Medical Education England

Written Evidence Submission
The evaluation of the Foundation Programme

Please respond to the following questions. Please use as much space as required and attach source documents if applicable. Give evidence/examples where possible and identify whether your comments are general or linked to a particular profession or specialty within that profession. When returning your response by email, please keep it in an unlocked and editable format (no PDF documents please).

All responses must be received by Friday 26t[h] March 2010. The group will consider all evidence submitted, and will produce a final report in June 2010

1. About you
Mandatory questions are marked *

If you are responding on behalf of an organisation	
*Please provide your name:	**Professor Tony Weetman**
*Please provide your job title:	**Chair**
*Please provide the organisation's name:	**Medical Schools Council**

Confidentiality	
*Do you consent for your name or the name of your organisation to appear in the index of responses in the group's final report? Please delete as applicable:	**Yes**
*Do you consent for your response to be quoted in the group's final report? Please delete as applicable:	**Yes**

2. Consultation questions

1.	**What were the original objectives of the Foundation Programme?** Respondents may wish to consider both educational objectives and other objectives (e.g. service provision, workforce planning etc.)

The Foundation Programme was born out of a major concern about risk and the belief that patient safety would be improved by reducing medical interventions to a series of competencies which, if assessed sufficiently frequently, would optimise patient care. The introduction of a formal curriculum would ensure all competencies required of doctors in the early years post-qualification were covered. It was hoped that the Foundation Programme would deliver safer doctors as a result of broad based formal programmes of training that would be time-capped and individually tailored.

The drivers were:

- a surfeit of staff in the SHO grade who were not on training programmes (as a result of the decision to allow Trusts to employ additional staff into non-training posts);
- an aspiration for a consultant delivered service in order to improve patient safety;
- the need for a more structured and focused training programme because of the reduction in the time available for training as a result of the EWTD;
- an aspiration to reduce the length (and cost) of training;

a concern about new doctors' abilities in relation to the care of acutely ill patients.
Multiple objectives have, with hindsight, been ascribed to the Foundation programme – unfortunately they were not considered *in toto,* were not aligned, and to this day, the overall strategic objectives of greater care in the community, delivered safely by a motivated, UK-educated workforce that accepts the need for further training post-CCT, have not been achieved.

No account was taken of the fact that the old system worked well for the >50% of SHOs who were in training programmes {ref Aspiring to Excellence p 33}

2.	**How successfully is the Foundation Programme delivering against those objectives?**

The highly centralised conception and delivery of postgraduate medical education was particularly challenging in an increasingly decentralised NHS. The Foundation Programme is not working well and, at best, is only delivering its original objectives in part.

There is already considerable overlap between the undergraduate and Foundation Years' curricula, leading to boredom amongst trainees. Further, the 'tick box' culture which developed has led to a loss of faith in the value of the assessments. The overlap of curricula and the methods of assessment need to be addressed urgently. New developments in the revised 2009 version of *Tomorrow's Doctors*, especially with regard to student assistantships, should be anticipated by this Review, and a clear vision of the additional outcomes expected at the end of the Foundation Programme should be established. The vital importance of PGY1 in providing a protected environment for the provisionally registered doctor to gain confidence in putting into practice the knowledge, skills, attributes and behaviours acquired as an undergraduate should be acknowledged.

The Foundation Programme curriculum focuses on the management of the acutely ill. It is essential that the next revision of the curriculum includes chronic disease management. Unfortunately the educational objective of safer care through the assessment of competencies is not evidence based, and is not aligned with the key service priorities of chronic disease management and greater care in the community. The limited number of placements in the community is detrimental to the requirement to move more service delivery into primary care. It has been made insufficiently clear that more than 50% of trainees will need to consider a career in primary care. Realistic careers advice needs to be integral to undergraduate and postgraduate education.

The concentration on time-out for structured education and the need for continuous assessment, makes trainees think of themselves as students rather than employees, which is both demotivating and demoralising. Foundation doctors – in both Years 1 and 2 – are doctors, who, like other members of the healthcare professional team, seek to develop and expand upon their education. In PGY1 there is however the additional requirement to demonstrate that they are fit to be entered on the Medical Register.

The short rotations work against the creation of effective teams and prevent the trainees from

making material contributions. The four month rotations are too short to develop team spirit and a culture of support. Doctors need to be team-players, but also to show leadership and to take responsibility for suggesting change where systems could be improved. These qualities need to be instilled from the beginning of medical school and reinforced in postgraduate training.

Teamwork was one of the tenets of the new arrangements for PG education and training – yet teams no longer select their own members.

The reduction in the time available for service delivery by trainees coincided with the time when Trusts were under severe pressure to perform against centrally imposed targets. The need for additional training post-CCT as a result of the reduced time available was considered 'too difficult' by those charged with implementing MMC and not addressed. These challenges have been exacerbated recently by further reductions in time with the implementation of the EWTD. It is essential that the findings of the Temple Inquiry into the impact of EWTD on training are taken into account in future plans for the Foundation Programme.

The Academic Foundation programme and the new academic training pathways are however to be commended.

3.	**What are the future needs of the service and trainees from the first two post-graduate years (PGY1 and PGY2)?** Respondents may wish to consider both educational objectives and other objectives (e.g., service provision, workforce planning, etc.)

The length of training is determined by EU law, but within this constraint, from both a service and a personal perspective, there is much to be said for the earliest possible acquisition of expertise and the ability to take responsibility. The introduction of student assistantships should enable the *New Doctor* to put into practice with greater confidence, the knowledge, skills and attributes acquired at Medical School. The time taken to assess competence should be reduced and allocated to supervised service delivery with regular feedback and the gradual acquisition of responsibility. At the end of Foundation Year 1 trainees should enter a period of broad based basic specialist training that would equip them to enter a range of specialties in the future as described in Recommendations 33 and 34 of *Aspiring to Excellence*. The curricula for undergraduate and Foundation training should form a continuum with a clear statement of the capabilities required of trainees by the end of Foundation Year 1.

Service needs are moving towards a reduction in the number of trainees in hospital specialties. Applicants to Medical School need to have a much clearer view of life as a doctor in the mid 21st century, with an understanding that more than half of graduates will be expected to become GPs. Undergraduates require improved career advice and exposure to the multiple hospital and community based specialties available, including academic medicine.

The Medical Schools Council has already asked all Medical Schools to draw applicants' attention to the consensus statement on the Role of the Doctor. It should be made clear to applicants that in the later years of the 21st century the focus will be on the delivery of care in the community.

Applicants will be asked to confirm from the outset that they give permission for their UG files to be transferred by the Medical School to their PG educational supervisor.	
4.	**How successfully is the Foundation Programme delivering against those future needs?**

The Foundation Programme focuses on the acutely ill – rather than chronic care in the community. The limited number of placements in the community is detrimental to the requirement to move service delivery into primary care. This needs to be addressed to enable Foundation Year doctors to gain appropriate experience and exposure, to match future service needs in the community. It is essential that the new curriculum takes into account chronic disease management in the community. CHMS (as was) argued for this during the development of MMC. There must be seamless alignment between Tomorrow's Doctors 2009, the New Doctor and the Foundation Programme Curriculum

For service to be delivered by UK-educated doctors, more needs to be done to make the specialties of psychiatry, obstetrics & gynaecology, paediatrics and pathology, amongst others, attractive. This will require Medical Schools and Foundation Schools to work together to improve careers advice. There will also need to be sufficient flexibility to allow movement between specialties if the career of choice does not prove to be possible. Royal Colleges must be encouraged to accept related, general experience in other specialties as counting towards the experience required for entry onto the Specialist Register.

Anecdotal feedback from both Foundation Year doctors and Consultants emphasises the potential benefit of continuity of clinical experience and service, as opposed to the four-month rotations in both years of the Foundation Programme. Indeed short rotations militate against the creation of effective teams and effective team-working, and prevent trainees from making material contributions.

Furthermore, Foundation Year 2 has, for many, failed in the objective of providing tasters. There is evidence that individuals make career choices early for many specialties and that Foundation Year 2 in its current form prevents trainees from progressing with the training they would prefer. There needs to be clarity around the responsibilities of a Foundation Year 2 doctor.

5.	**What changes are needed to ensure that PGY1 and PGY2 deliver against future needs?** Respondents may wish to consider changes to the purpose, curricula, length, rotational structure, assessments, educational environment, selection processes, governance, career advice, and implications for training both pre-and post PGY1 and PGY2

	This Review provides a unique opportunity to design a radically new system to fit the requirements of the 21st century, rather than accepting that we are irrevocably trapped by history. A clear set of objectives should be articulated and the system re-designed to deliver the desired outcomes. Cognisance must be taken of EU requirements concerning length of training – but within those constraints, the length of each stage should be determined by the outcomes required and not by the current situation. *Tomorrow's Doctors 2009* has transformed the landscape of medical education. Through student assistantships students will acquire, whilst undergraduates, even more of the skills and experience currently reinforced by the Foundation Programme. Urgent work will be required to revise the postgraduate curriculum to reflect these changes and to ensure that unnecessary repetition is avoided and that education and training become a more seamless process from undergraduate through to postgraduate and beyond. These discussions need also to address assessment matters. These issues will generate enormous opportunities which will certainly fit with Patient Safety requirements. As long as universities retain responsibility for confirming that a Foundation Year 1 doctor is fit to be fully registered with the GMC, they must be provided with a mechanism for doing so effectively for trainees working out of the area of their original Medical School. The newly formed four nation Transition Group is addressing issues such as the alignment of portfolios across the undergraduate student/ Foundation Year 1 doctor boundary, the harmonisation of shadowing and induction, and improved information flows from the university to the employer. We are in active discussion with the Information Commissioner who understands the over-arching requirement to protect patients. All UK educated medical students must be provided with the opportunity to become fully registered. This is particularly important given that the average final year debt amongst medical students was £22,821 in 2009 (RMBF survey) and is predicted to rise to over £30,000 from 2011. Selection into Foundation Year 1 should involve an assessment of clinical communication in English for EU and IMG students who have not undertaken their medical education in English.
6.	**Any other points you wish to raise?** Legal advice is required to answer the questions: ***1*** *Assuming that application to UK university medical schools is a fair and open process, Counsel is requested to advise on what action would be required in order to make legally defensible the assignment of F1 posts to graduates of UK medical schools prior to opening any remaining posts to open competition from EEA applicants?* **Medical Schools Council perspective** The Medical Schools Council's perspective is that Foundation year 1 cannot be seen simply as employment – it is also the year of experiential learning that allows the new graduate to put into practice the knowledge, skills, behaviours and attitudes acquired as an undergraduate – and which allows the University to confirm to the GMC at the END of F1

	that the doctor has reached the required standard to be admitted onto the Medical Register for full registration. Without full registration it is impossible for a doctor to practise, and thus his or her basic medical training must be regarded as incomplete, as defined by the EC Directive. This is also confirmed by the Government practice of voting funds from Parliament specifically for education and training. At present 100% of the basic funding for F1 doctors comes from the Multi Professional Education and Training budget (although there is a proposal to reduce this to 80% in recognition of the service component of the doctors' work). Out of hours work is paid for by the Trust. Provisionally registered doctors are entitled to work only in posts which have been specifically approved for the purpose of pre-registration training. Given the demonstrable focus on completion of basic education during the F1 year, the Medical Schools Council wishes to test whether the fact that the F1 trainee is seen as an "employee" must of necessity impose rights and obligations that over-ride educational obligations and commitments. ***2*** *Medical Schools invest much effort into ensuring that the assessments used to consider student performance are fair, valid and reliable. We are aware of pre-employment tests being used variably across the country to assess whether graduates are suitable for practice but have concerns about the utility and purpose of these non-standardised tests which seem more intended to address communication problems with non-UK graduates. Is it legal for employment to be refused as a result of the outcome of a 3 station OSCE devised by a Trust when a 5 year programme, quality assured by the GMC has provided evidence that the applicant is fit for purpose?*

Medical Education England

3. Publications to be considered as evidence

Please list any published articles or research papers that you would like the group to consider as evidence. Please note that where the referenced article appears on a password-protected site, a copy should be submitted alongside your response. Given the limited timeframe of this consultation, if you are unable to provide a valid web-link, electronic or hard copy for all other articles/papers, we may not be able to consider your submission. Please also submit copies of unpublished but relevant documents: e.g., surveys, audits, etc.

Article/ paper title	**Author(s)**	**Source journal**	**Web-link**	**Have you submitted a copy? (Applicable only where web-link is not provided) Indicate if submitted by post or email**
The Future of Medical Education in Canada (FMEC): *A Collective Vision for MD Education*				Pdf attached
Get Career Savvy	Edited by Najette Ayadi O'Donnell, Imperial College		http://www1.imperial.ac.uk/resources/08849AAD-7FE0-45E9-A14D-09551FEA96FF/	

Medical Education England

4. Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you would explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

Medical Education England will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.