Developing people for health and healthcare

Better training better care

Evaluation of the National Elements Report

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NHS
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Contents

Foreword

The reports by Professor Sir John Temple and Professor John Collins (*Time for Training*[1] and *Foundation for Excellence*[2]**,** respectively) have been seminal in the development of thinking on postgraduate medical education over the past few years. In broad terms, the findings of the two reports were welcomed and supported by the Academy of Medical Royal Colleges (AoMRC) and its member organisations as the professional representatives of over two million doctors in the UK.

AoMRC therefore fully supported the Better Training Better Care (BTBC*)* programme, initiated by Medical Education England (MEE) and subsequently taken forward by Health Education England (HEE), which sought to take forward the recommendations of the two reports. AoMRC and individual College members have been actively involved in the various BTBC workstreams at both national and local level.

We were very pleased that HEE commissioned evaluations of the BTBC programme. Too often it has been the case that there has not been an effective evaluation of nationally initiated programmes and so it has not been possible to learn lessons for the future of what worked well and less well. Without that learning we are surely not going to make progress in improving medical education and, hence, patient care, which is the key objective of all concerned.

AoMRC was therefore pleased to support HEE with the evaluation of the eight national elements of the BTBC programme. This work was carried out for AoMRC by Dr Sonia Panchal, a Clinical Fellow on the NHS England Medical Director's Clinical Fellowship scheme working for AoMRC in 2013-14.

Whilst as chair of AoMRC I supported Dr Panchal, as did AoMRC's Chief Executive, Alastair Henderson, the evaluation is the independent work of Dr Panchal rather than a report agreed and endorsed by all AoMRC members. I certainly believe this to have been the right approach to this evaluation.

1 Temple J (2010)
2 Collins J (2010)

You will see from the report that the BTBC workstreams have either been completed or successfully transitioned into other national programmes within HEE. That is a positive outcome. It is also clear from the report that it has been less easy to be certain in all cases as to the impact the programmes have had. That too is unsurprising but does mean that we must continue to ensure that the work delivers benefit.

I welcome this evaluation and applaud HEE for commissioning the work. I warmly commend Dr Panchal on her report. I know that it has been a time-consuming and complex task, which, I believe, she has carried out with great skill. It is now up to all of us involved in postgraduate medical education to ensure that momentum is maintained and the benefits outlined in the Temple and Collins reports are fully realised.

Professor Terence Stephenson, Chairman, Academy of Medical Royal Colleges

Patient perspective

Elizabeth Manero was the lay representative on Medical Education England (MEE) and on the Better Training Better Care (BTBC) Taskforce. She is a solicitor by background and has significant experience in patient and public involvement and education. She is currently a lay representative on the General Medical Council (GMC) Education and Training Advisory Board and a member of the Health Education England (HEE) Patient Advisory Forum.

The BTBC programme is a comprehensive project taking forward recommendations from the Collins[3] and Temple[4] reports through national and local workstreams. This work goes beyond quality of medical education to the quality of current and future patient care. If the outcome of training is an inadequate education, not only will the workforce fail to deliver good patient care, it will also fail to pass on the right education to those whom it, in turn, will train. Furthermore, during training, the trainees provide a service so the process of medical education has as much of an impact on patients as its outcome does.

Medical education must be seen as a collective endeavour between trainees, trainers and providers of the training environment, all working in the patients' interest. The inextricable link between medical education and service delivery can sometimes have an impact on patients. There is evidence that the supervision of doctors in training was not always as well managed as it should be. One way of addressing this has been to delineate the role of the trainee consistently (Workstream 2), balancing learning and service delivery to avoid asking more of trainees than they can give. Similarly, the proper development of technology enhanced learning including simulation, through the dedicated strategy in Workstream 6, can support trainees and staff to acquire, develop and maintain the essential knowledge, skills, values and behaviours needed for safe and effective patient care. Work to reduce the risk of those trainees with problems not being identified as they move between training environments is ongoing under Workstream 8.

The BTBC programme, however, goes beyond safety alone. Safety for patients is the minimum standard – a patient may receive care 'safely' but emerge confused, anxious and in unnecessary pain if the doctor treating them is inadequately skilled in shared decision-making and pain management. Different methodologies to capture patient feedback on trainees, as recommended by Collins, which would capture such issues, are still being explored.

The *Education Outcomes Framework*[5] has been developed contemporaneously with BTBC by the Department of Health and sets out what the end product of professional education should be. The quality of the education to deliver those outcomes must be calibrated and measured. Quality assurance of trainer input has been advanced through Workstream 3 while work on the quality of trainer outputs through education metrics continues in Workstream 9.

3 Collins J (2010)
4 Temple J (2010)
5 Department of Health (2013)

Medical education must be mapped to the patient need – trainees must learn how to do their job in areas of medicine where patients are going to need them. Workstreams 4, 5 and 7 have helped this realignment.

The BTBC programme methodology aimed to stimulate solutions from the people with the most immediate understanding of the problems – the trainees. There is currently no incentive for trainees to address any shortcomings they find, because their placement will end and they will move on elsewhere. The BTBC methodology of engaging trainees and valuing their innovation has created such an incentive. The Inspire Improvement projects in Workstream 2 show how trainees have been empowered to cut through organisational boundaries and question established ways of doing things.

The Temple and Collins reports look across the four perspectives that make up the collective education endeavour – trainee, trainer, training environment provider and patient. BTBC has made a powerful contribution to that endeavour. It has kickstarted important initiatives to strengthen the educational governance of the system. The delivery of so much at a time of education reform is a tribute to the team. **Stimulating local solutions through a national programme is a successful improvement methodology offering valuable lessons. The challenge now is to pick up all the learning from the BTBC programme and apply it across this complex system, depended upon equally by patients for their care and by trainees for their professional success.**

Elizabeth Manero, Patient lay representative, BTBC Taskforce

Executive summary

Introduction

The Better Training Better Care (BTBC) programme aimed to improve both the quality of medical education and training and the quality of patient care by enabling the delivery of 66 key recommendations from Professor Sir John Temple's *Time for Training*[6] and Professor John Collins' *Foundation for Excellence*[7]. The recommendations were mapped against nine workstreams, which included both local and national elements.

Sonia Panchal, national leadership clinical fellow, linked to the Academy of Medical Royal Colleges (AoMRC) led this evaluation. Workstream 1 has been evaluated and reported on separately.[8] This evaluation has been designed to assess whether the national workstreams (2-9) implemented the recommendations from Temple and Collins. This was completed with support from the AoMRC chairman, Professor Terence Stephenson.

Methodology and approach

Qualitative assessments were used to measure the outcomes. Supporting evidence such as reports, documents and curricula (see Appendix 1) were collected to show how each recommendation had been met. In addition, interviews were held with each workstream lead and relevant external stakeholders. Further insights into the challenges faced were sought and summarised and descriptors were assigned to each of the 66 recommendations to indicate whether they had been achieved.

6 Temple J (2010)
7 Collins J (2010)
8 NHS Employers (2013)

Overview of the results

Workstream 2: Role of the Trainee

Recommendations: Met

There were three initiatives underpinning this workstream: Inspire Improvement, Learning to Make a Difference, and the Value of the Trainee consensus statement.

Inspire Improvement has empowered trainees to challenge the system and break through organisational barriers to improve patient safety, quality of care and training through a bottom-up approach. These projects have demonstrated how low-cost, high-impact initiatives can drive change with successful results. The recently published *Value of the Doctor in Training* charter provides further definition on the role of a trainee doctor in supporting NHS trusts and employers, and includes priorities for continuing support and appropriate supervision.[9] The Learning to Make a Difference programme provided valuable quality improvement methodology training to those in core medical training.

Workstream 3: Role of the Trainer

Recommendations: Met

The team worked with the National Association of Clinical Tutors (NACT UK), General Medical Council (GMC), the Faculty of Medical Leadership and Management (FMLM), NHS Employers and other key partners to raise the profile of the role of the trainer. Work to embed these deliverables and share learning is ongoing and has led to a wider multi-professional project, which aims to improve the role of the trainer and educator across all professions.

Workstream 4: Workforce Planning

Recommendations: Partially met

The Health Education England (HEE) *Workforce Plan for England 2014/15*[10] is a step in the right direction to help maintain and plan future services and accommodate consultant numbers. The HEE *Broadening the Foundation Programme* report[11] sets out a road map for increased training within the community setting to provide safe, high-quality integrated care. The Workforce Planning workstream has now transitioned into a national programme in its own right.

Workstream 5: Improving Careers Guidance and Availability

Recommendations: Partially met

The careers guidance portal has been developed by the medical and dental recruitment and selection programme to support trainees with their career choices, and to define good practice for the provision of careers information and advice. Further work is ongoing

9 Academy of Medical Royal Colleges (2014)
10 Health Education England (2013c)
11 Health Education England (2014)

within this workstream, which will be led by the Medical and Dental Recruitment and Selection (MDRS) programme.

Workstream 6: Technology-Enhanced Learning

Recommendations: Partially met

The technology-enhanced learning (TEL) strategy was created in partnership with the Higher Education Academy to devise a programme of work aimed at the share and spread of TEL technologies and techniques that support high-quality education and training healthcare. This is initially focused on three key areas: simulation, e-learning and m-learning (mobile learning). The value of using technology to enhance learning in healthcare is quite significant and as such, it was recognised at HEE that this should be a programme of work in its own right that focuses on enhancing technology-based learning for all health professionals.

Workstream 7: Improving the Foundation Programme

Recommendations: Partially met

Following on from a review of the Foundation Programme Curriculum, this work focused on delivering a more even distribution of trainee placements across specialities, particularly general practice, psychiatry and other community-based placements. The *Broadening the Foundation Programme* report was published in February 2014 and is now being taken forward by the UK Foundation Programme Office (UKFPO).

Workstream 8: Regulatory Approach to Supporting Better Training Better Care

Recommendations: Met

HEE also worked in partnership with the GMC to produce a definition of the outcomes required to complete Foundation Year 2 (F2), a review of the 2011-13 *GMC Education Strategy*[12] and an updated GMC *Good Medical Practice Guide*[13].

Workstream 9: Funding and Quality Metrics

Recommendations: Remains under development

The BTBC team explored opportunities with partner organisations to support effective commissioning and delivery of quality training. This was facilitated by the introduction of the *Education Outcomes Framework*[14], which defines and initiates new educational outcome measures.

12 General Medical Council (2010b)
13 General Medical Council (2014)
14 Department of Health (2013)

Conclusion

BTBC is not a linear programme; the scale of change alone means that the objectives and deliverables that were initially outset will continue to evolve over time.

The evaluation of this programme has shown that the primary objectives of the Temple and Collins recommendations have been achieved. Trainees, trainers, employers, regulators and external organisations have been encouraged to increase the profiling of medical education and training for trusts and other local education providers as a result of BTBC.

A number of workstreams have now transitioned into national programmes and will continue to develop and deliver initiatives to improve patient care and safety through education and training.

This programme has demonstrated that by focusing on medical education and training, improvements can be made to multi-professional teams, service delivery and most importantly, patient safety and patient care.

1 Introduction

1.1 Aim of the evaluation

The Better Training Better Care (BTBC) programme consisted of nine workstreams in total. Following the independent evaluation of Workstream 1 (NHS trust local implementation and pilots)[15] conducted by Matrix Knowledge, the AoMRC clinical fellow, with the support of the HEE BTBC team, was asked to undertake an evaluation of the remaining workstreams (2-9) and to produce this document.

The principle aim of this evaluation is to assess whether the key recommendations from Professor Sir John Temple's *Time for Training*[16], and Professor John Collins' *Foundation for Excellence*[17], have been delivered, and how each workstream has contributed to fulfilling these recommendations.

Whilst the two evaluation reports have been produced separately, it is important for them not to be viewed in isolation. There is a direct relationship between Workstream 1 (the local trust pilots) and Workstreams 2-9, which focus on the national elements. This relationship can be seen throughout the document, across a number of the national workstreams.

1.2 Background

In recent years, there have been significant developments in medical education and training across the UK. These developments have been made following recommendations from a number of influential reports,[18],[19] which have highlighted the need to develop the current structure of postgraduate medical training so that we continue to deliver high-quality education for doctors in England and throughout the UK.

The reports have evidenced that quality and investment in training leads to professionals who deliver the highest standard of safe patient care. They also highlighted that the traditional experiential model of learning had to change, and that consultants needed to be more directly responsible for the delivery of 24/7 care.

One of these reports, Professor Sir John Temple's *Time for Training* review, assesses the impact of the European Working Time Directive[20] on a complex and ever-changing healthcare system. The report concludes that high-quality training can be delivered in reduced hours, but that this is precluded when trainees have a major role in out-of-hours service, are poorly supervised and access to training is limited.

15 NHS Employers (2013)
16 Temple J (2010)
17 Collins J (2010)
18 Department of Health (2008)
19 Tooke J (2008)
20 PMETB (2009)

Time for Training called for better use of the expanded consultant workforce, in terms of efficiency savings for the service as well as enhanced safety and higher quality care for patients.

Another significant report, Professor John Collins' evaluation of the medical Foundation Programme, *Foundation for Excellence*, echoed and built upon several of the themes from *Time for Training*. While commending many aspects of the current education programme, he particularly highlighted the issue of some trainees being asked to practice beyond their level of competence, without adequate supervision, and the consequences this has for patient care and safety.

A clear, evidence-based picture emerged from these reports, which demonstrated how doctors in training felt, at times, that they were being asked to operate beyond their competence, particularly at nights and at weekends, without the right level of support. This was supported by a rise in mortality at weekends and out of hours, with a direct correlation to the number of doctors available and their level of experience.

Professor Sir John Temple said: *"The roles of consultants need to be developed for them to be more directly involved in out-of-hours care...*[21] *The expansion of consultant presence can result in efficiency savings and enhanced patient safety.* [22]*"*

Professor John Collins said: *"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."*[23]

The BTBC programme aimed to address these issues by developing an innovative and dynamic approach to implementing the Temple and Collins recommendations through nine workstreams. By focusing on education and training, the programme improved service delivery and multi-professional team working, which resulted in better patient care, improved patient safety and increased staff satisfaction.

1.3 Better Training Better Care programme

The BTBC programme aimed to improve both the quality of training and the quality of patient care by enabling the delivery of key recommendations from Temple's *Time for Training* and Collins' *Foundation for Excellence,* as well as other related reports[24].

21 Temple J (2010), page vii
22 Temple J (2010), page 33
23 Collins J (2010), page 15
24 Wilson I (2009)

Department of Health ministers commissioned both *Time for Training* and *Foundation for Excellence,* and in 2011, following the publication of these reports, the Secretary of State requested for Medical Education England (MEE) to run the programme. The programme transitioned to Health Education England (HEE) when the organisation was established in October 2012.

BTBC reflected the urgent need to address recommendations from the Temple and Collins' reports to ensure the priorities for the NHS are met. In particular, that doctors' are properly equipped to care for the whole patient resulting in improved safety, outcome and experience for patients. The programme focused on improving the quality of postgraduate medical training and reducing the risks associated with reduced available hours from the *European Working Time Directive*[25] 2009 report through the establishment of nine key workstreams.

1.3.1 Workstreams

Temple and Collins produced 66 recommendations in total. These recommendations were mapped across the programme and nine workstreams were created (see Table 1).

Table 1: Workstreams

Local elements	
1	Local NHS Trust Implementation and Pilots
National elements	
2	Role of the Trainee
3	Role of the Trainers
4	Workforce Planning
5	Improving Careers Guidance and Availability
6	Improving the Foundation Programme
7	Technology Enhanced Learning
8	Regulatory Approach to Supporting BTBC
9	Funding and Education Quality Metrics

The local elements included the identification, piloting, evaluation and dissemination of good education and training practice across local NHS trusts, being delivered through Workstream 1.

25 PMETB (2009)

The national elements included improvements to curricula and the underpinning of education and training frameworks to ensure training is fit for the purpose of providing safe, effective and improved patient care. This was delivered through eight workstreams (see Table 2).

Table 2: Workstream descriptions

No.	Workstream	Description
LOCAL ELEMENTS		
1	Local NHS Trust Implementation and Pilots	One of the largest workstreams within BTBC, which involved funding 16 NHS trust sites to implement pilot projects aimed at improving education and training, and therefore patient care. The pilots ranged from a series of themes and areas, such as redesigning the working model within an emergency department, implementing a RAT+ (Rapid Assessment and Treatment) model to increase senior decision-making, clinical handover, communication skills in consultations, prescribing, improving confidence in psychiatric decision-making, serious incidents, quality improvement projects, surgery and telemedicine.
NATIONAL ELEMENTS		
2	Role of the Trainee	This workstream focused on the role of the trainee in terms of trainee supervision and the principles required to ensure an appropriate level of trainee supervision. Three initiatives underpinned this workstream: **Inspiring Improvement:** funding was awarded for nine trainee-led project teams to implement a range of training innovations to improve patient care. **Learning to Make a Difference:** Embedding quality improvement methodology across core medical trainees. **Value of the Trainee:** Working with key stakeholder groups (NHS Employers, British Medical Association Junior Doctors Committee, General Medical Council (GMC) and Health Education England) to develop a consensus statement on the role of the trainee.

3	Role of the Trainers	This workstream involved a number of organisations that were seeking to ensure trainers are recognised and rewarded, and to raise the profile of training. The main stakeholders involved included the GMC, Academy of Medical Educators (AoME), National Association of Clinical Tutors (NACT UK) and the Faculty of Medical and Leadership Management (FMLM). The GMC set the standards for training and the AoME focused on developing guidance on how to meet these standards. NACT UK aimed to develop guidance on the role of faculty and the importance of the learning environment, and FMLM focused on the need to change the culture within organisations to ensure the principles of recognising and rewarding training are embedded.
4	Workforce Planning	This project aimed to support effective workforce planning and maintain a viable service through joint working groups. The first *Workforce Planning Guide for England*[26] was published in December 2013, followed by an updated *2014 Workforce Planning Guidance*.
5	Improving Careers Guidance and Availability	Through the Medical and Dental Recruitment and Selection (MDRS) Programme, this workstream aimed to develop a careers guidance portal to support trainees with their career choices. It also aimed to address perceptions of particular careers, encouraging a more even distribution of trainee placements across different disciplines.

26 Health Education England (2013a)

6	Technology Enhanced Learning	Following the Temple and Collins recommendations and the publication of the Framework for Technology Enhanced Learning (TEL), this workstream aimed to engage with key partners and stakeholders nationally to look at opportunities for the sharing and spread of TEL interventions and techniques. The main focus was to support high-quality training and education in healthcare through the promotion and sharing of three key TEL areas: simulation, e-learning and m-learning (mobile learning).
7	Broadening the Foundation Programme	This workstream consisted of a number of components, the first of which was to review the Foundation Programme Curriculum.The remainder of the workstream focused on addressing specific recommendations by Collins for more trainees to undertake community-facing placements and support a more even distribution of trainee placements across specialities with particular emphasis on general practice, psychiatry and other community placements. Three groups were tasked to complete this piece of work and develop a report with recommendations to broaden the Foundation Programme.

8	Regulatory Approach to Supporting BTBC	The GMC worked with HEE and others across England, Scotland, Wales and Northern Ireland to meet specific Collins recommendations on regulation, and aimed to produce: • approval of the outcomes for F2 developed by the Academy Foundation Committee as part of the overall approval of the Foundation Programme Curriculum 2012 • revised good medical practice • implementation plan for recognising and approving trainers • Quality Improvement Framework (QIF) • a new online tool for the National Trainee Survey, providing reports around a month after the survey closes • a new process for enhanced monitoring in situations where local systems have not been able to resolve issues in a timely manner • focused thematic reviews including investigating supervision of foundation doctors in emergency medicine posts. The GMC aimed to do this by working with postgraduate and undergraduate deans as well as royal colleges to develop systems for sharing information and escalating concerns.
9	Funding and Education Quality Metrics	The purpose of this workstream was to explore opportunities with partner organisations to support effective commissioning and delivery of quality training. This was facilitated by the introduction of the *Education Outcomes Framework*[27], which defines and initiates new educational outcome measures, and the development of a clinical supervisor framework, which was done in conjunction with the UK Foundation Programme Office (UKFPO).

27 Department of Health (2013)

A thematic analysis, which comprises a list of the recommendations and the workstreams they have been mapped to, can be found in Appendix 1.

1.3.2 Governance

The programme was overseen by a taskforce led by Sir Jonathan Michael. The BTBC Taskforce, as it was more formally known, was responsible for the outcomes of the programme and for ensuring HEE's Board[28] were regularly updated on progress.

The operational day-to-day management of the programme was monitored through weekly meetings of the programme delivery group, which reported into the BTBC Taskforce. See Appendix 4 for the terms of reference.

28 http://hee.nhs.uk/about/our-board-2/

2 Approach

The evaluation applied a qualitative approach to assess the outcomes of each workstream.

2.1 Key lines of enquiry

Interviews with workstream leads were undertaken between March and May 2013, to gain knowledge on their activities and documents produced that addressed the Temple and Collins' recommendations. Further interviews were conducted with patient lay representatives, relevant external stakeholders and other relationship managers working within the workstreams. These discussions also covered the successes, challenges and progress made within the workstream against the recommendations and objectives.

Table 3: Key lines of enquiry

Achievements	Success factors
Challenges	Experiences in the delivery of the recommendations
Expected outcomes	Discussion on the proposed benefits
Overall programme	Benefits of the programme to address the recommendations

2.2 Questions

How did you address the Temple and Collins recommendations within your workstream?

- What were the key deliverables?
- What were the strengths of your workstream?
- What were the weaknesses of your workstream?
- What would you have done differently if you had the opportunity to do it again?
- What were the significant challenges that you faced?
- What impact would you expect from the deliverables?
- How did you find the overall BTBC programme structure and support?

Each lead was asked to provide supporting evidence, such as relevant documents and reports, to determine whether the workstream had met the relevant Temple and Collins recommendations. Additional insights on each workstream's strengths and weaknesses, as well as suggestions about how the workstream management could be improved in the future, were also sought and summarised.

Once the evidence had been collated, the information was assessed to determine its sufficiency and whether the key recommendations had been met. The results were then mapped according to the descriptors in Table 4.

Table 4: Descriptors assigned to delivered recommendations

Recommendation descriptors	Evidence
A: Met	Evidence available
B: Partially met	Evidence available with more work being undertaken
C: Remains under development	Requires further work

3 Evaluation of results

This chapter presents the findings from the evaluation of each workstream, commencing with an overview of the Temple and Collins recommendations that were relevant to that particular workstream and the corresponding descriptor indicator, which highlights whether the recommendations have been met. Each section concludes with an overview of the current status of the workstream. For further details see Appendix 1.

3.1 Workstream 2: Role of the Trainee

Box 1: Recommendations

Temple	
[Recommendation 34] Training must be planned and focused for the trainees' needs	A
[Recommendation 35] Training requires a change from traditional perceptions of learning to a model that recognises the modern NHS	A
[Recommendation 36] Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers	A
Collins	
[Recommendation 6] MEE should develop a consensus statement on the role of the trainee so NHS trusts have a detailed understanding of the role of foundation doctors	A
[Recommendation 7] The GMC should consider producing guidance to support the development of professionalism among trainees	A
[Recommendation 27] The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training; graded responsibility should be allowed with some degree of clinical discretion	A

Collins explicitly states that the role of the trainee needs to be more clearly defined to enable doctors in training to be appropriately educated, deployed, supervised and valued for their service contribution. The key is to maintain a balance between clinical service demands and training requirements.

This workstream focused on the role of the trainee in ensuring that every moment counts and that appropriate trainee supervision is embedded into the planning and delivery of education and training. The initiatives that underpin this workstream include the BTBC Inspire Improvement projects, Trainee Charter, Trainee Professionalism, Trainee Supervision, and Learning to Make a Difference.

These initiatives have been elaborated on below with some examples on local delivery via the pilot projects. Overall this workstream successfully met the recommendations outlined above and HEE is working with partner organisations to explore how these deliverables can be embedded.

3.1.1 Inspire Improvement projects [Recommendations 34, 35, 36]

Doctors in training are ideally positioned to see where things could be improved, but often lack the senior support, financial backing or voice to be able to effectively implement these changes[29]. The Inspire Improvement projects aimed to change this by empowering trainees to lead on projects that aim to improve education and training, and ultimately patient safety and patient care.

HEE identified £100,000 to fund nine trainee-led projects that demonstrated outstanding potential to meet the challenges set out in three of Temple's recommendations:

1. Training must be planned and focused for the trainees' needs.
2. Training requires a change from traditional perceptions of learning to a model that recognises the modern NHS.
3. Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers.

Trainees were encouraged to apply and presented to a panel of judges who assessed their innovative ideas against the following criteria:

Table 5: Judging criteria

Inspire Improvement judging criteria
Quality (70%)
1. How original or innovative your idea is (15%)
2. How effectively your project meets one or more of Temple's recommendations (20%)
3. How cost effective your project is and what return on investment it will have (on trainee education and training, financially, and on patient care and safety) (10%)
4.To what degree your project will impact nationally on the role of the trainee, or have the ability to be adopted nationally (15%)
4. The sustainability of your project after the initial trainees have moved on – do you have robust plans in place to ensure longevity and potentially adoptability? (25%)
6. The ability to implement your project effectively, in precise and realistic timescales, with an understanding of potential risks (15%)
Cost (30%)
7. How much funding you need to run your project

29 Department of Health (2011b)

From over 200 applications, twelve were selected for shortlisting, with nine successful ideas awarded with funds to implement their improvement projects.

These Inspire Improvement projects have demonstrated how simple trainee-led initiatives can have a high impact on patient care and safety whilst also improving doctor training and education, with low cost implications. For further information on these trainee-led projects, see Appendix 2.

For example, the Avoiding Grey Wednesdays project, led by Dr Tim Robbins, developed an inter-rotation shadowing programme and peer mentoring initiative for Foundation Stage 1 (F1) doctors to enable trainees to be more prepared for their upcoming clinical rotations. This aimed to improve patient safety during the vulnerable changeover period and to enable earlier identification of learning requirements to fulfill training needs. The pilot, conducted within the Coventry and Warwickshire Foundation School, showed a 42 per cent increase in F1 doctors meeting their new team prior to starting the new clinical rotation and a 25 per cent increase in those receiving a handover before starting the rotation.

The Handbook project, led by Dr Michael Davies, aimed to remove the concept of "I wish I had known that before I started" to aid doctors in training during the transition from one department/rotation to another. The Handbook is a secure online web portal for transition forms submitted by the outgoing doctors. This in turn improves handover and efficiency, and reduces the number of serious incidents during transition periods.

Other successful projects are described in Table 6:

Table 6: Inspire Improvement project successes

Inspire improvement project	Objectives	Achievements
Confusion smartphone app	To improve cognitive assessment by junior doctors in line with NICE guidelines on delirium and the National Dementia Strategy To increase early recognition of cognitively impaired patients To identify important points on history and examination To fulfil curriculum outcomes for junior doctors To increase patient safety and clinical care	For trainees: The use of handheld resources for assessing cognitive impairment and to aid daily practice Easy-to-use app and helpful clinical scenarios For patients: Improvements in the quality of patient care and clinical outcomes For the multi-disclipinary team: Earlier identification of cognitively impaired patients, allowing their needs to be presented to the team earlier in order to prevent adverse events

Move, Eat, Treat: How to Deliver Effective Lifestyle Advice	To equip all foundation trainees in the Oxford Deanery with the ability to deliver effective lifestyle advice To evaluate and measure impact, and to disseminate these findings To ensure sustainability in the Oxford Deanery To disseminate widely via presentation and publication, and to catalyse national adoption through the development of an open-access toolkit of teaching resources To contribute to a change in perception of the role of health professionals in the modern NHS	For trainees: Doctors in training received teacher training and teaching experience, as well improved knowledge on lifestyle factors Delivered teaching to F1s and F2s at 4 of 5 trusts in the Oxford Deanery Achieved statistically significant improvements in knowledge and confidence about lifestyle advice delivery among the learners, therefore equipping them with new skills that will improve the quality of care they can deliver to patients For trainers: Teaching was more innovative and interactive than standard Foundation Programme teaching, and therefore added additional value to the Foundation Programme teaching programme In their capacity as trainers, the project team developed valuable time management, financial management and personnel management skills For patients: Lifestyle-driven chronic disease is a huge source of suffering for patients; these trainees will hopefully be more effective at working with patients to improve their lifestyles, which will significantly improve patient health and hopefully alleviate suffering

		Value for money: The Department of Health's Director of Long Term Conditions has described lifestyle-driven chronic disease as healthcare's equivalent of climate change. Diabetes already accounts for 10% (more than £10bn) of the NHS budget and this is set to worsen. This intervention has the potential to reduce the burden of chronic disease and is vital to the future financial viability of the NHS, therefore providing significant value for money.

Training Professionals	To re-define the relationship between educational supervisor and trainee The trainee will be enabled to behave as an independent professional who develops goals, demonstrates the ability to achieve those goals and takes responsibility for meeting those goals Trainees will be encouraged to aim beyond the minimum requirements and look to achieve significant progress in their non-clinical careers The educational supervisor will be expected to demonstrate regular oversight of their trainee's progress and provide specific insight and knowledge to encourage them as they meet their goals, using an existing internet-based platform and face-to-face meetings as appropriate	For trainees: Developed a tool to enable professional development and focused mentoring of trainees, which encourages trainees to behave in a professional manner and develop personal goals specific to their career aims The tool is simple to use, easy to adopt and readily available for all medical specialties and other disciplines within the NHS For trainers: The tool provides a useful method for supervisors to enable their trainee to develop goals and support them without the need of meeting face to face Trainers can now produce evidence of fulfillment of their role for appraisal and revalidation For patients: The tool will add to the appraisal and revalidation process, enabling medical professionals to continue to meet appropriate standards and maintaining public confidence in doctors

These are just some of the examples from the Inspire Improvement projects that demonstrate how trainee initiatives can make a significant impact on doctors in training, which in turn improves the quality of patient care and patient safety.

Although trainees were able to create change within their local environments, a number of them indicated that what they really needed was a national body to support their idea. This would engage their senior colleagues and enable them to have conversations about their initiatives with senior managers and those on the board.

Trainee Perspective

Other Inspire Improvement project leads have provided an individual qualitative assessment on how they have addressed specific Temple recommendations and what they aim to achieve, going forward:

Recommendation 35: Training requires a change from traditional perceptions of learning to a model that recognises the modern NHS

Dr Ed Maile (F2 trainee, Oxford University Hospitals NHS Trust) addresses the modern NHS and how education and training need to adapt to the environment.

Eat Move Treat: How to deliver effective lifestyle advice to patients

"The modern NHS faces huge financial and clinical challenges from lifestyle-related chronic diseases such as diabetes and ischaemic heart disease. Training has traditionally been highly medicalised, focusing on pharmacological and surgical interventions to treat disease. However, for the health of patients and the modern NHS, it is imperative that we change the perception of the role of healthcare professionals. Through a change in training they can become more effective at working with patients to change their lifestyles and therefore prevent disease.

Our teaching project aims to meet this challenge by delivering teaching on effective lifestyle interventions for patients. Through this, we hope to change the practice of healthcare professionals and to make a contribution to a changed culture in the modern NHS that values prevention and treatment equally."

Dr Michael Davies (F2 trainee, University Hospital Aintree NHS Trust) also focused on how learning needs to relate to the modern NHS.

The Handbook

"Currently when junior doctors begin work on a new ward, information handed over by the outgoing doctor comes in the form of a current patient list and/or word of mouth on how the ward runs on a daily basis. Very little actual information one doctor has spent accumulating over a 3-4 month rotation on how their job is actually done is passed on, meaning that every time there is a rotation change, the incoming doctor must learn all of this again. This is a very inefficient process as the junior doctor has to not only learn about and provide care for their new patients but also take time to get to grips with how to undertake and what their new role is for that ward.

A modern NHS recognises the importance of information handover between healthcare professionals. This has been seen in numerous trusts taking on or improving their evening, morning and weekend patient handovers in both medicine and surgery. This importance of handover is no more obvious than in the changeover of junior doctors or even the start of working life as a junior doctor. The aim is for foundation trainees to have the collective information gained and collated by their predecessors, the tips, advice and general 'I wish I had known that before I started' information in an easily accessible document. This is so trainees not only feel more confident in their new working environment but more comfortable quicker, therefore being able to give more time to the delivery of care to their patients.

Finally in a time when cost effectiveness is of significant importance within the NHS, The Handbook recognises and utilises that fact the information and training required by trainees is often already available, in the seniors, colleagues and predecessors all around us. By creating an accessible, updatable system, The Handbook can be edited and updated by junior doctors throughout the year to ensure the information is correct, relevant and up to date for the trainee."

Dr Will Barker (GP trainee, North West London Local Education Training Board) highlights how technology can enhance learning within the context of the modern NHS.

Dr Toolbox

"Over the last decade there have been huge advances in technology and now every health professional is equipped with a smartphone with more capability than science fiction from when the NHS was born in the 1940s. Thankfully HEE has recognised the potential of the smartphone in the modern NHS. Dr Toolbox enables trainees to improve quality and patient safety by streamlining the complexity of modern care, and to eliminate common errors in everyday tasks such as making referrals or booking investigations. Already this is freeing up trainees from the burdensome administrative aspects of their job, allowing them to focus on training and why they joined their profession – providing high-quality care to patients."

Recommendation 36: Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers

Dr Barker also addresses how doctors in training are pivotal to training innovations for their present and future careers and development:

"Ultimately the future of the NHS is with its trainees yet they often feel transient and unappreciated as they rotate around hospitals in the early part of their career. Dr Toolbox allows them to improve their hospital and leave a lasting legacy improving quality and safety long after they have left. It also encourages them to think about service development early on in their careers, providing valuable experience for future roles."

Dr Davies demonstrates how The Handbook enables trainees to be involved in the decision-making process of their training:

"The Handbook is designed, run and maintained by junior doctors on the hospital's intranet system. All junior doctors are given access to The Handbook in order to edit and update the documents available. The Handbook can only be reached once junior doctors have logged on to their hospital computer, creating a password-protected and secure system. The project is supported by the trust itself with overseeing supervision of the Medical Education Department. The role of The Handbook is to assist trainees in their work and also encourage them to be involved with a service development project. Trainees are able to not only help other junior doctors by contributing to The Handbook but also benefit themselves from the handover information given by their colleagues, creating a mutually beneficial system. One of the overall aims of this pilot project is to assist junior doctors, when starting a new rotation, to hit the ground running so they can feel more confident in their clinical environment and hopefully make the most of their training within each rotation."

Each trainee project lead is responsible for considering how their projects can be adopted on a national basis, with HEE support. They are currently developing an adoptability strategy and working with Local Education and Training Boards (LETBs) and partner organisations to promote the learning and outcomes from these projects to support national spread and adoption. The BTBC team is currently in the process of drafting a phase 2 national adoptability strategy to support the national spread of these projects.

The local delivery of BTBC from Workstream 1 also demonstrated significant improvements for trainees. The Matrix evaluation found that trainees were very positive about their experiences with the pilot projects. In addition to improving skills, knowledge and confidence, trainees were presented with the opportunity to:

- Develop leadership skills
- Develop within a service-driven area
- Attend training sessions
- Improve productivity and completion of workplace-based assessments (WBAs)
- Become more integrated in multi-disciplinary teams

As a result of the positive impact and the level of satisfaction, trainees have been taking on the role of champions and change agents to support and facilitate spread and adoption across new departments and trusts. For example, the Pennine Emergency Physician In-house Challenge (EPIC) project, which used gaming theory to score trainees on specific activities and enabled trainees to view results and areas of improvement, was implemented successfully with the help and support of trainees who demonstrated leadership skills by championing the project during implementation and outside of the

pilot environment. Another example of the positive impact trainees can have as change agents is the Mid Cheshire pilot project, which used an electronic handover device to support trainees with handovers. Trainees who then rotated began asking other hospitals and departments to introduce and utilise the electronic handover device, which helped foster spread and adoption. Further information about these projects can be found in the Workstream 1 evaluation report.

3.1.2 Trainee Consensus Statement [Recommendation 6]

Although trainees must play a part in defining their roles within their present and future careers, it is acknowledged that NHS trusts and employers must also have a detailed understanding of the role of the doctor in training. To support this, the Academy Trainee Doctors Group of the AoMRC developed *A Charter for Postgraduate Medical Training: Value of the Doctor in Training*[30] in March 2014.

This charter defines the guiding principles for the delivery of and participation in medical training across the four nations of the UK, building on the *Charter for Medical Training*[31] developed by the Royal College of Physicians of Edinburgh. It articulates the wider value of postgraduate medical training, providing a practical foundation to ensure the highest standard of doctors' training and quality of care.

The priorities detailed in the charter include the appropriate balance between service provision and learning, adequate induction, supervision and continuing support, freedom from bullying and harassment, and leadership and management experience.

The charter was endorsed by the BTBC Taskforce and published as part of the *Shape of Training*[32] final report, which was sponsored by relevant stakeholders. The charter is available for review online and the AoMRC are currently engaging with external stakeholders and local education providers to embed this charter into postgraduate training.

3.1.3 Learning to Make a Difference [Recommendation 35]

Doctors in training bring fresh eyes and unique perspectives to ways of working within an organisation; they are an untapped source of potential for improving patient care. The Learning to Make a Difference programmes provide the resources and support for core medical trainees to put their improvement ideas into action, using a simple structured framework, whilst simultaneously enhancing their training through learning and developing new skills in quality improvement methodology. This is a change to the traditional perceptions of learning and encourages doctors in core medical training to complete a quality improvement project and improve ways of working across the multi-professional team. Training programmes were designed to develop consultant capability in quality improvement methodology, considering how this can be applied in practice and how to provide effective support for their trainee.

30 Academy of Medical Royal Colleges (2014)
31 Royal College of Physicians of Edinburgh (2011)
32 Greenaway D (2013)

3.1.4 Trainee Professionalism [Recommendation 7]

All doctors are required to maintain a level of professionalism. The *GMC Good Medical Practice (GMP) 2013*[33] is the core ethical guidance provided to doctors. It is also intended to inform the public about what they should expect from their doctors.

The 'Professionalism in action' section[34] explains the GMC expectations of a doctor, whilst 'Develop and maintain your professional performance'[35] outlines further details on how doctors should develop their professionalism through maintaining their knowledge and updating their skills to ensure competence and performance. The BTBC programme recognised and supported the GMC's guidance.

3.1.5 Trainee Supervision [Recommendation 27]

Both Temple and Collins have made recommendations to improve trainee supervision in their reports. Trainees may be working with limited supervision and can feel that, at times, they're working beyond their competence level.

The GMC sets explicit standards for the supervision of foundation doctors, requiring that onsite supervision is available at all times. Quality assurance is achieved through GMC multiple mechanisms outlined in the QIF[36], including visits and data collected via the GMC Trainee Survey. Where there are specific localised areas of supervision risk, these are audited by the GMC and subsequently followed up to ensure improvement. Patterns of risk are also identified and investigated through thematic review, such as with emergency medicine posts.

3.1.6 Role of the Trainee – summary

From this overview, it is evident that the Role of the Trainee workstream has delivered successfully on the related Temple and Collins recommendations. Trainees were supported and encouraged to implement innovations through the Inspire Improvement and Learning to Make a Difference projects. A consensus statement (a trainee charter) was developed to enable trusts to have a better understanding of the role of the F2 doctor.

HEE is continuing to work with partner organisations to share the learning from this workstream and to help embed these principles into everyday practice. The Role of the Trainer work through the trainee-led pilot projects and the trainee charter have been recognised as being relevant on a national level.

33 General Medical Council (2014)
34 General Medical Council (2014), paragraphs 1-6
35 General Medical Council (2014), paragraphs 7-13
36 General Medical Council (2010)

3.2 Workstream 3: Role of the Trainer

Box 2: Recommendations

Temple	
[Recommendation 37] All consultants, when they come into contact with trainees in a clinical situation, will have a role in teaching and supervising them	A
[Recommendation 38] Consultants formally and directly involved in training should be identified	A
[Recommendation 39] They must be accredited and supported: • Job plans • Reduced service load • Trainees more closely aligned*	A
[Recommendation 40] Organisations involved in the standard-setting and regulation of training must co-ordinate their approach and ensure clarity of these training roles	A
[Recommendation 41] Trainer excellence must be appropriately rewarded	A
Collins	
[Recommendation 19] Need a framework for the approval of trainers involved in teaching and assessing trainees	A
[Recommendation 21] NHS employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees*	A
[Recommendation 23] All FP assessments should be conducted and signed off by resourced, trained and regularly reviewed assessors	A
[Recommendation 27] The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training; graded responsibility should be allowed with some degree of clinical discretion	A

High-quality training is essential for safe, high-quality patient care. It is paramount that education and training are valued, protected and improved, even during times of resource constraint, service reconfiguration and organisational change.

This workstream focused on the role of the trainer to ensure the delivery of high-quality education and training. HEE commissioned guidance on how best to recognise, develop and reward trainers and training environments, including the recognition and accreditation of trainers and protecting time for trainers. The initiatives that underpin this workstream include the development of the GMC's *Recognising and Approving Trainers: The Implementation Plan*,[37] NACT UK's faculty guide,[38] and AoME's *Essential User Guide to Recognition of Trainers in Secondary Care*.[39] HEE is working with partner organisations to continue in shared learning.

3.2.1 Recognition and Approval of Trainers [Recommendations 19, 21, 38, 39, 40, 41]

In August 2012, the GMC published *Recognising and Approving Trainers: The Implementation Plan*[40], a regulatory structure for safe, effective medical education that includes standards for medical trainers.

The plan recommends the use of existing standards for postgraduate training set out in *The Trainee Doctor*[41] and for undergraduate education in *Tomorrow's Doctors*[42]. It was also designed to provide assurance to patients that medical education and training develops doctors with the appropriate knowledge, skills and behaviours, consistent with GMP 2013[43].

On 25 June 2013, HEE and the GMC hosted a workshop with varying stakeholders (see Appendix 4b) to share good practice in supporting trainers. It was understood that even though there was guidance in place, something more needed to be done to promote and recognise the role of the trainer. The workshop focused on:

- the challenge to recognise trainers in the current financial environment
- the learning environment
- adopting the seven framework areas outlined in the AoME's *Framework for the Professional Development of Postgraduate Medical Supervisors*[44] engagement with trust boards and chief executives.

37 General Medical Council (2012)
38 National Association of Clinical Tutors (2013)
39 Academy of Medical Educators (2013)
40 General Medical Council (2012)
41 General Medical Council (2011)
42 General Medical Council (2009)
43 General Medical Council (2014), paragraphs 39-43
44 Academy of Medical Educators (2010), page 9

The workshop concluded that healthcare organisations and employers play a key role in providing safe clinical training environments. As clinical care providers, they are responsible for patient safety and providing effective, safe educational environments, and should:

- ensure patient safety through the appropriate clinical supervision of students and trainees at all times
- agree effective job plans for trainers that reflect their educational responsibilities
- ensure educational responsibilities are appropriately reviewed in appraisals
- account for the resources they (the healthcare organisations) receive to support training
- fund and enable trainers' educational development through appropriate continuing professional development (CPD)
- hold trainers to account for the resources they receive in support of training
- demonstrate that trainers are fit for purpose to discharge their educational roles and responsibilities
- work with postgraduate deans and medical schools in recognising, valuing and rewarding trainers.

Following the outcomes of the workshop, the GMC and HEE worked in partnership to develop a number of UK-wide initiatives, which included *The Essential User Guide to Recognition of Training in Secondary Care 2013*[45], developed by the AoME. This UK-wide 'how-to' guide was produced for secondary care doctors to support the implementation of the GMCs framework, *Recognising and Approving Trainers*.6 NACT UK also developed their *Faculty Guide*[46] that addresses the impact of the workplace environment and the role of the faculty on the success of training and education, and therefore patient care, within the NHS.

These documents helped to support the accreditation, recognition and support of consultant trainers or educators and further ensured that training environments deliver high-quality clinical care and are conducive to learning.

3.2.2 Time for Trainers [Recommendation 39]

This element of the Role of the Trainer workstream focused on providing time for trainers. The GMC supported this and regulated that training must be mandatory for consultants who are trainers, or aspiring to be. Employers then reinforced this advice through supporting professional activities (SPA) and ensuring sufficient SPA time is provided in a consultant's job plan for training activities.

45 Academy of Medical Educators (2013)
46 National Association of Clinical Tutors (2013)

3.2.3 Pilot projects – Role of the Trainer and trainee impact [Recommendation 37]

Of the 16 Workstream 1 pilot projects, 12 designed solutions that would enable improved mentoring and support for doctors in training, either by providing innovative solutions that allow the consultant to have more input into, and oversight of, the activities of the trainee, or by incorporating training into service delivery and drawing on the wider team for support.

East Kent, Leeds and York pilot projects restructured rotas and patient schedules to maximise the learning from everyday activity, which increased opportunities for trainees to attend training sessions and also increased opportunities for supervision. Trainers commented that they felt they had more time to supervise trainees, especially at weekends, and were able to provide more feedback to support their development.

The Kings College pilot project improved the amount of supervised activity in an emergency department and improved trainee involvement by implementing the RAT+ model. The Airedale and Western Sussex pilot used telemedicine to share consultant resources from resource locations, allowing consultants to remotely have oversight of, and input into, the handover process. The North Bristol pilot project used video feedback to improve trainees' consultation skills and to improve trainers' mentoring and feedback skills.

The Mid Cheshire pilot project used a Situation, Background, Assessment and Recommendation (SBAR) mechanism and an electronic handover solution to improve consultant input and provide greater supervision and support to doctors in training. The South Manchester pilot project improved the amount of support and training for doctors, as did Tees Esk and Wear Valleys Trust by restructuring roles to improve supervision and support for trainees new to psychiatry and the trust.

These are just some of the examples from the local trust pilot projects, which demonstrate how local medical education innovations can make a significant impact on the relationship between consultants and doctors in training and how simple solutions can improve supervision, and ultimately improve patient care and safety.

3.2.4 Role of the Trainer – summary

From this overview, it is evident that this workstream has delivered on the Temple and Collins recommendations. However it is clear that further work is required to embed these principles into everyday practice. This workstream has led to a wider multi-professional project looking at the role of the trainer and educator.

3.3 Workstream 4: Workforce Planning

Box 3: Recommendations

Temple	
[Recommendation 42] A clear alignment between service need and the number of new Certificates of Completion of Training (CCT) awards in terms of workforce planning is urgently needed to enable a consultant-delivered service	B
[Recommendation 43] Services must be designed and configured to deliver high-quality patient care and training, which may be departmental, trust, regional, or national level but will require a critical mass of professionals to maintain a viable service	B
[Recommendation 44] As the ratio of trainees to consultants changes with increasing consultant numbers, it may not be feasible to train in all hospitals	B
Collins	
[Recommendation 17] Distribution of foundation posts across a broader base of specialties	A

HEE aims to support the delivery of high-quality healthcare by ensuring that the workforce has the right numbers, skills, values and behaviours. Effective workforce planning is required to enable a consultant-delivered service and to maintain a viable service. This workstream transitioned to business as usual from 2012 and was developed within other programmes of work initially within the Department of Health and now within HEE, where the Temple and Collins recommendations were addressed.

3.3.1 Medical Workforce Advisory Group [Recommendations 42, 43, 44]

A Medical Workforce Advisory Group was established to support the need to determine medical education commissions alongside, and in the context of competing priorities, balancing local and national priorities. The group also provides a forum for expert advice, supporting HEE in its accountability for investment decisions. The function of this advisory group was to assess the available intelligence on future supply and demand for medical staff and make recommendations to the HEE senior leadership team (see Appendix 4c).

3.3.2 Workforce Planning Guide 2013 [Recommendations 42, 43, 44]

A *HEE Workforce Planning Guide*[47] for the NHS was published in early 2013, which clearly laid out the responsibilities of employers and HEE with defined timelines and milestones to deliver the *Workforce Plan for England*[48]. The Plan – the first national Workforce Plan for England – was published in 2013 by HEE and included guidance ensuring that there was one process that pulled together medical and non-medical planning decisions.

Commissions for postgraduate medical and dental education are forecast to produce an average increase in the consultant workforce of between three to four per cent per annum, continuing the historic trend of growth observed over the past ten years. It is noted that this will need to be aligned to service delivery to enable a consultant-delivered service.

3.3.3 Distributing of foundation posts across a broader base of specialties [Recommendation 17]

The *Broadening the Foundation Programme*[49] report sets out a road map for a managed and phased transfer of a greater amount of training into community settings. This will provide the next generation of foundation doctors with the skills to deliver safe and effective integrated care.

The report states that foundation doctors should not rotate through a placement in the same specialty grouping more than once, unless this is required to enable them to fulfill the outcomes set out in the curriculum. Any placements repeated in F2 must include opportunities to learn outside the traditional hospital setting.

3.3.4 Workforce Planning transition – summary

Workforce planning is an evolving process that will continue to shape over time, even over the time it takes to train healthcare professionals. This is one of the reasons why this area of work is now being managed by a team that is dedicated to ensuring that we have a workforce with the right skills, in the right numbers to deliver safe and high-quality patient care. Planning guidance has been developed to support a consultant-delivered service and the model for training through innovations such as telemedicine, simulation, m-learning and e-learning. The focus now is to revisit this guidance with all stakeholder groups to ensure that the planning guidance is multi-professional and to work together with partner organisations to ensure that service delivery is aligned with training and education.

47 Health Education England (2013a)
48 Health Education England (2013c)
49 Health Education England (2014)

3.4 Workstream 5: Improving Careers Guidance and Availability

Box 4: Recommendations

Temple	
[Recommendation 11] All of the organisations must work together to define good practice for the provision of careers information and advice	B

A group was established through the MDRS programme to define good practice for the provision of careers information and advice.

A careers guidance portal, designed to support trainees with their career choices and to define good practice for the provision of careers information and advice, was developed and is currently being refined to address perceptions of particular careers, encouraging an even distribution of trainee placements across all disciplines.

3.4.1 Medical and dental recruitment and selection programme [Recommendation 11]

The MDRS programme was in existence prior to the recommendations outlined in the BTBC programme. The objectives of MDRS are to ensure fairness and quality in selection and recruitment processes used, to ensure high standards are applied consistently against agreed criteria and that outcomes are evaluated and widely shared.

The MDRS programme works in partnership with many stakeholder groups including the Devolved Nations, British Medical Association (BMA), medical royal colleges, NHS Employers, regulatory bodies (GMC and General Dental Council) and LETBs, to introduce improvements and work to ensure that NHS staff have the right skills, values and competencies to deliver excellent clinical outcomes, together with patient-centred care.

A planning group was established as part of this programme to define good practice for careers information and advice as per Temple's recommendations (see Appendix 4d). This group is still working together and continues to promote a strategic approach to medical and dental career planning and support in the UK. This is achieved by determining how career planning information should be cascaded, collating information for medicine and dentistry, and optimising career planning for less popular specialties where recruitment has been difficult.

3.4.2 Career developments [Recommendation 11]

The working group developed a number of deliverables to define good practice, support the availability of information and improve the understanding of careers. This includes:

Table 7: Career development deliverables

Deliverables	
BMJ careers article	Publication of competition ratios for specialty training
College of Emergency Medicine	Promotion material (oral presentation, videos) to raise the profile of an emergency medicine career amongst undergraduates and foundation doctors
Engaging with the BMA	Share information and good practice with the BMA
NHS medical careers website	https://www.medicalcareers.nhs.uk/
BMJ Career Fair 2013	Career advice stands manned by HEE and LETB career advisors

The working group also identified specialties with a shortage in recruitment, such as emergency medicine and general practice, allowing them to target the respective medical royal colleges to promote relevant materials to enhance recruitment in those specialties.

Competition ratios were published to inform trainees which specialties were over- or undersubscribed, as a means to support decision-making when choosing a certain specialty. It's crucial that this data collection is accurate to inform trainees, through improved publication and communications, and by encouraging them to review the competition ratios when deciding upon their specialty.

Stakeholder engagement is crucial to help to improve communication and increase publication of recruitment data. The NHS medical careers website has specialty pages[50] with information on over 60 specialties within medicine, including case studies and video-casts about the different specialty areas. It also features useful pages for foundation trainees[51] and specialty trainees[52].

50 http://www.medicalcareers.nhs.uk/specialty_pages.aspx
51 http://www.medicalcareers.nhs.uk/postgraduate_doctors/pg_doctors/foundation_doctors.aspx
52 http://www.medicalcareers.nhs.uk/postgraduate_doctors/specialty_trainee_doctors.aspx

3.4.3 Improving Careers Guidance and Availability – summary

HEE is continuing to work with partner organisations to define good practice for the provision of careers information and advice, not just for doctors but for all professions. The careers guidance portal has been an effective way of showcasing and sharing information about careers and what certain specialties can offer. This work will continue under the MDRS programme, alongside NHS careers, and will liaise closely with workforce planning to increase the profile of those specialties that are undersubscribed but are required to sustain the NHS and support patient care.

3.5 Workstream 6: Technology-Enhanced Learning

Box 5: Recommendations

Temple	
[Recommendation 45] The coordinated, integrated use of simulation can provide a safe, controlled environment and accelerate learning	B
[Recommendation 46] Where appropriate, skills and expertise should be learnt in a simulation environment and from other modern techniques, not on patients	B
Collins	
[Recommendation 18] Need for more widespread use of technology to support learning	B

Evidence[53] and work to date shows that learners expect high-quality experiences based on a combination of face-to-face contact and access to a range of technology enhanced resources. Integrated TEL makes a vital contribution to meeting this expectation. At a time when larger cohorts create challenges for maintaining high levels of personal interactions between trainees and their supervisors, TEL can provide an alternative rich environment for support and communication.

The majority of UK graduates across all healthcare professional groups have had extensive experiences of TEL and expect their training in practice to take this further. They expect approaches and resources that are flexible, responsive, active, problem-based, 'just-in-time' and 'just-for-me'. Increasingly they are 'transliterate' – they have the technical ability to read, write and interact across a variety of platforms, tools and media.

Personalisation, mobility, choice and sociability are key features of technology use in trainees' lives that they will expect to transfer to their CPD.

3.5.1 The Technology Enhanced Learning strategy [Recommendations 18, 45, 46]

The TEL strategy was put together with a number of national stakeholders, aimed at ensuring TEL technologies and technologies are shared and spread across the UK.

53 As well as the Temple and Collins reports, other key reports/links include:

- *Department of Health (2011a)*
- *NHS Simulation Provision and Use Study (February 2010)*
- *ELearning in the Health Sector, some key quality principles (2011)*
- *Commissioning eLearning Resources in the NHS - key principles and guidance (October 2012)*
- *CMO's recommendations from the CMO's Annual Report 2008 – Safer Medical Practice http://www.timeshighereducation.co.uk/403135.article*

This strategy was underpinned by the Department of Health's *A Framework for Technology Enhanced Learning* (2011),[54] which highlights that existing and emerging technologies in education, training and development should be the 'norm' and where TEL:

- is patient-centred and service driven
- is based on clearly articulated learning needs that are aligned to service needs
- is innovative and evidence-based
- is demonstrably delivering high educational outcomes
- is delivering value for money through improving learning, productivity, avoidance of waste and duplication and by being affordable and cost effective
- provision across the health and social care workforce is demonstrably equitable.

3.5.2 A national programme [Recommendations 18, 45, 46]

TEL was established as a national programme in 2013[55] with the vision that healthcare in the UK is underpinned by world-class education and training is enhanced through innovation and the use of existing, evidence-based and emergent technologies and techniques.

This programme has four working groups, with members from a range of stakeholder organisations across the UK, and an overarching steering group overseeing the programme work.

3.5.3 A Technology Enhanced Learning hub [Recommendations 18, 45, 46]

The programme is delivering a number of key projects, the first of which is the development and launch of the TEL hub – an online portal and repository for TEL information and resources, initially in the areas of simulation, e-learning and m-learning. It is planned that this hub will be launched by March 2015 and it is being developed in partnership with the Higher Education Academy.

In addition to specific TEL content, this hub will be scalable to incorporate multiple 'microsites' or 'portals' that deliver the objectives of separate HEE programmes of work around innovation and knowledge – all of which will have the same focus: to share and spread good practice UK-wide.

54 Department of Health (2011a)
55 Health Education England (2013b) See also Appendix 4g for an extract of this report.

The aim of the TEL hub is to establish a national picture of where TEL activities are being developed and look at opportunities to align and embed good practice activities and approaches in healthcare education and in curricula. The hub will:

- be a go-to place for examples, guidance and TEL resources that are delivering major benefits in health education and training
- enable the share and spread of good practice and innovation across higher and postgraduate education
- promote innovation and creativity in the use of TEL to enhance learning and teaching.

Currently the project is progressing well. A statement of requirements has been drafted, which will inform the selected developers to create the TEL hub, and the programme team are carrying out detailed research to ensure the final product effectively meets user needs. A showcase event for stakeholders to preview the programmes and products took place on 10 June 2014 with positive feedback widely received. The launch of the TEL hub is planned in 2015, with rigorous testing on usability and access before going live.

3.5.4 Other key projects

Other key projects are also being developed, looking at TEL commissioning and curricula, issues and barriers around IT in the NHS, digital literacy and effective horizon scanning.[56]

3.5.5 Pilot projects – Technology Enhanced Learning

Of the 16 Workstream 1 pilot projects, 10 included solutions that would enable the use of simulation and other technology innovations to deliver quality patient care and improved education and training for trainees and trainers.

56 For more information on the programme and projects, visit www.hee.nhs.uk/work-programmes/tel

Table 8: Assessment of pilot projects[57]

Pilot project	Initial objectives	Impact
Airedale and Western Sussex	1. Deliver direct patient care in out-of-hours and elective (satellite clinics) settings 2. Deliver training to healthcare professionals 3. Maximise training opportunities by using a network of hospitals for shared training	Telemedicine was thought to be a good way of providing consultant support during handovers and improving patient care. It was also an invaluable tool to facilitate teaching across sites, making efficient use of resources and thus freeing up clinician time. The quality of interactions is an issue that needs to be addressed; providing just the means might not be sufficient.

57 NHS Employers (2013), pages 29-37

Pilot project	Initial objectives	Impact
Pennine EPIC	1. To pilot the EPIC rewards system 2. Develop a system that trainees can access and use to engage in the project, with a dashboard to display the results 3. Improve the involvement of trainees in all aspects of training and service delivery 4. Improve patient care and safety through better and earlier training of doctors 5. Encourage doctors to excel and get involved in projects that will allow them to develop personally, as well as improve patient care 6. Encourage increased productivity (see also point 2 above)	This pilot was designed to follow gaming theory – using a points system to 'reward' targeted clinical and training activities. Productivity increased and a greater number of WBAs were carried out as a result. An additional technical element of the pilot was to develop a dashboard so that trainees and trainers could view results and progress remotely. At the time of going to press, this was in development.

Pilot project	Initial objectives	Impact
Mid Cheshire	To improve the handover process through an enhanced training package complemented by an e-handover solution, managed and delivered by Ascribe	The pilot project has supported handovers using this e-handover solution. Trainees benefited from seeing task allocation and prioritisation at a glance, which helps them with decision-making and managing workloads.
Heart of England	1. To increase learning opportunities for F1 doctors 2. To improve the educational experience of F1 doctors	The pilot project team used an e-learning tool to increase learning opportunities and improve mentoring during shadowing week, and to support trainee doctors in difficulty. The pilot project increased the opportunity for the trainee/learner to be engaged with the learning material and increased the learning opportunities, which has had a positive impact on the trainees when compared to the control group.

Pilot project	Initial objectives	Impact
Leeds and York Partnership	1. To improve the quality and outcomes of referrals between multi-disciplinary teams and doctors in training, through implementation of the SBAR tool to all multi-disciplinary staff on psychiatric inpatient wards in the Leeds area 2. To increase curriculum competencies in the fields of communication and Core Training (CT) teaching skills, following the introduction of a programme of development through CT, years 1-3 that utilises clinical simulation training and support of mentors, in addition to protected supervised teaching experience for second year medical students in the field of mental health 3. To review and develop resources available to support training successfully	The simulated sessions on 'recognising a medical problem in a psychiatric setting' were positively received by trainees and trainers. Based on serious incidents, these sessions are now being rolled out regionally.

Pilot project	Initial objectives	Impact
East London	1. To embed simulation training in the Trust's training programme for clinicians 2. To engage all levels of clinical staff in the promotion of learning from serious incidents via simulation training 3. To use in-house expertise to deliver and facilitate training sessions 4. To provide a detailed schedule of training that will enable the attendance of a large number of delegates over a six-month period 5. To access the benefits of simulation training in relation to the prevention and management of serious incidents 6. To promote learning in multi-professional teams and highlight the importance of team working and communication in the clinical arena	Simulation sessions were designed to provide training around serious incidents by using actual incidents as examples. This has provided a successful training model, drawing on expertise within the department. Trainees did feel that the sessions would change their practice and have demonstrated an improvement in knowledge and confidence, which is likely to impact on patient care.

Pilot project	Initial objectives	Impact
Leeds Teaching	1. To create an enhanced training programme 2. To improve the technical ability of trainee general surgeons 3. To improve the analytical ability of trainee general surgeons 4. To increase confidence and accuracy in decision-making 5. To enhance communication skills 6. To develop trainer skills and enhance time for training 7. To improve the training experience for core and specialist trainees 8. To measure accurately the time required by a trainer to complete a WBA	The pilot project provided before and after self-reported measures of trainee confidence to show an improvement in confidence and skills amongst trainees following simulated sessions using cadavers.

Pilot project	Initial objectives	Impact
North Bristol	1. To estimate the desire for consultations skills training 2. To estimate the feasibility of using video recordings in an outpatients setting to facilitate training in consultation skills 3. To study whether reflection and personal feedback on outpatient video recordings is an acceptable teaching method for specialist trainees in secondary care 4. To enhance trainer/ trainee interaction 5. To add value to the completion of WBAs 6. To develop the skills of consultant trainers in providing consultation skills training	The pilot project was designed around enhancing trainer and trainee interactions through video feedback, which supported the completion of WBAs in an outpatient setting. This was a novel way for consultant trainers to assess and develop trainee consultation skills, especially since a third of the responding consultants had never observed registrars in consultation in outpatient clinics. Consultants felt this was a useful way to assess trainee consultation skills, provide feedback and develop trainees' consultation skills.

3.5.6 Inspire Improvement project – Technology Enhanced Learning

Of the nine Inspire Improvement projects, five use TEL to deliver education and training to improve patient care and enhance trainee education. Table 9 outlines the TEL focus of each project.

Table 9: Inspire Improvement projects with a TEL focus (see Appendix 2)

Inspire Improvement projects	TEL focus
Confusion App	M-learning via smartphone app
The Handbook	Intranet based documents
Micro-Surgical Training	M-learning via tablets at home
Utilising Serious Games to develop the Decision-Making Skills of Foundation Doctors: an Implementation and Evaluation Study	Virtual environment learning
Dr Toolbox	M-learning via smartphone app

3.5.7 Technology Enhanced Learning – summary

HEE is continuing to work with partner organisations to share the learning and development from this workstream and to help embed these principles into everyday practice. The initial focus of the programme is looking at simulation, e-learning and m-learning, although this will expand into all areas of TEL as the work progresses.

3.6 Workstream 7: Improving the Foundation Programme

Box 6: Recommendations

Temple	
7.1 Curriculum development	
[Recommendation 1] MEE should confirm the purpose of the Foundation Programme	A
[Recommendation 2] The GMC should define the outcomes required to complete F2	A
[Recommendation 15] The Foundation Programme Curriculum should be revised to place greater emphasis on the total patient, long-term conditions, community care and changing ways of working	A
[Recommendation 15] The Foundation Programme Curriculum should integrate fully with medical school curricula	A
[Recommendation 20] Streamlining of assessment in the Foundation Programme	A
[Recommendation 22] Patient feedback should be part of the foundation doctor assessment	A
7.2 Improving selection	
[Recommendations 4&5] Improving selection into the Foundation Programme	A
7.3 Harmonisation and improved delivery	
[Recommendation 9] The Foundation Programme should remain as two years with a review in 2015	A
[Recommendation 10] Foundation Programme placements must be for a minimum of four months and a maximum of six months	A
[Recommendations 10&14] The length, content and organisation of the rotational programme must be clearly disclosed in foundation school materials	A
[Recommendations 12&14] Greater flexibility in allocation of F2, including 'swap shops'	A
[Recommendation 12] F1 and F2 should remain generic	A

[Recommendation 12] F2 placements should be aligned, as far as possible, with broad areas in which trainees hope to pursue their careers	A
[Recommendation 13] Must address mismatch between expectation and reality about career prospects in different specialities	A
[Recommendations 13&16] Successful completion of the FP should normally require completion of a placement in the community, such as community paediatrics, general practice or psychiatry	A
[Recommendation 17] Distribution of foundation posts across a broader base of specialties	A
[Recommendation 23] All Foundation Programme assessments should be conducted and signed off by resourced, trained and regularly reviewed assessors	A
[Recommendation 24] Healthcare professionals and employers must understand the Foundation Programme objectives, become quickly conversant with their foundation doctor's prior experience and level of competence, and ensure that no foundation doctor practices beyond their level of competence or without appropriate supervision	A
[Recommendation 25] The Foundation Programme structure should ensure a more even demand on clinician time for teaching and supervision	A
[Recommendation 28] Ensuring appropriate balance between service and education with right of redress by trainees	A
[Recommendations 31&32] Transfer of relevant information about medical students and trainees across the continuum of education and training	A

This workstream consists of a number of components – the first of which was to review the Foundation Programme Curriculum. The remainder of the project addresses specific recommendations by Collins for more trainees to undertake community-facing placements, and for a more even distribution of trainee placements across specialties with particular emphasis on general practice, psychiatry and other community placements.

Working across the health education and provider landscape, three groups were established to explore these aims and develop the deliverables. The Better Training group focused on the training implications of re-distributing foundation posts, increasing the number of trainees in the community, and the Better Care group looked at the impact that this will have on the service.

Overall, the recommendations have been met although there are still discussions regarding fully integrating the Foundation Programme Curriculum with medical school curricula.

3.6.1 Curriculum development [Recommendations 1, 2, 15]

In *Foundation for Excellence,* Collins highlighted positive aspects of the curriculum but four particular areas of concern were the purpose of foundation training, the value of F2 training, long-term condition management and excessive assessments.

The AoMRC were tasked to address these issues and by result produced the Foundation Programme Curriculum 2012[58]. The purpose of the Foundation Programme is to build on undergraduate education, professionalism and patient welfare, generic training, team working and experience to inform career choice.

The following changes were made to the curriculum to address the concerns raised:

Curriculum changes 2012
New curriculum syllabus headings
High-level descriptors to distinguish between F1 and F2 outcomes
Supervised learning event (SLE) forms and guidance introduced
Changes to assessment
Detailed clinical supervisor's end-of-placement report
Detailed educational supervisor's end-of-placement and end-of-year report
Introduction of Foundation Programme Annual Review of Competence Progression (ARCP) process and forms (see Appendix 4f)
Sign-off documents reformatted into certificates

3.6.1.1 Patient feedback tools [Recommendation 22]

In October 2011, the GMC approved a proposal from the AoMRC for a feasibility study into developing a patient feedback tool to help in the professional development of foundation doctors. From the outset the project was clear that any process or tool(s) would have to add value to the training of foundation doctors and be a methodologically robust feedback tool/mechanism, as well as being feasible to deliver.[59]

Patient response was low across all four UK countries, with significantly more responses from primary care than secondary care. Educational supervisors felt the process was either unnecessary or merely confirmed what they already knew. Administrators found it challenging to get doctors and supervisors to participate in the pilot due to workload and lack of engagement.

58 Academy of Medical Royal Colleges (2012)
59 Picker Institute Europe (2013)

The pilot identified significant barriers to collecting patient feedback using the current methodology, which included time pressures, work patterns, cost implications and IT development.

The proposed process of patient feedback did not add value to the training of foundation doctors and potentially would not be cost effective. It was concluded by the taskforce that alternative methods of seeking patient feedback for foundation doctors are required and will still need to be explored.

3.6.1.2 Streamlining assessments [Recommendation 20]

Collins concluded that assessment of trainees was excessive, onerous and not valued by trainees or trainers. WBAs formed a substantial component of this burden. In response to Collins, supervised learning events (SLEs) were introduced to replace WBAs in the Foundation Programme Curriculum in 2012.

SLEs are designed to encourage better trainer/trainee interactions, ensure immediate feedback about the effectiveness of care and the trainee's performance and interactions with others, and to demonstrate engagement in the educational process. They draw upon the same tools utilised within WBAs, such as case-based discussion, mini clinical evaluation exercises and direct observation of procedural skills (see Appendix 4e).

The AoMRC has been commissioned by the GMC to undertake an evaluation of SLEs in the Foundation Programme, which is due for publication soon. The report concludes that SLEs are appreciated when understood and implemented properly, however, further work is required to embed them into everyday practice.

The educational supervisor's end-of-placement report enables a record to be uploaded to the trainee's e-portfolio to assess and review any areas of excellence and identify potential areas of concern.

The educational supervisor's end-of-year report draws together all evidence gathered to enable a recommendation for satisfactory ARCP sign-off to be made.

With the introduction of the Foundation Programme ARCP (see Appendix 4f), the panel will review whether the foundation doctor has satisfactorily met the requirements for sign-off, which will be underpinned by the use of the e-portfolio.

3.6.1.3 The Foundation Programme Curriculum should integrate fully with medical school curricula [Recommendation 15]

The outcomes expected of graduates described in *Tomorrow's Doctors* have been mapped against the outcomes required of foundation doctors, as described in *The Trainee Doctor*.

Significant work has been undertaken examining the evidence about preparedness of new doctors for practice.

3.6.2 Improving selection for the Foundation Programme [Recommendations 4, 5]

A Situational Judgement Test (SJT) and an Educational Performance Measure (EPM) were initially piloted to assess whether they should form part of the selection criteria for the Foundation Programme.[60,61] In August 2011, a report was produced on the design, analysis and evaluation of an SJT for selection to the programme, including the specification of the domains to be targeted in the SJT. The recommendations favoured the implementation of the SJT, alongside the EPM, for entry to the Foundation Programme 2013. All applicants to the Foundation Programme commencing in August 2014, including the Academic Foundation Programme, are now required to take the SJT in the UK.

3.6.3 Harmonisation and improved delivery

3.6.3.1 Broadening the Foundation Programme [Recommendations 12, 13, 16, 17]

The *Broadening the Foundation Programme* report sets out a road map for a managed and phased transfer of a greater amount of training into community settings. This will enable the next generation of foundation doctors to be better equipped to provide safe, effective and integrated care.

A key recommendation is educational supervisors should be assigned to foundation doctors for at least one year, so they can receive supervision for the whole of F1, F2, or both years.

Foundation doctors should not rotate through a placement in the same specialty or specialty grouping more than once, unless this is required to enable them to meet the outcomes set out in the curriculum. Any placements repeated in F2 must include opportunities to learn outside the traditional hospital setting.

At least 80 per cent of foundation doctors should undertake a community placement or an integrated placement from August 2015, and all foundation doctors should undertake these placements from August 2017. It should be noted that both community and integrated placements are based in a community setting, and that an acute-based community-facing placement is not a substitute.

HEE is leading the implementation of the report's recommendations, and will be monitoring progress.

60 http://www.foundationprogramme.nhs.uk/pages/medical-students/how-to-apply
61 http://www.foundationprogramme.nhs.uk/pages/medical-students/SJT-EPM

3.6.3.2 The Foundation Programme Reference Guide 2012 [Recommendations 9, 10, 12, 13, 14, 16, 23, 24, 28]

The latest Foundation Programme Reference Guide[62] provides guidance to deaneries and foundation schools about the structures and systems required to support the delivery of the Foundation Programme Curriculum 2012. First published in 2005, the guide has been updated in response to Professor John Collins' report.

The key changes in the updated version set out the agreed purpose of the Foundation Programme, clarify the optimal placement length, outline the exceptional arrangements for swapping F2 rotations and reflect the improving selection to the Foundation Programme project as well as changes to transfer of information (TOI).

The report also reflects the changes required to support the 2012 curriculum and reaffirms that foundation schools should provide details about how trainees can raise concerns if they consider that there is not an appropriate balance between education and training. It also describes a range of options for providing community experience and offers guidance for the support and management of doctors in difficulty.

Foundation Programme assessments are to be signed off by trained assessors. As minuted at the Foundation School Directors' Committee meeting of 17 January 2013 (which has membership from every UK foundation school), it was confirmed that all 25 schools had provided training on the changes to the 2012 Foundation Programme Curriculum. Many different mechanisms have been used to educate supervisors across the UK.

The monitoring of foundation doctors competence will be carried out through the completion of the GMC National Training Survey (NTS), foundation school reviews and postgraduate dean review of trusts. Wider learning from the BTBC pilot projects (see Appendix 3) demonstrates how trusts can be more innovative in providing appropriate supervision.

The UKFPO has noted a lingering perception that the title of Senior House Officer (SHO) refers to a more competent doctor than an F2. Therefore NHS employers have removed reference to the SHO title from their employer contracts. However no evidence is available to confirm that this terminology is no longer used.

The Foundation Programme is structured to ensure even teaching and supervision. Trainees can raise concerns if they consider that there is not an appropriate balance between service and training.

3.6.3.3 Transfer of Information [Recommendations 31, 32]

Medical education and training is a continuing process with a number of different phases,

62 UK Foundation Programme Office (2012)

and it is important that individuals are supported as they move from one phase to the next. The TOI process was introduced in 2013 and improved by 2014,[63] and is designed to help students make the transition from medical school to postgraduate training and employment. The TOI is separate from employment and the GMC registration process.

The UKFPO, Medical Schools Council and Conference of the Post Medical Deans of the United Kingdom (COPMeD) operationalise the agreed TOI process (from medical school to foundation school for the 2013 Foundation Programme intake), develop and implement the exchange of information for doctors who have not completed F1 as expected, and develop documentation and implement TOI between F1 and F2 doctors.

3.6.3.4 Continuum of education and training

The UKFPO has set up a foundation doctor's advisory board to ensure full engagement with F1 and F2 doctors, and to ensure all issues surrounding education and training are raised and dealt with in the appropriate manner. A medical student board also exists to help inform development of the Foundation Programme Curriculum.

3.6.4 Improving the Foundation Programme – summary

The revised Foundation Programme Curriculum was introduced to reflect the purpose of foundation training, the value of F2 training and methods to streamline assessments through the introduction of SLEs. The *Broadening the Foundation Programme* report highlights and sets out a clear path for phased transfer of increased community-based training. The UKFPO will continue to take forward the recommendations from this report.

63 Medical Schools Council and UK Foundation Programme Office (2014)

3.7 Workstream 8: Regulatory Approach to Supporting Better Training Better Care

Box 7: Recommendations

Collins	
[Recommendation 2] The GMC should define the outcomes required to complete F2	A
[Recommendation 7] The GMC should consider producing guidance to support the development of professionalism among trainees	A
[Recommendation 8] The GMC should review the timing of full registration, student registration and marking completion of the Foundation Programme	A
[Recommendation 26] The GMC must ensure that the Foundation Programme's standards for training relating to patient safety are understood by foundation school directors and NHS employers	A
[Recommendation 27] The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training; graded responsibility should be allowed with some degree of clinical discretion	A
[Recommendation 30] The GMC should describe good practice for pastoral support	A
[Recommendation 33] Medical schools should explore how best to share information with the GMC about medical students	A

Regulatory support is required to enable changes to medical education and training. This was highlighted by Collins, who explicitly states that the GMC should produce and define guidance to support the development of doctors in training.

The GMC merged with the Postgraduate Medical Education and Training Board (PMETB) in April 2010 to take responsibility for regulating all stages of medical education. The GMC sets standards for delivery of foundation training, sets outcomes for foundation doctors that must be met in order to apply for full registration with a licence to practice, and approves the Foundation Programme Curriculum.

3.7.1 Completion of Foundation Stage 2 outcomes [Recommendation 2]

The GMC Postgraduate Board agreed for the AoMRC to lead on the development of F2 outcomes, which would lead to consistency and build on F1. The GMC approved the outcomes that were embedded into the Foundation Programme Curriculum 201219.

Following this approach, clear outcome definitions were derived for better understanding of the progression from F1 to F2, with measurable competencies.

3.7.2 Trainee professionalism [Recommendation 7]

The GMC's good medical practice (GMP) guidance[64] supports the development of professionalism amongst all doctors, including trainees. This raised questions about whether the GMP should have specific guidance for doctors in training. A consensus was reached that it should continue to apply to all doctors. As the GMC develops online tools to support the interpretation of GMP, it is taking into account scenarios of relevance to trainees..

3.7.3 Medical students and full registration [Recommendation 8]

The GMC undertook a review of its position on medical student registration and specifically considered the introduction of either mandatory or voluntary registration. It concluded that neither was necessary to ensure the promotion of professional values or to support a smoother transition to practice.

This decision was informed by the Government Command Paper, *Enabling Excellence,*[65] which made clear that the Government would not extend statutory regulation to currently unregulated professional groups except where there is a compelling case on the basis of a public safety risk. The GMC considered that student registration would not meet that threshold and the alternative of a voluntary register was ruled out as potentially confusing for the public.

The GMC continues work to strengthen engagement with medical students, for example, through the regional liaison advisors network that provides advice and support to medical schools and LETBs. In 2013, the GMC began issuing GMC reference numbers to medical students at the beginning of the final year of their course, rather than towards the end of their final year. This brings forward the point at which medical students engage formally with the GMC. The GMC is clear that issuing a reference number does not mean that a student is registered, to ensure there is no misunderstanding over their status. The GMC has undertaken to revisit this decision in 2015.

The GMC tasked its Education and Training Committee with gathering evidence on the impact of moving the point of full registration to completion of F2. Subsequently, the point of full registration is being considered within the *Shape of Training Review*[66] recommendations.

64 General Medical Council (2014)
65 Great Britain. Parliament. House of Commons (2011)
66 Greenaway D (2013)

3.7.4 The Foundation Programme – patient safety [Recommendation 26]

The standards for patient safety are described explicitly in *The Trainee Doctor*, which, following the merger of GMC with PMETB, set out the standards for management and delivery of postgraduate training in the UK. In 2011 the GMC published the QIF, which sets out how the GMC will quality assure medical education and training across all stages of education and training in the UK. The QIF includes a number of tools for deans and placement providers to identify and manage risks to patient safety. These include the GMC NTS, which has a response rate of over 95 per cent from trainees, and also the online reporting tool, which provides results approximately a month after the survey closes and empowers LETBs and local providers to identify risks and drive quality improvement.

The survey identified, for example, concerns about induction and shadowing for foundation doctors, which have been addressed through national programmes. Regular reporting processes identify risks according to a Red, Amber, Green (RAG) rating and the enhanced monitoring process supports the escalation of concerns about patient and trainee safety, as well as education quality, when local systems are not able to resolve concerns in a timely manner.

The GMC has also used thematic reviews to investigate patterns of risk relating to foundation doctors in emergency departments. This piece of work, which identifies indicators of concern and areas of good practice, was incorporated into the BTBC review.

3.7.5 Trainee supervision for level of training [Recommendation 27]

The GMC sets explicit standards for the supervision of foundation doctors, requiring that onsite supervison is available at all times. Quality assurance is achieved through GMC multiple mechanisms outlined in the QIF, including visits and also data collected via the GMC NTS. Where there are specific localised areas of supervision risk, these are audited by the GMC and subsequently followed up to ensure improvement. Patterns of risk are also identified and investigated through thematic review, such as with emergency medicine posts.

3.7.6 Good practice for pastoral support [Recommendation 30]

The GMC describes standards for pastoral support in Domain 6 of *The Trainee Doctor*: 'Support and development of trainees, trainers and local faculty'. The GMC NTS provides benchmarked reports so that LETBs and providers can easily identify areas that are perceived by trainees as performing well. While recognising that practice is not always transferable, the GMC has worked with LETBs and providers to develop case studies to describe good practice, which have been published in survey reports and on the GMC website.

3.7.7 Medical schools should explore how to share information with the GMC about medical students [Recommendation 33]

The GMC, Medical Schools Council and UKFPO have worked together to improve the TOI process to support the transition from medical school to foundation training, and the separate but concurrent process for students to declare any information relevant to their fitness to practice when applying to the GMC for provisional registration.

3.7.8 Regulatory Approach to Supporting Better Training Better Care – summary

From this overview, it is evident that this workstream on the regulatory approach to support BTBC has delivered successfully on all the Collins recommendations and the GMC has worked in close collaboration amongst organisations to deliver this workstream.

3.8 Workstream 9: Funding and Education Quality Metrics

Box 8: Recommendations

Temple	
[Recommendation 47] Commissioner levers should be strengthened to incentivise training, ensure accountability and reward high quality and innovation	C
[Recommendation 48] Prioritise training in providers by linking training criteria to performance targets (training quality must be included in performance management processes)	C
[Recommendation 49] Educational governance must be recognised on every trust board by the appointment of a person specifically responsible for education and training (in addition to an MD)	C
[Recommendation 50] Monitor the quality of training with a rational, realistic system that looks at a range of indicators to measure the impacts and outputs	C
[Recommendation 51] Include training outcomes as part of the quality assessment of provider institutions	C
Collins	
[Recommendation 25] MEE should explore the factors required for quality supervision, including time	C
[Recommendation 29] Trusts must identify an educational lead	A
[Recommendation 29] Need for quality metrics available at deanery, programme and hospital level (GMC)	C

Better quality patient care has a direct link with good quality education and training. The way in which we commission and assure education and training services should be strengthened to incentivise training and reward high quality and innovation. This workstream aims to explore and identify methods to improve the quality of training for the healthcare workforce and in turn improve the delivery of patient care through the development of education quality indicators.

This workstream requires further development to fully meet the recommendations, and this has been elaborated on within this section.

3.8.1 Education commissioner levers – Quality and Innovation in Education [Recommendations 29, 47-51]

The 2013 *Education Outcomes Framework* sets the outcomes expected to be achieved by reforms in education and training, and is used to measure improvements in education, training and workforce development as well as the impact on the quality and safety of patient services.

There is increasing recognition of the need for indicators of quality in education and training to measure the effectiveness of clinical education delivery and support better outcomes for patients and value for money.

The development of the Education for Quality and Innovation (EDQUINs) framework sets out to deliver in education what the Commissioning for Quality and Innovation (CQUINs) payment framework aims to deliver in healthcare; enabling commissioners to reward excellence by linking a proportion of the income of English healthcare providers to performance targets. The MEE Task and Finish Group have determined the important principles underpinning these indicators, which will be central to their development.

Proposed quality standards need to consider national priorities across the system and recognise variances amongst local education providers, as well as differences in the delivery and governance of training of the individual professions. Bespoke, individualised quality standards for the different healthcare professions will develop as the scheme evolves.

Table 10: Proposed national and local standards

National standards
• Senior level engagement in education and training - Member of the board responsible for education and training • Safe supervision - Guidelines for supervision of learners • Formal educational programme - Existence of a formal education programme with regular feedback and review • Informal educational programme - Regular informal education opportunities
Local standards
Build on the use of existing information about quality indicators that is already being collected by the LETBs

The transitional tariffs for postgraduate medical training programmes in secondary

care aim to develop a fair and transparent payment system for education and training so that funding more closely reflects the costs of providing clinical placements. As a consequence, some local education providers have had a loss of income and therefore a staged implementation process of the EDQUINs system is proposed to avoid potential destabilisation of service provision (see Table 11).

Table 11: EDQUINs proposed timeline

Events	Proposed Timeline
Evaluation from HEE Director of Education and Quality	2014
Evaluation from LETB Directors of Education and Quality	2014
Presentation to Executive Team and Board of HEE	2014
Stakeholder engagement	2014
Evaluation from stakeholder engagement	2015
Sponsor (Department of Health) approval	2015
Rollout of scheme without financial attachments	2015
Financial incentives attached (at the point of introduction of placement tariffs)	2016

The *Education Outcomes Framework* is in the second year of collecting performance indicators to demonstrate sufficient progress towards introducing the framework. The outcome of this will need to synchronise with the EDQUINs.

3.8.1.1 Support for the EDQUINs from local education providers

Many local education providers and postgraduate deans support the notion of incentivising medical education delivery. It will raise the profile and change the culture of quality education and training and provide levers to make a difference. The quality metrics must be rationalised via national and local providers and linked with quality surveillance groups.

3.8.1.2 Challenges for EDQUINs from local education providers

Despite the support for incentivising the delivery of quality medical education and training, concerns have been raised from some local education providers. The notion of EDQUINs is not based on evidence and questions have been raised over whether this should be required. A standardised method should be adopted that uses precise measurements to compare each LETB on an equal footing.

3.8.2 Monitor quality of training at Local Education and Training Board level

[Recommendation 50]

Quality is now on the agenda of all LETBs.

Table 12: Methods for measuring quality of training

Area	Method
LETB-wide	• Quality on the agenda • Postgraduate school visits • Quality reporting process via LETB head of schools and trust reports
Trust-wide	• Annual trust quality reports that address predetermined local quality metrics • Quality performance visits

3.8.3 Trainee outcomes as part of quality assessment [Recommendation 51]

The ARCP outcomes form part of the quality assessment.

3.8.4 Trust educational leads [Recommendation 29]

Each trust has a Director of Medical Education and a non-medical tutor, who form a team with equal responsibility and overlap with the multi-disciplinary teams.

3.8.5 Funding and Education Quality Metrics – summary

This workstream has transitioned in to HEE core business for further development and implementation, as outlined in Table 8.

4 Conclusion

This evaluation sets out how each of the nine workstreams of the BTBC programme has contributed to fulfilling the recommendations from Temple's *Time for Training* and Collins' *Foundation for Excellence*, on both a national and local level.

This programme was not linear. With some recommendations there has been more than one piece of work or project that has led to its successful delivery. Workstream 2: Role of the Trainee is a good example of this, whereby trainees were involved in a number of workstreams and led a number of projects to develop their leadership skills, to encourage and support their development, and to ensure they have the right supervision to enable them to evolve and grow as the future leaders of tomorrow.

Medical education and training has been the underpinning link to delivering improvements for this programme and has demonstrated the value of involving trainers, trainees, regulators, patients and partner organisations to engage in and deliver these recommendations. By simply focusing on medical education, the results have shown improvements to multi-professional team working, service delivery and most importantly, patient safety and care.

The programme has received an outstanding level of support from external stakeholders who have believed in and advocated it from the early stages. It is this support that has helped to embed the work of BTBC so intrinsically into the organisations that have been involved since the programme's inception in 2011. It is of credit to the programme team that many of these organisations have pledged to continue their support as it moves into the next phase, to spread and adopt the learning of each workstream on a national basis.

The results from this evaluation have shown that the key recommendations have been delivered through the BTBC programme. HEE will continue to spread the learning from these projects with national partner organisations to support improvements to patient care and safety through education and training.

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Appendices

Appendix 1: Temple Recommendations

Key Descriptors

A	Fully met	B	Partially met	C	Remains under development

Workstream & Recommendations	Evidence	
2. Role of the Trainee		
[Rec 34] Training must be planned and focused for the trainees' needs	Appendix 2: Inspire Improvement! Projects	A
[Rec 35] Training requires a change from traditional perceptions of learning to a model which recognises the modern NHS		A
[Rec 36] Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers		A
3. Role of the Trainer		
[Rec 37] All consultants when they come into contact with trainees in a clinical situation will have a role in teaching and supervising them	Appendix 3: Pilot projects East Kent, Guys & St Thomas, Leeds & Yorkshire Partnership, South Manchester, Tees, Esk and Wear Valley	A
[Rec 38] Consultants formally and directly involved in training should be identified	NACT UK Faculty Guide page 7 http://www.gmc-uk.org/Faculty_Guide_Oct13.pdf_53817349.pdf AOME Essential User Guide to Recognition Of Trainers in Secondary Care http://hee.nhs.uk/wp-content/uploads/sites/321/2013/10/AoME-Essential-User-Guide1.pdf	A
[Rec 39] They must be accredited and supported: o Job plans o Reduced service load o Trainees more closely aligned *		A
[Rec 40] Organisations involved in the standard-setting and regulation of training must co-ordinate their approach and ensure clarity of these training roles	GMC Recognising and Approving Trainer: The Implementation Plan http://www.gmc-uk.org/Approving_trainers_implementation_plan_Aug_12.pdf_49544894.pdf	A
[Rec 41] Trainer excellence must be appropriately rewarded		A
4. Workforce Planning		
[Rec 42] A clear alignment between service need and the number of new CCT awards in terms of workforce planning is urgently needed to enable a consultant present model	HEE Workforce Planning Guide 2013 http://hee.nhs.uk/wp-content/uploads/sites/321/2012/08/Workforce-Planning-Guide-Final-June-2013.pdf Workforce Plan for England - Proposed Education and Training Commissions for 2014/15 http://hee.nhs.uk/wp-content/uploads/sites/321/2013/12/Workforce-plan-UPDATE-interactive.pdf	B
[Rec 43] Services must be designed and configured to deliver high quality patient care and training (may be		B

departmental, trust, regional, or national level but will require critical mass of professionals to maintain a viable service)	Appendix 4: Medical Workforce Advisory Group Terms of Reference	
[Rec 44] As the ratio of trainees to consultants changes with increasing consultant numbers, it may not be feasible to train in all hospitals	HEE Workforce Planning Guide 2013 http://hee.nhs.uk/wp-content/uploads/sites/321/2012/08/Workforce-Planning-Guide-Final-June-2013.pdf Workforce Plan for England - Proposed Education and Training Commissions for 2014/15 http://hee.nhs.uk/wp-content/uploads/sites/321/2013/12/Workforce-plan-UPDATE-interactive.pdf	B
5. Improving careers guidance and its availability		
6. Developing and integrating technology enhanced learning to improve training, patient care and safety		
[Rec 45] The coordinated, integrated use of simulation can provide a safe, controlled environment and accelerate learning	Appendix 4: TEL project plan	B
[Rec 46] Where appropriate, skills and expertise should be learnt in a simulation environment and from other modern techniques, not on patients		B
7. Improving the Foundation Programme **7.1 Curriculum Development**		
7.2 Improving Selection		
7.3 Harmonisation & Improved Delivery		
8. Regulatory…		
9. Funding and education quality metrics		
[Rec 47] Commissioner levers should be strengthened to incentivise training, ensure accountability and reward high quality and innovation	See report section 3.8	C
[Rec 48] Prioritise training in providers by linking training criteria to performance targets. training quality must be included in performance management processes		C
[Rec 49] Educational governance must be recognised on every trust board by the appointment of a person specifically responsible for education and training (in addition to a MD)		C
[Rec 50] Monitor the quality of training with a rational, realistic system that looks at a range of indicators to measure the impacts and outputs.		C
[Rec 51] Include training outcomes as part of the quality assessment of provider institutions.		C

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Appendix 1: Collins Recommendations

Key Descriptors

A	Fully met	B	Partially met	C	Remains under development

Workstream & Recommendations	Evidence	
2. Role of the Trainee		
[Rec 6] MEE should develop a consensus statement on the role of the trainee so NHS Trusts have a detailed understanding of the role of foundation doctors	A Charter for Postgraduate Medical Training: Value of the Doctor in Training http://www.aomrc.org.uk/doc_details/9750-a-charter-for-doctors-in-training-value-of-the-doctor-in-training	A
[Rec 7] The GMC should consider producing a guidance to support the development of professionalism among trainees	GMC Good Medical: Practice Professionalism in Action (para 1-6) Develop and Maintain Your Professional Performance (para 7-13) http://www.gmc-uk.org/guidance/good_medical_practice.asp	A
[Rec 27] The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility	GMC National Trainee Survey http://www.gmc-uk.org/education/surveys.asp	A
3. Role of the Trainer		
[Rec 19] Need a framework for the approval of trainers involved in teaching and assessing trainees	GMC Recognising and Approving Trainer: The Implementation Plan http://www.gmc-uk.org/Approving_trainers_implementation_plan_Aug_12.pdf_49544894.pdf	A
[Rec 21] NHS employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees*		A
[Rec 23] All FP assessments should be conducted and signed off by resourced, trained and regularly reviewed assessors	*Appendix 4* Foundation Programme Reference Guide 2012 • Supervised learning (para 2.3) • Foundation Training Programme Director/Tutor (para 5.25-5.29) • Educational supervisor (para 5.30-5.35) • Clinical supervisor (para 5.36-5.41) • Educational framework for Foundation Programme (para 8.1-8.6) http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 27] The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility	GMC National Trainee Survey http://www.gmc-uk.org/education/surveys.asp	A
4. Workforce Planning		
[Rec 17] Distribution of foundation posts across broader base of specialties	Broadening the Foundation Programme (Chapter 4) http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V15-Final.pdf	A

5. Improving careers guidance and its availability		
[Rec 11] All of the organisations must work together to define good practice for the provision of careers information and advice	*Appendix 4:* Careers Planning Group ToR & Minutes BMJ Careers Article: Publication of Competition Ratios for Specialty Training http://careers.bmj.com/careers/advice/view-article.html?id=20015362 College of Emergency Medicine: Careers promotional material http://secure.collemergencymed.ac.uk/Training-Exams/Training/Applying%20for%20Specialty%20Training NHS Medical Careers https://www.medicalcareers.nhs.uk/ BMJ Careers Fair – Career Advice Exhibit	B
6. Developing and integrating technology enhanced learning to improve training, patient care and safety		
[Rec 18] Need for more widespread use of technology to support learning	Appendix 4: TEL Programme Projects Appendix 4: TEL Central Plan	B
7. Improving the Foundation Programme **7.1 Curriculum Development**		
[Rec 1] MEE should confirm the purpose of the Foundation Programme	Foundation Programme Curriculum 2012 Page 8 http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment/fpcurriculum2012	A
[Rec 2] The GMC should define the outcomes required to complete F2	Foundation Programme Curriculum 2012 Syllabus Page 13-50 http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment/fpcurriculum2012	A
[Rec 15] The FP curriculum should be revised to place greater emphasis on the total patient, long-term conditions, community care and changing ways of working	Foundation Programme Curriculum 2012 Chapter 10 http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment/fpcurriculum2012 Broadening the Foundation Programme Para 10.1 http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V15-Final.pdf	A
[Rec 15] The FP Curriculum should integrate fully with medical school curricula	Currently the FP Curriculum is not fully integrated with the medical school curricula due to each medical school having individual curricula GMC Tomorrow's Doctors synchronised with the FP Curriculum	C
[Rec 20] Streamlining of assessment in FP	Appendix 4: Supervised learning event (SLE) and end of placement forms	A
[Rec 22] Patient feedback should be part of foundation doctor assessment	Appendix 4 – Collecting Patient Feedback on Foundation Doctors Final Report	A
7.2 Improving Selection		
[Rec 4&5] Improving selection Improving selection into FP	FP/AFP 2014 Applicant's Handbook http://www.foundationprogramme.nhs.uk/pages/medical-students/how-to-apply SJTs Applicants Guide http://www.foundationprogramme.nhs.uk/pages/medical-students/SJT-EPM	A
7.3 Harmonisation & Improved Delivery		
[Rec 9] The FP should remain 2 years with review in 2015	Foundation Programme Curriculum 2012 http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment/fpcurriculum2012	A
[Rec 10] FP placements must be for a minimum of four months and a maximum of six months	Foundation Programme Reference Guide 2012 Para 4.5 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.	A

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[Rec 10 &14] The length, content and organization of the rotational programme must be clearly disclosed in foundation school materials	PDF	A
[Rec 12&14] Greater flexibility in allocation of F2 including "swap shops"	Foundation Programme Reference Guide 2012 Para 7.11 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 12] F1 and F2 should remain generic	Foundation Programme Reference Guide 2012 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 12] F2 placements should be aligned, as far as possible, with broad areas in which trainees hope to pursue their careers	Foundation Programme Reference Guide 2012 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF Broadening the Foundation Programme (Chapter 4) http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V15-Final.pdf	A
[Rec 13] Must address mismatch between expectation and reality about career prospects in different specialities	Foundation Programme Reference Guide 2012 Para 5.35, 8.42-8.43 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 13&16] Successful completion of the FP should normally require completion of a placement in the community eg. Community paediatrics, general practice, psychiatry	Foundation Programme Reference Guide 2012 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF Broadening the Foundation Programme (Chapter 4) http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V15-Final.pdf	A
[Rec 17] Distribution of foundation posts across broader base of specialties	Broadening the Foundation Programme (Chapter 4) http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V15-Final.pdf	A
[Rec 23] All FP assessments should be conducted and signed off by resourced, trained and regularly reviewed assessors	*Appendix 4:* Foundation school director's committee meeting (17.01.13) Confirmation all 25 foundation schools had provided training on the FP Curriculum 2012 Foundation Programme Reference Guide 2012 • Supervised learning (para 2.3) • Foundation Training Programme Director/Tutor (para 5.25-5.29) • Educational supervisor (para 5.30-5.35) • Clinical supervisor (para 5.36-5.41) • Educational framework for Foundation Programme (para 8.1-8.6) http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 24] Healthcare professional and employers must understand FP objectives, become quickly conversant with their prior experience and level of competence and ensure that no foundation doctor practices beyond their level of competence or without appropriate supervision	Foundation Programme Reference Guide 2012 Para 8.50 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF Letter to NHS Employers re: removal of the term "SHO"	A
[Rec 25] The FP structure should ensure a more even	Appendix 3 – Pilot projects	A

demand on clinician time for teaching and supervision		
[Rec 28] Ensuring appropriate balance between service and education with right of redress by trainees (rec 28)	Foundation Programme Reference Guide 2012 Para 8.50 http://www.foundationprogramme.nhs.uk/download.asp?file=Reference_Guide_2012_WEB_Final_August_2012.PDF	A
[Rec 31&32] Transfer of relevant information about medical students and trainees across the continuum of education and training	National Transfer of Information http://www.foundationprogramme.nhs.uk/download.asp?file=TOI-Guidance-for-medical-students.pdf	A
8. Regulatory approach to BTBC		
[Rec 2] The GMC should define the outcomes required to complete F2	Foundation Programme Curriculum 2012 Syllabus Page 13-50 http://www.foundationprogramme.nhs.uk/pages/foundation-doctors/training-and-assessment/fpcurriculum2012	A
[Rec 7] GMC should consider producing guidance to support the development of professionalism among trainees	GMC Good Medical: Practice Professionalism in Action (para 1-6) Develop and Maintain Your Professional Performance (para 7-13) http://www.gmc-uk.org/guidance/good_medical_practice.asp	A
[Rec 8] GMC should review the timing of full registration, student registration, marking completion of the FP	On-going review but currently there are no plans for registration to mark the completion of the Foundation Programme as no benefits have yet been realised	A
[Rec 26] GMC must ensure that standards for training for the FP relating to patient safety are understood by foundation school directors and NHS employers	GMC Quality Improvement Framework http://www.gmc-uk.org/Quality_Improvement_Framework.pdf_39623044.pdf	A
[Rec 27] GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility	GMC National Trainee Survey http://www.gmc-uk.org/education/surveys.asp	A
[Rec 30] GMC should describe good practice for pastoral support	GMC National Trainee Survey http://www.gmc-uk.org/education/surveys.asp	A
[Rec 33] Medical schools should explore how best to share information with the GMC about medical students	GMC position – Medical student registration http://www.gmc-uk.org/20111025_Student_registration.pdf_45213188.pdf	A
9. Funding and education quality metrics		
[Rec 25] MEE should explore the factors required for quality supervision, including time	NACT UK Faculty Guide http://www.gmc-uk.org/Faculty_Guide_Oct13.pdf_53817349.pdf	C
[Rec 29] Trusts must identify educational lead	Report Section 3.8	A
[Rec 29] Need for quality metrics available at deanery, programme and hospital level (GMC)	Report Section 3.8	C

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Appendix 2: Inspire Improvement! Projects

No.	Inspire Improvement Project	Trust	Overview	Achievements
1	Barriers to Effective Discharge	Whipps Cross University Hospital, Barts Health NHS Trust	'Barriers to Effective Discharge: Breaking the Bottleneck' is a pilot teaching programme that has been introduced in 2013-14 at Whipps Cross Hospital at Bart's Health Trust, London and the Royal Lancaster Infirmary Hospital, Lancaster. The programme teaches FY1 doctors the process of discharge planning, continuation of care in the community and inter-disciplinary team working. The consultants and other members of the multi-disciplinary team have delivered the pilot with teaching material from case based learning theory with an overview from senior clinicians. There have been five sessions that will commence in August- December 2013. This aim is for this project to form part of the mandatory Foundation Programme teaching schedule.	Project in progress
2	Confusion App	North Cumbria University Hospitals NHS Trust	This pilot set out to develop a smartphone app that explored the topic of confusion based on delirium and dementia. The app has been designed as teaching aid and bedside reference guide to provide information on cognitive assessment methods, interactive sections, patient	The success of the app amongst peers across the country, particularly for a project from a small team within a district general hospital. The main success factor has been the use of social media, which has allowed the app to spread via word of mouth particularly as cognitive impairment is currently a very topical issue. For trainees: The use of hand held resources for assessing cognitive

			medication review assistance and example case studies for reinforcement of knowledge. On completion of a case study and evaluation, a certificate is obtained to evidence curriculum learning. The project has developed an iPhone and Android. The app will also be useful for other healthcare professionals.	impairment, and aiding their day to day work. All the doctors asked via questionnaire reported the app was easy to use and the scenarios were helpful. All the doctors found improved knowledge of the topic after using the app. A case study available to work through with certificate on completion that can be linked to the e-portfolio was also a training tool provided with the app. For patients: To improve the quality of patient care and clinical outcomes. For the multidisciplinary team (MDT): This project helped to identify cognitively impaired patients and allowing their needs to be presented to the MDT earlier in order to prevent adverse events
3	Shadowing and Peer Mentoring: Avoiding Grey Wednesdays	University Hospitals Coventry and Warwickshire NHS Trust	Following the success of a Department of Health initiative, where a shadowing programme for new foundation doctors prior to commencing their role as FY1 was introduced, an unmet need for improving handover during further rotations throughout the year was identified. The Grey Wednesday's project aimed to develop FY1 inter-rotation shadowing and peer mentoring to improve patient safety, junior doctor competence and the clinical learning environment. Foundation year one trainees are therefore more prepared for their rotations, identifying learning requirements and fulfilling their training needs earlier. The project was piloted in the Coventry and Warwick Foundation School and has scope to develop into a regional/national	This project demonstrates that inter-rotation shadowing generates statistically significant improvements to patient safety, quality of care and trainee learning. Such benefits have enabled the project to progress forward to both regional and (in progress) national adoption at incredibly low financial costs. For Trainees: Inter-rotation shadowing ensures that trainees are more confident about changing rotation, are better prepared to change rotation, learn from changing rotations and identify learning points of relevance to their training in general. It ensures trainees can deliver safe care to patients whatever day that patient arrives to hospital. For Trainers: This inter-rotation shadowing project demonstrates to trainers that trainees can take the initiative to develop patient safety themselves as the trainees in this project organise the shadowing days themselves at a time appropriate to the ward they are on. It further demonstrates as with many of the BTBC project that trainees are capable of designing and leading simple effective innovations that benefit the NHS

			programme. The greatest achievement of this project has been demonstrating that inter-rotation shadowing generates statistically significant improvements to patient safety, quality of care and trainee learning. Such benefits have enabled the project the project to go forward for both regional and (in progress) national adoption at incredibly low financial costs.	For patients: At the most basic of levels this project enables patient safety. This project (coupled with earlier work on Black Wednesdays by the NHS) ensures that whenever patients present to hospital they can be treated by a doctor who is prepared for the rotation they are currently on. It ensures safe levels of care by a team who have achieved the basics- eg meeting one another! There are also benefits to patient flow through our hospitals.
4	The Handbook	Aintree University Hospitals NHS Foundation Trust	The handbook project aimed to remove the feeling of "I wish I had known that before I started", to aid junior doctors during their transition period from one department/rotation to another. Changing rotations throughout training can be a stressful time as new challenges are faced whilst still maintaining patient care. The transition forms created by junior doctors help to provide information relevant to the rotation for the new incoming doctors. This will aid a swift transition by making them more comfortable and confident in their new rotations and aiding them to maintain a high level of clinical care. The handbook provides a secure online web portal for the submission of transition forms produced by the outgoing doctors. Junior doctors are able to view the transition forms for all	Taking an idea from personal experience and feedback from colleagues, developing this in to a project with the support of the Trust and other team members, then implementing and achieving a sustainable project that does benefit trainees has proven successful. Although a small scale project, The Handbook does work and can be adopted within other Trusts. Support from the Trust and seniors has been vital to successfully implementing the project as well as determination and committing a lot of personal time to it outside of work to keep the project rolling and moving forward. For trainees: Improved transition of junior doctors during clinical rotation changeovers Online portal, accessible throughout the Trust containing relevant and useful information to help the trainee on a day to day basis Easily editable so is up to date with correct information at time of each changeover For trainers: A location to place information they wish trainees to be able to access/read, relevant to their postgraduate training. For Patients:

			departments via the trust intranet system and provide suggestions/recommendations to ensure information is kept up-to-date, particularly at the end of the rotations. Examples of the information provided include: how to complete tasks, who and where to contact relevant staff and ward round information as well as many other helpful tools. All junior doctors are to be involved with the system, creating a self-sustaining programme. Each year a junior doctor will be selected via an application process to co-ordinate the system. They will be required to maintain the completeness of the system, ensuring that forms are submitted and the online portal is kept up to date.	Trainees are able to focus more time towards patient care as they understand their role on the ward and feel confident in their new working environment. Value: The project is free to run and maintain providing value for money. The project also saves the Trust money as The Handbook has replaced the previous paper based junior doctor introductory booklet.
5	Micro-Surgical Training at Resident	Guy's and St Thomas' NHS Foundation Trust	Evidence shows that simulated training on low fidelity models in microsurgery is an effective intervention that leads to acquisition of transferable skills and improved technical performance. This project has been designed to provide a structured training programme at home allowing trainees to practice relevant skills with their available resources at home. Several models of practice have been designed including tablet, microscope and loupes. Practice is further enhanced through obtaining regular feedback from	For trainees: Home and lab-based training groups both demonstrated statistically significant improvement between baseline and post-training performances. Observed consistent improvement of skills in trainees using a tablet device compared to lab training, which displayed a wider level of skills attained. This means more of the trainees in the tablet-trained group were able to achieve competencies compared to lab training group in the time period. The data supports the use of tablet training in early phases of microsurgery skills to be as efficacious, if not better, than lab training. For trainers: The tablet devices are not the perfect models for training. However, the versatility of the device makes it suitable adjunct to training in the modern NHS. Trainees and trainers are no longer confined to a specific location or time

			experts, or clinical learning mentors.	commitment, as equal results can be achieved with either methods. Modern tablets offer recording facilities, thus the trainer is able to view, assess and provide feedback on trainees practice sessions, at anytime, anywhere. Thus, making training easier and accessible for both. Furthermore, the opportunity of video recordings can be uploaded and provided as evidence in trainee's portfolio. For patients: The aim of the project was to improve the quality of training. Better training, better care. Considering the current political direction of consultant led care, trainees will be able to develop and maintain skills without compromising patient care.
6	'Move, Eat, Treat' – How to Deliver Effective Lifestyle Advice	Oxford University Hospitals NHS Trust	Effective lifestyle advice and evidence-based behavioral techniques is poorly taught at medical school and is underutilized in practice. The "Move, Eat, Treat – How to Deliver Effective Lifestyle Advice project aimed to equip Oxford Deanery Trainees with a toolbox of core skills required to deliver a broad range of effective lifestyle advice and evidence-based behavioral techniques to patients with a particular focus on diet, exercise, smoking, alcohol and sleep. Small teaching sessions are planned to be provided through the formal foundation teaching programme over a two year period, provided by junior doctors from FY1 through to registrar level. All trainers will attend a training day to obtain the required	Twenty junior medics received teacher training and concrete teaching experience, as well as an in-depth understanding of the subject. Significant improvements in knowledge and confidence of learners about lifestyle advice was evident through the evaluation, which will translate into positive changes in patient care. Critical Success Factors Funding from HEE. Credibility through endorsement by HEE. Fantastic support, advice and opportunities from HEE relationship manager A great team in Oxford. Support from the Trusts, Deanery and Oxford University. Clear goals which we were all passionate about. For trainees: We gave 20 junior medics teacher training and concrete teaching experience, as well as a deep understanding of the subject. Delivered teaching to FY1's and FY2's at 4 of 5 Trusts in the Oxford Deanery. Achieved statistically significant improvements in knowledge and confidence about lifestyle advice delivery among the

			teaching material. In addition to equipping trainees with skills for their whole career, this teaching will help doctors to see the role of lifestyle in disease from a new perspective and encourage gradual cultural change towards prevention of illness via effective management of patients' lifestyles.	learners, therefore equipping them with new skills which will improve the quality of care they can deliver to patients For trainers: Delivered part of the Foundation Programme teaching curriculum which reduced the workload for the Foundation Training Programme Directors in those Trusts. Teaching was more innovative and interactive than normal foundation programme teaching, and therefore added additional value to the Foundation Programme teaching programme. In our capacity as trainers, the project team developed valuable time management, financial management and personnel management skills. For patients: Lifestyle-driven chronic disease is a huge source of suffering for patients and we hope that the trainees we taught will be more effective at working with patients to improve their lifestyles (stopping smoking, reducing ETOH, exercising etc.), which will significantly improve patient health and hopefully alleviate suffering. Value for money: Lifestyle-driven chronic disease has been described as healthcare's equivalent of climate change by the Department of Health's Director for Long Term Conditions. Diabetes already accounts for 10% (more than £10bn) of the NHS budget and this is set to worsen. Therefore, we believe that interventions such as ours, which have the potential to reduce the burden of chronic disease, are vital to the future financial viability of the NHS and therefore provide significant value for money.
7	Training Professionals	King's College Hospital NHS Foundation Trust	The central goal of Training Professionals was to take the non-clinical training time junior doctors receive and convert it from a didactic, non-specific process into a learner centered,	For trainees: Developed a tool to enable professional development and focussed mentoring of trainees. The tool encourages trainees to behave in a professional manner and develop personal goals specific to their won career aims. The tool is simple to use, easy to adopt and readily available

			goal directed activity. The aim was to give trainees control over their learning whilst providing an improved level of individualised educational supervision. In order to facilitate this learning model, a structure for education was adapted from an industry tool.	for all medical specialities and other disciplines within the NHS. Produced a newsletter within the anaesthetic department that has encouraged sharing of project ideas, encouraged success and circulated opportunities for professional development. Explored the use of social media and websites to encourage trainee engagement. For trainers: The tool we have developed provides a useful method for supervisors to enable their trainee to develop goals and support them without the need of meeting face to face. Trainers can now produce evidence of fulfilment of their role for appraisal and revalidation. For patients: The tool will add to the appraisal and revalidation process enabling medical professionals to continue to maintain appropriate standards ensuring the continuation of public confidence in doctors. Value: Explored the use of freely available technology for use in medical education and shown that much software is currently available for use by medical educators to support trainees. Used less than half the money allocated to us. Looked at the use of websites and social media to disseminate information, including reviewing relative costs and benefits. This information is useful for other medical departments when considering investing in IT to promote projects.
8	Utilising Serious Games to develop the Decision Making Skills of Foundation Doctors: an implementation and evaluation study	University Hospitals of Leicester NHS Trust	Serious gaming (SG) is a new educational development area within medicine. Its ability to provide a virtual environment to practice decision-making in different clinical scenarios can be used as an innovative tool for the delivery of education. It has also shown to improve the decision-	

			making skills of undergraduate medical students. This project aimed to develop a DVD based video game to support the decision making by Foundation doctors and the project team monitored demand and feasibility to develop a web-based version. The game is based on pre-recorded film clips following a clear storyline from START Surgery course modules. The course material has been extensively piloted in London, Yorkshire, Humber and Leicester and feedback obtained from trainees in the early stages of generic medical training indicated a need for post course support consolidating new learning in a 'safe' environment. Developing a SG meets this need; making learning engaging, interactive and recognising the role new technologies play in the lives of trainee doctors.	Project in progress

9	Doctor's Toolbox	NW Thames Deanery	Trainees often find themselves frustrated by not being able to quickly find information for administrative tasks like how to make referrals, book investigations and contact other professionals in their hospital. In addition much of the knowledge trainee's gain throughout the year is lost when they rotate to another team or hospital. This has led to the development of the Dr Toolbox, an initiative that tackles the unmet need for retaining such knowledge, in order to facilitate better patient care during periods of junior doctor transition. Dr Toolbox is uniquely available through intranet, internet and smart phone platforms. As it is in 'wiki' format, simple updates are possible in minutes. They are made by 'editors'; trainees at individual trusts who build on the toolbox as part of their own safety project. Attending teaching is contingent on completing work safely and efficiently in rota'd hours. Being more efficient at arranging investigations and referrals allows the trainee more time both at the bedside with patients and achieving competencies.	For trainees: The Toolbox can be accessed via intranet, internet or offline app. A desktop link has been placed on hospital computers that further improve access. - Multiple ways of accessing Dr Toolbox- app, intranet, internet - More efficient administrative practice - More time to complete personal competencies, goals. Hopefully also enhanced patient care - A tried and tested way of sharing useful information with other trainees and facilitating quality improvement or patient safety projects For trainers - More efficient trainees, hopefully more engaged - Smoother administrative workings 'at the coalface' - Dr Toolbox template provides an educational tool for junior doctors to educate themselves about hospital services in a self-directed manner - Inspired trainees, hopefully more willing to engage with quality improvement For patients - More efficient trainees, hopefully more engaged. Jobs get done quicker and better. - Smoother administrative workings 'at the coalface' - Safer care by better quality referrals

Appendix 3: Workstream 1 pilot projects

Description of the Pilot Projects

	Pilot site	Description
1	Airedale NHS Foundation Trust (FT) & Western Sussex Hospitals NHS FT	The aim is to show telemedicine can be used over large geographical distances to: 1. Deliver direct patient care in out-of-hours and elective (satellite clinics)settings 2. Deliver training to healthcare professionals 3. Maximize training opportunities by using a network of hospitals for shared training. This is being delivered in 3 main locations and over 4 sites, with each main site focusing on different aspects of the objectives.
2	King's College Hospital NHS FT	The RAT system places a senior clinician at the beginning of the patient journey in the 'Majors' area of A&E, enabling early decision making and thus improving the quality of care and reducing the length of time spent in the ED. RAT+ places 2 consultants in the patient journey: one as part of the initial assessment team and the other working with doctors in training in the 'Majors' area, supporting their decision making, training and development.
3	Pennine Acute Hospitals NHS Trust (EPIC)	EPIC was designed as a 'game': doctors in training receive weighted credits for specific types of clinical work, WBAs, procedures and teaching. Doctors in training can access results to check their own progress and how they compare with their colleagues. They are awarded small prizes when they reach certain 'levels'. The aim is to motivate doctors in training working in A&E through competition and instant feedback, and to encourage them to engage in more formative educational learning from an earlier stage of their placements
4	East Kent Hospitals University NHS FT	This pilot project aims to improve training by enhancing supervision out of hours and at weekends. The project involves the creation of a new service model in medicine at the William Harvey Hospital in Ashford, Kent. Learning opportunities are maximised for doctors in training by rotating them through 'hot' and 'cold' teams: under the former they treat acutely ill patients under supervision without being pulled into wards; under the latter they are focussed on maximising learning through attending clinics, observing/practicing procedures, experiencing simulated environments and WBAs.
5	Pennine Acute Hospitals NHS Trust	The aim of this pilot project was to optimise training and education by giving doctors in training in the Infectious Diseases Department networked iPads to record a brief summary of any issues, actions planned, tasks already undertaken and any follow-up or review required for each patient. The consultant will have direct and detailed access to the progress of the on-call shift and the care of individual patients so they can follow up any serious issues or educational opportunities immediately and identify areas for group training sessions.
6	Mid Cheshire Hospitals NHS FT	The aim of this pilot project is to improve clinical handover, so that patients benefit from better continuity of care and Improved safety. The pilot project delivers enhanced training and education to medical doctors in training on what makes a good clinical handover, as well as introducing a new electronic handover tool on the acute medical unit. The tool enables staff to schedule and record the completion of clinical tasks electronically, patient lists, and ward and admission details. As well as supporting doctors in training with decision making and effectively recording and prioritising patients, the aim is to reduce the risks associated with paper-based handover. This was piloted on one

		ward before adoption by other wards.
7	Heart of England NHS FT	The aim of this pilot project is to enhance the transition from student to doctor, promoting excellence in safe patient care. To do this the pilot project uses an e-learning tool called VITAL. The STEPS programme provides improved mentoring during the shadowing week and support for doctors in training in difficulty. The initiative aims to 'make every moment count', using mobile technology enhanced learning, mentoring and support.
8	The Dudley Group NHS FT	The pilot project is based upon the ethos of a synergistic relationships fostered by having pharmacists and medics working and learning together, and is likely to be of huge potential benefit to training and patient care. This pilot project focusses on improving prescribing from the point of view of doctors in training and improving the understanding of the clinical context of prescribing from the point of view of young pharmacists. The idea is to get trainee/preregistration pharmacists and doctors in training learning together and developing closer working relationships on the wards as a result.
9	Leeds and York Partnership NHS FT	This pilot project focussed on a radical overhaul of the out-of-hours care pathway and working patterns to bring more doctors in training into daytime hours, where they can benefit from greater supervision and support. For doctors in training working out of hours WBAs are carried out by the multidisciplinary team so every last drop of learning can be extracted from the work that they do. The pilot project is also delivering an improved package of training focussed on enhancing key skills such as communication and clinical interviews and for undergraduate teaching.
10	Tees, Esk and Wear Valley NHS FT	This pilot project focussed on enabling doctors in training new to adult and old age psychiatry services to perform core tasks more quickly, and earlier into post. By reconfiguring posts each doctor has a 'home team' where they carry out the greater part of their clinical work and they then rotate to other teams to ensure they get access to the right mix of clinical experience. Doctors in training go through a familiarising 'green phase' followed quickly by a 'blue phase' where they complete a core list of psychiatric tasks in key areas (e.g. information gathering and processing, communications and prescribing). New processes for clinical supervisors mean they carry out WBAs with doctors in training for every patient encounter.
11	East London NHS FT	This pilot project aims to enable members of multidisciplinary teams to learn from simulated serious incidents. The training will be developed in-house using anonymised information from Trust internal serious incident reviews, which will inform the learning points included in the clinical simulation scenarios.
12	Royal Berkshire NHS FT	The pilot project 'Making Every Moment Count' aims to address the apparent gap between learning opportunities from every day recognised problems (e.g. working at the front line, from incidents or complaints) and how these translate into effective action and improvement change. Doctors in training across all specialities are encouraged to design and implement a quality improvement project with multidisciplinary team involvement to address these everyday problems
13	University Hospital of South Manchester NHS FT	This pilot project focussed on increasing learning and training opportunities for core surgical doctors in training by creating dedicated 'BTBC surgery lists' so doctors in training could undertake a variety of procedures and all aspects of surgery from pre-checks to postoperative care under direct supervision. The pilot project also delivered cadaveric skills workshops to allow doctors in training to develop skills in a safe environment and which could be transferred to the clinical setting as part of their training timetable.
14	Leeds Teaching Hospitals NHS Trust	This pilot project was aimed at advanced training and education in acute general surgery alongside normal surgical training through WBAs targeted to specific areas, a specially designed 'power wall' hosting an array of learning materials and cadaveric dissection to simulate surgical procedures.
15	Guys and St Thomas NHS FT	This modular training project was planned with rotation based on training modules, rather than traditional firm or

		service focussed cover. As a pilot project, the feasibility was tested in a specific core training module. Balancing excellent service provision with delivering first class training has remained a challenge since the introduction of the EWTD and MMC in specialties such as obstetrics and gynaecology. Provision of facilities, such as StratOG (the RCOG's online learning resource), regional training programmes and local teaching programmes has addressed this issue partially in the unit. With the traditional rota, exposure to various subspecialty modules within the specialty has been luck of the draw, with a few trainees spending 6 months in a particular subspecialty such as gynaecology oncology, and a few other trainees finishing their core training without having had enough exposure to or experience in all the modules in the RCOG curriculum.
16	North Bristol NHS Trust	The Video Assisted Consultation Programme pilot project uses video recording of the consultations of doctors in training as a training tool in the outpatients department. The pilot project aims to improve training in consultation skills and to investigate the use of video-recorded consultations as a training tool for specialty doctors in training in secondary care.

NHS
Health Education England

Appendix 4

BETTER TRAINING BETTER CARE TASKFORCE TERMS OF REFERENCE

INTRODUCTION

1. Better Training Better Care is an integrated programme that brings together several areas of Medical Education England's (MEE) work in a comprehensive overall plan to improve patient care and safety through provision of high quality medical education and training (referred to hereafter as training).

2. It has been developed at the request of the Secretary of State for Health to meet the aspirations, recommendations and key themes arising from Professor Sir John Temple's report *'Time for Training'*, Professor John Collins' review *'Foundation for Excellence'* and related initiatives.

BACKGROUND

3. The first report, Professor Sir John Temple's *'Time for Training*', looked at the impact of the European Working Time Directive on the quality of postgraduate medical training.

4. Sir John concluded that high quality training can be delivered in reduced hours but this is precluded when trainees have a major role in out of hours service, are poorly supervised and access to training is limited.

5. He emphasised that high quality training leads to professionals who deliver high standards of safe patient care but he said the traditional experiential model of learning had to change and that consultants needed to be more directly responsible for the delivery of care.

6. The second report, Professor John Collins' *'Foundation for Excellence'*, particularly highlighted the issue of some trainees being asked to practise beyond their level of competence and without adequate supervision.

7. The issues being raised in both of these reports were not new.

8. Secretary of State for Health asked Medical Education England (predecessor of Health Education England) to draw up an action plan that would address the issues that had been highlighted and to implement recommendations from both the Collins and Temple reports that would meet the aspirations for higher quality education and training and better, safer patient care.

9. This led to the development of the Better Training Better Care programme to look at the national and local aspects of both reports as well as related projects such as the Shape of Training and Shadowing.

PURPOSE OF THE TASKFORCE

10. The taskforce will oversee the work within the Better Training Better Care programme. The programme covers a number of projects, at both national and local level, and the Taskforce is responsible for the governance and outcomes of the work and for ensuring the Health Education England Board and the Medical Professional Board are kept regularly updated on progress.

AIMS AND OBJECTIVES

11. Oversight and governance of the national and local elements of the Better Training Better Care programme

12. Development and management of a work programme that considers each of the relevant reports (Wilson, Temple, Collins), deciding upon the appropriate recommendations to take forward and providing clarity where work is for others to lead

13. Ensuring a comprehensive overview of programmes related to Better Training Better Care, being sensitive to pre-existing governance arrangements for parallel initiatives such as the Shape of Training and Technology Enhanced Learning

14. To ensure that developing projects take into account Lord Patel's review of arrangements for the regulation of education and training

15. Avoid duplication of effort or work by considering each project and its current status in one of four ways:

    a. projects where solutions had already been developed but not implemented
    b. projects recognised as important but where work is already in development or is planned
    c. projects that can be developed within existing structures (not currently underway but could be started without major change required)
    d. 'blue sky' work – development work that has not already been considered e.g. cross-professional initiatives.

16. Successful implementation of recommendations in Professor Sir John Temple's '*Time for Training'*, Professor John Collins' '*Foundation for Excellence*' and Dr Ian Wilson's Medical Programme Board task and finish group report on maintaining quality of training in a reduced training opportunity environment – focusing on outcomes that deliver better, safer patient care and improved education and training for junior doctors

17. Ensure knowledge of, and alignment with, other projects that are closely related but do not fall directly within the Taskforce remit, e.g. Shape of Training

18. Regular reporting to the MEE Board via the Medical Programme Board to ensure all stakeholders are aware of development and progress.

SCOPE

19. There are a number of national programme elements, a number of local ones, and others that may require national work for local delivery.

20. A preliminary review of the three relevant reports (Wilson, Temple and Collins) suggests that themes can be broken down into a number of broad areas. It will be for the taskforce to take a formal view on the breakdown.

21. The national (including local delivery) elements, which all seek to improve patient safety and quality of care, can be divided into the following areas:

    a. Role of the trainee (national for local delivery)
    b. Role of trainers including educational supervisors (national for local delivery)
    c. Workforce planning (national for local delivery)
    d. Regulation (national)
    e. Funding and education quality metrics (national)
    f. Improving career guidance and its availability (national for local delivery)
    g. Technology enhanced learning (national for local delivery)
        - Using technology to facilitate support of training and clinical care
    h. Harmonisation and improving foundation training (national for local delivery):
        - Foundation Programme Curriculum development (national for local delivery)
        - Improving selection of trainees (national)
        - Harmonisation and shadowing (national for local delivery)
        - Reference guide development (national)
        - Prepare for 2015 evaluation (national)

22. The local elements can be broken down into two main areas:

    1. Improve training and learning to improve patient care:-
        - Appropriate supervision and implementing a consultant present service[1]
        - Service delivery must explicitly support training
        - Make every moment count:
          a. Planned and trainee-focused training

[1] The term 'consultant present' rather than 'consultant delivered' service has been used as this is the generally accepted terminology

b. Use all learning opportunities
c. Integrate use of technology to support learning

2. Delivery of revised UK Foundation Programme

22. While a major part of the Better Training Better Care programme will involve locally developed solutions to meet specific service and geographical needs, the clinical leadership of the national element of the work will be crucial, creating the conditions that will allow some of the change at local level.

MEMBERSHIP

24. The stakeholder groups represented on the taskforce are:

Name	Representation
Alastair Henderson	Chief Executive, Academy of Medical Royal Colleges
Anne Eden	Chief Executive, Buckinghamshire Healthcare
Arun Gupta	Director of Multi-professional Education, Cambridge University Health Partners
Ben Molyneux	Chair, Junior Doctors Committee, British Medical Association
Chet Trivedy	Academy Trainee Rep
Chris Butler	Chief Executive, Leeds Partnership NHS Foundation Trust
David Grantham	HR Director, Kingston Hospital NHS Trust
Derek Gallen	National Director, UK Foundation Programme Office
Elizabeth Manero	HEE Lay Representative
Iain Cameron	Chair, Medical Schools Council
Jacky Hayden	Postgraduate Dean
Justin Allen	Royal College of General Practitioners
Kirsty White	Head of Education Quality Assurance, General Medical Council
Lisa Bayliss-Pratt	Director of Nursing, HEE
Nigel Sparrow	National Clinical Advisor, Care Quality Commission
Paddy Woods	Deputy CMO, Northern Ireland
Sara Hedderwick	Deputy Chair, Consultants Committee, British Medical Association
Sarah Parsons	Medical Workforce Manager, NHS Employers
Sir Jonathan Michael (Chair)	Chief Executive, Oxford University Hospitals NHS Trust
Stewart Irvine	Director of Medicine, NHS Education Scotland
Tunji Lasoye	Director of Medical Education, Kings College Hospital NHS Foundation Trust
Paul Buckley	Director of Education, General Medical Council
Elizabeth Hughes	Chair, English Deans
Sonia Swart	Medical Director, Northampton General Hospital NHS Trust
Jonathan Foulkes	Associate GP Dean, Wessex
Terence Stevenson	Chair, Academy of Medical Royal Colleges

25. The project team members are:
    - Dr Alison Carr
    - Emma Scales
    - Heather Murray
    - India Peach
    - Megan Storey
    - Patrick Mitchell
    - Professor Stuart Carney

GOVERNANCE

26. The Better Training Better Care Taskforce will report through the Medical Programme Board to the main MEE Board.

MEETING ARRANGEMENTS AND FREQUENCY

2011	
Tuesday 12 July 10.00 – 13.00	The Old Library, Richmond House, 79 Whitehall, London SW1A 2NS
Wednesday 21 September 10.30 – 13.00	The Old Library, Richmond House, 79 Whitehall, London SW1A 2NS
Tuesday 13 December 10.30 – 13.00	TBA
2012	
Tuesday 6 March 10.30 – 13.00	TBA
Tuesday 12 June 10.30 – 13.00	TBA
2013	
January	
Tuesday 12 March 10:00-13:00	Boardroom,16th Floor, Portland House, London, SW1E 5RS
Tuesday 11 June 10:00-13:00	Piccadilly Room, 27th Floor, Portland House, London, SW1E 5RS
Tuesday 3 September, 10:00-13:00	
2014	
January	

27. The need for further meetings will be determined at a later date. Health Education England will provide the Secretariat for the above meetings.

WAYS OF WORKING

28. Members of the Taskforce may be asked to work on and complete actions assigned to them at Taskforce meetings to time and quality. This may require

additional meetings/teleconferences with sub-groups between meetings of the main Taskforce.

QUORUM

29. The quorum necessary for the transaction of the business of the Taskforce is 12 members, plus the Chair.
30. Where a member is unable to attend a meeting a nominated representative can deputise. Members are asked to inform the secretariat of their designated deputy.
31. Panel members must declare any conflicts of interest. Registered conflicts do not automatically result in exclusion from the Panel but will be managed by the Secretariat and the Chair.

Appendix 4

General Medical Council

Regulating doctors
Ensuring good medical practice

NHS
Health Education England

Sharing good practice on supporting trainers:
A GMC/HEE event

25 June 2013
10:30 – 13:30

The Burroughs Room
Wellcome Collection Conference Centre
183 Euston Road
London NW1 2BE

Attendance list

Organisation	Name	Position
Academy of Medical Royal Colleges	Ms Jo Penney	Education Manager
Academy of Medical Royal Colleges	Mrs Winnie Wade	Director of Education, Royal College of Physicians
Academy of Medical Sciences	Professor Edwin Chilvers	Professor of Respiratory Medicine
Academy of Medical Educators	Ms Julie Browne	External Relations Manager Wales Deanery, Academy of Medical Educators office
Academy of Medical Educators	Professor Alison Bullock	Director of the Cardiff Unit for Research and Evaluation in Medical and Dental Education

Organisation	Name	Position
Association for Simulated Practice in Healthcare	Mrs Lesley Scott	ASPiH/HEA National Simulation Development Lead
COPMeD	Professor Derek Gallen	Chair
East of England Deanery	Professor John Howard	Head of Primary and Community Care, GP Dean
Faculty of Medical Leadership and Management	Mr Peter Lees	Founding Director
Faculty of Surgical Trainers	Mr Craig McIlhenny	Surgical Director
General Medical Council	Ms My Phan	Education & Standards
General Medical Council	Mr Paul Buckley	Director of Education and Standards
General Medical Council	Dr Vicky Osgood	Assistant Director Postgraduate Education
General Medical Council	Mr Ben Griffith	Policy Manager, Education & Standards
General Pharmaceutical Council	Mr Damian Day	Head of Education and Quality Assurance
Health Education England	Mr Patrick Mitchell	Director of National Programmes, Medical Education
Health Education England	Dr Lisa Bayliss-Pratt	Director of Nursing

Organisation	Name	Position
Health Education England	Mrs Heather Murray	Business Manager
Health Education England	Dr Alison Carr	Senior Clinical Advisor re BTBC
Health Education England	Ms Megan Storey	Communications Manager
Health Education England	Mr Chris Munsch	Senior Clinical Advisor re BTBC
KSS Deanery	Professor David Black	Dean Director
Medical Schools Council	Dr Katie Petty-Saphon	Executive Director
NACT UK	Dr Claire Mallinson	Chair
NES	Professor Gillian Needham	Postgraduate Medical dean
NHS Employers	Miss Sarah Parsons	Medical Workforce Manager
NHS Employers	Mr Bill Macmillan	Head of Medical Pay and Workforce
NIMDTA	Dr Claire Loughrey	Director of Postgraduate General Practice Education
NMC	Mrs Anne Trotter	Standards Compliance Manager
Wessex Deanery	Professor Johnny Lyon-Maris	Associate Dean for GP Education Southampton, SW Hampshire and The Channel Islands

Part 1: Chair – Paul Buckley, GMC

Introduction

1. Paul Buckley opened the meeting. The intention was to share good practice recognising that trainers need proper recognition particularly in a challenging financial environment.

Dr Vicky Osgood, GMC: Recognising and approving trainers

2. Dr Osgood pointed out that the GMC formally approves GP trainers and has developed a system for recognising other trainers, fitting with the Better Training, Better Care (BTBC) programme and adopting seven areas from the *Framework for the Professional Development of Postgraduate Medical Supervisors* published by the Academy of Medical Educators (AoME). The GMC has obtained timelines for implementation from the Education Organisers (medical schools and postgraduate deans) and will publish these with an overall summary.

Winnie Wade, AoMRC: The contribution of the Royal Colleges and Faculties

3. Winnie Wade described the role of the Academy and its constituent Royal Colleges and Faculties. There is a wide range of approaches to supporting trainers through courses, conferences and resources with a particular focus on the role of Educational Supervisors and Clinical Supervisors and their need for continuing professional development. Trainers need to consider their skills and take learning points away from training sessions and the RCP's system of Educational Supervisor Accreditation is designed in that spirit. We need to achieve a level of consistency and make sure that all the seven areas are addressed in training and reflection. While the time made available for training is challenging, there is a real opportunity to improve its quality.

Professor Derek Gallen, COPMeD: Recognising trainers

4. Professor Gallen pointed out that, as with the approval of GP trainers, we are on a journey in developing systems for recognition. We need to ensure that trainers' role and skills are reflected in job plans. Trainers can be keen to attend training events, partly due to revalidation, and it is important to maintain that momentum. All the deans have arrangements in place with a variety of approaches to recognition. Training events can disseminate substantial information quickly and the deans see CPD as making a key contribution. It is also important to obtain feedback from trainees and to reflect training responsibilities in job plans. The GMC should acknowledge the deans' progress and review it again in a year. The work on educational environments will also be important.

Craig McIlhenny, Faculty of Surgical Trainers: Supporting surgical trainers

5. Craig McIlhenny said that the Faculty of Surgical Trainers (FST) now has 470 trainers signed up, 18 months after its formation. But awareness of the recognition process and the seven AoME domains is limited. The FST has modified the descriptors in the AoME documents and identified surgical sources of evidence, also adding aspects eg to incorporate a safety checklist. *Standards for surgical trainers* have been published alongside a trainer's journal that incorporates feedback forms, a prompting structure for reflective notes and a documents library. The proposals will be subject to a Delphi consultation and piloting.

6. In response to questions, Mr Ilhenny confirmed that the FST is open to all surgeon trainers. He felt that revalidation had provided an impetus but also trainers were frustrated with the quality of surgical training and it was important to provide practical resources to keep trainers engaged. The resources should be helpful both in 'high density' and 'low density' training.

7. Vicky Osgood explained that the recognition requirements apply only to specific categories of undergraduate trainers and Named Educational Supervisors and Named Clinical Supervisors. The process is open to other 'sessional

supervisors' on a voluntary basis. Where trainers are HEI employees, evidence of their training activities should be considered through their HEI appraisals.

8. Bill Macmillan pointed out that appraisals need to be carried out effectively, cover Personal Development Plans, involve reflection and result in change in practice which includes training.

Part 2: Chair – Patrick Mitchell, HEE

9. Patrick Mitchell pointed out that Trust Boards and Chief Executives often give less attention to training compared to clinical care, research and commercial income. So we need to consider how to raise the profile of training and support trainers. The role of trainers is one stream under the BTBC programme now run by HEE. The GMC has provided the 'what' in the recognition of trainers. HEE has commissioned the Academy of Medical Educators to provide the 'how' in *The Essential User Guide to Recognition of Training in Secondary Care*, NACT UK has considered the learning environment through *The Role of the Environment on Postgraduate Medical Training* and the Faculty of Medical Leadership and Management is looking at the change needed in culture and behaviour.

Professor Alison Bullock, Academy of Medical Educators: Domains and descriptors

10. Professor Bullock set out various visualisations of domains and descriptors. She discussed the development of standards by the Academy of Medical Educators (AoME) and COPDEND as well as the seven areas originally developed for AoME by Tim Swanwick and adopted by the GMC. The structure of seven areas does not bring out core values explicitly or provide a model for trainer development. There is also some difference in domain content, for example the seven areas do not cover educational management. There are many potential sources of evidence but key are the perspectives of the learners and of peers or colleagues as well as CPD records and reflection. The structure of Reflections in Clinical Experience (RICE) developed at Cardiff provides a model. Questions include the impact of recognition, how best to share good and interesting practice and what further support is needed.

Dr Clare Mallinson, NACT UK: Supporting faculty

11. Dr Mallinson discussed the new document on *The Role of the Environment in Postgraduate Medical Training*. Four key elements are the learning culture in the workplace, the arrangements for supporting individual trainees, the department faculty group and safe service provision. The faculty should be seen as extending beyond medical consultants and covering all those involved in training including service managers. Leadership is required in departments with clinical tutors working closely with business managers, not allowing educational contracts to gather dust. A supportive environment with effective feedback is essential.

Peter Lees, Faculty of Medical Leadership and Management: Promoting cultural

change

12. Peter Lees feared that training will not get the priority it needs in the harsh financial climate and its budgets may be raided. Training and service appear to be in parallel universes. Service managers cast aspersions on whether training is fit for purpose. It needs to be understood that effective training takes time. Happy staff will put in discretionary effort but trainees do not feel valued. We need to demonstrate that better training leads to better patient care and clinical outcomes.

Discussion

13. Dr Katie Petty-Saphon asked how we can ensure that money intended for training is spent properly. Dr Lisa Bayliss-Pratt said it was important to develop transparency in resources. Patrick Mitchell pointed out that we are in a transitional phase and that cultural change is needed as well.

14. Professor David Black was concerned about standards and consistency, for example if arrangements develop differently across specialties and postgraduate training areas. Dr Bayliss-Pratt foresaw a more consumer-driven approach whereby the key players take the lead in defining what is most needed.

15. Bill Macmillan stressed the need for effective job planning and setting objectives for CPD as well as providing time for training. Professor Michael West's research on appraisal was very powerful.

16. Julie Browne was concerned that the extended faculty were not covered by the seven areas. The areas did not provide a good structure for educational researchers and managers. Vicky Osgood explained that the GMC had adopted the seven areas in a pragmatic spirit to create a starting point.

17. Professor Edwin Chilvers stressed that trainee doctors are not happy and often leave the UK after the Foundation Programme.

18. Dr Osgood saw scope for more work to ensure that appraisal covers educational roles effectively so that educational supervisors and clinical supervisors can demonstrate their ability. Dr Mallinson said the NACT UK document provided a resource to help with appraisals.

19. Professor John Howard argued that it should be possible to mandate hours required for training. It is important to strive for consistency but there is still inconsistency even in GP training.

20. Professor Gallen said that the GMC as the regulator should set out what is expected in relation to appraisal and job planning. Professor Chilvers asked whether it was appropriate for the GMC to lead. Patrick Mitchell said the various bodies needed to work together. Paul Buckley agreed and stressed the importance of

developing an evidence base on the link between education and patient care.

21. Anne Trotter reported that the NMC have standardised arrangements for training. There are opportunities to develop an interprofessional approach. Damian Day pointed out that for pharmacists most placements are in private firms which will invest in training but need incentives to do so.

22. Winnie Wade said that trainees need to value education more highly. Patrick Mitchell said that a BTBC pilot in Reading had demonstrated the potential impact of trainee involvement in quality management. Peter Lees said that education needs to be seen as a corporate pursuit. Bill Macmillan said that trainees were disengaged from the corporate perspective. Professor Gallen pointed out the trainees do not always recognise educational activities such as feedback. Educational contracts are important. Patrick Murray said that the BTBC pilot sites demonstrated that a systematic approach tied to the curriculum could help to engage trainees.

23. Dr Mallinson said that administrative support for trainee doctors and physical spaces for training were also important.

24. Patrick Mitchell pointed out that a range of issues had been raised and important initiatives had been described. He asked participants to feed back proposals for next steps. HEE, the GMC and other organisations could then consider the way forward.

Appendix 4

HEE Medical Workforce Advisory Group

Meeting Date	10 September 2013
Report Title	'MWAG' ***DRAFT*** Terms of Reference
Paper Number	MWAG02
Report Author	HEE Planning and Info Team
Lead Director	Jo Lenaghan/Wendy Reid
FOI Status	-

Report Summary	**Initial terms of Reference for 'MWAG'**
Purpose	Discussion and approval
Recommendation	

Medical Workforce Advisory Group Terms of Reference – Draft 10th Sept 2013

1 Context

HEE is committed to developing an integrated and multidisciplinary approach to workforce planning which:

- recognises the need to determine medical education commissions alongside and in the context of competing priorities;
- balances local and national priorities;
- provides a forum for expert advice to HEE which supports HEE in its accountability for the investment decisions that will be made.

HEE's review of advisory structures has resulted in a new governance structure designed to ensure:

- clarity about where responsibility for decisions lie;
- that HEE as the accountable body is informed by the advice and expertise that exists in the system;
- with a better connection between local workforce requirements and national policy and advice;
- and a better connection between decisions and actions (LETBs and HEE as vehicles for action);
- resulting in reduced duplication of effort and illusory powers;
- and which recognises the necessity to determine medical education commissions alongside and in the context of competing priorities.

In the new system, the HEE Senior Leadership Team (consisting of all LETB Managing Directors and HEE National Directors) will collectively determine medical education commissions for the 2014 intake and subsequent years.

The Medical Workforce Advisory Group (MWAG) will support this process.

2 Functions

The functions of this new Advisory Group are:

- to assess the available intelligence on future supply and demand for medical staff;
- to make recommendations to HEE Senior Leadership Team (SLT);
- to review and monitor, on behalf of HEE, implementation of actions agreed by SLT.

3 Membership

The Medical Workforce Advisory Group has been established with a membership which:

- Reflects the pivotal role of medical Royal Colleges (through the inclusion of representatives nominated through the Academy of Medical Royal Colleges, and through specific invitations to individual organisations as and when required/requested);

- Ensures staff representation (through the inclusion of representatives from the BMA);
- Preserves 'organisational memory' and so ensures a safe transition to the new system (through the inclusion of members of the pre-exiting Joint Working Group on Medical Specialty Numbers (JWG));
- Recognises the role of the DEQs, national planners and HEE Deans in the new HEE Governance and Advisory structures and ensures provider representation in the provider-led system (through the inclusion of staff of HEE's LETBs).

The current membership is at Appendix 1. This includes 5 'standing' representatives from the medical Royal Colleges nominated through the Academy of Medical Royal Colleges. Standing membership will be reviewed annually in April (at the beginning of the annual workforce planning/education commissioning process).

As MWAG develops as an expert group fielding of Deputies will be discouraged, although it is understood this may be necessary in the early stages of the group.

Each year in January MWAG will agree its work programme for the year ahead and colleagues from relevant organisations will be invited to attend particular meetings of MWAG.

Further details on the planning round are set out in HEE's national Workforce Planning Guidance available at

http://hee.nhs.uk/work-programmes/workforce-planning/

4 Meetings

- Meetings will usually be held in London at the offices of HEE.
- Dial-in and VC facilities will not be deployed as the business of the meeting will require focussed discussion of complex issues and detailed data.
- Meetings will be scheduled around the key points in the annual planning round. A provisional schedule of meeting dates is at Appendix B.

5 Papers and outputs

- The agenda and relevant papers will be circulated a week in advance of each meeting.
- Further papers and presentations will be tabled at meetings where MWAG needs to hold initial conversations 'in camera' and be assured of confidentiality.
- The minutes style will be brief focussing on a summary of main points from discussions, agreed outcomes and required actions, owners and timescale

6 Secretariat

The Secretariat will be provided by the HEE Strategy and Planning Directorate.

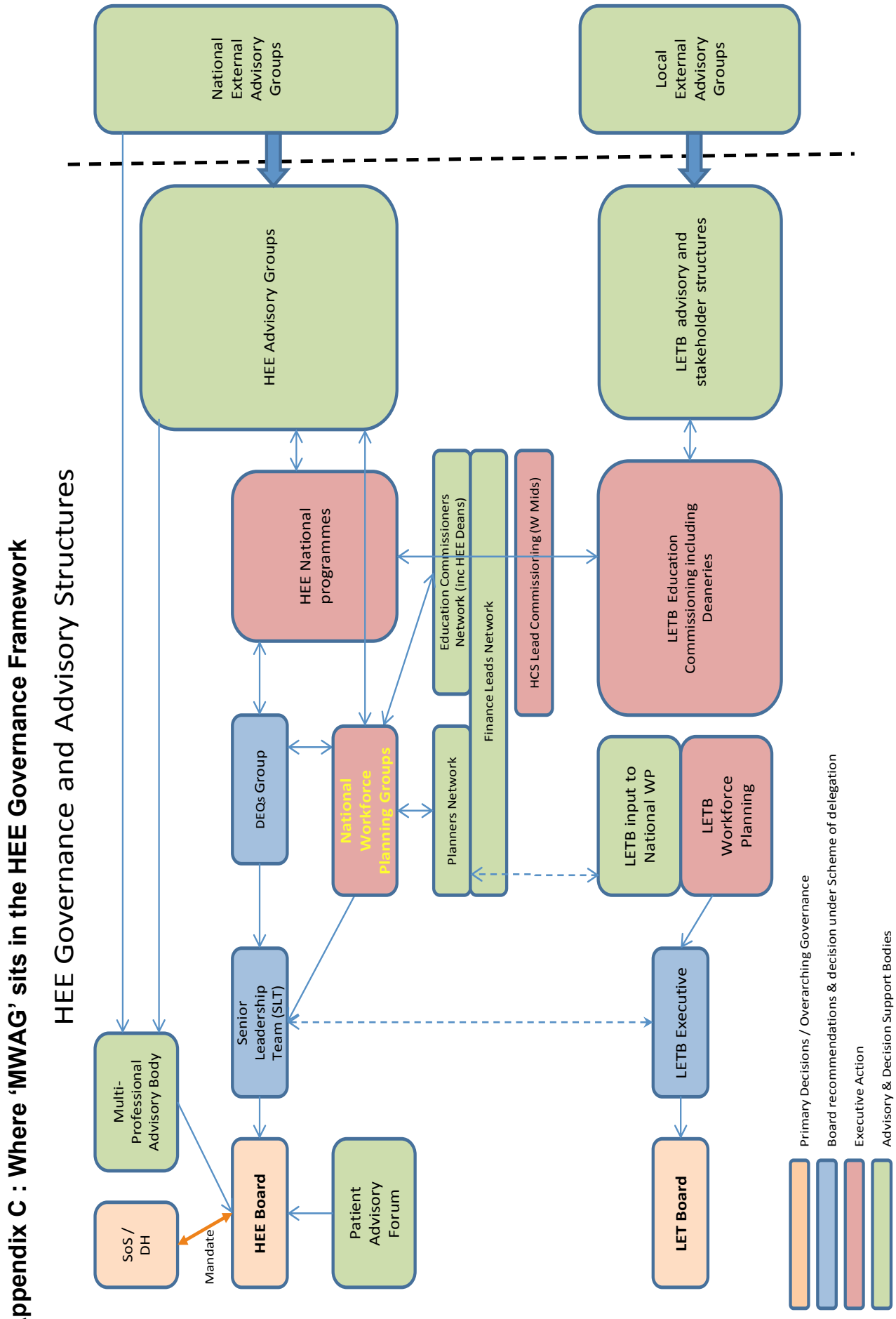
Appendix A – HEE Medical Workforce Advisory Group Membership (10/09/13)

Wendy Reid (co-Chair)	HEE Medical Director
Jo Lenaghan (co-Chair)	HEE Director of Planning and Strategy
Alison Crombie	DEQ, HE Kent, Surrey & Sussex
Dr Andrew Goddard	Workforce Lead, Royal Coll. of Physicians of London
Ben Molyneux	Chairman Junior Doctors Committee, BMA
Bill McMillan	Head of Medical Pay, NHS Employers
Chris Fowler	MD, HE North Central and East London
Mr David Ward	Vice President, .Royal Coll. of Surgeons of England
Derek Marshal	Chief Workforce Strategist HE NE
Dr Giles Maskell	President, Royal College of Radiologists
Dr Hillary Cass	President, Royal College of Paediatrics & Child Health
Jeremy Levy	DEQ, HE NW London
Kylie Lewington	Research Analyst, BMA
Liz Hughes	Chair, English Deans
Dr Maureen Baker	Chair Elect, Royal College of GPs
Mark Newbold	Chair, Birmingham and Solihul LETC
Prof. Martin Beaman	PGM Dean (Peninsula) HE South West
Michael Bannon	HE Thames Valley
Nigel Burgess	Head of Wkfce & Ed. Planning, NC&E Lon
Paul Holmes	MD, HE Wessex
Prof Jacky Hayden	Xx HE North West
Sharon Oliver	DEQ, HE Northern & Yorkshire
Simon Gregory	DEQ, HE East of England
Trish Knight	DEQ, HE East Midlands
Secretariat & Advisory	
Alison Carr	HEE Clinical Advisor
John Stock	Workforce Planning Lead, Dir S&P
Jonathan Howes	National Specialty Training Manager
Patrick Mitchell	Dir. of Nat. Progs, Dir. Education & Quality
Rob Smith	Head of Planning, Dir. of Strat, & Planning
Simon Plint	HEE Clinical Advisor

Appendix B

Meeting dates and venues

10th September 2013	3:00-5:30 pm	Portland House, London	Confirmed
4th October 2013	3:30-6:00 pm	Portland House, London	Confirmed
20th November 2013	*3:30-6:00 pm*	*Portland House, London*	*Provisional*
9th April 2014	*2:00-4:00 pm*	*Portland House, London*	*Provisional*
9th July 2014	*2:00-4:00 pm*	*Portland House, London*	*Provisional*
1st October 2014	*2:00-4:00 pm*	*Portland House, London*	*Provisional*


Appendix C : Where 'MWAG' sits in the HEE Governance Framework
HEE Governance and Advisory Structures
National External Advisory Groups
Local External Advisory Groups
HEE Advisory Groups
LETB advisory and stakeholder structures
HEE National programmes
Education Commissioners Network (inc HEE Deans)
Finance Leads Network
HCS Lead Commissioning (W Mids)
LETB Education Commissioning including Deaneries
DEQs Group
National Workforce Planning Groups
Planners Network
LETB input to National WP
LETB Workforce Planning
Senior Leadership Team (SLT)
LETB Executive
Multi-Professional Advisory Body
SoS / DH
Mandate
HEE Board
Patient Advisory Forum
LET Board
Primary Decisions / Overarching Governance
Board recommendations & decision under Scheme of delegation
Executive Action
Advisory & Decision Support Bodies

Appendix 4

MDRS Medical Careers Working Group

Terms of Reference

Purposes of this Working Group
This group is to be convened to promote a strategic approach to Medical career planning and support in the UK. The group will discuss developments, research and knowledge and examine ways to facilitate an integrated approach across the 4 nations of the UK. The group will bring together stakeholders to ensure that organisations effectively promote learning of career management skills and the importance of ongoing career planning for all doctors throughout a working lifetime.

The group aims to promote the provision of appropriate information to prospective medical students and to medical students and doctors to make a seamless transition between undergraduate and postgraduate level, and to qualified doctors to make informed, pragmatic and realistic choices throughout their medical careers.

The Medical and Dental Recruitment and Selection (MDRS) Medical Careers Group was founded to support trainee doctors in the making of well-informed, realistic career choices. It is working to ensure that HEE effectively promotes the learning of essential career planning skills across the medical workforce; from school leavers to postgraduate doctors and trainers.

To achieve this, the Medical Careers Group is bringing different stakeholder groups to the table, so that we ourselves can be informed by expert opinion, and works closely with junior doctors so that we might, in turn, foster consistent communication with those doctors who might need extra careers guidance on the paths available to them.

Furthermore, the Medical Careers Group intends to promote the inclusion of career management skills in all university curricula, and moreover, is discussing with universities ways to ensure that all medical students and foundation trainees have access to a careers advisor.

Whilst the Group is considering which medical specialties remain popular with trainee doctors, it is also focusing on how HEE can work to raise the profile of all medical and surgical specialties; so that medical students and junior doctors can decide upon well-informed aspirations on which medical career path might be best suited to them.

Recently, the Medical Careers Group has been investigating how best to inform [junior doctors/the medical workforce] on which medical careers they might be best suited to, and is going to work together with undergraduates and foundation programme trainees to develop through social media and a mobile app how to empower doctors to make pragmatic career choices.

Key Objectives

- To bring together stakeholders involved in medical and dental career decision-making, support, advice and careers' education across the UK
- To promote the provision of appropriate information for those considering a career in medicine and dentistry. To inform potential medical and dental students of the options for careers in medicine or dentistry. Career planning needs to start early: potential medical and dental students need to identify with the likely career paths.
- To promote a unified approach to careers support across the undergraduate and postgraduate fields which balance expectation with reality in medical and dental careers, such that informed, pragmatic and realistic choices can be made.
- To promote the inclusion of careers management skills in curricula.
- To discuss ways to ensure all medical students and foundation trainees have access to a careers advisor.
- To promote the availability of accurate, consistent and comparable information about competition ratios and workforce planning. Doctors and dentists applying for training posts need to recognise and understand the competition for specialties when considering their career choices.
- To promote a range of online and offline resources which ensure accurate information on career thinking to help school students, medical and dental trainees, trainers and careers services to guide decision-making
- To promote the provision of coherent information for those wishing to change medical career path within training or out of training
- To define good practice for the provision of careers information and advice (recommendation 11 Temple Report, BTBC)

Membership

- Department of Health, England
- Wales - Assembly government and Deanery
- Scotland- Parliament and Deanery
- NI – Parliament and Deanery
- UKFPO – FPD and Foundation Doctor Advisor
- Academy of Medical Royal Colleges
- KSS Deanery for UK Medical Careers Website
- BMA Medical Students' Committee and Junior Doctors' Committee
- National Education Advisors Forum (NEAF) Careers – PG deaneries careers
- PG deaneries Business Managers
- General Medical Council (GMC)
- Medical Careers Advisors Network (MCAN) – UG careers services
- Medical Schools Council (MSC)
- NHS Employers
- Additional members may be co-opted for specific task and finish matters or to provide expert opinion

2

Proposed activities for 2012-13

1. **Determining how career planning Information should be cascaded:** The group will consider all existing resources and will determine the optimal ways of providing career planning within the current financial constraints. Much of this will involve coordinating and sharing current career planning information and ensuring that the information is readily accessible to trainees and trainers.

2. **Collating information to inform career planning in medicine and dentistry**: The group will consider what useful information may be derived from selection data to inform trainees and trainers on the likelihood of appointment into medical specialties and dentistry in future recruitment rounds. The group will determine the form of any data collection and a standard way of presenting information across the four countries.

3. **Optimising career planning for specialties difficult to recruit to:** Some of the medical specialties are finding recruitment and the retention of their trainees difficult, for example, Psychiatry, Emergency Medicine, ACCS – Acute Medicine. The group will determine in conjunction with the specialties, methods of augmenting career guidance for the specialties and ways of promoting them to school students, medical students, postgraduate trainees and trainers.

Meetings and Procedures

- Co-Chairs – Alison Carr, Senior Clinical Advisor, METP, Department of Health and Melanie Jones, Associate Dean for Careers, Wales Deanery
- Secretariat support – DH.
- Meetings to take place in London four times a year with occasional additional meetings as required.
- Members unable to attend may send a deputy with the approval of the Chair.
- The group will report to the HEE
- Representatives from Scotland, Northern Ireland and Wales to communicate with relevant organisations within their nation.
- Travel expenses for members to be reimbursed by the individual's employing organisation.

Date: Dec 2012
Review Date: Dec 2013

Appendix 4

The UK Foundation Programme Office

ACADEMY OF MEDICAL ROYAL COLLEGES

FP Curriculum 2012

Supervised learning event (SLE) and End of placement forms

Please note that for the purpose of this paper, 'F1' and 'F2' labels have been merged e.g.: The actual forms within the e-portfolio will however specify either F1 or F2.

F1 & F2

Direct observation of procedural skills (DOPS)

This form provides a structured checklist for giving feedback on the foundation doctor's interaction with the patient when performing a practical procedure. This should be managed by the foundation doctor and observed by a trained trainer for teaching purposes. Procedures should be chosen jointly by the foundation doctor and trainer to address learning needs. Feedback and actions advised for further learning are recorded solely for the foundation doctor's benefit.

Foundation doctor's name:

GMC number:

Date (dd/mm/yy)

Trainer's details

Name:

Position: GP ☐ Consultant ☐ Specialty/SASG ☐ ST3 or above/SPR ☐ ST/CT 1/2 ☐ Other (please specify) ☐.....

GMC /other registration number:

Email address:

Have you been trained in providing feedback? Yes ☐ No ☐

Signature:

Clinical setting	Procedure	Focus of encounter	Syllabus sections covered
Please select: ED, OPD, Ward, Admissions, GP surgery, Home visit , Other (please specify)	Please specify:	Please select: Demonstrates understanding of indications/anatomy/technique, Obtains informed consent, Preparation pre-procedure, Appropriate analgesia, Safe sedation, Technical ability, Aseptic technique, Seeks help where appropriate, Post procedure management, Communication skills, Consideration of patient/professionalism, Other (please specify)	Please select:

Feedback based on the behaviours observed. The trainer should focus on those areas performed well and also identify areas for development

Agreed action:

F1 & F2

Mini-clinical evaluation exercise for learning (mini-CEX)

This form records a "*patient/foundation doctor encounter*" observed by a trainer for teaching purposes. Topics should be chosen jointly by the foundation doctor and trainer to address learning needs. Feedback and actions advised for further learning are recorded solely for the foundation doctor's benefit.

Foundation doctor's name:

GMC number:

Date (dd/mm/yy)

Trainer's details

Name:

Position: GP ☐ Consultant ☐ Specialty/SASG ☐ ST3 or above/SPR ☐ ST/CT 1/2 ☐ Other (please specify) ☐.....

GMC /other registration number:

Email address:

Have you been trained in providing feedback? Yes ☐ No ☐

Signature:

Clinical setting	Clinical problem category	Focus of encounter	Syllabus sections covered
Please select: ED, OPD, Ward, Admissions, GP surgery, Home visit , Other (please specify)	Please select: New patient, Follow up, Complexity, Airway, Breathing, Circulation, Neuro and Visual, Psych, Pain, Long term illness, Communication, Other (please specify)	Please select: History, Diagnosis, Examination, Management plan, Communication, Discharge, Other (please specify)	Please select:

Feedback based on the behaviours observed. The trainer should focus on those areas performed well and also identify areas for development

Agreed action:

F1 & F2

Developing the clinical teacher

This form aids the development of a foundation doctor's skills in teaching and/or making a presentation. The nature and content of the teaching encounter should be chosen jointly by the foundation doctor and trainer to address the learning needs of both the foundation doctor and those being taught. Feedback and actions advised for further learning are recorded solely for the foundation doctor's benefit.

Foundation doctor's name:

GMC number:

Date (dd/mm/yy)

Trainer's details

Name:

Position: GP ☐ Consultant ☐ Specialty/SASG ☐ ST3 or above/SPR ☐ ST/CT 1/2 ☐ Other (please specify) ☐.....

GMC /other registration number:

Email address:

Have you been trained in providing feedback? Yes ☐ No ☐

Signature:

Clinical setting	Clinical problem category	Focus of encounter	Syllabus sections covered
Please select: Ward based, Journal Club, Lecture, Tutorial, Other (please specify)	Please select: Medical students, Foundation doctors, Mixed medical, Multidisciplinary team, Other (please specify)	Please select: Preparation and setting (creating an appropriate environment for teaching, utilisation of resources), Teaching (clarity, logical sequence), Subject knowledge, Ability to answer questions, Interaction with group (gained their attention, facilitated group participation), Other (please specify)	Please select:
Feedback based on the behaviours observed. The trainer should focus on those areas performed well and also identify areas for development			
Agreed action:			

F1 & F2

Case-based discussion (CBD)

This form records a structured discussion for teaching purposes of a clinical case managed by the foundation doctor. It is usually based on case note entry, and takes place between the foundation doctor and a trained trainer. Cases should be chosen jointly by the foundation doctor and trainer to address a spread of topics which reflect individual learning needs. Feedback and actions advised for further learning are recorded solely for the foundation doctor's benefit.

Foundation doctor's name:

GMC number:

Date (dd/mm/yy)

Trainer's details

Name:

Position: GP ☐ Consultant ☐ Specialty/SASG ☐ ST3 or above/SPR ☐ ST/CT 1/2 ☐ Other (please specify) ☐.....

GMC /other registration number:

Email address:

Have you been trained in providing feedback? Yes ☐ No ☐

Signature:

Clinical setting	Clinical problem category	Focus of encounter	Syllabus sections covered
Please select: ED, OPD, Ward, Admissions, GP surgery, Home visit, Other (please specify)	Please select: New patient, Follow up, Complexity, Airway, Breathing, Circulation, Neuro and visual, Psych, Pain, Long term illness, Communication, Other (please specify)	Please select: Medical record keeping, Clinical assessment, Investigations and referrals, Treatment, Follow-up and future planning, Professionalism, Other (please specify)	Please select:

Feedback based on the behaviours observed. The trainer should focus on those areas performed well and also identify areas for development

Agreed action:

F1 & F2

Clinical supervisor's end of placement report

Name of foundation doctor:	GMC number:
Training period:*(From)*	*(To:)*
Hospital/GP/Other	Specialty:

The following individuals from the foundation doctor's placement supervision group contributed to this end of placement report:

Name	Job title and grade	GMC or other identifier
*		

* If members did not contribute please insert 'NOT APPLICABLE'. This field will expand as necessary.

By completing this form the clinical supervisor and Placement Supervision Group are taking responsibility for describing accurately this foundation doctor's performance in the workplace and highlighting any areas of excellence or areas of concern which may require educational support.

	EVIDENCE CONSIDERED				
	Direct observation in the work place	**Attendance record**	**E-portfolio**	**Comments from Placement Supervision Group**	**Other (please specify)**
Yes					
No					
Comments					

Describe this foundation doctor's observed performance in the workplace against the outcomes specified in the syllabus of the Foundation Programme Curriculum in a range of situations of differing complexity using the following descriptors.

Please comment on this foundation doctor's areas of excellence or areas of any concern under the following headings. Be as specific as possible.

Professionalism, probity and health (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- professionalism/probity

Comment

- time management

Comment

- continuity of patient care

Comment

- team working skills

Comment

Relationships with patients and communication skills (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- communication with patients/carers/family

Comment

- ability to obtain appropriate valid consent

Comment

Safety and clinical governance (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- recognises fatigue/stress/illness in self and others in the work place

Comment

- involvement in quality improvement/audit

Comment

Teaching and training (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- abilities to teach colleagues

Comment

- presentation skills

Comment

Maintaining Good Medical Practice (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- commitment to engagement in the educational process

Comment

- Commitment to evidence-based practice

Comment

Good clinical care (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

- ability to take a history and examine a patient

Comment

- diagnosis and clinical decision making

Comment

- ability to prescribe safely and effectively

Comment

- medical record keeping and correspondence

Comment

- interface with different specialties and with other professionals

Comment

- ability to recognise and manage the acutely ill patient

Comment

- ability to resuscitate

Comment

- management of patients with long term conditions

Comment

- ability to plan for discharge

Investigations (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

Please comment on this foundation doctor's areas of excellence or areas of any concern regarding their ability to discuss investigations and their results with patients. Be as specific as possible.

Comment

Procedures (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

Please comment on this foundation doctor's areas of excellence or areas of any concern regarding their ability to perform procedures. Be as specific as possible.

Comment

Do you have any concerns about the Foundation doctor's health (select ONE only)	Yes	No concern

If you have concerns about this foundation doctor's health, please describe your concerns:

Comment

Overall assessment

How has the foundation doctor performed in this placement? (select ONE only)	Excellent	No concern	Some concern	Major concern	N/A

Please comment on this foundation doctor's overall performance in this placement.

Comment

Does this foundation doctor reach the level to satisfy the end of year requirements? (select ONE only)	Exceeds	Satisfies	Does not meet
Comment			

Any other comments:

Comment

Supervisor's signature
Supervisor's surname
Supervisor's registration number
Date

F1 & F2

Educational supervisor's end of placement report

Name of foundation doctor:		**GMC number:**	
Training period *From:*		*To:*	
Hospital/GP/Other:		**Specialty:**	

Evidence considered:	Yes	No	Excellent	No concern	Some concern	Major concern	Comments
Clinical supervisor's report*							
E-portfolio							
Engagement in Supervised Learning Events**							
Attendance at formal educational events							
Comments from Placement Supervision Group							
TAB							
Overall judgement of placement performance							

*The inclusion of a clinical supervisor's end of placement report is mandatory, but in exceptional circumstances where this is not possible, the educational supervisor has responsibility for completing as much of the clinical supervisor's report as possible.
** This means serial engagement throughout the placement

Comment on any areas of excellence

Comment on achievements of the foundation doctor

Comment on any areas that need to be prioritised in the foundation doctor's next placement

How do you judge this foundation doctor's performance at the end of the placement compared to a doctor ready to complete F1/F2?

Any other comments

Supervisor's name:	**Supervisor's signature:**
Supervisor's GMC/registration number:	**Date:**

This guide is currently being updated for 2014

The UK Foundation Programme Office

Guide to the Foundation Annual Review of Competence Progression (ARCP) Process

Guide to the foundation ARCP processes

Guide to the foundation Annual Review of Competence Progression (ARCP) process.

First edition, April 2013.

Produced by:

The UK Foundation Programme Office

Project manager: Miss Stacey Forde.

FP Curriculum Lead: Dr Clare Van Hamel.

ARCP Advisor: Mrs Angela Burton.

Acknowledgements:

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Introduction:

Embedding the Annual Review of Competence Progression (ARCP) into the Foundation Programme.

With the new editions of the *FP Curriculum 2012* and the *FP Reference Guide 2012* came the introduction of the Annual Review of Competence Progression (ARCP) process into the Foundation Programme. It is expected that every foundation doctor will be subject to this process each year (circa 14,000 doctors).

Aligning with specialty training, the Foundation Programme adopts the ARCP process which serves to ensure a formal, consistent and robust mechanism for annual review of each doctor's achievement and progression. An effective ARCP process will ensure that sign-off is a transparent and fair process.

By introducing ARCP into foundation, we hope that foundation doctors are better prepared with a 'taste of what's to come' as they continue along their medical training pathway. The structured review and sign-off process should also aid expectation of what is required to satisfactorily complete the Foundation Programme. Furthermore, the ARCP review outcomes should help to identify and structure the doctors learning needs, areas for development and highlight areas of excellence.

It is not only the foundation doctor who can expect to benefit from ARCP, but also the wider public and all educational faculties. The benefit of adopting this proven and well-established ARCP process is to provide assurance of national consistency for every doctor training within the Foundation Programme. The ARCP process will strengthen the well embedded and successful year-end sign-off processes that already exist within foundation management across all areas of the UK. A robust sign-off process will help to improve patient safety and the quality of care given by doctors in the longer term.

The main intended audience of this ARCP guide is the foundation school/educational faculty; although foundation doctors may also find this resource useful.

We have included contributions and case studies from many stakeholders including experienced ARCP foundation doctors, clinical tutors, educational supervisors, a postgraduate dean and others involved in foundation programmes across the UK. This document is not exhaustive, but provides a good starting point to find out more about the ARCP process and signposts to more detailed useful resources that you may wish to consider.

For full and complete details about the foundation ARCP processes and framework, please refer to chapters 10 and 11 of the *FP Reference Guide 2012*.

We hope that you find this guide useful and welcome feedback on this document's detail, your experiences and any other comments for improvement. Please contact: enquiries@foundationprogramme.nhs.uk.

Miss Stacey Forde,
Project Manager, UKFPO.

Overview of foundation ARCP (principles and processes)

What is ARCP?
Annual Review of Competence Progression (ARCP) is a process that provides a formal and structured review of evidence to monitor a doctor's progress throughout each stage of medical training.

It is the ARCP process that aims to protect patients and assures the doctor, educational faculty employers, and the public that foundation doctors are receiving appropriate experience and that outcomes are being gained at an appropriate rate. .

ARCP function within the Foundation Programme
The ARCP processes are set to fulfil the following functions:

- To document the judgement about whether a foundation doctor has met the requirements and has provided documentary evidence for the satisfactory completion of F1/F2;
- To document recommendations about further training and support where the requirements have not been met.

ARCP review is not an additional method of assessment within the Foundation Programme.

Basic constitution of foundation ARCP
Table 1 uses the basic '5W' theory (who, what, when, where and why) to provide an overview of the ARCP constitution within foundation training.

Table 1: 5w's of foundation ARCP

Who	Key stakeholders involved in ARCP: • Clinical and educational supervisors • The foundation doctor • ARCP Panel (FTPD/T as chair, plus two other members) • Other members within the FP educational faculty
What	To prepare and conduct a review of every foundation doctor's achievements and progression, using evidence within the e-portfolio and other resources. The review is designed to assign an ARCP outcome which either recommends to the FSD (for F1) and PG Dean or other (for F2) that the doctor has/has not met the requirements for satisfactory completion of F1/F2.
When	Typically annually, with the ARCP review being conducted towards the end of the F1 and F2 year. A clear timetable is required. (ARCP reviews can be conducted more frequently if there is a need to deal with progression issues outside the annual review e.g. convening a panel earlier if there are significant concerns or even conducting a review prior to taking a maternity leave etc. as a check-point of progress)
Where	ARCP e-portfolio reviews can be conducted remotely. All ARCP outcomes to be recorded within the e-portfolio. Deaneries/foundation schools will need to manage the operational ARCP processes and timetables locally. Collaborative working with trusts/LEPs is strongly recommended.
Why	To provide a clear, transparent, robust and fair process for F1 and F2 sign-off. This dually aligns with the proven ARCP processes used in specialty training.

ARCP principles
It is imperative that the following principles are clearly represented and act as the foundation of the ARCP process:

- Systematic
- Evidence-based
- Visible and open to audit
- Based upon explicit standards
- Consistent and reliable
- Credible and defendable.

How does the ARCP process work?
With effect from July 2012, **every foundation doctor** (regardless of training status) should be **subject to an Annual** Review of Competence Progression. The annual review should take place towards the end of the F1/F2 training year which typically completes in July. Schools may have to adjust the timetable accordingly and conduct **additional ARCP reviews throughout the year** i.e. on a pro-rata basis for those doctors who train less than fulltime (LTFT), are out of phase or are not actively in the programme at the time of the annual review (maternity etc). Please see page 15 for further details.

Every foundation doctor is also required to participate in the GMC revalidation process which includes submission of details of any significant events, and any health or probity concerns. Where possible, the FP Curriculum Delivery Group has embedded these revalidation questions into the ARCP process to aid monitoring and reporting of such issues.

Foundation schools/deaneries are charged with implementing and timetabling an ARCP review process for all foundation doctors accordingly. The following information is therefore provided as an overview of the ARCP process:

- Page 6 provides a detailed text-based account of the process
- Page 7 offers the information using a flow diagram structure (some basic information has been duplicated to explain each stage of the process)

It is important to note that this guide is not exhaustive and cannot be a substitute for reading sections 10 and 11 of the FP Reference Guide 2012 when designing local ARCP processes and timetables!

Overview of the ARCP process:

1. At the beginning of F1/F2 and at the start of each placement, every foundation doctor (in collaboration with their supervisor) should create a PDP to identify placement specific and career objectives

2. Throughout F1/F2: regularly reviewing the curriculum and requirements for satisfactory completion of F1/F2 will help identify progress and any gaps/evidence required to meet all outcomes at year end. Gathering of evidence and utilising the e-portfolio on a continuous basis is vital to aid a smooth ARCP review. This includes timely submission of End of Placement assessments by the educational and clinical supervisors.

3. Towards the end of the F1/F2 year: an agreed deanery/foundation school ARCP timetable should be published. The FTPD/T, acting on behalf of the deanery/foundation school, should establish an ARCP panel and make clear the local arrangements to receive the necessary documentation from foundation doctors. This means that at least six week notice must be given of the submission date, so the foundation doctor can check their e-portfolio, and the educational supervisors can meet with the foundation doctor and complete the required structured reports (including the educational supervisor's end of year report, the enhanced Form R etc.).

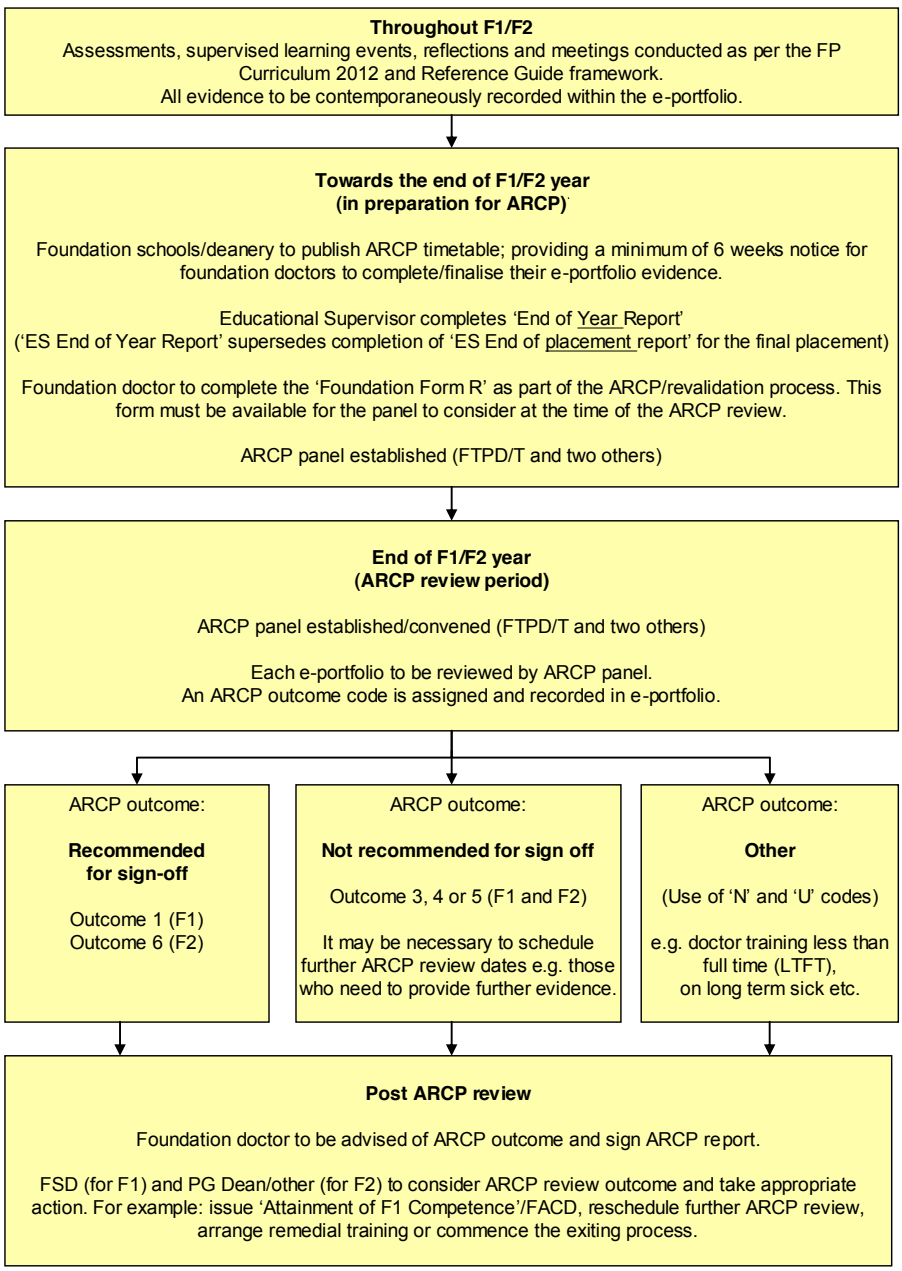
4. At the end of F1/F2: An ARCP panel is convened (please see page 8 for full details of the panel). The panel may benefit from prior administrative support and being issued/utilising tools such as 'checklists' and other tools to benchmark the e-portfolio evidence against the requirements for satisfactory sign–off. The ARCP review is conducted and outcome recorded by means of the FTPD/T (Chair of the panel) completing an 'F1/F2 ARCP Outcome Report Form' within the e-portfolio. (Please note: more than one ARCP review may be required, however there should only be one ARCP outcome form per ARCP review)

5. Following the ARCP review: The foundation doctor must be informed of the ARCP outcome and must sign the ARCP outcome report within 10 days of the panel meeting.

6. Depending on the ARCP (please see page 14 for ARCP Outcomes) outcome assigned, different actions will be required. Foundation schools will need to consider the following scenarios/actions and account for these within the ARCP timetable:
   - Time to allow a meeting with the foundation doctor to fully discuss an extension to FP training
   - Scheduling of further ARCP review dates (e.g. for those who presented incomplete evidence and will be subject to another review)
   - Further ARCP review dates for those doctors who train LTFT, are out of phase or are not actively undertaking the programme at time of the 'annual' ARCP review.
   - The time and process to manage ARCP outcome appeals
   - Process and time for FSD (for F1) and PG Dean/other authorised signatory (for F2) to review the ARCP outcome and sign the 'Attainment of F1 Competence'/ FACD.

The Foundation Programme

Foundation ARCP process 2012-13



The foundation ARCP Panel

The ARCP panel has an important role which its composition should reflect.

The panel should consist of at least three panel members; one of which should be a registered and licensed medical practitioner on the specialist or GP register.

The panel typically comprises of the FTPD/T (Chair of the panel) and two other members. Additional /other members could include:

- a postgraduate centre manager/other senior administrator
- specialty training doctor (ST4 or above)
- clinical supervisor
- educational supervisor
- lay representative
- external trainer
- employer representative
- external deanery/foundation school representative.

Where it is likely that a foundation doctor may be assigned an outcome indicating insufficient progress, the panel should typically include at least one external member e.g. lay representative, external trainer, deanery/foundation school representative.

Top tip for ARCP panel membership:

Having educational supervisors (ES) and clinical supervisors (CS) as panel members can offer substantial benefit to the ARCP process. Benefits include not only the knowledge and expertise of foundation training being brought to the panel, but more strategically, supervisors being exposed to the ARCP process will acquire a deeper understanding of how integral their roles are throughout the foundation year. For example, ARCP panellists need to review every ES and CS End of Placement reports to make an informed judgement.
Greater ES and CS engagement with the assessment process and e-portfolio recording throughout the year may be enhanced as a result.

(Please remember that supervisors cannot conduct review of those doctors under their own supervision)

All panel members will require access to the e-portfolio. Arrangements to provide this access must be in place and should be organised by the foundation school in advance of the panel review dates. If using the NES e-portfolio, guidance on how to assign an 'ARCP panel member' role is available here: http://talkback.nhseportfolios.org/wordpress/?p=471

Panel members should note that not every member will necessarily need to review each foundation doctor's e-portfolio. At least two members (one of which should be a registered and licensed medical practitioner on the specialist or GP register) should systematically consider the evidence.

If there is a disagreement between the two panel members, the evidence should be scrutinised by a third member and the majority decision used in determining the outcome should be made. Example: if the FTPD/T and postgraduate centre manager conduct a review of the evidence (using the e-portfolio and other sources of

information), and they agree the same outcome, the third panel member is not necessarily required to review evidence/the e-portfolio.

The panel should also note that it is not essential to review the e-portfolio at the same time. Panel members may scrutinise the e-portfolio separately and provide feedback.

Key facts to remember about the panel:

- Minimum of three panel members (FTPD/T and two others)
- FTPD/T should chair the panel
- All members must be trained in equality and diversity
- All Panel members must have training in ARCP process (familiar with FP Curriculum, e-portfolio navigation etc.)
- Additional members should not include anyone who has been directly involved in the supervision of the doctor under consideration
- ARCP panel members will require access to the e-portfolio
- Not all ARCP panel members necessarily need to review each e-portfolio
- One of the members reviewing evidence/e-portfolio should be a registered and licensed medical practitioner on the specialist or GP register
- Panel to be fully accountable for decisions and all proceedings recorded within the e-portfolio (audit trail)

To help place ARCP panel membership and its role into practice, schools may find the Northern Deanery's detailed guide on the ARCP Panel and Procedures useful. Please see: http://northerndeanery.ncl.ac.uk/NorthernDeanery/foundation/key-documents/ndfs-arcp-policy-2013-final.

The foundation ARCP review

Having issued an ARCP timetable, notified foundation doctors of the pending ARCP review dates and establishing the ARCP panel (including the organisation of appropriate access to the e-portfolio), the ARCP review is ready to commence.

Minimum requirements for satisfactory completion of F1 and F2
To ensure that the ARCP process is consistent, reliable and based upon explicit standards, every panel member must be fully aware of the mandatory, minimum requirements for satisfactory completion of F1 and F2 respectively.

The FP Reference Guide 2012 provides comprehensive tables of all the requirements for satisfactory completion of F1 and F2 (Please see sections 10 and 11). The FP Curriculum 2012 specifies the expected outcomes and competences for both F1 and F2 doctors.

An overview of the requirements/evidence required for satisfactory completion of F1 and F2 (and the difference between each training year) is provided in table 2 below. These standards should be used as the minimum benchmark when reviewing evidence for the purpose of ARCP.

Table 2: Overview of the requirements/evidence required for satisfactory completion of F1 and F2

F1	F2
• **Provisional** GMC registration • Completion of 12 months training • Coverage of FP Curriculum outcomes • Satisfactory ES End of Year Report • ES End of Placement Reports • CS End of Placement Reports • Completion of the required assessments (**TAB & core procedures**) • Valid **Immediate Life Support** certificate • **Participation** in QIP & national surveys • Completion of SLEs • Acceptable attendance at teaching sessions (typically 70%) • Signed probity & health	• **Full** GMC Registration • Completion of 12 months training • Coverage of FP Curriculum outcomes • Satisfactory ES End of Year Report • ES End of Placement Reports • CS End of Placement Reports • Completion of the required assessments (**TAB**) • Valid **Advanced Life Support** certificate • **Analysis & Presentation** in QIP & surveys • Completion of SLEs • Acceptable attendance at teaching sessions (typically 70%) • Signed probity & health

* FP Curriculum outcomes
The FP Curriculum 2012 is outcome based. ARCP panel members must therefore be aware of the FP Curriculum content, structure and outcomes. As a guide, it should be noted that:

> ***"Each (Curriculum) subsection is headed by outcome descriptors indicating the levels of performance that foundation doctors must achieve…"***
> ***"…the outcomes are the standard against which their performance will be judged…"*** (Page 10, *FP Curriculum 2012*)

Review of ARCP evidence
The majority of evidence required to make an informed ARCP judgement should be available within the e-portfolio. There may also be other additional local requirements and other sources that need to be collected locally e.g. an accurate record of sickness and absence, a copy of the completed 'Enhanced form R' for both F1 and F2 doctors, copies of certificates (ILS/ALS and GMC registration etc).

All ARCP panel members must be familiar with the requirements of satisfactory completion of F1 and F2 in order to identify and consider appropriate evidence as part of the actual review.

There are **ARCP tools and checklists** that can be used to support and aid the review of evidence. These tools are explored within the next chapter; please see 'ARCP resources'.

It should be noted that when reviewing ARCP evidence, additional reports from the FTPD/T (for example a report detailing events that led to a negative assessment by the foundation doctor's educational supervisor) may need to be reviewed and considered by the panel.

The foundation doctor may also submit a report to the panel, in response to the educational supervisor's end of year report or to any other element of the assessment process. Please refer to paragraphs 10.23–10.24 (F1) and paragraphs 11.23–11.24 (F2) of the FP Reference Guide 2012 for full details of how to manage such reports.

TIP / IMPORTANT NOTE WHEN REVIEWING EVIDENCE:

ARCP panel members should **be mindful of any evidence added to the e-portfolio after the notified submission date.** Foundation schools may want to consider employing a virtual 'e-portfolio lockdown' as such, and panel members should be aware of the date of evidence provided.

The ARCP panel should **review evidence first** and then create/complete the ARCP Outcome Report form. If the panel create the ARCP Outcome Report form first, by the time the review and agreed conclusion is made, it is likely that the **e-portfolio will have 'timed-out'**. (NES functionality: When completing a form, you have unlimited time to complete the form as long as you are actively typing. Once you stop typing, you will be logged out after 60 minutes; a pop-up message informing you of this).

Where the evidence submitted is incomplete or otherwise inadequate, the panel should not take a decision about the performance or progress of the foundation doctor. The failure to produce timely, adequate evidence for the panel will result in an Incomplete Evidence Presented outcome (Outcome 5) and will require the foundation doctor to explain to the panel, in writing, the reasons for the deficiencies in the documentation.

By means of sharing existing and good practice, detailed working 'Guidance on ARCP evidence' is offered by Northern Deanery and can be accessed via: http://northerndeanery.ncl.ac.uk/NorthernDeanery/foundation/key-documents/guidance-for-completing-evidence-for-arcp

Foundation ARCP resources

To assist the review of ARCP evidence within the e-portfolio, there are a number of tools designed to quickly identify relevant ARCP evidence and to support ARCP review.

Optional supporting tools:
Schools may wish to use many of the e-portfolio tools (as explained below) and/or consider developing local 'checklists of evidence' to be reviewed and benchmarked when conducting the ARCP review.

The e-portfolio offers the following ARCP resources*
(* As these samples are in paper format, the electronic functionality cannot be fully demonstrated e.g. use of drop down menus/branching of information etc.)

Resource	Sample*	Mandatory / optional	Purpose / notes
Curriculum Overview page (NES sample shown)	Page 21	Optional	To support the review of evidence. The curriculum overview page offers a Red-Amber-Green facility allowing the foundation doctor and educational supervisor to rate if the required outcomes of each Curriculum syllabus heading have been met. If supervisors are engaged and utilise this functionality, it is a much more efficient way for the panel to make a quicker and better judgement about curriculum coverage and achievement.
Review of F1 evidence	Page 22	Optional	To support the review of evidence. This resource acts as a central portal of 'quick links' to relevant evidence in accordance with the core requirements for satisfactory completion of F1 (FP Reference Guide 2012).
Review of F2 evidence	Page 24	Optional	(As above but with relevance to F2) Remember: Core procedures from F1 do not need to be repeated in F2, however evidence of the procedures from F1 is required for successful completion of F2. Users of this form may therefore need to visit the doctor's F1 details.

F1 ARCP outcome form	Page 26	Mandatory	This is the mandatory ARCP outcome report form to be completed by the FTPD/T (Chair of the ARCP panel) to record the ARCP outcome. Only one form per review should be complete.
F2 ARCP outcome form	Page 28	Mandatory	(As above but with relevance to F2)

Only one F1/F2 ARCP outcome form should be complete per ARCP review i.e. there should not be an outcome form saved within the e-portfolio by each ARCP panel member.

IMPORTANT:
It may be the case that more than one ARCP review is held for each doctor; in this case, there should be more than one ARCP Outcome Report form recorded within the e-portfolio and any other data sources you use (e.g. Intrepid).

ONE ARCP REVIEW = ONE ARCP OUTCOME FORM RECORDED/SAVED.

The NES e-portfolio is designed to only allow the FTPD/T to create the F1/F2 ARCP outcome form. This functionality exists to limit/avoid any confusion as to the official, agreed ARCP review outcome. If for any reason, the FTPD/T has assigned a deputy; a trust/LEP e-portfolio administrator can create the outcome form.

Key notes:

- There are optional tools available within the e-portfolio to help review evidence
- Schools may wish to design their own checklists/tools to review evidence
- Only the FTPD/T (chair of the panel) should complete the F1/F2 ARCP outcome form
- Only one F1/F2 ARCP outcome form per each ARCP review
- Only where more than one ARCP review is held, should there be more than one ARCP outcome form.

Foundation ARCP outcomes

The FP Reference Guide 2012 mandates use of the following foundation ARCP outcome codes:

Outcome Code	Description	Notes
1	**Satisfactory completion of F1**	The F1 ARCP panel should only use this outcome for foundation doctors who meet the requirements for satisfactory completion of F1
3	**Inadequate progress – additional training time required**	(Applicable to both F1 and F2) This outcome should be used when the ARCP panel has identified that an additional period of training is required which will extend the duration of training. The panel must make clear recommendations about what additional training is required and the circumstances under which it should be delivered (e.g. concerning the level of supervision). It will, however, be a matter for the deanery/foundation school to determine the details of the additional training within the context of the panel's recommendations, since this will depend on local circumstances and resources. The overall duration of the extension to training should normally be for a maximum of one year. The panel should consider the outcome of the remedial programme as soon as practicable after its completion. The deanery/foundation school should inform the employer and training placement provider if this outcome is assigned.
4	**Released from training programme**	(Applicable to both F1 and F2) If the panel decides that the foundation doctor should be released from the training programme, the deanery/foundation school should discuss with the GMC as there may be fitness to practise concerns. The panel should seek to have employer representation.
5	**Incomplete evidence presented – additional training time may be required**	(Applicable to both F1 and F2) The panel can make no statement about progress or otherwise since the foundation doctor has supplied either no information or incomplete information to the panel. If this occurs, the foundation doctor may require additional time to complete F2. The panel will set a revised deadline for completion of the e-portfolio and associated evidence. Once the required documentation has been received, the panel should consider it. The panel does not have to meet with the foundation doctor and the review may be done "virtually" and issue an alternative outcome.
6	**Recommendation for the award of the Foundation Achievement of Competence Document**	The F2 ARCP panel should only use this outcome for foundation doctors who meet the requirements for satisfactory completion of the Foundation Programme/F2.
8	**Time out of**	(F2 only) It is unusual for foundation doctors to take

	Foundation Programme	such a career break. However, the panel should receive documentation from the foundation doctor indicating what they are doing out of programme and their expected date of return.

Please note that outcomes 2 and 7 (as used in specialty training) are not used/transferable to foundation training.

Use of explanatory/supplementary codes within foundation ARCP
To help support the deaneries/foundation schools with capturing appropriate ARCP data for those doctors who:

- train less than full time (LTFT)
- are out of phase
- are on statutory leave or other at the time of the annual review (e.g. towards July); or for those whom
- are assigned an unsatisfactory outcome (3, 4 or 5)

It has been agreed that the foundation ARCP process will adopt many of the specific, explanatory/supplementary codes as used within specialty training.

Explanatory/supplementary codes are different to, and used in addition to, the recognised ARCP outcome codes as numbered 1 – 8. These codes are a requirement within the GMC Annual Deanery Report dataset. Such explanatory/supplementary codes are coined as 'N' and 'U' codes.

These codes will not only be familiar to colleagues with knowledge of specialty training, but aim to essentially remove data duplication for schools/deaneries when having to re-interpret/code ARCP data for the purpose the GMC Annual Deanery Report and UKFPO FP Annual Report etc. Using these codes should also benefit the school/panel members in applying a consist approach to identify and record the reason(s) for an unsatisfactory outcome being assigned.

What is an 'N' code and when does it apply?
When annual ARCPs are conducted (e.g. May-July), if a doctor is LTFT, out of phase, not actively in the programme or other, which means that they are not due a summative ARCP review, an explanatory '**N**ot reviewed' code (i.e. 'N code') is required.

When completing the ARCP outcome report form, the option of 'Other' should be selected (outcomes 1, 3, 4, 5 and 6 will not apply). Having selected 'Other', the e-portfolio form will present a list of reasons to explain why this option has been chosen. The list of options presented are the explanatory 'N' codes of which more than one may apply. Please see page 32 for the list of 'N' codes.

What is a 'U' code and when does it apply?
In the event of an unsatisfactory ARCP outcome code being assigned (outcome 3, 4 or 5); an explanatory **U**nsatisfactory reason (i.e. a 'U code') is required.

When completing the ARCP outcome report form, if outcome 3, 4 or 5 is selected, the e-portfolio form will present a list of reasons to explain why this option has been chosen. The list of options presented are the explanatory 'U' codes of which more than one may be apply. Please see page 33 for the list of U codes.

Flow diagrams to demonstrate how these codes will be presented within the electronic format (i.e. once in the e-portfolio) are provided as per pages 34 and 35.

Managing the ARCP outcomes and providing feedback post-ARCP review

As progression is monitored robustly throughout the year, ARCP reviews are not expected to present any surprises or dispute.

All foundation doctors must be informed of their ARCP outcome and should sign the ARCP outcome report form within 10 days of the panel meeting. (Electronic signature via the e-portfolio is accepted). Discussion points about targeted learning, areas for improvement and/or areas of demonstrated excellence as noted within the review should also be shared with the doctor when providing feedback.

In some cases, it may be necessary to invite the doctor to attend a meeting immediately following the panel's ARCP review (e.g. where it is expected that a non-satisfactory outcome would be assigned) to provide feedback and discuss the particulars of supporting the doctor or possibly the exiting process, depending on which outcome is assigned.

In reality, we appreciate that there may be a very small number of doctors who do not agree with the outcome and may even wish to appeal. In either case it is important (for the purpose of audit) that the ARCP report form is signed and acknowledged by the foundation doctor. To help schools address this issue, please note the statement at the bottom of the form which states that 'the doctor may not accept or agree with the panel's decision'.

In terms of the actions that should be taken, the FP Reference Guide 2012 offers in-depth detail as to the correct management of appeals and those outcomes which require further management:

- Managing **F1** ARCP outcomes: Chapter 10 (FP Reference Guide 2012)
- Managing **F2** ARCP outcomes: Chapter 11 (FP Reference Guide 2012)

For those doctors assigned an outcome 5 (Incomplete evidence presented), schools will need to schedule a further ARCP review. For information only: within specialty training, the doctor has two weeks to provide complete/sufficient evidence.

As an overview of doctors assigned a satisfactory outcome (i.e. 1 or 6), it is expected that the following will be taken:

- F1s: the FSD reviews the ARCP panel's recommendation (i.e. outcome 1) and if satisfied, s/he may then issue the 'Attainment of F1 competence' certificate to confirm successful completion of the F1 year.

- F2s: the PG Dean or other authorised signatory reviews the ARCP panel's recommendation (i.e. outcome 6) and if satisfied, s/he issues the 'Foundation Achievement of Competence Document (FACD) to confirm successful completion of F2/the Foundation Programme.

Remember:

All **foundation doctors** must be informed of their ARCP outcome and **should sign** the ARCP Outcome report **form within 10 days** of the panel meeting.
(Electronic signatures via the e-portfolio are accepted).

Regardless of which ARCP outcome is assigned and whether or not an appeal is submitted or further reviews required; it is imperative that
every ARCP review has an outcome and all are recorded within the e-portfolio.
An audit trail must always be kept and managed appropriately.

A valued ARCP experience

ARCP has proven to be a valued process, not only based on evidence within specialty training, but as experienced by foundation schools already operating under the ARCP framework.

Northern Deanery has over six years experience of operating ARCP within the foundation training model. A complete guide on ARCP processes from the Northern Denary can be accessed here: http://northerndeanery.ncl.ac.uk/NorthernDeanery/foundation/key-documents/ndfs-arcp-policy-2013-final

Comments from foundation doctors and other colleagues at Northern Deanery are shared here for your information:

What foundation doctors value about the ARCP process:

"it helps you to prepare for yearly ARCP after foundation."

"working to achieve a satisfactory ARCP outcome indirectly meant I was preparing for my speciality application form and interview. You will appreciate that when you realize you have it all sorted on your e-portfolio! If it wasn't for all the competencies, reflections and positive feedback I wouldn't have scored so high to get into the speciality I wanted!!"

"It is good to have feedback from impartial sources about how they rate your own personal strengths and weaknesses."

"I think at the end of the day it also ensures that you achieve the outcomes when ARCP is looming at the end!"

"I have to say at times, though it felt like hoops to jump through, having an ARCP in foundation gave me focus in terms of a date and a structure to guide my professional development"

"I think that ARCP in foundation gave us a taster of what is to come for the rest of our careers. It gave us a goal to work towards."

"Best thing about ARCP in foundation: it is well supported and gives you practice before you have to start doing it much more on your own like CMT/CST"

"The thing I valued most about the ARCP deadlines looming ahead was that it encouraged you to focus and actively seek out assessments that actually improved us as doctors, weather it was learning a new skill via DOPS or learning more about a topic in order to have a semi intelligent conversation with a consultant via CBD that demonstrated my understanding, knowledge and application of medicine. You

definitely don't appreciate it at the time but these experiences help you in becoming a safe and competent doctor."

"Remember to think of the ARCP not just as a tick box exercise to pass the year. Like most areas of medicine, when broken down into small goals and approached in a calm and organised manner anything is achievable. Embrace the process as a valuable learning and reflective tool and it will be used to your advantage, not just for the ARCP but to organise your achievements for future job applications."

Comments from the ARCP Panel Chair

Challenges
I don't know the trainee personally and have to make a value judgement on "the evidence".

Resources

1. Assessments:
The immediate resources I seek to review include quality CS and ES reports and MSF. TABs are fundamental to assessing a doctor. The free text comments are the most revealing. "The most important piece of evidence for me is the multisource feedback".

2. E-portfolio
A portfolio tells me a lot about the individual and whether or not they have engaged with the educational process. It is possible to "tick the boxes" however it is often the way in which these boxes are ticked that gives the game away e.g minimum requirements met just prior to ARCP / excessive linkage to cover deficiencies / over-reliance on 1 or 2 pieces of weak evidence / over-reliance on e-learning / inappropriate WPBA mandatory requirements missing etc. This is the realm of the ES and ARCP panel chair.

However there is an art to completing a portfolio and trainees can be taught how to produce a good portfolio to demonstrate achievement of their competence and clinical progression.

Recommended approach to ARCP review:

When reviewing ARCP evidence, I ask myself two simple questions:

- **Is this doctor making satisfactory progress?**
- **Can they progress or are there significant issues that must be addressed at this current time?**

I can only answer these questions if the agreed educational standards have been met (e-portfolio) and colleagues have written quality feedback (CS reports, ES reports and MSF). Engagement from all faculty colleagues is therefore fundamental to the success of this ARCP process and needs to be fully agreed and understood from the word go!

Comments from ES & CS after their experience as ARCP assessors

"Has made me aware of the need for well-structured and plentiful documentary evidence"

"Learnt the e-Portfolio!!"

"Better insight to MDT view of ARCP"

"More insight to ARCP process from another angle as an assessor"

"More aware of expectations of ARCP panel such that I will be a more effective ES"

"Thank you the ARCP training prepared me well for the real panel. This has been very good for my own personal development"

"It's a pleasure to be involved with the FY programme and the ARCPs – thank you."

"Having assessed at my first ARCP panel I have a much better understanding of e-portfolio, how to complete it and do assessment in a planned way for my trainees"

"Train & value your assessors and they will value and engage in the process"

Foundation School Manager comments on ARCP

Foundation school manager:
"As a Foundation School Manager, I have found the ARCP process incredibly reassuring when managing the sign-off process each year for our FP doctors. Knowing that every single one of our FP doctors have been through a rigorous ARCP panel before they progress through training builds confidence into what is such a critical part of the School's job. Ultimately, ARCP gives our trainees, our faculty and our patients the peace of mind that only trainees who are competent to move on in their training do so."

Mrs Gemma Crackett, Business Manager, Northern Deanery Foundation School.

Appendices:

Curriculum Overview page (NES sample shown)

Review of F1 evidence

Review of F2 evidence

F1 ARCP Outcome report form

F2 ARCP Outcome report form

List of N Codes

List of U codes

Flow diagram of N codes

Flow diagram of U codes

Curriculum Overview page (NES sample shown)

The curriculum overview page contains a number of indicators to monitor and rate progress as mapped to the FP Curriculum 2012 syllabus headings.

The rating system translates the syllabus sub heading ratings into a red-amber-green coloured indicator. The indicators will reflect the number of ratings made by both the foundation doctor ('trainee') and the Educational Supervisor. There is also a 'manual' Overall Educational Supervisor Rating that can be set from their account. This may help the ARCP review panel at year end, especially when considering the doctor's engagement and reviewing the Educational Supervisors engagement and opinion of Curriculum coverage.

Competencies — Expand All

Outcome	Evidence	Trainee Rating	Ed Sup Rating	Overall Ed Sup Rating
1 Professionalism	10 links	(2/6)	(1/6)	
2 Relationship and communication with patients	4 links	(1/6)	(0/6)	Fully met
3 Safety and clinical governance	1 links	(0/3)	(0/3)	
4 Ethical and legal issues	1 links	(0/4)	(0/4)	
5 Teaching and training	1 links	(0/1)	(0/1)	
6 Maintaining good medical practice	3 links	(0/3)	(0/3)	
7 Good clinical care	3 links	(0/10)	(0/10)	
8 Recognition and management of the acutely ill patient	4 links	(0/7)	(4/7)	
9 Resuscitation and end of life care	3 links	(0/3)	(1/3)	
10 Patients with long-term conditions	4 links	(0/6)	(0/6)	
11 Investigations	1 links	(0/1)	(0/1)	
12 Procedures	7 links	(0/16)	(0/16)	

The indicator key is as per the table below:

Status type	Status	Consideration
Evidence	Number	Number of evidence items
Trainee rating	Grey	No Trainee rating
	Red	Trainee has self-rated some items 'not met'
	Amber	Trainee has self-rated some items 'some experience'
	Green	Trainee has self-rated some items 'F1/F2 level competent'
Educational supervisor assessment of individual competencies	Grey	No supervisor rating
	Red	Supervisor has self-rated some items 'not met'
	Amber	Supervisor has self-rated some items 'some experience'
	Green	Supervisor has self-rated some items 'F1/F2 level competent'
Educational supervisor assessment of trainees achievement of the desired outcome (Overall Ed Sup Rating)		This should be manually set based upon the supervisors judgment of the overall evidence presented
	Grey	No selection made
	Red	Manual selection of 'Not been met'
	Amber	Manual selection of 'Partially met'
	Green	Manual selection of 'Fully met'

Important: The lowest rating (a red indicator) of any area will be displayed as the main/overview indicator i.e. if 19 sub items are green and 1 is red, it is the red indicator that will be displayed.

Please contact your deanery/foundation school if you wish to receive further guidance on using this functionality (or whichever local body provides your e-portfolio training).

F1

Review of F1 evidence

Name of foundation doctor	(Auto populated)	GMC number	(Auto populated)

Listed below are the national minimum requirements for satisfactory completion of the F1 year as laid down by the GMC and set out in the *Foundation Programme Curriculum* and the *Foundation Programme Reference Guide.* Your foundation school may have additional requirements that have to be met. Please check with you foundation school for full details.

IMPORTANT: Evidence listed below does NOT indicate that the evidence provided is satisfactory or that the requirement has been met.

The table acts as a central portal from where evidence can be easily viewed in accordance with the set national requirements.

Requirement	Notes	View evidence
Provisional registration and a licence to practise with the GMC	To undertake the first year of the Foundation Programme, doctors must be provisionally registered with the GMC and hold a licence to practise. In exceptional circumstances (e.g. refugees) a fully registered doctor with a license to practise may be appointed to the first year of the Foundation Programme.	
Completion of 12 months F1 training (taking account of allowable absence)	The maximum permitted absence from training, other than annual leave, during the F1 year is four weeks (see GMC guidance on sick leave for provisionally registered doctors).	
A satisfactory educational supervisor's end of year report	The report should draw upon all required evidence listed below.	(Quick link to report)
Satisfactory educational supervisor's end of placement reports	If the F1 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F1 doctor has met the requirements for satisfactory completion of F1. An educational supervisor's end of placement report is not required for the last F1 placement; the educational supervisor's end of year report replaces this.	(Quick link to all reports)
A satisfactory clinical supervisor's end of placement report for each placement	If the F1 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F1 doctor has met the requirements for satisfactory completion of F1. The last end of placement review must be satisfactory.	(Quick link to all reports)
Satisfactory completion of the	Team assessment of behaviour (TAB) (Minimum of one per year)	(Quick link to TAB

required number of assessments The minimum requirements are set out in the Curriculum. The deanery/foundation school may set additional requirements.		assessment)
	Core procedures (all 15 GMC mandated procedures)	Completed __/15
A valid Immediate Life Support (or equivalent) certificate	If the certificate has expired, it may be appropriate to accept evidence that the doctor has booked to attend a refresher course.	
Evidence of participation in systems of quality assurance and quality improvement projects	Foundation doctors should take part in systems of quality assurance and quality improvement in their clinical work and training.	
	Completion of GMC national trainee survey.	
Completion of the required number of Supervised Learning Events The minimum requirements are set out in the Curriculum. The deanery/foundation school may set additional requirements.	Direct observation of doctor/patient interaction: Mini CEX DOPS *(minimum of 9 observations per year; at least 6 must be mini-CEX)*	Completed: __ miniCEX __ DOPS
	Case-based discussion (CBD) *(minimum of 6 per year / 2 per placement)*	__ CBD
	Developing the clinical teacher *(minimum of 1 per year)*	__ DCT
An acceptable attendance record at generic foundation teaching sessions	It is recommended that postgraduate centres (or equivalent) provide a record of attendance for each F1 doctor. It has been agreed that an acceptable attendance record should typically be 70%. However, if the F1 doctor has not attended 70% of teaching sessions for good reasons, it may still be appropriate to confirm that the F1 doctor has met the required standard. If there are concerns regarding engagement or if attendance is below 50%, the FTPD/T should discuss this with the FSD.	
Signed probity and health declarations	Separate forms must be signed for each year of foundation training (F1 and F2). This is in addition to the Declaration of Fitness to Practise required by the GMC when applying for full registration.	

F2

Review of F2 evidence

Name of foundation doctor	(Auto populated)	GMC number	(Auto populated)

Listed below are the national minimum requirements for satisfactory completion of the F2 year as laid down by the GMC and set out in the *Foundation Programme Curriculum* and the *Foundation Programme Reference Guide.* Your foundation school may have additional requirements that have to be met. Please check with you foundation school for full details.

IMPORTANT: Evidence listed below does NOT indicate that the evidence provided is satisfactory or that the requirement has been met.

The table acts as central portal from where evidence can be easily viewed in accordance with the set national requirements.

Requirement	Notes	View evidence
Full registration and a licence to practise with the GMC	To undertake the second year of the Foundation Programme, doctors must be fully registered with the GMC and hold a licence to practise.	
Completion of 12 months F2 training (taking account of allowable absence)	The maximum permitted absence from training (other than annual leave) during F2 is four weeks (i.e. the same as F1).	
A satisfactory educational supervisor's end of year report	The report should draw upon all required evidence listed below.	(Quick link to report)
Satisfactory educational supervisor's end of placement reports	If the F2 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F2 doctor has met the requirements for satisfactory completion of F2. An educational supervisor's end of placement report is not required for the last F2 placement; the educational supervisor's end of year report replaces this.	(Quick link to all reports)
A satisfactory clinical supervisor's end of placement report for each placement	If the F2 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F2 doctor has met the requirements for completion of F2. The last end of placement review must be satisfactory.	(Quick link to all reports)
Satisfactory completion of the required number of assessments The minimum requirements are set out in the Curriculum. The deanery/foundation	Team assessment of behaviour (TAB) (Minimum of one per year)	(Quick link to TAB assessmer
	Evidence that the foundation doctor can carry out the procedures required by the GMC	Completed __/15

Comment [f1]: Remember: Core procedures from F1 do not need to be repeated in F2, however evidence of the procedures from F1 is required for successful completion of F2. Users of this form may therefore need to visit the doctor's F1 details.

school may set additional requirements.		
A valid Advanced Life Support (or equivalent) certificate	If the certificate has expired, it may be appropriate to accept evidence that the doctor has booked to attend a refresher course.	
Evidence of participation in systems of quality assurance and quality improvement projects	The Curriculum requires that F2 doctors manages, analyses and presents at least one quality improvement project and uses the results to improve patient care.	
	Completion of the GMC national trainee survey.	
Completion of the required number of Supervised Learning Events The minimum requirements are set out in the Curriculum. The deanery/foundation school may set additional requirements.	Direct observation of doctor/patient interaction: Mini CEX DOPS *(minimum of 9 observations per year; at least 6 must be mini-CEX)*	__ miniCEX __ DOPS
	Case-based discussion (CBD) *(minimum of 6 per year / 2 per placement)*	__ CBD
	Developing the clinical teacher *(minimum of 1 per year)*	__ DCT
An acceptable attendance record at foundation teaching sessions	It is recommended that postgraduate centres (or equivalent) provide a record of attendance for each F2 doctor. It has been agreed that an acceptable attendance record should typically be 70%. However, if the F2 doctor has not attended 70% of teaching sessions for good reasons, it may still be appropriate to confirm that the F2 doctor has met the required standard. If there are concerns regarding engagement or if attendance is below 50%, the FTPD/T should discuss this with the FSD.	
Signed probity and health declarations	A separate form should be signed for F2. This is in addition to the Declaration of Fitness to Practise required by the GMC when applying for full registration.	

F1

F1 ARCP outcome form

Foundation doctor: (Auto populated)	GMC No: (Auto populated)

Foundation training:						
	Specialty	**Clinical Supervisor**	**LEP**	**Date from** (dd/mm/yy)	**Date to** (dd/mm/yy)	**FT/PT as % FT**
1	(Auto populated)					

Names of the foundation ARCP Panel members *(FTPD/T and two others)*	1.
	2.
	3.
	Other(s):
Date of Review:	

Evidence considered (please list as many as appropriate)			
Educational supervisor's end of year report	☐	*(Please specify)*	☐
E-portfolio	☐	*(Please specify)*	☐
(Please specify)	☐	*(Please specify)*	☐

F1 ARCP review panel outcome (please select only one):	
Recommended for sign off	
Outcome 1: Satisfactory completion of F1	☐
Not recommended for sign off	
Outcome 3. Inadequate progress – additional training time required	☐
Outcome 4. Released from training programme	☐
Outcome 5. Incomplete evidence presented – additional training time may be required	☐
No ARCP review/outcome	
Other *(e.g. working LTFT, on sick leave, missed review etc.)*	

Comment [f2]: If outcome 3, 4 or 5 is selected. The form will present a menu of reasons to document why this outcome has been assigned. 'U' codes.

Comment [f3]: If 'Other' is selected, the form will present a menu of reasons to document why a satisfactory/unsatisfactory outcome has not been assigned. 'N' codes.

Transfer of information between F1 and F2 (please select only one):	
There are no known causes of concern	☐
There are causes of concern	☐
Brief summary of concern:	

Comments and recommended action(s): *(Include areas of excellence, areas for targeted training, level of supervision, any additional training time and the action plan etc.):*

Signed by chair of panel (FTPD/T or deputy)			
Name	Signature	Designation	Date
Additional comments			
Signed by foundation doctor*			
Signature			Date

* By signing the form, the foundation doctor acknowledges receipt of this information and understands the recommendations arising from the review. It does not imply that the doctor accepts or agrees with the panel's decision. The foundation doctor may make an appeal as described in *Foundation Programme Reference Guide*.

F2

F2 ARCP outcome form

Foundation doctor: (Auto populated)	GMC No: (Auto populated)

Foundation training:

	Specialty	Clinical Supervisor	LEP	Date from (dd/mm/yy)	Date to (dd/mm/yy)	FT/PT as % FT
1	(Auto populated)					

Names of the foundation ARCP Panel members *(FTPD/T and two others)*	1.
	2.
	3.
	Other(s):
Date of Review:	

Evidence considered (please list as many as appropriate)			
Educational supervisor's end of year report	☐	*(Please specify)*	☐
E-portfolio	☐	*(Please specify)*	☐
(Please specify)	☐	*(Please specify)*	☐

F2 ARCP review panel outcome (please select only one):	
Recommended for sign off	
Outcome 6. Satisfactory completion of F2 - Recommendation for the award of the Foundation Achievement of Competence Document (FACD)	☐
Not recommended for sign off	
Outcome 3. Inadequate progress – additional training time required	☐
Outcome 4. Released from training programme	☐
Outcome 5. Incomplete evidence presented – additional training time may be required	☐
No ARCP review/outcome	
Outcome 8. Time out of Foundation Programme (up to 12 month career break/research)	☐
Other *(e.g. working LTFT, on sick leave, missed review etc.)*	☐

Comment [f4]: If outcome 3, 4 or 5 is selected. The form will present a menu of reasons to document why this outcome has been assigned. 'U' codes.

Comment [f5]: If 'Other' is selected, the form will present a menu of reasons to document why a satisfactory/unsatisfactory outcome has not been assigned. 'N' codes.

Revalidation:	
There are no known causes of concern	☐
There are causes of concern	☐
Brief summary of concern:	
Comments and recommended action(s): *(Include areas of excellence, areas for targeted training, level of supervision, any additional training time and the action plan etc.):*	

Signed by chair of panel (FTPD/T or deputy)			
Name	Signature	Designation	Date
Additional comments			
Signed by foundation doctor*			
Signature			Date

* By signing the form, the foundation doctor acknowledges receipt of this information and understands the recommendations arising from the review. It does not imply that the doctor accepts or agrees with the panel's decision. The foundation doctor may make an appeal as described in *Foundation Programme Reference Guide*.

Reasons for doctors not assigned a satisfactory/unsatisfactory outcome (list of 'N' codes)

More than one reason may be selected.

Remember:
Most important is recording accurate reason(s) and not learning the codes!

Reason	Explanatory Notes	'N' code	Used in specialty
Less than full time (LTFT) / out of phase – no concern	Achieving progress and the development of outcomes at the expected rate.	N14	☒
Less than full time (LTFT) / out of phase – some concern	May not be achieving progress or development of outcomes at the expected rate.	N15	☒
Trainee Sick Leave	Trainee on long term sickness or other health issues have impacted on ability to complete the year of training being reviewed.	N1	☑
Trainee Maternity/ Paternity Leave	Trainee cannot be reviewed whilst on maternity leave	N2	☑
Trainee Missed Review	Trainee did not attend the Review when required. I.e. Analysis from Deaneries is that where a review panel was not arranged until July at end of reporting year and trainee could not attend; for last minute family reasons, transport problems etc. Panel had to be rearranged in early August but outside of GMC reporting period.	N6	☑
Trainee on suspension for Gross Misconduct	Trainee currently suspended from training either as a result of GMC Suspension or local Trust or other local disciplinary proceedings due to gross misconduct.	N10	☑
Trainee on suspension - other reason	Trainee currently suspended for reasons other than gross misconduct.	N11	☑
Trainee Resignation	The trainee has left the training programme prior to its completion. Please specify if: • Resignation: no remedial training undertaken • Resignation: received remedial training	N12 N21 N22	☑ ☒ ☒
Trainee dismissed	The trainee was dismissed prior to programme completion. Please specify if • Dismissed: no remedial training undertaken • Dismissed: received remedial training Also whether: • Dismissed: no GMC referral • Dismissed: following GMC referral	 N16 N17 N18 N19	 ☒ ☒ ☒ ☒
Other reason	(Please specify)	N13	☑

(Codes N3-N5 and N7-N9 are intentionally not included. These codes are not transferable to foundation)

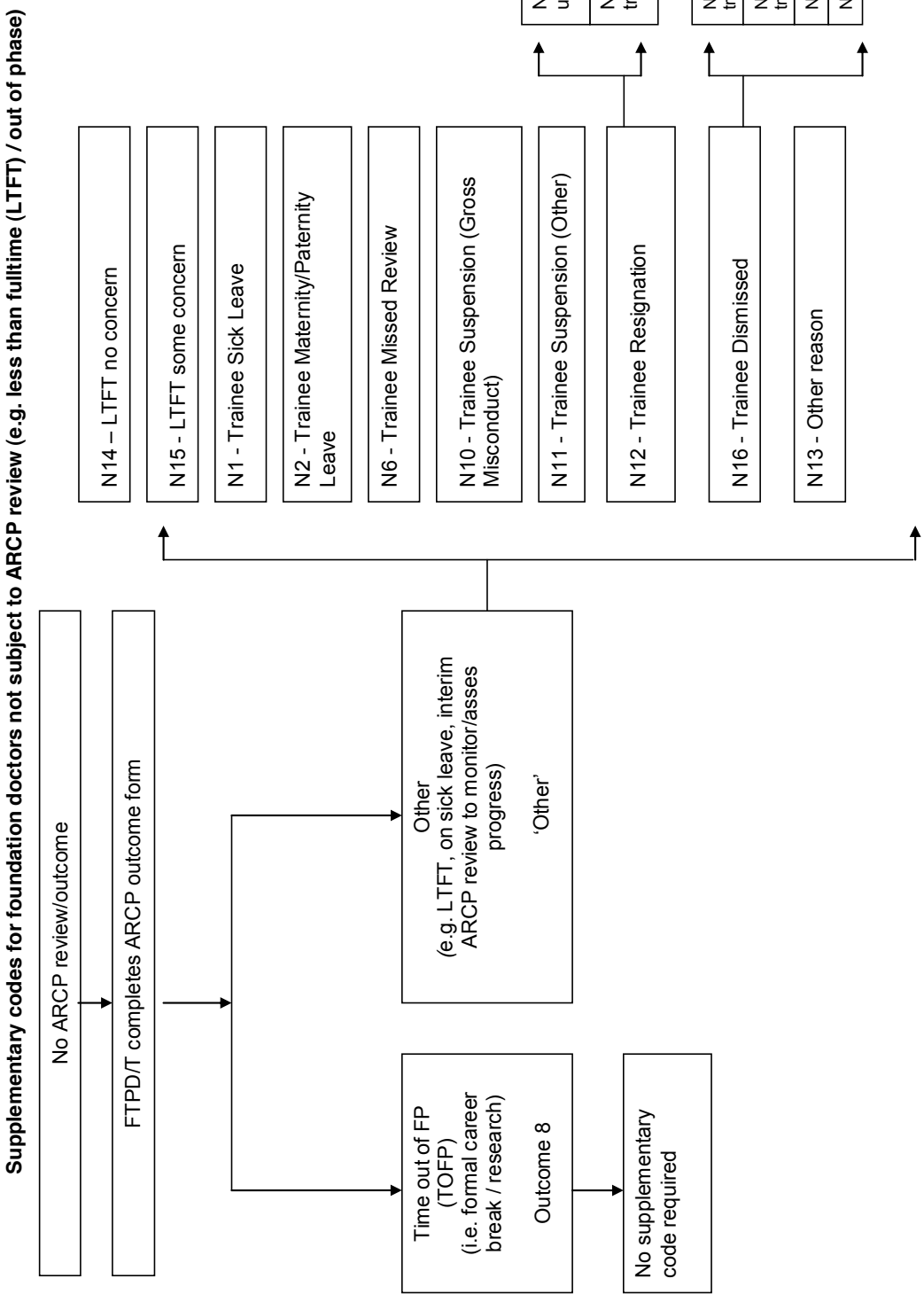
Reasons for doctors not recommended for sign-off (list of 'U' codes)

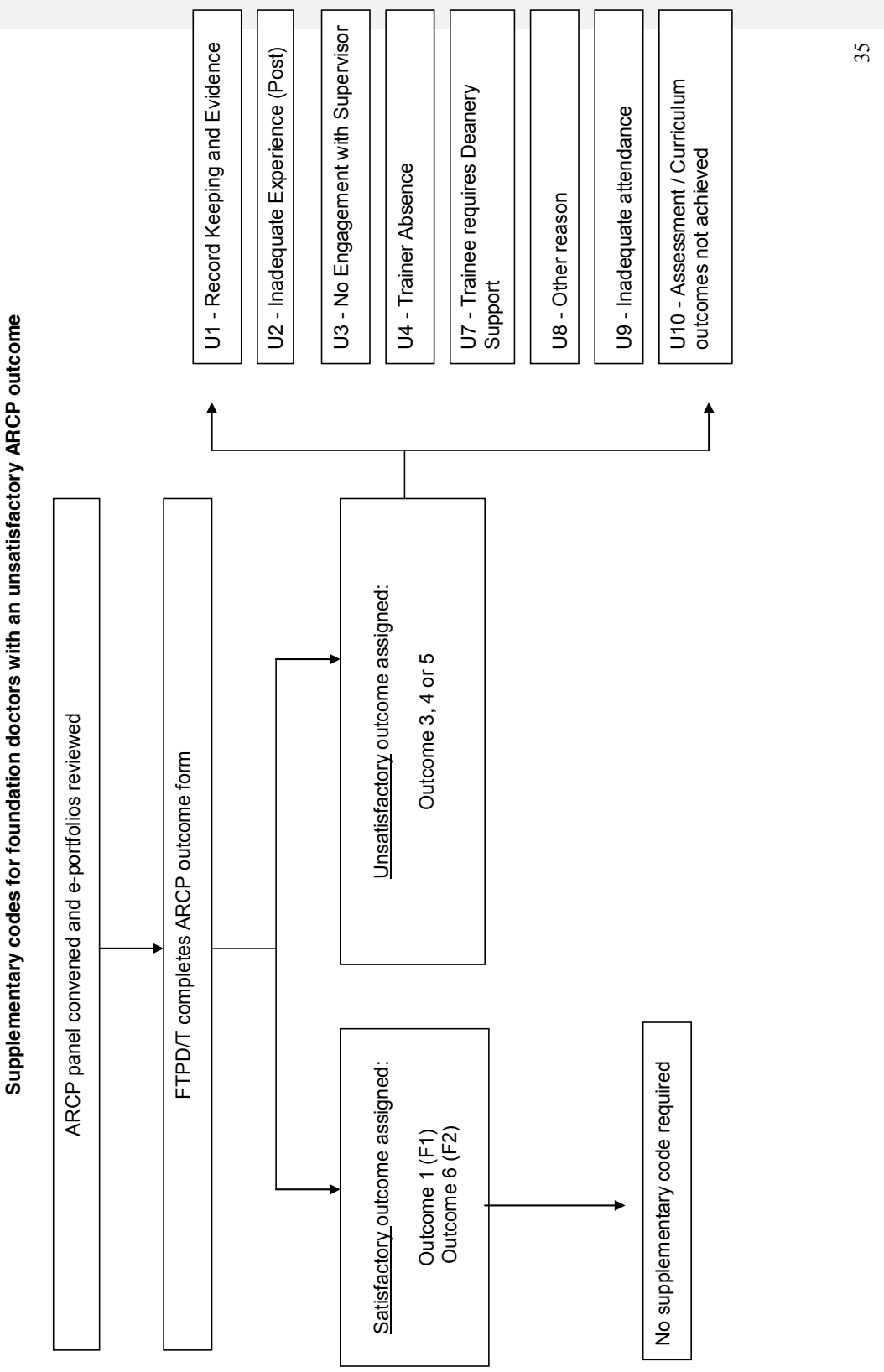
More than one reason may be selected.

Remember:
Most important is recording accurate reason(s) and not learning the codes!

Reason	Explanatory Notes	'U' code	Used in specialty
Record Keeping and Evidence	Trainee failed to satisfactorily maintain their Royal College/ Faculty/ Foundation E-Portfolio including completing the recommended number of Work Placed Based Reviews; Supervised Learning Events, Audits; Research; structured Education Supervisors report; in accordance with recommendations for that particular Year of Training in line with the Royal College/Faculty/Foundation curriculum requirements.	U1	☑
Inadequate Experience	Training post (s) did not provide the appropriate experience for the year of training being assessed in order to progress. As a result the trainee was unable to satisfy the Royal College/Faculty/Foundation curriculum requirements for the year of training.	U2	☑
No Engagement with Supervisor	Trainee failed to engage with the assigned Educational Supervisor or the training curriculum in accordance with the Royal College/Faculty/Foundation requirements for that particular year.	U3	☑
Trainer Absence	Nominated Educational Supervisor or Trainer did not provide the appropriate training and support to the Trainee because of their absence on a sabbatical; through illness or other reasons; and no nominated Educational Supervisor deputy took over to ensure that an appropriate level of training was maintained. As a result the trainee was unable to satisfy the Royal College/ Faculty/ Foundation curriculum requirements for the year of training.	U4	☑
Trainee requires Deanery Support	Trainee has issues to do with their Professional personal skills for example: - behaviour / conduct / attitude / confidence / time keeping / communications skills etc and requires the support of the Deanery Performance Team.	U7	☑
Other reason	This may include the trainee having failed to participate in systems of quality assurances and quality improvement projects. (Please specify)	U8	☑
Inadequate attendance	Trainee exceeded the maximum permitted absence of 4 weeks from training (other than annual leave) and/or has unsatisfactory attendance at formal teaching sessions. *This code should NOT be used to describe a less than fulltime (LTFT) foundation doctors who has satisfactorily attended their pro-rata FP/formal teaching sessions.	U9	☒
Assessment / Curriculum outcomes not achieved	Trainee has failed to meet the outcomes of the FP Curriculum and/or pass the assessments required for satisfactory completion of F1/F2. Formal assessments include: • Core procedures for F1 • TAB • Clinical supervisor end of placement reports • Educational supervisor end of placement reports; and • Educational supervisor's end of year reports.	U10	☒

(Codes U5 and U6 are intentionally not included. These codes are not transferable to foundation)


Supplementary codes for foundation doctors not subject to ARCP review (e.g. less than fulltime (LTFT) / out of phase)
No ARCP review/outcome
FTPD/T completes ARCP outcome form
Other
(e.g. LTFT, on sick leave, interim ARCP review to monitor/asses progress)
'Other'
Time out of FP (TOFP)
(i.e. formal career break / research)
Outcome 8
No supplementary code required
N14 – LTFT no concern
N15 - LTFT some concern
N1 - Trainee Sick Leave
N2 - Trainee Maternity/Paternity Leave
N6 - Trainee Missed Review
N10 - Trainee Suspension (Gross Misconduct)
N11 - Trainee Suspension (Other)
N12 - Trainee Resignation
N16 - Trainee Dismissed
N13 - Other reason
N21 - no remedial training was undertaken prior to resignation
N22 - resignation was post remedial training
N17 - Dismissed no extended/remedial training undertaken
N18 - Dismissed following extended/ remedial training
N19 - Dismissed with no GMC referral
N20 - Dismissed following GMC referral


Supplementary codes for foundation doctors with an unsatisfactory ARCP outcome
ARCP panel convened and e-portfolios reviewed
FTPD/T completes ARCP outcome form
Satisfactory outcome assigned:
Outcome 1 (F1)
Outcome 6 (F2)
No supplementary code required
Unsatisfactory outcome assigned:
Outcome 3, 4 or 5
U1 - Record Keeping and Evidence
U2 - Inadequate Experience (Post)
U3 - No Engagement with Supervisor
U4 - Trainer Absence
U7 - Trainee requires Deanery Support
U8 - Other reason
U9 - Inadequate attendance
U10 - Assessment / Curriculum outcomes not achieved

Technology Enhanced Learning (TEL) Programme

Health Education England

TECHNOLOGY ENHANCED LEARNING (TEL) PROGRAMME

Introduction

The national HEE TEL programme was formally established in October 2013 to enable the share and spread of TEL good practice and activities and effective UK-wide engagement.

This programme was an emergent programme[1] derived from a number of key reports and the HEE mandate[2].

During August 2014, the TEL Programme team undertook an internal review to reflect on the programme direction and work delivered to date. The purpose of this review was to ensure the programme's effectiveness and provide a clearer definition for the programme projects that will enable the delivery of the programme core objectives.

Programme definition document

Following the review, the central programme definition document was put together. This can be found at: **LINK** and includes the following programme information and documentation:

1. Vision statement
2. The programme governance
2.1. Risk management strategy and risk register
2.2. Quality management strategy
2.3. Governance structure
2.4. Programme plan
2.5. Stakeholder engagement plan
3. Projects overview
4. Communications strategy
5. Benefits realisation strategy.

For the latest updates on the programme and projects, visit www.hee.nhs.uk/work-programmes/tel

1. Programme vision

The programme overarching vision is that healthcare in the UK is underpinned by world-class education and training that is enhanced through innovation and the use of existing, evidence-based and emergent technologies and techniques.

This vision originates from the Department of Health's *A Framework for Technology Enhanced Learning* (2011) where existing and emerging technologies in education, training and development should be the 'norm' and where TEL:

[1] **Emergent programmes** evolve from current uncoordinated initiatives, where there is recognition of the value of joined-up approach with an emergent vision and end goal. Source: http://www.best-management-practice.com/gempdf/MSP_White_Paper_V5.pdf

[2] Derived from:

- The HEE Mandate: Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March 2015. Key references to the mandate can be found in **Appendix 1** of this document.
- The Department of Health's A Framework for Technology Enhanced Learning (2011)
- NHS Simulation Provision and Use Study (February 2010)
- ELearning in the Health Sector, some key quality principles (2011)
- 'Commissioning eLearning Resources in the NHS - key principles and guidance' (October 2012)
- CMO's recommendations from the CMO's Annual Report 2008 – Safer Medical Practice;
- Time for Training (May 2010);
- Foundation for Excellence (October 2010)

- is patient-centred and service driven,
- is based on clearly articulated learning needs that are aligned to service needs,
- is innovative and evidence-based,
- is demonstrably delivering high educational outcomes,
- is delivering value for money through improving learning, productivity, avoidance of waste and duplication and by being affordable and cost effective,
- provision across the health and social care workforce is demonstrably equitable.

2. The programme governance

2.1. Risk management strategy and risk register

The programme Risk Management Strategy outlines how the programme will establish and operate procedures for capturing and managing risks (i.e. threats and opportunities). It defines the relationship between risk handling at corporate, programme and project level and the escalation mechanisms that must be put in place between these levels. All programme risks are recorded and tracked on the central programme risk register

2.2. Quality management strategy

The programme quality management strategy outlines which aspects of the programme are subject to quality assurance and control, an outline of the quality criteria that will apply, quality management activities, as well as relevant corporate and external standards and the approach to information management.

2.3. Governance structure

This chart provides an overview of how the programme is governed including the management of the programme projects.

2.4. Programme plan

The programme plan is designed to deliver the future state as set out in the Vision Statement. Given the scale of the programme and the fact that, post transition, new processes, priorities and mandated work will inevitably emerge and be absorbed into the programme, the plan will always be an evolving one.

2.5. Stakeholder engagement plan

As with any national programme, there is a clear need to not only identify and communicate with stakeholders, but to generate greater understanding of their needs, perceptions and priorities in order to ensure its success.

3. Programme projects

The programme is delivering a number of key projects, the first of which is the development and launch of the TEL hub. Below is an overview of the projects and their aims. The projects are underpinned by the overarching programme plan.

3.1. TEL Hub Project

This project sees a future state where there is a national hub/repository in use by all in healthcare as a place to lodge, find, use, co-create, discuss, review the widest range of TEL resources and techniques.

3.2. Barriers and solutions project

This project sees a future state where existing barriers to the easy, equitable, cost effective and innovative use of learning technologies and techniques in the NHS have been reduced or removed and where there are processes and mechanisms in place to prevent and/or resolve any emerging barriers.

3.3. User Needs Research Project
This project sees a future state where the TEL programme team has collected and analysed sufficient user needs data in order to justify, support, monitor and evaluate the TEL Hub Project and other planned projects.

3.4. Stakeholder Involvement Project
This project sees a future state where users have been and are involved in the decision-making, co-creation, monitoring and evaluation of the TEL programme.

3.5. Expert Groups Project
This project sees a future state where there are expert groups/panels who inform HEE on TEL activities and future plans.

3.6. Horizon scanning project
This project sees a future state where HEE has established appropriate processes and mechanisms at national and regional levels whereby horizon scanning is robust and effective.

3.7. Curricula and Training Pathway Project
This project sees a future state where TEL is integral to every curriculum and training pathway and where HEE has established processes whereby data on TEL in curricula/pathways can be obtained.

3.8. Communities of Practice Project
This project sees a future state where HEE is aware of, initiates and supports the development of active communities and networks who come together around specific and generic subject areas/technologies and techniques and works with them as channels of communication and providers of experience and expertise.

3.9. Commissioning Project
This project sees a future state where there are clear commissioning guidelines for TEL technologies and technologies which are adhered to and inform all future TEL commissioning decisions. There is little to no duplication and value for money and high quality is assured.

3.10. Digital Literacy Project
This project sees a future state where clear education strategies that have been developed and adopted nationally and which that all healthcare learners are technologically literate and able to promote and sustain the adoption and spread of new technologies and techniques.

3.11. Integration project
This project sees a future state where the TEL Programme is effectively engaged and integrated with other HEE Programmes that have similar aims and objectives to that of the TEL programme: to enable the share and spread of good practice and avoid duplication via an online hub.

4. Communications Strategy
This Strategy should be used in conjunction with the engagement plan to ensure that all relevant stakeholders nationally are aware or the TEL programme of work. This covers internal (staff) stakeholders and partners as well as individuals, groups and organisations UK-wide.

5. Benefits realisation
This strategy is used to establish the approach within the programme to realising benefits and the framework within which benefits realisation will be achieved.

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