despite recent efforts, not least through the five new medical schools established as part of the recent expansion of undergraduate medical places, the lack of students from disadvantaged and lower socio-economic backgrounds still remains a reality. HEE is working with the Medical Schools Council and medical schools across England to expand opportunities and widen access to undergraduate study in medicine. Through this review, we have debated how we can better facilitate the access of graduates from widening participation backgrounds into foundation training.

We will, therefore, launch a formal consultation on how the NHS can best achieve this, in order to ensure that those with the potential to become a doctor are given every opportunity through an appropriately supported start in foundation training. In turn, this will ensure our NHS better reflects and understands the needs of its patients into the future.

Finally, we know that some healthcare systems in England struggle to attract and retain doctors at all stages of their careers. Providers and geographies

that provide foundation training placements have a responsibility to do more, as employers, to address these challenges. Concerted efforts to attract, value and support trainees in these areas like providing high-quality exposure in specialties where there are shortages, could transform the likelihood of retaining these doctors throughout their training careers and into their working lives as consultants and GPs.

To support this endeavour HEE has made a commitment through the Foundation Review to preferentially distribute the 1,500 additional medical graduates to the most under-doctored locations as they incrementally enter their NHS careers on foundation programmes from 2023 onwards.

In parallel, we want to prepare the ground for their foundation training and begin to address the distribution imbalances, particularly in remote, rural and coastal geographies. We also want to address the choice of specialty of foundation doctors. From August 2019, HEE will launch a range of Foundation Priority Programmes to attract and retain trainees in these areas and provide enhanced exposure to specialties with the greatest shortages (with our initial priority of psychiatry). These programmes will be advertised and appointed to earlier in the recruitment process. They will seek to provide a range of enhancements

like additional educational components, leadership development, fellowships, longitudinal study and enhanced employer offers in hard-to-recruit regions. These are being developed and delivered in partnership with foundation training providers and provide an ideal opportunity for emerging Integrated Care Systems to use their leverage to attract and retain trainees.

I would like to thank Sam Illingworth, Director of Education Quality & Reform and Professor Sheona MacLeod, Deputy Medical Director for Reform at HEE, for their leadership of this programme and look forward to the next stage of this important piece of work.

Professor Wendy Reid
Medical Director and Executive Director of
Education & Quality, HEE



I am pleased to share this report, which details the conclusions of the wide-ranging discussions held across many workshops, focus groups and working groups over the last year. We have enjoyed the challenge and support provided by those who have worked with us and helped co-create a set of recommendations which we believe can make a significant difference to the training experiences of trainee doctors and to future patient care.

This report focuses on how we improve training for doctors in the most junior stage of their training pathway but it also highlights many issues that are relevant across all healthcare education, training and personal development. The importance of feeling valued, working safely and having time to learn and develop are clear whatever stage of learning development or teaching you are at. This review highlights the importance of making the NHS an appropriate environment for individuals to learn and work, echoing a key theme in the Interim NHS People Plan.

The contributions from foundation and specialty doctors in training and their representatives, lay partners and senior educational leaders have been essential to enable us to fully explore the issues and develop possible solutions. The review

also had input from a number of individuals and organisations like postgraduate deans, foundation school directors, the Royal Colleges, the Medical Schools Council, the General Medical Council (GMC) and the British Medical Association (BMA). It has heard from NHS employers, representatives from the devolved nations, education and training bodies and health professionals involved in a similar programme in Malta.

The different perspectives and views have helped shape both the structure of the Foundation Review and its recommendations and we have learnt from, and with, everyone involved. We would like to thank all those who have taken part in this review for their valued contributions and for the time and enthusiasm that they generously gave.

We would also like to thank the programme team and Dr Nick Spittle, Dr Tony Choules and the Chairs and members of the various working groups, for their support in delivering, co-ordinating and linking across this programme.

We look forward to continuing to work with the many partners involved as we start to implement our shared recommendations and to consult on some of the important initiatives presented in this report.

Professor Sheona Macleod



Sam Illingworth



Executive Summary

This report details the findings of a review into the delivery of the UK Foundation Programme, which prepares graduates from medical school for specialty training. The report and its recommendations have been developed by HEE and as such, its focus is the delivery of the foundation programme in England. The findings and recommendations have been developed in partnership with, and are relevant to, all the four nations of the UK.

This review is timely as current models of care are evolving. Technology and digital health will change healthcare provision and the needs and expectations of patients, and doctors are changing. There will be an additional 1,500 medical students in foundation training in England from 2022/23 with graduates from five new medical schools helping provide a more equitable geographical spread. As a result, it is hoped that doctors will remain in foundation posts in those areas. These doctors and indeed all doctors in training regardless of grade, need high-quality learning environments at a time of increasing pressures in the NHS, and in parallel with a need to expand education and training opportunities for a range of healthcare professionals.

The Foundation Review was structured and delivered based on collaborative co-design with a wide range of stakeholders, including doctors in training. The review report is structured around six key themes, deemed to be the elements most in need of consideration:

- It aimed to clarify the purpose of foundation training to see how expectations had evolved and were currently being met
- It explored how the programme could help address medical workforce issues relating to geographic and specialty shortages and the academic medical supply
- It considered how the foundation programme could better support widening participation and equal opportunity for all with the potential and desire to enter medicine
- It considered whether doctors were able to make informed career choices for specialty recruitment towards the end of the programme
- It recognised the need to support and value this junior workforce and those who educate and train them in line with the Interim NHS People Plan aspirations, and
- It considered, throughout, the need to work in alignment with our partners.

A key finding was that it is important for both patients and doctors that there is recognition of the different skills and competencies of doctors at various stages of training and that there are significant differences between the two foundation years. The review highlighted that, in order to maximise the potential of the medical workforce, doctors in training need to be supported to learn and develop with appropriate supervision at this stage in their careers. This should happen across a range of specialties as they are working, usually for the first time, to provide frontline medical services as part of a multi-professional team.

The review found that there are elements of the delivery of training which can and must be improved, as detailed in the recommendations. It also sets out the strategic direction for adaptations to the programme that would address important issues such as widening participation into medicine on which we will further consult with our key partners.

The recommendations are;

| Shared Recommendations | |
|------------------------|--|
| 1 | The transition for, and preparation of, those entering Foundation training must be improved to better prepare foundation doctors for the next stages of their development. |
| 2 | HEE will consult with stakeholders to define the principles which should govern an expansion in the use of pre-allocation due to 'special circumstance' to make it accessible to a broader range of students. |
| 3 | HEE will develop and consult on policy options to support Widening Participation initiatives for graduates entering the Foundation Programme. |
| 4 | HEE will work with NHS Employers to develop a Foundation Doctor Charter defining how Local Education Providers (LEPs) will support Foundation training, including best practice and minimum standards. |
| 5 | Doctors who do not progress to training directly from FY2 will be able to access on-going support via their Foundation School and return to training support initiatives such as Supported Return to Training (SuppoRTT) will be encouraged for those who have spent time away from NHS practice. |
| 6 | HEE will establish a common framework for early years careers support, in line with NHS People Plan, to better inform the expectations of doctors in training about the changing needs of the NHS in England. |
| 7 | HEE will preferentially distribute the 1500 Foundation Doctor training places in the geographies where the NHS most needs them in alignment with regional plans to support population healthcare needs and local specialty recruitment. |
| 8 | During 2019/20 and 2020/21, HEE will introduce and evaluate a number of Foundation Priority Programmes, specifically designed to attract and retain trainees in: Remote, rural and coastal geographies, under doctored geographies and shortage specialties, aligned to the Long-Term Plan with Psychiatry as the initial priority |
| 9 | HEE will work with the relevant UK bodies to introduce and evaluate adaptations to specialty and foundation programme application and allocation processes to help address geographic variations in fill rates. |
| 10 | HEE will work with Foundation Schools to identify opportunities to enhance support to doctors with specific needs including wider use of supportive placements. |
| 11 | Foundation Schools will support greater flexibility in foundation training, including expanding access to Less Than Full Time Training (LTFT) and allowing access to a greater variety of working patterns and percentages of full time. |
| 12 | LEPs must ensure that Foundation supervisors are valued and have appropriate training and skills and specific time allocated for their roles. |
| 13 | Senior trainees should be encouraged to take on the role of mentors. Trusts should develop this based on successful local 'good practice' schemes. To support this, HEE working with the Academy of Medical Royal Colleges (AoMRC), will develop plans for a sustainable model for the role of senior trainees as mentors, including how such a role could be incorporated as a training opportunity for senior trainees. |
| 14 | HEE will engage with key stakeholders to assess how Foundation doctors can be given time in the working week for professional self-development ('self-development' time). |
| 15 | HEE will work with the devolved administrations and the AoMRC to explore the need for a structure to support for the foundation programme and faculty. |
| 16 | There should be a local academic lead involved in the design and running of research in AFP programmes to ensure good integration with the training and wider local research community, and links to NIHR. New options for AFP recruitment should be agreed to ensure those without research experience are not excluded from academic foundation training. Priority Foundation Programmes should be developed for management and leadership, QI and education and teaching with a similar structure to academic programmes. |

Introduction

Context

The UK Foundation Programme is a key stage along the continuum of training, bridging the gap between medical school and specialty training. The programme has undergone significant evolution since its inception in 2005 and is considered a world-leading programme of training for newly-qualified doctors that has influenced the development of similar programmes internationally.

Under the leadership of Professor Wendy Reid, HEE is working with partners and stakeholders across England and the UK devolved administrations to progress postgraduate medical education reforms to benefit patients and doctors. A key component of this is to consider how the medical workforce can better support the long-term vision of the NHS, including how medical training may be reformed to better produce the required supply of doctors in the right geographies and specialties, and with the appropriate skills, attributes and experience to deliver care in the ever evolving landscape of modern healthcare. Fundamental to delivery of these factors are high-quality learning environments for trainees. Although the focus of this report is for England, the findings and recommendations have been developed in partnership with, and may be relevant to, all the four nations of the UK, and others with a similar foundation programme such as the model seen in Malta. The NHS Long Term Plan¹, published in January 2019 and subsequent NHS Interim People Plan², published in May, set the direction for the future of medical education in England, outlining reforms including:

- Exploring how medicine can shift from a dominance of highly specialised roles to provide a better balance of generalist skills for all doctors.
- The development of incentives to ensure that the specialty choices of trainees meet the needs of patients by being better aligned with the specialty and geographical requirements of the NHS.
- Offering increased flexibility to doctors in training, part of a long-term HEE-led programme to enhance the working lives of doctors in training.



¹ NHS Improvement - NHS Long Term Plan, January 2019 <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf>

² NHS Improvement - Interim NHS People Plan, June 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/interim-nhs-people-plan_june2019.pdf

Models of healthcare provision are evolving with prevention, population health and community-based care becoming increasingly important. In February 2019, the Topol Review outlined how new technology and digital are changing the skills required by the future healthcare workforce. Medical training, from undergraduate to postgraduate and beyond, will need to reflect these changes in order to ensure effective doctors. As the needs and expectations of patients evolve, so too do the expectations of doctors of their career in medicine. Increasingly doctors are demanding training pathways which offer more flexibility, with more control over how, where and when they train.

The Foundation Review also considered the impact and strategic need of the additional 1,500 medical students who will progress to foundation training incrementally from 2022. The location of five new medical schools (in Sunderland, Liverpool, Chelmsford, Lincoln and Kent) provide a more equitable geographical spread of medical graduates. A key requirement of the new medical schools was to develop programmes to help to address some of the current recruitment issues, including widening participation initiatives and ensuring focus on General Practice and Psychiatry³.

These themes underpin the focus of this review, and their delivery is dependent upon an effective foundation programme, which in turn is dependent on high-quality learning environments.

The Foundation Programme Review Structure

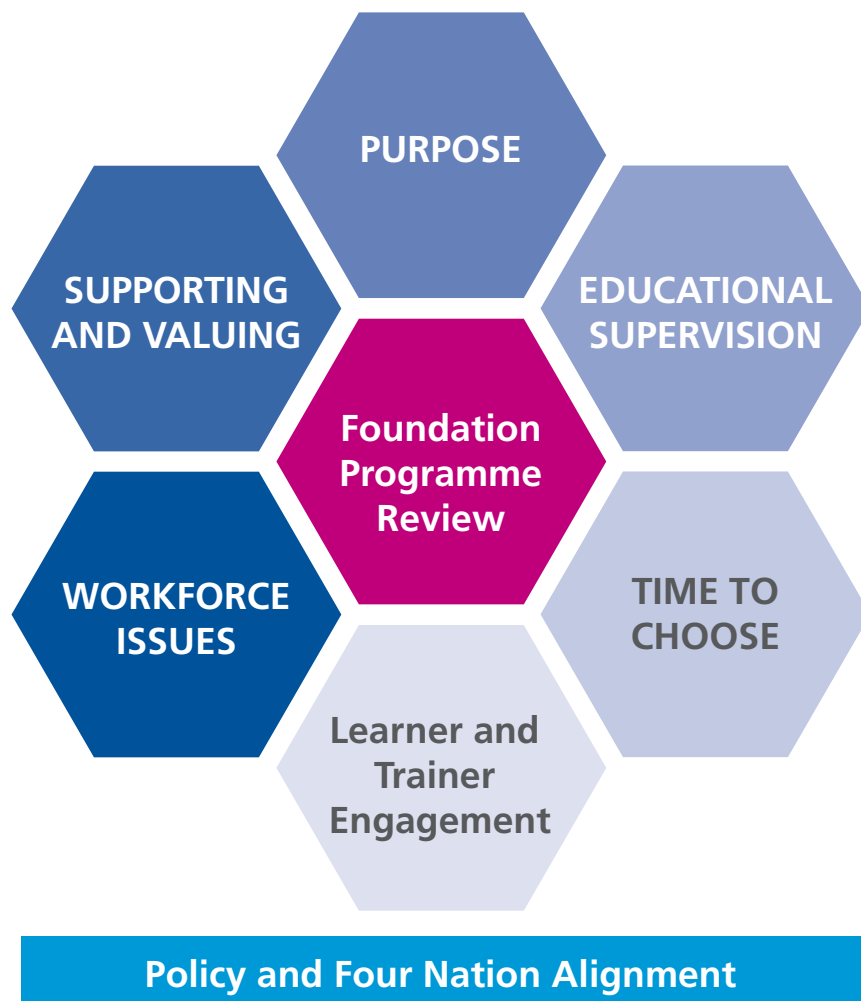
This review has been conducted with medical students, trainee doctors and their representatives, senior educational leaders including postgraduate deans, foundation school directors, the Royal Colleges, medical schools and the GMC, as well as NHS employers and representatives from the devolved nations and Malta, where a similar programme operates.

The structure of the Foundation Review and the outcomes contained within this report are the product of a collaborative co-design with this wide range of stakeholders. The review was launched via an initial system-wide design event which developed its scope. It was organised across six key working groups overseen and chaired by HEE postgraduate deans and foundation school directors.

To ensure that the ambition of this report is realised and the recommended changes to foundation training are delivered, HEE will publish an implementation plan for England to accompany this report. This will set out how each of the recommendations will be delivered and monitored and evaluated.

³ Department of Health Expansion of Undergraduate Medical Education August 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/636527/Expansion_undergraduate_medical_education_consultation-response_2_.pdf

The key working groups



1. **Clarify the purpose:** To assess whether the original purpose and vision of the foundation programme is being met and is still appropriate and, if not, identify required changes
2. **Time to choose:** To consider how the programme can ensure that foundation trainees are given appropriate exposure to specialties and the time and support needed to choose future specialty options
3. **Workforce issues:** To consider how the foundation programme might address current and future workforce issues. In particular focusing on expansion linked to increased medical student numbers
4. **Supporting and valuing individuals:** To explore how foundation trainees can be best supported across the programme and empowered to take responsibility for their training
5. **Education support:** To consider how foundation training is supported and what changes and improvements might be appropriate
6. **Four nation and policy:** As the foundation programme is UK-wide, one workstream focused on ensuring thinking aligned with the GMC as regulator and the AoMRC for curriculum development and with future planning for postgraduate medical education across the four UK nations.

The working groups comprised panels of experts from our broad stakeholder groups who developed initial recommendations. These were tested and refined over the course of the review through further consultation, including large stakeholder events, smaller focus groups involving foundation doctors and trainers, and discussions across national NHS bodies.

HEE supports the proposal to bring full GMC registration forward to the point of graduation from medical school, in line with the UK-wide Shape of Training Review, led by Professor David Greenaway. Although the review did not consider this, the final recommendations can be delivered should the point of full registration be moved.

Finally, it is important to note that while the foundation programme is delivered across all four UK administrations, this review is focused primarily on its delivery in England. However, throughout the review, engagement and co-design has been undertaken with colleagues from Scotland, Wales and Northern Ireland to ensure that consideration is given to the impact any of the findings and recommendations may have upon the devolved administrations.



Chapter 1: The Purpose Of The Foundation Programme

History

The concept of a two-year foundation programme was introduced by Sir Liam Donaldson, in his report *Unfinished Business* in 2002⁴. Following a number of pilots, the foundation programme was rolled out across the UK in 2005 as part of the Modernising Medical Careers (MMC) programme⁵.

The stated aim of the new FY2 year was “to imbue trainees with basic practical skills and competencies in medicine and will include: clinical skills; effective relationships with patients; high standards in clinical governance and safety; the use of evidence and data; communication, team working, multi-professional practice, time management and decision making and an effective understanding of the different settings in which medicine is practised”⁶. Also, for the first time, newly-qualified doctors had a formal curriculum with defined outcomes that had to be evidenced using workplace-based assessments for them to progress to specialty training.

The foundation programme has continued to evolve over subsequent years. In response to the 2008 *Aspiring to Excellence* report on MMC by Professor Sir John Tooke⁷ an increased emphasis on the management of chronic diseases was introduced into the curriculum.



⁴ Donaldson report - Proposals for reform of the Senior House Officer Grade A report by Sir Liam Donaldson Chief Medical Officer for England A paper for consultation August 2002

⁵ Department of Health, 2004, Modernising Medical Careers, The next steps: https://webarchive.nationalarchives.gov.uk/20110929193948/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4079532.pdf

⁶ Donaldson report - Proposals for reform of the Senior House Officer Grade A report by Sir Liam Donaldson Chief Medical Officer for England A paper for consultation August 2002

⁷ *Aspiring to Excellence* Prof Sir John Tooke, January 2008 http://www.asit.org/assets/documents/MMC_FINAL_REPORT_REVD_4jan.pdf

In 2010, a formal evaluation of the foundation programme, Foundation for Excellence by Professor John Collins,⁸ recommended a number of further changes to the foundation programme. The current review considered the progress made on the changes recommended by Professor Collins – these are detailed in Appendix 6.

In 2014, Health Education England's Broadening the Foundation Programme report⁹ responded to issues raised in both the Collins report and the 2013 Shape of Training report¹⁰ by setting in progress a phased transition to there being less dominance of surgical and medical posts in foundation rotations, all foundation doctors gaining experience in a community-based post and 22.5% of all Foundation Year 1 (FY1) and Foundation Year 2 (FY2) trainees rotating through a psychiatry post¹¹.

In 2016, the UK Medical and Dental Recruitment and Selection (MDRS) careers planning group explored how foundation and other doctors could be supported throughout their career¹².

The foundation programme is now recognised internationally as a leading scheme for the training of newly-qualified doctors and is consistent with the development of similar programmes around the world in countries like New Zealand, Canada, Japan, Malta and Australia. The foundation programme undertook a literature search which mapped, compared and considered foundation training models in other countries in order to benchmark against the UK foundation programme. Please see [Appendix 3](#) for details into this literature search.

Why A Foundation Programme?

The review acknowledged that, in the context of the healthcare systems across the UK, the purpose of postgraduate medical education is to introduce sufficient numbers of highly-skilled doctors to the workforce to provide the required level of medical care to the population.

The foundation programme is the only part of the continuum of medical education common to all UK medical graduates. It ensures that newly-qualified doctors have the opportunity to work and learn in the NHS, to develop their clinical and professional skills in the workplace in preparation for progression to core, specialty or general practice training. It also provides a mechanism for assessing those skills and providing extra support if needed.

It is worth highlighting that foundation doctors, as do most doctors in training, learn while providing service - the balance and form being dependent on stage, grade specialty, curriculum and learning needs.

⁸ Foundation for Excellence An Evaluation of the Foundation Programme Professor John Collins 2010 https://www.copmed.org.uk/images/docs/1314194412_fhWH_foundation_for_excellence_an_evaluation_of_the_fou.pdf

⁹ Broadening the Foundation Programme Recommendations and implementation guidance 2014 <https://www.hee.nhs.uk/sites/default/files/documents/Broadening%20the%20Foundation%20Programme%20-%20Recommendations%20and%20implementation%20guidance.pdf>

¹⁰ Securing the future of excellent patient care, Final report of the independent review Led by Professor David Greenaway, October 2013 https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

¹¹ Broadening the Foundation Programme Recommendations and implementation guidance 2014 - Appendix 1: Guidance for LETBs <https://www.hee.nhs.uk/sites/default/files/documents/Broadening%20the%20Foundation%20Programme%20-%20Recommendations%20and%20implementation%20guidance.pdf>

¹² MDRS Careers Strategy <https://www.nwpgmd.nhs.uk/sites/default/files/MDRS%20Careers%20Strategy%20July%202016%20%281%29.pdf>

Overview Of Foundation Training

Reflecting upon the development of the foundation programme to date and the evolving requirements of the doctors of the future, the review considered the core purpose of foundation training. Several key functions are identified for the programme ([see box over the page](#)). Underpinning these is the recognition that the foundation programme must allow doctors to make the difficult transition from being a student to a doctor in a safe, supported environment.

Within the present foundation programme, the concept of developing generic clinical and professional skills is central. On completion of the programme, doctors should have received sufficient exposure to the breadth of medical practice including the interrelationship between physical and mental health that will allow them to progress into any core or specialty training programme, and be equipped with the knowledge to make decisions around their career within medicine.

The need for better mental health training for doctors has been apparent for some time¹³. Because most doctors (whether they choose psychiatry as a career or not) will encounter patients with mental health issues, the foundation programme should give trainees the opportunity to improve their mental health skills, whether through having a post in a psychiatry unit or through other teaching opportunities. Specialty recruitment to psychiatry may benefit from this, with foundation doctors being inspired by role models, high-quality multidisciplinary working and experience of good mental healthcare.

The key essential functions of the foundation programme are:

- To welcome future doctors to the healthcare workforce, and support for continued self-development and professional self-development.
- Provide a safe space environment in which to learn and care, allowing transition from student to doctor and an increasing level of responsibility as the programme progresses.
- Allow development of clinical skills through the delivery of patient care under supervision, taking increasing responsibility for guiding others as the programme progresses.
- While training, allow doctors to learn to play an increasingly important role in service delivery, including gaining experience in the provision of out-of-hours care.
- Offering exposure to the breadth of medicine and an introduction to the delivery of compassionate, effective care across a range of clinical environments based on an understanding of patient and service needs. Within the programme, foundation doctors should be offered additional opportunities to develop specific skills such as research, management and quality improvement.
- To be able to demonstrate the professionalism expected of doctors, for those they care for, the healthcare system in which they work and the requirements of the regulator.
- Develop an interest in pastoral care, moving from self-care to the support of other foundation doctors where appropriate.

¹³The Five Year Forward View for Mental Health – February 2016 - <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

- Develop the ability to learn while working, ensuring self-directed learning through the seeking out and giving of feedback where appropriate.
- Future proofing the doctor, by instilling a lifelong commitment to learning and improving practice.
- Establishing a professional careers portfolio which will allow the doctor to demonstrate up-to-date clinical practice.
- The independence and preparedness to progress through the foundation programme and into specialty training.

Details of how these apply to FY1 and FY2 are given later in the chapter.

Key functions of the two levels of foundation training

The foundation programme should teach generic skills that will provide doctors capable of entering any core or specialty training programme and provide a 'safe space' to transition from student to doctor. Within this, there are two levels of foundation training.

The purpose of Foundation Year 1 is to provide a safe transition from the undergraduate/student role to the postgraduate/healthcare provider role. This is the point at which the newly-qualified doctor takes on the professional responsibility for patient care for the first time. To achieve this, FY1 placements would usually be expected to last four months although where good educational reasons and practice exist, other formats could be considered.

Foundation Year 2 involves the development of independence, decision-making skills and the opportunity to develop other professional skills more extensively. In order to achieve this, a number of placements are required. The length of most FY2 placements is likely to remain at four months although in certain circumstances, six-month or longitudinal placements could allow more in-depth experience.

The review showed strong consensus that these skills are best facilitated by placing the newly-qualified doctor in a supported role on the frontline of patient care as part of multidisciplinary teams.

The purpose of foundation training as defined by the review.

Within the functions required from the programme, the review concluded that there is a clear distinction between the purposes of each year of the two-year programme.

The purpose of Foundation Year 1 is to provide a safe transition from the undergraduate/student role to the postgraduate/healthcare provider role where the newly-qualified doctor takes on some of the professional responsibility for patient care for the first time. The review found strong consensus that this transition was best facilitated by placing the newly qualified doctor in a supported and properly supervised role on the front line of patient care, as part of multidisciplinary teams.

At present the GMC requires one year of working as a provisionally registered FY1 before full registration is awarded. There have been suggestions elsewhere, including in the Shape of Training Report that the point of full registration should move to the time of medical school graduation. The review discussed the current length and format of FY1 and concluded that the recommendations would remain relevant and workable should the point of registration change.

The purpose of Foundation Year 2 is to enable a doctor with some postgraduate experience to take up a greater degree of responsibility than is expected at FY1 level via a supported introduction to decision-making and leadership within the healthcare team. This is best facilitated by ongoing experience of front-line patient care mixed with opportunities to develop other professional skills including experience of speciality care, research, quality improvement and teaching skills.

According to the UK Foundation Programme Office (UKFPO) annual report, over 98% of foundation placements are now of four months duration¹⁴. This allows six different specialties to be experienced across FY1 and FY2. The optimal length of training placements has been debated for many years and the arguments were covered in detail in 'Foundation for Excellence' in 2010. The review heard that some foundation doctors and trainers would prefer six-month placements which allowed them more time to become familiar with one provider, but on balance the majority opinion remained that four-month placements offer the best compromise between educational benefit, service delivery and opportunity to experience a wide range of specialties. As noted above, this is a recommendation and, if good educational reasons exist, there is no reason why this should be changed. This length of placement and movement between one placement to the next should be facilitated by lead employer arrangements to ensure that foundation doctors do not have to undertake repeated new employer checks. Although the majority of foundation doctors remain with the same employer for their foundation programme, there would be benefit of adding them onto existing lead employer arrangements. This would reduce the need for them to repeat mandatory training etc, if they stay locally for specialty training. The review supports the ongoing work of the Doctors in Training programme (Streamlining), which is improving the doctor in training rotation and deployment experience.

The review also acknowledged that currently less than half of foundation doctors move immediately into core or specialty training. Many of those that do not choose to progress to specialty training, work elsewhere within medicine, returning to formal training later¹⁵. Stakeholders reported a number of reasons for this, including doctors wanting more time to explore career options, feeling 'burned out' and wanting to gain additional clinical skills or experience in areas such as teaching or quality improvement. This led to consideration as to whether providing more flexibility within the foundation programme would allow this to be accommodated without the need to step out of training.

¹⁴ UKFPO Annual Report 2016 <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-09/2016%20FP%20Annual%20Report.pdf>

¹⁵ Training pathways: analysis of the transition from the foundation programme to the next stage of training, November 2017
https://www.gmc-uk.org/-/media/documents/Training_pathways_1_FINAL2.pdf_72695703.pdf

In summary, employing organisations and HEE must ensure the foundation programme provides the following:

| Function | FY1 requirement | FY2 requirement |
|-------------------------------------|---|--|
| Welcome and support | A welcome to the healthcare workforce (especially care for those in more isolated sites) and a positive learning and working experience | Ongoing support including the provision of time for professional self-development |
| Safe space to learn and care | A supported and supervised environment to facilitate the transition from student to doctor and integrate into local team and wider medical workforce as a valued member | A supported and supervised environment to take increasing responsibility for patient care, facilitate decision making, learn to deal with uncertainty and, with support, lead the multi-professional team in the management of patients |
| Clinical skills development | Deliver direct patient care under direct competent supervision | The opportunity to build on the skills needed for direct patient care learned in FY1, to guide others in the delivery of care and, if appropriate, to learn some subspecialty skills |
| Service delivery | FY1 is about moving from student to doctor and taking responsibility both for patient care and as an employee of the healthcare workforce; including an understanding of out-of-hours care | FY2 is about taking increased responsibility both for patient care and as an employee of the healthcare workforce, including an understanding of out-of-hours care |
| Breadth of medicine | To build on the experiences of undergraduate training in the practice of medicine and the delivery of compassionate and effective care across different care settings | An opportunity to experience the practice of medicine across different care environments based on an understanding of patient needs and service needs. FY2 must also provide an opportunity to develop specific skills, research, management and quality improvement |
| Professionalism | An opportunity to demonstrate the professional responsibilities that all healthcare professionals must hold towards those for whom they care, the healthcare system in which they work and the professional requirements of the regulator in order to achieve full registration | An opportunity to demonstrate the professional responsibilities that all healthcare professionals must hold towards those for whom they care, the healthcare system in which they work and the professional requirements of the regulator |
| Pastoral care | Development of 'self-care' skills to promote resilience | When appropriate, to provide support to other professionals including FY1 doctors' and support others to develop pastoral and self-care skills |
| Learning how to learn while working | Able to self-direct their learning whereby the doctor seeks out relevant knowledge and engages in professional development by feedback and reflection | Continue to seek out relevant knowledge and engage in professional development by feedback and reflection and have confidence to give feedback to less experienced staff |
| Future proofing | Instilling a commitment to lifelong learning and an ability to improve personal practice as medical practice evolves; the career of the newly-qualified doctor is likely to span 40 years | Instilling a commitment to lifelong learning and an ability to adapt personal practice as medical practice evolves |
| Generic skills | Generic clinical and professional skills | Generic clinical and professional skills must be further developed at this stage of a doctor's career to allow holistic care |
| Careers portfolio | Establishment of a professional portfolio which for the foreseeable future is likely to remain the way a doctor will be expected to demonstrate up-to-date practice | Development of a professional portfolio which for the foreseeable future is likely to remain the way a doctor will be expected to demonstrate up-to-date practice |
| Independence and preparedness | Developing the independence that will be required of an FY2 doctor. | Preparedness to enter specialty training or other areas of the workforce under indirect and, in certain areas, under strict and specific circumstances remote, supervision. |

Chapter 2: Improving Transition And Allocation To Foundation

2.1 Transition Points

Throughout the review, we have consistently heard from doctors, their educators, medical schools and local education providers, that the transition points from medical school to FY1 and from FY2 to core or specialty training can be extremely difficult for some doctors.

Surveys show that new graduates can experience significant anxiety at the transition from undergraduate training to postgraduate practice and can feel ill-prepared for the FY1 role^{16,17}. In some cases this can be exacerbated by significant geographic movement away from their customary supportive environments, especially if the doctor is experiencing health issues or has caring responsibilities. While most newly-qualified doctors make this transition relatively easily, a significant number need additional support to adapt to the compounding stresses that affect doctors¹⁸. This may be reflected in burnout reported by foundation doctors, with the number of doctors intending to take a career break or work Less Than Full Time increasing significantly from the start of FY1 to the completion of FY2. Burnout and stress are cited as just two of the reasons^{19,20,21} however individual doctors may have other reasons for choosing to work LTFT or take a career break for individual reasons unrelated to their working environment.

It is the responsibility of all involved in the education and support of medical students and doctors in training to ensure that these transition points are managed as effectively and efficiently as possible and that all appropriate support is in place to aid this for all doctors. Work is already underway to help ensure the effective transfer of information between bodies, particularly regarding support required for significant academic difficulties and reasonable adjustments for chronic illness and/or disability. This is crucial to ensuring that LEPs are able to welcome trainees upon their arrival and ensure appropriate adjustments are in place where needed.

2.2 Preparedness For Foundation

During the review, we heard from foundation doctors that where medical schools offered a more 'apprenticeship' style final year (see Exeter case study on p20), there was an easier transition between undergraduate study and the foundation programme. This is illustrated in the Severn Foundation School administered 'Shadowing and Induction yearly survey', which suggests that medical students who identify themselves as spending a significant proportion of their final year in student assistantships or similar initiatives feel the best prepared for their role as an FY1 doctor (see chart over page²²). Similarly, we heard during the review that extending the shadowing opportunities available to foundation doctors before taking up employment, would allow them to gain insight into the expectations and pressures of working as a doctor, and this in turn would help prepare them for the transition into the work environment.

¹⁶ GMC National Training Survey <https://www.gmc-uk.org/education/reports-and-reviews/progression-reports/foundation-year-1-preparedness>

¹⁷ Medical graduates' preparedness to practice: a comparison of undergraduate medical school training, 2017 <https://bmcomeduc.biomedcentral.com/articles/10.1186/s12909-017-0859-6>

¹⁸ NHS Staff and Learners' Mental Wellbeing Commission' in Feb 2019 <https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf>

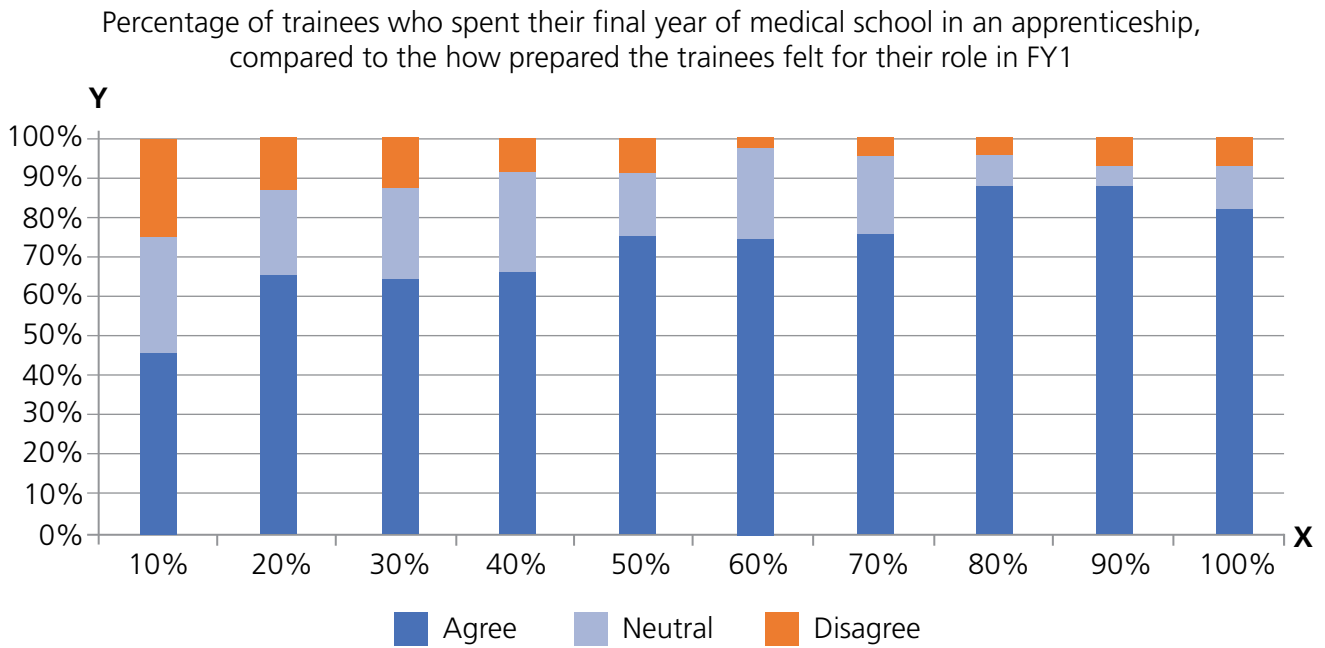
¹⁹ The UKFPO F2 Career Destination Report 2018 http://www.foundationprogramme.nhs.uk/sites/default/files/2019-01/F2%20Career%20Destinations%20Report_FLNAL.pdf

²⁰ BMA Supporting health and wellbeing at work, December 2018 <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/supporting-health-and-wellbeing-at-work>

²¹ Department of Health NHS Health and Well-being Review, November 2009

https://webarchive.nationalarchives.gov.uk/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799

²² Severn Foundation School, F1 induction survey 2018



(See REF 22)

X axis shows reported percentage of final year spent in apprenticeship

Y axis shows agreement with the statement 'I felt prepared for my role as an FY1 doctor'

Recommendation 1

The transition for, and preparation of, those entering Foundation training must be improved to better prepare foundation doctors for the next stages of their development.

- HEE should work with medical schools to maximise the number and quality of 'apprenticeship' opportunities available to undergraduate students, particularly during their final year which offer an insight into the role of an F1 doctor
- Medical schools and foundation schools should collaborate more closely to facilitate preparation of new graduates to ensure a smooth transition
- HEE should work with NHS Employers and the devolved nations to expand shadowing opportunities.

Case study – Exeter Medical School

Exeter Medical School has incorporated a greater emphasis on apprenticeship style training in its final year. The fifth year starts with five clinical blocks whereby the student shadows the doctor on a training placement as the main focus of their educational attachment. During these blocks the students complete workplace-based assessments and attend half a day's teaching per week with the rest of the time dedicated to working alongside the doctor in training. By the end of each block the students are able to act up into the role of an FY1 in all aspects other than prescribing. For the final six weeks before graduation, the students move to a full shadowing placement. At this point, they have been signed off as competent in all areas and there are no requirements to complete any assessments or attend teaching. The full focus is on shadowing the FY1 or FY2 including matching their working hours at night, at weekends and in the evening gaining valuable experience of out-of-hours work. Evaluation feedback from students who have completed this style of final year apprenticeship shows that they feel better prepared for becoming an FY1. Further evaluation is taking place from these students at the end of their FY1 but is not yet published.

2.3 Special Circumstances

Allocation to a foundation school is via a UK-wide meritocratic process. Applicants are asked to list their preference order for all foundation schools. All applicants are then ranked according to a scoring system which takes into account their educational performance at medical school and any other educational achievements such as publications and additional degrees. These are combined to create an Educational Performance Measure (EPM) which apply to all applicants along with their score in a Situational Judgement Test (SJT). Foundation school places are allocated on the basis of applicants' combined EPM and SJT scores – meaning higher scoring applicants are more likely to get their top ranked schools. Allocation to individual rotations within foundation schools is subsequently carried out at school level. As the number of applicants often exceeds the number of available programmes, the lowest scoring applicants may not get allocated to their school of choice and may, indeed, be displaced from their preferred school by higher scoring candidates who have themselves not obtained a place in their own preferred school. This means that they may not be allocated in the primary round of allocations and instead are placed on a reserve list until a programme becomes available due to either finals' failures or applicants withdrawing from the programme.

Under this allocation process, in 2018 77% of the 6,964 applicants on the primary list were allocated to their top preference foundation school and 84% were allocated to one of their top two preferences²³. However, 3% of UK graduates were allocated posts from the reserve list, meaning a significant number of newly-qualified doctors are allocated to a school that may be geographically remote from their original home or medical school. The review did look at the foundation allocation process, comparing the current allocation based on score to one based on allocating via first preference. Through the first preference methodology, 6.6% more applicants received their first preference. Although positive, it is difficult to determine whether this would occur in a live allocation environment as previous evidence shows that applicant behaviour can change significantly depending on the allocation procedure in place. A further review of allocation processes both in foundation and speciality recruitment will be undertaken as a recommendation of this review.

²³ UKFPO 2018 Recruitment Stats and Facts Report http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2018%20Recruitment%20Stats%20and%20Facts%20Report%20V2_0.pdf



Students with the lowest EPM scores are most likely to be either allocated to a foundation school lower down their preference list or from the reserve list. These are often the graduates with educational or other issues who therefore require greater support. This is counter to good educational practice and undermines the principle of the foundation programme to prepare doctors for their future.

The special circumstances process allows applicants to be pre-allocated to a specific foundation school if they meet one of four nationally agreed criteria. Only 2% of applicants make use of this process and there is significant variation between foundation schools²⁴. Some of this variation could relate to lack of awareness of the process, and some to the lack of opportunity for applicants to specify a location in very large schools. The review also heard that a process of pre-allocation to the local medical school could be of benefit to other groups of students including those who had required significant support to progress through medical school and who would benefit from foundation training close to their established support network. The ability to apply for pre-allocation to a local foundation school may also be an appropriate option to support some students who were recruited to medical school as part of a local widening participation project. Significant geographic movement might prove difficult for some of this group who could benefit from greater local choice in the allocation process.

HEE has undertaken work exploring the use of special circumstances in recruitment to specialty training programmes which has been well received by both doctors in training and their representatives which should be considered as a part of a consultation.

Recommendation 2

HEE will consult with stakeholders to define the principles which should govern an expansion in the use of pre-allocation due to 'special circumstance' to make it accessible to a broader range of students.

²⁴ UKFPO 2018 Recruitment Stats and Facts
http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2018%20Recruitment%20Stats%20and%20Facts%20Report%20V2_0.pdf

2.4 Widening Participation

HEE's Widening Participation – It Matters! Strategy²⁵, published in 2014, set out the aim for the healthcare workforce to be representative of the communities it serves. HEE subsequently published its national strategic framework to look at how organisations could create a diverse workforce. This review considered evidence which found that foundation and specialty trainees felt that there remained relatively limited representation from those from lower socio-economic backgrounds within medicine, with only 6% of participants growing up in a deprived area within the UK²⁶. This picture has improved slightly in recent years. The Higher Education Statistics Agency report that in 2016, 16% of medical students were from POLAR groups 1 and 2²⁷, compared with 26% of the wider student population. Work is underway to improve this further. The award of new medical school places (see [Chapter 3](#)), considered how existing medical schools being awarded more places could offer more 'Gateway' schemes, and the creation of new medical schools was in part based upon proposals to help widen participation in medicine.

Effective widening participation initiatives provide access to education, employment and development opportunities for under-represented individuals (and groups) helping them to realise their personal potential and, in doing so, reduce cultural, social and economic disadvantage. However, there can be a significantly greater impact on the individual when there are financial pressures from geographic movement at an early stage in their medical career or from a perceived need to pay for additional courses and qualifications in order to be competitive when applying for specialty training posts. We heard that some students from a widening participation or under represented background left medicine for financial reasons. In order for these initiatives to succeed, greater attention must be given to the financial impact of training processes.

In addition, widening participation should be a greater part of our approach to workforce planning and development to better enable an NHS workforce that is more representative of the communities it seeks to serve. This is a central tenet of the NHS Constitution (2013)²⁸ and is a key driver for the work that HEE supports.

In this context, the foundation programme could provide support to students who were recruited to medical school as part of a local widening participation initiatives. Such support may include offering the option of pre-allocation to the local foundation school.

Recommendation 3

HEE will develop and consult on policy options to support Widening Participation initiatives for graduates entering the Foundation Programme.

The most effective initiatives need further exploration and HEE will engage more widely to scope the policy options on which it will consult during 2019/20.

²⁵ Widening Participation – It Matters, October 2014

https://www.hee.nhs.uk/sites/default/files/documents/Widening%20Participation%20it%20Matters_0.pdf

²⁶ GMC National Training Survey 2013 p2&3 https://www.gmc-uk.org/-/media/documents/Report_NTS_Socioeconomic_Status_Questions.pdf_53743451.pdf as cited within Widening Participation – It Matters, October 2014 p27 https://www.hee.nhs.uk/sites/default/files/documents/Widening%20Participation%20it%20Matters_0.pdf

²⁷ Higher Education Statistics Agency <https://www.hesa.ac.uk/data-and-analysis>

²⁸ NHS Constitution, July 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

2.5 Transition To Foundation

Foundation doctors reported that the four days spent shadowing before beginning their placements as foundation doctors were valuable. However, feedback suggested this period was not used to its full potential because of time pressures. As an essential part of the transition from student to doctor, this opportunity must be maximised.

After discussion, the opinion of many of experts on the review was that an induction for FY1 doctors should involve a period of around ten days based on the current practice of four to five days' shadowing the outgoing FY1, two days of mandatory training/induction and two days of a 'sick patient' course. Such arrangements would benefit both the Trust and foundation doctors because well-executed induction processes enable effective and safer training environments. It would also increase the confidence of new doctors by giving them the opportunity to become familiar with the processes applied to the environment in which they are to be working. Please see [Appendix 5](#) for an example of a model induction.

While training in work-based environments, foundation doctors also contribute to valuable service delivery. However, the primary aim of these placements is to provide training that allows them to become competent as more senior doctors. We heard from a number of foundation doctors and trainers on the working groups that there can be significant issues with departmental inductions and they often lack relevance to the foundation doctor's role. To ensure the safety of doctors and patients and adequate supervision of out-of-hours work, it is essential to make sure there is an appropriate handover at the start of each shift and the opportunity for rest breaks. However, we heard these often do not happen. These are covered in greater detail in Chapter 4 of this report.



To become confident and competent practitioners, FY1 doctors must be involved in the hands-on delivery of patient care for a significant part of their working day. During this time, it is critical that they are directly supervised in their practice with immediate access to senior support at all times. As they are not fully registered with the GMC they should not be responsible for the unsupervised discharge of patients and are usually limited to some degree in their prescribing. However, most patients and many staff do not recognise the distinction between the abilities of doctors at different stages of their training which can lead to inappropriate expectations and could be a risk to patient safety. Good practice with clear understanding of the different levels of responsibility and competency at different grades is important, as are an awareness of which tasks are appropriate to their level of training and proper supervision. It is therefore essential that Local Education Providers educate all members of the multi-professional clinical team on the relative inexperience of FY1 doctors and allow them to develop as a part of a supportive, nurturing team. This means that FY1s should be encouraged, as part of the multidisciplinary team (MDT), to discuss wider patient care concerns with other professionals. The MDT should be aware that in instances where the FY1 will need to seek clarification with their senior colleagues, that they will do so in a timely manner.

The review recognised the importance of learning all aspects of the role of the doctor, although some tasks cease to provide useful learning with excessive repetition and interfere with training opportunities. Where this is the case, training providers should review their workforce skill mix and distribution to enable foundation doctors to maximise the learning potential in the placement, which can also benefit service effectiveness.

Successive national surveys of FY1s in their first post have indicated the considerable stress and anxiety felt by many newly-graduated doctors^{29,30}. The review heard about the importance of both pastoral support from the LEP and support from peers in ameliorating this anxiety and stress. It also heard that FY1s whose first post was outside an acute hospital environment, for example, in a geographically remote psychiatry unit, sometimes felt isolated from peer support. They also felt their skills in acute care diminished which led to significant stress when placed in an acute setting for their second FY1 post.

Foundation schools will therefore ensure that any initial FY1 post based outside an acute hospital setting is a high-quality post which has appropriate measures in place to ensure peer support and the maintenance of acute care skills. Initiatives such as Longitudinal Integrated Foundation Training (LIFT) have shown that innovative educational approaches can maximise learning and the value placed on primary care. HEE is exploring this further with similar initiatives in mental health training.

One of the main concerns expressed by doctors in training is the anxiety they feel when dealing with the acutely unwell patient and the associated human factors and communication required. As required by a spiral curriculum, revisiting some undergraduate teaching to consolidate existing knowledge is vital for maintaining confidence and competence. A review undertaken by foundation school directors³¹ of commonly used training scenarios around the very sick patient produced a list of the most beneficial common acute simulation packages ([see table over the page](#)). The review found that overall there is evidence that simulation-based training can contribute towards improving trainee doctors' skills and

²⁹ GMC National Training Survey <https://www.gmc-uk.org/education/reports-and-reviews/progression-reports/foundation-year-1-preparedness>

³⁰ Severn Foundation School, F1 UK Induction Survey stats analysis 2018

³¹ Work undertaken by Dr Julian Chilvers, Consultant Anaesthetist, Director of Medical Education SWBH Foundation School Director – West Midlands Central via the FSD committee to inform the work of the Education Support group as part of a West Midlands Scoping Exercise (14 trusts within West Midlands and data from the Wessex Foundation School website).

knowledge around patient safety, with some limited case-based evidence demonstrating direct impact³². The encouragement of simulation-based training on these scenarios helped foundation doctors to manage acutely unwell patients. It is therefore essential that LEPs provide foundation doctors with high-quality training that covers these core emergency situations and focuses on patient/carer communication, human factors, leadership and team-working skills, including appropriate debrief.

| Acute Simulation Packages | | | |
|--|------------------------|-------------------------------|------------------------------------|
| Cardiac Arrest/ Acute Coronary Syndrome (ACS) | Major haemorrhage | Diabetic Ketoacidosis (DKA) | Anaphylaxis |
| Asthma/ Chronic Obstructive Pulmonary Disease (COPD) | Sepsis | Trauma | Supraventricular Tachycardia (SVT) |
| Pulmonary Embolism (PE) | End of life/bad news | Seizure/reduced consciousness | Acute mental health |
| Congestive Cardiac Failure (CCF) | Drug/blood admin error | Ischaemic stroke | Frailty |

Recommendation 4

HEE will work with NHS Employers to develop a Foundation Doctor Charter defining how Local Education Providers (LEPs) will support Foundation training, including best practice and minimum standards.

This will cover the need for Local Education Providers to meet the requirements for training:

- **Recognise the anxiety and, in some cases, isolation experienced by foundation doctors and take steps to ensure they are welcomed as valued employees and integrated into the existing workforce.**
- **Ensure other healthcare staff are aware of the relative inexperience of foundation doctors compared with other doctors so they can develop their skills within a safe and appropriately supported environment.**
- **The minimum requirements for foundation training, include:**
 - **Ensure that at all times while providing clinical care, the foundation doctor has a competent named individual to whom they can escalate any concerns or queries.**
 - **When undertaking work out-of-hours the foundation doctor has an appropriate handover at the start of the shift and has the opportunity to take rest breaks.**
 - **Foundation doctors should have access to high-quality training covering core emergency situations and appropriate sharing of tasks in out-of-hours shifts.**

HEE will work with providers to ensure these are implemented at scale and pace, and that progress and quality will be reviewed through the HEE quality framework.

³² Deshmukh, A. 2018. Does simulation in medical foundation training lead to improvements in patient safety? Redhill: Surrey and Sussex Library and Knowledge Services

2.6 Transition From Foundation To Core/ Specialty Training

At the inception of the foundation programme, the expectation was that on completion of FY2 the doctor would progress to specialty training. The review acknowledged the current trend for more than half of those completing the foundation programme to take one or more years out of training^{33,34}. Many of these doctors remain in the healthcare workforce either on a regular or ad-hoc basis but the review noted the detrimental effect this uncertainty can have on workforce planning. Doctors currently in training told the review that deferral of entry to specialist training was because of many factors including 'burnout', the limited time trainees have to make career decisions and a desire to gain other experiences and skills, both within and outside of medicine³⁵. While a number of the recommendations of the review may influence this, it is likely that a significant number of trainees will continue to take time out of training after FY2.

Data from the 2018 UKFPO FY2 Destination Report reinforces the need for careers support to be available to both foundation doctors and those taking time out of formal training after completing FY2. Only 49.7% of new FY1s, starting in 2016, intended to progress directly to specialty training and 35% of these doctors subsequently changed their choice of specialty during foundation training. Only 37.7% of FY2s actually progressed directly to specialty training³⁶. The review heard that, because of the time pressures of work and maintaining a portfolio, many foundation doctors had not prioritised career planning and instead intended to use the time after foundation training to consider their plans. This unpredictability in the workforce is particularly felt in certain geographical areas and 'shortage' specialties.

Recommendation 5

Doctors who do not progress to training directly from FY2 will be able to access on-going support via their Foundation School and return to training support initiatives such as Supported Return to Training (SupportTT) will be encouraged for those who have spent time away from NHS practice.

³³ GMC Training pathways: analysis of the transition from the foundation programme to the next stage of training November 2017 <https://www.gmc-uk.org/-/media/documents/dc10999-evi-training-pathways-analysis-of-transition-from-foundation-to-next-stage-of-train-74522826.pdf>

³⁴ The UKFPO F2 Career Destination Report 2018 http://www.foundationprogramme.nhs.uk/sites/default/files/2019-01/F2%20Career%20Destinations%20Report_FINAL.pdf

³⁵ General Medical Council – July 2018 https://www.gmc-uk.org/-/media/documents/dc11392-training-pathways-report_pdf-75268632.pdf

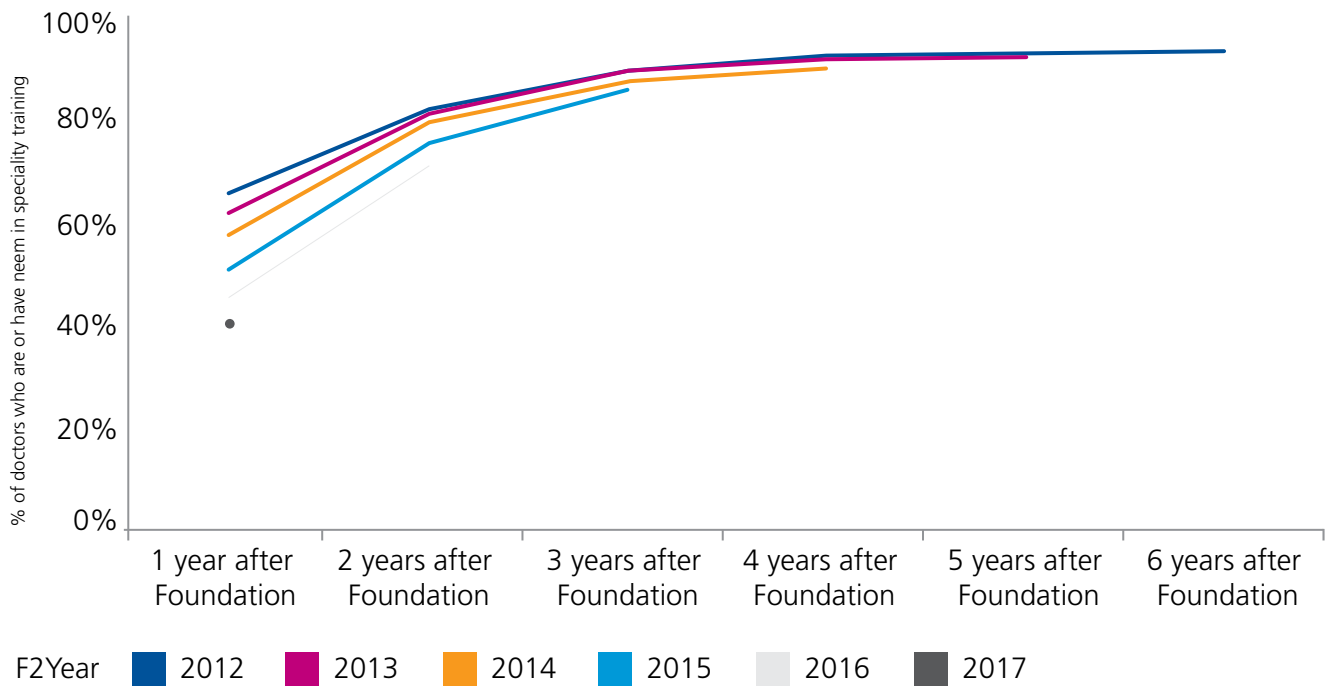
³⁶ The UKFPO F2 Career Destinations Report 2018 Table 1, 3 & 4 http://www.foundationprogramme.nhs.uk/sites/default/files/2019-01/F2%20Career%20Destinations%20Report_FINAL.pdf

Proportion of doctors in training each year following completion of F2 (2018)

Release Date: 6/2/2019

The graphs below gives the proportion of all Foundation Year 2 doctors who had entered speciality training with five years of completing F2. This highlights that many doctors enter speciality training after the first round of each year's recruitment.

Other graphs in this report are regarding only applications made in the first round of recruitment.



GMC NTS Data³⁷

The review heard examples of locally-led Integrated Care System and LEP initiatives which encourage doctors to remain in a geographical area after completing the foundation programme in order to continue their careers as specialty trainees. These offers can be effective in improving retention and are beneficial to both the doctor (who benefits from increased stability, enhanced supervision and a focus on work/life balance) and the provider organisation who has a more stable medical workforce.

Greater equity in early years medical careers support is needed in line with the recommendations of the Medical and Dental Recruitment Service Careers Strategy³⁸, and the principles of the NHS Long Term Plan. A common framework for support across all regions would help to better align the expectation of doctors in training with the changing needs of the NHS, nationally and regionally. With the support of a national strategy, this would be best managed at a local level with foundation schools as an appropriate contact point (as with graduates and their medical schools).

³⁷ GMC National Training Survey Portal <https://webcache.gmc-uk.org/ntsportal/Account/GuestLogin.mvc>

³⁸ MDRS Careers Strategy <https://www.nwpgmd.nhs.uk/sites/default/files/MDRS%20Careers%20Strategy%20July%202016%20%281%29.pdf>



Supported transition to specialty training and improved support for the workforce could be facilitated by an appropriately trained and qualified regional careers lead to coordinate local careers support, signpost careers resources, encourage the use of 'taster' weeks, deliver careers advice/planning and support individuals or groups as well as facilitate training of supervisors to provide careers advice. They could also work with specialties which struggle to fill all core and speciality training places to ensure that doctors in postgraduate training have enough information to be able to make careers decisions.

A regional careers' specialist should be supported by a nationally agreed central suite of careers resources. Undergraduate and postgraduate careers resources should be aligned to provide realistic and consistent ongoing careers advice throughout the continuum of medical education.

Recommendation 6

HEE will establish a common framework for early years careers support, in line with NHS People Plan, to better inform the expectations of doctors in training about the changing needs of the NHS in England.

Chapter 3: Rebalancing The Geographical And Specialty Distribution Of Doctors To Meet The Needs Of The NHS

3.1 Geographic Distribution Of Posts

There is a recognition that medical training posts have been distributed across England based on historical arrangements and that this has not fully aligned with the current or future health needs of local populations and the NHS. Issues relating to this have previously been considered by HEE and detailed in the 'Training In Smaller Places' report in 2016³⁹.

A commitment to address geographic healthcare inequalities has been a key focus of this foundation programme review. This commitment was echoed in the NHS Long Term Plan and subsequent Interim NHS People Plan, to "ensure specialty choices made by doctors are better aligned to geographical shortages" and to develop "incentives to ensure that the specialty choices of trainees meet the needs of patients by matching specialty and geographical needs, especially in primary care, community care and mental health services"⁴⁰.

The review explored several levers and initiatives with foundation doctors, partners and stakeholders to identify how this could be most effectively achieved. Tackling these inequalities aligned to three main areas:

1. Distribution (and redistribution) of foundation training places that is fair and equitable in meeting the needs of patients, the NHS as a whole and the educational and supervision needs of trainees
2. 'Incentives', be they educational, programme themes, wider educational components, financial, enhanced employer offers often referred to as 'hygiene factors' or a combination of these
3. Recruitment and selection processes that preferentially pre-allocate foundation doctors to shortage geographies like those in place at The Northern Ontario School of Medicine in Canada. The school has developed a residency programme for psychiatry with an option to focus on rural practice. Applicants for the programme are expected to demonstrate an interest in working in community settings with healthcare teams⁴¹.

³⁹ Training In Smaller Places: Product of a task and finish group commissioned by Health Education England Spring 2016 <https://madeinheene.hee.nhs.uk/Portals/0/Policies/overarching/Training%20in%20Smaller%20Places%20June%202016.pdf>

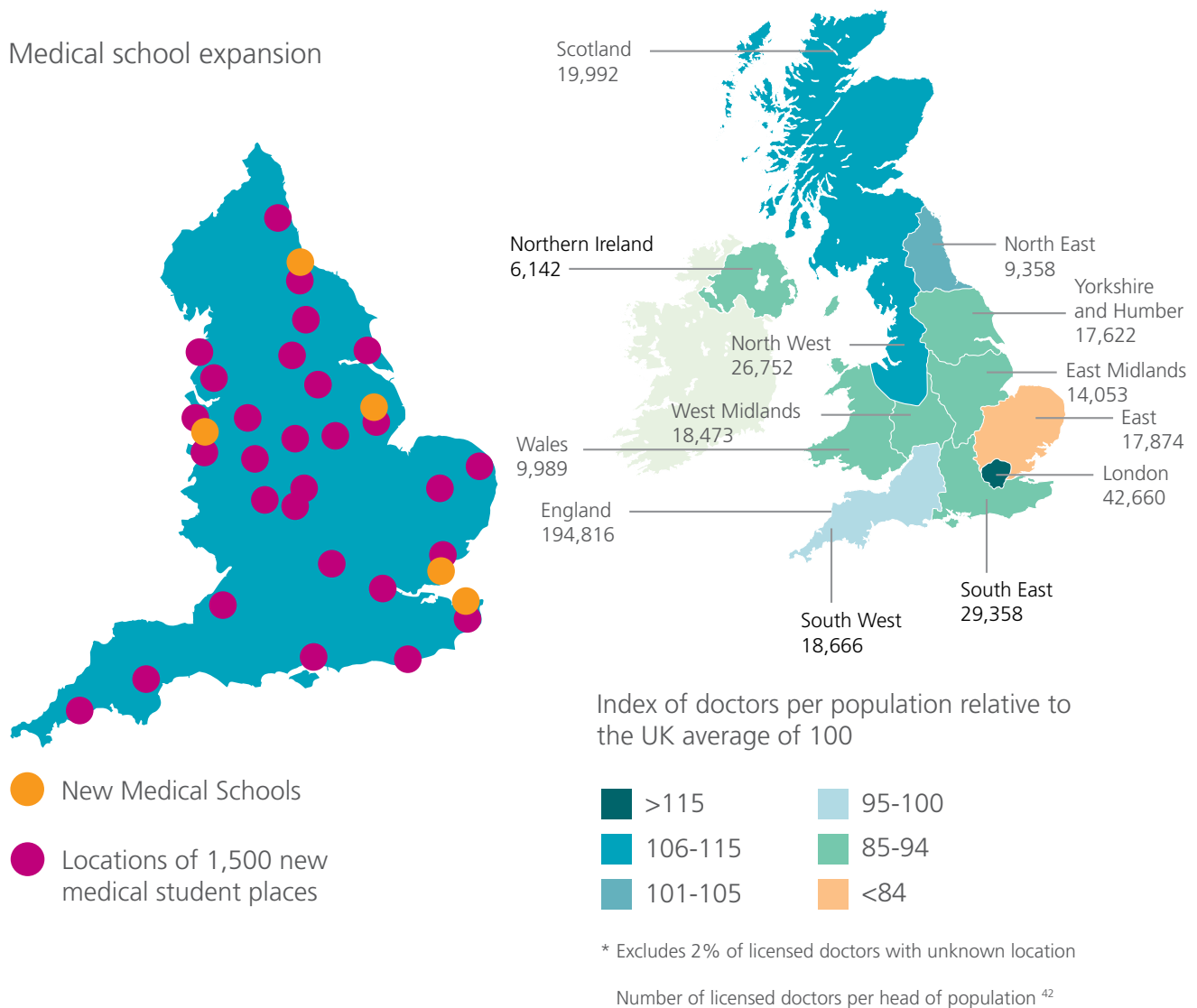
⁴⁰ NHS Improvement - NHS Long Term Plan, January 2019 <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf>

⁴¹ Northern Ontario School of Medicine. 2018. Program overview & highlights. Ontario: Northern Ontario School of Medicine. <https://www.nosm.ca/psychiatry/program-overview-highlights-2/>

Found within Surrey and Sussex Library & Knowledge Services, Archana Deshmukh, October 2018 - International models, case studies and literature about the facilitation of postgraduate medical training in rural and underserved areas

Pivotal to the review's focus of the distribution of foundation posts, was the additional 1,500 undergraduate medical graduates in England who will incrementally join the NHS via foundation training from 2022/23.

Medical school expansion



The location of these additional medical school places aimed to address current recruitment issues as well as support a rebalancing in the ratio of doctors to patients across the country. They led to the creation of five new medical schools, namely:

- The University of Sunderland
- Edge Hill University, Liverpool
- Anglia Ruskin University, Chelmsford
- University of Lincoln
- Canterbury Christ Church University and University of Kent

⁴² GMC The state of medical education and practice in the UK 2017 – p114 figure 48: <https://www.gmc-uk.org/-/media/about/somep-2018/version-one---0412pm/somep-book-20187.pdf?la=en&hash=69655DF4D8E2B6039E463BFD7309C91B78A3D7B1>

In considering the distribution of foundation posts the review considered the following:

- **Training location** – Evidence indicates⁴³ that trainees are more likely to remain in the geographical area where they grew up or trained and thus consultants and GPs are much more commonly recruited from trainees who trained locally. It is therefore crucial to attract and retain trainees in those areas that the NHS most needs them. There is evidence to suggest that the main pull for doctors when starting FY1 is working in the area in which they grew up⁴⁴. This means recruiting doctors from areas perceived as being ‘under-doctored’ would have an impact.
- **London** – Historical debate has focused on London having a higher percentage of training posts against its population numbers and need. However, it is recognised that the issue is more complex and there are geographical areas of London that remain under-doctored, which suggests that the distribution within regions could support addressing some imbalances.
- **Fill rates** – There are areas of the country that have difficulties in filling some specialty programmes and the NHS Long Term Plan sets clear priorities for primary and community care and mental health. The exploration of how to provide adequate and innovative exposure to specialties in high-quality placements during foundation training, coupled with ‘incentives’ that attract and retain trainees in specific locations and influence choice at specialty level, was a key focus for the review.
- **Wider healthcare workforce** – In geographical areas with proportionately fewer medical trainees there are increasing examples of more advanced development of the wider healthcare workforce through the transformation agenda.

The review recommends that the new foundation places required for the medical students should be distributed to the geographies where both foundation and specialty trainees are needed most.

Recommendation 7

HEE will preferentially distribute the 1500 Foundation Doctor training places in the geographies where the NHS most needs them in alignment with regional plans to support population healthcare needs and local specialty recruitment.

⁴³ South Central NHS, Migration Patterns of the Recently Trained Medical Workforce, March 2010

⁴⁴ BMC Medical Education Geographical mobility of UK trainee doctors, from family home to first job: a national cohort study, December 2018
<https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-018-1414-9>



3.2 Attracting Doctors To Specific Locations

The review heard that historically the foundation programme has initially been oversubscribed⁴⁵. However once the number of students who fail their final examinations and withdrawals are taken into account there are usually a number of vacancies by the start of the training year. These vacancies are not spread evenly across the foundation schools because the meritocratic allocation process, in part based on academic performance at medical school, means that the less popular schools tend to have more students allocated to them who are at higher risk of failing or deferring finals.

It is also the case that, under the current process, a trainee who achieves a higher application score could be allocated a place at a foundation school they had given a lower preference to above another trainee who had given a higher preference to this school. There is some evidence to suggest that in such scenarios the trainee is more likely to apply for an inter deanery transfer, apply for a stand-alone FY2 or leave the area on completion of the foundation programme, please see [Appendix 7](#) for more detail on this. Applications for standalone FY2 posts suggest such foundation doctors are more likely to leave the programme part way through and apply for a standalone FY2 placement. This model is inefficient from a HEE perspective and does little for stability of the medical workforce in less popular (and often underdoctored) areas.

Such a model perpetuates an unequal distribution of doctors across the country and means that not only do some geographies struggle to retain foundation doctors, they experience difficulties in encouraging doctors to remain within the locality for specialty training.

To address this issue, the review proposes the introduction of Foundation Priority Programmes (FPP). These programmes will be introduced to support specific areas of England that have historically found it difficult to attract and retain trainees through the foundation and specialty recruitment processes. They will maximise the opportunity for applicants who wish to be located in less popular areas and therefore improve supply for specialty training and beyond.

⁴⁵ UKFPO recruitment stats and facts reports 2018 http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/2018%20Recruitment%20Stats%20and%20Facts%20Report%20V2_0.pdf

Offers for FPP will be developed and agreed upon locally and bespoke additional educational offers should be developed collaboratively between HEE and foundation placement providers utilising the evolving Integrated Care Systems and Primary Care Networks where appropriate. It is envisaged that these programmes could offer opportunities such as:

- Longer programmes (up to three years) that provide opportunities to undertake additional training or train more flexibly and provide geographic stability for those that desire it
- Opportunities that might allow trainees to realise their potential by undertaking parallel management and leadership programmes
- Opportunities to gain academic experience
- Opportunities to undertake quality improvement projects or teaching roles
- Offers of increased geographical stability
- Other incentives such as financial support with accommodation and innovative rotas.

The review heard that some Trusts⁴⁶ in under-doctored areas (especially those in rural and remote areas) and some were already taking a similar approach to attract doctors. This can be seen in the example of Bangor Emergency Department, detailed below.

Case study – Bangor Emergency Department Clinical Fellow Scheme

In 2011, the Bangor Emergency Department in rural Wales was suffering a severe shortage of doctors.

Agency locums were used for all annual and study leave and were required to top-up cover every weekend. It was an expensive staffing model.

Following the introduction of the Clinical Fellow Scheme, the hospital has since achieved a substantial boost to its recruitment. There are now more doctors than posts and some doctors are having to queue in order to return to Bangor for the next stage of their career.

The Clinical Fellow Scheme is 100% clinician-led. Its success has in large part been because of the flexibility and trust that the department has shown its staff. By allowing clinicians to take ownership of the problem and to 'get on with solving it' with minimal interference, posts have been designed that doctors actually want.

Furthermore, the fundamentals of the strategy underpinning the Clinical Fellow Scheme are 100% transferable to other settings in medical recruitment.

These programmes will start to address some of the historic imbalances and reflect future patient and service needs set out in the NHS Long Term Plan while at the same time aiming to retain more doctors. Providers also have a role in developing greater support of undergraduate clinical placements. This would help develop foundation places in the right geographies with the relevant exposure to shortage specialties in order to attract and retain doctors in the long-term. It will also be important in supporting the expansion in medical graduates from 2023/24 onwards.

⁴⁶ Medical Recruitment, Learning from Bangor Emergency Department. Written evidence submitted to the National Assembly for Wales Inquiry into Medical Recruitment, 2017



3.3 Attracting Doctors To Specific Specialties

As well as looking to address the geographical distribution of doctors in training, the NHS Long Term Plan also outlines an ambition to address the current imbalance in the specialty training options that are chosen. Evidence from the FY2 Destination Survey and pilots of different models of integrating GP into foundation rotations (such as the LIFT programme, see below) indicate that positive experiences of specialties during foundation can lead to trainees changing their career choice to these specialties⁴⁷. There is further evidence from Northern Ireland where 33% of FY2s do a psychiatry placement, well above the UK average. And in the last three years, Northern Ireland has had between 90-100% recruitment rates at core and higher training levels, compared with the UK rate of between 60-70%⁴⁸. It is therefore proposed that Foundation Priority Programmes should include innovative and exciting options in general practice and psychiatry.

Longitudinal Integrated Foundation Training (LIFT)

Following the success of the Longitudinal Integrated Foundation Training (LIFT) programmes involving general practice, pilots will be developed for two-year training programmes configured as six four-month placements in acute specialties with a longitudinal attachment to a senior mental health professional for the duration of the two-years. The initiative is aimed at broadening the doctor's exposure to mental health issues across primary, secondary and community care and breaking down the barriers that currently prevent seamless integrated care between mental and physical health providers. Each programme also offered targeted teaching and learning across longitudinal competency themes such as values, leadership and quality improvement.

The programme will no doubt be of interest to those considering a career in psychiatry and would provide a good basis from which to apply for RCPsych fellowships. However, it is hoped the initiative would be of equal interest to foundation doctors interested in a number of future careers including general practice, acute medicine, rehab medicine, oncology, etc.

⁴⁷ UKFPO F2 Career Destination Report 2018 http://www.foundationprogramme.nhs.uk/sites/default/files/2019-01/F2%20Career%20Destinations%20Report_FINAL.pdf
⁴⁸ RCPsych Insight, Autumn 2017 https://www.rcpsych.ac.uk/docs/default-source/members/rcpsych-insight-magazine/members-rcpsych-insight-magazine-issue-2.pdf?sfvrsn=748254b_2

These initiatives will be developed for piloting along with reviewing the Medical and Dental Recruitment and Selection recruitment process⁴⁹ to enable trainees to remain in under-doctored geographies if they wish to. This would also help reduce geographic variation in fill rates as doctors progress to specialty training.

Recommendation 8

During 2019/20 and 2020/21, HEE will introduce and evaluate a number of Foundation Priority Programmes, specifically designed to attract and retain trainees in:

- **Remote, rural and coastal geographies**
- **Under-doctored geographies**
- **Shortage specialties, aligned to the NHS Long-Term Plan with psychiatry as the initial priority**

Recommendation 9

HEE will work with the relevant UK bodies to introduce and evaluate adaptations to specialty and foundation programme application and allocation processes to help address geographic variations in fill rates.

⁴⁹Health Education England, Medical Recruitment, Our Work <https://www.hee.nhs.uk/our-work/medical-recruitment>

Chapter 4: Improving Morale, Reducing Burnout And Improving The Working Lives Of Foundation Doctors

Concerns over the morale of doctors in training have been raised with several recent reports^{50,51} highlighting high levels of stress and burnout among this group. The review wished to address this and considered a number of suggestions for how the working lives of foundation doctors could be improved.

We heard that some staff in LEPs do not have a clear understanding of the foundation doctor's role and where it fits in the medical education pathway. Therefore there is a lack of awareness of what they can be safely asked to do. This can lead to doctors feeling anxious and isolated when they are left working without appropriate supervision or asked to work beyond their competencies. This creates a risk not only to the safety, wellbeing and registration status of the doctor, but to the safety of patients under their care.

To attract and retain a workforce, LEPs must ensure that foundation doctors are welcomed into the workforce. It is essential for patient safety that they are adequately supported in the workplace and that members of the multi-professional clinical team and supporting administrative staff are aware of foundation doctor's competence and experience. To support this process, HEE will develop further guidance for LEPs, to be used alongside the Foundation Doctor Charter.

Changes in medical service provision have led to an increase in shift working. This means that on occasions there is less 'near-peer' support available to doctors than at the time the foundation programme was introduced. While senior cover and supervision should always be available, we heard about the benefit in having near peer support and that some foundation doctors felt uncomfortable reaching out to senior colleagues for advice relating to what they perceived to be routine matters. Senior staff and supervisors must ensure that foundation doctors know that they can approach them for help. Several initiatives have been developed by both trainees and LEPs to try and address this.

Peer support case studies:

Musgrove Park Hospital

Musgrove Park Hospital run by Taunton & Somerset NHS Trust scored highly in satisfaction levels by its trainee foundation doctors.

The General Medical Council's National Training Survey asks all trainee doctors to report their training experiences in the hospitals they are working in - 100% of foundation doctors on the programme in Taunton responded in the 2016 survey.

The trainees had positive feedback about their medical training in a number of the hospital's specialty areas including medicine, surgery, obstetrics and gynaecology, paediatrics, ophthalmology and trauma and orthopaedics.

⁵⁰ BMA, Caring for the mental health of the medical workforce, April 2019

<https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/supporting-the-mental-health-of-doctors-in-the-workforce>

⁵¹ GMC National training surveys 2018: initial findings report https://www.gmc-uk.org/-/media/documents/dc11391-nts-2018-initial-findings-report_pdf-75268532.pdf

WARD (Well and Resilient Doctors)

WARD (Well and Resilient Doctors) was founded in 2017 at Southmead Hospital in Bristol. It now operates throughout the Severn region in order to provide wellbeing and mental health support to trainee doctors.

WARD is first and foremost an organised peer support group. It runs workshops in safe reflection, mindfulness and physical health while facilitating senior trainee-led peer support.

Those who support WARD are Registrar and above junior doctors who have been through multiple assessments, exams and sign-offs and have worked in the NHS for a long time. They provide impartial and important advice on a range of topics that affect foundation doctors from their medical education to personal wellbeing.

FY1 Buddy Network

The F1 Buddy Network is a support network on social media that provides an individual buddy mentor to FY1s for their first year of being a doctor.

The scheme is available to all FY1s in the UK through Facebook and Twitter. The scheme links FY1s with doctors (FY2 and above) who are willing to provide informal support and mentoring to help with issues like confidence and settling in.

Work is ongoing by HEE and NHS Improvement to streamline the HR processes associated with rotating between LEPs in order to avoid doctors having to repeat HR and generic induction packages every time they change employer. The review recognised that this would reduce some of the stresses described by foundation doctors.

Recommendation 10

HEE will work with Foundation Schools to identify opportunities to enhance support to doctors with specific needs including wider use of supportive placements.



4.1 Less Than Full Time (LTFT) Training

We heard that the options for LTFT working can be limited in the Foundation Programme, and there is a lack of consistency between different locations in how LTFT programmes are organised and funded. Trainees highlighted the need for greater flexibility in the ways in which their training is provided, and for more support when working LTFT. The review heard that the majority of LTFT foundation doctors are in job-shares or are working LTFT as the only doctor in a full-time post. Foundation schools face the challenge of creating processes to accommodate the range of working patterns that foundation doctors request, including more flexibility of whole-time-equivalent (WTE) percentage, the location of posts and the specialties within programmes.

With the increase in training places there is an opportunity for foundation schools to be more flexible about tailoring LTFT opportunities to meet the needs of the individual trainee and to explore broadening the offer of LTFT to a wider cohort of doctors. The pilot offering LTFT to emergency medicine trainees⁵² who did not meet the traditional criteria for LTFT working, reported improved levels of job satisfaction and reduced burnout and no negative impact on service provision.

Foundation Priority Programmes may also offer opportunities to foundation doctors to lengthen or broaden their training to help reduce stress. HEE will therefore pilot more flexible methods of delivering foundation training, including more options for LTFT training at varying percentages of WTE, longer innovative programmes offering additional development opportunities, for example, extension of the LIFT programme.

Recommendation 11

Foundation Schools will support greater flexibility in foundation training, including expanding access to Less Than Full Time Training (LTFT) and allowing access to a greater variety of working patterns and percentages of full time.

⁵² Interim Evaluation of Emergency Medicine Trainees LTFT Pilot 2017-18
<https://www.hee.nhs.uk/sites/default/files/documents/Interim-Evaluation-of-EM-Trainees-LTFT-Pilot-2018-19.pdf>

Chapter 5: Improving Supervision And Educational Support

This review has outlined many of the challenges facing foundation doctors as they transition from medical school students to working as doctors. It identified systems to help ensure that the programme delivers the right doctors with the right skills to deliver the care required by patients of the future. Underpinning these systems and central to the purpose of the foundation programme is the clinical learning environment in which foundation doctors will train. A high-quality, supportive environment with strong supervision ensures the safety of both doctors and patients and guarantees the highest standards of training. Such an environment also improves the recruitment and retention of doctors, and improves the wellbeing of all healthcare staff working on those wards.

5.1 Supervision

The supervision required of foundation doctors is multifaceted and involves individuals in both formal and informal roles. This report has discussed some of the factors and pressures that set the foundation programme apart from the wider medical education pathway, and we heard through the review that as a result, these supervision requirements differ from those of doctors who are further advanced in training. We have heard that on occasions the vulnerability experienced by some foundation doctors as they move from medical school to becoming a working doctor can mean that to ensure the safety of both doctors and patients, intensive support is required from those in a formal supervisory capacity and from the wider multi-professional team. Throughout the review we heard several examples of excellent clinical learning environments which have supported and facilitated the development of foundation doctors. However, we also heard examples of doctors feeling isolated and without essential support. This chapter looks to identify the elements of good supervision to ensure that good practice is replicated across England.

There are two formal roles involved in the supervision of foundation doctors, namely the educational supervisor and the named clinical supervisor⁵³.



⁵³ UK Foundation Programme Reference Guide, May 2017 <http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/Reference%20Guide.pdf>

The educational supervisor is the named individual who is responsible for supporting, guiding and monitoring the progress of a foundation doctor for a specified part of their training (this could be either FY1, FY2 or the entirety of the foundation programme). They must have undergone specific externally-validated training, including gaining a working understanding of the foundation programme curriculum, to carry out this role. They may be in a different department or organisation to the trainee but must be accessible to the trainee. If the trainee is within their department, the educational supervisor may also act as the named clinical supervisor for that placement and must understand both these additional responsibilities. The National Association of Clinical Tutors has developed job descriptions for both roles⁵⁴. The review heard of good practice where the skills and knowledge of the educational supervisor were matched to specific needs of the foundation doctor, for example LTFT foundation doctors being allocated a supervisor with more in-depth knowledge of the management of LTFT training.

In addition to the need to meet these core standards for educational supervision the review also heard of opportunities to further enhance the support provided by educational supervisors. For example, it is possible to align the specialty of the educational supervisor to the career ambitions of the individual trainee which may be particularly beneficial for specialties like psychiatry.

The named clinical supervisor is responsible for supporting the development of trainees' professional and clinical skills during a particular post. They should work within the department on the same site and be in a position to work alongside the foundation doctor in clinical practice for long enough to be able to give specific, individual feedback on the clinical performance of the trainee. Where they are unable to work regularly alongside the foundation doctor, they should seek feedback on the performance and development of the foundation doctor from members of the multidisciplinary team. The clinical supervisor role is often not explicit in an individual's job plan. This role is clearly defined by the GMC and the review strongly supports an explicit recognition both in job planning and departmental responsibilities for individuals with this commitment.

In addition to these two formal roles, the review heard from trainees that the provision of a more informal supervisory function while in placement was equally important. This type of supervision is referred to as workplace supervision.

Workplace supervision can be provided by anyone within the multidisciplinary team who is competent to carry out the task in question. Foundation doctors should always have someone located within the same building who is accessible and approachable and able to offer advice about patient care and feedback on the foundation doctor's clinical thinking.

Effective workplace supervision includes functions such as handovers, briefings, debriefings and links to Hospital at Night services ([see out-of-hours care over the page](#)). Members of the multidisciplinary team who provide workplace supervision will frequently provide informal feedback to the foundation doctor and should also provide formal feedback about the performance of the doctor in the workplace, for example by using the Placement Supervision Group form on HORUS eportfolio).

⁵⁴ NACT UK, Job Roles & Descriptions <http://www.nact.org.uk/documents/job-descriptions/>

The importance of supervision is highlighted by the fact that in 2017 enhanced monitoring was in place for 100 issues in 50 foundation programme posts. Sixty of these issues were related to supervision. Underpinning these supervisory processes, the clinical learning environment supports the provision of structured and constructive feedback throughout the wider clinical team, aiding the development of the foundation doctor.

Recommendation 12

LEPs must ensure that Foundation supervisors are valued and have appropriate training and skills and specific time allocated for their roles.

- Foundation educational and named clinical supervisors should be doctors recruited from as wide a range of backgrounds as possible (including SAS doctors) and current NACT/Gold Guide job descriptions should be used to standardise the role. They should be allocated specified time in their job plans likely to equate to an hour a week per foundation doctor supervised. Consideration should be given to the use of different models of supervision that might allow supervisors to take on a number of trainees leading to a more efficient use of time e.g. across a clinical directorate.
- Educational supervisors of foundation doctors should have specific knowledge of foundation training and the role of the doctor in training across the NHS as well as an understanding of NHS careers structures. They should meet their trainees regularly and between these meetings should review their trainee's portfolio. It is expected that educational supervisors should meet their trainee at least ten times in the FY1 year and six times in FY2. Not all these meetings would have to be face-to-face and the use of technology to facilitate contact should be encouraged.
- LEPs must ensure foundation doctors and their educational supervisor know who the named clinical supervisor is before starting in that post. Named clinical supervisors must understand the role of trainee doctors within their departments and, where necessary, liaise with the specialty tutor for the department to ensure a safe and appropriate educational environment.
- The placement supervision group (PSG) should be used in all placements and, at the start of the post, the clinical supervisor must identify the individuals who make up the PSG.
- The GMC should consider if these roles should be annotated on the Specialist and GP register.

Further details on supervision structures and governance (including how other ALBs are working in partnership with HEE to enhance supervision) can be found in the [HEE Enhancing Supervision guidance and toolkit](#).

5.2 Support

The need for support is emphasised in the report published by NHS Staff and Learners' Mental Wellbeing Commission in Feb 2019⁵⁵. During our consultation, foundation doctors frequently suggested that senior trainees would make effective supervisors. The challenges in allowing doctors in training to act as educational supervisors while managing their own training, supervision and rotations were considered prohibitive. However, the use of senior trainees as mentors was strongly supported. HEE will work with the Academy of Medical Royal Colleges to explore the role of senior trainees as mentors.

Recommendation 13

Senior trainees should be encouraged to take on the role of mentors. Trusts should develop this based on successful local 'good practice' schemes. To support this, HEE working with the Academy of Medical Royal Colleges (AoMRC), will develop plans for a sustainable model for the role of senior trainees as mentors, including how such a role could be incorporated as a training opportunity for senior trainees.

During the review we heard that out-of-hours work provides a unique opportunity for foundation doctors to take on more responsibility in managing acutely unwell patients. With fewer staff per patient, and many routine services unavailable, trainees are usually responsible for a higher number of patients than on their day shifts, covering multiple wards and potentially across different sites. While senior support must be available, supervision is often indirect, and trainees are expected to manage the acutely unwell patient for longer periods of time until more senior help arrives. This can present difficulties and risks, especially as FY1s will often require direct supervision. While this is an important learning experience for the trainee, it is also vital that they are adequately supported both to safeguard patient safety and to ensure suitable levels of clinical, professional and emotional support for trainees. Planning of rotas needs to explicitly take into account the level of trainee. It is the responsibility of the LEP to ensure adequate supervision is available and gaps on the rota are covered.

⁵⁵ NHS Staff and Learners' Mental Wellbeing Commission, February 2019 <https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf>

5.3 The Clinical Learning Environment

This report has emphasised the importance of foundation doctors being placed within a high-quality learning environment to aid their development and ensure they are adequately supervised and supported. The review recommends the development of a charter that sets out the requirements of each LEP hosting foundation doctors. The charter would sit alongside the HEE Quality Framework⁵⁶ and would be based on conversations with trainees, educators and wider stakeholders who outlined what they felt a high-quality clinical learning environment should look like for foundation doctors. The broad areas covered in the conversations are summarised in the table below.

| Function | Factors contributing to a high-quality learning environment |
|---|--|
| High-quality teaching | <ul style="list-style-type: none"> • Bleep free • Clearly nominated teaching cover for teaching release • Relevant topics mapped to curriculum |
| Handover | Daily clinical handover - 'Board Round' involving a more senior clinician to facilitate learning opportunities |
| Minimising unnecessary tasks | Workforce transformation engagement to reduce repetitive tasks, e.g. phlebotomy, pharmacists/physicians' associates assist by drafting simple routine discharge information, etc |
| Simulation | Mapped to curriculum and professional needs |
| Feeling valued culture | Regular feedback from multi-professional team |
| Involve multi-professional team in feedback for educational supervisor | <ul style="list-style-type: none"> • Formally via TAB • Informally and routinely at regular educational supervisor meeting |
| Actively encouraged and empowered to raise concerns | Anonymous reporting of concerns available via either electronic or paper process. Option to reveal name of individual subject to the complaint, but not expected, although important if feedback is wanted. |
| Pastoral support | <ul style="list-style-type: none"> • Named person available in Trust • Pastoral tutor separate to educational supervisor⁵⁷ |
| Involvement of multi-professional team | <ul style="list-style-type: none"> • Encourages inter-professional learning and support. • Sessions could be led by dietitians/physios etc. with relevant expertise in their area • Attendance at teaching sessions |
| Name of available senior workforce clinical supervisor at start of each shift and how to contact them | Improves permission to seek advice and support for clinical decision making |

⁵⁶ NHEE Quality Framework 2017-2018 https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf

⁵⁷ NHS Staff and Learners' Mental Wellbeing Commission, February 2019 - Recommendation 13 - <https://www.hee.nhs.uk/sites/default/files/documents/NHS%20%28HEE%29%20-%20Mental%20Wellbeing%20Commission%20Report.pdf>

The review heard that foundation doctors can often struggle to find time to carry out essential educational activities such as completing their portfolio, reflecting on practice and meeting with their supervisors. Dedicated time, during the working week, for these educational activities and also for considering career pathways would be beneficial. We are aware of the pressures that such time would place on service provision, and will engage with employers, doctors, LEP representatives and other relevant stakeholders to explore how to provide this.

Recommendation 14

HEE will engage with key stakeholders to assess how Foundation doctors can be given time in the working week for professional self-development ('self-development' time).

- **FY1s should have one hour per week of non-clinical professional self-development time in their job plan. This could be delivered as a block – for example four hours once per month and coordinated to match the availability of their supervisors.**
- **FY2s should have three hours per week of non-clinical professional self-development time. This will include time for preparing for specialty application as well as developing skills in quality improvement, teaching and leadership.**

The use of this time should be discussed with the educational supervisor and the outcome recorded in the eportfolio.

5.4 The Quality Framework

The factors that have been highlighted as contributing to a high-quality learning environment reflect the quality standards within the HEE Quality Framework⁵⁸. Both the GMC and HEE have statutory responsibilities related to the provision of education and training. HEE has a duty to improve the quality of education and training for all learners with the GMC having a specific duty to oversee medical education and training. Following a period of extensive internal and external stakeholder engagement and co-production, the HEE Quality Framework and associated Quality Standards, were published in April 2016. The Quality Framework provides the infrastructure and resources to drive improvements in the quality of the clinical learning environment.

The intelligence gathered from National Education and Training Survey (NETS)⁵⁹, HEE's multi-professional learner survey, added to the substantial longitudinal evidence from the GMC National Trainee and Trainers surveys. The findings give HEE an understanding of the quality of clinical learning environments for all learner groups.

⁵⁸ HEE Quality Framework 2017-2018 https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf

⁵⁹ National Education and Training Survey (NETS) <https://www.hee.nhs.uk/our-work/quality/national-education-training-survey>



Chapter 6: Support For The Foundation Training Faculty

The foundation programme, which provides the generic training for all newly-appointed doctors, does not link to a specific college-like structure although it has huge numbers of doctors in training at an important and vulnerable time in their career. Nationally, the UK Foundation Programme Office develops and delivers the recruitment to the foundation programme. The Academy of Medical Royal Colleges Foundation Programme Committee (AoMRC FPC) is responsible for devising the foundation programme curriculum⁶⁰, which guides the training of all foundation doctors.

At a local level, foundation training is organised by foundation schools. These are part of the structures of the relevant four nations' educational organisation and report to Postgraduate Deans - see [Appendix 4](#) for a visual representation. Schools are led by a strategic board and run by a management group comprising representatives from medical schools, local offices/deaneries, employers and other organisations such as hospices. Foundation schools deliver training according to national guidance developed by the UKFPO and the AoMRC FPC with appropriate local variation.

This matrix can limit the opportunities for a strategic focus on foundation training and result in uncertainty in the responsibility and accountability for specific decisions.

Schools, individual educators and administrators have built up considerable experience of what is effective in this early training. In order to maximise the potential for innovative ongoing development of the programme, HEE will explore with the academy and devolved administrations possible mechanisms for providing a single college or faculty structure for foundation programme training.

Recommendation 15

HEE will work with the devolved administrations and the AoMRC to explore the need for a structure to support for the foundation programme and faculty.

⁶⁰The Foundation Programme Curriculum 2016 [http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/FP_Curriculum_2016_V2%20\(1\)_0.pdf](http://www.foundationprogramme.nhs.uk/sites/default/files/2018-07/FP_Curriculum_2016_V2%20(1)_0.pdf)

Chapter 7: Academic Training

In 2004, 'MMC The Next Steps'⁶¹ said that the foundation programme should include 'a clear structure to encourage and support the development of academic, research and teaching skills and to support those who opt for an academic career'. This has been achieved by foundation schools identifying local academic opportunities and recruiting to these in school-specific recruitment processes prior to the main foundation programme allocation process. The nature and number of academic foundation posts varies considerably from school to school.

The review explored both the intended purpose and the current utilisation of the Academic Foundation Programme (AFP), holding focus groups with both academic foundation doctors and educators. While feedback from trainees was very positive (as is substantiated by the last survey relating to the programme in 2015⁶²), the review heard that it was serving multiple purposes to different groups of doctors.

We heard from trainees that they currently perceive the programme as serving three purposes:

- The AFP provides an opportunity for foundation doctors to 'dip a toe into the water' of academia to see if this career option is right for them. However, it was felt that these doctors were disadvantaged because of recruitment prioritising of those with previous academic experience. The trainees thought that this purpose could be significantly strengthened.
- The AFP can form part of a clear academic career pathway leading into an Academic Clinical Fellowship (ACF) or a Clinical Lectureship (CL). There are increasing numbers of medical students who have academic experience either before medical school or gain it during medical school. They see the AFP as the next logical step in an academic career.
- For some, the AFP is used mainly as an opportunity to enhance an individual's CV.

The review felt that while the first two functions were important, the AFP should not simply offer an opportunity for foundation doctors to enhance their CV.

Current academic trainees told us that there were several elements of the programme that they felt were particularly successful:

- Many programmes offer well-prepared academic and clinical supervisors who understand the AFP.
- Trainees often valued programmes where the academic component is longitudinal and continuous through FY1 and FY2 rather than an isolated four-month academic block.
- Trainees valued formalised networking events throughout the AFP with ACFs, CLs and senior academics.
- Integration with undergraduate training and the Integrated Academic Training Programme (IAT) enhances the AFP.

⁶¹ Modernising Medical Careers The next steps, 2004 https://webarchive.nationalarchives.gov.uk/20110929193948/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/en/documents/digitalasset/dh_4079532.pdf

⁶² UKFPO - 2015 National Evaluation: Academic Foundation Programme Survey https://heeo.hee.nhs.uk/sites/default/files/2015_academic_survey_outcomes.pdf



Many foundation doctors who intercalated at medical school and thus obtained research experience at undergraduate level believed that the AFP did not add value beyond allowing them to ‘keep their hand in’ before application to ACF posts. Furthermore, the importance they placed on this ability to keep in touch with academia varied greatly.

It is the role of the IAT lead therefore to ensure that the programme is able to add value and avoids repeating or prolonging previous experience.

Those involved felt the foundation programme should offer opportunities for trainees who wished to excel in research-facing jobs in order to develop themselves to their full potential. Many academic foundation doctors felt they gained significant personal benefit from the programme.

It was recognised that the application process is biased in favour of graduates with research skills and experience and the programme would need to alter to enable those who have not been able to intercalate, perhaps due to financial reasons, or who have come late to an interest in research, to access the opportunity afforded by the AFP. There should therefore be exploration of more innovative options for recruitment to the AFP to encourage a broader pool of applicants and ensure those without a research background have an opportunity to undertake academic foundation training. We will ask the Academic Foundation School Director sub-committee and the National Institute for Health Research (NIHR) to work together to develop a national selection process that allows applicants with the desire and attributes, but little or no prior research experience, to be appointed to the AFP.



Current academic foundation doctors reported that research AFP posts benefit from having close links to other local research programmes and that the input of the local IAT lead was important in developing these links. In order to maximise the potential opportunities of an AFP, input from the local IAT lead into the design and running of research AFP programmes at foundation school level encourages coordination with the ACFs, CLs, the wider local research community and the NIHR. The AFP should be designed to ensure good research-based programmes with a view to encouraging academic careers.

The current posts for development of skills in leadership, education and quality improvement which have been labelled as Academic Foundation Programme posts were considered extremely valuable. However, these should be developed separately and in parallel to research-based programmes. They could be taken forward as part of the priority programme initiative which could include development of management and leadership, quality improvement and education and teaching placements. It would provide opportunities for foundation doctors who wish to enhance their professional portfolio and realise their full potential through a range of opportunities.

Recommendation 16

There should be a local academic lead involved in the design and running of research in AFP programmes to ensure good integration with the training and wider local research community, and links to NIHR.

New options for AFP recruitment should be agreed to ensure those without research experience are not excluded from academic foundation training.

Priority Foundation Programmes should be developed for management and leadership, QI and education and teaching with a similar structure to academic programmes.

Chapter 8: Next Steps

This report outlines 16 recommendations that set out how Health Education England will work with partners to deliver the doctors of the future and in doing so, realise the ambitions for the medical workforce set out in the NHS Long Term Plan.

Some of these recommendations can and will be delivered immediately and indeed, in some instances, such as ensuring an equitable distribution of doctors, work is already underway following the awarding of additional medical school places and creation of new medical schools.

The delivery of many of these recommendations will require close collaborative working with partners, such as with medical schools to improve the transition from undergraduate to postgraduate medicine, and with Local Education Providers and their local doctors in training to enhance the quality of the clinical learning environment and the support provided to foundation doctors while they are in placements.

Other recommendations that HEE is in a position to lead on include the development of an enhanced careers function. This would ensure that doctors on the foundation programme are given appropriate advice and guidance to help align their career aspirations with the needs of the patients. It would also support doctors who have left medical education after completing the programme but who would like to return to the next stage of training.

To ensure that the recommendations made within this report are delivered, HEE will work with partners to publish an implementation plan.

HEE will therefore:

- Engage with key stakeholders to assess how best we can support the inclusion of self-development time within foundation doctors work plans
- Engage with key stakeholders to assess the need for an expansion in the use of 'special circumstances' in allocation to the foundation programme and to consider the rules which govern them
- Develop options and consult on how widening participation options can be supported in the allocation process for the foundation programme.

Appendices

Appendix 1 – Glossary Of Abbreviations And Initialisations

| | |
|-----------|--|
| ACF | Academic Clinical Fellowships |
| ACS | Acute Coronary Syndrome |
| AFP | Academic Foundation Programme |
| ALB | Arm's Length Body |
| AoMRC | Academy of Medical Royal Colleges |
| AoMRC FPC | Academy of Medical Royal Colleges Foundation Programme Committee |
| CCF | Congestive Cardiac Failure |
| CiP | Capabilities in Practice |
| CL | Clinical Lectureships |
| COPD | Chronic Obstructive Pulmonary Disease |
| CS | Clinical Supervisors |
| CSR | Comprehensive Spending Review |
| DKA | Diabetic Ketoacidosis |
| EPM | Educational Performance Measure |
| ES | Educational Supervisor |
| FD | Foundation Director |
| FPP | Foundation Priority Programmes |
| FPC | Foundation Professional Capabilities |
| FSD | Foundation School Director |
| FY1 | Foundation Year One |
| FY2 | Foundation Year Two |
| GMC | General Medical Council |
| HEE | Health Education England |
| HORUS | (Provider used to deliver the Foundation Programme e-portfolio) |
| IAT | Integrated Academic Training |
| LDA | Learning Development Agreement |
| LEP | Local Education Provider |
| LIFT | Longitudinal Integrated Foundation Training |
| LTFT | Less Than Full Time Training |
| LTP | Long Term Plan |
| MDRS | Medical and Dental Recruitment and Selection |
| MDT | Multidisciplinary Team |
| MLE | Managed Learning Environment |
| MMC | Modernising Medical Careers |
| MSF | Multisource Feedback |
| NACT | National Association Clinical Tutors |
| NCS | Named Clinical Supervisor |
| NETS | National Education and Training Survey |
| NIHR | National Institute for Health Research |
| OOH | Out Of Hours |
| PE | Pulmonary Embolism |
| PG | Postgraduate |
| PSG | Placement Supervision Group |
| PSU | Professional Support Unit |
| QI | Quality Improvement |



| | |
|-------|--|
| SAS | Specialist and Associate Specialist |
| SJT | Situational Judgement Test |
| SVT | Supraventricular Tachycardia |
| TAB | Team Assessment of Behaviour |
| ToI | Transfer of Information |
| UG | Undergraduate |
| UKFPO | United Kingdom Foundation Programme Office |
| WARD | Well and Resilient Doctors |
| WTE | Whole Time Equivalent |



Appendix 2 – Acknowledgements

Foundation Programme Review Chairs and Leads:

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 Samantha Illingworth, Foundation Programme Review Deputy Chair
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 Dr Jon Scott, Health Education England
 Dr Mike Masding, Health Education England
 Professor Namita Kumar, Health Education England
 Dr Nick Spittle, Health Education England
 Dr Peter Hockey, Health Education England
 Professor Russell Smith, Health Education England

Foundation Programme Review Programme Team:

Andrew Milner, Health Education England
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 Chris Watt, Health Education England
 Jenna Harrison, Health Education England
 Rebecca Shaw, Health Education England

Stakeholder Engagement Events Attending Organisations:

Academy of Medical Royal Colleges
 Bedford Hospital
 British Medical Association
 Cardiff University
 Central and North West London NHS Trust
 Essex, Bedfordshire and Hertfordshire Foundation School
 Federation of Royal Colleges of Physicians
 Foundation School, Leicester, Northamptonshire and Rutland
 Foundation School, South Thames
 Foundation School, North West
 Foundation School, Northern
 Foundation School, Severn
 Foundation School, Yorkshire and Humber
 General Medical Council
 Health Education England
 Health & Social Care Services in Northern Ireland
 Medical Schools Council
 National Institute for Health and Care Excellence
 NHS Education for Scotland
 NHS Employers
 NHS England

NHS Improvement
 Northern Ireland Medical and Dental Training Agency
 Norwich Medical School
 Plymouth NHS Trust
 Royal College of Emergency Medicine
 Royal College of General Practitioners
 Royal College of Physicians
 Royal College of Psychiatrists
 Royal College of Surgeons of England
 Shelford Group
 South West London and St George's Mental Health NHS Trust
 Swansea University
 The Health Foundation
 The Royal Free London NHS Foundation Trust
 Trainee Representatives
 UK Foundation Programme Office
 University of Birmingham
 University Hospitals Birmingham NHS Trust
 University Hospitals Coventry & Warwickshire NHS Trust
 University of Exeter
 University of Oxford Medical School
 University of Sheffield
 University of Southampton
 University Hospital Southampton NHS Foundation Trust
 University of Warwick
 Wales Deanery

Organisational representatives for working groups:

Academy of Medical Royal Colleges
 British Medical Association
 Cardiff University
 Defence Deanery
 Department of Health and Social Care
 Foundation School, East Anglia
 Foundation School, Leicester, Northamptonshire and Rutland
 Foundation School, North Central & East London
 Foundation School, North West of England
 Foundation School, Northern
 Foundation School, Oxford
 Foundation School, South Thames
 Foundation School, Peninsula
 Foundation School, Scotland
 Foundation School, Severn
 Foundation School, South Thames

Foundation School, West Midlands
 Foundation School, Yorkshire and Humber
 General Medical Council
 Health Education England
 Health Education and Improvement Wales
 Health and Social Care Services in Northern Ireland
 Hull York Medical School
 King's College London
 Mater Dei Hospital - Ministry for Health
 Medical Schools Council
 National Association of Clinical Tutors'
 NHS Education for Scotland
 NHS Employers
 NHS Greater Glasgow and Clyde
 Northern Ireland Medical and Dental Training
 Agency
 Oxford University Hospitals
 Royal College of Emergency Medicine
 Royal College of General Practitioners
 Royal College of Pathologists
 Royal College of Psychiatrists
 Royal Free London NHS Foundation Trust

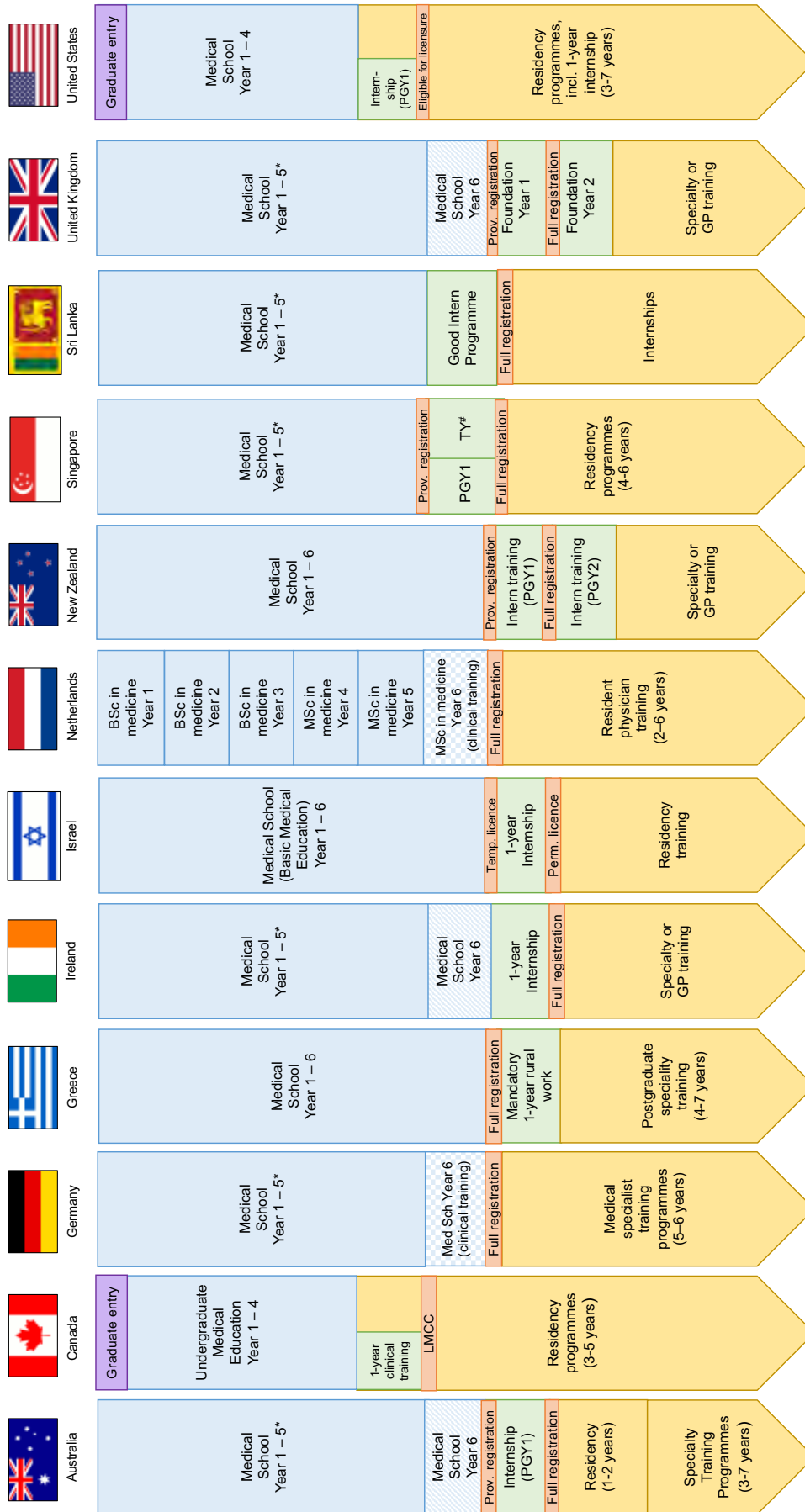
Salisbury NHS Foundation Trust
 Swansea University Medical School
 Surrey and Sussex Healthcare NHS Trust
 Taunton and Somerset NHS Foundation Trust
 The Mid Yorkshire Hospitals NHS Trust
 The Royal Marsden NHS Foundation Trust
 Trainee Representatives
 Lay Representatives
 Queen's University Belfast
 UK Foundation Programme Office
 University of Birmingham
 University College London
 University Hospital Coventry and Warwickshire
 University Hospitals Plymouth NHS Trust
 University Hospital Southampton NHS Foundation
 Trust
 University of Bristol
 University of Malta
 University of Oxford Medical School
 University of Southampton
 University of Warwick
 Wales Deanery



Appendix 3 – International Approaches To “Foundation-Level” Postgraduate Medical Training

International approaches to “foundation-level” postgraduate medical training












The Clarify the Purpose working group undertook a literature search to identify early years (“foundation”) postgraduate medical training in countries outside of the UK, to establish the purpose and structure of this training. Some of the countries identified in the search results are below, following a search of online resources, articles and databases for the period from 2010–2018. Countries listed below are where search results have retrieved substantial information about their medical education & training model. Other countries included in the search results are Botswana, Japan, Norway and Pacific island countries.



Acknowledgement to Deshmukh, A. 2018. Models, approaches and case studies of international approaches to ‘foundation-level’ postgraduate medical training. Redhill: Surrey and Sussex Library and Knowledge Services. Available under a [Creative Commons Attribution-NonCommercial 4.0 International Licence](#). Modified for illustrative purposes and information added where not stated in the literature search summary.

* Four-year course for graduate entrants
“Transitional year”

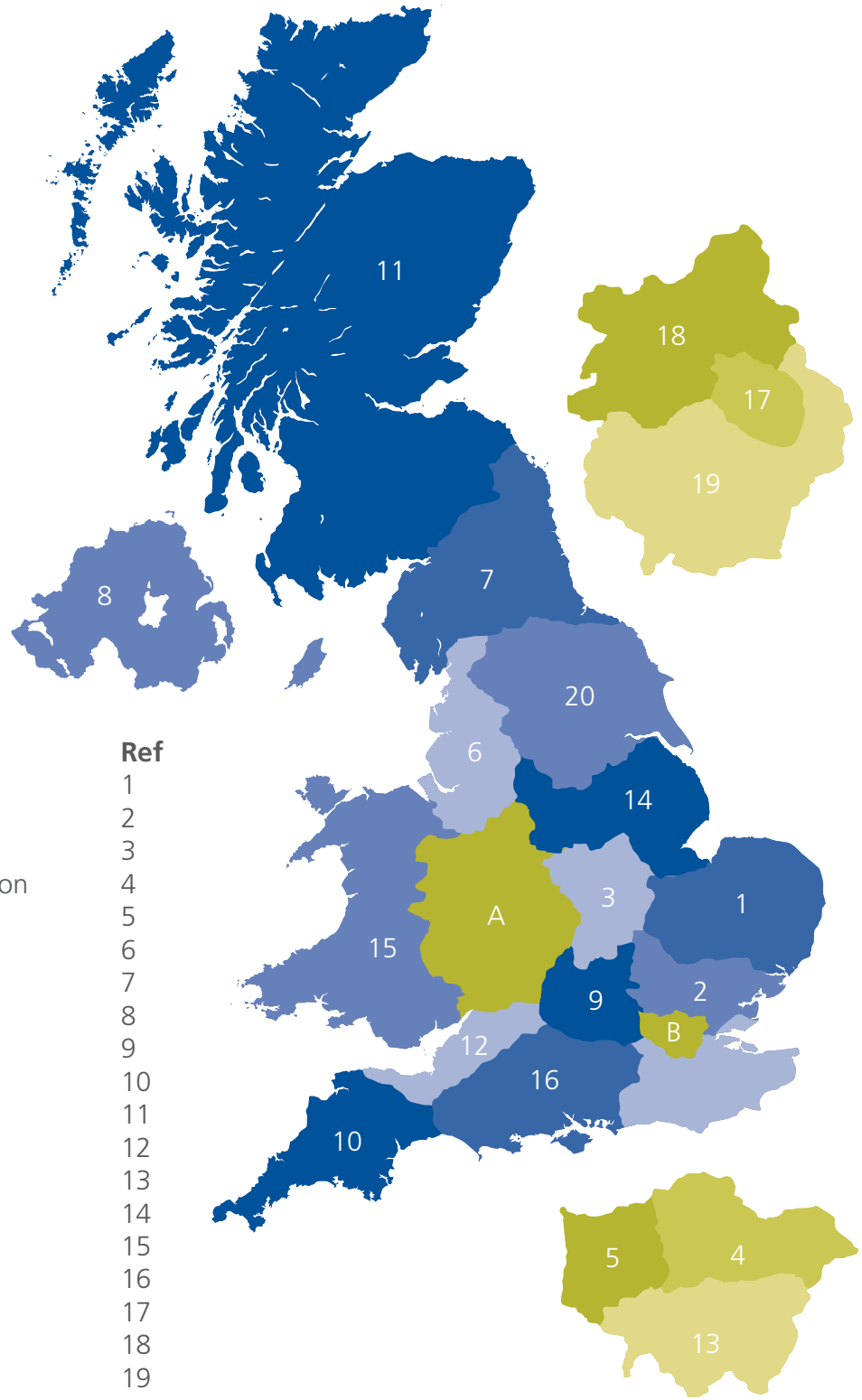
Summary of literature search findings: Deshmukh, A. 2018. Models, approaches and case studies of international approaches to ‘foundation-level’ postgraduate medical training. Redhill: Surrey and Sussex Library and Knowledge Services.

| | |
|---|--|
|  Australia | <p>The review of medical intern training by the Australian Health Ministers’ Advisory Council has recommended changes to the existing model to a 2-year transition period.</p> |
|  Canada | <p>In Canada medical licensure is gained after successful completion of a one-year of post-graduation clinical medical training programme. The Royal College of Physicians and Surgeons of Canada has developed the CanMEDS framework which is “an educational framework that describes the abilities physicians require to effectively meet the health care needs of the people they serve. It is the basis for the educational and practice standards of the Royal College”.¹</p> |
|  Germany | <p>Full registration is available on successful completion of the six-year undergraduate degree. The final year, which may map to the UK PGY1 is divided into three full-time clinical rotations, each lasting about four months.</p> |
|  Greece | <p>A year of work in a rural area is mandatory prior to proceeding to postgraduate specialty training. The sixth year of training may map to the UK FY1 year.²</p> |
|  Ireland | <p>A year of internship, which may map to the UK PGY1, follows completion of a medical undergraduate degree.</p> |
|  Israel | <p>Following completion of a medical education undergraduate degree, an additional year of rotating internship is completed. It has been suggested that the rotating internship “only loosely integrates the interns’ competencies and their specific needs for skills acquisition and improvement” and that the increase in newly licensed doctors may present a challenge to limited residency slots.³</p> |
|  Netherlands | <p>Undergraduate medical education has a duration of six years and full registration is granted upon graduation. The Utrecht model consists of a 3+3 years Bachelor-Master structure. Final year students are semi-physicians in a clerkship of this transitional year to residency. This year may be mappable to the UK’s FY1 but is embedded within a vertically integrated education model.^{4,5,6}</p> |
|  New Zealand | <p>Two year period of prevocational medical training (the intern training programme). Prevocational training (PGY1 and PGY2) in New Zealand now includes a requirement to complete a three-month placement in primary care medicine.</p> |
|  Singapore | <p>After completion of an undergraduate degree, graduates undertake a year of training as a house officer with three rotations, each lasting four months. The system in Singapore has recently transitioned to a US-style residency programme, although there is a transition period to allow for adjustment.</p> |
|  Sri Lanka | <p>Following completion of an undergraduate degree, graduates take part in the Good Intern Programme (GIP) which aims to “facilitate the transition of medical graduates in Sri Lanka using a multimodal, integrated and sustainable platform”.⁷</p> |
|  United Kingdom | <p>The UK Foundation Programme is a two-year generic training programme which is intended to equip doctors with the generic skills and professional capabilities to progress to specialty training.</p> |
|  United States | <p>Following completion of a four-year medical degree, graduates undertake a one-year internship (also known as postgraduate year one residency), at the end of which the doctor is eligible for full registration. However, most residents continue their residency training to enter a chosen specialty.⁸</p> |

Acknowledgement to Deshmukh, A. 2018. Models, approaches and case studies of international approaches to ‘foundation-level’ postgraduate medical training. Redhill: Surrey and Sussex Library and Knowledge Services. Available under a Creative Commons Attribution-NonCommercial 4.0 International Licence. Modified for illustrative purposes.

Appendix 4 – A Geographic Distribution Of Medical And Foundation Schools

<http://www.foundationprogramme.nhs.uk/content/foundation-schools>



| Unit of Application | Ref |
|-----------------------------|-----|
| East Anglia | 1 |
| EBH | 2 |
| LNR | 3 |
| North Central & East London | 4 |
| North West London | 5 |
| North West of England | 6 |
| Northern | 7 |
| Northern Ireland | 8 |
| Oxford | 9 |
| Peninsula | 10 |
| Scotland | 11 |
| Severn | 12 |
| South Thames | 13 |
| Trent | 14 |
| Wales | 15 |
| Wessex | 16 |
| West Midlands Central | 17 |
| West Midlands North | 18 |
| West Midlands South | 19 |
| Yorkshire and Humber | 20 |



Appendix 5 – Model Shadowing/Induction:

Shadowing (Based on HEE national shadowing advice)

Learning outcomes

1. Demonstrate that they are familiar with their new working environment; and
2. Describe their responsibilities for safe and effective patient care, including how to seek supervision
3. Demonstrate familiarity with appropriate IT systems and procedures
4. Understand what their roles and responsibilities are, and their limitations.

Good practice recommendations:

Ideally shadowing should occur in whole days – ensure that it includes the morning handover

Information technology

F1s should be given their ID badges and passwords for appropriate IT systems as soon as possible.

Near-peer teaching

Top tips from outgoing FY1s

Identify appropriate outgoing FY1s; not all FY1s are great at teaching, identify those that are enthusiastic to deliver these opportunities in advance.

Eportfolio training in small groups – the outgoing FY1s are better placed to describe how to access the portfolio from a trainee perspective

Virtual patient

Going through a virtual admission with the FY1s making the management decisions and completing appropriate investigation request forms; prescription charts and referrals may help to familiarise the FY1s with documents and processes.

Departmental Induction

If possible, provide a handbook to facilitate understanding of the FY1 responsibilities for a particular placement, including how to access appropriate protocols.

The FY1 should be familiarised with any equipment they will be expected to use regularly

The FY1 must be aware of how to access senior support within and out of hours

Consider creating a checklist to remind outgoing FY1s what should be included in the handover to the incoming FY1.

Guided tour of the working environment
Discussion of specific clinical responsibilities

Ward Exposure

An opportunity to take some responsibility
An opportunity to undertake some ward-based tasks

Additional Support

Consider having an additional night nurse practitioner on duty during the first few days
If the FY1 is commencing with an out of hours shift, try to arrange for the FY1 to shadow an out of hours shift.

Consider limiting leave for the outgoing FY1s
Consider dividing the FY1s into groups if one department has a large number of FY1s
'Debrief' sessions with education team to review/consolidate

Ref: https://www.nwpgmd.nhs.uk/sites/default/files/HEE%20Shadowing%20Guidance%202014_0.pdf

This is a suggested timetable

| | |
|-----|--|
| Thu | Welcome and Mandatory Training |
| Fri | Hospital orientation and ward induction |
| Mon | Ward day |
| Tue | Ward |
| Wed | Evening shift/hospital at night/out of hours etc |
| Thu | Sick patient course |
| Fri | Sick patient course |
| Mon | Ward |
| Tue | Ward handover of patients |

Or for seven days

| | |
|-----|---|
| Mon | Welcome and mandatory training |
| Tue | Hospital orientation and ward induction |
| Wed | Ward day |
| Thu | Sick patient course |
| Fri | Sick patient course |
| Mon | Ward |
| Tue | Ward handover of patients |

Appendix 6 – Progress Since Collins

Progress since Collins:

Refs:

Collins Report

<http://cmec.info/wp-content/uploads/2014/07/Foundation-for-Excellence-An-evaluation-of-The-Foundation-Programme-The-Collins-Report.pdf>

GMC Promoting Excellence (Standards for Medical Education and Training)

https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715_pdf-61939165.pdf

GMC Excellence by Design (Standards for PG Medical Curricula)

https://www.gmc-uk.org/-/media/documents/Excellence_by_design_standards_for_postgraduate_curricula_0517.pdf_70436125.pdf

GMCs Outcomes for Graduates

https://www.gmc-uk.org/-/media/documents/outcomes-for-graduates-a4-5_pdf-78071845.pdf

GMC Generic Professional Capabilities (a list of the 9 domains is appended at the bottom of this document)

https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--0817_pdf-70417127.pdf

| | Collins Recommendation | Current Status | To be done |
|---|---|--|---|
| Issue 1: Lack of a clearly articulated purpose for the programme | | | |
| 1 | Medical Education England (through the Medical Programme Board) – working with its counterparts in the other UK countries – should confirm the purpose of the foundation programme as those set out in this report by 2012. | There are now 4 broad aims for the foundation programme: From the curriculum 2016: Build on undergraduate education by instilling recently graduated doctors with the attributes of professionalism and the primacy of patient welfare, which are required for safe and effective care of patients with both acute and long-term conditions. Provide generic training that ensures that foundation doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of their specialty. Provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support. Provide foundation doctors with a variety of hospital, community and academic workplace experience during their foundation programme in order to inform career choice. All foundation doctors must have opportunities to understand community care provision and by 2017, every foundation trainee will have a community placement; 45% of trainees will have a placement in psychiatry and 5% will be in academic programmes. | These aims do not align clearly with to the FPCs (Foundation Professional Capabilities) or the expected (levels of) performance. The Academy of Medical Royal Colleges Foundation Programme Committee is considering this. Stakeholder consultations are ongoing. |

| | Collins Recommendation | Current Status | To be done |
|---|---|---|---|
| 2 | By the end of 2011, the GMC should define, in a revised edition of The New Doctor, the outcomes required to complete the second year (FY2) of the foundation programme. | <p>This is historical. Currently the requirements are:</p> <p>Has taken additional responsibility for decision making in clinical practice including: recognises, assesses and manages the acutely ill patient until senior help is required or available (FPC 9) recognises, assesses and manages patients with long term conditions (FPC 10) obtains history, performs clinical examination, formulates differential diagnosis and management plan in increasingly complex situations (FPC 11) requests relevant investigations and acts upon results (FPC 12) is trained and manages cardiac and respiratory arrest (FPC 15) demonstrates and teaches an understanding of the principles of health promotion and illness prevention (FPC 16) manages palliative and end of life care with guidance (FPC 17)</p> <p>Has started to develop a leadership role within the healthcare team Works effectively as a team member in differing roles (FPC 7) Demonstrates increasing leadership skills (FPC 8)</p> <p>Has been able to adapt practice to new clinical settings with new challenges e.g. outpatient clinics communicates clearly in a variety of settings (FPC 6) prescribes safely in differing environments (FPC 13) recognises and works within limits of personal competence in areas where support is less readily available (FPC 18)</p> <p>Has demonstrated the ability to teach as well as learn in the workplace keeps practice up to date through learning and teaching (FPC 4) demonstrates engagement in career planning (FPC 5)</p> <p>Has demonstrated (and taught to others) a progressive increase in knowledge, skills and behaviours applied across the professional duties, principles and responsibilities set in accordance with Good Medical Practice, Generic Professional Capabilities Framework, other professional guidance and statutory legal requirements. acts professionally (FPC 1) delivers patient centred care and maintains trust (FPC 2) behaves in accordance with ethical and legal requirements (FPC 3) makes patient safety a priority in clinical practice (FPC 19) contributes to quality improvement (FPC 20)</p> <p>Has increased their ability to perform the core procedures mandated by the General Medical Council (GMC) e.g. can perform them in more challenging circumstances and has increased the scope of procedures they are able to perform. performs an increasing range of procedures safely (FPC 14).</p> | <p>This will be defined by the Academy of Medical Royal Colleges Foundation Programme Committee based on the GMC's 9 GPCs (General Professional Capabilities) and approved by the GMC's Clinical Academic Group (CAG).</p> <p>It is likely the Academy of Medical Royal Colleges Foundation Programme Committee will recommend higher level outcomes around:</p> <p>The doctor as a carer: clinical skills (acute, chronic, health promotion, communication, professional skills)</p> <p>The doctor in the healthcare team (teamworking, leadership, the role of the doctor, 24/7 healthcare, values, role as an employee, communication)</p> <p>The doctor in society (safeguarding, safety and quality improvement, research and scholarship, education and training)</p> <p>The doctor as a professional (professional behaviours, professional knowledge, legal issues, responsibility for own development including maintaining careers, eportfolio etc)</p> <p>In the context of an outcomes based curriculum, it is likely the FD will need to provide evidence of these capabilities (capabilities in practice) at an appropriate level of the scale of entrustable professional activities i.e. indirect (remote) supervision.</p> <p>NB: Some have expressed anxiety about the use of CiP which is understood by many to refer to cost improvement programme.</p> |
| 3 | The success of the foundation programme in achieving the purposes outlined and in providing value for money should be evaluated Medical Programme Board working with UKFPO, on a regular basis. The Medical Programme Board will need to develop appropriate indicators by 2011 so that performance data can be prospectively collected by Deaneries and foundation schools and be made available for external evaluation. Deaneries should self-assess against these indicators. | UKFPO is a very small resource for a very large number of doctors (almost 15000) | |
| Issue 2: Misgivings about the selection of trainees into the programme | | | |
| 4 | The evaluation supports the action being taken by the Improving Selection into Foundation Project Group to identify the best approach for selection of applicants into the UK Foundation Programme and allocation to foundation schools and recommends that a decision is made by 2012 so as to inform those candidates applying to commence in August 2013. | <p>Situational Judgement Test (SJT)</p> <p>Educational performance measures comprising medical school decile ranking, extra degrees and publications.</p> | <p>SJT remains unpopular/controversial and there is concerns about a limited question bank leading ability to 'learn' for the test – i.e. it is a test that is studied for rather than a selection process based on personal values/ professionalism.</p> <p>Managed Learning Environment (MLE) will give all graduates a score and will allow medical schools to be assessed against each other. Currently no plans to use score as a ranking. UKFO has just announced tender for application (and this may be an opportunity to change process of allocation)</p> |

| | Collins Recommendation | Current Status | To be done |
|---|--|--|---|
| 5 | A standardised and uniform process should be developed for the recruitment, selection and appointment of foundation doctors by 2012, taking into account the guidance provided by the GMC in Tomorrow's Doctors and The New Doctor. | There is a clear standardised 4 nation process that has been used for many years. Standard national portal, ranking, preferencing etc. | Tom Yapp leads on this as Foundation School Director (FSD) supported by UKFPO. Standards are set by Rules Group (Led by Tom Yapp). |
| Issue 3: Confusion over the role of the trainee | | | |
| 6 | MEE should work with its members and partners to develop a consensus statement on the role of the trainee by 2012. NHS Trusts and the HR departments which draw up service rotas must have a detailed understanding of the role of foundation doctors. | There is clear guidance: FY1s must have direct supervision. FY2s must have onsite supervision. However, confusion over roles remains a problem. This is compounded by historical rotas that mix FY2, the General Practice Vocational Training Scheme and ST1-2 (and now 'F3s') – still colloquially referred to as 'SHOs'. | 'Doctor in training' / 'trainee' terminology remains vague and controversial. The non-training grades use LEDs (locally employed doctors or trust grades). The term 'foundation doctor' should probably be encouraged as should 'doctor in specialty training'. |
| 7 | The GMC should consider producing guidance to support the development of professionalism among trainees, given the particular ethical and professional challenges that they face. This could be carried out as a component of its planned review of Good Medical Practice in 2011 and completed by 2012 | There are clear guidelines on professionalism. These are incorporated into the curriculum. | Ongoing in curriculum development. |
| Issue 4: Questions about GMC registration of trainees and medical students | | | |
| 8 | The GMC should review the timing of full registration. It should also review the merits of marking on the Medical Register the successful completion of the Foundation Programme. Wider consultation including with NHS Employers is recommended. The GMC should review the issues involved in student registration, including the options of registering all medical students or confining this to students who are in their clinical years. It is recommended that these important issues be addressed by 2012. | Review of timing of full registration is still ongoing. Currently no register entry for completion of FP though this is used as a standard for entry to specialty training entry via the 'Alternative certificate'. | Ongoing. A FCC certificate is issued at the end of FY2. eportfolio is available to non-training grade doctors and could be used to record capability in a more robust way than is currently required for the alternative certificate. |
| Issue 5: Dissension over the length of the programme and its rotations | | | |
| 9 | The length of the Programme should remain at two years for the present, and be reviewed in 2015 when the changes in undergraduate medical programmes required by the GMC in Tomorrow's Doctors (2009) will have been fully implemented and evaluated. In the meantime F2 must demonstrate that it is a step-up in experience from F1 and be able to prove its overall value beyond doubt. | Outcomes for graduates have just been published (2018). (Procedures have not been finalised). This follows the GMC's GPCs. FY2 has more advanced outcomes than FY1. This largely represents progress along the EPA (entrustable professional activities) pathway from observes/performs under direct supervision at the start of FY1 to performs under indirect supervision at the start of FY2 achieving competent/entrustable in basic medical care by the start of ST or 'trust grade' employment. | UG and core procedures need to be clarified. The FP curriculum needs to form a link between OfG and specialty curricula/ non-training in supervised work. |

| | Collins Recommendation | Current Status | To be done |
|--|--|---|---|
| 10 | <p>The length of rotations must ensure that a foundation doctor is in a single placement for a minimum of four and a maximum of six months by 2012, with the precise configuration within each year to be discussed by the Deaneries/Foundation Schools.</p> <p>The length and content of the rotational programme must be clearly disclosed in foundation school materials.</p> | <p>4 month placements are the standard. There are some posts with year-long attachments running through and a formal pilot of these in the Northern School. (e.g. 1 day per week in liaison psychiatry for the year or shorter blocks spread through the year).</p> <p>There is significant concern that 4 months limits the ability to form relationships (limiting the opportunity to provide support, role modelling and to assess trainees effectively). Integrating into teams in shorter timescales is particularly hard for IMGs and is part of the cause for differential attainment.</p> <p>Length is clear. Placement descriptors are variable. Occasionally jobs have to change due to service reorganization or change of supervision/problems with placements.</p> | <p>6 months placements may confer and advantage.</p> <p>Trainees like the idea of linked placements (e.g. half time in acute stroke and half time in stroke rehab across a single team – it is easy to see the advantages of this including the ability to stay in a single extended team, gain an understanding of long term conditions and provide cross cover through the placement helping with acute rotas.</p> <p>Foundation doctors are usually unhappy with change but most areas seem to recognise this and minimise it. This can lead to a significant imbalance in cover if there are rota gaps.</p> |
| Issue 6: Perceived deficiencies in careers information and advice | | | |
| 11 | <p>All of the appropriate organisations must work together to define good practice for the provision of careers information and advice. Such information must be easily accessible, simple to understand and contain transparent data on each specialty, including competition ratios and a potential applicant's "likelihood of success".</p> | <p>There is an FSD rep (Tony Choules) on the MDRS careers subcommittee. Various resources are available online.</p> <p>There has recently been a significant cut in 'deanery' careers budgets leading to a reconfiguration of services.</p> <p>Careers guidance tends to be organized at a school/'deanery' level. Cuts from the comprehensive spending review (CSR) will inevitably put more pressure on Educational supervisors to deliver careers advice. While this is part of the AoME 6 standards, many ES find this challenging.</p> <p>Colleges publish clear advice and many run training sessions/experience programmes.</p> <p>FD attendance at large 'careers days' is variable.</p> <p>FDs like to be told about careers by senior trainees as well as consultants. (There are some good examples of trainees organizing workshops). Advice and reminders need to be on-going as ST application is in the first post of FY2. FDs find this a challenge.</p> <p>FDs are encouraged to take 5 days of 'tasters' but this can be difficult at times due to rota commitments.</p> <p>Competition ratios are published yearly. There is evidence that FD choice (for FP, ST and 'Trust' posts) is very 'geographically' lead.</p> | <p>Support, training and time for ES to provide careers advice is required.</p> |
| Issue 7: Lack of flexibility in the programme | | | |
| 12 | <p>Greater flexibility should be available within a single programme, allowing F1 trainees to have greater input into the allocation of their F2 specialty placements and rotations. The generic, broad based experience of F1 and F2 should be retained, with F2 placements aligned as far as possible to the broad areas in which trainees hope to pursue their careers. This should be balanced by the future workforce needs of the NHS and its patients, and the requirement to meet all Foundation Programme generic competences. This should be achieved by 2013.</p> | <p>The Collins report drive to 'broaden training' (must do community, must not repeat a specialty, a certain number must do psychiatry) lead a number of schools to move from 1 year programmes with a choice of FY2 to a system of 2 year programmes fixed at the start. This reduced flexibility. It also lead away from 'themed' FY2 rotations.</p> <p>(NB Wales does allow FY1s to choose their FY2 post).</p> <p>There is a general feeling (including among FSDs) that all foundation (not just FY1) should be completely generic.</p> <p>Some schools allow a 'swap shop' but there are issues with this – particularly administrative work and a concern that swaps could lead to underfilling of less popular posts/trusts and could risk trainees being bullied into a swap by their peers.</p> | <p>It would need a clear steer to ensure all FDs were given the opportunity to change/swap posts and to allow themed rotations. One advantage of themed rotations/posts in less available specialties be that it could attract enthusiastic trainees to less popular locations e.g. a year in various surgical specialties at a small DGH that struggles to fill posts.</p> |
| 13 | <p>Flexibility must be accompanied by actively addressing the current mismatch between expectation and reality which exists in the minds of some trainees about career prospects in different specialties. Flexibility must also take into account the importance of ensuring that Foundation doctors undertake community placements.</p> | <p>Many FDs are clear about careers with many opting to take a break from training after FY2. Studies show this relates to a variety of issues – need for time out from the 'burden' of training, wishing to explore various career options, travel, social.</p> <p>Trusts are beginning to understand this and engage with FY2s by offering contracts that support this process.</p> <p>All FDs in a 2 year programme undertake community placements.</p> | <p>The need to train FDs to perform in supervised practice rather than specifically in a training grade needs to be emphasised.</p> <p>The offer of a 'training programme' to obtain an SAS type role might be attractive to some FDs. (Two years, possibly flexibly leading to a 'second on call' position.)</p> |



| | Collins Recommendation | Current Status | To be done |
|--|--|---|--|
| 14 | Deaneries/foundation schools should make a greater effort to meet one of the important purposes of the Programme – to ensure that trainees experience many different specialties – by maximising and simplifying access to Tasters and by implementing organised “swap shops” for trainees to exchange rotations by 2013. Foundation Schools should disclose through their local Deanery website the degree of flexibility allowed by their programme in a standardised format. | See 12 and 13 above | |
| Issue 8: Gaps in the curriculum | | | |
| 15 | The foundation programme curriculum should be revised to give greater emphasis to the total patient, long-term conditions and the increasing role of community care. It should also reflect the changing ways of working, in particular the need for team-working skills within a multi-professional environment. This revision should be completed by 2013, which will allow time for the content of the revised edition of The New Doctor (due in 2011) to be considered. Those involved in the revision of the curriculum must ensure that the new curriculum integrates fully with medical school curricula. | <p>Long term care is mostly encountered in community placements. FDs often do not have an opportunity to attend outpatient clinics where most hospital based long term care is conducted.</p> <p>Team-working is part of the curriculum and will be in the new curriculum as it is part of the GPCs.</p> <p>The new curriculum will also align to OfGs. (OfGs and GPCs/Excellence by Design has replaced the New Doctor).</p> | <p>Outpatient attendance should be encouraged.</p> <p>The ‘3 hours per week of mandated teaching’ could be used for this. If some of the time was given to departments and there was a responsibility to ensure this was achieved then OPD and other activities could become part of the ‘teaching culture’ in the department.</p> |
| Issue 9: Maldistribution of placements by specialty | | | |
| 16 | The successful completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, e.g. community paediatrics, general practice or psychiatry. The GMC should consider whether this aspiration should be reflected in The New Doctor (due in 2011) and be able to obtain evidence of its implementation by 2012. | <p>Surgical posts have been reduced.</p> <p>Community posts and psychiatry posts have been increased. Many areas have reached the 45% psychiatry target. Some schools offer every trainee a GP post.</p> <p>(The 2016 UKFPO report gives a breakdown of FDs by specialty). It should be remembered that core medical and surgical posts often provide good acute medical skills. The same is true of ED posts.</p> | <p>FDs need to acquire core ‘medical’ skills: acute care skills, ability to provide long term care, mental health and health promotion.</p> <p>According to ‘Shape’ we should be aiming to develop ‘generalists’. They also need to gain ‘professional’ skills.</p> |
| 17 | The distribution of specialty posts in the Foundation Programme is predominantly in two specialties and this must be reviewed by 2013 to ensure broader based beginnings, to share the supervision of trainees among a wider number of supervisors and to ensure closer matching with current and future workforce requirements. Transitional arrangements may need to be put in place – at least in the short term – to ensure that service delivery is not adversely affected by such change. | See 16 above. | |

| | Collins Recommendation | Current Status | To be done |
|--|--|---|---|
| Issue 10: Shortcomings in technology-enhanced learning | | | |
| 18 | The importance of learning resources including skills labs and simulated patient environments, as described in paragraph 5.9 of The UK Foundation Programme Reference Guide and in paragraph 115 in The New Doctor, is reaffirmed. The strategic group currently reviewing the appropriate use and provision of technology to enhance learning in England is requested to provide advice by 2011 on the more widespread use of technology in the Foundation Programme. Concerted efforts need to be made across the different organisations involved to co-invest in facilitating innovations in the delivery of education and training. | This is progressing but is variable across schools. The CSR has led to a problem in some areas. NB The use of simulation has moved away from teaching technical skills towards 'human factors'. | |
| Issue 11: Equipping and approval of trainers is necessary | | | |
| 19 | A framework for the approval of trainers involved in teaching and assessing trainees is a high priority and the professional standards developed and published by the Academy of Medical Educators provides a useful resource for this. The work commissioned by DH and recently commenced by the Academy of Medical Educators should be taken forward in partnership with the GMC and completed by 2012. | They are now approved but standards vary. Ongoing CPD/development follows the AoME standards but its application varies and there is no specific distinction between Foundation supervisors and those supervising higher grade trainees. | |
| Issue 12: Assessment is excessive, onerous and not valued | | | |
| 20 | The range of assessment tools and the number of times assessment must be repeated in the Foundation Programme should be reviewed, with a view to reducing these to the minimum required by 2013. The opportunity to avoid repetitive assessments, by improved transfer of information between undergraduate and postgraduate schools, should be actively explored. | Numbers of assessments have reduced. At stakeholder consultations, trainees felt the burden of assessment was not onerous. There is good evidence to support MSF (TAB) and, increasingly PSG (placement supervision group) assessments. It is widely accepted that assessment by a senior practitioner/expert is appropriate. Medical school finals assesses that a new graduate has the knowledge and basic skills to practice medicine. Foundation must allow FDs to apply this knowledge and develop these skills. It is important that attitudes (equating to 'NHS values) are also developed. The principle of EPAs holds that an activity must become 'entrustable' but that it is acceptable to be able to carry it out in straightforward situations while needing help to achieve it in more complex situations. There is thus some benefit in repeating/demonstrating skills in more challenging cases. However, when OfG skills have been agreed it should be possible to accept UG signoff. | Await OfG review. |
| 21 | NHS Trust employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees. | Some Trusts allocate 0.25 SPAs to ES but not to CS (fewer to CS). Clinical supervision is often regarded as in the job plan but the time for feedback etc and administration is not really considered. In a time when job plans are agreed to 0.05 PA (12 minutes) this, understandably causes frustration among CS. | A steer for fair allocation of time for this work would be useful. |
| 22 | Feedback from patients who have been in contact with the foundation doctor should be part of assessment by 2013 and the GMC should be invited to oversee research to identify best practice in this regard. | This was piloted in 2013 with support from the Picker Institute but was found to be unworkable. RCP have also assess this. It is part of consultant appraisal. At the AFPC, the patient reps felt that patient views were not likely to be reliable of helpful to trainee doctor development. Patients are widely included in curriculum and assessment design. | This is probably not an avenue to pursue at this time. |
| 23 | All foundation programme assessments should be conducted and signed off by resourced and trained assessors by 2013. Assessors should undergo regular review of their performance for this role. | CSR/ESR are done by trained assessors. MSF(TAB) and PSG (which contributes to CSR) is carried out by a variety of professionals, many of whom are not trained or accredited assessors. CS and ES are all accredited and required to show ongoing evidence of good practice and CPD at appraisal. The process for this is possibly not robust but does fall within the GMC guidance about consultant appraisal. The northern deanery has a policy for removing trainers from the register. | This process is well established but variable standards of assessment could lead to inequality. This process probably needs improving/standardising. |

| | Collins Recommendation | Current Status | To be done |
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| Issue 13: Variability in the deployment and supervision of trainees | | | |
| 24 | Methods must be developed to ensure that all health professionals and employers understand the objectives of the foundation programme, become quickly conversant with the prior clinical experience and level of competence of individual FY1 and FY2 trainees, and support the standard that no Foundation doctor will be required to practise beyond their level of competence or without appropriate supervision. This should be achieved by 2012. | Rules are clear: FY1 needs direct supervision, FY2 needs onsite supervision (not necessarily by a doctor) but individual situations vary both from trainer and trainee perspective. Issues arise sporadically with change of rotas etc, especially in psychiatry and in GP practice (see also 6 above). | Requires ongoing monitoring. |
| 25 | The factors determining the quality of clinical and educational supervision should be explored further by MEE through the MPB by 2012; in particular, the time required for quality supervision needs to be identified. The structure of the Programme at local level should ensure a more even demand on clinician time for teaching and supervision, consistent with successful delivery of the curriculum. | This is still highly variable. GP and psychiatry offer 1 hour per week in most cases and practice lends itself to more 1:1 supervision. | Though a significant resource implication, one hour per week for all Foundation CS doctors to undertake f2f would ensure a far greater degree of 'supervised training'. This would not have to be 1:1 as much learning can occur in groups (e.g. as occurs GPVTS training). This would also support careers advice (11 above) FD stakeholder groups state that meeting together and sharing thoughts/ ideas is valued by FDs. |
| 26 | The GMC must ensure that the standards for training for the Foundation Programme relating to patient safety as outlined in Domain 1 of its document The New Doctor (2009) are understood and achieved by all Foundation School Directors and by NHS Employers. | Patient safety is now a GPC: Domain 6: Capabilities in Patient Safety and Quality Improvement. | It is important that this is reflected in the updated FP curriculum. |
| 27 | The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training by 2013; graded responsibility should be allowed with some degree of clinical discretion based on clear communication of the individual trainee's capability and informed by its two publications Tomorrow's Doctors (2009) and The New Doctor (2009). | This remains an issue. Discretion is clearly required to allow individual trainees to develop at their own pace. The GMC has essentially delegated this to colleges (and hence Foundation) in Excellence by Design (the development of PG curricula using GPCs). In the workshops around EBD the GMC clearly favoured EPAs (Entrustable Professional Activities): Observe -> Direct Supervision -> Indirect Supervision -> Independent Practice (but not necessarily 'expert' practice – i.e. the foundation 'graduate' should be capable of instituting the management of a patient they encounter in practice who has a common condition with well recognized complications and know to seek help in more unusual cases). The use of CiPs (Capabilities in Practice) is used in some curricula – including the new CMT) to show the level at which a doctor undergoing PG training is 'entrusted' e.g. managing the acute take. | This will be reflected in the FP curriculum. (It will be important to ensure trainees are conversant with patients presenting with multiple comorbidities). |
| Issue 14: Variability in the quality of education and learning | | | |
| 28 | The Postgraduate Deans, the GMC and NHS Trusts must clarify the appropriate balance between service and education during F1 and F2 and ensure that the effective monitoring of this balance is being achieved by 2012. Clear pathways must be available for trainees to obtain satisfactory resolution if the appropriate balance is being eroded. | The Guardian of Safe Working is established in England. FDs make variable use of this process. FDs are surprisingly nervous about raising complaints even in anonymous surveys. The FP curriculum currently states 3 hours/week of 'Foundation' training is expected. This is rarely achieved with some schools expecting no more than 30 hours/year. Recent stakeholder meetings have suggested that the 3 hour/week of 'Foundation' training sends the wrong message as it often leads to 'filling the slot' and devalues teaching in departments. At stakeholder meetings it has become clear that, in some areas, trainees have limited patient contact and little opportunity to learn by presenting cases and discussing treatment plans. In the GMCs 'Promoting Excellence', the standards expected for training in Trusts/Departments is set out. The NACT Specialty Tutor job description entrusts the college/specialty tutor in a department to take responsibility for the training environment. | A review is needed of the way FP 'teaching' is delivered and 'policed'. Generic FP teaching should be towards generic FP skills not individual pathologies/presentations. Departmental teaching should be valued. An hour/ week of direct CS supervision would be highly valued by trainees. Trusts need to conform to Promoting Excellence. An individual in a training department needs to hold responsibility for training within it and be accountable to the DME. |

| | Collins Recommendation | Current Status | To be done |
|--|---|--|---|
| 29 | The GMC should define measures of quality and require Deaneries to collect performance data on an ongoing basis. Results should be published and be publicly available at programme and hospital level. Educational performance measures should be a required element of senior manager evaluation in Trusts receiving funding for a Foundation Programme. Institutions receiving such funding should identify the educational lead in the Trust as a prerequisite for receiving this funding. These recommendations should be implemented by 2012. | GMC survey is undertaken by all trainees. New NETS survey still under development. GMC currently relies on Dean's report. New QA process is currently being developed – needs development of RAG rating and triggers for visits. Most Trusts now have DME. Many have education governance boards. | This topic is wider than FP but it is important 'carrot and stick' approaches are maintained. Close working to provide support to work within Promoting Excellence is as important as sanctions against LEPs who fail to comply. |
| Issue 15: Lack of pastoral support for trainees | | | |
| 30 | Each institution training foundation doctors must have well defined and functional procedures to escalate any quality and safety issues related to education and training. Good practice with regard to pastoral care needs to be defined and the GMC should require evidence of its availability in Foundation Programmes in accordance with Domain 6 of The New Doctor (paragraph 96) by 2011. | Most trusts use their standard safety reporting system for incidents. Some have developed specific education reporting tools. Pastoral care is usually provided by supervisors and education staff supported where necessary by Professional Support Units (PSUs) though in some areas these have been reduced following the CSR. Some trusts have a specific individual to deal with 'doctors in difficulty'. There is clear evidence that a number of trainees are isolated and unable to seek support. This probably includes a disproportionate number of BME/IMG doctors. The GMC continues to work on differential attainment. | Possibly a national standard for reporting of educational issues within training organizations that could work alongside exception reporting in England. Consideration of a requirement for all lead LEPs to employ an individual to provide pastoral and professional care. |
| Issue 16: Inadequate transfer of information about trainees | | | |
| 31 | In the interests of patient safety and in order to help trainees to address issues which have been identified, the transfer of relevant information about medical students and trainees across the continuum of education and training must take place (within carefully defined limits) by 2012. | The transfer of information (ToI) process is now formally established from medical schools to Foundation. It is embedded in the eportfolio via reports during Foundation. Some medical schools undertake this process very well and send letters to accompany ToI forms giving clear information and, often, a clear plan. The process is less formal at the end of Foundation with the transfer to further training or service posts. It is possible for trainees to 'drop off the radar', especially if they take a career break with the only consistency being the GMC. | With large number so graduates declaring issues on medical school ToI forms, some form of register may be appropriate to ensure ongoing support and the need for reasonable adjustments. However, it is likely that many trainees would find this intrusive. In special circumstances the GMC Welcome and Valued guidance may guide this. |
| 32 | Guidelines must be developed by 2012 by the relevant organisations with input from student and trainee representatives on the appropriate information relating to the knowledge, skills and professional behaviour of medical students and trainees which should be made available, who can request and receive this information and how it will be shared and stored. | Eportfolio is well established and a repository for information on doctors in a particular postgraduate training programme. However, at the end of this programme this information is not necessarily shared (see 31 above). It is unlikely that all PG training programmes will be willing or able to align their eportfolios. Stakeholder meetings raised the suggestion of beginning eportfolio in medical school thereby allowing doctors to be familiar with the process at graduation. This would reduce the need to repeat some achievements from UG to PG. (see also 20 above). | Consider introduction of eportfolio at undergraduate level to record achievements and allow familiarity with the process. This could be NES in the DAs and Horus in England but, ideally should be a single entity to ensure equality across the FP. |
| 33 | Medical schools should explore how best to share information with the GMC about medical students by 2012. | | |

Appendix 6 – continued

Domain 1: Professional values and behaviours

Domain 2: Professional skills

Practical skills

Communication and interpersonal skills

Dealing with complexity and uncertainty

Clinical skills

Domain 3: Professional knowledge

Professional requirements

National legislative requirements

The health service and healthcare system in the four countries

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team working

Domain 6: Capabilities in patient safety and quality improvement

Patient safety

Quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

Appendix 7 – Standalone FY2 Recruitment Process Data

Table 1 – Current FY1s applying to FY2. Current FS v New FS.

Those coloured in pink have applied to the same area, so assuming they wanted a preferable specialty or location with the foundation school

| Row Labels | Scotland | Northern Ireland | South Thames | West Midlands | Thames Valley | South West | Yorkshire | East of England | North East | Wessex | North West | East Midlands | Grand Total |
|-----------------------|----------|------------------|--------------|---------------|---------------|------------|-----------|-----------------|------------|--------|------------|---------------|-------------|
| East Anglia | | | | 1 | 2 | 1 | 1 | | 1 | | | | 6 |
| EBH | | | | | 2 | 1 | | | | | | | 3 |
| LNR | | | 1 | | | | | | | | | | 1 |
| North West London | | | | | | 1 | | | | | 1 | | 2 |
| North West of England | 1 | 1 | | 1 | | | 1 | | | | 1 | | 5 |
| Northern | | 1 | 1 | | 2 | 1 | 1 | | 1 | | 2 | | 9 |
| Northern Ireland | 1 | 1 | | | | 1 | | | | 1 | | | 4 |
| Oxford | | | | | 4 | | | | 1 | | | | 5 |
| Peninsula | | | | | | | | | | 1 | | | 1 |
| Scotland | 10 | 1 | 1 | | | 2 | | | 2 | | | | 16 |
| Severn | | | | 1 | 2 | 2 | 2 | | | | 1 | | 8 |
| South Thames | | | 1 | 1 | 5 | 1 | | | 2 | 3 | | | 13 |
| Trent | | | | 1 | 2 | | 1 | | 1 | | 1 | 4 | 10 |
| Wales | | | 1 | | | | 1 | | 1 | 1 | 1 | | 5 |
| Wessex | 1 | | | | 5 | 3 | | 1 | 1 | 1 | | | 12 |
| West Midlands North | | | | 5 | | | | | 1 | | | 1 | 7 |
| West Midlands South | | | 1 | | | 1 | | | | 1 | | | 3 |
| Yorkshire and Humber | | | | | 1 | 1 | 4 | | 1 | | 2 | | 9 |
| East of England | | | | | | | | 2 | | | | | 2 |
| Grand Total | 13 | 4 | 6 | 10 | 25 | 15 | 11 | 3 | 12 | 8 | 9 | 5 | 121 |

UKFPO data

Table 2

Interestingly, 44/121, over 30% of applicants into standalone got their 1st preference in their initial allocation to FY1

| Current Foundation School | 1st Preference |
|--|----------------|
| East Anglia | 1 |
| East of England | 2 |
| Leicestershire, Northampton, Rutland (LNR) | 1 |
| North West London | 1 |
| North West of England | 2 |
| Northern | 6 |
| Northern Ireland | 3 |
| Oxford | 3 |
| Scotland | 8 |
| Severn | 3 |
| South Thames | 2 |
| Trent | 1 |
| Wales | 1 |
| Wessex | 4 |
| West Midlands North | 2 |
| West Midlands South | 2 |
| Yorkshire and Humber | 2 |
| | 44 |

UKFPO data



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