

Foundation for Excellence An Evaluation of the Foundation Programme

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“Properly planned and carefully conducted medical education is the foundation of a comprehensive health service.”
(The Goodenough Report, 1944)



Medicine is changing rapidly. Scientific and medical knowledge is advancing quickly and the health system is witnessing far-reaching changes in its structure. If we are to deliver high quality, efficient healthcare that puts patients first, the education of the country’s medical workforce must be of prime importance.

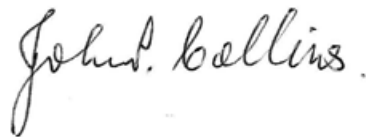
The preparation of medical doctors in the UK starts in medical school. After graduation it continues through the Foundation Programme. This is followed by one of the specialty training programmes, completion of which is marked by certification as a specialist including in general practice.

This report is based on an evaluation of the Foundation Programme five years after its introduction in 2005. We have examined whether new medical graduates are able to learn efficiently and effectively, and whether they are working in a supportive and supervised environment, where they learn the importance of safe patient care and the necessity to work within their level of competence while at the same time being encouraged to extend the boundaries, enhance their contribution and strive for excellence.



We have found that the Foundation Programme has many strengths. But there are questions over key aspects of design, content, safety and quality. A number of changes to the current system have therefore been recommended to tackle these problems in a spirit of evolution not revolution. The principles underlying these recommendations are to prioritise patient safety, the interests of the trainees and the need to improve quality and efficiency in a transparent way.

These changes will require concerted and co-operative action by the many organisations involved, including employers. But they are essential. The National Health Service is one of the country's great national institutions. The Government has set an ambitious goal for it: that the NHS should be as good a health service as any in the world. We should aim to have the best medical education in the world and the Foundation Programme must be one of the key platforms for this pursuit of excellence.



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1. Introduction and context

Rationale for the Evaluation

After graduation, doctors in the UK enter the two-year Foundation Programme, which is designed to give trainees broad general experience before choosing an area of medicine in which to specialise. The Programme is delivered across the UK's 25 Foundation Schools, 22 in England and one each in Scotland, Wales and Northern Ireland. Learning takes place predominantly in the context of healthcare delivery.

The implementation of the Foundation Programme in 2005 was a major step in a substantial restructuring of medical education and career paths known as Modernising Medical Careers (MMC), a reform process that had been ongoing for some time. However, the implementation of MMC was beset by problems. Professor Sir John Tooke was invited to lead an Independent Inquiry into MMC and his Report, published in 2008, proposed that "the structure of postgraduate training should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence".

Recommendations in the *Tooke Report* on the Foundation Programme were subsequently addressed in the *NHS Next Stage Review*. This led Medical Education England (MEE) to commission a formal Evaluation of the Programme in 2009.

Scope and approach of the Evaluation

The Terms of Reference for the Evaluation were to assess how successfully the Foundation Programme is delivering against its original objectives, as well as against the future needs of the National Health Service and of trainees. The Evaluation was to recommend changes to the Foundation Programme to ensure that the first two postgraduate years deliver against future needs.

In conducting the Evaluation, the Independent Chair was supported by an Expert Advisory Panel. The Panel assisted with the gathering and analysis of evidence and advised on recommendations.

The Evaluation sought evidence from a variety of sources to ensure that its conclusions and recommendations would be as robust as possible. Oral and written evidence was received from 67 organisations or sources closely

involved with medical education; and the Evaluation reviewed over 285 publications. The Panel also met with medical students and trainees; local trainers and others involved in the delivery of the Programme; and hospitals, strategic health authorities and the Department of Health (DH).

Context of the Evaluation

The importance of preparing tomorrow's healthcare workforce was recognised in the *NHS Next Stage Review*, which stated that "the delivery of high quality education and training is an essential part of delivering high quality patient care". As in many other countries, medical education and training in the UK must deal with a number of forces for change; it is therefore timely to consider whether current medical educational programmes can respond to these changes.

This Report describes the Evaluation of one such programme – the UK Foundation Programme – and makes a number of recommendations with timelines for their implementation. One of the difficulties faced during this Evaluation lay in deciding which of the different organisations involved should be named as responsible for implementing the recommendations. The recent (2010) Government White Paper, *Equity and Excellence: Liberating the NHS*,¹ states that "education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists and pharmacists. Similar mechanisms will be put in place for nurses and midwives and the allied health professions." For the Evaluation Panel and many of those interviewed there remains a lack of clarity as to where the responsibilities reside or will reside in the future. This requires urgent clarification if the recommendations are to result in actions. The Evaluation has listed in Appendix 7 the key MEE partners to take the recommendations forward based on the current landscape.

This report was being finalised as the General Medical Council (GMC) published the 2010 National Training Survey. Concerns raised in the GMC report over supervision of trainees are reflected in our own findings.

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Key considerations for the Evaluation

The Evaluation has taken into account several specific issues.

The first is the **role of the trainee**. This role needs to be more clearly defined so that doctors in training are appropriately educated, deployed, supervised and valued for their service contribution.

Second, the Evaluation has considered the **major changes in society, the health service and in education**, including:

- the significant increase in the over-65 population, with the related increase in the prevalence of long-term conditions; and successive government efforts to move more care into the community and closer to home;

- specialisation becoming the norm in secondary care medical practice, making explicit the need for broad based beginnings in order to provide a foundation for subsequent learning and practice;
- the European Working Time Directive, which limits the maximum working week to an average of 48 hours over a six-month period;
- a more learner-centred approach to medical education and training; and the introduction of new, innovative approaches to healthcare education including e-learning, simulation and clinical skills facilities; and
- future plans for the NHS in the light of a challenging economic situation.

Third, the Evaluation has considered the importance of promoting clinical academia and leadership among medical students and trainees.

Finally, the Evaluation has considered the **regulatory environment**, including:

- the GMC, which absorbed the Postgraduate Medical Education and Training Board (PMETB) in 2010 and is responsible for regulating all postgraduate medical education and training in the UK; and
- the Quality Assurance of Basic Medical Education Programme (QABME) implemented by the GMC in 2003; and the Quality Assurance of the Foundation Programme (QAFP) implemented by the GMC in 2008.

2. Evaluation findings – strengths of the Foundation Programme

The Evaluation analysed a large body of evidence and found widespread support for the Foundation Programme, but also a number of important issues which need to be addressed. This section considers the strengths of the Programme, under the headings of design, content, and safety and quality.

Design strengths

The Foundation Programme has **established a credible UK-wide generic training programme**. The Programme has created placements that are part of a defined and time-capped two-year programme with a regulator-approved curriculum and programme of assessment, with progress being dependent upon the acquisition of key competences mapped to the curriculum.

An **educational infrastructure and faculty** focusing on the first two years of postgraduate medical education has been created. This includes Foundation Schools, which combine the expertise of the staff of medical schools, the local Deanery, primary and secondary care Trusts and others responsible for the delivery of healthcare. The Foundation Schools provide Foundation doctors with exposure to a wide range of clinical and patient settings. Further, the Foundation Programme has provided a **national programme for entry into postgraduate medical education** in which all trainees must achieve a standardised list of generic competences.

Content strengths

A clear, well defined and broadly supported **national curriculum** has been developed, providing a structure for the content of early postgraduate medical education that did not exist during the SHO years. A revised curriculum was published in 2010 in response to *The New Doctor*, published in 2009 by the GMC. The curriculum makes clear the competences which have to be acquired for progression and the method and the timing of this acquisition. It also makes clear what doctors should and should not be doing at different stages in the Foundation Programme and seeks to avoid the practice of doctors working beyond their level of competence.

The Foundation Programme facilitates the **exposure of trainees to a range of medical specialties**, including shortage specialties (a shortage specialty is one in which available senior posts may exceed the number of appropriately qualified applicants). Trainees across the Foundation Schools have access to experience in 48 specialties, with a preponderance in adult medicine and surgery. Around 24% of F2 doctors (doctors in the second year of the Foundation Programme) spend four months in shortage specialties. A major emphasis has been placed on exposure to emergency care to ensure that doctors become competent at recognising the acutely ill patient and instituting appropriate initial management.

The Programme has provided a **vehicle for trainee assessment** and feedback. Workplace-based assessment and feedback are now central to the philosophy of Foundation Programme training. Regular assessment ensures progression, provides documentary evidence of achievements and can be used to identify trainees with problems.

The **Academic Foundation Programme** is a further significant contribution to the content of early postgraduate medical education. It provides Foundation trainees with the opportunity to develop research, teaching and leadership/management skills in addition to the current basic clinical competences outlined in the curriculum. The Academic Foundation Programme has filled most of its available placements, with research providing the greatest number of opportunities. The National Institute for Health Research and the Medical Schools Council strongly support the academic programme, as do the trainees in the programme.

Safety and quality strengths

For the first time, there is a clearly defined curriculum and an operational framework for early postgraduate medical education. Significant efforts have been made to manage the quality of the Foundation Programme and ensure robust educational outcomes. Patient safety was reported to the Evaluation Panel as a key component of the Foundation Programme. All Foundation doctors are assessed in the workplace and judgements about satisfactory completion of F1 (doctors in the first year of the Foundation Programme) and F2 are made against agreed national criteria. In 2009, 96% of F2 doctors completed the Foundation Programme successfully. There is also a robust

and transparent quality assurance process, QAFP, based on GMC visits to the Deaneries. The introduction of QAFP has resulted in greater scrutiny and transparency, and provides an inbuilt improvement mechanism.

3. Evaluation findings – concerns about the programme

This section sets out the issues of concern about the Foundation Programme that emerged from the evidence submitted to the Evaluation. Again, these issues are listed under the headings of design, content, and safety and quality.

Design issues

The Programme **lacks a clearly articulated and generally accepted purpose**. In particular, the lack of an articulated purpose for the Programme's second year has led some to question its value in terms of educational objectives, its role in relation to the first year and specialty training, and whether it delays career progression. The Evaluation recommends that MEE, through its Medical Programme Board (MPB) and working with its counterparts in the other UK countries, should confirm the statement of the purpose of the Foundation Programme as set out in this Report (page 60). The success or otherwise of the Foundation Programme in achieving these purposes and in providing value for money should be monitored on a regular basis and based on prospectively collected evaluative data. (*Recommendations 1–3*)

Misgivings have been raised about the **process and methodology used to select trainees** for entry to the Foundation Programme and hence employment. DH commissioned the Medical Schools Council to lead a Project Group to consider the best approach, and two new selection methods are currently undergoing pilot testing. The Evaluation supports the actions being taken by the Project Group. The importance of UK medical graduates being able to obtain F1 positions in order to fully register with the GMC is reaffirmed. However, efforts to achieve this must comply with the requirements of UK employment legislation. (*Recommendations 4 and 5*)

Confusion exists about the role of the medical trainee in the NHS and in NHS-related academic employment. Trainees are postgraduate learners as well as paid employees of the health services. They provide an important contribution to the healthcare of patients and are not supernumerary to service requirements. In return they receive education and training predominantly in the clinical environment. The key is maintaining a balance between the demands of the clinical service and the requirements for their learning. Without a clear understanding of the role of trainees in the NHS there is a real risk that the long-term educational mission of the service will be inappropriately dominated by short-term service requirements. In addition, a lack of understanding of the level of competence of F1 and F2 doctors may have led to their deployment in inappropriate roles and beyond their level of competence. Equally, it is recognised that trainees must be encouraged to extend the boundaries, step up and enhance their contribution, particularly in F2.

A consensus statement on the role of the trainee in the Foundation Programme is required to provide a wider understanding of the strengths and limitations of this role and to ensure that trainees are appropriately deployed, educated and supervised. Trainees have a unique set of circumstances and guidance is necessary to support the development of their professionalism. *(Recommendations 6 and 7)*

Questions have been raised about the **registration of trainees and medical students with the GMC**. UK medical graduates receive provisional registration at the end of medical school and must undertake a further year (F1) to complete their studies and receive full registration. It is unclear whether this yields the best outcomes for trainees or the NHS.

The current process necessitates shared governance of the Foundation doctor between the Postgraduate Deanery responsible for managing and delivering the Foundation training and the graduate's previous medical school, which remains responsible for sign-off of the trainee as ready for full registration. Forty per cent of graduates move away from the Deanery of their medical school to undertake the Foundation Programme in another Deanery area and this was reported by some as problematic for governance. However, there is no significant support for changing the current sign-off arrangements.

6 *There are conflicting views on the appropriate length of the Foundation Programme and its constituent rotations.* ▶

Limitations on prescribing by provisionally registered F1 doctors have been put forward as a reason why they are of limited utility in general practice. It is said that this hinders the Government's efforts to achieve a target of exposing 55% of Foundation doctors to general practice.

A number of submissions suggested that the need to find better ways of gradually introducing medical students to the principles and practice of professionalism would be helped by student registration with the GMC. This was in place in the UK until November 1940 when it was suspended by the GMC "in order to secure an economy under war efforts". The predominant focus of previous discussion has been on issues related to fitness to practise but the development of professional values is equally important. The Evaluation recommends that student registration be reconsidered.

The outcome from F1 is clearly defined in terms of meeting the requirements for full registration with the GMC. The end of F2 completes the Foundation Programme and this important "waypoint" needs to be more formally recognised. One possibility is for the GMC revalidation process to commence at this point. *(Recommendation 8)*

There are conflicting views on **the appropriate length of the Foundation Programme and its constituent rotations**. The *Tooke Report* recommended shortening the Programme from two years to one year, with the second year to be incorporated into the first year of Core Specialty Training. This position was supported by a number of submissions to the Evaluation. Others proposed one Foundation Year followed by three years of Core Training, or, as an alternative, two Foundation Years but with the second year themed to the specialty being considered as a future career by a trainee.

However, the majority of submissions, including those from trainees, supported the continuation of the current two-year programme – at least for the present. A two-year integrated programme is considered necessary for trainees to develop the generic skills required of all doctors and to help them to make a more informed career decision based on exposure to a broad range of specialties.

Given the lack of overall support and paucity of supportive evidence for shortening the programme, the Evaluation recommends that it should remain at two years but this must be fully reviewed in 2015. By this time, the changes in undergraduate programmes required by the GMC in *Tomorrow's Doctors* (2009) should have taken effect and lead to medical graduates being more prepared for medical practice. During the intervening period, F2 must demonstrate that it is a significant step-up in terms of experience and responsibility from F1.

Ninety per cent of Foundation School rotations comprise three placements of four months in each year. Opinions vary between those who favour four and six-month placements but there is no support for placements that are shorter or longer than this. The Evaluation therefore recommends that placements should be of four or six months' duration. (*Recommendations 9 and 10*)

The Evaluation Panel received submissions that the timely **provision of careers information and advice may be inadequate**, hampering trainees in making informed career decisions. However, extensive careers information is available, including information about competition ratios and probabilities of success in certain specialties. It is perhaps the lack of balanced and reasonable advice on careers which needs to be rectified.

A major issue which must be addressed relates to the large number of medical graduates who continue to apply for oversubscribed specialties. Many of those who are successful in gaining entry to Core Training and completing the requirements of such training are unable to progress to advanced training in the same specialty. This is compounded by the failure of other specialties to recognise the competences achieved, forcing the trainee to commence training at the beginning of the course in another specialty.

The challenge which remains is how best to help trainees to manage their career expectations against realistic opportunities and the needs of the service, while at the same time encouraging them in their overall aspirations. Guidance is required in defining best practice in the provision of careers information and advice, and obtaining key workforce data collated to help trainees to make early and wise decisions regarding their long-term careers. (*Recommendation 11*)

The **lack of flexibility in the Foundation Programme** has been extensively highlighted in submissions, especially those from trainee-related organisations and trainees themselves. Fifty-five per cent of Foundation Schools in 2009 had a fixed two-year programme which means that specialty placements for F2 were fixed prior to trainees commencing F1.

A number of trainees are keen to discuss access to specialty placements in F2 in which they have a particular interest or aptitude and/or are considering as a possible long-term career. In this they are supported by a number of medical colleges and other organisations.

At the same time there is general agreement that broad based beginnings are very important and, provided all of the Foundation Programme generic competences can be met, a wide spectrum of specialty placements should be available.

Some Deaneries and Foundation Schools organise “swap shops” which allow trainees to swap either complete or individual rotations. A further method of achieving a broader exposure to a range of specialties is through Tasters – a short period, usually of two weeks, in a particular specialty.

The Evaluation recommends that Deaneries and Foundation Schools should maximise the flexibility of their programmes and strive to align F2 rotations to the broad areas in which trainees hope to pursue their careers – provided all the Foundation Programme competences can be met. At the same time, efforts to achieve flexibility must be accompanied by actively addressing the current mismatch between expectation and reality which exists in the minds of some trainees around career prospects. (*Recommendations 12–14*)

Content issues

Gaps are present in the Foundation Programme curriculum despite the strengths noted earlier. The major focus of the curriculum is correctly on acute illness, but there is insufficient emphasis on the total patient and on long-term conditions. Concern was expressed to the Evaluation Panel that overlap with the undergraduate curriculum is leading to boredom among some trainees. The Foundation Programme curriculum is based on the spiral curriculum model which involves revisiting clinical and professional practice and recognising that levels of expertise generally increase with practice and reflection. Competence successfully demonstrated by students in medical school is therefore demonstrated again as a professional in the workplace but at a higher level.

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It is acknowledged that the acute setting of large hospitals presents some challenges in delivering a curriculum which includes long-term illness and the more appropriate learning environment is the community setting. However, current arrangements for teaching and learning in the community are not sufficient. While these challenges are real and may take time to rectify, the 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. (*Recommendation 15*)

The distribution of placements by specialty does not reflect the current and future needs of the NHS. The balance and distribution of Foundation posts is dominated by opportunities in adult medicine and surgery, which reflects in part the GMC requirements implemented in 1967.

These requirements were discontinued in 2007, opening up a wide range of specialties. While it is recognised that medicine and surgery can provide an excellent and important learning experience, Foundation doctors can equally benefit by spending time in paediatrics, general practice, psychiatry and other areas as part of their important broad based beginnings.

Furthermore, a greater share of healthcare is now delivered in the community with successive governments supporting a model in which this will expand. The balance of placements in the Foundation Programme does not reflect this change. It is acknowledged that there are significant challenges in delivering a greater share of the Foundation Programme in community settings because of the limited range of posts available. Current workforce planning assumptions suggest that around 50% of doctors in training will need to become GPs, yet there are no placements in F1 in general practice and there were only 796 (15%) in F2 in 2008. These issues and those relating to services for children and young adults discussed in the body of this Report must be addressed.

The Evaluation recommends that the successful completion of the Foundation Programme should normally require trainees to undertake a community placement. The balance of placements in the Programme between the different specialties should be reviewed to help to share the burden of supervision as well as to more closely align training to workforce requirements. The difficulties in implementing such changes in the present financial and service climate within the NHS and the wider public sector are fully acknowledged. (*Recommendations 16 and 17*)

Shortcomings have been reported in opportunities for technology-enhanced learning. The implementation of the Foundation Programme included the establishment of a curriculum, educational infrastructure and facilities, and the appointment of those to manage and deliver the Programme. Learning resources such as skills laboratories and simulated environments were and are an important part of this innovation. A number of trainees commented on the variation in the provision and use of simulation as an aid to learning. There is, however, a paucity of reliable information about the use of technology-enhanced learning in the Foundation Programme upon which to make a reliable recommendation.

The importance of these learning resources is reaffirmed and guidance is required to facilitate their more widespread use. A number of different groups use these innovations and co-ordination of their individual investment resources would assist in the progress of implementation. (*Recommendation 18*)

Equipping and approval of trainers is necessary. The creation of the Foundation Programme gave rise to new requirements for supervisors and trainers, including workplace-based assessments. It is now accepted that those who teach and assess learners should be equipped and approved for these vital roles. In addition, they must be formally recognised and allocated the necessary time to properly undertake this work. It is recommended that a framework be developed for the approval of trainers. The professional standards published by the Academy of Medical Educators for the

accreditation of trainers should provide a very useful resource in helping to achieve this. The danger of alienating some of those with long-standing experience in teaching and assessment who have yet to be convinced of the benefits of courses and workshops in education must be sensitively managed as they are a vital and scarce resource. (*Recommendation 19*)

Assessment of Foundation doctors is considered to be excessive, onerous and not valued. Although workplace-based assessment and feedback is central to the philosophy of the Foundation Programme, it has not yet gained the widespread support of trainers or trainees. The validity of the assessment tools has been questioned, and their variable application has been attributed to the lack of preparation of the assessors and insufficient time in which to undertake these assessments properly.

The number of assessments required is formidable. Figures from 24 of the 25 UK Foundation Schools show that between August 2008 and August 2009 a total of 249,564 clinical assessments were performed and 193,338 multi-source feedback appraisals undertaken on about 14,500 trainees.

The introduction of these assessments has provided confidence in the competence of Foundation trainees, but has placed a very substantial demand on trainer time. The high scores suggest that the tools are not discriminating of less good performance, but, given that the benchmark is competence rather than excellence, this is not surprising.

The Evaluation Panel found support for feedback from patients who have been in contact with the Foundation trainee to be included as part of assessment, and further research should be undertaken to identify best practice in this regard.

The range of assessment tools and the frequency of assessments must be urgently reviewed and modified based on the data now available on assessment in the GMC surveys and feedback from trainers; otherwise, the credibility of the Foundation Programme in the eyes of teachers and trainees will be compromised. Improved transfer of information between undergraduate and postgraduate schools should be explored to help to avoid unnecessary and repetitive assessments. Furthermore, methods must be found to support and recognise those who “aspire to excellence”.

The opportunity for Foundation doctors to take medical college examinations is contentious and considered by some to be disruptive to the aims of the Foundation Programme. However, many colleges in the UK allow candidates to sit their core specialty examinations prior to commencing their training programme and, although the educational basis to support this practice can be challenged, it is nevertheless a reality. (*Recommendations 20–23*)

Safety and quality issues in the learning environment

Evidence was presented regarding **variation in the proper deployment and supervision of trainees, the quality of education and learning and the lack of pastoral care.**

In meetings with trainees across England, the Evaluation Panel heard the repeated theme of some trainees being asked to practise beyond their level of competence and without adequate supervision. This was supported by similar findings in the 2009 PMETB Survey of Foundation doctors and by the evidence collected during the recent reviews by Lord Patel and Sir John Temple. QAFP reports based on visits to Deaneries and Foundation Schools have also raised concerns about lack of clinical supervision.

The 2009 PMETB Survey showed that, while virtually all Foundation doctors were able to identify their supervisor, the quality of supervision was not always rated highly. The scores for supervision varied significantly between specialties. Because of the large number of Foundation placements in some specialties there is a particularly high demand on time for supervision and undertaking assessments. The lower supervision score for these specialties suggests that some of these placements should be reviewed.

Trainees must “step up” in their level of responsibility as they progress through their training and learning, including on moving from F1 to F2. However, this must be undertaken under appropriate supervision. We are extremely concerned that some Foundation trainees are expected to practise outside their level of competence and without appropriate supervision. This places patients at unnecessary risk and gives the trainee the message that suboptimal care is condoned, neither of which is part of the professional values and aspirations of a good doctor.

The lack of availability of pastoral support was raised by trainees and others, and confirmed in the 2009 PMETB Survey. Good practice with regard to pastoral care needs to be developed, with evidence of its availability being assessed in quality assurance visits to Deaneries and Foundation Schools. The commitment expressed in the Government’s recent White Paper to implementing Dr Steven Boorman’s recommendations on improving staff health and well-being is welcomed. (*Recommendations 24–30*)

Inadequate transfer of information is said to occur between medical schools and those responsible for the subsequent education, training and employment of medical graduates. It was alleged that this can be more of a problem when students move away from their home medical school to another region in order to undertake the Foundation Programme.

Transfer of relevant information needs to occur in order to help trainees to address issues which have been identified during the undergraduate course and to ensure patient safety. The public expects this. The Transition Group has recognised its importance and is currently working on this issue with the Information Commissioner. The Evaluation Panel would like to see this quickly

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resolved but recognises the importance of guidelines around this sensitive subject. (*Recommendations 31–33*)

4. Conclusions

In its Terms of Reference, this Evaluation was given the task of examining four questions within the context of the needs of patients, the needs of trainees and the changing environment.

The original purpose of the Foundation Programme

The original objectives of the Foundation Programme gradually evolved throughout its development and implementation and have continued to evolve based on experience of its application in the workplace. For this reason there are diverse views on its purpose but within these a number of consistent themes have been identified. These are summarised in this Report and should form the basis of a generally accepted purpose for the Programme. This needs to be clearly stated and widely understood to ensure that Foundation doctors receive the best education possible and contribute to the delivery of safe patient care.

Whether the Foundation Programme is meeting its original purpose and objectives

The lack of an agreed purpose and of prospectively collected evaluative data made it difficult to accurately quantify how successfully the Foundation Programme is delivering against these objectives. Nevertheless, there is widespread support for the Programme and indirect evidence that it has delivered successfully against a broad number of objectives.

The current priorities for the early years of postgraduate medical education

The future needs of the NHS are rapidly changing with an ageing population, an increase in long-term illness, and new and expanding medical knowledge and ways of preventing and managing various diseases. At the same time increasing efforts are being made to deliver a greater share of healthcare in the community. These changes have a far-reaching impact on efforts to prepare the nation's medical workforce to meet society's needs. At the same time, a number of factors have led to calls for reform in medical education, and for greater recognition of the importance of broad based beginnings during the first two years after graduation. The Foundation Programme has made major strides to address these future needs. Over the two-year programme, a number of generic competences aligned to a clearly defined curriculum must be achieved.

Whether the Foundation Programme meets the current strategic direction of the NHS

High quality patient care and the first-rate education and training of Foundation doctors have been central to this Evaluation. These are closely entwined and, in order to achieve these goals, the role of the trainee must be better defined and accompanied by the appropriate deployment, supervision and education of these trainees. The Evaluation Panel found evidence of widespread commitment to these aims but at the same time is very concerned by its findings of many Foundation doctors being expected to work beyond their level of competence and without adequate supervision. We admire and applaud the large number of doctors, other health professionals and employers who work hard to ensure safe patient care and to provide the best education and training of the UK's medical workforce. Equally, we were alarmed by the evidence presented to us reflecting unacceptable practice. This must be addressed as a matter of urgency.

5. Recommendations

It is essential that the following recommendations are addressed, to build on what is learned in medical school, so that Foundation doctors are appropriately supported and supervised, and so that the priorities of the NHS are met – in particular, that doctors are equipped to care for the whole patient and improve patient safety, outcomes and experience. Key partners to take the recommendations forward based on the current landscape and timelines for completion are listed in Appendix 7.

Issue 1: Lack of a clearly articulated purpose for the Programme

1. *MEE (through the MPB) – 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.*
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 (F2) of the Foundation Programme.*
3. *The success of the Foundation Programme in achieving the purposes outlined and in providing value for money should be evaluated by the MPB working with UK FPO, on a regular basis. The MPB 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.*

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.*

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.*

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.*
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.*

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.*

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.*
10. *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. The length and content of the rotational programme must be clearly disclosed in Foundation School materials.*

Issue 6: Perceived deficiencies in careers information and advice

11. *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".*

Issue 7: Lack of flexibility in the Programme

12. *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.*
13. *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.*
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.*

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.*

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.*
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.*

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.*

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.*

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.*
21. *NHS Trust employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees.*
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.*
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.*

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 F1 and F2 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.*

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.*
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.*
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).*

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.*
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.*

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.*

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.*

- 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.*
- 33. Medical schools should explore how best to share information with the GMC about medical students by 2012.*



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Chapter 1: Introduction and context



In 2009 Medical Education England (MEE) commissioned a formal Evaluation of the two-year Foundation Programme for postgraduate doctors. This Report contains the findings of the Evaluation, in three chapters:

- Chapter 1 provides the **introduction and context** for the findings, setting out: the rationale for the Evaluation; its scope, approach and context; the evolution of the Foundation Programme within the continuum of medical education; and key considerations for the Evaluation.
- Chapter 2 discusses the **strengths of the Foundation Programme**, based on the evidence submitted to the Evaluation. These strengths are detailed under the headings of design, content, and safety and quality.
- Chapter 3 sets out the **concerns about the Foundation Programme** that emerged from the evidence submitted. These issues are detailed under the headings of design, content, and safety and quality. For each issue, the Evaluation's recommendations are provided.

The Appendices cover: the Terms of Reference of the Evaluation; the members and role of the Evaluation's Expert Advisory Panel; medical workforce reports reviewed by the Evaluation; bodies submitting oral and written evidence to the Evaluation; abbreviations; an action plan; and acknowledgements.

1.1 Rationale for the Evaluation

The Foundation Programme was established in August 2005 as the first phase of a series of reforms known collectively as Modernising Medical Careers (MMC). These reforms were in turn a response to the Chief Medical Officer's (CMO's) report, *Unfinished Business*, in 2002.² *Unfinished Business* highlighted a number of issues with the education of postgraduate medical trainees, particularly the excess of Senior House Officers (SHOs) in the system, many of whom were not in structured training programmes and were repeatedly required to apply for jobs at short intervals. The MMC reforms attempted to address these issues as part of far-reaching modernisation of postgraduate medical education.

The Foundation Programme was designed as a two-year generic training programme to form a bridge between medical school and specialist/general practice training. The first year (F1) built upon the knowledge, skills and competences acquired in undergraduate training. In order to attain full registration with the General Medical Council (GMC), doctors must achieve specific competences by the end of this year. The learning objectives for this year are set by the GMC. The second year of the Foundation Programme (F2), which must be seen as a part of a two-year integrated programme, augments the first year of training. The main focus in F2 is on training in the assessment

■ *The Foundation Programme was designed as a two-year generic training programme to form a bridge between medical school and specialist/general practice training.* ▶

and management of the acutely ill patient. Training also encompasses the generic professional skills applicable to all areas of medicine – teamwork, time management, communication and IT skills.

The introduction of the Foundation Programme is generally considered to have been project managed successfully. This was in contrast to the problems experienced with the next phase of MMC reforms, the transition to “run-through” specialist training which commenced in 2007. In response to the problems, the then Secretary of State for Health announced an Independent Inquiry into MMC, chaired by Professor Sir John Tooke.

The final Report of this inquiry, *Aspiring to Excellence*, known also as the *Tooke Report*, was published in January 2008.³ The Report made 47 recommendations, including four specifically related to the Foundation Programme.

The Department of Health (DH) welcomed the *Tooke Report*. The Secretary of State’s formal response⁴ deferred the balance of decisions regarding changes to the Foundation Programme. These recommendations were subsequently addressed in the *NHS Next Stage Review: A High Quality Workforce*.⁵ This committed DH to requesting MEE “to commission a formal evaluation of the two-year Foundation Programme”. This Evaluation is contained in this Report.

1.2 Scope and approach of the Evaluation

The Terms of Reference for the Evaluation included:

- what were the original objectives of the Foundation Programme?
- how successfully is the Foundation Programme delivering against these objectives?
- what are the future needs of the service and of trainees from the first two postgraduate years?
- how successfully is the Foundation Programme delivering against these future needs?
- what changes are needed to ensure that the first two postgraduate years deliver against future needs?
- the needs of patients and trainees must be central to the Evaluation; and
- the recommendations must be affordable within current budgets.

Recommendations by the Evaluation could also be made for the improvement of undergraduate and postgraduate education as they relate to the Foundation Programme and in the context of the wider consideration by MEE of postgraduate medical education and training. The Terms of Reference are laid out in Appendix 1.

1.2.1 Role and objectives of the Expert Advisory Panel

The role of the Expert Advisory Panel was to support the Independent Chair in conducting the Evaluation, developing final recommendations and writing the Report. This included support in:

- determining the sources of information and evidence to be considered;
- obtaining and considering written and oral evidence;
- considering the evidence gathered from publications and policy documents relating to the Foundation Programme and the broader aspects of medical education; and
- discussing analysis of the evidence and advising on the conclusions and recommendations to be made to the Medical Programme Board (MPB) and later the Board of MEE.

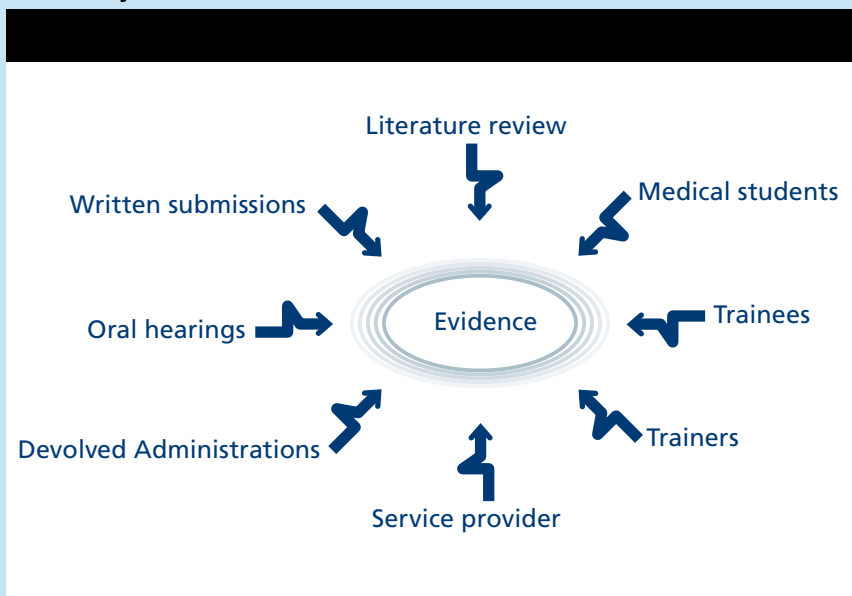
A list of members of the Expert Advisory Panel is provided in Appendix 2.

1.2.2 Approach to the Evaluation

The Foundation Programme was introduced in 2005 and because of its short history and the absence of prospectively recorded outcome evaluative measures, conclusive evidence of its effectiveness and efficiency as a training approach is not available.

The Evaluation therefore sought evidence from a variety of sources including publications on the Programme to ensure that its conclusions and recommendations are as robust as possible (Exhibit 1).

EXHIBIT 1 The evaluation has sought evidence from a variety of sources



❖ The role of the Expert Advisory Panel was to support the Independent Chair in conducting the Evaluation, developing final recommendations and writing the Report. ❖

Oral and written evidence

Organisations most closely involved with undergraduate and/or postgraduate medical education and a number of individuals were invited to provide oral and written evidence.

The opportunity to submit written evidence was also advertised on the MEE website. Written evidence was received from 67 sources which are listed in Appendix 5. All submissions were read by a resource investigator and the Chair, while all key themes and individual comments were captured and stored in a dedicated database.

Over 30 oral evidence sessions were conducted to explore key issues. Each session was recorded and full transcripts were produced and later sent to those giving evidence for factual confirmation. The main points from each session were circulated to attending Panel members for factual confirmation. Appendix 4 lists the bodies and individuals that submitted oral evidence.

Literature and other evidence review

The Evaluation reviewed policy documents related to the Foundation Programme as well as relevant documents from the GMC, independent reviews, education providers and service providers. Over 285 publications were reviewed which included those relating to the Foundation Programme and the broader aspects of medical education. Of particular interest were the recent review reports on educating physicians in the United States^{6,7} and on the future of medical education in Canada,⁸ both of which were produced to mark the centenary of the Flexner Report.⁹

Engagement with medical students and trainees

The Panel was keen to meet with medical students, Foundation trainees and those doctors who had completed the Foundation Programme within the last two years. The goal was to listen to their views and personal experiences of the Programme.

6 The Panel was keen to meet with medical students, Foundation trainees and those doctors who had completed the Foundation Programme within the last two years. 7

Meetings were held with the British Medical Association (BMA) Medical Student Committee, the BMA's Junior Doctors Committee and the Academy Trainee Doctors Group. Five meetings were arranged with trainees across England and medical students were welcome to attend. Invitations to the trainees were sent via a variety of routes, including the BMA, the English Postgraduate Deaneries, the UK Foundation Programme Office (UK FPO), the National Association of Clinical Tutors (NACT), the Academy Trainee Doctors Group and RemedyUK. These meetings and the opportunities they would give for trainees to provide feedback to the Expert Advisory Panel were highlighted in *BMA News* and *Student BMJ*.

Trainees were encouraged at each meeting to comment from their own experience on the Foundation Programme and each trainee was invited to articulate what was the single most important point for them. A written summary was made of these meetings, with all comments recorded anonymously.

The Chair also attended a meeting with trainees organised by Lord Patel to obtain feedback on the Foundation Programme as part of his review of medical education and training (the *Patel Review*).¹⁰

Other working sessions

The Panel was keen to meet with local Foundation Programme trainers and others involved in the delivery of the Programme. Invitations were sent via NACT. In addition, members of the Panel met informally with others involved in postgraduate medical education across the system.

These meetings enabled the Panel to hear directly from those involved in the day-to-day delivery of the Programme across different parts of England.

Service perspective

The Evaluation recognised the vital perspective that service providers, Strategic Health Authorities (SHAs) and DH would bring to the review of the Foundation Programme. The Expert Advisory Panel was constituted to ensure service provider, SHA and DH participation. Written and oral evidence was sought and received from hospitals, SHAs and DH. In addition:

- the Evaluation met with representatives from SHAs and worked closely with them throughout the Evaluation through their workforce directors;
- the Evaluation met informally with hospital senior managers; and
- the Evaluation met formally and informally with senior DH staff.

Liaison with the Devolved Administrations

The Independent Chair attended two meetings of the simultaneous but separate Evaluation of the Foundation Programme being carried out in Scotland and has worked closely with the Chair of the Scottish Evaluation. Discussions have also taken place with those involved in the Evaluations in Northern Ireland and Wales. Those responsible for the Foundation Programme in Northern Ireland have shared the written report of findings from their Evaluation. Every effort has been made to ensure that the content of this MEE Report has the broad support of the other Administrations. This is important so as to ensure that there is no disruption to trainees' education and training as they move between the different countries in the UK.

1.3 Context of the Evaluation

1.3.1 Importance of educating and training a nation's medical workforce

At a time of unprecedented advances in medical knowledge and rapid changes in the organisation and delivery of healthcare, the primacy of the education of a nation's healthcare workforce remains constant. In 2002 a report in the United States¹¹ stated that "the physician remains a critical factor in determining the quality and cost of care... and that the content and quality of physician training will remain vital for the foreseeable future to the health of the people".

The roles of the doctor in the contemporary healthcare team were explored in the *Tooke Report*, which highlighted their “frequent role as head of the healthcare team and commander of considerable clinical resource”.¹²

The importance of preparing tomorrow’s healthcare workforce was recognised in DH’s *Next Stage Review* which stated that “the delivery of high quality education and training is an essential part of delivering high quality patient care”. The provision of this first-rate education and training is dependent upon:

- the recruitment and selection of high quality medical students and trainees;
- the development and delivery of integrated high quality education and training programmes across the continuum of learning;
- access to accredited hospital and community training positions that provide the necessary broad based educational experiences;
- an equipped, motivated and sustainable education faculty; and
- exposure of the learner to high quality patient care.

A large investment and a long time are required to train a doctor. This means that workforce planning is essential. The creation of the Centre for Workforce Intelligence in 2010 is intended to help the NHS and social care providers to plan their workforce around shifting resources to the front line, removing bureaucracy and moving care from hospitals into people’s homes and the community. The close linkage between workforce planning and education and training will be vital if the NHS is to train the correct number of doctors with the necessary skills to meet societal needs across all geographical locations.

The Government’s vision for the NHS and for the training and education of health professionals is described in a new White Paper, *Equity and Excellence: Liberating the NHS*,¹³ and has important implications for the future.

1.3.2 Broader concerns with postgraduate medical education

The Terms of Reference of the Evaluation rightly focused its work on the Foundation Programme. However, during the Evaluation a number of those who were involved raised questions and presented evidence that addressed broader issues outside of this scope. In particular, questions were raised on how effectively the medical education continuum was meeting the longer-term needs of the NHS.

They also highlighted a number of strategic questions to which clear answers had not previously been articulated. These included:

- what objectives should a nation have for its medical education system?
- how successfully is the medical education system delivering against those objectives? For example:
 - is the system delivering the doctors with the skills and capabilities that the NHS will need in the near future, and with the ability to acquire new skills as those needs change over the longer term?
 - is medical education efficient and providing good value for money?

Others identified a number of system-design questions that do not appear to have been consistently answered. For example:

- to what extent should the system aspire to reward excellence versus focus on ensuring that minimum standards are met?
- should all hospitals and all doctors be involved in educating and training trainees?
- what level of flexibility – which increases choice but reduces certainty – should be built into the system?

Nearly £5 billion is spent annually on clinical education in the UK, the majority of this on medical education.¹⁴ Subsequent to the completion of this Evaluation it will be important that a full strategic review of the medical education continuum is undertaken. It is vital to ensure that the considerable public resources being spent on educating doctors are being spent in a way that meets national needs, provides good value to the taxpayer and is befitting to the talented young people who have chosen the medical profession as their career. Equally these UK medical graduates need to commit and contribute to the public well-being.

1.3.3 Calls for reform of medical education and training

One hundred years ago Abraham Flexner conducted a comprehensive study of medical education in the United States and Canada.¹⁵ This led to widespread changes in the structure, curriculum and delivery of medical education in the United States and Canada. Many of these changes were adopted by other countries including the UK and much of Flexner's legacy remains in place.

Major changes have taken place since then, particularly over the past 50 years with the rise of biomedical research, the transformation of clinical practice into a large business¹⁶ and changes in the delivery of healthcare. Patient care and research have become the dominant source of funds and prestige for clinical departments and individuals, leading to a decline in the recognition and value of medical education and of the importance of excellent teachers and educational scholarship.¹⁷ As a result, medical education faces a new set of challenges.

A recent review of medical education in the United States¹⁸ reported that "medical training is inflexible, overly long, and not learner-centred. Clinical education for both students and trainees excessively emphasises mastery of facts, in-patient clinical experience, teaching by residents and supervision by clinical faculty who have less and less time to teach in hospitals with marginal capacity or willingness to support the teaching mission". The authors call for reform and make a number of recommendations.

A similar recent review of medical education in Canada¹⁹ has examined how medical education programmes can best respond to society's evolving needs. It identified a number of evidence-based priority areas for change.

6 Nearly £5 billion is spent annually on clinical education in the UK, the majority of this on medical education. **2**

In the past 17 years two major reforms of medical education have been undertaken in the UK, including that on specialist medical training by Sir Kenneth Calman in 1993 and subsequently (2003) MMC which led to reform of the SHO grade.

A number of observations have been made, including the following:

- postgraduate medical education and training is inextricably linked with health service delivery and medical workforce planning considerations;
- the health service, workforce planning, the regulatory environment and clinical academia have been through a period of significant change and all have a bearing upon the continuum of medical education; and
- medical education is distinct from teaching in higher education in general because of the central place that patient care occupies, not only in teaching and learning but also in assessment and feedback and in quality assurance.

1.4 Evolution of the Foundation Programme

Medical education consists of several distinct but related stages, some of which are being further developed as a part of MMC.

UK medical education and training consists of three principal stages (Exhibit 2). The first is undergraduate medical education, a four to six-year period of study at one of the UK's medical schools with clinical placements in hospital and community settings.

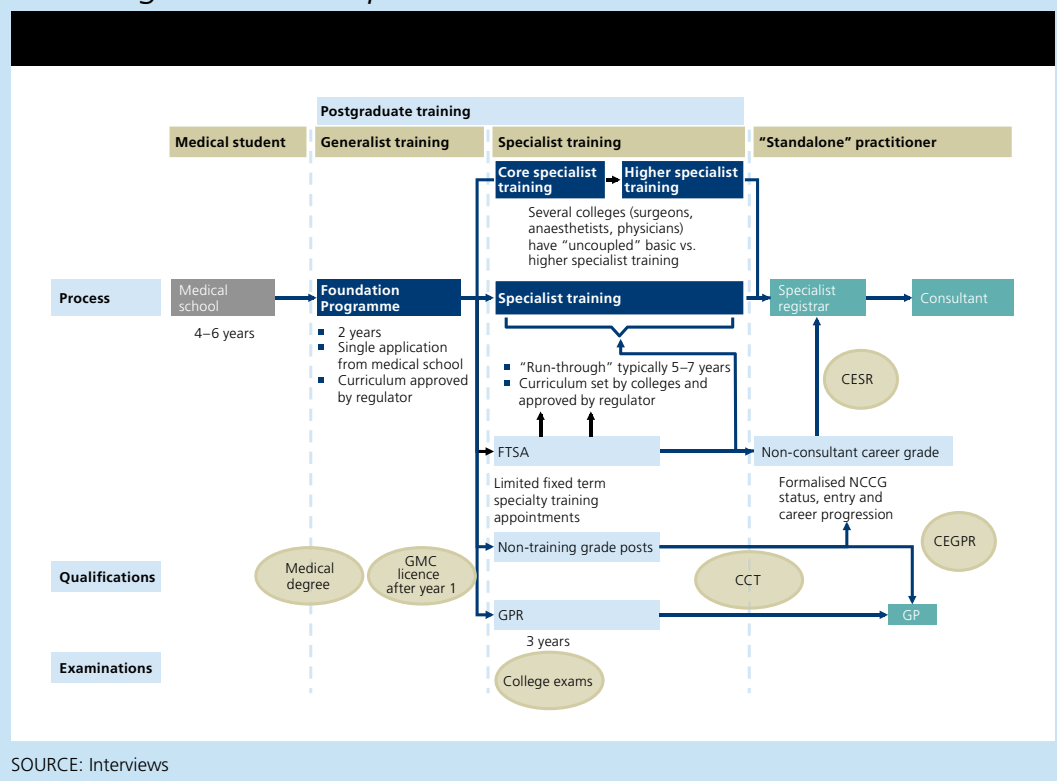
The second stage is the Foundation Programme, a two-year period which all UK medical graduates must complete satisfactorily before progressing to specialist education.

The third stage is specialist training, a period lasting for several years during which doctors are educated and trained in one of a number of specialties. Key characteristics of this stage are as follows:

- the length and structure of specialty training depend upon the specialty area and the particular career structure which the individual wishes to pursue, e.g. academic/research, full-time clinical practice;
- some specialties have "run-through" training that consists of between five and seven years of uninterrupted progression through a defined specialist training programme; and
- a number of the Medical Royal Colleges, including the Royal Colleges of Surgeons, Physicians and Anaesthetists, have uncoupled the previous "run-through" nature of specialist training into a two to three-year period of Core Training followed by three-plus years of higher specialist training. In these instances there are separate selection episodes to enter core and higher specialist training.

Following the completion of specialist training, doctors will continue to build skills with Continuous Professional Development.

EXHIBIT 2 Schematic of current postgraduate training in the UK following the *Tooke Report*



1.4.1 Undergraduate medical education and training

Undergraduate medical training is available in a variety of formats lasting between four and six years, with direct entry from secondary school being the predominant method. A number of places are available for graduate entry in UK medical schools. This is the standard process for entry in the United States and Canada and increasingly so in Australia.

There has been a considerable growth in the number of medical places available in recent years. The number of medical school acceptances grew by roughly 4% per year or by almost 40% in England between 2000 and 2008. The increase in undergraduate medical education capacity has been achieved by: increasing student places at existing medical schools; creating shortened programmes open to science graduates; "twinning" arrangements, which host an existing curriculum at a new site; and by establishing new medical schools.²⁰

The GMC document *Tomorrow's Doctors* (2009) sets the outcomes and standards for undergraduate medical education under three separate headings relating to the doctor as a scientist and a scholar, as a practitioner, and as a professional. These categories cover the development of the knowledge, skills and behaviour which students must demonstrate by the time they graduate. The document also sets out the outcomes the GMC expects medical schools to deliver and what the employers of new UK medical graduates can expect to receive. In addition to these required outcomes and standards, UK medical schools are free to require their graduates to demonstrate additional competences; this enables each school to have a unique identity.

1.4.2 A national qualifying examination

The desire for explicit national standards and publicly available endpoints has engendered some support for a national qualifying examination.²¹ On the surface this may enable the comparison of an individual student from one university with one from another and may provide national ranking. The difficulty, however, of producing national assessments that reflect all of the dimensions of clinical competence and thus miss many relevant areas of performance must be acknowledged. Furthermore, the inhibition of diversity or regeneration of educational programmes, the slowness of national examinations to respond to rapidly developing science and the loss of touch with clinical reality that extraneously designed examinations (especially those limited to assessing knowledge) can have must be recognised.²²

1.4.3 Postgraduate medical education and training

After graduation, doctors in the UK enter a two-year Foundation Programme. During the first year they are provisionally registered with the GMC. On the successful completion of this first year, trainees are fully registered with the GMC. F1 was previously known as the Pre-Registration House Officer or PRHO year. The Foundation Programme is designed to give trainees a range of broad general experience before choosing an area of medicine in which to specialise.

1.4.4 Evolution of the Foundation Programme and broader medical education

The implementation of the Foundation Programme was a major step in a substantial restructuring of medical education and career paths known as MMC, a reform process that had been ongoing for some time (Exhibit 3).

EXHIBIT 3 The move from PRHO to Foundation

- Apr 1997 GMC publishes *The New Doctor* setting out recommendations for PRHO year
- May 2001 GMC publishes *Good Medical Practice* guide setting out expectations for registration
- Apr 2002 GMC education committee begins major review of PRHO year
- Aug 2002 CMO publishes *Unfinished Business* recommending creation of Foundation Programme
- Feb 2003 Four UK Health Ministers endorse setting up foundation training system
- Aug 2003–04 Foundation pilots carried out
- Jan 2005 Consultation on curriculum closes
- Mar 2005 Foundation curriculum published – single UK curriculum, competence based
- May 2005 *Rough Guide to the Foundation Programme* for trainers and students published
- Aug 2005 First intake from medical school into F1
- Dec 2008 *Aspiring to Excellence* published

6 The desire for explicit national standards and publicly available endpoints has engendered some support for a national qualifying examination... The difficulty, however, of producing national assessments that reflect all of the dimensions of clinical competence and thus miss many relevant areas of performance must be acknowledged. 7

Unfinished Business

Problems with the early years of postgraduate medical education had been acknowledged prior to the review of specialist training undertaken by DH, known as the *Calman Report*,²³ in 1993. This helped to resolve the problems with the Registrar/Senior Registrar grade but some problems with the SHO grade increased following implementation of its recommendations. Trainees were perceived as spending increasing amounts of time at SHO grade and the quality of training within this grade was perceived to deteriorate: posts were often poorly structured and not linked to any defined programme; training was inflexible; selection and application processes were alleged to be weak and cumbersome; and workloads were seen to be increasing. The balance between training and service delivery in SHO posts shifted increasingly towards service. Trainees hoping to move into certain specialties began to spend long and undefined periods of time hoping to build the expertise required to be selected into specialty training.

In 2002, *Unfinished Business* proposed reforms to the SHO grade to address some of these problems. Key recommendations included:

- introduction of a two-year Foundation Programme;
- creation of eight time-capped basic specialist training programmes after the Foundation Programme;
- creation of a single training grade;
- a move to greater emphasis on competence-based training and assessment;
- assumption of responsibility for training programmes, including appointment arrangements by Postgraduate Medical Deans; and
- award of the Certificate of Completion of Specialist Training (CCST) earlier in specialist training in order that holders could be eligible for generalist consultant posts in their specialty (with the option to pursue further sub-specialist or other training).

The initial response from UK Health Ministers to *Unfinished Business* was broadly positive, as set out in the publication *Modernising Medical Careers*.²⁴ This addressed many of the issues raised in the Report but went much further, proposing major changes to the structure of specialist medical training. Core recommendations included:

- the introduction of the Foundation Programme with a focus on generic competences;
- full registration to remain at the satisfactory completion of year 1;
- the development of “run-through” training – a single training grade encompassing both basic (core) and higher specialty training; and
- a review of non-training grades to better align them with training posts and allow more opportunities for re-entering training towards consultant level.

Unfinished Business envisaged a Foundation Programme in the context of progression to a themed basic training rotation as the intermediate step prior to specialisation. In contrast, MMC outlined plans for “run-through” specialist training directly out of the Foundation Programme, removing the themed basic training rotation step as set out in *Unfinished Business*.

MMC and the Tooke Inquiry

In April 2004 the UK Strategy Group, charged with overseeing MMC, published its blueprint for the shape of the Foundation Programme and for specialist training including general practice. Following a number of pilots, the Foundation Programme was introduced in 2005 and replaced the PRHO and first SHO years across the UK.

The implementation of MMC was beset by problems, particularly around selection into specialty training. Professor Sir John Tooke was invited “to lead an Independent Inquiry into MMC in the wake of the problems surrounding the Medical Training Application System (MTAS), the process used for selecting trainee doctors for specialist training”.²⁵

As well as identifying the underlying causes of the challenges with implementation, the *Tooke Report* also recommended changes to the structure of medical education – going beyond the selection into specialist training – noting:

“The structure of postgraduate training proposed by MMC is unlikely to encourage or reward striving for excellence, offer appropriate flexibility to trainees, facilitate future workforce design, or meet the needs of particular groups (e.g. those with academic aspirations, or those pursuing a non-consultant career grade experience). It risks creating another ‘lost tribe’ at FTSTA [Fixed Term Specialist Training Appointment] level.”

The Report²⁶ proposed:

“The structure of postgraduate training should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence.”

With regard to the Foundation Programme, the Report²⁷ made the following recommendations:

“Recommendation 31:

Under the Medical Act, Universities already have responsibility with regard to FY1. By breaking the employment linkage with FY2, it will be possible to guarantee an FY1 position in the new graduate’s local Foundation School subject to prevailing local selection processes. The employment linkage between FY1 and FY2 should cease for 2009 graduates.

Recommendation 32:

FY1 should be reviewed to ensure that i) harmonisation with year 5 is optimised; ii) the curriculum more clearly embraces the principles of chronic disease management as well as acute care; iii) competency assessments are standardised and robust. In future doctors in this role should be called ‘Provisionally Registered Doctors’.

Recommendation 33:

Foundation Year 2 should be incorporated as the first year of Core Specialty Training. This will require broad based 'theming' of the current FY2 provision. The acquisition of competences of the current Foundation Programme should continue across FY1 and first year of Core pending formal review of this curriculum and development of detailed Core curriculum objectives. The current commitment to FY2 GP placements should continue as part of Core Specialty Training and be developed further as resources permit. Doctors in Core Specialty Training should be called Registered Doctors."

While many of the recommendations of the *Tooke Report* were accepted and acted upon by the Secretary of State, decisions on those relating to the Foundation Programme were deferred pending a formal Evaluation of the Foundation Programme including a decision as to whether to continue with the Foundation Programme or to move to an alternative model linked to the wider reform of postgraduate medical education structures.

1.5 Key considerations for the Evaluation

The Evaluation has taken into account several specific factors which impact on the Foundation Programme, including the role of the trainee and changes in society and in the environment relating to learning, service, academia and regulation.

1.5.1 The role of the trainee

One of the issues identified in the Independent Inquiry into Modernising Medical Careers²⁸ was the need for clarification on the role of the doctor.

Recommendation 5 in the Report called for:

"a common shared understanding of the roles of all doctors in the contemporary healthcare team that takes due account of public expectations".

It also stated that:

"clarity of the doctor's role must extend to the service contribution of the doctor in training".

In response, a *Consensus Statement on the Role of the Doctor* was developed by a number of organisations, patient groups and medical and lay delegates participating in the Role of the Doctor Conference held in October 2008.²⁹ This Consensus Statement should be seen in the context of the Duties of a Doctor as defined by the GMC.³⁰ It adds to the pioneering work carried out by the Royal College of Physicians and Surgeons of Canada³¹ in defining the different roles society expects of its medical practitioners.

❖ The Evaluation has taken into account several specific factors which impact on the Foundation Programme, including the role of the trainee and changes in society and in the environment relating to learning, service, academia and regulation. ❖

The more specific role of the trainee has not been clearly defined and this is necessary to provide a wider understanding of the strengths and limitations of this role so that trainees are appropriately deployed, educated and supervised in the workplace.

1.5.2 The learning environment

The Foundation Programme is delivered across the UK's 25 Foundation Schools, 22 of which are based in England. Foundation Schools bring together medical schools, the local Deanery, Trusts (acute, mental health and Primary Care Trusts) and other organisations (e.g. hospices) to offer Foundation doctors training in a range of different settings and clinical environments. The schools are administered by staff supported by the local Postgraduate Deanery.

The Postgraduate Deaneries are responsible for the management and delivery of postgraduate medical education. This includes ensuring that all training posts provide the necessary opportunities for doctors (and dentists) who are in training to realise their full potential and provide high quality patient care. The Deaneries are also responsible for ensuring that trainers, educational supervisors and educational leaders meet the standards set by the GMC.

Teaching and learning take place predominantly in the context of healthcare delivery. In addition, innovative approaches to education which include e-learning, simulation and clinical skills facilities are used to enhance the learning environment. It is considered necessary that "Foundation doctors should have opportunities to develop and improve their clinical and practical skills, in clinical skills labs and simulated patient environment".³²

1.5.3 Changes in the service environment and in society

There are a number of significant changes that are impacting UK patients, including:

- the ageing population and the significant increase in the over-65 population;
- the related increase in the prevalence of long-term conditions;
- successive governments' efforts to move care closer to home;
- changes in patients' expectations of doctors and clinical care; and
- the increase in ambulatory care and the reduction in the length of time patients stay in hospital.

European Working Time Directive

The European Working Time Directive (EWTD) is a directive from the Council of Europe which lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted into UK law in 1998 as the Working Time Regulations. The Government negotiated an extension of up to 12 years to prepare for full implementation for doctors in training.

6 *The more specific role of the trainee has not been clearly defined and this is necessary to provide a wider understanding of the strengths and limitations of this role so that trainees are appropriately deployed, educated and supervised in the workplace.* 7

The *New Deal for Junior Doctors*, agreed in 1991, aimed to improve the conditions under which they work, primarily by reducing working hours.³³ From August 2003 all junior doctors were limited by contract to 56 hours of active work per week.

August 2009 was the deadline for implementation of the EWTD 48-hour maximum working week. This could exceptionally be extended by another three years at 52 hours, with 48 hours being implemented only in 2012.

In 2009 MEE was requested by the Secretary of State for Health to instigate a review of the impact of EWTD on postgraduate medical education. The review, chaired by Sir John Temple, has been completed and the Report (*Time for Training*) was published in June 2010.³⁴ In overview, its recommendations are:

- implement a consultant-delivered service;
- service delivery must explicitly support training;
- make every moment count;
- recognise, develop and reward consultants who are trainers; and
- training excellence requires regular planning and monitoring.

Time for Training included a number of important statements relating to postgraduate medical education and training, which will be referred to throughout this Report.

Future plans for the NHS and training and education

The recently published White Paper³⁵ makes it clear that the NHS continues to face a challenging fiscal environment. The Coalition Government reaffirms its commitment to patient-centred care and choice and to driving quality outcomes through transparency and robust evidence and data. The Government's intended reforms "will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve". Clinical leadership and involvement in service commissioning and design will be strengthened.

The NHS is committed to providing the best possible care and to improving health outcomes for patients. The Government has committed to providing real terms growth in resources to support this commitment. Forecasted growth in demand, however, means that the NHS cannot rely on traditional ways of working. Therefore, the challenge is to ensure that the growing needs of patients and the public to improve quality and efficiency are met, and at a pace and on a scale not previously achieved.

The Government foresees that DH will have a progressively reducing role in overseeing education and training and that "healthcare employers and their staff will agree plans and funding for workforce development and training". A major change highlighted in the recent White Paper³⁶ is that "education commissioning will be led locally and nationally by the healthcare professions, through Medical Education England for doctors, dentists, healthcare scientists and pharmacists... Similar mechanisms will be put in place for nurses and midwives and the allied health professions". In addition "the professions will

have a leading role in deciding the structure and content of training, and quality standards”.

There are a number of players in the field and their roles and responsibilities are not as clear as they should be. This has created difficulties in articulating who will be responsible for implementing or overseeing the recommendations outlined later in this Report.

1.5.4 The academic environment

The health of the UK population depends in part on the significant contribution of clinical academics to teaching, research and clinical practice. Clinical academics are at the forefront of medical discoveries and play an important part in national and international medical affairs as well as teaching across the education continuum.

The declining interest in biomedical research among medical students and graduates was first raised in 1979,³⁷ with others adding similar concerns. This led to the recognition that academic medicine was in crisis and required revitalisation and reinvention.³⁸

There have been a number of initiatives to promote clinical academia among medical students and trainees and recognition that academic medicine requires a “structured and adequately supported clinical environment and well trained clinicians”.³⁹ The formation of the National Institute for Health Research (NIHR) and the establishment of Biomedical Research Centres with similar initiatives in the Devolved Administrations are some examples.

The Academic Foundation Programme has been designed to enable Foundation trainees to develop additional skills in research, education or leadership/management at the same time as exploring academia as a career during the overall Foundation Programme.

1.5.5 The regulatory environment and evolution of the pre-registration year

The GMC was established under the Medical Act of 1858 and is the regulator of all medical doctors in the United Kingdom. The Medical Act of 1983 gave the GMC the responsibility to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine and promoting high standards of medical education.

In 1944 the Goodenough Report⁴⁰ advocated the introduction of the pre-registration year, arguing that it was no longer appropriate for newly qualified doctors to enter independent practice without a period of service providing general experience under supervision, prior to the acquisition of full registration. This period was an extension of the undergraduate course and still under the authority of the university, with a significant educational component and with increasing responsibility for the care of patients.

6 *The health of the UK population depends in part on the significant contribution of clinical academics to teaching, research and clinical practice.* **7**

Provisional registration, covering the pre-registration year, was introduced in 1953. In 1967, the GMC Council in its *Recommendations as to Basic Medical Education* suggested that all pre-registration appointments be held in posts affording general experience in medicine or surgery of one year's duration, of which six months should be in medicine and six months in surgery. In 1980 the GMC *Recommendations on Basic Medical Education* reiterated the principal purpose of pre-registration:

“to afford the graduate balanced clinical experience with increasing responsibility for the care of patients, under supervision of consultants and other senior medical staff who accept the educational nature of the posts held by the graduate. The patterns of experience should prepare the graduate for subsequent specialty training, whether for general practice or any other specialty.”

Quality assurance activity was referred to for the first time and the Education Committee was given powers to visit approved hospitals and institutions. Schools which had some of their medical graduates moving to other geographical areas were advised to establish liaison with medical schools in receiving regions and reach agreement about their respective responsibilities.

In 1992 the GMC issued new *Recommendations on General Clinical Training* focusing on the PRHO year. The recommendations were primarily intended for universities which had a duty to prescribe the content and supervision of the training given, in terms set by the GMC, in order to complete basic medical education. The Postgraduate Deans were expected to exercise the responsibility for assuring the education standards of posts and for guiding and assisting graduates to obtain a suitable combination of posts on behalf of the university. *It was thought inadvisable for the length of posts to be less than three months.*

In 1997 the GMC's Educational Committee issued *The New Doctor*,⁴¹ setting out the clinical educational and personal needs of PRHOs and making explicit the responsibilities of those concerned with the pre-registration year. The role of Postgraduate Deans in working with the NHS Trusts to establish organisational frameworks to manage training was specifically referred to for the first time.

The recommendations to be implemented by April 2000 emphasised the responsibilities of the Postgraduate Deans. The competences to be acquired at the end of the pre-registration year were to be set by the university which had, and still has, responsibility under the Medical Act for signing off the graduate at the end of the pre-registration year as being fit to be entered onto the Medical Register. The recommendations also emphasised the need to develop methods of formative assessments of PRHOs and the procedures to be followed in case of poor performance.

A report on the Education Committee's informal visits to UK universities (1998–2001) was published in 2002. It identified a number of difficulties with PRHO training, including: tensions between education and service; workload and work intensity; and a lack of clarity about responsibility and constructive

working relationships, such as sharing information about PRHO training between the university, Postgraduate Deanery and health service organisations to improve posts. The problem was recognised that although universities had clear statutory responsibility for the PRHO year, the PRHOs themselves no longer had formal associations with their universities and were employees of the NHS.

In 2002, the Education Committee commenced a review of the PRHO year.⁴² Among its aims was the need to ensure an education continuum between undergraduate medical education, the Foundation Programme (then being developed) and postgraduate medical training, along with a clear set of outcomes to be demonstrated by medical graduates before being granted full registration.

In developing *Modernising Legislative Policy: The Proposals for Legislative Reform* (2004),⁴³ the Education Committee Chairman and the Deputy CMO for England agreed that the current experience-based framework was too rigid for the requirements of contemporary medical education and training. New arrangements were proposed which came into force in 2007 following a two-year transition period (2005–07) which allowed training programmes and assessment processes and tools to develop.

During this period *Good Medical Practice* and *The New Doctor* outcomes for F1, mapped to each of the Foundation Programme curriculum versions of 2005, 2007 and 2009, became available.

In 2006 and again in 2009 the GMC approved the Foundation Programme curriculum as enabling the outcomes for F1 to be met.

In 2007 the Education Committee agreed that Postgraduate Deaneries would co-ordinate and quality assure programmes for provisionally registered doctors. A Quality Assurance of the Foundation Programme (QAFP) process was agreed and the first Postgraduate Deaneries were quality assured under the new QAFP regulatory framework in 2008. The Quality Assurance of Basic Medical Education Programme (QABME) provided for GMC visits to medical schools during which F1 doctors are questioned on how prepared they are for the Foundation Programme.

In 2003 the Postgraduate Medical Education and Training Board (PMETB) was established as the independent statutory body to regulate all postgraduate medical education and training in the UK. It aimed to achieve excellence in postgraduate medical education and training throughout the UK and to improve the knowledge, skills and experience of doctors and the health and healthcare of patients and the public. In February 2008, the Secretary for State decided, based upon a recommendation in the *Tooke Report*, to merge PMETB with the GMC, making the GMC responsible for the regulation of all medical education and training. This merger was completed in 2010.

The GMC has taken over the functions formerly undertaken by PMETB and now is responsible for regulating all stages of medical education and training in the UK. This includes undergraduate medical education, the Foundation Programme, specialty training and Continuing Professional Development. This resolved the split of regulatory responsibilities between PMETB and the GMC that had historically complicated the Foundation Programme as a whole and in relation to individual posts.

The GMC is responsible for setting and securing standards for specialty training including GP training, leading to the award of a Certificate of Completion of Training. This includes: curriculum and assessment system approval; prospectively approving all training programmes, posts and GP trainers; quality assuring and evaluating the management of specialty training including GP training; and dealing promptly with concerns that have not been resolved locally.

1.6 Concluding comments

Major changes have taken place in society, in medical education and in the delivery of healthcare. These have necessitated progressive reforms in how medical students and graduates learn and are taught. Specialisation has become the norm, making explicit the need for broad based beginnings in order to provide a foundation for subsequent learning and practice.

The Foundation Programme was introduced to ensure that all UK medical graduates would become sound professionals, proficient in the management of ill patients in particular, in a range of environments and locations, and to provide a suitable underpinning for future medical practice.

The next two chapters present the findings of the Evaluation of the Foundation Programme.

6 *The GMC has taken over the functions formerly undertaken by PMETB and now is responsible for regulating all stages of medical education and training in the UK. This includes undergraduate medical education, the Foundation Programme, specialty training and Continuing Professional Development.* **9**

Chapter 2: Evaluation findings – strengths of the Programme



2.1 Overview

Analysis has been carried out on the large body of information collected through written submissions, formal oral hearings of evidence, feedback from meetings with medical students, trainees and tutors, and attendance by invitation to a number of meetings and conferences organised by the Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD), Postgraduate Deaneries and the UK FPO.

The Evaluation found widespread support for the Foundation Programme, but has also identified a number of important issues that need to be addressed.

This chapter considers the strengths of the Programme, under the three headings of design, content, and safety and quality.

Design:

- establishment of a UK-wide generic training programme;
- creation of an educational infrastructure and faculty; and
- development of a national programme for transition to specialty training.

Content:

- development of a national curriculum;
- exposure of trainees to a range of medical specialties;
- implementation of workplace-based assessment; and
- development of the Academic Foundation Programme.

Safety and quality of the learning environment:

- clarification of Foundation trainees' responsibilities; and
- introduction of quality assurance.

2.2 Strengths of the Programme – design

2.2.1 Establishment of a UK-wide generic training programme

The Foundation Programme has established a credible, time-bound, generic, UK-wide medical training programme with a defined and distinct set of competences that have to be acquired in order to progress to specialty training.

As a consequence, the Programme has eliminated the following problems identified with SHO training in *Unfinished Business*:

- around half of the SHO posts were free-standing or did not form part of any rotation or training programme; the quality of training could be indifferent, with many rotations not meeting the requirements of a managed programme of training;
- there was no defined endpoint to SHO training; several trainees spent longer as SHOs than was required to satisfy training requirements and effectively repeated training. The SHO training was open-ended, with SHOs in posts for four or more years; and
- structured training was limited, with no defined curriculum and no means of formally assessing the development and progress of the junior doctor.

It is worth pointing out that, despite the problems with SHO training, the system worked well for more than half of those involved.⁴⁴

For programmes starting in August 2010, there were 7,145 F1 posts advertised through national recruitment across the UK.⁴⁵ In addition, there were 450 posts in academic programmes. This means that there are approximately 7,600 places in F1, which suggests that there are around 15,000 places for doctors currently in the Foundation Programme. These posts are part of a defined and time-capped programme with a regulator-approved curriculum and programme of assessment, and progress is dependent upon the acquisition of key competences mapped to the curriculum. The central co-ordination of this programme is a major task that is run efficiently by the UK FPO.

2.2.2 Creation of an educational infrastructure and faculty

The establishment of the Foundation Programme has created an extensive educational infrastructure focused on the first two years of postgraduate medical education. There are 25 dedicated Foundation Schools, 22 of which are located in England.⁴⁶ The Foundation Schools combine the expertise of the staff of medical schools, the local Deanery, primary and secondary care and mental care Trusts, and other organisations such as hospices. Together, these provide Foundation doctors with exposure to a wider range of clinical and patient settings.⁴⁷ The Deaneries are responsible for the management and delivery of the Programme, as well as for the trainers, educational supervisors and educational leaders charged with delivering it.

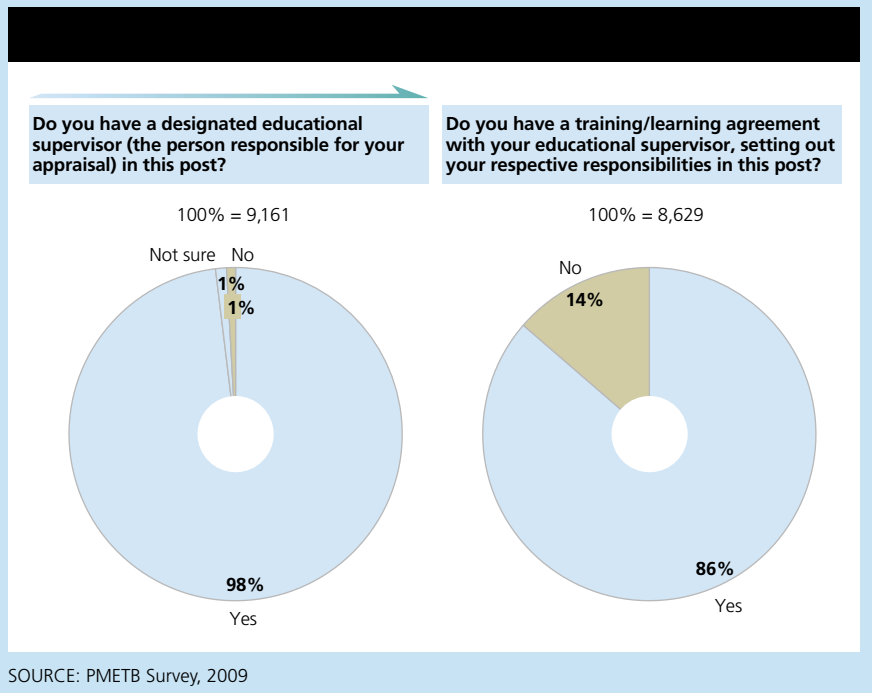
Each Foundation School has a Foundation School Director, with a Foundation Training Programme Director responsible for delivering the Programme. There is also a dedicated cohort of educational and clinical supervisors, with each trainee having an allocated educational supervisor. Quality assurance is provided through a single educational and professional regulator (the GMC) for the entirety of medical education through the QAFP process.

6 *The establishment of the Foundation Programme has created an extensive educational infrastructure focused on the first two years of postgraduate medical education.* 9

During the establishment of the Programme, Deaneries and their Foundation Schools were required to provide trainers and trainees with access to appropriate learning resources and facilities, including libraries, IT facilities, skills labs, simulated patient environments and teaching accommodation. Significant financial outlay was therefore involved in setting up Foundation Schools across the UK.

A clear example of the scale of the educational infrastructure is demonstrated in the 2009 PMETB Survey, which showed that 98% of Foundation trainees have an assigned educational supervisor (Exhibit 4). This infrastructure and its inbuilt management processes are in stark contrast to the previous haphazard SHO system, where there was no entity or clear governance structure to manage appointments to the Programme, or for the delivery and assessment of SHOs' training and development.⁴⁸

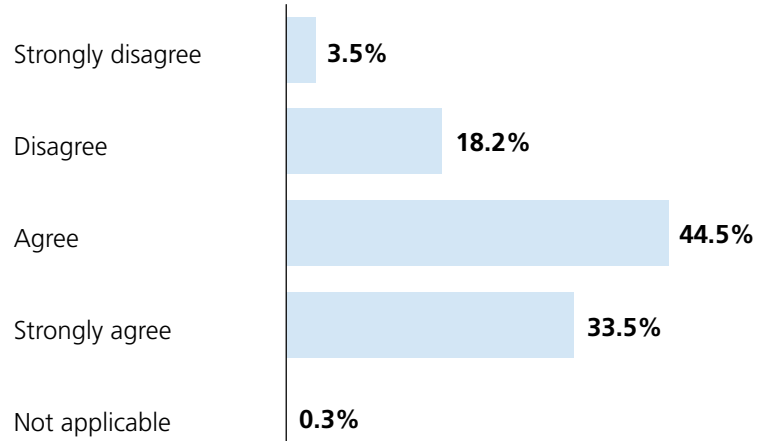
EXHIBIT 4 98% of Foundation trainees have an educational supervisor



The Foundation Programme has also created an environment where approximately 80% of trainees report that they have received feedback on their performance (Exhibit 5).

EXHIBIT 5 "I received regular feedback on my performance from my clinical and educational supervisors"

100% = 659 Foundation trainees



SOURCE: South Yorkshire Foundation School End of Placement questionnaire 2008/09, English Postgraduate Deans

2.2.3 Development of a national programme for transition to specialty training

The Foundation Programme has provided a national programme for entry into postgraduate medical education that provides a more controlled transition from undergraduate to postgraduate training – at least as far as the first two years after graduation are concerned.

Following pilots in 2004/5 and 2005/6, a national selection process was launched in time for the August 2007 intake to the Programme. The processes for selection have evolved and include a nationally agreed timetable, scored questions together with defined scoring criteria, an approach to scoring applications and an appeals process.

The 2009 UK FPO *Annual Report*, based on a review of 23 out of 25 Foundation Schools, reported that there were 385 unfilled F1 places out of 6,982, i.e. 5.5% of the total available places in 2009.⁴⁹ Consequently, appropriately qualified UK medical applicants have up to now been almost certain of gaining appointments to the Programme. This is in contrast to the past, when many PRHO/SHO posts did not form part of a formal, structured training programme.

The ability of UK medical graduates to obtain a position in the Programme is vital, since without such opportunities these junior doctors will not be able to complete their undergraduate education and meet the requirements to become fully registered with the GMC.

The majority (90%) of the approximately 7,000 applicants to the Programme in 2009 were successful in obtaining their first choice of Foundation School.⁵⁰

In terms of outcomes from the Programme, a survey of the 835 F2 doctors completing the programme at the South Thames Foundation School in 2010 showed that of the 95% (794) who responded, 72% have been appointed to a specialist training post; 9% are still seeking such a post; 6% have been appointed to a service post and 7% are taking a career break. Some 51% (402) have taken a postgraduate examination during the programme, with 55% taking the MRCP, 28% the MRCS, 7% the MRCPaeds and 3.4% the MRCOG. A total of 64% (257) passed these examinations. Figures should soon be available from other Foundation Schools, which will give a clearer national picture.

2.3. Strengths of the Programme – content

2.3.1 Development of a national curriculum

The Foundation Programme has developed a clear, well defined and broadly supported national curriculum that provides a structure to the content of early postgraduate medical education which did not exist during the SHO years.⁵¹ The curriculum is approved by the GMC and is publicly available.

4 *The Foundation Programme has provided a national programme for entry into postgraduate medical education that provides a more controlled transition from undergraduate to postgraduate training – at least as far as the first two years after graduation are concerned.* **5**

The Department of Health, in partnership with the health departments of the Devolved Administrations, commissioned the Academy of Medical Royal Colleges (AoMRC) to produce the curriculum. The Foundation Programme curriculum follows the spiral curriculum model⁵² and builds on the outcomes set out by the GMC in 2009 in *The New Doctor*. Foundation doctors must provide evidence that they have met the same outcomes by the end of both F1 and F2, but the standard expected is higher at the end of F2. The GMC and PMETB approved each of the three editions of the curriculum (2005, 2007 and 2010). The third edition draws upon the evidence presented in the AoMRC's report, *Improving Assessment*,⁵³ and specifies the workplace-based assessments required across the UK.

The GMC Postgraduate Board sub-committee and the PMETB Panel commended the AoMRC on several areas of notable practice in the third edition, including placing professionalism at the beginning of the document and emphasising its importance in underpinning all medical practice.

The updated and impressive curriculum was developed in response to *The New Doctor*, and to *Modernising Medical Careers: The Next Steps*.⁵⁴ The curriculum gives a framework for educational development that supports the first two years of professional development after graduation from medical school and emphasises the importance of supervised, practice-based learning.

The curriculum makes clear the competences that have to be acquired, the timing of these acquisitions to enable progression, and what is necessary to achieve them. It also makes clear what doctors should and should not be doing at different stages in the Foundation Programme, and seeks to avoid the practice of Foundation doctors working beyond their level of competence.⁵⁵

The curriculum is captured through the ePortfolio, a tool that has been shown in the 2009 PMETB Survey to be used by trainees in 95% of Foundation posts.

2.3.2 Exposure of trainees to a range of medical specialties

The Foundation Programme facilitates the exposure of trainees to a broad range of medical specialties, including those experiencing recruitment difficulties.

Trainees have access to experience in about 48 specialties,⁵⁶ with a preponderance of surgery and medicine (Exhibit 6).

Twenty-three Foundation Schools provided information about the specialties offered in Foundation placements. The percentage is calculated using the total training experiences available, which does not equate to the number of Foundation Programme placements since some placements cover more than one specialty.

EXHIBIT 6 Trainee access to experience in specialties

CCT specialty	F1	F2
Allergy		0.1%
Anaesthetics	1.8%	0.8%
Cardiology	4.7%	2.7%
Clinical Oncology	0.6%	1.1%
Clinical Pharmacology and Therapeutics		0.2%
Clinical Radiology	0.2%	0.2%
Dermatology	0.1%	0.3%
Emergency Medicine (Accident and Emergency)	2.2%	19.5%
Endocrinology and Diabetes Mellitus	3.8%	1.4%
Gastroenterology	4.9%	1.9%
General (Internal) Medicine	24.4%	12.3%
General Practice		16.3%
Genito-urinary Medicine	0.1%	0.9%
Geriatric Medicine	9.4%	5.7%
Haematology	0.7%	1.1%
Infectious Diseases	0.4%	0.3%
Intensive Care Medicine	2.4%	2.5%
Medical Education		0.2%
Medical Oncology	0.4%	0.6%
Medical Ophthalmology		0.1%
Neurology	0.3%	0.8%
Nuclear Medicine	0.1%	0.1%
Obstetrics & Gynaecology	1.4%	5.5%
Occupational Medicine	0.1%	
Ophthalmology	0.1%	1.1%
Paediatrics	2.6%	6.0%
Palliative Medicine	0.4%	0.7%
Pathology		1.0%
Psychiatry	1.1%	5.4%
Public Health Medicine		0.6%
Rehabilitation Medicine	0.3%	0.5%
Renal Medicine	1.2%	1.1%
Respiratory Medicine	5.0%	1.7%
Rheumatology	1.0%	0.5%
Surgery	43.6%	22.3%

The UK FPO 2009 *Annual Report* indicates that 16% of Foundation doctors experience a general practice placement, 6% are appointed to an Academic Foundation Programme and around 24% of F2 doctors spend four months in shortage specialties.

2.3.3 Implementation of workplace-based assessment

Workplace-based assessment (WPBA) is central to the philosophy of the Foundation Programme.⁵⁷ The introduction of WPBA into postgraduate training in the UK occurred for Foundation trainees under the umbrella of Modernising Medical Careers.⁵⁸

A number of assessment methods have been developed, suitable for providing feedback based on the observation of trainees' performance in the workplace. The following are used in the Programme:

- mini-clinical evaluation exercise (mini-CEX);
- direct observation of procedural skills (DOPS);
- case-based discussion (CBD); and
- multi-source feedback (MSF).

Three significantly different tools have been used in the UK for MSF:

- mini-peer assessment tool (mini-PAT);
- team assessment of behaviour (TAB); and
- 360 degree feedback.

Agreement has recently been reached on the use of a single multi-source feedback technique – TAB – in the Programme throughout the UK from 2010.

The *UK Foundation Programme Curriculum (2010)*⁵⁹ recommends a minimum of six mini-CEXs in F1 and another six in F2, spaced throughout each year, with at least two mini-CEXs completed in each four-month period. Foundation doctors may submit up to three DOPS as part of the minimum requirement. At least six CBDs should be completed, with at least two CBDs undertaken in any four-month period. MSF should usually take place at least once a year and it is suggested that the recommended tool, TAB, be taken in the first four months of F1 and F2 training. Foundation doctors are requested to nominate 15 raters (assessors) with a minimum of 10 returns required. No other Foundation doctor can be a rater. The GMC requires demonstration of competence in a series of procedures for full registration, and these are recorded and signed off in a log book, which is found in the ePortfolio. A completed log book is also required for successful completion of the Programme.

During the Evaluation, English Postgraduate Deans⁶⁰ recommended the inclusion of a mandatory clinical supervisor's report in the ePortfolio.

The main purpose of WPBA is to help trainees to identify areas for improvement and it is thus formative not summative. A further purpose is to promote learning and inform the relationship between the educational supervisor and the trainee. The research literature on such formative

assessment and feedback suggests that it is a powerful means for changing learners' behaviour.⁶¹ The most vital aspect is the inferred ability of WBPA to detect and inform the developmental needs of a doctor.⁶²

The Foundation Programme has provided a vehicle for trainee assessment and feedback that is an improvement on what was previously available. The *Tooke Report* commented on the lack of any form of robust mechanism for regularly appraising performance or providing formal assessment.⁶³ The impact of these limitations in assessment and appraisal was that poor performance by trainee doctors was not reliably recognised or addressed.⁶⁴ The *Tooke Report* highlighted the need for programme-based training with formal systems of appraisal and assessment, and a move to competence-based assessment, when practicable, that would support the GMC's system of revalidation.⁶⁵ The Programme has made significant progress in addressing these limitations.

Regular assessment ensures progression, provides documentary evidence of achievements and can be used to identify any problems.⁶⁶ The goal is to help trainees to provide better and safer care to patients and to help them to address any areas of weakness that have been identified.⁶⁷ Assessments are designed to measure progress through F1 and doctors are assessed against the standard of competence that is expected of a doctor completing this year. At the end of F1, trainees are expected to have progressed to a satisfactory level,⁶⁸ which enables them to achieve full registration with the GMC.

Written evidence has highlighted the benefit of the Foundation Programme's assessments: "They help F1s to concentrate their minds on professional development, facilitate discussion between senior doctors and trainees on their performance, and encourage and ensure senior doctors' input into their training".⁶⁹ A number of organisations highlighted in their submissions the ability of MSF to identify the underperforming trainee, and they also supported the use of CBD.⁷⁰

2.3.4 Development of the Academic Foundation Programme

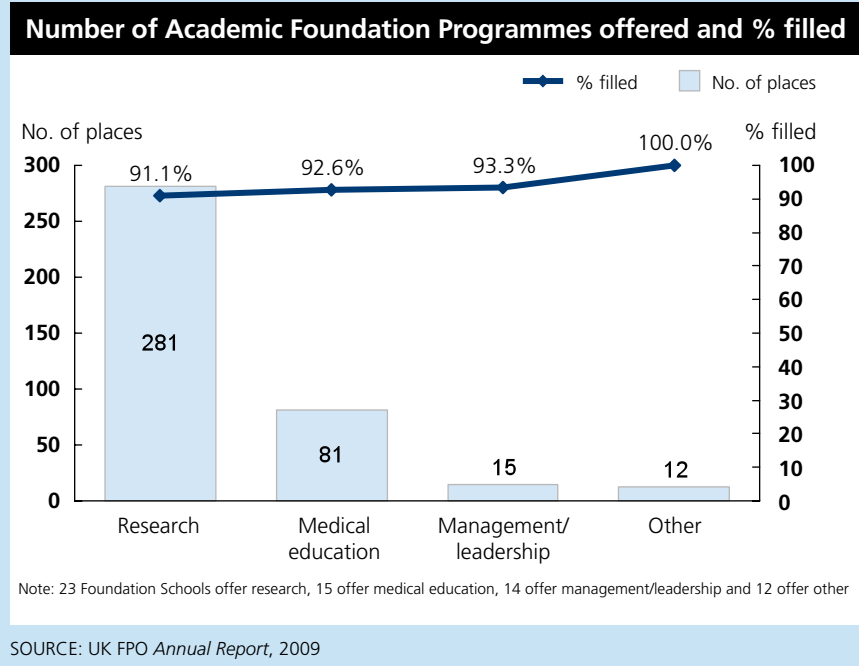
The Academic Foundation Programme is a significant contribution to the content of early postgraduate medical education. It focuses on three main topics: research, medical education and leadership/management.⁷¹ This provides Foundation doctors with the opportunity to develop research, teaching and leadership/management skills in addition to the basic clinical competences outlined in the curriculum.⁷²

6 The Foundation Programme has provided a vehicle for trainee assessment and feedback that is an improvement on what was previously available. 7

6 The Academic Foundation Programme is a significant contribution to the content of early postgraduate medical education. 7

The Academic Foundation Programme is intended to stimulate new graduates' interest in research, medical education or leadership/management. The Academic Foundation Programme has filled most of the available placements (Exhibit 7), with research being the most commonly available topic in the programme.

EXHIBIT 7 Academic Foundation Programme places are mainly in research and 94% are filled



In some Foundation Schools the Academic Foundation Programme is delivered in a discrete four-month block; elsewhere it is spread over the two years with an expectation of regular “protected time” for academic education and training.⁷³

The NIHR and the MSC strongly support the research opportunities provided by the Academic Foundation Programme.⁷⁴ Feedback from trainees who have completed or are currently undertaking the Programme has been universally supportive, and the delivery of academic programmes has been noted as a strength in the QAFP reports on visits to Deaneries.⁷⁵

2.4 Strengths of the Programme – safety and quality of the learning environment

2.4.1 Safety: Clarification of Foundation trainees' responsibilities

The Foundation Programme curriculum clarifies what doctors should and should not do in F1 and F2, emphasises the importance of supervised, practice-based learning and seeks to avoid Foundation doctors working beyond their level of competence.⁷⁶ Patient safety was reported to the Evaluation Panel as a key component of the Programme, and “where training within simulation centres is available, training in the clinical team development

of aspects of managing acutely ill patients in a multi-disciplinary environment has been a significant achievement".⁷⁷

2.4.2 Quality: Introduction of quality assurance

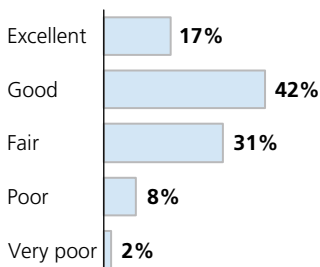
The Foundation Programme has made significant efforts to manage quality and ensure robust educational outcomes. For the first time there is a clearly defined curriculum and an operational framework. All Foundation doctors are assessed in the workplace and judgements about satisfactory completion of F1 and F2 are made against agreed national criteria.

In terms of outcomes measures, 96% of F2 doctors successfully completed the Foundation Programme in 2009.⁷⁸ The 2009 PMETB Survey shows that 59% of 9,160 Foundation trainees rated the practical experience in their current post as good or excellent, with 72% being confident that it will enable them to acquire the competences they need at their current stage of training (Exhibit 8).

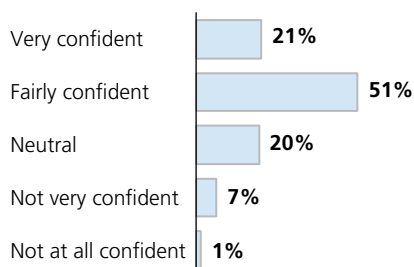
EXHIBIT 8 59% of trainees rate their practical experience in post as at least good and 72% are at least fairly confident that they will acquire the competences they need

100% = 9,160

How would you rate the practical experience you are getting in this post?



How confident are you that your current post will help you acquire the competences you need at this stage of your training?



SOURCE: PMETB Survey, 2009

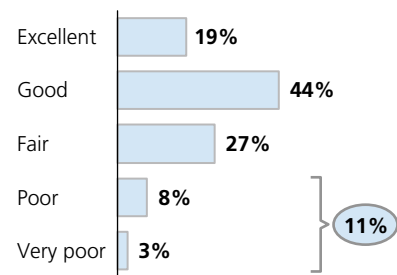
6 *The Foundation Programme has made significant efforts to manage quality and ensure robust educational outcomes.* **7**

Further analysis of the results of this survey (Exhibit 9) shows that 89% would describe their post as excellent, good or fair to a friend thinking of applying; likewise, 89% would describe their post as very useful, useful or fairly useful for their future career. While acknowledging that 11% of trainees responded negatively and that their voice must not be ignored, it must be said that the figures are very satisfactory for this large and widely located new Programme.

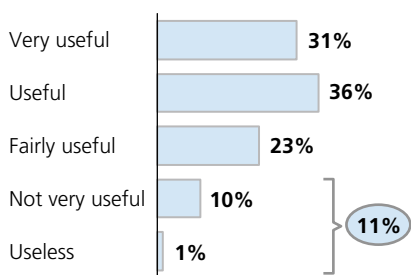
EXHIBIT 9 89% of trainees would describe their post as very useful, useful or fairly useful

100% = 9,161

How would you describe this post to a friend who was thinking of applying for it?



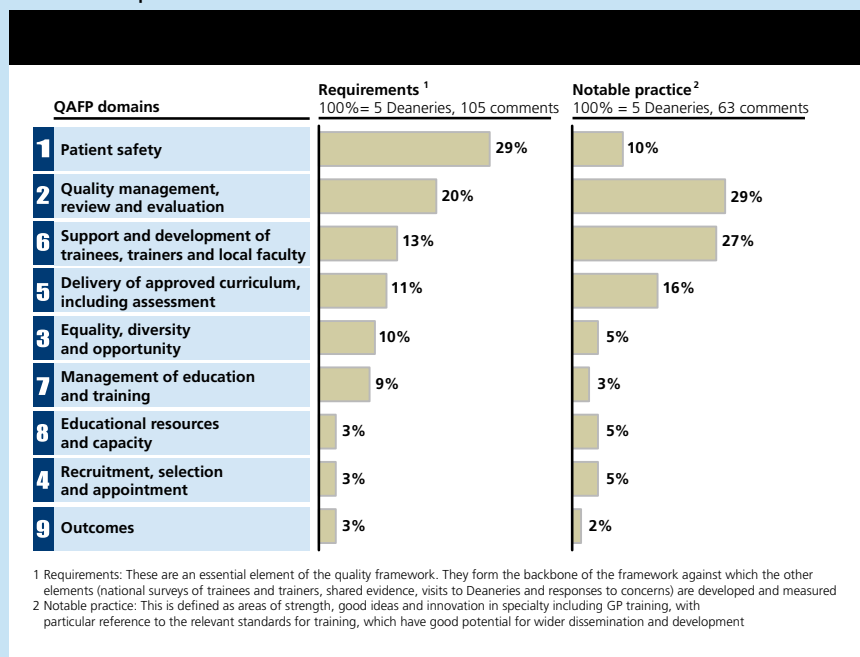
How useful do you feel this post will be for your future career?



SOURCE: PMETB Survey, 2009

A robust and transparent quality assurance process, QAFP, has been implemented, which determines whether the standards outlined in *The New Doctor* are being achieved. QAFP has been a joint undertaking between the GMC and PMETB (now merged) and is based on Deanery visits. The QAFP reports highlight areas that require improvement as well as areas of notable practice (Exhibit 10).

EXHIBIT 10 The QAFP reports highlight areas that require improvement and strong areas of notable practice



SOURCE: QAFP reports, England, 2008–10

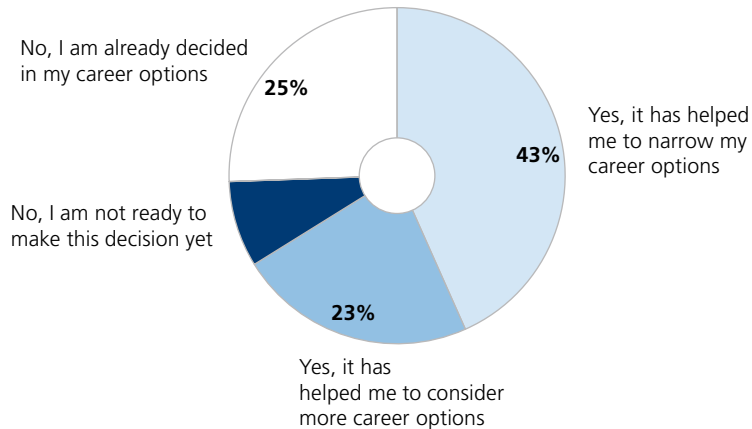
The introduction of QAFP has resulted in greater scrutiny and transparency of F1 and F2. The process draws upon evidence from a range of sources (e.g. surveys and visits) and has identified a number of areas of notable practice and areas for improvement. These include induction, supervision, management of education and training, identification of and support for the training of doctors in difficulty and the sign-off process for full registration. Reports are published together with Deanery action plans. The GMC monitors progress against the agreed actions. Consequently, the Foundation Programme has an inbuilt improvement mechanism.

The Foundation Programme has also made considerable progress in the early identification of doctors in difficulty. The UK FPO *Annual Report 2009* shows that about 7% of F1 doctors and 5% of F2 doctors were identified as requiring additional support. Of these, 77% were either signed off at the expected time or were likely to be signed off following an extension of training. Health problems were the most common reason for requiring additional support (55% of F1, 43% of F2).⁷⁹

Approximately two-thirds of trainees in the 2009 PMETB Survey reported that the Programme had been helpful in making career decisions (Exhibit 11).

EXHIBIT 11 Two-thirds of trainees report that the Foundation Programme has helped them to make career decisions

Has your experience in this post influenced your career choice?
100% = 9,161 (Figures may not add up to 100 as a result of rounding)



SOURCE: PMETB Survey, 2009

There is limited data on the relationship between the performance of the Programme, education quality, and patient outcomes, safety and experience. Specifically, there is a lack of objective evidence on patient safety and this must be part of future, inbuilt, continuous evaluation of the Programme.

Chapter 3: Evaluation findings – concerns about the Programme



3.1 Overview

Analysis of the oral and written evidence that formed part of the Evaluation demonstrated that, aside from the strengths elucidated in the previous chapter, there are also a number of issues for concern about the Foundation Programme in its current form.

This chapter sets out these issues under three headings: design, content, and safety and quality.

Design:

- lack of a clearly articulated purpose;
- misgivings about the selection of trainees;
- confusion over the role of the trainee;
- questions about GMC registration of trainees and medical students;
- dissension over length of the Programme and rotations;
- perceived deficiencies in careers information and advice; and
- lack of flexibility in the Programme.

Content:

- gaps in the curriculum;
- maldistribution of placements by specialty;
- shortcomings in technology-enhanced learning opportunities;
- equipping and approval of trainers is necessary; and
- assessment is excessive, onerous and not valued.

Safety and quality of the learning environment:

- variability in the deployment and supervision of trainees;
- variability in the quality of education and learning;
- lack of pastoral support; and
- inadequate transfer of information about trainees.

3.2 Concerns about the Programme – design

3.2.1 Lack of a clearly articulated purpose for the Programme

The majority of oral and written submissions commented that there is no clear and generally accepted articulation of the purpose of the Foundation Programme.⁸⁰ In particular, the lack of an articulated purpose for F2 has led to questioning of its value in terms of educational objectives,⁸¹ its role in relation to F1 and specialty training⁸² and whether it delays career progression.⁸³

A number of objectives have, with hindsight, been ascribed to the Foundation Programme; unfortunately, these were not considered *in toto* and were not aligned. While there was some variance in the views collected through written and oral evidence, the following common themes have emerged during the Evaluation as to the purpose of the Foundation Programme.⁸⁴

- a. To enable medical graduates to put into practice the knowledge, skills, behaviours and attitudes acquired as an undergraduate and to meet the requirements of the EU Directive with regards to 5,500 hours or six years of instruction under the supervision of a university. This allows the relevant university to confirm to the GMC, at the satisfactory completion of F1, that the doctor has reached the required standard to be admitted on to the Medical Register for full registration.
- b. To enable Foundation doctors to acquire a range of generic clinical skills that are required of all doctors in order to practise safely in an emergency and be able to make independent clinical decisions at a level that provides for the safe and effective care of acute and long-term conditions.
- c. To bridge the gap between undergraduate and specialty training through supporting the application of theoretical knowledge within the clinical environment under supervision and through ensuring a broad based beginning which will prepare trainees for any one of the specialty training programmes.
- d. To instil recently graduated doctors with the instincts of professionalism and the primacy of patient welfare in their actions.
- e. To enable junior doctors to become familiar with the health system, to help them to make decisions regarding their future career directions and to provide the opportunity for trainees to begin to develop the leadership, team working and supervisory skills that are needed to deliver care in the context of a contemporary multi-disciplinary team.
- f. To ensure that early postgraduate medical training is time-limited, curriculum-based, accountable and closely managed to a set of national standards.⁸⁵
- g. To be a trainee-centred programme with a publicly available curriculum and defined set of core competences and generic skills, and a nationally agreed assessment methodology that can be reproduced consistently.⁸⁶
- h. To give medical graduates a broader experience of medicine and career options and to strengthen their insights into the links between different specialties and between primary and secondary care.⁸⁷

6 *The majority of oral and written submissions commented that there is no clear and generally accepted articulation of the purpose of the Foundation Programme.* 7

The importance of ensuring access to the F1 year for UK medical graduates in order that they might complete their basic medical education is reiterated. Without full registration it is impossible for a doctor to practise, and thus his or her basic medical training will be regarded as incomplete, as defined by the EU Directive.⁸⁸

A clear articulation of the purposes of the Foundation Programme that is widely understood and accepted across the NHS and the continuum of postgraduate medical education and training is essential. Failure to articulate these purposes will lead to ongoing confusion among Foundation Programme leaders, trainees, trainers, non-medical health professionals and employers, and may impact negatively on the quality of care delivered to patients. Furthermore, lack of clarity will have an ongoing detrimental effect on the Programme's ability to deliver high quality education and to demonstrate its value.

Recommendations

1. *MEE (through the MPB) – working with its counterparts in the other UK countries – should confirm the purpose of the Foundation Programme as set out in this Report by 2012.*
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 (F2) of the Foundation Programme.*
3. *The success of the Foundation Programme in achieving the purposes outlined and in providing value for money should be evaluated by the MPB working with UK FPO, on a regular basis. The MPB 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.*

3.2.2 Misgivings about the selection of trainees

The *NHS Next Stage Review*⁸⁹ stated that “new work needs to be undertaken to develop more reliable and valid selection tools for recruitment to Foundation Programme Training”. Concerns had arisen because candidates answer “white space” questions in their own time, which makes it harder to ensure that the work is their own and because marking the answers to these questions is labour intensive and costly – with much consultant time taken away from services.

The MSC was therefore commissioned by DH to lead a Project Group to carry out an option appraisal for the best approach to selection of applicants into the UK Foundation Programme and for allocation to Foundation Schools. This was a collaborative venture between all interested parties with a steering group.

As part of a nine-month option appraisal, the Project Group commissioned three academic literature reviews on international good practice in high-stakes

selection in medicine. An international panel of experts reviewed these and drew up a shortlist of preferred selection tools. After extensive consultation and after considering all the evidence, the Project Group decided to pilot two new selection methods – Educational Performance Measure (EPM) to evolve from the current quartile rankings and Situational Judgement Test (SJT) to replace the current “white space” questions – and to continue with the current method of selection unless the pilots show substantial and convincing evidence for change.

If the pilots that are currently underway prove to be successful, it is envisaged that every applicant will also undergo an invigilated test which is designed to assess professional judgement and the appropriate behaviours expected of a Foundation doctor, as defined in the person specification. The results of the SJTs will be combined with the EPM score to produce a ranking that will be used in the allocation of applicants to Foundation Schools. The earliest that any change might take place will be for applicants to Foundation Programme training beginning in August 2013.

The importance of UK medical graduates being able to obtain F1 positions in order to fully register with the GMC was highlighted in the *Tooke Report*⁹⁰ and by the MSC.⁹¹ This is reaffirmed by this Evaluation. At the same time, the selection process is expected to meet the requirements of UK employment legislation.

Concerns about the methodologies being used for recruitment, selection and appointment of Foundation trainees by some NHS employers have been raised with the Evaluation Panel by the MSC. In *Tomorrow's Doctors*, the GMC states: “by awarding a medical degree, the awarding body is confirming that the medical graduate is fit to practise as a Foundation Year One doctor to the high standards that we have set in our guidance to the medical profession, Good Medical Practice”. It also states that “students who do not meet the outcomes set out in *Tomorrow's Doctors* or are otherwise not fit to practise must not be allowed to graduate with a medical degree”. Medical schools are responsible for ensuring that their assessment processes meet these requirements, and the GMC accreditation of each UK medical school requires evidence of satisfactory assessment processes for accreditation or re-accreditation.

During the recruitment, selection and appointment of Foundation trainees, responsibility for ensuring fitness for the post lies with the “Deaneries and local faculty and, through these, employers”⁹² with “open, fair and effective” being the standard expected for the process. The Evaluation was concerned to learn, however, that some NHS employers include a small number of OSCE-type (Objective Structured Clinical Examination) assessment stations in this process. The educational validity of this process is questionable, particularly for UK medical graduates who have recently been signed off as fit to practise by their medical school, on the basis of repeated assessments over an extended period by a wide range of faculty.

Recommendations

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 the Programme in August 2013.*
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.*

3.2.3 Confusion over the role of the trainee

A number of oral and written submissions of evidence referred to a confusion about the role of the medical trainee in the healthcare system. An uneasy tension already exists between the educational needs of trainees and their role in the delivery of healthcare services. Without a clear understanding of their role there is a real risk that the long-term educational mission of the service will be inappropriately dominated by short-term service requirements. The danger of focusing predominantly on service was pointed out in the report based on the review of the EWTD.⁹³ It stated: "the NHS can no longer afford to sacrifice the training of the medical workforce of tomorrow just to cover service today".

Trainees are postgraduate learners as well as employees of the health services. They provide an important contribution to the healthcare of patients and in return receive significant assistance in their training from medical and other health professionals, as well as from the healthcare institutions which employ them. Trainees are learning to become future specialists and this can only be achieved in the clinical environment by undertaking increasing responsibility for service delivery under graduated supervision.

Trainees are a key part of the delivery of the NHS and are not supernumerary to service requirements. Suggestions that trainees should be supernumerary fail to acknowledge that modern approaches to learning build on the concepts of adult education. These rely on situational learning and are active, self-directed, learner-centred and experiential.⁹⁴ Learning is problem-centred, or relates the learning experience to practice. "Learning by doing" is fundamentally important and learners learn more effectively when they are responsible for their actions.⁹⁵ This includes managing patient care with progressively greater skill, ability and autonomy, and with exposure to routine, complex and diverse practice, and participation in all aspects of service delivery, including out-of-hours work.

Recommendation 4.1.4 of the review of EWTD⁹⁶ states:

"Train in a service environment with consultant support. A consultant delivered service does not mean that trainees will no longer have a service role. Trainees should not be 'supernumerary' except where clinical complexity makes that appropriate. Delivering direct patient care is an important part of training in both elective and emergency situations."

❏ *A number of oral and written submissions of evidence referred to a confusion about the role of the medical trainee in the healthcare system. An uneasy tension already exists between the educational needs of trainees and their role in the delivery of healthcare services.* ➤

This Evaluation affirms this recommendation.

A number of changes have taken place which have impacted on the role of the trainee. The working patterns of junior doctors have altered by an increase in shift-based working for trainees in recent years (as a result of the EWTD and current contract structure) and the roles of other healthcare professionals have expanded. Junior doctors are now involved in the wider aspects of the profession and play a major role in discussions on setting standards, regulation and workforce planning. In addition, they play an integral part in advising on education, occupational issues and in the support and advocacy of colleagues.⁹⁷

Education and training is changing to become more learner-centred, and today's medical graduates are experienced in self-directed learning and expect a more collaborative and integrated approach to their learning. Innovative modern education techniques, including e-learning and simulation, have become available, enhancing the learning environment. At the same time, trainees use all of the modern methods of communication for their learning. Generational changes among today's medical students and graduates, the so-called "Generation Me",⁹⁸ call for a more structured and interactive learning experience. Trainees in the Foundation Programme are now required to demonstrate a range of competences aligned to a defined curriculum, and it is their responsibility to record their learning in an ePortfolio and to ensure they complete a range of workplace-based assessments.

The tension between education and service has been raised in a number of the written submissions:

- "The needs of the service and trainee overlap, but are not the same."⁹⁹
- "Service delivery should not have such an impact on the delivery of the Foundation Programme, as is currently happening."¹⁰⁰ (Exhibit 12)
- "The Programme is service centred, with education benefit of the trainee coming second."¹⁰¹
- "The Foundation Programme should focus more on education and learning to be a doctor than purely on service provision."¹⁰²
- Service pressures appear to have impacted on the education of more than 80% of trainees.^{103, 104, 105}

6 *Innovative modern education techniques, including e-learning and simulation, have become available, enhancing the learning environment.* 7

EXHIBIT 12 BMA junior doctors' working arrangements survey 2010

Table 1 – Have you regularly missed out on training opportunities since August 2009?

		Yes	No	Total	No reply
F1	n	98	154	252	4
	%	38.9	61.1	100.0	–
F2	n	98	106	204	0
	%	48.0	52.0	100.0	–
Total	n	196	260	456	4
	%	43.0	57.0	100.0	–

Table 2 – What training opportunities have you missed?

	F1 (n = 98)		F2 (n = 98)		Total (n = 196)	
	n	% of cases	n	% of cases	n	% of cases
Lectures/training days	77	78.6	77	78.6	154	78.6
Observation training/clinical supervision	62	63.3	65	66.3	127	64.8
Meeting with educational supervisor	34	34.7	43	43.9	77	39.3
Opportunities to complete procedures/demonstrate skills necessary to evidence your competencies	62	63.3	62	63.3	124	63.3
Planned study leave	15	15.3	40	40.8	55	28.1
Opportunities to complete workplace assessments	52	53.1	45	45.9	97	49.5
Other	3	3.1	4	4.2	7	3.7

SOURCE: BMA Survey of Junior Doctors' Working Arrangements 2010

The previous nomenclature of PRHO and SHO has led to confusion over the role of the F1 and F2 trainee. The proficiency of F2s in particular is often assumed to be at the same level as those who held these positions previously where a significant step-up was expected and aspired to from the PRHO year. In addition, some may have worked in the service for a number of years within the old SHO grade. This factor and the lack of understanding of the purpose of the Foundation Programme may have resulted in a broad range of health professionals overestimating the competence of a Foundation Programme doctor.¹⁰⁶

More alarmingly, many of the trainees interviewed suggested that the failure to acknowledge that F1 doctors are new and inexperienced medical graduates who are working towards full registration, coupled with the lack of understanding of the level of competence of F1 and F2 doctors, may have led to the deployment of trainees in inappropriate roles and beyond their level of competence.¹⁰⁷

Conversely, the change in nomenclature and the introduction of the two-year Foundation Programme has resulted in some F2 doctors perceiving that their development of clinical skills and knowledge is not fully recognised and may hinder their desire to step up in F2. This is likely to have a detrimental impact on their self-esteem and confidence.

The current perception of the role of the trainee and how they are regarded by other healthcare professionals must change and a level of mutual trust be regained. Clearly, a number of changes including those relating to working hours have rightly or wrongly altered the perception of the level of trainees' commitment in the eyes of some other health professionals and of employers. Employers speak of trainees as having "no sense of belonging" or "no allegiance" to the organisation which employs them and is responsible for their education and training.

One of the accreditation criteria assessed during the accreditation of training sites by some medical colleges is "trainees' responsibilities to employers" with the minimum requirement being "trainees satisfactorily fulfil their agreed contract requirements".¹⁰⁸ This is an important requirement.

Trainees need to be treated with greater respect. They need to be valued and rewarded for the contribution they make to the health service, and be carefully prepared for the significant responsibilities which lie ahead of them through a joint and collaborative partnership. Equally, trainees must earn this respect and will only be valued if their contribution is tangible, and if F2 doctors are perceived as equivalent to previous first-year SHOs, who were by and large respected.

Trainees make up around 25% of all doctors on the Medical Register and need particular attention because they have a unique set of circumstances:

- they are vulnerable in the workplace;
- there are ethical challenges surrounding the learning curve;
- issues exist relating to obtaining consent; and
- they are mobile across working environments, educational bodies and multi-disciplinary teams.

This raises the question as to whether better recognition should be given to trainees as a special group, and the Evaluation Panel believes this should be so.

6 Trainees need to be treated with greater respect. They need to be valued and rewarded for the contribution they make to the health service, and be carefully prepared for the significant responsibilities which lie ahead of them through a joint and collaborative partnership. 7

Recommendations

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.
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.

3.2.4 Questions about GMC registration of trainees and medical students

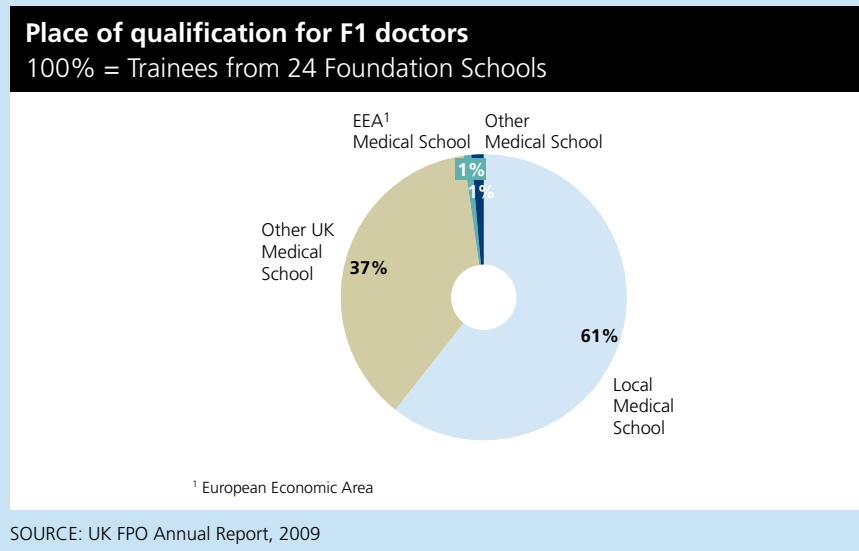
Following the satisfactory completion of medical school, UK medical graduates are provisionally registered with the GMC and must undertake a further year (F1) to complete their studies and receive full registration. It is unclear whether this timing yields the best outcomes for trainees or the NHS.

Full registration at the end of F1 has a number of major impacts on medical education and the broader healthcare system:

- Although there is no legal impediment to doctors with provisional registration (e.g. F1s) prescribing in general practice, each case must be considered and judged on its merits and in all cases the supervising practitioners must be able to justify their actions. Furthermore, the GMC recommends that such issues of delegation in general practice are clearly documented to avoid any confusion. The provisionally registered F1 doctor is considered to be of less utility in general practice than F2s, and some have argued that educationally F1s will not benefit as much as F2s from time in general practice. This hinders the government's efforts to achieve a target of exposing 55% of Foundation Programme trainees to general practice.
- It necessitates shared governance of the Foundation Programme trainee in F1 between the Postgraduate Deanery responsible for delivering the Foundation Programme training and the trainees' previous medical school. The medical school, which may have little contact with the student following graduation, retains responsibility for the sign-off of trainees as ready for full registration. This is compounded by 40% of trainees undertaking their Foundation Programme away from their university region (Exhibit 13).

The Evaluation Panel heard a number of different views on the shared governance for F1, but there was insufficient support for a major change at this time.

EXHIBIT 13 Nearly 40% of trainees move away from their medical school for the Foundation Programme



The PRHO year was introduced in 1953 to address concerns at that time about allowing medical graduates to go directly into independent practice. It exposed newly qualified doctors to the responsibilities of looking after medical and surgical patients, but was loosely structured and had no formal supervised training, education or assessment. Given the significant changes that have taken place in undergraduate and postgraduate medical education since 1953, questions have been raised as to whether the pre-registration year is still necessary. Other countries such as the United States of America and Canada do not have a pre-registration year, with Canada removing this requirement in 1993.

A minimum of one period of Student Assistantship during the final year of undergraduate medical education is now required by the GMC.¹⁰⁹ During this period a medical student acts as an assistant to a junior doctor, with defined duties under supervision. Extensive experience with similar assistantships in the case of every final-year medical student in New Zealand over many years has shown that it leads to an increase in experience and readiness for practice by new graduates. However, NHS employers and NHS Trusts must actively support this concept if students are to obtain these opportunities.

The outcome from F1 is clearly defined in *The New Doctor* in terms of meeting the requirements for full registration with the GMC. The end of F2 completes the Foundation Programme and this important “waypoint” needs to be recognised. One possibility is for the GMC revalidation process to commence at this point, using the GMC’s *Annex 1 – Good Medical Practice Framework for Appraisal and Assessment*.¹¹⁰ This Framework has been developed as the basis for a standardised model to be incorporated in all appraisal systems, and there is merit in commencing its use at the successful completion of F2. While medical students and trainees support the recognition of satisfactory completion of the Foundation Programme, they are wary of any process which could conceivably be used as a further formal summative assessment.

A number of organisations raised for discussion the reintroduction of medical students' registration with the GMC, a practice that was in place in the UK until November 1940 when it was suspended by the GMC "in order to secure an economy under war conditions".¹¹¹ In the opinion of some, student registration would give a clear signal to students of the importance of professionalism and the responsibilities which come with medical practise. It is also thought that it would help to find better ways of gradually introducing medical students to the principles and practice of professionalism.

In 2005 the GMC and the MSC established the joint Student Fitness to Practise Working Group which developed guidance for medical schools and medical students relating to: the professional behaviour expected of medical students; the scope and threshold of student fitness to practise; making decisions; and the key elements in student fitness to practise arrangements. A number of reasons for supporting the regulation of medical students have recently been put forward by Dacre and Raven while an opposing view has been voiced by Davies.¹¹² Registration of medical students has recently been introduced in Australia.¹¹³

The main focus of the recent debate has been on fitness to practise. Learning to become a medical practitioner involves the progressive development and formation of a professional identity or the professional values, actions and aspirations necessary. There must be a major focus on this across the continuum of medical education commencing with a clear message of its importance for medical students. It is now timely to review the whole question of student registration with the GMC.

Recommendation

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.*

3.2.5 Dissension over length of the Programme and rotations

There are conflicting views about the appropriate length of the Foundation Programme and of its constituent rotations.

Length of the Programme

The *Tooke Report* recommended shortening the Foundation Programme from two years to one year with the second year incorporated into the first year of Core Specialty Training. Tooke argued that this would accelerate training and enable medical graduates to qualify as independent practitioners more quickly. The Evaluation Panel heard evidence from the Royal College of Surgeons of England¹¹⁴ to support this view. The possibility of one Foundation Year followed by three years of Core Training was raised by the Royal College of

Physicians of London, or as an alternative, two Foundation Years but with the second year themed to the specialty being considered by a trainee.¹¹⁵ A similar viewpoint was presented by the Joint Committee on Surgical Training.¹¹⁶ The MSC supported the earliest possible acquisition of expertise by the trainee and the ability for them to take responsibility.¹¹⁷

The vast majority of written submissions and oral evidence received, however, supported the continuation of the Programme at two years – at least for the present time. In meetings with trainees, the Expert Advisory Panel found there was almost unanimous support for a two-year Programme. Submissions were of the view that a two-year integrated Programme was necessary for trainees to develop the generic skills required of all doctors, and to ensure they have broad based beginnings and are able to make informed career decisions based on a sufficient number of specialty rotations.

There is little robust evidence from which to draw a definitive conclusion about the optimal length of the Foundation Programme. As pointed out in one submission, the length of each stage of training should be determined by the outcomes required.¹¹⁸ What does seem clear is that any decision on length of the Programme must ensure that it:

- delivers the maximum educational value;
- delivers maximum service return and value for money; and
- provides the widest exposure to specialties in order to inform career choice.

There is a lack of support and of conclusive evidence for shortening the Programme at this time. There is a wish to allow the implementation of *Tomorrow's Doctors* to occur and have its impact, including its requirement for medical schools to substantially increase student assistantships. This should increase the experience and preparedness for practice of all new UK medical graduates and provide a timely opportunity in 2015 for a review of the length of the Foundation Programme.

Recommendation

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.*

Length of rotations

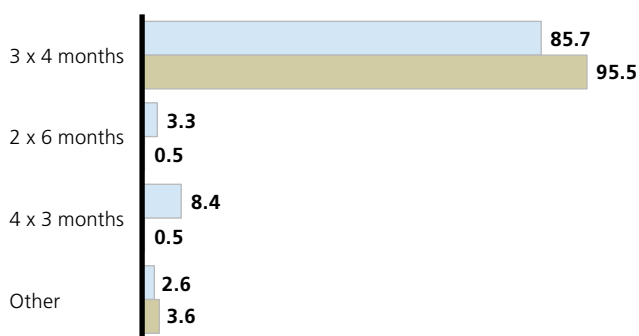
The length of rotations varies across the Foundation Programme. Of all Foundation School placements, 90% are three periods of four months in each year, with a greater variation in the configuration in F1 than in F2 (Exhibit 14).

EXHIBIT 14 90% of Foundation School placements are 3 x 4 months, with more variation in configuration in F1 than F2

100% = Trainees from 25 Foundation Schools

F1
F2

Configuration of Foundation Programmes



SOURCE: UK FPO Annual Report, 2009

Opinions vary between those who favour four or six-month rotations but there is no support for rotations of less than four months.¹¹⁹ In 1967 the GMC recommended six-month rotations and in 1992 stated that it would be “inadvisable for the length of posts to be less than three months”. Opinion varies on the time necessary to maximise the educational value of the rotation versus the greater value of service provided by the trainee as they gain more experience during a longer rotation.¹²⁰ Shorter rotations prevent trainees from fully integrating with the team in which they are working, therefore limiting the development of team skills. Short rotations can also result in limited trainee exposure to senior medical staff¹²¹ and provide insufficient time to make an effective assessment of performance. Longer rotations limit the number of specialties each trainee can experience in any one year. Trainees interviewed by the Panel had experienced rotations varying between two to six months and provided a consistent message that rotations of less than four months did not meet their requirements.¹²²

NHS employers prefer longer rotations so that trainees can develop competences and expertise which will enable them to provide a more significant service contribution within each rotation and optimise their learning of team dynamics. Increasing the diversity of exposure has advantages but it would necessitate shortening rotations in the two-year time-frame of the Programme.

Although submitted evidence failed to reveal a clear consensus on the desirable length of rotations, the majority favoured either four or six months or a mix of these two over the two years of the Programme.

Opinions vary between those who favour four or six-month rotations but there is no support for rotations of less than four months. ➤

Support for four-month rotations is based on:

- educational benefits (GMC,¹²³ NACT¹²⁴); and
- the opportunity to gain exposure to a greater range of specialties than is possible with the adoption of six-month rotations (Academy of Trainee Doctors Group (ATDG),¹²⁵ Academy of Medical Educators¹²⁶).

There was support for six-month rotations as a consequence of:

- educational benefits (NIHR,¹²⁷ College of Emergency Medicine (CEM),¹²⁸ Faculty of Dental Surgery (FDS);¹²⁹
- lack of service provision in a four-month rotation (BMA,¹³⁰ NHS Employers¹³¹);
- more time to consolidate skills (CEM,¹³² Schools of Surgery¹³³); and
- a six-month rotation provides the benefits of the previous “apprenticeship” model (Royal College of Surgeons, England (RCSEng)¹³⁴).

There is, on the other hand, support for a mix in the length of rotations from the AoMRC,¹³⁵ NHS Employers¹³⁶ and SHA Workforce.¹³⁷

The Academy of Medical Educators suggests that length of placements should be judged on the desired learning experiences and outcomes and the ability of different rotations to help trainees to achieve these outcomes.¹³⁸

Recommendation

10. 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. The length and content of the rotational programme must be clearly disclosed in Foundation School materials.

3.2.6 Perceived deficiencies in careers information and advice

The provision of careers information and advice may be inadequate to enable trainees to make informed and realistic career decisions and manage their career expectations against service needs.

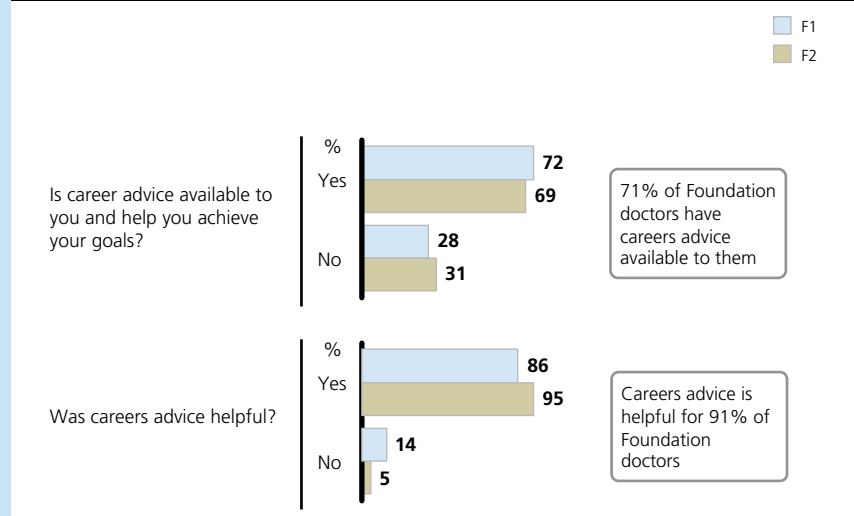
The availability and quality of careers information and advice to junior doctors has been a long-standing problem. *Unfinished Business* highlighted deficiencies in career advice and the mismatch between the number of applications and certain specialty training (ST) posts.¹³⁹ The introduction of a time-bound Foundation Programme has required trainees to focus on making earlier career decisions.

Although there is a perceived need for improvement, careers information and advice during the Foundation Programme is better than that provided during the previous PRHO/SHO years.¹⁴⁰ In 2005, the MMC working group for careers management published a comprehensive document designed for key stakeholders in doctors' careers.¹⁴¹ This document views career management provision as an integral part of effective medical education and human resource management. It contains most of the material and processes necessary to support an adequate career management continuum between medical school and postgraduate medical education and training.

An extensive choice of information relating to medical careers is now available on the websites of UK medical schools, Deaneries, UK FPO, Foundation Schools, colleges, the BMA, NHS Trusts and many others (Exhibit 15). One excellent example was included in the written evidence submitted by the Postgraduate Deanery for Kent, Surrey and Sussex.¹⁴² A number of helpful updates on careers have recently been published by DH.^{143, 144} The latter includes competitive ratios from 2008 and 2009. Career days or events are organised annually by a wide number of organisations including employers.

EXHIBIT 15 Most students have careers advice available to them and 91% find the advice helpful

100% = 433



SOURCE: BMA Cohort Study of 2006 Medical Graduates – second and third reports

Although extensive careers information is available it would appear that the quality of careers advice may be lacking. Those in established medical practice often tend to support their own specialty area or, through the “hidden curriculum”,¹⁴⁵ deter trainees from pursuing certain careers in medicine, such as general practice.

There is evidence that many doctors want career advice early in their careers; many do not feel self-sufficient in being able to make confident decisions about entry to specialties without knowledgeable advice.¹⁴⁶ There is also evidence that when some doctors needed careers advice in their early postgraduate years it was inadequate, and for some the lack of careers advice had hampered their career decision-making.¹⁴⁷

Recruitment to shortage specialties has improved with the introduction of the Foundation Programme.¹⁴⁸

6 Although extensive careers information is available it would appear that the quality of careers advice may be lacking. 7

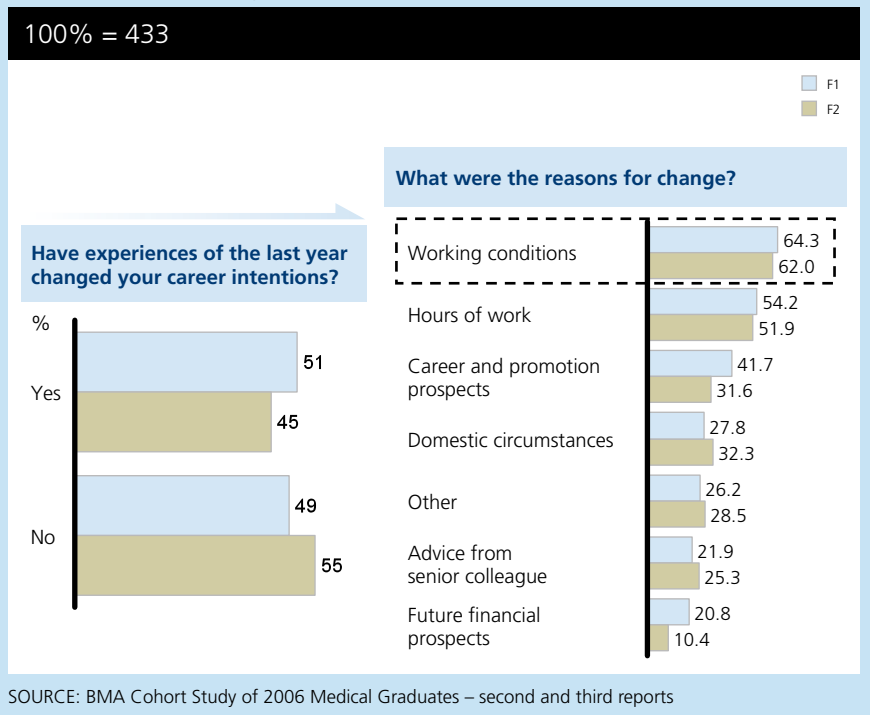
There is a lack of clarity on what information is desirable or needed by trainees to inform their career decision-making and manage their career expectations. Information that may help decision-making, such as competition ratios and probabilities of success in certain specialties, is not systematically collected, analysed or kept up to date.

The *Tooke Report* recommended that career aspirations should be informed by accurate data on likely employment prospects and competition ratios. It was also recommended that medical schools play a greater role in providing careers information and advice.

The optimal timing of careers decisions remains the subject of debate. Of those doctors who in their first year after graduation were definite about their specialty choice, 74% were in this specialty ten years later.¹⁴⁹

The 2006 BMA Cohort Study reported that 51% of F1 and 45% of F2 trainees changed their career intentions during the Programme (Exhibit 16) with the common most reason being attributed to working conditions.¹⁵⁰

EXHIBIT 16 Half of Foundation doctors change their career intentions while participating in the Foundation Programme



Comparisons with the timing of career decision-making by trainees in other countries is difficult given the many variables involved. North America and, to a rapidly increasing degree, Australia select graduates for entry to the medical course; many of these are older and frequently accrue significant debt. There is an expectation in these countries that a definitive long-term career choice will be made at graduation from medical school or immediately afterwards.

There is a belief among some health professionals in the UK that medical graduates have two Foundation years in which to sample various specialties in order to help choose their area of interest. Applications to Core Training usually open by the end of the first week in December and close by the end of the third week of that same month. This means that F2 trainees will have had experience in about four different rotations on which to help base their career decision.

Trainees need accurate information regarding future opportunities in various medical careers, and a realistic idea of where their career path is likely to lead. The delivery model for healthcare is changing, and trainees need to be clearer about the needs of the NHS and the wider health economy.

There is a broad consensus that careers information and guidance should be provided early in a student’s career, including prior to medical school. The majority of respondents advocate tailored information being provided early in medical school¹⁵¹ or immediately prior to graduation.¹⁵²

Likewise, there is significant support for greater transparency in the data made available on careers, particularly with regards to competition ratios. There should be a clear linkage with workforce requirements and planning and likely future employment opportunities.¹⁵³

Rates of career choices for general practice have changed across recent generations. Data from the long-standing cohort studies of the UK Medical Careers Research Group have shown that between 40% and 50% of UK qualifiers in the 1970s and 1980s expressed a first choice for general practice when in their first post-graduation year. This fell precipitately to about 25% in the 1990s and has remained below 30% in successive cohorts since then. Recent data from the Group show that although first choices for general practice remain below 30% there has been a substantial recent increase in the percentage of junior doctors who have indicated that they are considering general practice as a second or third preference of choice of career. The importance of these findings is considerable. First, the level of choice for general practice is not immutable; it has been much higher in the past and general practice can no doubt be made more attractive in the future. Second, junior doctors have in increasing numbers indicated that while general practice is not necessarily their first choice it is certainly on their list of acceptable careers within the profession.^{154, 155, 156}

One of the major issues which must be addressed is the large number of medical graduates who continue to apply for oversubscribed specialties. A large number of those who are successful in gaining a place in Core Training go on to meet all of the expected requirements of this training but are then unable to obtain a position in advanced training in this same discipline. Quality education and training is not about producing half-trained specialists and successful entrants to Core Training should have some level of certainty of progression if they meet all of the requirements.¹⁵⁷ Furthermore, the failure of other specialties to recognise the knowledge and competences (prior learning) achieved forces these trainees to commence training at the beginning in another specialty.

Close partnerships are required between those providing careers information and advice, including the Medical Royal Colleges, NHS Trusts and the Centre for Workforce Intelligence, to help these junior doctors to avoid making such costly wrong decisions.

In summary, the Evaluation Panel found that the provision of careers information and advice is extensive and should enable trainees to make informed career decisions. However, the challenge remains in helping trainees to manage their career expectations against the realistic opportunities.

Recommendation

11. *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".*

3.2.7 Lack of flexibility in the Programme

A substantial number of submissions, especially those from trainee-related organisations and trainees, highlighted the lack of flexibility in the Programme. Comments related particularly to the frequent lack of opportunity for trainees to discuss with the local Deanery which specialty placements in F2 would best align with their career aspirations, and the need to recognise the desire and ability of some trainees to progress at a faster pace.

Medical school graduates are a heterogeneous group of professionals with a broad demography and wide variation of aspirations. The previous PRHO/SHO system accommodated these differences by allowing significant flexibility. This provided trainees with the option to explore specialty areas in which they had an interest and provided more career decision-making time, but it also led to the lack of a fixed end-point.

The Foundation Programme introduced time-bound training and provided a structure for F1 and F2. This structure has resulted in decreased flexibility and has reduced the ability of some trainees to focus on specialties in which they have a particular interest or aptitude. Arguably, this works contrary to the needs of workforce planning which requires a flexible Foundation Programme that provides a broad range of career options and allows trainees to move between careers with varied competences.¹⁵⁸

Under the current model there is the danger that trainees can become disengaged and de-motivated if the placements allocated to them – or at least some of them – are not broadly aligned to their choice.¹⁵⁹ There was strong support for more flexibility and choice from the trainees in the BMA Cohort Study.¹⁶⁰ Likewise increased flexibility in rotations was supported by The Royal College of Surgeons of England,¹⁶¹ The Royal College of Physicians of Edinburgh,¹⁶² AoMRC,¹⁶³ Academy of Medical Educators¹⁶⁴ and RemedyUK.¹⁶⁵ Most of those submitting evidence accepted that the degree of choice may have to be somewhat constrained to reflect the need for a balanced educational programme in the context of service requirements. It is likely, however, that there will be improvements in trainee engagement and motivation if they have more direct input into the allocation of their F2 placements.

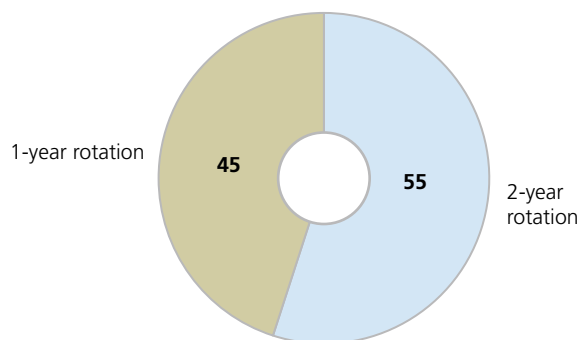
It is important to note that there is significant variance in practice across the Foundation Schools; approximately 55% of schools have a two-year fixed-rotation model in which the F2 placements are fixed at the beginning of the Programme (Exhibit 17).

❏ *A substantial number of submissions, especially those from trainee-related organisations and trainees, highlighted the lack of flexibility in the Programme.* ❏

EXHIBIT 17 At 55% of Foundation Schools, trainees' rotations for F1 and F2 are decided before they start the Programme

100% = Trainees from 25 Foundation Schools

Percentage of schools matching one and two-year rotations



SOURCE: UK FPO Annual Report, 2009

The Evaluation Panel found areas of best practice where trainees are given the opportunity during F1 to discuss the rotations they would prefer in F2. A number of Foundation Schools have organised “swap shops” which allow trainees to swap either an entire suite of rotations or individual rotations, while other Foundation Schools do not allow this degree of flexibility.

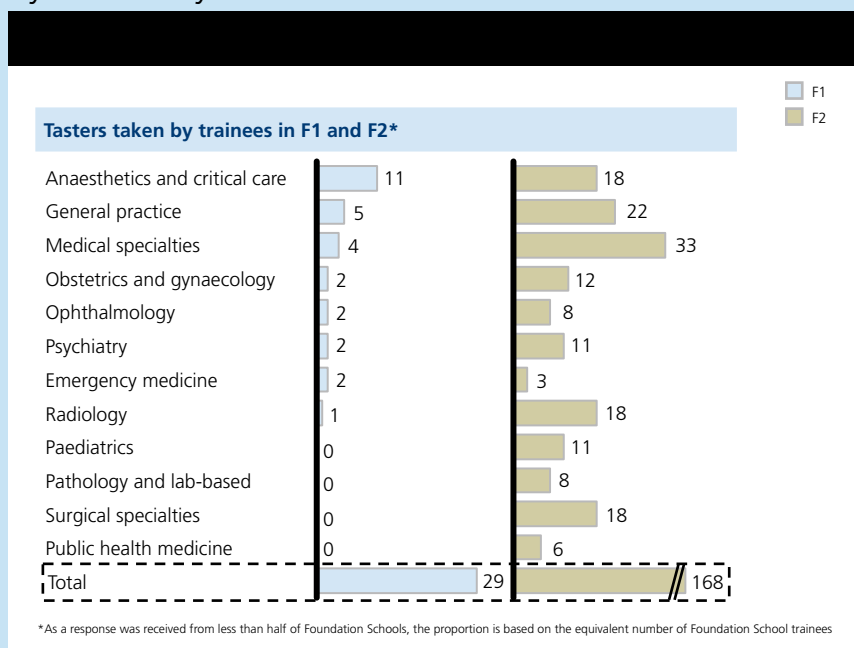
Broader exposure to a range of specialties could be supported in part by Tasters, which are defined by the UK FPO as:

“A period of time, usually two weeks, spent in a specialty in which the Foundation Programme trainee has not previously worked, which enables the development of insight into the work of the specialty and which promotes careers reflection.”¹⁶⁶

Tasters can aid career decisions.^{167, 168} Tasters are said to be available in around 40% of F1 and 60% of F2 Programmes,¹⁶⁹ although feedback from trainees suggests that it is difficult to access Tasters in F1. In 68% of cases, Tasters were requested and initiated by the trainee.¹⁷⁰ Tasters are predominantly undertaken in F2 and by only about 5% of F2 trainees; this number drops to less than 1% for F1 trainees¹⁷¹ (Exhibit 18). Much of the evidence submitted suggested that the provision of Tasters and the mechanisms for accessing them needs to be improved:

- tasters are too short (Royal College of Physicians of Edinburgh (RCPE)¹⁷²);
- tasters are delivered in F2 which is too late to be beneficial (RCPE,¹⁷³ BMA,¹⁷⁴ Kent, Surrey and Sussex (KSS) Deanery¹⁷⁵); and
- tasters are difficult to access (RCPE,¹⁷⁶ CEM,¹⁷⁷ KSS Deanery,¹⁷⁸ UK FPO¹⁷⁹).

EXHIBIT 18 Tasters are predominantly taken in F2 but by a minority of trainees



SOURCE: UK FPO Annual Report, 2009

The Foundation Programme needs greater flexibility for those who believe they have made a decision about their long-term career choice as well as those who remain undecided.¹⁸⁰ Where possible, decisions about placements for individual Foundation doctors should be influenced by whether the doctors have made a decision about their preferred eventual choice of career specialty. This must, however, be balanced by the reality that not all trainees finish up in their first choice for specialty training, and the need to take into account the future workforce requirements of the NHS and its patients.

The planning of likely demand for specialties in F2 should itself be based on evidence about when definitive career decisions are made by doctors. There is a substantial evidence-base on this in publications from the UK Medical Careers Research Group, covering the UK national cohorts studied prospectively by the Group, recently summarised in the *British Medical Journal (BMJ)*.¹⁸¹

This work shows findings from two complementary but distinctive perspectives. The first perspective starts with early career choice of specialty and looks forward in time to the specialties in which the doctors eventually practise. This shows that, at least in the past, a little over 50% of doctors eventually practised in the broad specialty group that they had given as their choice when asked in the first year after qualification, and a little under half eventually practised in a considerably different specialty from their early choice. About 80% of doctors eventually practised in the specialty that they had nominated as their first choice of career in the third year after qualification.

6 *The Foundation Programme needs greater flexibility for those who believe they have made a decision about their long-term career choice as well as those who remain undecided.* **9**

The time between years one and three is clearly, for many, a very key time in specialty decision-making. A number of factors come into play which include a genuine change in a previous career choice following experience in this or another specialty, or the failure to achieve a position in a specialty area of choice. Furthermore, by this time the mismatch between expectation and reality in the minds of trainees around career prospects will have become clearer.

There were large differences between specialties. Over 80% of doctors who nominated general practice as their first choice in the first year after qualification eventually became GPs. Of those who chose psychiatry in their first year 75% eventually became psychiatrists. About two-thirds of those who made an early choice for surgery eventually became surgeons. The predictive power of early career choices for some other specialties, such as the hospital-based medical specialties, radiology and public health, were much lower.

The second perspective, reported by the Medical Careers Research Group,¹⁸² started from the eventual career destinations of doctors and looked back at the specialties that the doctors had nominated as their preferred career in their early post-qualification years. Considering doctors in general practice, 50% had specified general practice as their first choice of career in the first year after qualification, as had 70% in year three. A little over 50% of doctors in psychiatry had specified psychiatry as their choice in the first year after qualification, as had 70% in year three. This shows that while the great majority of doctors who are “early-choosers” of general practice or psychiatry eventually practise those branches of medicine, they are also joined by substantial numbers of “late entrants”. By contrast, 90% of practising surgeons had already nominated surgery as their choice of eventual specialty in their first post-qualification year. Details for other specialties are given in the Medical Careers Research Group’s publications.

Although these findings refer to those who graduated some years ago, they do nevertheless support the view that Foundation Schools should seek to maximise the flexibility of their programmes to accommodate both those who are clearer on their future career direction and those who need more experience to help determine their choice. During this Evaluation, the Panel heard of a number of Foundation Schools where this is already being achieved and believes this “best practice” should become more universal.

Specialty recruitment data for 2010 reveals that 5,804 Foundation doctors applied for specialty training in England. Of applications from Foundation doctors, 45.6% were for general practice, with 1,148 (19.8%) applicants applying to general practice alone. This may reflect the success of communications about the opportunities to experience general practice during F2.¹⁸³ At the same time, there appears to have been a reduction in the number of places in specialty training for “shortage specialties” that have had to go through the second round of recruitment,¹⁸⁴ suggesting a better matching of supply and demand.

Recommendations

12. *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.*
13. *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.*
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.*

3.3 Concerns about the Programme – content

3.3.1 Gaps in the curriculum

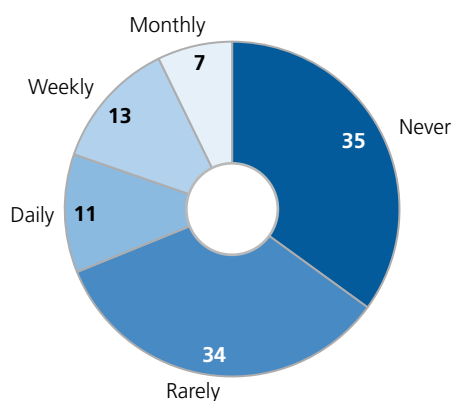
Despite the strengths of the Foundation curriculum noted earlier, there is insufficient emphasis on the total patient, long-term conditions and ambulatory or community care. There is also a degree of overlap with the undergraduate curriculum, which is said to lead to boredom among some trainees.¹⁸⁵

The education and training of doctors needs to prepare them for the changing dimensions in healthcare and its delivery. The NHS Confederation suggests that demand will increase as a result of long-term trends such as ageing and an increasing disease burden from improved survival.¹⁸⁶ Likewise, the Government’s intention is for more care to be provided closer to home.¹⁸⁷

The focus of the Foundation curriculum is on acute illness. This issue was highlighted in the *Tooke Report*, which noted the lack of emphasis on the management of long-term disease. It has been reported that “following the admission of patients in an emergency or urgent setting there is often no formal assessment of comorbidities” and that “many, otherwise remedial medical conditions go uncorrected, with problems overlooked”.¹⁸⁸ A number of submissions identified the lack of emphasis within the curriculum on assessment of key issues in modern healthcare, e.g. changing demographics, long-term care, multi-professional team-working and community care.¹⁸⁹ The 2009 PMETB Survey revealed that trainees had few opportunities for multi-professional learning (Exhibit 19). This is disappointing as much of healthcare is now delivered by a team of health professionals and knowing how to work together is vital.

EXHIBIT 19 Frequency with which trainees have the opportunity to learn together with other healthcare professionals (e.g. nurses, physiotherapists, etc)

100% = 9,161



SOURCE: PMETB Survey, 2009

A number of the trainees interviewed raised as a concern the requirement to repeat elements of the undergraduate curriculum and to demonstrate competences that had already been acquired and assessed as satisfactory in medical school. However, Foundation doctors are developing professionals who need to deepen and broaden their understanding and expertise. This involves revisiting clinical and professional practice and recognising that levels of expertise generally increase with practice and reflection. *The New Doctor* and the Foundation Programme curriculum are based on sound educational principles and use the spiral curriculum model.¹⁹⁰ Competences successfully demonstrated by students in medical school are demonstrated again as a professional in the workplace and at a higher level. Repetition of components of the curriculum and of assessment should be limited to these purposes and is explained in the UK Foundation Programme curriculum document (2010).

The GMC sets the standards and outcomes for undergraduate medical education in the UK. There is discretion as to how these are accomplished by each medical school, but the QABME process, external examiners and the sharing of examination questions between schools work to ensure a reasonably uniform product with common core clinical, professional and scientific skills and knowledge.

The outcomes and standards for undergraduate medical education outlined in *Tomorrow's Doctors* will help to achieve integration across the undergraduate and postgraduate medical education continuum. The newly formed Transition Group, comprising the MSC, the GMC, UK FPO, COPMeD, DH, NHS Education for Scotland (NES), BMA, NHS Employers, SHAs and the NHS Confederation are working together to achieve integration and to effect a smoother transition from medical school to employment. The merger of PMETB with the GMC will also enable a more effective integration.

The Foundation Programme of the future must place greater emphasis on the management of long-term illness and the delivery of care closer to home. This will require a structured implementation plan, covering availability of placements, changes to the curricula and changes to *The New Doctor*.

A number of organisations and individuals raised the difficulties of delivering a curriculum which includes long-term illness in the acute setting of large hospitals, pointing out that the community is the more appropriate learning environment for this. However, others reported that the current arrangements for teaching and learning in the community were not sufficient to deliver this extra load. While these challenges are real and may take time to rectify, they do not absolve those responsible for delivering the curriculum from making greater efforts to focus on the whole patient and long-term illnesses.

A very valuable leadership competence framework has been produced by the AoMRC and it is important that Foundation doctors experience this.

Recommendation

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.*

3.3.2 Maldistribution of placements by specialty

A greater share of healthcare is now delivered in the community, and the NHS is moving increasingly towards a model in which this will expand. The balance of placements in the Foundation Programme does not reflect this change.

The balance and distribution of Foundation placements within all Foundation Programmes is dominated by opportunities in adult medicine and adult surgery, reflecting in part the 1967 GMC requirements for the pre-registration year. These specific requirements were dropped in 2007, however, opening up a wide range of medical specialties. The 2008 PMETB Survey of Foundation trainees shows which specialty respondents were placed in at the time of the surveys (Exhibit 20). Clearly the balance is dominated by opportunities in adult medicine and adult surgery.

EXHIBIT 20 Specialty distribution of respondents at the time of the PMETB Survey

Specialty	F1 posts	F2 posts
Medicine	2674	1445
Surgery	2239	1033
Emergency Medicine	153	935
Paediatrics	166	320
General Practice	–	796
Anaesthetics	165	159
Obs & Gynae	96	273
Psychiatry	94	243
Radiology	23	43
Pathology	6	52
Ophthalmology	5	58
Public Health	–	41
Total	5621	5398

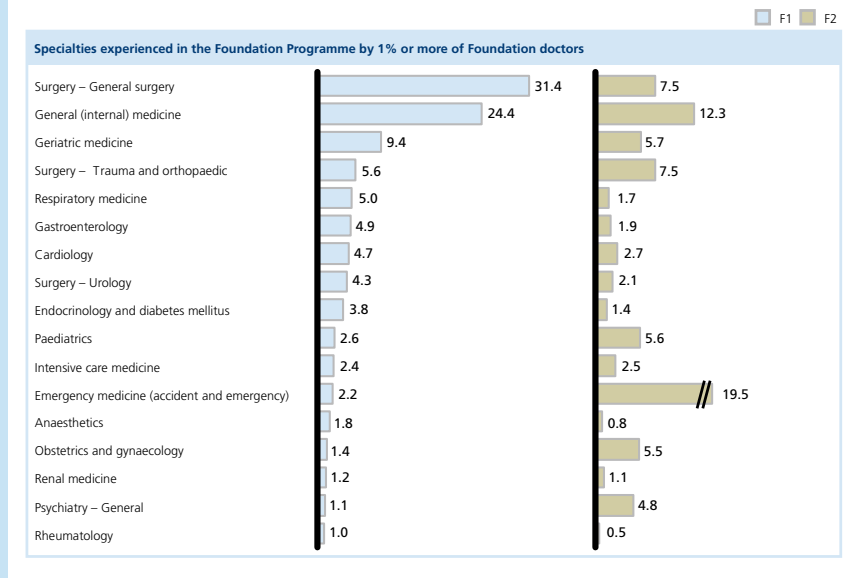
SOURCE: PMETB Survey, 2009

A similar distribution of specialty placements can be seen in the 2009 UK FPO Annual Report (Exhibit 21). This does not reflect the balance of available opportunities in specialty training or the future workforce requirements of the NHS. Specialties with recruitment problems such as paediatrics and psychiatry are under-represented in terms of opportunities to experience these specialties at Foundation level.¹⁹¹ Furthermore, many specialties deal with children and young people as part of their work, and exposure to paediatrics during the Foundation Programme would provide very important grounding.¹⁹² As pointed out by Professor Sir Ian Kennedy, children's health services need to be prioritised as highly as adult services.¹⁹³ Similarly, benefits apply to spending time in psychiatry.¹⁹⁴

6 Many specialties deal with children and young people as part of their work, and exposure to paediatrics during the Foundation Programme would provide very important grounding. 9

EXHIBIT 21 F2 doctors experience a greater range of specialties than F1

100% = Trainees from 23 Foundation Schools



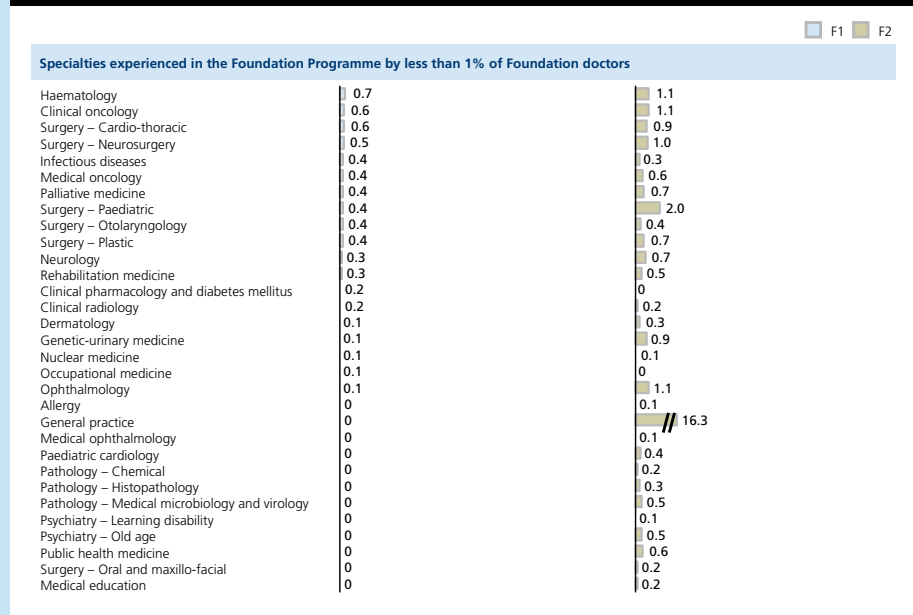
SOURCE: UK FPO Annual Report, 2009

Current workforce planning assumptions in the *NHS Next Stage Review*¹⁹⁵ suggest that in future at least half of doctors going into specialty training will be training as GPs. According to the 2009 UK FPO *Annual Report* (Exhibit 22) there are no posts in general practice in F1 and only 16% of F2 posts are in general practice.¹⁹⁶

Changes to the distribution of posts need to occur but will have repercussions for service delivery for specialties like medicine and surgery – at least in the short term.

EXHIBIT 22 Only 16.3% of F2s experience general practice

100% = Trainees from 23 Foundation Schools



SOURCE: UK FPO Annual Report, 2009

There are challenges in delivering a greater share of the Foundation Programme within community settings as there are a limited range of posts and learning environments available in community paediatrics, general practice and psychiatry. The difficulties in implementing such changes in the present financial and service climate within the NHS and the wider public sector are acknowledged. Greater community experience will benefit all Foundation trainees but may be unpopular especially with those who seek greater flexibility and choice. Nevertheless, the Evaluation Panel heard from a number of trainees who were initially dissatisfied about being allocated placements in the community but who went on to enjoy and benefit from this experience.

Recommendations

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.*
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.*

3.3.3 Shortcomings in technology-enhanced learning

The implementation of the Foundation Programme included the successful establishment of Foundation Schools and the appointment of Foundation School directors and managers, Programme directors or tutors and educational, clinical and academic supervisors as well as educational infrastructure and facilities.

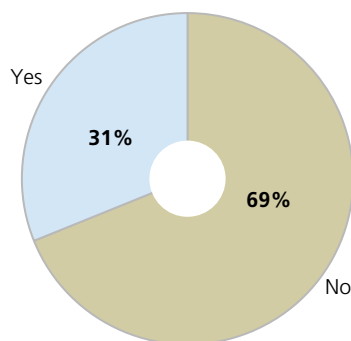
The UK Foundation Programme curriculum draws attention to the opportunity which simulation provides for learning practical procedures prior to undertaking these on patients. In addition, it highlights the value of simulation in deepening Foundation doctors' understanding of the importance of communication skills, human factors and teamwork when managing patients.¹⁹⁷ Similarly, *Time for Training* points out that learning can be accelerated by using simulation and technology in a safe and controlled environment.¹⁹⁸ The UK Foundation Programme Reference Guide¹⁹⁹ states that: "The Deanery/Foundation School must ensure Foundation doctors have access to appropriate learning resources and facilities, including libraries, IT facilities, skills labs, simulated patient environments and teaching accommodation."

Feedback from the trainees interviewed²⁰⁰ suggests that there is variation across England in the provision and use of simulation as an aid to learning. In the 2009 PMETB Survey approximately 30% of the trainees surveyed reported that simulation had been used during their current post to impart procedural skills (Exhibit 23). Although there is a paucity of reliable information about the broader use of technology-enhanced learning in the Foundation Programme, it is important that the educational environment integrates e-learning and face-to-face delivery utilising modern simulation techniques.²⁰¹

6 *The UK Foundation Programme curriculum draws attention to the opportunity which simulation provides for learning practical procedures prior to undertaking these on patients.* **7**

EXHIBIT 23 Proportion of trainees who have their procedural skills developed with simulator training

100% = 8,544



SOURCE: PMETB Survey, 2009

Recommendation

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.*

3.3.4 Equipping and approval of trainers is necessary

In their written submission, English Postgraduate Deans²⁰² stated that it was essential that trainers were adequately trained and given time in their job plans to deliver educational supervision.

The creation of the Foundation Programme has generated a range of new requirements for trainers, including WPBA. In general practice this has led to GPs being required to be formally selected, trained and appraised in their role as trainer. In 2007 PMETB approved standards for trainers and set a deadline for compliance by 2010. In the recent *Patel Review*,²⁰³ Recommendation 12 stated: "Having implemented the standards for trainers and evaluated their role and effect, the GMC should develop a framework for the accreditation of trainers." Although there are practical challenges in implementing this recommendation, including the potential costs for the service and the burdens on trainers themselves, there is an emerging consensus that all those who train or teach and assess as a formal part of their role should be properly equipped to carry this out effectively and be formally recognised. At the same time it is vital to be aware of the danger of alienating those with long-standing experience in teaching and assessment, some of whom have yet to be convinced of the benefits of courses and workshops in education. DH recently commissioned the Academy of Medical Educators to develop a framework for the approval of trainers and this should be taken forward as a matter of priority in partnership with the GMC.

Recommendation

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.

3.3.5 Assessment is excessive, onerous and not valued

A number of different assessment tools were introduced into the Foundation Programme, which has placed significant demands on both the trainee and the trainer. They are seen by many as an onerous tick-box exercise and may not be working efficiently or effectively.

Three different clinical assessment tools – the mini-CEX, DOPS and CBD (described in 2.3.3, p 52) were introduced into the Foundation Programme. The introduction of ePortfolio systems has facilitated the completion and recording of assessments, but the workload remains formidable. Between August 2008 and August 2009 almost 250,000 clinical assessments (25 out of 26 Foundation schools) were recorded in the NES ePortfolio on F1 and F2 trainees (Exhibit 24). This exhibit also shows the distribution of the different assessment tools.

EXHIBIT 24 Clinical assessments submitted to ePortfolio for Foundation trainees

(August 2008–August 2009)

(n = 12,739)	F1	F2	Total
CBD	37,901	34,585	72,486 <small>(mean = 5.7 per trainee)</small>
DOPS	63,474	41,485	104,959 <small>(mean = 8.2 per trainee)</small>
Mini-CEX	38,304	33,815	72,119 <small>(mean = 5.7 per trainee)</small>



The overall scores achieved in each of these assessments (Exhibits 25–27) are very high and suggest a high degree of clinical competence. While these findings are encouraging, it may be that the scores were recorded after the event or post attachments, whereas the recording of scores in a more formative fashion might have helped to demonstrate progression of learning. Trainees raised with the Panel the difficulties in getting assessors to record scores at the time of each assessment.

EXHIBIT 25 DOPS 2008/09

(n = 104,959)

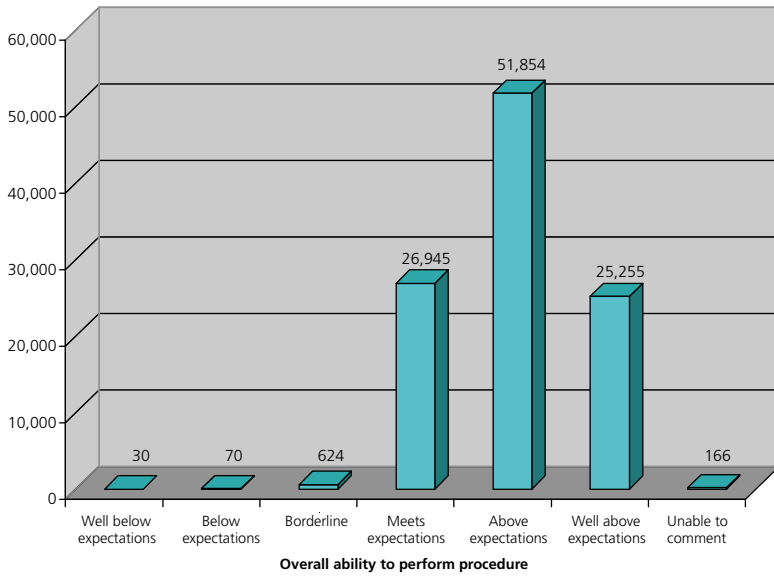


EXHIBIT 26 Mini-CEX overall clinical care scores

(n = 72,119)

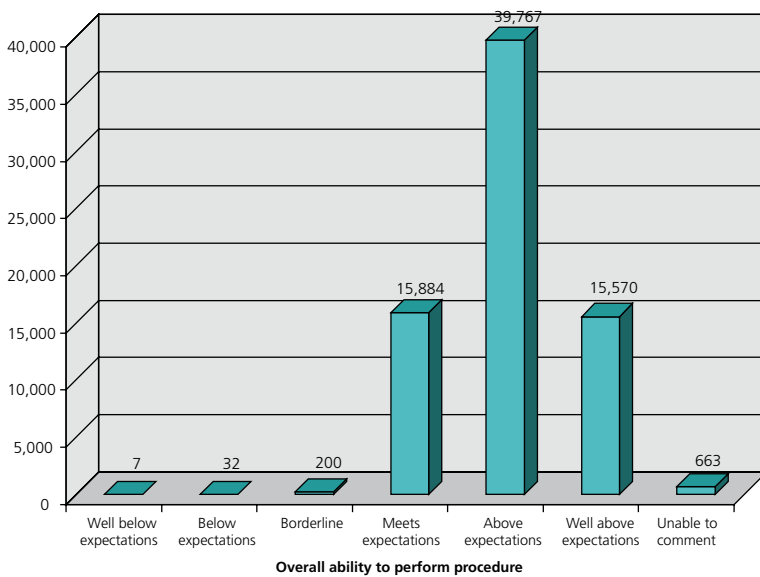
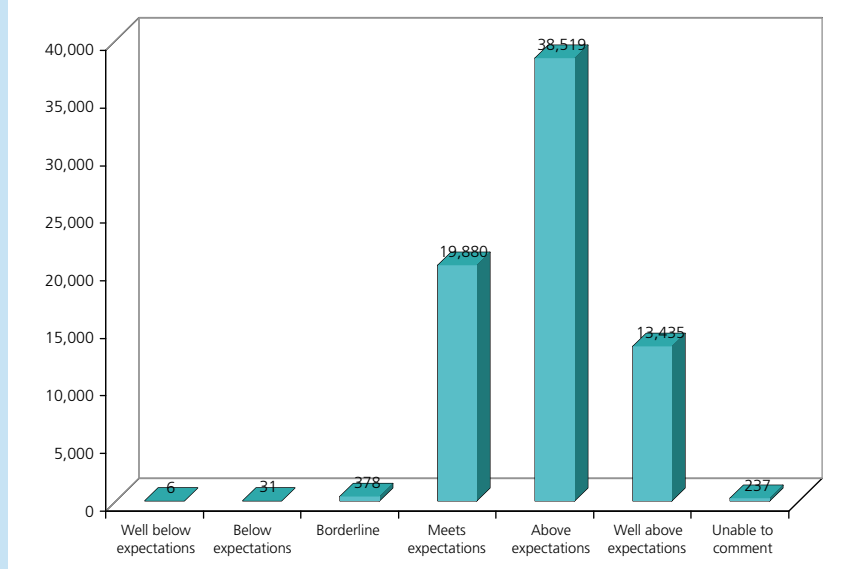


EXHIBIT 27 CBD Overall Clinical Judgement score

(n = 72,436)



The mandatory use of multi-source feedback (360 degree appraisal) within the Foundation Programme was a very significant development. Three different tools have been used across the UK for this feedback and include the mini-PAT, TAB and MSF (Exhibit 28). ePortfolio data shows that during the same period as that quoted for clinical assessments, a total of 193,388 MSF appraisals were submitted.

EXHIBIT 28 360 degree appraisals submitted to ePortfolio for Foundation trainees

(August 2008–August 2009)

(n = 12,739)	F1	F2	Total
Mini-PAT ¹	62,923	49,241	112,164
TAB ²	31,812	28,186	59,998
MSF ³	10,831	10,395	21,226
			193,388

- ¹ Mini-peer assessment tool
- ² Team assessment of behaviour
- ³ Multi-source feedback



Using this tool allowed comparison of a trainee’s self-assessment of their performance against those of their peer group. Exhibits 29 and 30 demonstrate that trainees in F1 rated themselves significantly lower than their peers, whereas the F2 cohort scored the same as their peers. This supports the contention that trainees are acquiring more confidence in their competence as they progress through the Foundation Programme.

EXHIBIT 29 Multi-source feedback scores F1 (7 point scale)

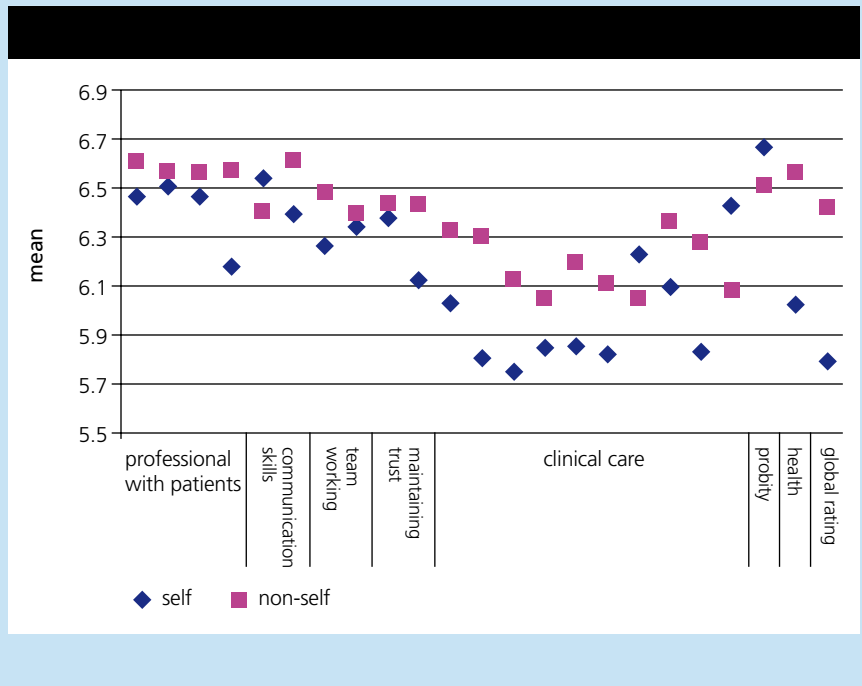
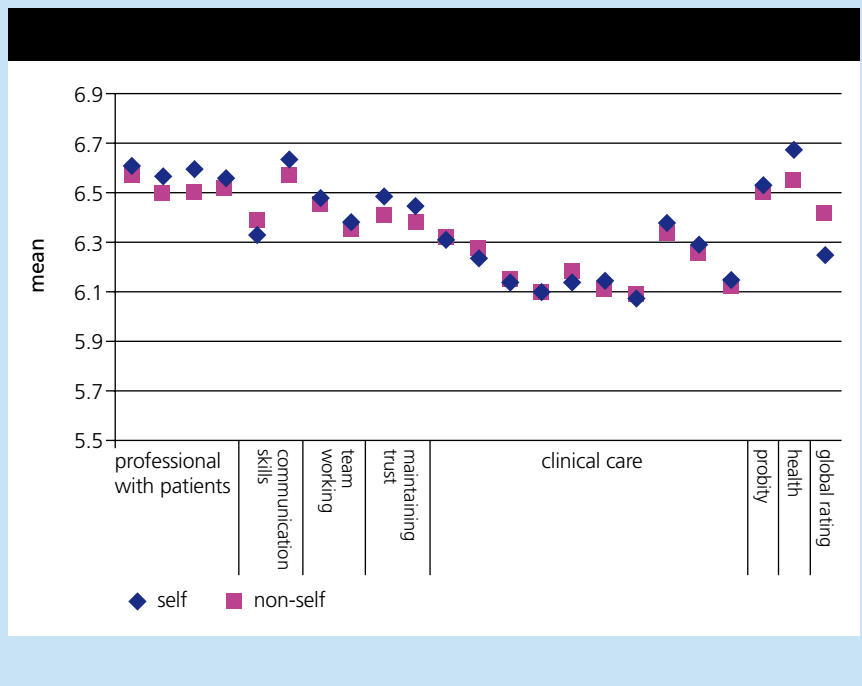
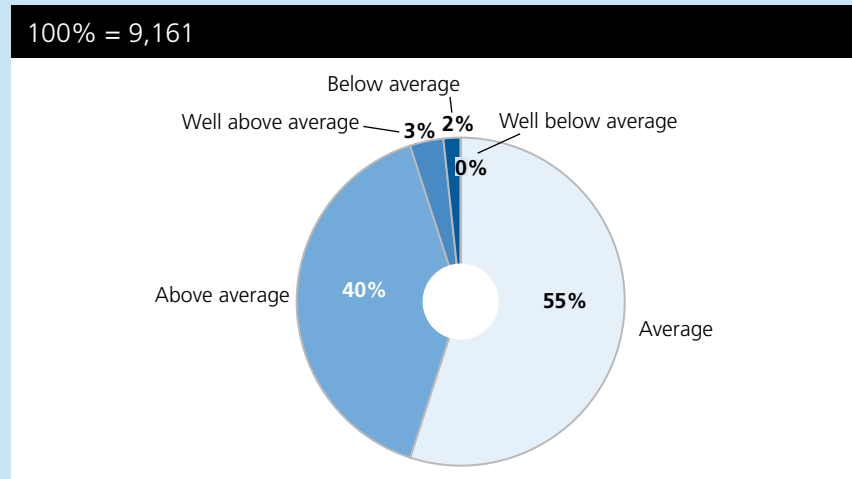


EXHIBIT 30 Multi-source feedback scores F2



The same survey found that 95% of trainees self-assessed their performance at the average or above average of their peers (Exhibit 31).

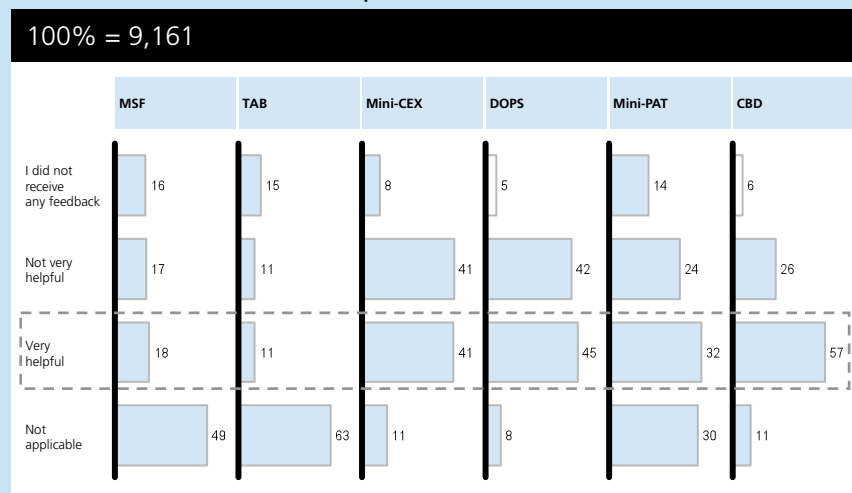
EXHIBIT 31 How trainees rate their current performance as a doctor compared with their peers at the same level



SOURCE: PMETB Survey, 2009

It is encouraging that there is some evidence that trainees are benefiting from structured feedback based around completion of assessments. The 2009 PMETB Survey of trainees (Exhibit 32) demonstrated clear value of structured feedback in relation to case-based discussion (CBD), but less so in relation to the other tools. CBD focuses on “evaluating the clinical reasoning of trainees so as to understand the rationale behind decisions made in authentic clinical practice”²⁰⁴.

EXHIBIT 32 How helpful the different types of structured feedback were to trainees’ development as new doctors (over the previous four weeks)



SOURCE: PMETB Survey, 2009

Taken in their totality, the introduction of a range of assessment tools has provided confidence in the competence of Foundation trainees but has placed a very substantial demand on trainer time. The high scores suggest that the tools are not discriminating of less good performance but, given that the benchmark is competence rather than excellence, this is not surprising.

The assessment of procedure skills (DOPS) in the F1 year repeats similar assessments carried out during undergraduate education. This repetition should be addressed and improvements may result from a closer alignment between the undergraduate and Foundation curricula regarding the frequency and nature of these assessments.

WPBA has many attractions but is time-consuming and faculty training is essential. Time for teaching and assessment compete in an already time-constrained environment and, although assessment can and should drive learning, assessment per se has come to dominate the Foundation Programme.

“We make the examination the end of education, not an accessory in its acquisition. The spirit is taken out of instruction and teacher and taught alike go down into the valley of Ezekiel – where they stay among the dry bones.”²⁰⁵

Furthermore, confusion persists over the purpose of the WPBA tools and in particular whether their role is summative or formative.²⁰⁶ These tools were designed to provide feedback to the learner and not to ensure or confirm competence. There is evidence that WPBA is being used for summative appraisal by some specialties that have requested applicants' WPBA scores for selection purposes.²⁰⁷

A major tension exists whenever trainees are being assessed in the workplace. Although the primary purpose is formative or “assessment for learning”, trainees and even assessors may see this as judgemental or “assessment of learning”. This conflict remains difficult to resolve. A further consideration relates to medical trainees being high achievers, who are used to attaining high marks in examinations and therefore consider a less than perfect score as a failure. This leads them to approach every assessment as if it were a high-stakes summative assessment, whereas the focus should be on receiving feedback in order to improve performance (formative assessment). Changing the mindset of trainees takes time and a culture change will only occur with support from those who have experienced properly implemented, formative WPBA.

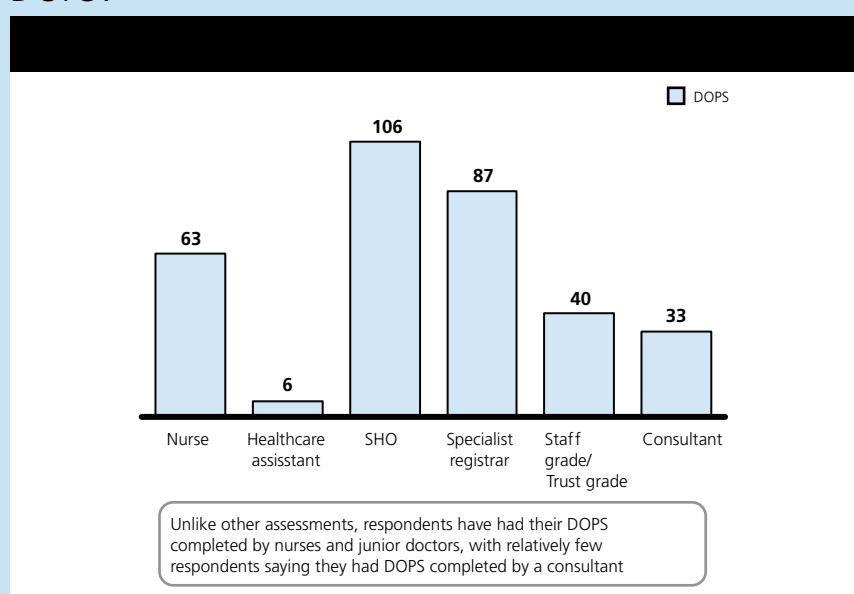
Each assessment tool must be reliable, valid and feasible within the normal time and resource constraints of clinical practice. Performance in a single assessment is very context specific²⁰⁸ and assessors can vary in their expectations. To improve reliability, multiple observations are required by a range of different assessors,²⁰⁹ and faculty development is critical to the quality and effectiveness of this assessment.²¹⁰ The “ability of faculty to accurately observe trainees performing history-taking and physical examination and provide effective feedback is one of the most important aspects of medical training”.²¹¹

The validity of WPBA tools has been questioned because of a perceived lack of evidence and variation in their application. It has been stated that “unrealistic timescales together with a lack of resources and inadequate assessor training led to the hurried implementation of WPBA and the development of undesirable practices... resulting in widespread cynicism about WPBA within the profession”.²¹²

In addition, trainees are being assessed by different grades of doctors, including trainees’ peers, and also by non-medical health professionals.²¹³ A helpful survey carried out by the East Midlands SHA found that DOPS was assessed predominantly by junior doctors, registrars and nurses (Exhibit 33), mini-CEX by registrars and consultants (Exhibit 34) and CBDs overwhelmingly by consultants and registrars (Exhibit 35). It is important to acknowledge the expertise of non-medical health professionals in medical education and their vital role in postgraduate medical education and training.

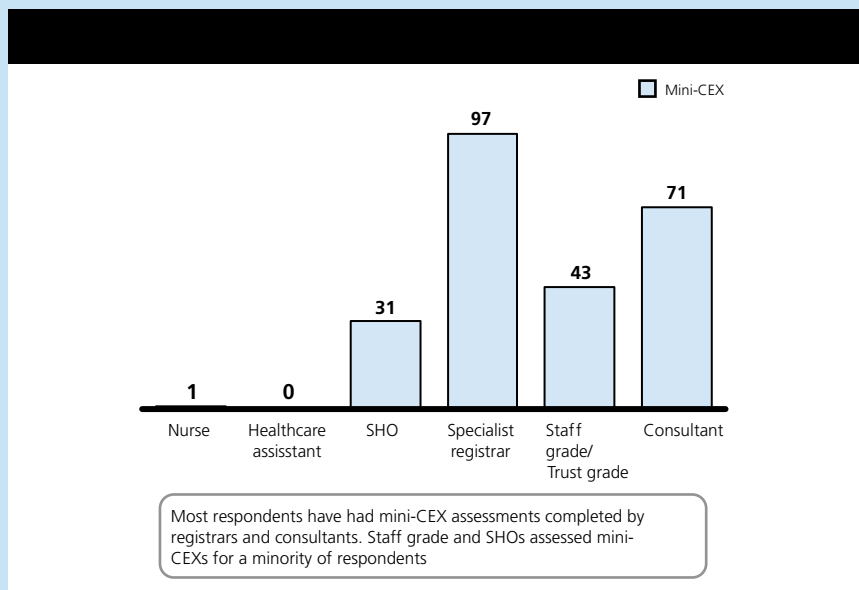
Each assessment tool must be reliable, valid and feasible within the normal time and resource constraints of clinical practice.

EXHIBIT 33 Who is assessing Foundation doctors’ DOPS?



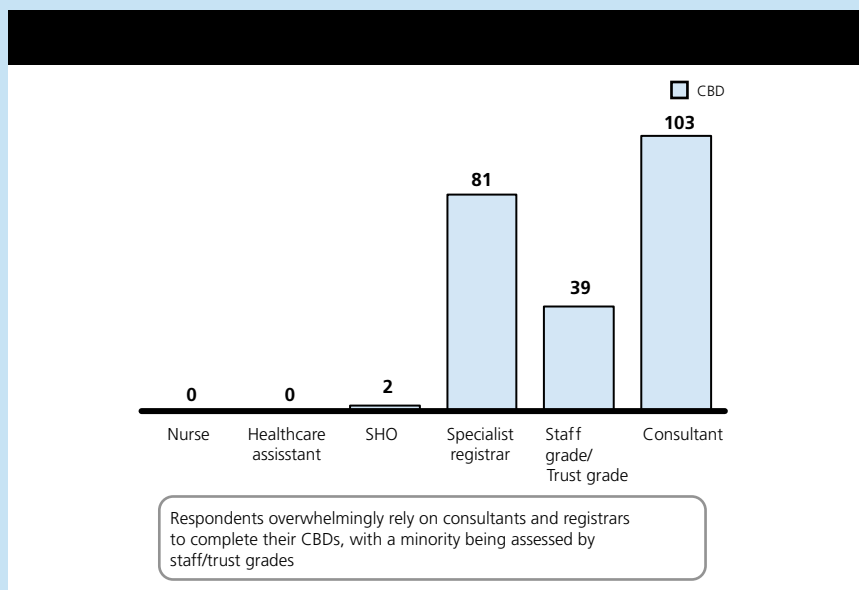
SOURCE: East Midlands SHA Survey, 2010

EXHIBIT 34 Who is assessing Foundation doctors' mini-CEXs?



SOURCE: East Midlands Survey, 2010

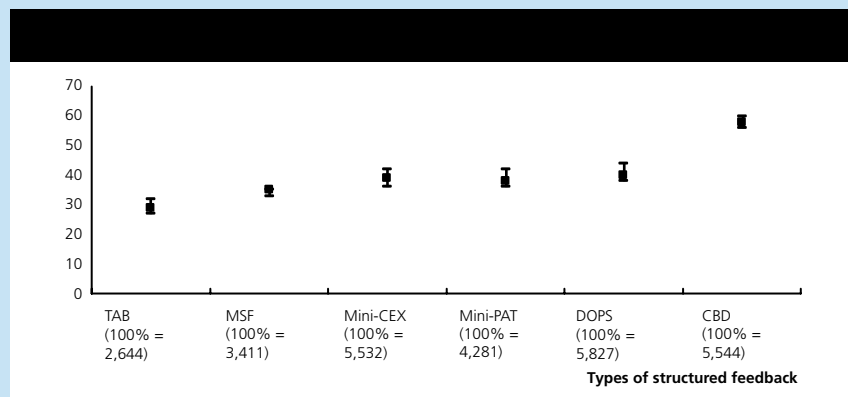
EXHIBIT 35 Who is assessing Foundation doctors' CBDs?



SOURCE: East Midlands SHA Survey, 2010

As pointed out earlier (Exhibit 32), a sizeable proportion of trainees who responded to the 2009 PMETB Survey reported receiving helpful feedback, especially as a result of CBD (Exhibit 36). This is a significant improvement on what occurred prior to the implementation of the Foundation Programme.

EXHIBIT 36 Structured feedback – percentage of Foundation doctors who reported receiving helpful feedback



SOURCE: PMETB/COPMeD National Surveys, London Deanery

Trainers and supervisors may not have sufficient time allocated to deliver the frequent and extensive array of WPBAs that are required for each trainee. To carry out these assessments thoroughly and as frequently as is currently required takes time and proper training, neither of which has been widely achieved.

As a result, many trainers and trainees have a lack of confidence in the assessment process. Assessment has come to be seen by trainees as more important to those administering the programme than ensuring that trainees gain the clinical experience necessary to advance their learning and enable them to step up in what they are capable of doing. A further issue relates to the lack of role modelling from their peers and seniors. It is clear that a culture change around assessment is required.²¹⁴

Those who had received assessor training for WPBA tools were more likely to rate WPBAs as providing a meaningful and sufficient data set about trainees' competence. However, none of the tools received a rating higher than 41% from consultants, even from those who had been trained in their use.²¹⁵ As many as 18% of consultant trainers (N = 10,133) think that there are trainees who have been signed off as competent despite not reaching the appropriate standard.²¹⁶ This requires further exploration.

There is support for feedback from patients who had been involved with Foundation trainees to be part of the assessment process. This has been part of the assessment process in paediatrics and general practice for many years; it is well described in the educational literature and its more general use is supported by the Evaluation.

The opportunity for Foundation doctors to take college exams is contentious and considered disruptive to the programme. In the South Thames Foundation School, 51% (402) of F2 trainees surveyed in 2010 had taken a postgraduate examination during the programme with 55% taking the MRCP, 28% the MRCS, 7% the MRCPaeds and 3.4% the MRCOG. A total of 257 (64%) passed these examinations. If the message from the medical colleges is

that passing these examinations will give a trainee an advantage in their application to specialty training, then this is precisely what they will do. A more major question surrounds the objectives of these examinations and whether they should take place within core specialty training.

Recommendations

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.*
21. *NHS Trust employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees.*
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.*
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.*

3.4 Concerns about the Programme – safety and quality of the learning environment

3.4.1 Variation in the deployment and supervision of trainees

The Evaluation Panel heard evidence from trainees and others regarding variation in the appropriate deployment and supervision of trainees, the quality of education and learning, and the lack of pastoral care. In interpreting this important feedback the Evaluation Panel was mindful of the major changes that take place as the newly qualified doctor moves from university to the employment sector.

Transition from university to the NHS

The most significant transition in culture and self-actualisation for medical graduates occurs with the progression from medical student to junior doctor.²¹⁷ Exchanging university for the NHS, the carefree life of a senior student is replaced by the demanding responsibilities of a worried employee. Switching simulation and the classroom for real practice, teachers for managers, peer support for competition and helpful feedback for summary judgement, is a major demand. Becoming the “person on the spot” is a new and unnerving experience which, if not carefully supervised, can leave scars for a lifetime.

The belief by some that “being thrown in at the deep end” remains an acceptable way to learn reflects a failure to recognise the centrality of safe patient care and a lack of understanding of the major advances in learner-centred education.

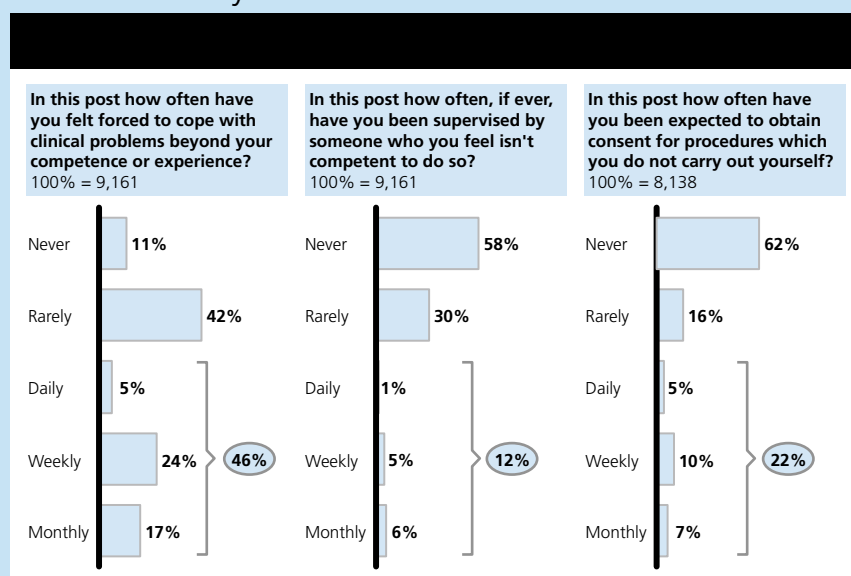
Deployment and supervision of Foundation trainees

In meetings with trainees the Evaluation Panel heard a repeated theme of some trainees being asked to practise beyond their level of competence and without adequate levels of supervision. One third of respondents in the BMA Cohort Study Third Report²¹⁸ reported that they had been asked “to undertake tasks which they felt were beyond their capabilities” during their F2 placements. Similar evidence was collected during the recent reviews by Lord Patel²¹⁹ and Sir John Temple.²²⁰ A recent review of those patients who died in hospital within four days of admission²²¹ reported that “junior doctors may not necessarily have the experience to recognise when a patient is developing a potentially serious problem, and a lack of input from senior doctors may lead to delays in giving patients timely and appropriate care”. The review states that “in 25% of cases who died, there was a clinically important delay in the first review by a consultant”.

Some 46% of Foundation trainees who responded to the 2009 PMETB Survey reported that they regularly had to cope with clinical problems beyond their level of competence (Exhibit 37). In addition, 12% recorded that they were supervised by a person whom they considered not competent to do so and 22% were expected to obtain consent for procedures beyond their own understanding.

6 In meetings with trainees the Evaluation Panel heard a repeated theme of some trainees being asked to practise beyond their level of competence and without adequate levels of supervision. 7

EXHIBIT 37 46% of trainees have felt forced to cope with clinical problems beyond their competence on at least a monthly basis



SOURCE: PMETB Survey, 2009

In addition, QAFP reports following visits to Deaneries included concerns about the level of supervision, obtaining consent²²² and the misunderstanding of the competence levels of Foundation doctors by other healthcare professionals.^{223, 224} According to one QAFP report,²²⁵ 24% of requirements and 22% of recommendations fall under this latter domain.

Further analysis of QAFP reports showed that a number of Deaneries were required to address inadequate clinical supervision of Foundation doctors, to improve communication of the roles and responsibilities of Foundation doctors' educational and clinical supervisors, and to improve the lead provider's understanding of the roles and competences of F1 and F2 doctors.

The effect of this lack of understanding included Foundation doctors being asked to carry out duties which they did not feel competent to perform. Close and effective clinical and educational supervision of trainees is crucial as they develop competence and confidence, and is likely to be a key determinant of patient safety.

The PMETB Survey of trainees has provided a wealth of data on the trainees' perception of the quality of supervision.²²⁶ Evidence indicates that while virtually all trainees are able to identify their clinical and educational supervisors, the quality of supervision is not always rated as highly.

Two indicator scores were used in the survey, one for educational supervision and the other for clinical supervision. Each of these indicator scores was calculated from the mean of the scores of a number of indicator items.

Indicator items for educational supervision:

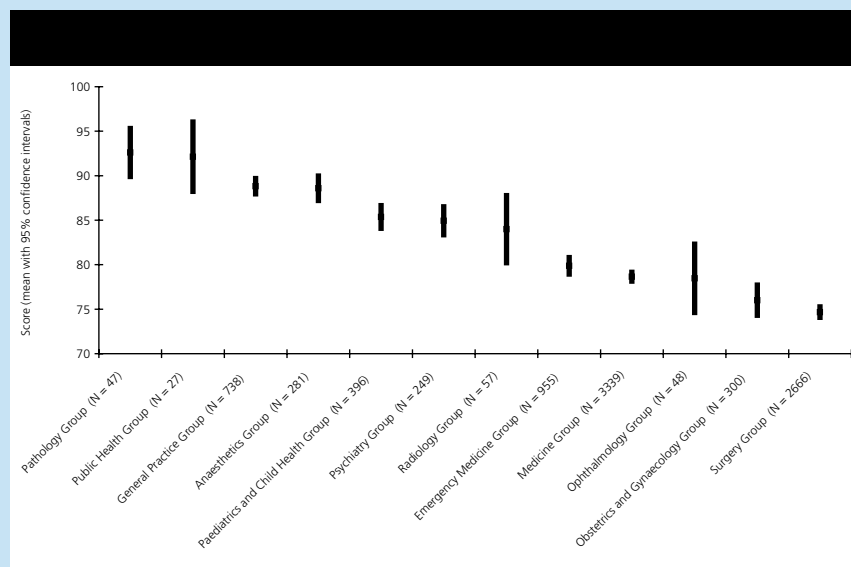
- Do you have a designated educational supervisor?
- Do you have a training/learning agreement with your supervisor, setting out your respective responsibilities?
- Are you using a learning portfolio in this post?
- Have you been told whom to speak to in confidence if you have concerns, personal or educational?

Indicator items for clinical supervision:

- How often have you felt forced to cope with problems beyond your competence or experience?
- How often, if ever, have you been supervised by someone who you feel isn't competent to do so?
- How often have you been expected to obtain consent for procedures which you do not carry out yourself?
- Do you always know who is providing your clinical supervision when you are working?
- Please indicate your perception of the way in which critical events and near misses are reported in your department.

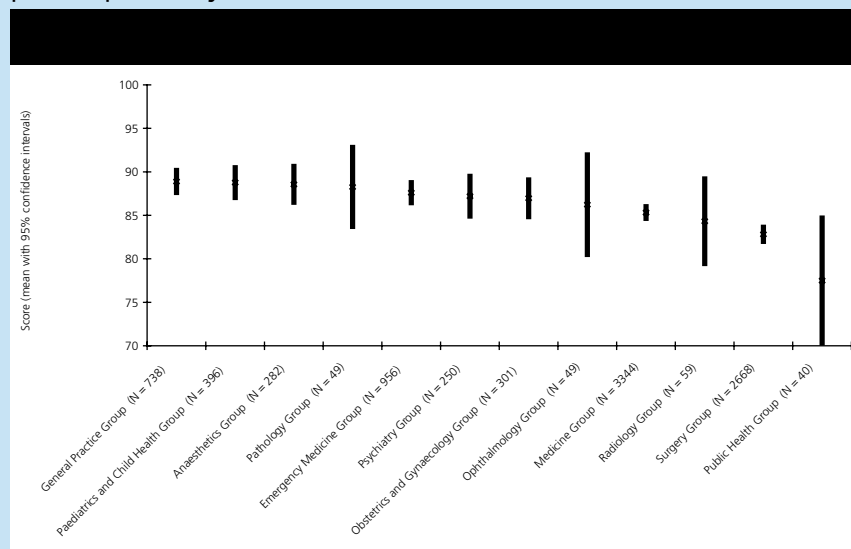
The scores for educational and clinical supervision vary significantly between the specialty groups for Foundation trainees (Exhibits 38 and 39). Mean scores for clinical and educational supervision in surgical posts (placements) were the lowest for those listed. Mean scores for medicine (the specialty with the largest number of posts) lay in the bottom four listed.

EXHIBIT 38 Clinical supervision by post specialty for Foundation trainees



SOURCE: PMETB Survey, 2009

EXHIBIT 39 Educational supervision by post specialty for Foundation trainees



SOURCE: PMETB Survey, 2009

As a consequence of the large number of Foundation placements in some specialties there is a particularly high demand on time for supervision and undertaking assessments. Data from the ePortfolio gives a measure of the clinician time taken in these activities. The lower score for certain specialties suggests that some of these placements should be reviewed.

The data (Exhibit 40) also suggests a close correlation between the clinical supervision score (%) and the frequency of reporting errors.

EXHIBIT 40

Medical error score	Mean clinical supervision score	Number
No medical errors reported on the survey forms in the previous four weeks	79.98	7,881
One or more serious or potentially serious medical errors reported on the survey form in the last four weeks	74.61	1,222
Total	79.26	9,103
F = 136.13 p<0.001		

It is recognised that trainees must step up in their level of responsibility in order to learn as they progress through their training. This is essential in the progression from F1 to F2. It has been shown, however, that “increased experience without supervision leads to increased confidence but not competence”.²²⁷ Increasing experience and responsibility with graduated supervision is the basis of learning, and trainees shared examples of where this is occurring in the Foundation Programme.

The Evaluation Panel is concerned that unacceptable practice in terms of the deployment and lack of supervision is occurring in some places and may be affecting patient safety. Furthermore, the message this gives to junior doctors about what is acceptable in terms of patient care is undesirable. This is best summarised in the words of Sir Donald Irvine: “Modern professionalism is about both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice”.²²⁸

Recommendations

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 F1 and F2 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.*

6 The Evaluation Panel is concerned that unacceptable practice in terms of the deployment and lack of supervision is occurring in some places and may be affecting patient safety. 9

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.*
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.*
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).*

3.4.2 Variation in the quality of education and learning

A further issue included in QAFP reports related to the need for improvements in induction and educational handover for Foundation doctors. The lack of adequate handover arrangements has led to educational and clinical supervisors not being aware of concerns raised about the progress of some Foundation doctors in previous placements.

One of the most significant trends identified in four recent QAFP visits was the need for Deaneries to improve their local quality management of the Foundation Programme. Recommendations were made to collect more quality data from Foundation doctors through the use of Foundation doctor surveys, representation of Foundation doctors on committees, and interviewing of Foundation doctors during quality management visits.

Recommendations

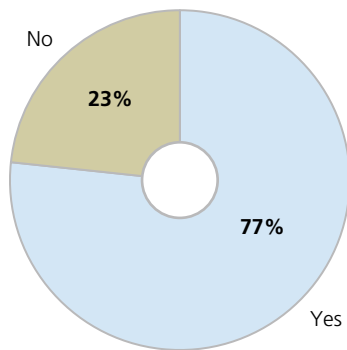
28. *The Postgraduate Deans, the GMC and NHS Trusts must clarify the appropriate balance between service and education during F1 and F2 and ensure that the effective monitoring of this balance is being achieved by 2012. Clear pathways must be available for trainees to obtain satisfactory resolution if the appropriate balance is being eroded.*
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.*

3.4.3 Lack of pastoral support

Trainees raised the issue of a lack of availability of pastoral support. The 2009 PMETB Survey suggests that nearly a quarter of trainees had not been informed about whom to talk to if they had personal or educational concerns (Exhibit 41).

EXHIBIT 41 Proportion of trainees who have been told whom to talk to in confidence if they have concerns, personal or educational

100% = 8,350



SOURCE: PMETB Survey, 2009

The BMA highlighted a more general lack of support for trainees,²²⁹ and the PMETB 2008 Survey of trainees showed that Foundation doctors were more likely to feel stress than any other grade. As pointed out by Boorman: “staff health and well-being is vital to enabling the NHS to deliver high standards of quality and good patient outcomes”.²³⁰ The commitment to implementing Boorman’s recommendations on improving staff health and well-being in the Government’s recent White Paper²³¹ is welcomed.

Recommendation

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.*

3.4.4 Inadequate transfer of information about trainees

There is some evidence of inadequate transfer of information between medical schools and those responsible for the subsequent education, supervision and employment of medical graduates.

The historical split governance of the Foundation Programme has meant that information about trainees has been held by different institutions as they progress through their education and training. F1 is governed by the GMC, and the medical schools sign off the trainee for full registration. F2 was governed by PMETB until 1 April 2010, but this has now come under the governance of the GMC.

The Evaluation Panel heard some evidence that information on students is not being freely transferred from medical schools to the Foundation Programme Schools, and in particular when the student moves away from the home medical school. This is exacerbated by the national recruitment process, which has enabled 40% of trainees to move away from their medical school for the Foundation Programme.²³² Oral evidence was presented that Foundation Schools which are closely linked to their local medical school have few problems with information transfer. This may be due to the presence of shared faculty members.

The Shipman Inquiry revealed that there was no systematic means of triangulating concerns or any means of effectively channelling them. In addition, there were deeply held cultural and social barriers – to the idea of whistle-blowing, to the challenging of doctors, and to believing patients or colleagues above the interests of doctors – that held people back from taking any action. *The Shipman Inquiry: Fifth Report*²³³ made over 100 recommendations, many of which had an explicit or underlying focus on information sharing and transparency. Recommendations included improving transparency, improved handling of concerns by patients and colleagues, and better use of data.

❖ *There is some evidence of inadequate transfer of information between medical schools and those responsible for the subsequent education, supervision and employment of medical graduates.* ❖

Disciplinary action taken against practising physicians by medical boards has been shown to be strongly associated with their earlier unprofessional behaviour in medical school. Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behaviour.²³⁴

Important information gathered in medical school may not always be transferred to employers. The *Tooke Report* recommended better harmonisation between Year 5 of medical school and the Foundation Programme.

There is a risk that trainees who are underperforming may not be identified early enough. RemedyUK suggests that there are tensions surrounding the management of weak or failing trainees, as consultants find it difficult to identify and act on underperforming trainees.²³⁵

The MSC is currently working with the Information Commissioner on the issue of transferring information. The Transition Group has recognised that transfer of information needs to be improved to facilitate the completion of training. It is working with the Information Commissioner to ensure that there is a firewall between the transfer of information around attainment and that around health/probity and other issues.²³⁶ The GMC has required medical schools to transfer information about trainees' areas of weakness, and the new Person Specification for application to the Foundation Programme will require applicants to accept this.

Transfer of information needs to be improved in order to help trainees to address issues that may have been identified during the undergraduate course, to tailor their supervision and training²³⁷ and to ensure patient safety. This requires a standardised format that includes the relevant domains about the trainee²³⁸ and needs to be managed so that only pertinent information will be passed on.²³⁹

Concerns were expressed to the Panel by medical students, trainees and others, including the BMA, on what will be considered worthy of being transferred, to whom it will be transferred, how it will be stored and for what purpose it will be used. These are legitimate considerations which must be carefully resolved.

Recommendations

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.*
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.*
33. *Medical schools should explore how best to share information with the GMC about medical students by 2012.*



Appendix 1: Terms of Reference

As described in the *NHS Next Stage Review*, Medical Education England (MEE) was asked to commission a formal Evaluation of the two-year medical Foundation Programme.

The Foundation Programme Evaluation examined:

- the original purpose of the Foundation Programme;
- whether the Foundation Programme is meeting its original purpose and objectives;
- the current priorities for the early years of postgraduate medical education; and
- whether the Foundation Programme meets the current strategic direction of the NHS.

Central to this Evaluation were the needs of patients and of trainees in the changing environment.

Because the Foundation Programme is just one component of the learner's journey along the continuum of lifelong learning, recommendations could also be made for improving the harmonisation between undergraduate and postgraduate education, including the preparation of medical students for practice, transition arrangements to the pre-registration year and improvement of the early years of postgraduate medical education and training.

While the Evaluation focused predominantly on the Foundation Programme, it considered in addition other aspects of the continuum of medical education in the context of the wider consideration by MEE of postgraduate medical education and training.

It was also a requirement of the Terms of Reference that the recommendations made had to be affordable within current budgets.

Appendix 2: Members and role of the Expert Advisory Panel

Role and objectives

The role of the Expert Advisory Panel was to support the Independent Chair in conducting the Evaluation, developing final recommendations and writing the Report. This included support in:

- determining the sources of information and evidence to be considered;
- obtaining and considering written and oral evidence from key partners;
- considering reports and studies already undertaken in this area and in the broader aspects of medical education by other relevant organisations or individuals; and
- discussing and supporting the analysis of the evidence and advising on the conclusions and recommendations to be made to the Medical Programme Board (MPB) and eventually the Board of MEE.

Members

Professor John Collins	Chair
Professor Dinesh Bhugra	Academy of Medical Royal Colleges
Mr Nicholas Deakin	British Medical Association (BMA) Medical Students Committee
Professor Michael Goldacre	Professor of Public Health, University of Oxford
Mr David Grantham	NHS Employers
Professor Jacky Hayden	Chair of English Postgraduate Deans
Professor Peter Kopelman	Principal of St George's, University of London
Professor Moira Livingston	NHS North East, Director of Workforce
Dr Johann Malawana	BMA Junior Doctors Committee
Mrs Sally Malin	Lay representative
Professor Stuart McPherson	Chairman, Postgraduate Medical Education and Training Board
Ms Christine Outram	Managing Director, MEE
Dr Michael Watson	UK Chair, Conference of Postgraduate Medical Deans of the United Kingdom
Professor Tony Weetman	Chair, Medical Schools Council
Dr Ollie White	Academy Trainee Doctors Group

Project management and governance

The Independent Chair was supported by a project management, administrative and research team. MEE established a Project Board, which included the Independent Chair, the project manager, a representative of the management company appointed to assist with the Evaluation and a secretariat. The Project Board monitored progress against the agreed project plan.

As the Evaluation was focused exclusively on medical training, it was agreed by MEE that the MPB, rather than the Board of MEE, should be the primary reference group for the work as it progressed.

Professor Collins attended an early meeting of the MPB to discuss the scope, process and objectives of the Evaluation. He has also provided regular updates to the Board of MEE.

The final draft of the Report and its recommendations were considered and debated by the MPB before being submitted to the Board of MEE for consideration. The final Report was submitted to the Secretary of State for Health.

Panel working

The Expert Advisory Panel met monthly to discuss progress to date, current findings and emerging recommendations. Following completion of the first draft of the Report, Panel members met fortnightly to discuss and refine its findings and recommendations.

Appendix 3: Medical workforce reports

Achieving a balance

Modernising Medical Careers was one of a series of reforms to medical education stretching back to 1986's *Achieving a Balance*,²⁴⁰ which proposed changes in the balance between consultants and doctors in training. At the time it was perceived that there existed a large surplus of registrar training posts compared with the number of consultant positions. Indeed, previous reports dating as far back as 1969 had called for an increase in the ratio of consultant positions to training posts but no significant progress had been made. A bottleneck at senior registrar level meant that consultant-level doctors were waiting for years for the opportunity to become a consultant. Among the recommendations contained within *Achieving a Balance* were:

- increase the number of consultant posts at a rate of 2% per year nationwide;
- link registrar numbers to prospective needs for consultant posts, with regional quotas imposed; and
- create a "staff grade" post for doctors who could not or did not want to achieve consultant status.

Senior House Officers (SHOs) were warned that these reforms were likely to increase the length of time spent at this grade.

The Calman Report

Achieving a Balance was followed in April 1993 by the *Calman Report*.²⁴¹ The genesis of the *Calman Report* was a court case, which required UK medical training to be brought into line with European medical training approaches, principally on the length of specialist training. Under European law, specialists registered in one country had the right to practise as a specialist elsewhere in the European community. British medical training was far longer than elsewhere in Europe and, due to the legal challenge, needed to harmonise more closely with European approaches.

In terms of the structure of training, the *Calman Report* had three key proposals:

- there should be mandatory defined end-point to training; the introduction of a Certificate of Completion of Specialist Training (CCST) was proposed, which would cap the time senior registrars would spend in training posts. CCSTs would be validated by the Royal Colleges and awarded by the General Medical Council to recognise consultant-level competence. Armed with a CCST, doctors could apply for consultant posts wherever they were advertised;
- the maximum length of specialist training should be reduced to seven years; and
- a national training number (NTN) should be introduced for each trainee to allow better monitoring of progress and to enable workforce planning.

The *Calman Report* was also intended to enable a move to an NHS that would be consultant-delivered and not just consultant-led, with greater demands on consultants' time for training and assessment.

Implementation of the recommendations of the *Calman Report* (1995–97) was not without incident. An inadequate number of clinical placements led to a rise in competition ratios. District General Hospitals (compared with bigger hospitals) struggled to obtain approval for training posts, in part due to stiffer college criteria. Progression in some specialties was made difficult by a continuing emphasis on research experience, rather than on clinical skills, and a requirement to have worked in locum positions in the specialty, which were, in themselves, rare.

There were also concerns that, due to the shorter training period and the focus on academia, doctors were ill-prepared for the consultant role.

The *Calman Report* achieved its core workforce planning objectives – specialist training became time-capped and better managed. However, the pressure in the system that had expressed itself as variations in the length of time spent in training by registrars was transferred to an earlier stage in medical training – the SHO grade.

Appendix 4: Bodies and individuals submitting oral evidence

Academy of Medical Educators
Academy of Royal Medical Colleges
Academy Trainee Doctors Group
British Medical Association
College of Emergency Medicine
Committee of General Practice Education Directors
Professor Jane Dacre
Department of Health
East Midlands Strategic Health Authority
English Postgraduate Deans
Faculty of Dental Surgery
Forum of the Heads of Postgraduate Schools of Surgery, England, Scotland, Wales and Northern Ireland
General Medical Council
Professor David Haslam
Joint Committee on Surgical Training
Medical Schools Council
National Association of Clinical Tutors UK
NHS Employers
Postgraduate Medical Education and Training Board
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of Edinburgh
Royal College of Physicians, London
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Strategic Health Authority Workforce
Professor Sir John Tooke
United Kingdom Foundation Programme Office

Appendix 5: Bodies and individuals submitting written evidence

Academy of Medical Educators

Academy of Royal Medical Colleges

Academy Trainee Doctors Group

Dr Yasmin Ahmed-Little

Dr Mark Alexander

British Association of Oral and Maxillofacial Surgeons

British Medical Association

Benjamin Brown

Angela Colclough

College of Emergency Medicine

Committee of General Practice Education Directors

Department of Health

East of England Multi-Professional Deanery

East Midlands Deanery

East Midlands Healthcare Workforce Deanery

English Postgraduate Deans

Forum of the Heads of Postgraduate Schools of Surgery, England, Scotland, Wales and Northern Ireland

General Medical Council

GP Education Unit, Southampton University Hospital Trust

Nicholas Grundy

Professor David Haslam

Imperial College Healthcare NHS Trust and Imperial College London

Joint Committee on Surgical Training

Simon Jones

Kent, Surrey and Sussex Deanery Careers Department

Kent, Surrey and Sussex Postgraduate Deanery

King's College Hospital NHS Foundation Trust

The London Deanery

Medical Schools Council

Dr David A S Marshall

Charles Mitchell

Dr Neil Munro
National Association of Clinical Tutors UK
National Institute for Health Research
Newcastle upon Tyne Hospitals NHS Foundation Trust
NHS Education South Central
NHS Employers
NHS North West Strategic Health Authority
North East Lincolnshire Care Trust Plus
Northern Deanery Foundation School
Northern Deanery, North East Strategic Health Authority
Northern Ireland Medical and Dental Training Agency
North Tees and Hartlepool NHS Foundation Trust
North Western Deanery
North Yorkshire East Coast Foundation School
Royal College of General Practitioners
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal College of Physicians, London
Royal College of Psychiatrists
Royal College of Radiologists
The Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Surgeons of England Faculty of Dental Surgery
Dr Samantha Scallan
Dr Neel Sharma
Professor David Sowden
United Kingdom Foundation Programme Office
Wessex Deanery

Appendix 6: Glossary of abbreviations

AFMC	Association of Faculties of Medicine of Canada
AoMRC	Academy of Medical Royal Colleges
ATDG	Academy of Trainee Doctors Group
BMA	British Medical Association
BMJ	British Medical Journal
CBD	Case-based discussion
CCST	Certificate of Completion of Specialist Training
CCT	Certificate of Completion of Training
CEM	College of Emergency Medicine
CMO	Chief Medical Officer
COPMeD	Conference of Postgraduate Medical Deans of the United Kingdom
DH	Department of Health
DOPS	Direct observation of procedural skills
EPM	Educational Performance Measure
EU	European Union
EWTD	European Working Time Directive
F1	First year of the Foundation Programme
F2	Second year of the Foundation Programme
FTSTA	Fixed Term Specialty Training Appointment
GMC	General Medical Council
GP	general practitioner
KSS	Kent, Surrey and Sussex
MEE	Medical Education England
mini-CEX	mini-clinical evaluation exercise
mini-PAT	mini-peer assessment tool
MMC	Modernising Medical Careers
MPB	Medical Programme Board
MRCOG	Membership of the Royal College of Obstetricians and Gynaecologists
MRCP	Membership of the Royal Colleges of Physicians of the United Kingdom
MRCPaeds	Membership of the Royal College of Paediatrics and Child Health

MRCS	Membership of the Royal College of Surgeons
MSC	Medical Schools Council
MSF	Multi-source feedback
MTAS	Medical Training Application System
NACT	National Association of Clinical Tutors
NES	NHS Education for Scotland
NIHR	National Institute for Health Research
NTN	National training number
PMETB	Postgraduate Medical Education and Training Board
PRHO	Pre-Registration House Officer
QABME	Quality Assurance of Basic Medical Education
QAFP	Quality Assurance of the Foundation Programme
RCPE	Royal College of Physicians of Edinburgh
SHA	Strategic Health Authority
SHO	Senior House Officer
SJT	Situational Judgement Test
TAB	Team assessment of behaviour
UK FPO	UK Foundation Programme Office
WPBA	Workplace-based assessment

Appendix 7: Action plan – Key MEE partners and timelines for completion of recommendations 1–33

Recommendation	Key partners	Timeline for completion
1	UK Health Departments	2012
2	GMC	2011
3	UK FPO, COPMeD	Ongoing; Indicators 2011
4	DH, MSC, UK FPO	2012
5	DH, GMC	2012
6	COPMeD, UK FPO, AoMRC, NHS Employers	2012
7	GMC	2012
8	GMC	2012
9	MEE	2015
10	COPMeD, UK FPO, NHS Employers	2012
11	DH, MSC, COPMeD, UK FPO, AoMRC	Ongoing
12	COPMeD, UK FPO	2013
13	COPMeD, UK FPO	2013
14	COPMeD, UK FPO	2013
15	AoMRC, MSC, COPMeD, UK FPO	2013
16	GMC	2012
17	COPMeD, NHS Employers, UK FPO	2013
18	DH, SHAs	2011
19	GMC, DH, AME, COPMeD	2012
20	AoMRC, MSC, COPMeD, UK FPO	2013
21	NHS Employers	Ongoing
22	GMC	2013
23	COPMeD, NHS Employers, UK FPO	2013
24	COPMeD, NHS Employers, MSC, UK FPO	2012
25	COPMeD, NHS Employers, UK FPO	2012
26	GMC	Ongoing
27	GMC	2013
28	GMC, COPMeD, NHS Employers	2012

	Recommendation	Key partners	Timeline for completion
29		GMC, COPMeD, SHAs, NHS Employers	2012
30		GMC	2011
31		GMC, MSC, COPMeD, UK FPO, NHS Employers	2012
32		MSC, GMC, COPMeD, UK FPO, NHS Employers	2012
33		GMC, MSC	2012

Appendix 8: Acknowledgements

This Report would not have been possible without input from a wide range of individuals and organisations. I offer my sincere thanks to all those involved for the commitment demonstrated to achieving excellence in the care of patients and the education and training of junior doctors.

Firstly, I must thank the members of the Expert Advisory Panel, who provided advice and guidance throughout the Evaluation process; to work with such a respected team has been a real honour and pleasure.

The Evaluation process was supported by guidance from Medical Education England and I thank the staff for their assistance.

I am grateful to those who made written submissions, those who gave oral evidence and those tutors, trainees, medical students and others who participated in meetings with the Panel across England.

The professionalism, expertise and commitment of the management consultancy firm involved in this evaluation have been highly valuable and are gratefully acknowledged.

It has been a privilege to be the Independent Chair for this important Evaluation and it has been an interesting and memorable experience. I have endeavoured to seek and digest views from a wide range of groups, organisations and individuals to ensure that the Report gives a fair and just picture of the current Foundation Programme and of the path that the evidence suggests it should follow.

Professor John P Collins
Independent Chair

October 2010

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