Developing people for health and healthcare

Broadening the Foundation Programme

Recommendations and implementation guidance

February 2014

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Foreword

With my many years of experience in the NHS, ranging from life as a frontline consultant to my current role as a Chief Executive, I have recognised the importance of having a flexible workforce, capable of meeting the needs of all our patients. I wholeheartedly support the recommendations in this report.

As we move away from the historic paradigms of primary and secondary care settings, we need to ensure that the training of our doctors continues to be aligned to the needs of the patient. This means we need to train our doctors so that they are capable of working in different, innovative, integrated care settings.

Our future medical workforce should not only have the right skills, values and behaviours, but the competence to provide care for the 'whole patient', as part of a multi-professional team working in a system that provides high-quality, timely and affordable care.

Changes are required in the current Foundation Programme to ensure that our newly qualified doctors can be trained so that they are better able to respond to future changes in the country's health and social care system. This report provides realistic guidance to support this development.

Sir Jonathan Michael
Chairman, Better Training Better Care Taskforce
Chief Executive, Oxford University Hospitals NHS Trust

Introduction

England's health and social care landscape is being radically reshaped in response to the many challenges it faces, including the growth in the number of people with long-term conditions and co-morbidities. There are national and international drivers of that change, which will provide more integrated care models and systems that are patient-centred and safe, and that focus on care of the whole patient. That care will increasingly be delivered closer to home.

The Foundation Programme Curriculum 2012,[1] Professor John Collins' *Foundation for Excellence*[2] and the recently published *Shape of Training* report[3] all anticipated these changing care needs for patients and the public, and recommended that foundation doctors develop their capabilities across a range of settings, including the community. This requires training a flexible workforce that is capable of providing care in a range of settings over the course of their careers.

Health Education England has made significant progress in ensuring that doctors in training have a greater awareness and experience of working in community settings, in the care and management of mental illness, and in interface and multi-professional working. To prepare properly for healthcare in the 21st century, this must be consistent across the country. In order to ensure that the doctors of today are being trained to deliver the care of tomorrow, all doctors must undergo the necessary broadbased Foundation Programme and this report provides guidance on how this can be achieved. There are opportunities for innovation in training and service, working together, which will result in better training and better care for patients.

The Task and Finish Group has endeavoured to make sure this is done right first time, and that appropriate and feasible recommendations are developed that respond to current and future issues. The group has worked hard to put process and structure in place, so that the recommendations can be implemented consistently across England, through Local Education and Training Boards.

This Broadening the Foundation Programme report sets out a road map for a managed and phased transfer of a greater amount of training into community-based settings, to ensure that the next generation of foundation doctors are better equipped to provide safe, effective and integrated care.

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1 www.foundationprogramme.nhs.uk
2 Collins J (2010)
3 See Appendix 7

Executive summary

There are significant challenges in preparing doctors for a 40-year career in a healthcare landscape where the only certainty is change. In common with others across the world, the UK healthcare system is changing in response to demographic changes, increasing clinical pressures, rising patient and public expectations and spiralling costs. In meeting these challenges, there are opportunities for both services and doctors to become more patient-centred, more integrated in approach and more effective in meeting the needs of patients, both now and in the future. This report builds on Professor John Collins' recommendations in *Foundation for Excellence*,[4] looks at progress to date in providing a broader-based Foundation Programme, and provides recommendations and guidance on how to achieve the desired changes in education and training.

Changing patient needs

People are living longer but are living with complex and chronic conditions. They are increasingly experiencing longer periods of disability, relating to either or both physical and mental illness. Mental illness accounts for 23 per cent of the burden of disease in the UK but there is a lack of parity in the treatment of physical and mental illness. These patterns demand changes in the way we provide healthcare and in the type of doctors that we need.

Changing healthcare provision

Healthcare provision in the UK is changing rapidly in order to meet the needs of both our patients today and those of tomorrow. Responding to the challenges above and in response to the recommendations of the Francis Report,[5] Keogh Review[6] and Berwick Review,[7] services are being reconfigured in order to provide appropriately patient-centred care. It is recognised that services are too often fragmented and that a more integrated approach is required. There is an increasing shift of services into settings other than the acute.

4 Collins J (2010)
5 The Stationery Office (2013)
6 NHS (2013)
7 Department of Health (2013c)

Changing education and training

The education and training of our doctors must keep pace with these changes. Training doctors must be provided with the foundations from which they can go on to practice in any healthcare setting, in multi-disciplinary teams, in any specialty. They must be trained in ways that enable them to understand healthcare as one system that works seamlessly and effectively to care for the whole patient. There are opportunities for education and training initiatives at foundation level to not only keep pace with service changes but help drive them.

Local Education and Training Boards (LETBs) and Local Education Providers (LEPs) have a key role in encouraging innovation and ambition in the education and training of doctors to meet the needs of patients both now and in the future.

At the request of the Secretary of State for Health, Health Education England (HEE) developed the Better Training Better Care programme to meet the key themes, recommendations and aspirations of Professor John Collins[8]. As part of the programme, three working groups were charged with producing this report on the broadening of the Foundation Programme.

Key messages from the results

Better Training

- There has been good progress towards meeting the Department of Health service level agreement (SLA) targets for multi-professional education and training (MPET)[9] with regard to the redistribution of foundation posts, but current provision does not yet optimally prepare foundation doctors for the changing care environment, or deliver on the Collins recommendations.[10]

- The burden of supervision is disproportionately concentrated in medicine and surgery and there is still insufficiently shared responsibility for supervision across the specialties.

- Placements that are based in the community offer specific, and often unique, learning opportunities that are mapped to the Curriculum and to the changing needs of patients and healthcare services.

- Psychiatry and community placements offer specific opportunities for trainees to develop transferable competencies that are appropriate for managing the 'whole' patient in any setting.

8 Collins J (2010)
9 Appendix 8
10 Collins J (2010)

- As integrated care models emerge, there are exciting placement opportunities for foundation doctors.
- There is a high level of overall satisfaction among trainees with regard to general practice and psychiatry placements.
- Views that community placements are of limited value are relatively common, but are almost universally overturned once these placements have been experienced.

Better Care

- The redistribution of posts has happened in some parts of the country without adverse effects on patient care or on training in the acute setting.
- Where successful redistribution of posts has occurred, it has been the result of planning, pacing and partnership-working, and where stakeholders have been persuaded of the rationale for and benefits of redistribution.
- Service responses to redistribution of posts have varied and are context-specific but substitution models have typically involved staff-grade doctors, nurse practitioners and physician associates.
- Lack of planning for redistribution or sudden removal of posts can result in weaker substitution models, such as agency locum doctors.
- There is reluctance in some areas to engage fully with the necessary planning, both for new posts and for reconfiguration or substitution models within the acute setting.
- Leadership is key in winning hearts and minds in and across organisations, and in developing collaborative solutions and initiatives.
- Negative attitudes towards some substitution models in acute settings have significantly altered once those models have been experienced. Exploration of the development and deployment of alternative healthcare professionals such as physician associates is happening increasingly.

Recommendations

Recommendation 1

Educational supervisors should be assigned to foundation doctors for at least one year, so they can provide supervision for the whole of Foundation Stage 1 (F1), Foundation Stage 2 (F2), or both years.

Recommendation 2

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.

Recommendation 3

a) At least 80 per cent of foundation doctors should undertake a community placement or an integrated placement from August 2015.

b) All foundation doctors should undertake a community placement or an integrated placement 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.

Implementation and impact

- There are challenges to increasing community placements in general practice but evidence suggests that expansion is achievable. Other specialties and integrated care models provide significant potential for additional placements for foundation doctors.
- The move towards 100 per cent of foundation doctors experiencing a four-month community or integrated placement is unlikely to be cost neutral and some investment now will be required.
- LETBs and LEPs must plan and pace redistribution in such a way as to ensure patient safety and high-quality training in both new and existing placements.
- The new integrated approach to education and training being developed within LETBs and in association with clinical commissioning groups and other partners, provides fertile ground for new alignments between service and education and training that will assist in meeting the challenge of implementation.

Innovative approaches

Innovative responses to this report are to be encouraged. Particularly welcome are those initiatives which:

- develop placements within emerging integrated care models
- provide foundation doctors with community experience during their two-year programme, in addition to the required four-month community-based placement
- re-examine existing placements with a view to removing obstacles to trainees developing the knowledge, skills and competence in managing the care of the 'whole' patient
- consider substitution and support models that promote the highest quality patient care in acute settings alongside the provision of similarly high-quality foundation placements.

Summary

- The opportunity to undertake a four-month community or integrated placement will enable foundation doctors to develop and demonstrate the requirements and ambitions of the Curriculum.
- Supervision of foundation doctors must be across a wider faculty and the redistribution of posts should reflect this. All placements should be planned carefully to ensure appropriate support and supervision. Educational supervision should monitor overall progress for a minimum of one year.
- Foundation doctors should ideally have experiences which enable them to understand the planning and delivery of service around patient care pathways. Working in multi-disciplinary teams in different settings and with different specialties will provide opportunities for unique learning outcomes.
- Wherever possible, all foundation placements should include opportunities for doctors to support and follow patients through their entire care pathway.
- Implementing the recommendations of this report will be challenging, however education and training must keep pace with changes in health and social care provision.

- There has been considerable progress towards achieving the aspirations of Collins in *Foundation for Excellence*[11] and there are valuable lessons to be learned from best practice. In areas where progress has been slower, there is a need for the early development of implementation plans that can deliver on recommendations within the timeframe specified.

- HEE has a critical role in developing alternative healthcare professionals such as physician associates and nurse practitioners.

- As integrated education and training strategies take shape, LETBs and LEPs are encouraged to promote innovative responses to the recommendations of this report.

11 Collins J (2010)

Chapter 1: Background

1.1 Introduction: Building a stronger foundation

Nationally and internationally, the health and social care sector is facing major challenges due to changing demographics and spiralling costs and demand.

In the UK, the increasing burden of chronic illness and an ageing population, alongside financial challenges and increasing patient needs, is putting the NHS under severe pressure. As a result, services are too often fragmented and insufficiently focused on patients and their families and carers.

In response to these pressures, our health and social care landscape is being radically reshaped – focusing on patient care pathways, putting mental health on a par with physical health, and becoming more integrated. Therefore, the education and training of the doctors of tomorrow must equip them with the right skills and values to deliver the safe, compassionate and effective care required in this new landscape.

Responding to this, Professor Sir John Temple's report, *Time for Training*,[12] and Professor John Collins' report, *Foundation for Excellence*,[13] made specific recommendations for the future of medical education.

At the request of the Secretary of State for Health, HEE developed the Better Training Better Care Programme to meet the key themes, recommendations and aspirations put forward by Professor Sir John Temple and Professor John Collins.

1.2 The challenges

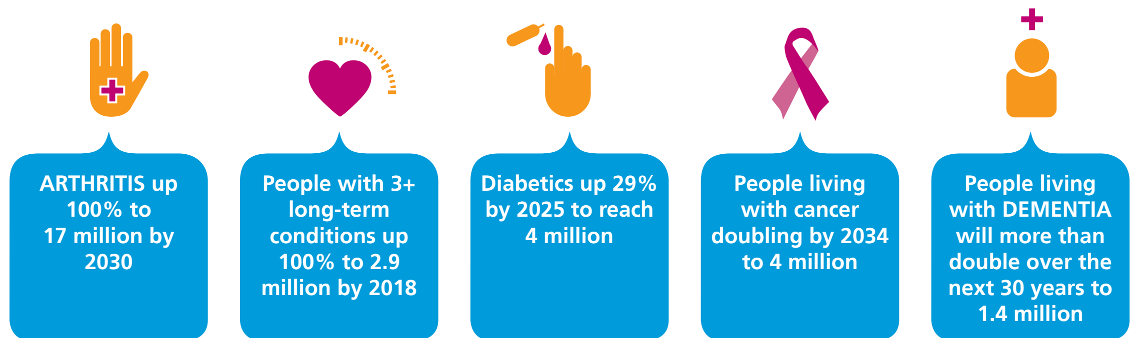
1.2.1 An increasing burden of long-term conditions

Changing demographics in the UK mean that our health and social care services must adapt to the increasing needs of patients with long-term conditions.

People are living longer lives, but face longer periods of disability, including both physical and mental health problems. Lifestyle factors such as smoking, physical inactivity and poor diet contribute significantly to the burden of both physical and mental illness.[14]

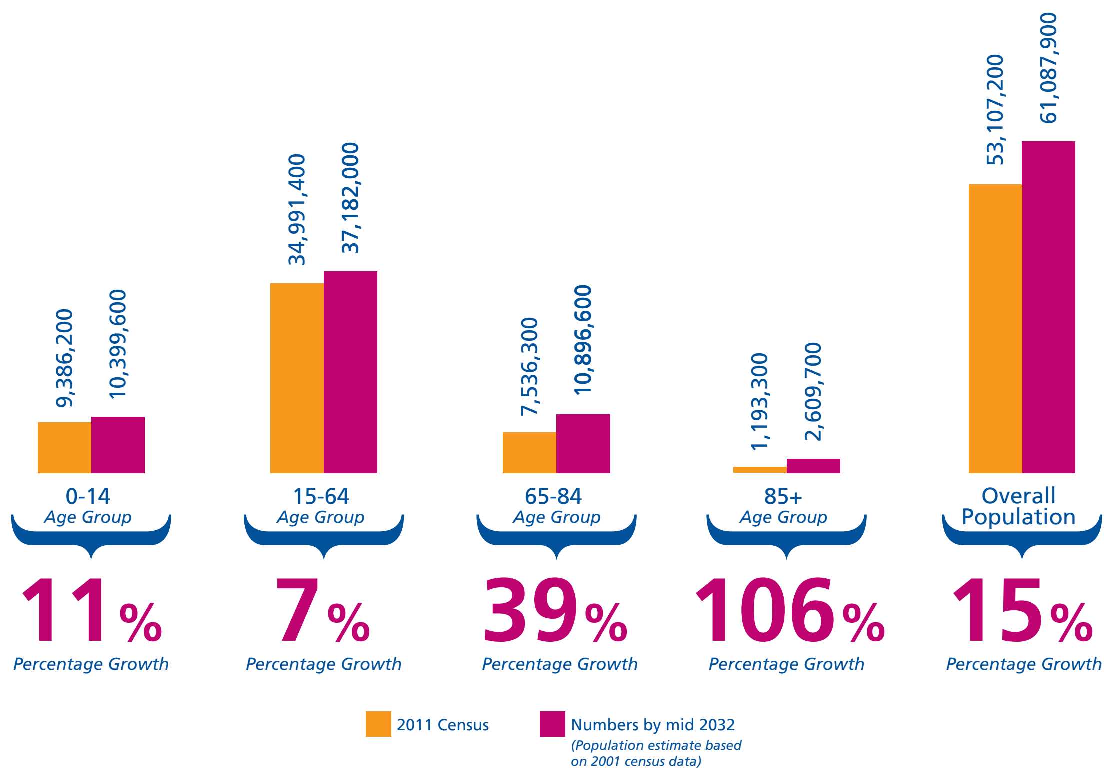
12 Temple J (2010)
13 Collins J (2010)
14 Department of Health (2010)

Figure 1: A rise in chronic disease



Source: Department of Health (2012a)

Figure 2: Ageing population



Source: The Kings Fund, 2011 census data and 2001 census population estimate for 2032, www.kingsfund.org.uk/time-to-think-differently/trends/demography

Figure 3: Population lifestyles present significant risks to health

Source: Naylor C, Parsonage M, McDaid D et al (2012)

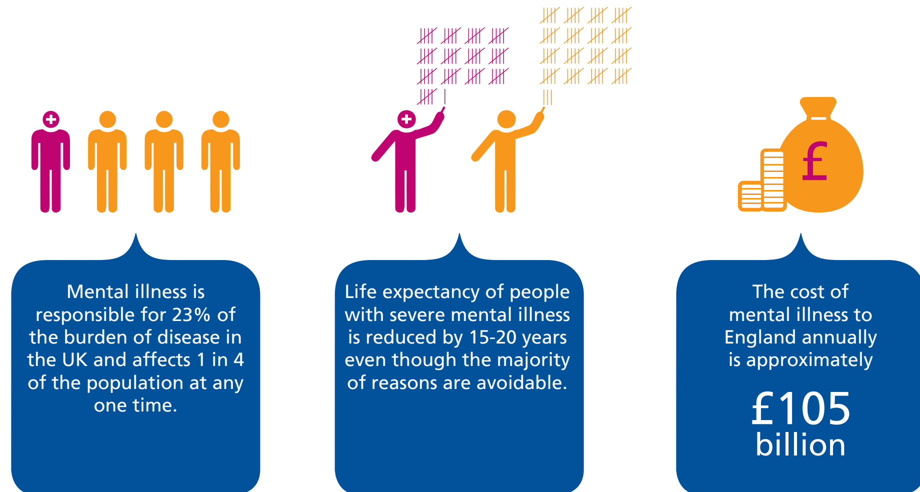
1.2.2 Achieving parity of mental and physical health

Mental illness is responsible for 23 per cent of the burden of disease in England,[15] affecting one in four of the population and costing around £105 billion each year.[16,17,18] Despite this, mental health does not receive the same attention as physical health.

There is a strong relationship between a person's mental health and their physical health. Poor mental health is associated with an increased risk of physical health problems,[19,20,21] and vice versa. The life expectancy of people with severe mental illness is reduced by 15-20 years – and many of the reasons for this are avoidable.[22,23] Providing care that recognises this, engages equally with physical and mental health and seeks to care for the whole person may help to achieve this.

15 World Health Organization (2008)
16 Wittchen HU, Jacobi F, Rehm J et al (2011)
17 McManus S, Meltzer H, Brugha T et al (2009)
18 Centre for Mental Health (2010)
19 Hemingway H, Marmot M (1999)
20 Nicholson A, Kuper H, Hemingway H (2006)
21 Fenton WS, Stover ES (2006)
22 Mykletun A, Bjerkeset O, Overland S et al (2009)
23 Chang C-K, Hayes RD, Perera G et al (2011)

Figure 4: Mental illness in the UK



Source: World Health Organization (2008); Wittchen HU, Jacobi F, Rehm J, et al (2011); McManus S, Meltzer H, Brugha T, et al (2009); Centre for Mental Health (2010); Mykletun A, Bjerkeset O, Overland S et al (2009); Chang C-K, Hayes RD, Perera G et al (2011)

Figure 5: The correlation between long-term and mental health conditions

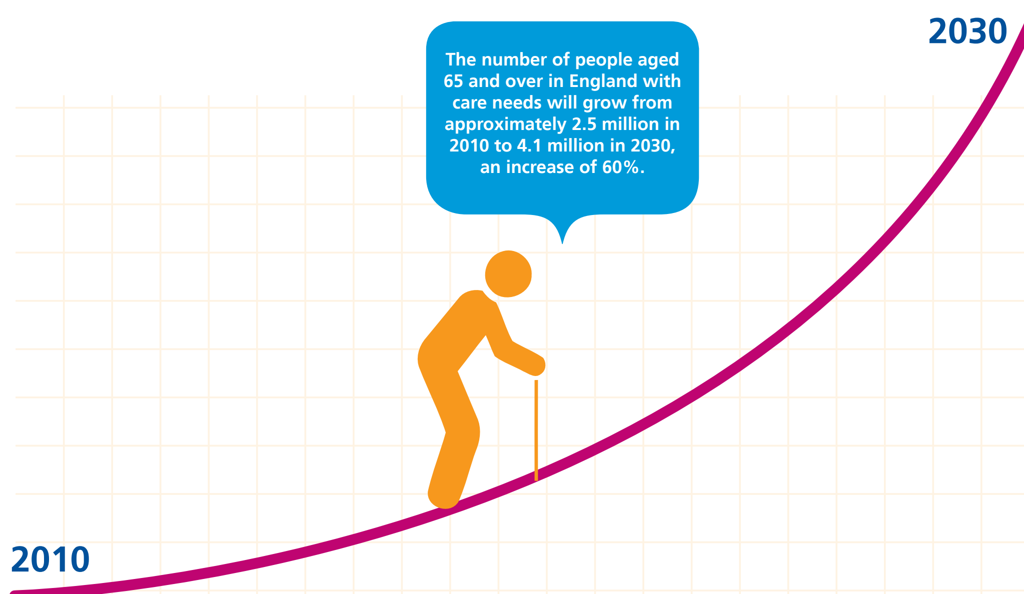
Source: Department of Health (2012a)

1.2.3 Fragmented systems

The existing health and social care systems in the UK are fragmented, and patient care can lack continuity and coordination. To patients and the public, the system doesn't always appear best-matched to their needs and wellbeing.

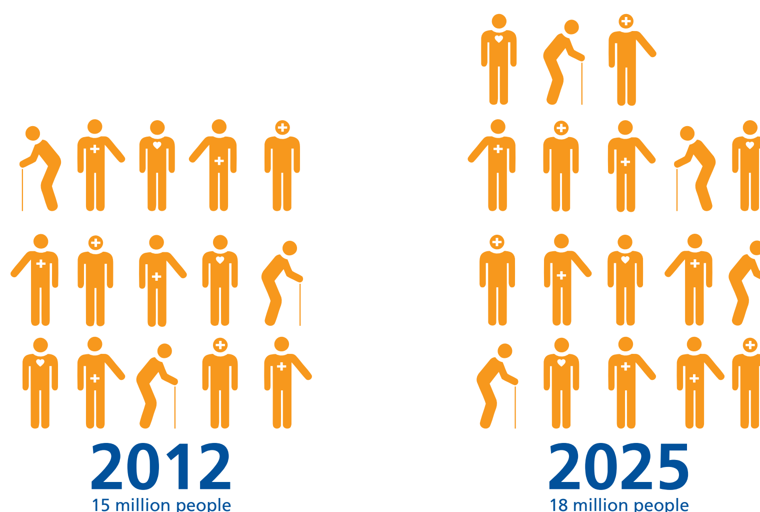
However, a vulnerable and ageing population, including patients with mental illness and patients with multiple, complex long-term conditions, requires health and social care that is coordinated, seamless, and closer to home.

Figure 6: Over 65s with care needs



Source: The King's Fund analysis of Office for National Statistics 2010-based National Population Projections, www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/care-demands-dementia
Note: these are based on Office for National Statistics mid-2010 estimates and will be superseded by 2011 census-based projections.

Figure 7: More people with long-term conditions



Source: Department of Health (2012a)

1.2.4 Putting the patient at the heart of everything we do

The Foundation Programme must allow doctors to develop professional and clinical skills, knowledge, and competencies to practise and promote safe, competent and compassionate medicine.

Building on the recommendations of *Time for Training*,[24] *Foundation for Excellence*,[25] and the Francis Report,[26] Keogh Review[27] and Berwick Review,[28] patient focus and patient safety must be at the heart of training and care. Any recommendations or guidance regarding the Foundation Programme must nurture and reinforce these values.

1.2.5 Broadening medical training and education

The Foundation Programme must prepare doctors to practise in any specialty, and in any setting, enabling them to provide effective and holistic care that includes physical and mental health, and both long-term and acute illnesses. They will require an understanding of all patient pathways, regardless of intended specialty.

24 Temple (2010)
25 Collins (2010)
26 The Stationery Office (2013)
27 NHS (2013)
28 Department of Health (2013c)

To deliver this successfully, all foundation placements should provide doctors with appropriate and effective supervision, and the opportunity to improve services, identify and reduce risk, and continuously improve patient care.

1.3 Integrated care

1.3.1 The move towards integrated care

Clinicians, healthcare managers and government are increasingly accepting that integrated care is the best way to align our healthcare services with current and future needs.

Integrated care emphasises the need for continuous and coordinated care that puts the patient perspective at its heart, reshaping traditional 'silo' working and enabling the planned and efficient delivery of care both within – and beyond – the NHS.

It is designed to address the disjointed and fragmented care that many patients currently experience, making the interactions that patients and their families and carers need to have with health and social services as simple, flexible and responsive as possible.

1.3.2 Achieving integrated care

Transformation of the NHS around the need for person-centred care, across a range of healthcare settings, is essential. Different parts of the NHS will need to work more effectively together, and with other organisations and services – such as social services and the third sector – in order to drive and deliver more 'joined-up care'.[29] Services must be better integrated around people's needs.[30]

Delivering reshaped services will require a workforce with the right skills, and the ability and experience to work effectively across clinical settings.[31] Increasing, and increasingly effective, cooperation, collaboration, and coordination between health services, social care, public health and the third sector is recognised as essential.[32]

29 Department of Health (2012b)
30 Department of Health (2011)
31 Department of Health (2013a)
32 Department of Health (2013b)

Figure 8: An integrated care model

Source: Adapted from a diagram from the Northern Ireland Department of Health, Social Services and Public Safety website www.dhsspsni.gov.uk/index/tyc/tyc-timeline.htm

1.4 The educational policy context: the recommendations of Professor John Collins

- The Foundation Programme "should remain at two years for the present and be reviewed in 2015".[33]

- The Foundation Programme should ensure that foundation doctors are able to contribute to the effective working of the multi-disciplinary team, and that supervisors can make informed judgements about their capabilities. To allow this, "the length of rotations must ensure that a foundation doctor is in a single placement for a minimum of four and a maximum of six months by 2012".[34]

- "The completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, e.g. community paediatrics, general practice or psychiatry."[35]

- "The distribution of specialty posts in the Foundation Programme is predominantly in two specialties and this must be reviewed by 2013 to ensure broader based beginnings, to share the supervision of trainees among a wider number of supervisors and to ensure closer matching with current and future workforce requirements."[36]

- The Foundation Programme should "give greater emphasis to the total patient, long-term conditions and the increasing role of community care".[37]

1.5 In summary

This report builds on previous recommendations and provides guidance that places safe, high-quality patient care at its heart – both for the patients of today, and the patients of tomorrow. With an emphasis on safe medical education and training that addresses the whole patient, across all settings and specialties, it reiterates existing recommendations around broadening the Foundation Programme and makes further recommendations on the precise nature and pace of change.

The report contains guidance for implementing the changes required, drawing on case studies, consultation data and focus group exercises, and the work of the three groups who have produced this report.

33 Collins J (2010, p70, Recommendation 9)
34 Collins J (2010, p72, Recommendation 10)
35 Collins J (2010, p86, Recommendation 16)
36 Collins J (2010, p86, Recommendation 17)
37 Collins J (2010, p83, Recommendation 15)

Chapter 2: Methodology

2.1 Working groups[38]

In September 2012, a Broadening the Foundation Programme Task and Finish Group was established to take forward key recommendations from *Foundation for Excellence*[39], and to steer and oversee the activities of two sub-groups, Better Training and Better Care.

The Better Training group was tasked with analysing the current allocation of foundation posts, assessing training capacity in under-represented specialties and community-based placements, and assessing what additional community-based placements were required. It was to provide recommendations as to how high-quality placements could be brought into practice and evidence that the proposed recommendations would enhance the training experience of doctors.

The Better Care group was tasked with gathering evidence regarding the redistribution of posts, providing guidance detailing good practice in terms of adapted clinical service in response to redistribution, making recommendations on transitional models to achieve redistribution targets, and providing best-practice models and ideas for innovative, integrated approaches to community provision.

2.2 Methods

The groups adopted a mixed methodological approach, using a range of qualitative and quantitative methods to gather data on placements, including:

- current provision
- available research on the educational value of placements
- attitudes and perceptions around the value and utility of placements
- deanery and foundation school plans for 2014-15, for the provision of placements in line with targets outlined in the Department of Health's MPET SLA 2012-13[40]
- the quality of training, and any correlation between a trainee's Foundation Programme or school and their specialty careers
- the quality of supervision

38 Fuller details of the working groups plus full institutional and individual membership of the groups can be found in Appendix 9, together with terms of reference for each group

39 Collins J (2010)

40 The Department of Health MPET SLA 2012-13 requirements of the Medical Foundation Programme can be found in Appendix 8

- the experience of trainees with regard to placements, person-centred care, supervision and any experience of interface working across traditional healthcare settings

- trainer and trainee perspectives on current placements, including integrated and community-facing placements, with regard to training as well as patient safety and care

- plans for, and responses to, any redistribution of foundation doctors' posts from specific specialties into community or integrated placements, with regard to the real or potential impact on patient safety and care, and indicative costs around any substitution or reconfiguration plans.

The groups undertook:

- a literature review

- General Medical Council (GMC) data analysis of the GMC trainee survey results

- a consultation exercise with deaneries, foundation schools and trusts

- a request to deaneries for plans for the provision of community and psychiatry placements over the next two to three years

- face-to-face and telephone interviews with a range of healthcare professionals across the country in order to create detailed case studies[41]

- two focus groups with training doctors[42]

- a consultation exercise with trusts to establish existing or planned activity around the redistribution of foundation doctor posts.

41 Further details about the case studies can be found in Appendix 5
42 Further details about the focus groups can be found in Appendix 6

The groups agreed on definitions for use within the report. A full list of definitions can be found in Appendix 11 but for easy understanding of subsequent chapters, the definitions in relation to community placements are:

Community placement: This is a four- to six-month placement with a named clinical supervisor, which is primarily based in a community setting, such as general practice, community paediatrics, palliative care, public health or community psychiatry. The learning outcomes will typically include the care of the whole patient, the care of patients with long-term conditions and the increasing role of community care.

Integrated placement: This is a four- to six-month placement with a named clinical supervisor, primarily based in a community setting, which crosses traditional care boundaries and supports the development of capabilities in the care of patients along a care pathway. As with community placements the learning outcomes should also include the care of the whole patient, long-term conditions and the increasing role of community care.

Community-facing placement: This is a four- to six-month placement with a named clinical supervisor where the foundation doctor is primarily based within an acute setting. In addition to the specific learning outcomes required to care for patients in the acute environment, the placement should also include opportunities to develop skills in the care of the total patient, long-term conditions and the increasing role of community care.

Chapter 3: Overview of the evidence

3.1 Current situation

The groups sought to review and analyse existing evidence whilst undertaking additional data-collecting exercises, which were dependent on response rates, participant availability and the timeframe of the work.

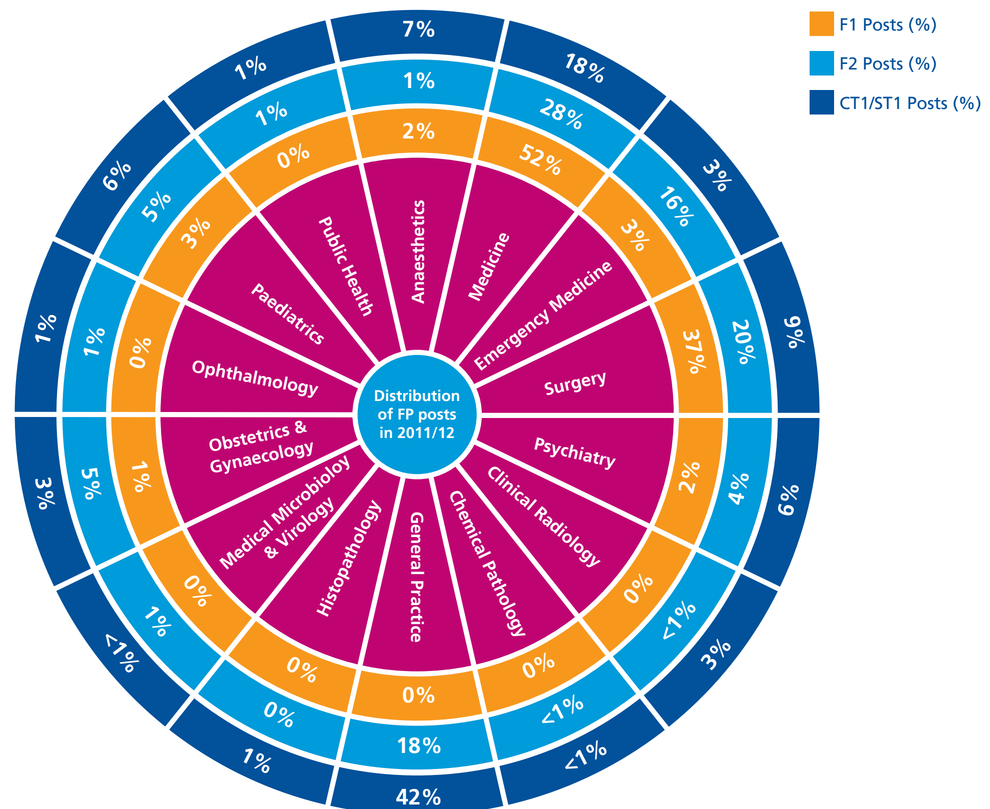
3.1.1 The Foundation Programme today

The current provision of training, including the distribution of posts, does not yet fully prepare all foundation doctors for the changing care environment or deliver on recommendations.

The default position remains that trainees should complete a four-month placement in a community setting, typically in general practice or psychiatry, however the emergence of innovative approaches – equally able to deliver the unique learning outcomes associated with community placements – is to be encouraged.

3.1.2 The current distribution of Foundation Programme posts

Figure 9: Distribution of foundation posts/supervision by specialty (England, 2012)



Data provided by UKFPO

3.2 The results

3.2.1 Quality of supervision

3.2.1.1 Evidence from working groups, focus groups and case studies

Placements in general practice

Trainees reported ready access to senior support and valued the regular, high-quality feedback that they received. General practice receives the highest satisfaction ratings of all specialty placements in the Foundation Programme, and trainees felt general practice supervision contrasted well against hospital supervision.

Placements in psychiatry

Whilst there is some evidence of inadequate supervision of foundation doctors participating in out-of-hours rotas, overall supervision in psychiatry was rated extremely highly. Trainees felt that, in terms of quantity and quality, the supervision they received exceeded that which was customary in acute placements.

Integrated placements

There is still little evidence on these emerging placements. Evidence available from the Oxfordshire case study[43] suggested carefully planned, close supervision within a multi-disciplinary team that is rated highly by trainees.

Community-facing placements

There is little specific evidence relating to supervision in these placements. Trainees are based in the acute setting, so evidence of supervision relates to the named specialty and not specifically to any community element within that placement.

43 See Appendix 5

Case Study 1: Integrated placement for F2 in the Emergency Multi-disciplinary Unit (EMU) at Abingdon Community Hospital, Oxfordshire

The unit, staffed by consultants, GPs, nurses, occupational therapists, social workers, healthcare assistants and an F2 doctor, gives urgent care patients access to speedy investigations and diagnosis in the community. Patients are typically referred by their GP, but also by the ambulance service, emergency departments and local hospital wards. EMU makes clinical decisions about whether patients need to go into an acute or community hospital, or receive care at home. It also facilitates discharge from the acute hospitals.

Patients are clerked, assessed and preliminary observations are undertaken. ECGs and blood transfusions are possible. Patients can remain in the unit and/or in dedicated EMU beds for up to 72 hours, when they may be admitted to the acute or community hospital if necessary. With its own transport, EMU can make prompt and flexible decisions, with patients, about length of stay in the unit.

Specific/unique learning opportunities for the foundation doctor

- Clear understanding, and experience of, clinical decision-making within a multi-disciplinary team
- Direct relationship with primary care colleagues – by the bedside
- Different cultural relationship in managing risk. In an acute setting, there is always an awareness of specialists within the same building, which can influence decision-making. In this setting, the trainee has to think through risk in a different way but in a safe context, within a multi-disciplinary team and with seniors to hand.

Supervision

- The supervisor works in close proximity to the trainee, and is an experienced senior used to working in an interface role. In terms of delegated supervision, the foundation doctor is working in a small unit within a team and is never alone.

This case study in full can be found in Appendix 5

3.2.1.2 *GMC analysis of supervision*

The GMC trainee survey reveals satisfaction levels regarding supervision, according to specialty. Analysis of the data shows that placement supervision is clearly variable, with post-specialty groups affecting the likelihood of a trainee scoring in the bottom quartile for certain indicators, particularly with regard to clinical supervision and overall satisfaction.

With regard to clinical supervision, surgery, obstetrics and gynaecology, medicine and emergency medicine showed significantly higher levels of dissatisfaction than other post-specialty groups, while dissatisfaction levels for anaesthetics, general practice, paediatrics and psychiatry were much lower. Trainees in surgical posts were between 2.8 and 6.1 times more likely than those in all other post-specialty groups to score in the bottom quartile for clinical supervision.

In terms of overall satisfaction, only surgery trainees were more likely to be dissatisfied than the norm, whereas trainees in anaesthetics, emergency medicine and general practice were less likely to be dissatisfied than the norm.

Overall, emergency medicine was the post-specialty group with a significantly positive effect on the most indicators, while surgery showed a significantly negative effect on the most indicators. Anaesthetics tied with psychiatry for the least number of indicator scores on which it had a significantly positive effect (four), and tied with general practice for the least indicators on which it had a significantly negative effect – none at all.

3.2.2 Foundation doctor satisfaction

3.2.2.1 *The literature review*[44]

Foundation doctors often find that any preconceived negativity about community placements, such as fears over a lack of clinical exposure or irrelevance to their learning, curriculum or intended career path, is overturned once having undertaken such a placement. Doctors comment positively on the opportunities to develop transferable skills, to treat people as ‘people’ and not ‘just diseases to be cured’, and to learn about interface working. Trainees perceive such placements as beneficial in terms of lifestyle and flexibility, although some comment on the risk of isolation to single doctors in geographically remote placements.

44 The full literature review can be found in Appendix 8

3.2.2.2 Evidence from the GMC survey, working groups, focus groups and case studies

Placements in general practice

General practice placements are associated with the highest satisfaction ratings of all specialties. Post-placement, they are considered to be of real educational value regardless of intended specialty.

Placements in psychiatry

Trainees, particularly those not intending a career in psychiatry, can have relatively negative attitudes towards these placements. The evidence suggests that the placement experience overturns these attitudes, resulting in high satisfaction rates and more positive attitudes towards the specialty. However, some trainees can feel isolated if on a site away from peers, and this was particularly true of F1 doctors.

Case Study 2: F1 psychiatry placement at the Bennion Centre, Glenfield Hospital, Leicester, Leicestershire Partnership NHS Trust

Trainees (two F1 doctors) expressed the view that more F1 doctors need to undertake a psychiatry placement. Although not intending a career in psychiatry, they valued this placement and felt it had improved their care of patients in an acute setting. They felt that a lot of acute patients have chronic pain that is treated with strong medication rather than through unpicking anxiety and depression.

They have found the placement offers a much better interface with community, offering more varied and frequent interface working in multi-disciplinary teams, for example, with community psychiatric nurses and social workers coming on ward rounds. They had never encountered these roles before, and in the acute setting it is often the nursing staff who liaise with other professionals, such as social workers: "This is my first real experience of multi-disciplinary working."[45]

The trainees offered a lot of praise for the team working at the centre, and the resulting feeling that they were an integral and valued part of this: "People look at you as the doctor. There is a lot of respect here … Everyone brings a lot to patient care. The occupational therapists are amazing. The nurses are amazing … It's a nice environment. Team work." The doctors recognised that they had not felt any isolation (when questioned about this) because there were five of them so they cover each other; there was a lot of team working.

This case study in full can be found in Appendix 5

45 All quotes in this results chapter are taken from consultation responses, focus group and/or case study participants.

Integrated placements
There is still little evidence on these emerging placements. Case study evidence reveals high levels of satisfaction, with specific and unique learning outcomes rated highly.

Community-facing placements
There is little specific evidence relating to supervision in these placements, which see trainees based in the acute setting, and therefore evidence of satisfaction relates to the named specialty and not specifically to any community element within that placement.

3.2.3 Knowledge, skills, competence and attitude

3.2.3.1 The literature review

The evidence shows that community placements offer better, even unique, opportunities to develop specific Foundation Programme competencies, with views expressed that long-term care is often best experienced in community-based placements. General practice placements are seen as better than other placements at providing and developing the skills expected from foundation doctors. In one study, 55 per cent of respondents ranked general practice top of specialties in terms of giving the experience and skills expected of the Foundation Programme Curriculum.

Negative attitudes towards community placements are relatively common, with perceptions that the placements are 'easy', the hours are reduced and there are fewer learning outcomes. The evidence shows a striking change in attitude following the placement, with nearly unanimous views that a community placement is beneficial and that previously held negative attitudes were incorrect.

3.2.3.2 Evidence from working groups, focus groups and case studies

Placements in general practice
Trainees felt that general practice placements offered better opportunities to develop competencies relating to long-term conditions and care, and had developed their skills to a greater extent than other placements. In particular, they felt that general practice offered unique opportunities around interface working, decision-making, dealing with uncertainty, communication skills and caring for the whole patient. Trainees valued the opportunity to gain greater understanding of the impact of illness on patients, family and community.

Prior to their placement, some trainees anticipated concerns such as loss of clinical skills, less complex cases, poorer training and education, and it being an 'easier' placement than others. However, there was a near unanimous view that, once undertaken, the experience of a general practice placement overturns preconceived ideas, concerns and prejudices.

"Even though I don't want a career as a GP, I found my placement so helpful when I came back into the hospital setting as it helped me understand the pressures they are under and provided me with the necessary links in and out of the hospital." (F1 from focus group)

"The supervision in general practice training is really good because the GP is around to ask questions, and dedicated time is given for this." (F1 from focus group)

Placements in psychiatry

Trainees felt that these placements offer unique opportunities to develop skills, understanding and empathy in caring for people with mental health illnesses and conditions. Specific learning opportunities included caring for the whole patient, learning about pain management, honing history-taking skills, interface and liaison working and multi-disciplinary working. Trainees spoke of the transferability of these skills and the benefit of employing them on return to the acute setting. There were concerns, particularly in advance of community psychiatry placements, that trainees risked losing some acute care/procedural skills and/or clinical confidence, and they would welcome increased opportunities to help maintain these through such placements. Notwithstanding, trainees interviewed found that such fears were largely unfounded on return to practice in the acute setting.

Integrated placements

The Oxfordshire case study[46] highlighted specific learning opportunities around decision-making within a multi-disciplinary team, gate-keeping, interface working, developing direct relationships with primary care colleagues and developing a different cultural relationship with regard to managing. The placement offered trainees the opportunity to assess and manage chronically and acutely ill patients in a setting more appropriate than A&E.

Community-facing placements

In some community-facing placements, the demands of service in the acute setting put pressure on the community elements of a placement to the extent that they can be lost entirely. Placements with community elements risk being seen as 'medical tourism', with trainees dipping in and out of sometimes tokenistic community experiences, where clear learning outcomes have not been defined and where there can be inadequate or inappropriate supervision.

46 See Appendix 5

3.2.4 Patient satisfaction/experience/outcomes

3.2.4.1 The literature review

There is very limited data that is specific to patients. The existing evidence pertained to general practice, and showed that patients highly rated the care they had received from foundation doctors.

3.2.4.2 Evidence from working groups, focus groups and case studies

In terms of patient experience, trainees' views suggested patients valued the amount of time that trainees could spend with them, both in general practice and in psychiatry placements. In one psychiatry placement, trainees spoke of the value to patients in having foundation doctors' medical skills available within multi-disciplinary mental health teams, where there can be a lack of recent medical experience.

3.2.5 Career choices

3.2.5.1 The literature review

In psychiatry, those who had undertaken a psychiatry placement showed a greater tendency to select this specialty than those without such exposure. With regard to general practice, there is clear evidence of foundation doctors changing their career preference following such a placement. In one study, the number of respondents planning a career in general practice increased from 60 to 77 per cent, following their general practice placement experience.

3.2.5.2 Evidence from working groups, focus groups and case studies

There is evidence to show that experience of psychiatry placements increases motivation towards psychiatry as a career choice. This is similarly true of general practice placements.

3.2.6 Financial considerations for trainees

3.2.6.1 The literature review

There was minimal evidence here. Community placements generally result in reduced banding, due to lack of on-call activity. This can be a disincentive for doctors when choosing their placements. The review found most evidence was in relation to placements in general practice, with relatively little focusing on placements in psychiatry. The literature review in Appendix 7 provides a fuller understanding of results.

3.2.6.2 Evidence from working groups, focus groups and case studies

The lack of increased banding potential in general practice and community psychiatry placements was a financial consideration for some doctors. This was not felt to be a significant issue among most of the doctors interviewed, although some did express the view that community placements with on-call potential would be an attractive proposition.

3.3 Consultation exercise

A questionnaire was sent out to foundation school directors/managers and directors of medical education in trusts, and 20 responses were received.

3.3.1 Community placements

These involved the trainee being based in the community on a four-month placement. Examples of community placements included general practice, psychiatry, public health, palliative care, general practice with public health, community geriatrics and genito-urinary medicine. Blended examples, with the trainee still based in the community, included:

- split general practice/community specialty, with three days in general practice and two in another community setting, such as substance abuse medicine, contraception and sexual health, palliative care, public health

- psychiatry, with one month spent in acute medicine and the following three in psychiatry

- an eating disorder unit, with some acute work in an emergency assessment unit.

3.3.2 Community-facing placements

These involved the trainee being placed in an acute post, but with some community experience. Examples included:

- one day a week with a dementia team
- paediatrics with community experience
- obstetrics and gynaecology with community experience, genito-urinary medicine (GUM) clinics
- cardiology with clinics in the community
- obesity, nutritional and exercise programmes in the community – built into any placement
- surgery – stoma care clinics, community clinics
- a series of modules, typically six to ten days, built up over a two-year period to allow sufficient community experience.

Case Study 3: Community-facing placement, Salisbury NHS Foundation Trust

From August 2013, one of the cardiology F1 posts will have a weekly commitment to psychiatry. The trainee will join the dementia ward round every Thursday morning to develop greater awareness and understanding of those patients being admitted with dementia and delirium. They will also gain an understanding of the role of Independent Mental Capacity Advocates (IMCAs) and when Deprivation of Liberty Safeguards (DOLS) and capacity assessments are required. In the afternoon, the trainee will join the mental health liaison nurse to gain further insight into the psychiatric conditions seen in an acute hospital and how they are managed.

This case study in full can be found in Appendix 5

It is clear from some of the responses to the consultation, and in discussion throughout the working groups, that there is some lack of clarity and understanding about community-facing placements. In working towards meeting existing targets, there is a mis-conception that a degree of community experience within an acute placement equates to or is a substitute for a four-month community placement.

3.3.3 Integrated placements

No examples of integrated placements were provided in the responses received.

3.4 Working towards Department of Health MPET SLA targets: the experience of LETBs and LEPs

3.4.1 Evidence from consultation exercise, case studies and representatives on working groups

There has been considerable progress in meeting the targets set in the 2012-13 Department of Health MPET SLA[47], and it looks likely that these targets will have been met by 2015. However, progress is variable around the country.

3.4.2 Views on challenges in meeting targets

3.4.2.1 Impact on service

The potential impact on service was most commonly presented as a major challenge in meeting targets. The potential financial impact and the potential negative impact on patient safety were also cited as reasons for slower progress in some parts of the country.

> "The loss of acute service from foundation doctors whilst they are moved to the community is an ongoing battle, as is the funding for the posts."

47 See Appendix 8

3.4.2.2 *Educational impact*

There were some concerns that reducing posts in a specialty through redistribution would impact negatively on the remaining foundation doctors in that specialty. However, those who had experienced a significant degree of redistribution reported that this had not been a problem.

3.4.2.3 *Supervision*

There is a need to recruit more general practice and psychiatry educational supervisors, which has been presented as a challenge in some areas.

> "We need to engage with more general practice and psychiatry trainers and to have them as educational supervisors ... and to participate more in delivering the teaching curriculum for both F1 and F2."

3.4.2.4 *Negative attitudes*

The case for the educational and service need for doctors who have experienced working in a community setting is not yet accepted by all.

Some respondents reported negative attitudes from both trainers and trainees towards community-based and psychiatry placements. Some are still to recognise the specific and unique educational outcomes that these placements can provide, and that are required in order to fulfil the expectations and aspirations of the Foundation Programme Curriculum.

> "Some foundation trusts … continue to ignore national directives."

> "There is a challenge about [trainees'] perception about posts and programmes [community] which is often hard to dispel."

3.4.2.5 *Unrealistic expectations*

It was reported that some trainees had unrealistic career expectations and that some were still unfamiliar with the availability of posts in different specialties.

3.4.2.6 *Learning outcomes*

There were some concerns expressed that trainees would not acquire sufficient clinical skills within the two-year programme if spending four months in a community setting.

3.4.2.7 *Environment*

Geographical isolation of lone trainees was raised as a consideration. Other challenges include the lack of physical space for trainees in some general practice environments.

> "Proposed posts [psychiatry] were suggested in a setting nearly one hour away from the base hospital, which would isolate the foundation doctors."

> "Lack of physical space in general practice … lack of rooms …"

3.4.3 Views on progress towards the targets

3.4.3.1 Impact on service

Where posts had been redistributed, comments suggested that service had not been adversely affected. In the main, this appears to be due to reconfiguration of services and substitution models that have ensured safe and appropriate patient care.

Varied experiences with regard to mitigating financial impact suggest that forward planning is essential. It is evident that partnerships with workforce, executive and operational colleagues are essential in planning for redistribution, in order to mitigate any adverse effects.

Initial scepticism and negativity regarding the impact on service seems to have subsided in those areas where there has been change, and there is also evidence of changed minds and attitudes.

> "Working closely with workforce and operations colleagues can result in data, for example around the use and cost of locums, that can help build business cases for the redeployment of monies within a trust, even if no new monies are available."

> "There is a need to help colleagues understand what change might mean and how it might not be as negative as initial perceptions might suggest. For example, Trauma & Orthopaedic colleagues with experience of surgical care practitioners can talk to general surgeons and explain that this type of substitution can work well, if not better."

> "Some of the most resistant have become quite evangelical." (Speaking about the introduction of physician associates)

3.4.3.2 Educational impact

Some comments considered the negative educational impact on those trainees who did not have experience of a community-based placement, explaining the difficulty in achieving all the intended learning outcomes of the Foundation Programme Curriculum without that experience.

> "For those trainees who do not go into psychiatry or general practice, it can be difficult to ensure that they understand the consequences of referring patients and the different complex systems and interfaces in place within the NHS and the social services."

3.4.3.3 Supervision

Comments from some respondents indicate enthusiasm on the part of psychiatry consultants in helping to shape new psychiatry placements, and in being instrumental in making real progress towards targets.

3.4.3.4 Negative attitudes

Some initial negativity, particularly from clinicians in the acute setting, is common. In terms of winning hearts and minds, the evidence suggests that close working in partnership, well in advance of redistribution of posts, is essential. It would seem that persuading key people of both the need for change and the opportunities it might present are essential in enabling planning for mitigation and/or innovation.

Where negative attitudes have been overturned, it seems that this has often been the result of speaking to colleagues with experience of change and learning from their experience.

> "The challenge … is that of enabling LEPs to understand the rationale for change, specifically around the movement of posts from acute care to community-based. This challenge was overcome by discussion with Foundation Training Programme Directors and using this group as the key personnel to win hearts and minds. This has enabled the school to look at different ways of organising specific posts."

> "Intensivists (practitioners of intensive care) are looking at the use of critical care practitioners in other parts of the country. Surgery is … looking at surgical care practitioners elsewhere. Surgical care practitioners are not doing ward-based care, but are going to be doing work that training doctors would have done, such as pre-op, consent, discharge and so on."
> "There was huge resistance initially … [this] has eroded quite a lot."

3.4.3.4 Learning outcomes

Some comments focused on the demands of service in the acute setting impacting negatively on education and training. In addition, there were comments about the need to reconfigure both service and posts, including redistribution of posts, to ensure trainees are able to meet the learning outcomes of the Foundation Programme over the two years.

There is evidence of planning to address concerns that doctors in community-based placements may become de-skilled and/or lacking in confidence. These mainly involve creating community-based placements that involve some acute work.

> "Trusts need junior doctors to staff rotas … [there is the] danger of this superseding educational needs."

> "[There is] the need to develop a service through reconfiguration that is not dependent on trainees, in order that trainees can be best directed/deployed in terms of their training requirements."

> "One of our challenges has been to ensure that trainees working in psychiatry can continue to progress their acute competencies by doing on-call in the acute hospital. To achieve this we have worked with our psychiatry colleagues to develop safe inductions to both organisations and to front load the acute medical work in the first few weeks of the placement."

3.5 Summary

a) The majority of community placements are typically situated in general practice.

b) There has been significant progress towards meeting the targets for general practice and psychiatry placements.[48]

c) The response to meeting targets in some areas has been the creation of community-facing rather than community-based placements, and a clearer understanding of the targets is needed.

d) The evidence from the literature review and other data sources highlights the benefits of community, psychiatry and integrated placements in the education and training of foundation doctors.

e) There is a broad consensus around the need for broadening the Foundation Programme as a means to ensure that the doctors of the future are appropriately trained, although there are some dissenting voices.

f) There is evidence of innovative responses to the creation of both community-based and community-facing placements.

g) Integrated care services are emerging around the country, but as yet there are very few Foundation Programme placements in such models. Some of the case studies reveal innovative placements either in existence or being planned.

h) Any negative attitudes towards community placements are almost always overturned following these placements. Trainee levels of overall satisfaction and satisfaction with supervision are very high for both community and psychiatry placements.

i) The redistribution of posts to create more community-based placements is clearly challenging but achievable, and has been successfully completed in a number of areas.

j) Any redistribution of posts has required careful planning and partnership working.

k) There is evidence around the country of sharing experience and practice regarding reconfiguration of service and/or substitution models as a way of improving patient care and meeting educational and training outcomes and targets.

l) In areas where significant progress towards integrated care models/systems has been made, there are plans to develop services to have less dependence on trainees, in order that they can be best deployed in terms of training requirements.

m) The perceived impact on service of the redistribution of posts has clearly been a disincentive in some areas.

n) Hearts and minds still need to be won with regard to the educational value of all trainees undertaking a community placement.

48 See Appendix 8

Chapter 4: Recommendations

Providing safe and effective care for patients with acute conditions, while enabling the healthcare system to support a growing population with multiple long-term conditions, requires a new approach to education and training.

As members of multi-disciplinary teams, medical graduates need to develop their capabilities to compassionately care for the whole person, including physical and mental health conditions, across a range of different settings. As service delivery increasingly shifts towards the community, doctors will have to be capable of leading teams in changing environments as they continuously strive to improve the quality of care.

The Foundation Programme is the first step in the medical graduate's journey to independent practice. The training experiences must nurture professional values and provide a managed environment for foundation doctors to develop the general capabilities required for safe and effective patient care in both acute and community settings. Further work is needed to broaden the range of learning experiences and ensure that every foundation doctor rotates through at least one placement outside of the traditional hospital setting.

This chapter sets out the principles and makes specific recommendations to broaden the Foundation Programme. Mindful that the clinical landscape is changing, local education and training boards also have an exciting opportunity to pilot innovative approaches.

4.1 Principles for broadening the Foundation Programme

4.1.1 The principles underpinning the proposed changes to the delivery of training in the Foundation Programme are to:

Remain patient-centred – any changes must safeguard patient safety, outcomes and experience, protecting current high-quality patient care while making the necessary changes to meet future healthcare demands.

Deliver broader educational outcomes – the changes aim to realise the ambitions and build on the outcomes set out in the Foundation Programme Curriculum 2012.[49]

Align to the work of the multi-disciplinary team – the arrangements must ensure that the foundation doctor becomes a member of the multi-disciplinary team.

Support high-quality supervision – workplace-based activities must enable the placement supervision group to make an informed judgement at the end of the placement, and the educational supervisor to do so at the end of each year.

Promote innovation – while the typical pattern of training in the Foundation Programme is six four-month placements, each in a single specialty, there is scope to explore and evaluate new approaches to delivering better training and better patient care.

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49 www.foundationprogramme.nhs.uk

Figure 10: The principles underpinning the proposed changes to the delivery of training in the Foundation Programme

4.1.2 Patient-centred

Broadening the Foundation Programme aims to improve future patient care by ensuring that foundation doctors are trained in high-quality placements across a range of different settings. Despite the relative inexperience of foundation doctors, many hospital-based services are currently dependent on them for patient care.

The pace of redistribution of posts must not destabilise safe clinical service provision. It will take time for clinical services to develop and fund alternative arrangements for the provision of patient care. These new arrangements have the potential to enhance patient safety, outcomes and experience, as the members of the team are unlikely to rotate as regularly as foundation doctors. HEE has a critical role in developing alternative healthcare professionals such as physician associates and nurse practitioners.

At the heart of these changes is the need to reinforce a culture of patient-centred care, which nurtures professional values, realises the expectations set out in the NHS Constitution and promotes compassionate care. Therefore, decisions about new posts and which posts to retain should be determined by both an assessment of the quality of the learning environment and the opportunities to expand the range of settings.

4.1.3 Delivering broader learning outcomes

The Foundation Programme Curriculum 2012 places greater emphasis on the care of patients with long-term conditions.[50] It begins to redress the balance of earlier editions, anticipating that all foundation doctors will have the opportunity to train in a community setting:

> "During the two-year programme, foundation doctors will increasingly be able to work adaptively in healthcare teams to manage acutely ill patients as well as those with long-term conditions. Competences in the syllabus should be acquired

50 www.foundationprogramme.nhs.uk

> in a variety of clinical settings. Some competences are achieved most readily in the context of specific placements; for example, those competences relating to long-term care are usually best experienced in community-based placements. The UK health service is moving towards delivering more care in the community and this will require foundation doctors to increasingly gain experience of and demonstrate competences within community placements. Many rotations already have placements, which allow for the experience of caring for patients with long-term diseases in the community and it is anticipated that the availability of community placements will increase. Foundation doctors should also learn about management of patients with long-term conditions by involvement in inpatient and outpatient care and meticulous discharge planning. This will further develop their understanding of long-term care in the community."

The Foundation Programme Curriculum 2012[51] is underpinned by two central concepts: patient safety and personal development. Foundation doctors are expected to continuously strive to improve their performance, in order to provide the highest possible quality of healthcare.

It focuses on good clinical care, including the recognition and management of the acutely ill patient.[52] Specific mention is given to the management of patients with acute mental disorders and who self-harm,[53] although many foundation schools have found it challenging to provide adequate experience in this area. Greater emphasis is now given to the management of patients with long-term conditions.[54] The opportunity to develop capabilities in the assessment and management of patients with long-term conditions is restricted by the lack of community placements and the chances to contribute to outpatient clinics.

The Foundation Programme uses a spiral approach to learning, affording foundation doctors the opportunity to revisit learning opportunities in a range of different specialties and develop their capabilities incrementally. They must not act beyond their competence and must be supervised at all times. The clinical placements typically focus on the component parts of patient care, recognising that it takes many years to develop the high-level capabilities required for integrated care.

It is unlikely that any single placement in the Foundation Programme will enable foundation doctors to demonstrate all of the learning outcomes set out in the Curriculum. Therefore the programme as whole must enable foundation doctors to acquire, develop and demonstrate these outcomes. Innovative approaches to foundation training are to be encouraged.

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51 www.foundationprogramme.nhs.uk
52 Section 8
53 Section 8.6
54 Section 10

Ensuring that all foundation doctors rotate through a placement in a community setting will enable them to develop and demonstrate the ambitions set out in the Curriculum. Providing a broader range of learning opportunities in the Foundation Programme will strengthen their capabilities in the following areas:

- A multi-disciplinary approach to patient-centred care
- Coordination of care across traditional boundaries in partnership with patients and their carers
- Identification, assessment and management of acutely ill patients in community settings
- Assessment and management of patients with long-term conditions, including the management of patients with long-term mental disorders.

4.1.4 Supervision and multi-disciplinary team working

The roles and responsibilities of educational and clinical supervisors are described in Chapter 5 of the *Foundation Programme Reference Guide 2012*.[55] These build on the GMC standards set out in *The Trainee Doctor.*[56] The GMC have provided further details about their requirements for clinical and educational supervisors in *Recognising and Approving Trainers: The Implementation Plan.*[57]

One of the drivers to redistribute posts in the Foundation Programme was the need to spread responsibility for supervision across a wider faculty. *Foundation for Excellence* recommended that the distribution of specialty posts in the Foundation Programme be reviewed "to share the supervision of trainees among a wider number of supervisors and to ensure closer matching with current and future workforce requirements".[58]

Due to the relative inexperience of F1 doctors and the need for closer supervision, F1 placements should be in settings where there is a critical mass of healthcare professionals who can provide immediate support and direct supervision. F2 will typically lend itself more towards integrated and community-based placements, although close supervision must be provided at all times.

At the end of each placement, the named clinical supervisor, along with the other members of the healthcare team (the placement supervision group), makes a judgement about the performance of their foundation doctors. Therefore, it is essential that foundation doctors

55 www.foundationprogramme.nhs.uk
56 GMC (2011)
57 GMC (2012)
58 Collins J (2010, p86, Recommedation 17)

spend sufficient time working with the clinical supervisor and the multi-disciplinary team. Professor John Collins, in *Foundation for Excellence*, recommended that: "The length of rotations must ensure that a foundation doctor is in a single placement for a minimum of four and a maximum of six months by 2012."[59]

There remains variation in practice around educational supervision. Most foundation schools assign an educational supervisor with responsibility for at least a year. This approach most closely aligns to the Curriculum and allows for the establishment of a supervisor/supervisee relationship over one or two years. This also enables the educational supervisor to monitor progress, support the supervisee's learning and ensure that issues identified are addressed.

The model of assigning a new educational supervisor risks creating a fragmented learning experience. Therefore it is recommended that foundation schools assign educational supervisors for a minimum of one year.

4.1.5 Promote innovation

Many traditionally hospital-based providers are moving to a more integrated model of patient care, which includes networks of community-based hospitals, clinics and shared care with general practice. While the high-level capabilities required to lead and deliver such care may take years to develop, foundation doctors can learn as members of these multi-disciplinary teams and contribute to a more integrated model of care.

> "There is a lack of knowledge about alternative systems and services available, other than hospital-based services. If juniors were utilised to go out into the community, we could perhaps help prevent admissions." (F2 from focus group)

Integrated models are typically organised around patient care pathways and often include different services and specialties. The underlying principle is that care is patient-centred and coordinated.

All foundation placements should consider how they can support the provision of integrated care across patient care pathways, such as timetabled opportunities to train under supervision in community clinics, and through domiciliary visits that meet the learning outcomes of the Curriculum.

All foundation placements should be planned and mapped within a coherent, broad-based two-year programme that is designed to deliver the learning outcomes of the Foundation Programme Curriculum.

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59 Collins J (2010, p72, Recommendation 10)

There may also be other approaches to delivering the learning outcomes. These innovative placements or learning experiences must ensure that the foundation doctor becomes a member of the multi-disciplinary team, support robust and coherent supervision and enable the placement supervision group to observe the foundation doctor over a reasonable period of time, to make an informed judgement about their capabilities. These innovative placements and learning experiences should be piloted and evaluated.

> "It would be much better to create a more rounded training experience so that trainees can deal with the whole patient, such as mental health issues." (F1 from focus group)

4.2 Recommendations

In order to deliver a broader experience in the Foundation Programme, provide a more consistent approach to supervision, and realise the ambitions set out in the Foundation Programme Curriculum, the following changes are needed:

4.2.1 Recommendation 1

Educational supervisors should be assigned to foundation doctors for at least one year, so they can provide supervision for the whole of F1, F2 or both years.

4.2.2 Recommendation 2

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 of the traditional hospital setting, for example, a programme might include a general medicine placement in F1 followed by an integrated F2 placement in geriatrics.

4.2.3 Recommendation 3

a) At least 80 per cent of foundation doctors should undertake a community-based placement or an integrated placement from August 2015.

b) All foundation doctors should undertake a community-based placement or an integrated placement from August 2017.

4.3 Reporting and monitoring

The following recommendations will be monitored by HEE through the established reporting mechanisms with the LETBs.

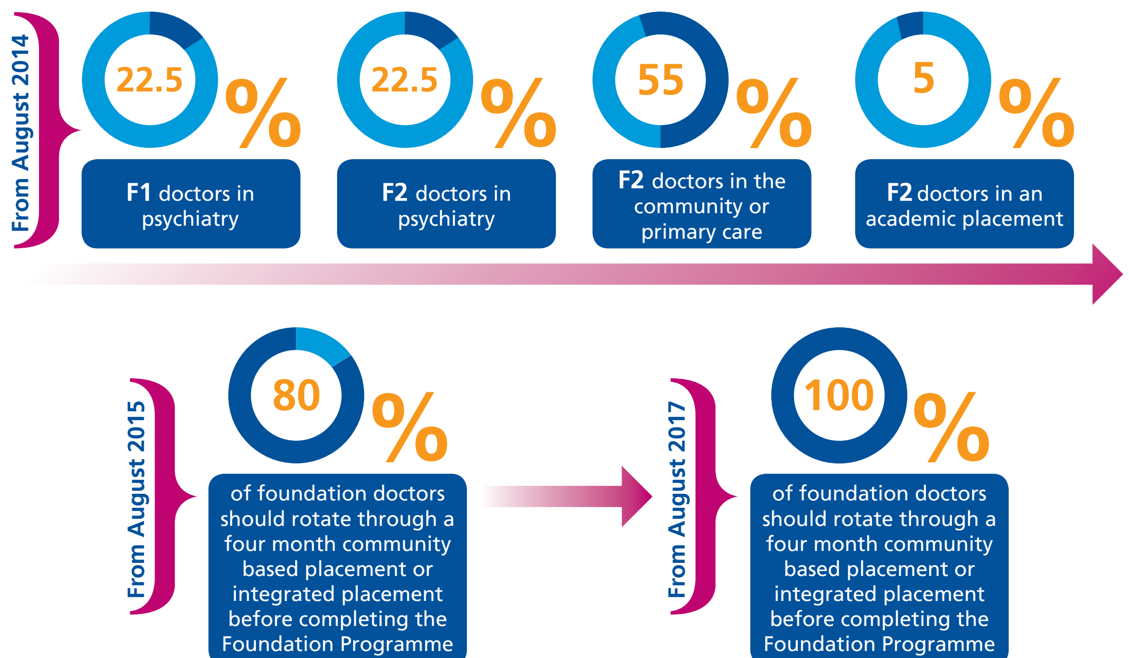
Medical Foundation Programme

- LETBs should ensure the provision of training placements and programmes for F1 and F2 doctors. This should include four-month placements for at least:
  - 22.5 per cent of F1 doctors in psychiatry
  - 55 per cent of F2 doctors in the community or primary care
  - 5 per cent of F2 doctors in an academic placement

- LETBs should indicate what plans they are putting in place to provide at least:
  - 22.5 per cent of F2 doctors with a four-month psychiatry placement, from August 2014
  - 80 per cent of foundation doctors with a four-month community-based placement or integrated placement before completing the Foundation Programme, from August 2015.

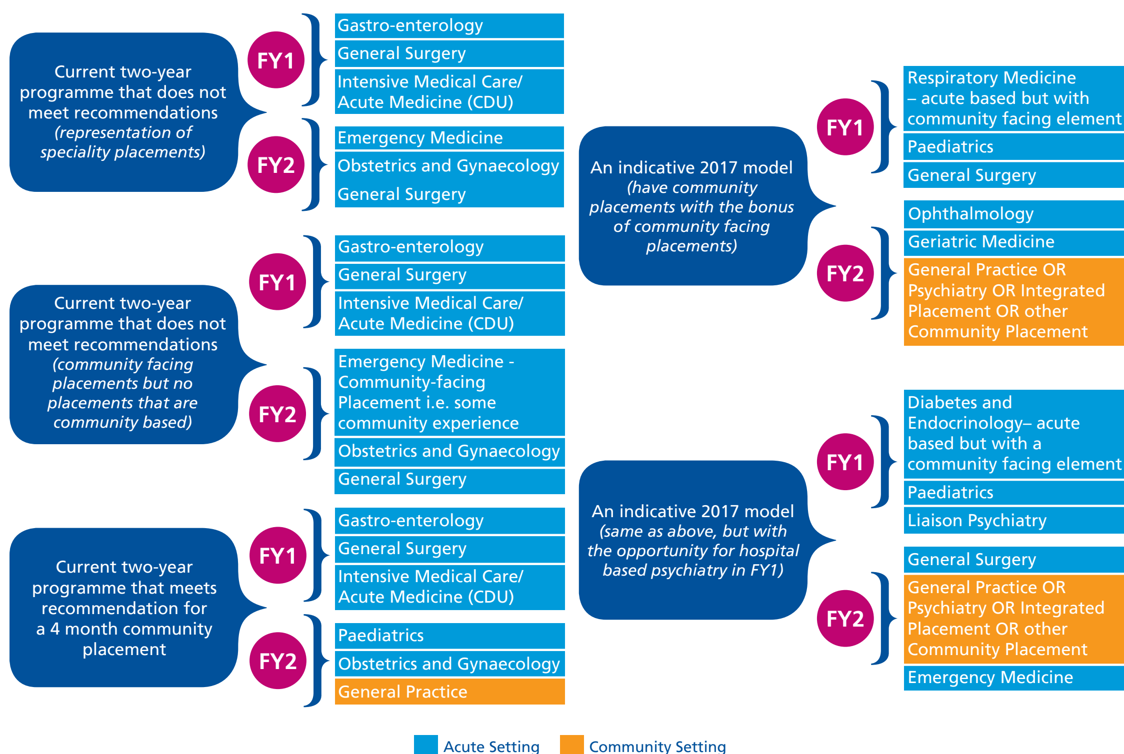
LETBs should also indicate what plans they have to provide a four-month community placement or integrated placement for all foundation doctors, starting in August 2017.

Figure 11: Recommendations for 2014-15



NOTE: Community-facing placements, although they can provide added value and can go some way to providing specific learning outcomes that can only be gained through community experience, are not to be considered as ways of meeting the above targets.

Figure 12: Indicative foundation programmes – current and future



Chapter 5: Implementation

5.1 Implementation and impact

In terms of the redistribution of posts from specific specialties, it is likely that posts will move from surgery and, to a lesser extent, from medicine.

> "The distribution of posts is predominantly in two specialties and this must be reviewed by 2013 to ensure broader based beginnings and to share the supervision of trainees among a wider number of supervisors and to ensure closer matching with current and future workforce requirements."[60]

Trainees should not, typically, undertake more than one placement in the same specialty (although, given the range of sub-specialties in medicine, it is accepted that some trainees will rotate through more than one medical placement during the two years), but there should be different, distinct and level-appropriate learning outcomes in each placement.

The evidence clearly shows that it is possible to achieve the set targets for F2 general practice placements. The North Western Deanery, whose functions have now been subsumed into Health Education North West, has achieved 100 per cent placements in this area, well above the target. In addition, other four-month community placements should come from other specialties or from integrated placements. Growth in the area of other community and integrated placements is expected and to be encouraged, given the growth in integrated care.

The current funding tariff will change from April 2014. Currently, 100 per cent of F1 and 50 per cent of F2 base salaries are fully funded from MPET. General practice posts are 100 per cent funded, whether in F1 or F2. The new model will see all posts moving to 50 per cent base salary funding, with an educational placement fee provided in addition. It is recognised that trusts will be modest losers on F1 doctors but will gain overall with regard to F2 doctors.

The potential for savings through integrated care models that reduce hospital admissions is likely to be in the longer term rather than short term. It is recognised that such savings will benefit commissioners rather than individual providers, but there may be indirect associated savings for LEPs also.

The move towards 100 per cent of foundation doctors experiencing a four-month community placement is unlikely to be cost neutral. As discussed in Chapter 1, the strategic drivers for change, in order to bring about the benefits for patients and to equip tomorrow's doctors for a changing world, require the system to invest now in order to bring about future savings.

60 Collins J (2010, p86, Recommendation 17)

There is a lack of evidence around the cost of redistribution of posts, with existing data rendered outdated, given the changes to the tariff from April 2014. With regard to costs, any redistribution of posts will need to be planned in advance in order to minimise or negate the costs of locum doctors, which will always be one of the most expensive substitution models. Evidence from group members suggests that any sudden or unplanned loss of training placements or posts can be very costly. Placements removed due to concerns about the quality of training, for example, have resulted in LEPs having to respond quickly with a substitution model that has proved very expensive, such as the use of agency locums.

Unplanned redistribution may result in a negative impact on remaining trainees and this needs to be factored into careful discussions around service and educational responses to reconfiguration and redistribution of posts.

Case Study 4: East Midlands

A coordinated approach across the region has been taken, with the foundation schools working with trusts to explain the need to meet national targets. Redistribution and conversion of posts were met with some initial resistance but the foundation school directors report that trusts accepted the fairness of the approach and the educational need for redistribution. A planned, phased approach was essential.

Trusts have responded in a variety of ways. Some have substituted foundation doctors with staff-grade doctors, while others have reorganised their services. There has not been a great deal of negative feedback in terms of financial impact on trusts. Similarly, feedback from trainee surveys has not shown a negative impact on trainees remaining in the acute setting.

This case study in full can be found in Appendix 5

5.2 Innovative approaches

The NHS mandate[61] and HEE mandate[62] charge the NHS with transformation in a changing health and social care landscape, particularly with regard to the reshaping of models and systems to provide integrated care. Therefore, innovation in the creation and/or reshaping of placements is essential if the workforce of the future is to acquire the appropriate skills.

61 Department of Health (2012b)
62 Department of Health (2013a)

Innovation in the provision of placements that meet the 2017 targets for community and integrated placements is essential but should not be restricted to these targets. Providing foundation doctors with community and other experience during their Foundation Programme, in addition to the required four-month community placement, is to be encouraged.

Innovation in terms of substitution models is also to be welcomed. The role of the physician associate is just one that is under increasing investigation. Trained in the medical model, physician associates are typically paid at Band 7 although some may be employed at Band 6 in their first post-qualification year.

Case Study 5: Physician associates at Shrewsbury and Telford Hospital, and Queen Elizabeth Hospital Birmingham

The role of physician associate (formerly known as physician assistant) is growing in the UK, and involves working alongside doctors in hospitals and in general practice. Physician associates work in a wide range of specialties and typical duties involve taking medical histories, performing examinations, analysing test results and diagnosing. They are responsible to a supervising clinician. Interviews were held with seven physician associates, across a range of specialties. Specific duties discussed were clerking, holding their own clinics, education of patients, trauma calls, assisting in theatre (for example, opening and closing), audit, holding post-operative clinics and working in a multi-disciplinary team.

"… saves a lot of money and energy … we offer a triaging service, surgery, post-operative etc … the consultant doesn't have to see everyone that walks in the door."

"The push is coming from consultants and they are convincing management."

This case study in full can be found in Appendix 5

Innovation with regard to training the workforce of the future should be considered from all perspectives and exploration of the 'right' roles and combination of roles is to be encouraged. In order for this kind of exploration to take place, it will be essential for both commissioners and providers to discuss the development of service and training in tandem.

Case Study 6: Dr Manjit Purewal, GP and Integrated Care Lead at North Leeds Clinical Commissioning Group

The Leeds Medical Senate Development Programme is a ten-month programme for the 26 doctors at the 'top' of the Leeds trusts and clinical commissioning groups (CCGs). Evaluation of the programme has demonstrated the development of more effective relationships between senior doctors across commissioning, primary and secondary care, and improved commissioner-provider relationships are highlighted as one of the significant reported changes that directly benefit patients.

There is a recognition that wide representation and engagement is needed from all commissioners and providers, and that those commissioning education and training need to be part of discussions and planning around healthcare provision.

"In the NHS we don't engrain a sense of 'one' organisation – too much silo working. This comes down to training, we need to change attitudes."

"I have encouraged my own F2 trainee to come to some CCG meetings. Foundation doctors often have no idea about management structure in the organisations in which they work … about the wider NHS … about commissioning … about leadership etc."

This case study in full can be found in Appendix 5