BETTER TRAINING BETTER CARE PROGRAMME THEMATIC ANALYSIS

Title of work-stream	Time for Training (Temple)	Foundation for Excellence (Collins)	Maintaining Quality of Training (Wilson)
1. Improve training and learning to improve patient care **1.1 Appropriate supervision and Implementing a consultant present[1] service** **1.2 Service delivery must explicitly support training**	• Training should be delivered in a service environment with appropriate, graded consultant supervision • Consultants must be more directly responsible for delivery of 24/7 care and will need to work more flexibly • Role of consultants needs to be developed for them to be more directly involved in out of hours care • The doctors clinically responsible for service delivery should be employed in substantive posts under the consultant contract • Newly appointed consultants require mentoring and support • Services must be designed and configured to deliver high quality patient care and training (may be departmental, trust, regional, or national level but will require critical mass of professionals to maintain a viable service)	• Healthcare professionals 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 [Rec 24] • MEE should explore the factors required for quality supervision [Rec 25] • Each institution must have well defined and functional procedures to escalate any quality and safety issues related to education and training [Rec 30]	• Commissioners of services should consider impact on training and education [Rec B] • Employers should tailor clinical sessions to allow for training working with commissioners and IT experts [Rec P]

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

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	• As the ratio of trainees to consultants changes with increasing consultant numbers, it may not be feasible to train in all hospitals • Reconfiguration or redesign of elective and emergency services and an effective Hospital at Night -programme • Rotas require organisation and effective management to maximise training in 48 hours • Current employment contracts need to be reappraised to ensure that they support training within the EWTD • Multidisciplinary team-working must be used to support training • An expansion of any other grade will not support the move to a consultant delivered service model		

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1.3 Make every moment count	• Training must be planned and focussed for the trainees' needs • Trainers and trainees must use the learning opportunities in every clinical situation • Handovers can be an effective learning experience when supervised by senior staff, preferably consultants • The co-ordinated, integrated use of simulation can provide a safe, controlled environment and accelerate learning • Where appropriate, skills and expertise should be learnt in a simulation environment and from other modern techniques, not on patients • Mentoring and support for support for trainees must be improved • Training requires a change from traditional perceptions of learning to a model which recognises the modern NHS • Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers • Extending the hours worked or the length of training	• The FP structure should ensure a more even demand on clinician time for teaching and supervision [Rec 25] • Ensuring appropriate balance between service and education with right of redress by trainees [Rec 28] • Transfer of relevant information about medical students and trainees across the continuum of education and training [Recs 31 and 32]	• Only where there is objective evidence that competences are not achieved within the indicative duration of training should consideration be given to lengthening of training [Rec E] • Frameworks for the delivery of training should allow an extension to training where access to training has been insufficient [Rec H] • Trainees should have greater influence over the location of their training based on evidence of quality training as well as their training requirement [Rec K] • Develop "training opportunities matrices" to make training opportunities clear and accessible [Rec L] • LEPs should establish a planning group with Board Level leadership to consider innovative approaches to maintain the quality of training in the light of reduced training opportunities [Rec N]

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	programmes are not sustainable solutions		
2. Role of the trainee	• Training must be planned and focussed for the trainees' needs • Training requires a change from traditional perceptions of learning to a model which recognises the modern NHS • Trainees must be involved in the decision-making and implementation of training innovations that affect their present and future careers	• 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 [Rec 6] • The GMC should consider producing guidance to support the development of professionalism among trainees [Rec 7] • The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility [Rec 27]	• Only where there is objective evidence that competences are not achieved within the indicative duration of training should consideration be given to lengthening of training [Rec E] • Monitorable standards for different elements contributing to learning and confidence to safely and appropriately use clinical and other skills [Rec G]
3. Role of trainers including educational supervisors	• All consultants when they come into contact with trainees in a clinical situation will have a role in teaching and supervising them • Consultants formally and directly involved in training should be identified • They must be accredited and supported: o Job plans o Reduced service load o Trainees more closely aligned *	• Need a framework for the approval of trainers involved in teaching and assessing trainees [Rec 19] • NHS employment plans for consultants should take account of the time and commitment necessary to undertake proper training and assessment of trainees [Rec 21] * • All FP assessments should be conducted and signed off by	• Guidance needed over time and balance of duties required to properly undertake training, education and monitoring roles [Rec D] • Further work needed on the training, accreditation and assessment/monitoring of trainers [Rec F] • LEPs must ensure medical staff have enough time to teach and train in their job plans [Rec M] *

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	• Organisations involved in the standard-setting and regulation of training must co-ordinate their approach and ensure clarity of these training roles • Trainer excellence must be appropriately rewarded *	resourced, trained and regularly reviewed assessors [Rec 23] • The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility [Rec 27] *	• The roles and responsibilities of trainers must be supported through time and resource and rewarded through the Clinical Excellence Awards schemes [Rec O] *
4. Workforce planning	• 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 • Services must be designed and configured to deliver high quality patient care and training (may be departmental, trust, regional, or national level but will require critical mass of professionals to maintain a viable service) • As the ratio of trainees to consultants changes with increasing consultant numbers, it may not be feasible to train in all hospitals	• Distribution of foundation posts across broader base of specialties [Rec 17]	
5. Improving careers guidance and its availability		• All of the organisations must work together to define good practice for the provision of careers information and advice [Rec 11]	

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6. Developing and integrating Technology Enhanced Learning to improve training, patient care and safety	• The co-ordinated, integrated use of simulation can provide a safe, controlled environment and accelerate learning • Where appropriate, skills and expertise should be learnt in a simulation environment and from other modern techniques, not on patients	• Need for more widespread use of technology to support learning [Rec 18]	
7. Harmonisation and improving foundation training **7.1 Curriculum Development**		• MEE should confirm the purpose of the Foundation Programme [Rec 1] • The GMC should define the outcomes required to complete F2 [Rec 2] • The FP Curriculum should be revised to place greater emphasis on the total patient, long-term conditions, community care and changing ways of working [Rec 15] • The FP Curriculum should integrate fully with medical school curricula [Rec 15] • Streamlining of assessment in FP [Rec 20] • Patient feedback should be part of foundation doctor assessment [Rec 22]	

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7.2 Improving selection		• Improving selection into FP [Recs 4 and 5]	
7.3 Harmonisation and improved delivery		• The FP should remain 2 years with review in 2015 [Rec 9] • FP placements must be for a minimum of four months and a maximum of six months [Rec 10] • The length, content and organisation of the rotational programme must be clearly disclosed in foundation school materials [Recs 10 and 14] • Greater flexibility in allocation of F2 including "swap shops" [Recs 12 and 14] • F1 and F2 should remain generic [Rec 12] • F2 placements should be aligned, as far as possible, with broad areas in which trainees hope to pursue their careers [Rec 12] • Must address mismatch between expectation and reality about career prospects in different specialties [Rec 13] • Successful completion of the FP should normally require completion of a placement in the community e.g. community	

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		paediatrics, general practice, psychiatry [Recs 13 and 16] • Distribution of foundation posts across broader base of specialties [Rec 17] • All FP assessments should be conducted and signed off by resourced, trained and regularly reviewed assessors [Rec 23] • Healthcare professionals 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 [Rec 24] • The FP structure should ensure a more even demand on clinician time for teaching and supervision [Rec 25] • Ensuring appropriate balance between service and education with right of redress by trainees [Rec 28] • Transfer of relevant information about medical students and trainees across the continuum of education and training [Recs 31 and 32]	

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8. Regulatory approach to supporting Better Training Better Care		• The GMC should define the outcomes required to complete F2 [Rec 2] • The GMC should consider producing guidance to support the development of professionalism among trainees [Rec 7] • The GMC should review the timing of full registration, student registration, marking completion of the FP [Rec 8] • The GMC must ensure that standards for training for the FP relating to patient safety are understood by foundation school directors and NHS employers [Rec 26] • The GMC should establish clear guidelines on the level of supervision required by trainees at each stage of their training allowing graded responsibility [Rec 27] • GMC should describe good practice for pastoral support [Rec 30] • Medical schools should explore how best to share information with the GMC about medical students [Rec 33]	

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9. Funding and education quality metrics	• Commissioner levers should be strengthened to incentivise training, ensure accountability and reward high quality and innovation • Prioritise training in providers by linking training criteria to performance targets • Educational governance must be recognised on every trust board by the appointment of a person specifically responsible for education and training * • Monitor the quality of training with a rational, realistic system that looks at a range of indicators to measure the impacts and outputs • Include training outcomes as part of the quality assessment of provider institutions	• MEE should explore the factors required for quality supervision [Rec 25] • Need for quality metrics available at deanery, programme and hospital level [Rec 29] • Trusts must identify an educational lead [Rec 29] *	• LEP measurement of quality of training should be part of the remit of the Care Quality Commission. Develop robust benchmarking standards [Rec A] • Commissioners of services should consider impact on training and education [Rec B] • Review of funding for postgraduate medical education must incentivise high quality training provision with clear tracking of funding [Rec C] • Guidance needed over time and balance of duties required to properly undertake training, education and monitoring roles [Rec D] • LDAs between commissioners and LEPs must contain special measurable objectives for training quality and value for money [Recs I and J]