



The UK  
**Foundation  
Programme**

# Curriculum

August 2011 -

Please note a minor  
amendment has been  
made\*



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\* The minor amendment for August 2011 is the renaming of the 'logbook' to 'core procedures' (formerly referred to as the logbook of the GMC core procedures)

## **How to navigate the Curriculum...**

*To make the Curriculum as easy as possible to find your way around, we have linked all the titles on the 'contents' and 'list of syllabus and competences' pages to the relevant sections. When you want to return to the contents, just click the link found at the bottom of each page.*

# Introduction

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The *Foundation Programme Curriculum* (the Curriculum) sets out the framework for educational progression that will support the first two years of professional development after graduation from medical school.

## Good medical practice

The Curriculum is based on *Good Medical Practice 2006* (GMP), [http://www.gmc-uk.org/static/documents/content/GMP\\_0910.pdf](http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf) as outlined by the General Medical Council (GMC) and this is emphasised throughout. All foundation doctors are expected to be familiar with GMP and follow the guidance contained therein on the principles and standards of clinical care, competence and conduct.

## Outcomes of foundation training

This programme will allow foundation doctors to apply their knowledge and skills in the workplace and demonstrate improving performance to the level that will satisfy the needs of the GMC, making them eligible to apply for full registration at the end of Foundation Year 1 (F1). At the end of Foundation Year 2 (F2) they will be ready to enter a core or specialty training programme.

## Who should use the Curriculum

The Curriculum is intended to be used by foundation doctors, deliverers of their education and those responsible for quality assurance (national), quality management (deanery) and quality control (local). Some areas of the document are most appropriate for particular groups (e.g. Syllabus and competences for foundation doctors).

*It is highly recommended that the section **How to use the Curriculum** is read thoroughly by all.*

## Key messages of the Curriculum

### Patient safety

- patient safety must be put at the centre of healthcare
- high-quality safe patient care depends, among other aspects of practice, on effective multi-disciplinary teams

### Personal development

- learning in, and from, practice is the most effective way for professionals to develop most of their expertise
- doctors are committed to life-long learning in, and from, the practice of medicine through repeated clinical experience. Foundation doctors will be expected to develop critical thinking and professional judgement, especially where there is clinical uncertainty
- every clinical experience is a learning opportunity and should be reflected upon in order to develop skills, understanding, clinical acumen and performance
- failure to recognise this calls into question an individual's commitment to lifelong learning and continuing professional development
- doctors must continuously work to improve performance, i.e. improve what you actually do as distinct from what you are capable of.

# Introduction

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## Assessment in foundation training

Workplace-based assessments (WPBA) will take place at regular intervals throughout foundation training. The assessment tools are designed to help doctors develop and improve their performance. Feedback is a key factor to enable this to happen.

In addition, the core procedures will provide objective evidence of competence to perform a range of procedures necessary for GMC registration at the end of F1. Successful completion of F1 is required for full registration and progression into F2. This is dependent on demonstration that the learning outcomes, listed in *The New Doctor* and mirrored in the Curriculum, have been achieved. Individuals develop at different rates and many foundation doctors are expected to achieve well beyond the minimum level specified in the Curriculum.

Throughout their careers, doctors should strive to improve their performance to ensure their progression from competence, through proficiency, to expertise. The vast majority of foundation doctors will have no difficulty with their assessments. When problems are identified, the doctor will be encouraged to work to find solutions with the support of their clinical and educational supervisors.

**The Foundation Learning Portfolio** (e-portfolio) is a record of a foundation doctor's progress and development through the foundation years. The completed e-portfolio will contribute to the end of year report and may also be used in interviews. This means that it may be used to help the foundation doctor gain further employment. Successful completion of the Curriculum requires the achievement of competence in a variety of domains based on *Good Medical Practice*. The assessments of these competences will be recorded in the e-portfolio.

This edition of the Curriculum updates the curriculum document originally published in 2005 and revised in 2007. It identifies the importance of supervised, practice-based learning. It is intended to be used with the e-portfolio and the *Foundation Programme Reference Guide* (the Reference Guide) 2010 produced by the national coordinating body for curriculum delivery, the UK Foundation Programme Office (UKFPO).



**Dr Ed Neville**

Chairman

Academy of Medical Royal Colleges Foundation Programme Committee

# How to use the Curriculum

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## Foundation doctor

To make the most of the opportunities available in foundation training you need to have an appreciation of how the *Foundation Programme Curriculum* (the Curriculum) works. The Curriculum assumes that all doctors will be proactive and organised in managing their continuing education. The first steps are to understand:

- **the purpose of foundation training:** read the *Introduction* and understand the purpose and key principles of foundation training
- **how you will be supported educationally:** read the sections on **Learning and Responsibilities of trainers** and understand the system of workplace based learning and other educational opportunities which should be made available to you
- **what you are expected to achieve:** review the **Syllabus and competences** section, looking at the main domains/headings applied to groups of competences and get an idea of what you should be aiming to achieve over the programme
- **how your competence will be assessed in the workplace:** familiarise yourself with the **Assessment** section in the Curriculum. You should always do your best to seek feedback which could prompt you to reflect on what you have learnt
- **how to record your progress in the e-portfolio:** enrol and become familiar with the e-portfolio as a record of learning (refer to the Reference Guide)
- **reflective practice:** foundation doctors should reflect on and learn from both their positive and negative experiences in order to demonstrate consistently good performance.

At the start of your Foundation Programme, there will be a local induction which introduces the programme and sets out how it is delivered and assessed by your education provider. There will be further induction sessions at the start of each placement.

At the first session with your educational supervisor, you may wish to discuss aspects of the Curriculum, which might include:

- known strengths from undergraduate training
- particular areas of interest to you
- any potential weaknesses which you feel may need to be addressed.

You should also agree a timeline for undertaking the required assessments and ongoing educational supervision.

## F1 and F2 competences

The Curriculum separates out F1 and F2 competences. At the start of the Foundation Programme you will concentrate your learning on the F1 competences. It is also important to keep an eye on further progression and the achievement of F2 competences from the outset. The outstanding foundation doctor may achieve all the competences, and much more, well within the two-year time frame. However, the foundation doctor will not be signed off for F2 completion before the minimum time frame of two years.

When engaged in reflection, formal assessment or self assessment, it is recommended that you continue to refer to the framework of competences to check your progress against the range of competences you are expected to achieve.

# How to use the Curriculum

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If you experience any difficulties with this, your educational and clinical supervisors are there to help you.

## Trainers

Please read the **Introduction** and **How to use the Curriculum** sections above and the definitions of clinical and educational supervisor (Appendix B).

Whilst ensuring patient safety throughout, your roles will vary and may involve:

- teaching
- contributing to other forms of learning
- making available other learning opportunities
- providing WPBA
- clinical and educational supervision.

You should be supported in your role by the Local Education Provider (LEP) and foundation school. You should also receive training for all your different roles which contribute to postgraduate education. You should negotiate adequate time within your job plan to carry out your agreed postgraduate training roles to a high standard.

# Syllabus and competences

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# Syllabus and competences

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# Syllabus and competences

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## The syllabus in practice

The syllabus sets out what foundation doctors need to learn in order to be able to begin to manage the acutely ill patient and to work adaptively in healthcare teams. Many acutely ill patients will also have a chronic disease. Foundation doctors will learn how to manage patients with these chronic diseases by involvement in their inpatient care and meticulous discharge planning. This will further develop their understanding of long term care in the community. Competences in the syllabus can be acquired in a variety of clinical settings. Foundation doctors should emerge with professional qualities outlined by the GMC.

Throughout the programme it is important that the foundation doctor should be encouraged to reflect on decisions, management plans and actions taken. They will be expected to discuss the thinking and reasoning behind the decisions in preparation for an increasing role in clinical leadership.

At all times foundation doctors will:

- practise within their competence level
- practise in accordance with the standards expected of them in the specialty unit in which they are placed
- always refer to more experienced clinicians when they are uncertain as to the best management of a particular patient
- practise according to prevailing professional standards and requirements.

## Outcomes

The outcomes and competences described for the F1 programme should be achieved by the end of the first year, when a provisionally registered doctor with a licence to practise is eligible to apply for full registration. Those involved in managing the F1 programme should refer to *The New Doctor* which sets out the GMC's formal requirements for competences to be included in the training programmes. UK graduates new to full registration, international medical graduates or those returning to the medical register after prolonged absence from UK practice, are required to work initially within an approved practice setting (APS) in the UK for a period of 12 months. Foundation doctors who have the requirement to work in an APS need to provide the GMC with evidence that they have completed a satisfactory pattern of experience e.g. the Foundation Achievement of Competency Document (FACD). Refer to the Reference Guide.

The F2 outcomes and competences should be achieved by the end of the second year. They include the application of clinical skills to patients who are acutely ill. A key feature of the F2 Curriculum is that all doctors must develop competences at a significantly higher level than those acquired in the F1 year. Foundation doctors will need to find out about the specific learning opportunities offered by the various specialty placements.

Evidence of the foundation doctors' learning and development achievements will be recorded in the e-portfolio. Further information and declaration forms for probity, professional behaviour and personal health can be found in the e-portfolio.

The following section outlines what needs to be learnt in the Foundation Programme. Throughout this section the term 'patient' or 'carer' should be understood to mean 'patient', 'patient and parent', 'guardian', 'carer', and/or 'supporter' or 'advocate' as appropriate in the context.

# Syllabus and competences

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## 1 Professionalism

**Outcome:** practise with professionalism including:

- integrity
- compassion
- altruism
- continuous improvement
- aspiration to excellence
- respect of cultural and ethnic diversity
- regard to the principles of equity
- ethical behaviour
- probity (refer to GMC *Fitness to Practise* declaration in F1 and *Standards for training for the Foundation Programme* in *The New Doctor*).
- leadership.

### 1.1 Behaviour in the workplace

#### Competences

- always recognises own level of competence and asks for help from appropriate sources
- demonstrates the ability and habit of reflection on experience, as well as learning from practice, then instituting appropriate changes in this practice
- acts with empathy, honesty and sensitivity in a non-confrontational manner
- respects and supports the privacy and dignity of patients
- is courteous, polite and professional when communicating with both patients and colleagues
- has a non-judgemental approach
- is aware of patient expectations around personal presentation of doctors such as dress and social behaviour
- in all interactions with both patients and colleagues takes account of factors pertaining to the patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sexual orientation, or social or economic status (*The New Doctor*, GMC)
- encourages an atmosphere of open communication and appropriately directed communication within teams
- recognises the potentially vulnerable patient, e.g. children, older people, those in need of extra support
- only shares clinical information, whether spoken or written, with appropriate individuals or groups
- seeks out role models and tries to learn from the behaviours of the best clinical practitioners and leaders
- takes part in systems of quality assurance and clinical improvement in clinical work and training.

# Syllabus and competences

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**Assessment:** *MSF, CBD, probity declaration and supervisor's report.*

## 1.2 Health and handling stress and fatigue

### Competences

- where relevant, takes responsibility for ensuring that personal or others' health does not compromise that of colleagues or patients
- ensures own immunisations are up to date.

**Assessment:** *MSF, supervisor's report and health declaration.*

### Knowledge

- the risks to patients if one's own performance is compromised by health problems
- the risks to patients from transmission of blood-borne infection
- the effects of stress and/or fatigue on performance
- the circumstances when self referral to occupational health services are appropriate
- which immunisations are necessary for self
- the availability of support facilities
- leadership

[http://www.institute.nhs.uk/building\\_capability/enhancing\\_engagement/enhancing\\_engagement\\_in\\_medical\\_leadership.html](http://www.institute.nhs.uk/building_capability/enhancing_engagement/enhancing_engagement_in_medical_leadership.html)

## 1.3 Time management and continuity of care

### Competences

#### F1

- is punctual for start of shifts, meetings, handovers and other duties
- keeps a list of tasks
- prioritises and re-prioritises workload appropriately
- delegates or calls for help in a timely fashion when s/he is falling behind
- ensures satisfactory completion of tasks at the end of the shift/day with appropriate handover
- makes adequate arrangements to cover leave.

#### F2

- demonstrates an ability to adjust decision-making in situations where staffing levels and support are reduced (e.g. out of hours)
- is aware of work pressures on others and takes appropriate action to help reorganise workloads.

**Assessment:** *MSF, supervisors report, feedback form and survey receipts.*

# Syllabus and competences

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## Knowledge

- which patients/tasks take priority
- which patients/tasks need formal hand-over
- relevance of continuity of care
- personal and collective responsibility for patient welfare.

## 2 Good Clinical Care

**Outcome:** demonstrates the knowledge, attitudes, behaviours, skills and competences to be able to take a history and examine patients, prescribe safely, keep an accurate and relevant medical record and use medical devices safely.

### 2.1 Eliciting a history

#### Competences

F1 and F2

- takes accomplished, concise, targeted history and communicates in complex situations, which include:
  - Clinical: both acute problems and background of chronic illness
  - psychological (e.g. the patient is confused, has psychiatric/psychological problems which impact on physical health)
  - social and personal (e.g. English is not the patient's first language, impaired hearing/vision, learning difficulties)
  - the patient's personal factors (see The New Doctors' list in Professionalism)
- takes account of background issues where relevant and appropriate, including verbal and non verbal cues
- takes a focused family history, and constructs and interprets a family tree where relevant
- obtains collateral history when available
- routinely scrutinises existing patient records
- manages three-way consultations (e.g. with an interpreter or with a child patient and their family/carers).

**Assessment:** *mini-CEX and CBD.*

#### Knowledge

- symptom patterns
- incidence patterns in primary care
- alarm symptoms
- how and when to use open and closed questions
- physical problems affecting psychological and social well-being

# Syllabus and competences

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- physical illness presenting with psychiatric symptoms
- psychiatric illness presenting with physical symptoms
- psychological/social distress manifesting as physical symptoms (somatisation)
- the possible impact of family dynamics.

## 2.2 Examination

### Competences

F1

- demonstrates accomplished and targeted examination skills and appropriate use of equipment, including an ophthalmoscope
- explains and gains appropriate consent for the examination procedure
- performs a mental state assessment
- demonstrates awareness of safeguarding children (Levels 1 and 2) and vulnerable adults
- asks for a chaperone where appropriate.

F2

- demonstrates the ability to identify, refer, and participate in both the medical assessment and care planning, in cases where a child's and/or vulnerable adult's interests need safeguarding
- demonstrates an awareness of the potential abuse of older patients, and manages such cases in a similar way to safeguarding children and vulnerable adults.

**Assessment: mini-CEX.**

### Knowledge

- patterns of clinical signs including mental state.

## 2.3 Diagnosis and clinical decision making

### Competences

F1

- establishes a differential diagnosis and problem list
- constructs a management plan and communicates requests/instructions to other healthcare professionals
- pursues further history and examination in the light of the differential diagnosis
- arranges appropriate basic laboratory tests and other investigations, including radiology, and interprets the results correctly within the context of the particular patient (see Investigations and Procedures section)
- describes the applicability and limitations of such investigations or tests
- makes a judgement about prioritising actions on the basis of the differential diagnosis and

# Syllabus and competences

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clinical setting

- negotiates a treatment plan with patients and allows patients to make informed treatment choices
- considers appropriate venous thrombo-embolic (VTE) prophylaxis and screening for Methicillin-Resistant Staphylococcus Aureus (MRSA)

F2

- reviews, and where appropriate, adjusts differential diagnosis in the light of developing symptoms and response to therapeutic interventions
- takes account of probabilities in ranking differential diagnoses
- helps other foundation doctors to prioritise their actions and to order appropriate tests and investigations.

**Assessment: mini-CEX and CBD.**

## Knowledge

- principles of clinical reasoning in medicine
- the factors involved in clinical decision-making such as knowledge, experience, biases, emotions, uncertainty and context
- sensitivity, specificity and predictive value of diagnostic tests within specific clinical contexts.

## 2.4 Safe prescribing

### Competences

F1

- takes an accurate drug history, including self-medication, use of herbal products and enquiry about allergic and other adverse reactions
- prescribes drugs and treatments (including oxygen and fluids) appropriately, clearly and unambiguously with date and printed surname clearly visible under a signature
- transfers previous prescriptions accurately and appropriately when patients move between different areas especially for those with chronic diseases
- discusses drug treatment and administration, including unwanted effects, with patients and, when appropriate, carers, using aids such as patient information leaflets
- understands and applies the principles of safe prescribing for different patient groups including children, women of child-bearing potential, pregnant women and those with hepatic and/or renal dysfunction
- demonstrates awareness of, and follows guidelines on, safe use of blood and blood products, including awareness of religious/cultural beliefs
- prescribes blood products appropriately and recognises transfusion reactions
- seeks evidence about appropriateness and effectiveness of therapies in making prescribing decisions, including evidence which may be available in NICE, SIGN and local guidelines
- demonstrates awareness of possible drug interactions

# Syllabus and competences

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- uses the *BNF* (and *BNF for Children* where appropriate), plus pharmacy and computer-based prescribing-decision support to access information about drug treatments, including drug interactions
- performs dosage calculations accurately and verifies that the dose calculated is of the right order
- works closely with pharmacists and more experienced prescribers to ensure accurate, safe and effective error-free prescribing, whilst recognising that the legal responsibility remains with the prescriber
- chooses appropriate intravenous fluids as vehicles for intravenous drugs and calculates the correct volume and flow rate
- monitors therapeutic effects and adjusts treatments and dosages appropriately
- recognises and initiates action for common adverse effects of drugs and communicates these to patients
- prescribes oxygen appropriately and identifies carbon dioxide retention
- prescribes controlled drugs within appropriate legal framework
- understands the importance of security issues in respect of prescriptions.

## F2

- facilitates F1 doctors in taking a drug history, in obtaining prescribing information, and in using appropriate, clear and unambiguous prescribing practice
- routinely notifies drug monitoring agencies of possible significant adverse drug reactions.

**Assessment: CBD.**

## Knowledge

- effects of patient factors on prescribing:
  - age (e.g. children, older people)
  - weight
  - drug allergy
  - genetic susceptibility to adverse drug reactions
  - pregnancy and breast feeding
  - cultural/religious beliefs
- effects of disease on prescribing:
  - hepatic
  - renal
  - other co-morbidities
- legal responsibility for safe prescribing and developing expertise lies with the foundation doctor
- effective use of common drugs in the current supervised specialty placement
- effects of drug interactions or sensitivities/reactions
- metabolism by CYP450 isoenzymes

# Syllabus and competences

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- drugs that require therapeutic monitoring
- sources of medication error and how this can be minimised
- evidence-based and safe prescribing, using NICE or SIGN guidelines
- principles of safe prescribing of oxygen and blood products
- factors that affect concordance (compliance, adherence)
- principles of prudent antimicrobial prescribing and the impact of resistance on prescribing
- limitations of prescribing chemotherapy as a foundation doctor
- importance of summaries of product characteristics as the authorised source of information on indications, dosage, warnings and adverse effects of medicines
- access to publications that will help keep doctors up to date with emerging information on medicines risk, (e.g. Drug Safety Update)
- tools for critical review of industry advertising
- understanding of how professional responsibility changes when prescribing medicines off-label or unlicensed medicines, including the need to obtain consent
- difference between prescribing by brand name and by generic name and is aware of circumstances when brand names should be used
- appropriate choice of formulation and route of administration of medicines and appreciation that change of route or formulation can affect dose and response
- inappropriate therapeutic duplication (e.g. two NSAIDs, two opioids)
- hazards of polypharmacy, especially in older people.

## 2.5 Medical record-keeping and correspondence

### Competences

#### F1

- routinely records:
  - comprehensive, accurate, logical medical records and pertinent accounts of history (both acute and long term), examination, investigations, management plans and clinical decisions that are timed, dated and clearly attributable
  - patient's progress and multidisciplinary management plans
  - information given to patients, details of discussion with patients, and patients' views on investigative and therapeutic options
  - a summary of professional telephone communications and telephone consultations with patients
  - all information in compliance with the Academy of Medical Royal Colleges' *Clinician's Guide to Record Standards*
- describes the medico-legal importance of good record keeping.

#### F2

- structures letters clearly to communicate the details of long term conditions and the findings and outcomes of acute episodes so that they can be read and understood by other professionals and patients

# Syllabus and competences

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- ensures that letters and discharge summaries are written and sent out in a timely and efficient manner
- demonstrates record keeping and intra/internet access skills to F1 doctors or students.

**Assessment: CBD.**

## Knowledge

- structure of:
  - medical notes
  - discharge letters
  - discharge summaries
  - outpatient letters
  - prescriptions
- importance of:
  - good medical records as a sound basis for any subsequent legal action
  - clear definition of diagnoses and procedures to allow accurate coding for both central returns and local payment by results
  - making notes accessible to all members of the team and realisation that they may be read by the patient.

## 2.6 Safe use of medical devices

### Competences

- demonstrates an ability to set up and use appropriate medical devices safely e.g. for monitoring blood pressure, pulse and oxygen saturation, infusion of fluids etc (NB this excludes implantable devices).

**Assessment: mini-CEX, DOPs, core procedures and CBD.**

### Knowledge

- the definition, range and scope of medical devices
- the operation and maintenance of devices
- the disposal of single use devices
- cleaning, sterilisation and decontamination of all re-usable devices
- training in the use of medical devices
- limitations of devices and their function, including recognition of failure.

# Syllabus and competences

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## 3 Recognition and management of the acutely ill patient

**Outcome:** achieve competence in the early management of emergency patients and of those with acute illness superimposed on a background of chronic disease.

Competences are context-dependent and so will not necessarily be at the same level in all acute situations. For example, foundation doctors will not be expected to have the same level of competence to manage seriously ill children as that expected with adults.

### 3.1 Promptly assesses the acutely ill or collapsed patient

#### Competences

##### F1

- assesses conscious level
- ensures airway is supported and cleared
- observes respiratory pattern and rate, identifies inadequate ventilation, and measures oxygen saturation
- assesses pulse rate, rhythm and volume
- measures blood pressure using automated methods or sphygmomanometer
- makes a clinical assessment of cardiac output and oxygen delivery (end organ perfusion)
- measures capillary blood glucose
- completes comprehensive initial assessment within three minutes.

##### F2

- selects, prescribes and ensures timely administration of appropriate antimicrobials in the infected patient (see Good Clinical Care: Safe Prescribing and Infection Control)
- is capable of leading multidisciplinary team
- considers and ensures relatives are being supported if present.

### 3.2 Identifies and responds to acutely abnormal physiology

#### Competences

##### F1

- calls for help early
- administers oxygen safely, monitors effectiveness (see Good Clinical Care: Safe Prescribing)
- identifies oliguria, checks for common causes, intervenes appropriately
- identifies and tries to correct circulatory failure appropriately.

# Syllabus and competences

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F2

- describes where to find normal age-related reference ranges for vital signs in infants and children where appropriate
- anticipates and prevents deterioration in vital signs
- recognises patients at risk including those with chronic and co-morbid disease
- investigates causes of abnormal vital signs.

3.3 Where appropriate, delivers a fluid challenge safely to an acutely ill patient

## Competences

F1

- selects an appropriate fluid for intravenous resuscitation
- sets up fluid administration giving-set correctly
- administers fluid bolus(es), observes response, ensures continued administration with monitoring of effect to desired end-points
- identifies hypokalaemia, chooses a safe and effective method of potassium supplementation, and monitors the response
- reviews impact of fluid administration on organ system function.

F2

- considers additional electrolyte replacement requirements.

## 3.4 Reassesses ill patients appropriately after starting treatment

### Competences

F1

- implements a system of checking unstable patients regularly
- prioritises problems
- calls for senior and more experienced help if patient does not respond to initial measures.

F2

- provides clear guidance to medical and nursing colleagues about further monitoring and calling criteria
- ensures that communication to absent relatives is carried out by someone competent to advise progress
- considers psychiatric/psychological aetiology (e.g. deliberate self harm).

# Syllabus and competences

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## 3.5 Undertakes a further patient review to establish a differential diagnosis

### Competences

F1

- recognises the importance of iterative review
- recognises that the acute illness may be an acute exacerbation of a chronic disease
- assesses for prevention and recognition of acute organ injury.

F2

- undertakes focused further history-taking in difficult circumstances and/or when the patient is unable to co-operate
- plans appropriate further investigations to confirm or refute a diagnosis
- recognises the influence of chronic or co-morbid disease and its treatment on the presentation of acute illness.

## 3.6 Obtains an arterial blood gas sample safely, interprets results correctly

### Competences

F1

- takes an arterial sample in an adult safely using a heparinised syringe
- records results clearly in the case record
- describes common causes of abnormal values
- communicates significant acid-base disturbances to others in the team.

F2

- interprets results in context
- takes appropriate action to correct abnormalities in acid-base balance and blood gas results.

## 3.7 Manages patients with impaired consciousness, including convulsions

### Competences

F1

- appreciates urgency of the situation
- administers oxygen, maintains airway in unconscious patient
- places unconscious patient in recovery position, if safe and appropriate
- calls for help if fitting patient does not respond to immediate measures
- follows local protocols
- seeks and corrects causes for impaired consciousness.

# Syllabus and competences

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F2

- warns patients about the legal implications of fitness to drive.

## 3.8 Uses common analgesic drugs safely and effectively

### Competences

F1

- evaluates the patient in pain
- makes patient comfort a priority
- prescribes opioid and non-opioid analgesic drugs safely
- re-evaluates in a timely manner the efficacy of analgesia
- monitors patients for common side effects of analgesic drugs
- safely uses anti-emetic drugs to treat and prevent nausea and vomiting.

F2

- considers the effect of hepatic and renal dysfunction on analgesic pharmacology.

## 3.9 Understands and applies the principles of managing a patient with acute mental disorder including self harm

### Competences

F1

- describes and recognises common presenting features of acute mental disorder including disturbance of behaviour, mood, thought/cognition, and perception
- knows how to access national information systems and does so when necessary
- does a mental state assessment
- understands the potential risks to self and others
- recognises the need for involvement of mental health or more experienced personnel
- summons experienced help promptly.

F2

- discusses use of general measures and understands the local protocol for rapid tranquillisation including the associated risks
- takes appropriate steps to protect the patient, dependants, self and colleagues from harm
- performs an assessment of mental capacity and communicates the outcome
- considers underlying causes of severe mental disturbance including acute confusional states, psychosis and substance use/withdrawal.

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## 3.10 Ensures safe continuing care of patients on handover between shifts, on-call staff or with “hospital at night” team by meticulous attention to detail and reflection on performance

### Competences

#### F1

- accurately summarises and documents the main points of patients’ diagnoses, active problems, and management plans
- provides clear information to colleagues
- attends handovers punctually and accepts directions and allocation of tasks from seniors.

#### F2

- supports colleagues in forward planning at handover
- can, and sometimes does, organise handover, briefing and task allocation
- anticipates potential problems for next shift and takes pre-emptive action.

***Assessment: MSF, core procedures and CBD (for all competences in recognition and management of the acutely ill patient).***

### Knowledge

- common presenting symptoms and signs of acute illness, including: hypotension ± oliguria, breathlessness ±, hypoxaemia, chest or abdominal pain, nausea, vomiting, headache, and confusion or coma
- frequently occurring causes of the above
- causes of acute abdominal pain, including surgical, gastrointestinal, gynaecological/obstetric, urological, cardiac/vascular and neurogenic
- clinical interpretation of acutely abnormal physiology with a clear understanding of normal limits
- common derangements of arterial blood gases
- causes of impaired level of consciousness, including fits and faints
- common acute presentations of chronic illness and the modifying effects of chronic disease or its treatment on acute presentations
- effects of co-morbidity on decision-making in managing acute illness
- safe oxygen therapy
- safe use of analgesic drugs; routes and methods of administration
- the risk of addiction to pain-relieving medication if taken in a non-therapeutic situation
- acute and acute-on-chronic confusional states, including acute psychosis: causes, assessment and initial management
- serious mental illness: modes of presentation, assessment including suicidal risk and initial management

# Syllabus and competences

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- deliberate self-harm: modes of presentation, causation, initial treatment for most common forms of self-poisoning, psychological and mental health team support
- the underlying principles of mental health law relevant to the country of practice
- the underlying principles of mental capacity law relevant to the country of practice
- causes of acute visual impairment
- recognition of serious illness in infants and children and when to seek help promptly
- different trajectory of illness in children (compared with adults) where the signs of critical illness are often subtle or vague in the early stages.

## 4 Resuscitation

**Outcome:** demonstrates the knowledge, competences and skills to be able to recognise critically ill patients, take part in advanced life support, feel confident to initiate resuscitation, lead the team where necessary, and use the local protocol for deciding when not to resuscitate patients.

### 4.1 Resuscitation

#### Competences

F1

- is trained to the standard of immediate life support.

F2

- is trained in advanced life support (ALS or equivalent)
- is trained in basic paediatric life support (for doctors working with infants and children).

**Assessment:** *MSF, CBD and ILS/ALS/equivalent course.*

### 4.2 Discusses Do Not Attempt Resuscitation (DNAR) orders/advance directives appropriately

#### Competences

F1 and F2

- describes the criteria for issuing DNAR orders and the level of experience needed to issue them
- discusses DNARs with multi-disciplinary team and the patient, and can observe or take part in discussions with relatives
- facilitates the regular review of DNAR decisions and understands actions required if decision is challenged
- recognises actual and potential conflicts between patients and their relatives.

**Assessment:** *MSF and CBD.*

# Syllabus and competences

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## Knowledge

- contents of advanced life support course
- contents of basic paediatric life support course
- local and national protocols for DNAR orders
- legal and ethical considerations of DNAR orders
- the impact of chronic or co-morbid disease on patient outcomes
- the place of living wills and advance directives, and their limitations.

## 5 Discharge and planning for chronic disease management

**Outcome:** demonstrates the knowledge and skills to care for patients with chronic diseases during their in-patient stay. Plans discharge for all patients, starting from the point of admission and encourages patients in self-care where appropriate.

## Competences

F1 and F2

- accurately re-prescribes long-term medications (checking for side effects and significant interactions) (see Good Clinical Care: Safe Prescribing)
- checks for new complications of long-term illnesses
- recognises the need for physiotherapy and occupational therapy for inpatients with long term mobility problems
- starts planning discharge from the time of admission, including early referral to the appropriate members of the multidisciplinary team
- takes an active part in discharge planning meetings
- liaises and communicates with patient, family and carers
- finds out about family dynamics and socio-economic factors influencing success of discharge
- recognises the potential impact of long term conditions on the patient, family and friends
- recognises and records when patients are medically fit for discharge
- ensures with appropriate, timely information that the primary care team is aware of the discharge of patients
- arranges secondary care follow-up when appropriate
- evaluates a patient's capacity to care for themselves where appropriate, and to ensure that necessary environmental adaptations and care plans are in place before discharge
- promotes self-care for patients, where appropriate
- promotes and encourages involvement of patients in appropriate support networks, both to receive support and to give support to others
- puts patients in touch with the relevant agency, including the voluntary sector, from which they can access advice and information, and procure equipment and devices to improve quality of life in the home

# Syllabus and competences

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- produces a competent, legible immediate discharge summary that identifies principle diagnoses, key treatments/interventions, discharge medication and follow-up arrangements.

**Assessment: CBD and MSF.**

## Knowledge

- impact of short and long-term physical problems on daily living
- effect of chronic disease on rehabilitation potential
- how clinical information is conveyed from secondary to primary care on discharge
- roles and skills of members of the multidisciplinary team, including nurses, occupational therapists, physiotherapists, discharge co-ordinators and social workers
- impact of unnecessary hospitalisation
- support available in community settings
- concept of self-care and the role of the expert patient.

## 6 Relationship with patients and communication skills

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to be able to communicate effectively with patients, relatives and colleagues in the circumstances outlined below.

### 6.1 Within a consultation

#### Competences

F1

- is always polite and considerate to patients
- explains options clearly and checks understanding, encouraging patients with knowledge of their condition to make appropriately informed decisions about their care.

F2

- provides or recommends relevant written/on-line information for patients
- deals appropriately with angry or dissatisfied patients.

**Assessment: mini-CEX, DOPS and MSF.**

# Syllabus and competences

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## Knowledge

- how to structure the interview to identify the patient's:
  - concerns/problem list
  - expectations
  - understanding
  - acceptance
- environments in which patients from different social and cultural backgrounds are able to talk about their health beliefs and practices, particularly when discussing different treatment options
- materials in alternative formats (e.g. Braille, audio media, subtitled videos) for people who cannot access visual information or those who cannot or find it difficult to use written materials (e.g. people with dyslexia).

## 6.2 Breaking bad news

### Competences

- demonstrates the ability to 'break' bad news to a patient or carer effectively and compassionately, and provides support when necessary
- demonstrates ability to communicate complicated or bad news to vulnerable patients, people who are dying, their carers and relatives.

### *Assessment: CBD and MSF*

## Knowledge

- where the interview should take place and who should be present
- the components of the bereavement process and behaviour
- awareness of organ donation procedure and role of local transplant co-ordinators
- the effect of cultural and/or religious differences in end-of-life care and bereavement processes.

## 7 Patient safety within clinical governance

**Outcome:** demonstrates a clear commitment to maintaining patient safety and delivering high-quality reliable care. Understand that clinical governance is the over-arching framework that unites a range of quality improvement activities to safeguard standards and facilitate improvements in clinical services.

# Syllabus and competences

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## 7.1 Treats the patient as the centre of care

### Competences

F1 and F2

- listens actively and enables patients to express concerns and preferences, ask questions and make personal choices
- respects the right to autonomy and confidentiality
- recognises the patient's confidence and competence to self-care and need for support, notably when an acute problem is superimposed on a chronic illness
- seeks advice promptly when unable to answer a patient's query or concerns
- respects the patient's right to refuse treatment or take part in research
- considers care pathways and the process of care from the patient's perspective
- describes common reactions of patients, family and clinical staff to error
- places the needs of patients above own convenience without compromising the safety of self or others.

**Assessment: CBD and MSF.**

## 7.2 Makes patient safety a priority in own clinical practice

### Competences

F1

- identifies and minimises potential risks and main hazards to patients
- delivers protocol-driven care
- describes a critical incident and methods of preventing an adverse event
- identifies or describes a potential complaint and the role of the multidisciplinary team in methods of resolution
- complies with information governance standards of confidentiality and data protection.

F2

- provides reliable best practice care based on clinical care pathways, care bundles or protocols
- maintains professional development to enhance personal contribution to quality of patient care.

**Assessment: CBD and MSF.**

# Syllabus and competences

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## 7.3 Promotes patient safety through good team-working

### Competences

F1 and F2

- works in partnership with patients and colleagues to develop sustainable care plans to manage patients' acute and chronic conditions
- cross-checks instructions and actions with colleagues, e.g. medicines to be injected
- draws attention to risks or potential risks to patients regardless of status of colleagues
- describes ways of identifying and dealing with poor performance in self and colleagues, including senior colleagues.

**Assessment: CBD and MSF.**

## 7.4 Understands the principles of quality and safety improvement

### Competences

F1

- demonstrates knowledge of how and when to report adverse events and 'near misses' to local and, where appropriate, national reporting systems.

F2

- describes opportunities for improving the reliability of care following adverse events or 'near misses'
- describes root-cause analysis.

**Assessment: CBD and MSF.**

## 7.5 Complaints

### Competences

F1 and F2

- is sensitive to situations where patients are unhappy with aspects of care and seeks to remedy concerns with help from senior colleagues and/or other members of the multi-disciplinary team
- always behaves in a way that appropriately minimises the risk of causing patient dissatisfaction.

**Assessment: MSF and supervisor's report.**

# Syllabus and competences

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## Knowledge

- local complaints procedures
- principles of:
  - error disclosure, apology, and restitution where possible
  - risk management
  - conflict management
- actions that minimise risk of complaints
- awareness of health inequalities
- the links between need, demand and supply of resources
- principles of how processes of medical care affect outcomes (including examples)
- the nature of human error and the importance of systems factors in relation to patient safety
- principles of the investigation and analysis of adverse events and patient safety incidents as a means to making care safer
- awareness of the prevailing NHS best practice standards (including those published by NICE, SIGN or equivalent and in NSFs)
- definition of clinical governance and its various components
- the theoretical and policy frameworks for clinical governance
- the contribution of clinical governance to the monitoring and continuous improvement of the quality of healthcare
- the concept of accountability in respect of own practice
- factors likely to lead to complaints by patients (e.g. lack of communication, lack of apology for mistakes, dishonesty in dealing with patients or inappropriate expectations of patients).

## 8 Infection control

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to reduce the risk of cross-infection.

### Competences

#### F1

- demonstrates correct techniques for hand hygiene with hand gel and with soap and water
- consistently uses hand hygiene appropriately in clinical settings
- follows aseptic technique
- uses personal protective equipment (gloves, masks, eye protection etc.) appropriately
- adheres to policy regarding the disposal of sharps and clinical waste
- participates in and promotes practice to minimise healthcare-associated infections
- involves the infection control team at an appropriate early stage
- takes appropriate microbiological specimens in a timely fashion

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- follows local guidelines/protocols for antibiotic prescribing
- informs the competent authority of notifiable diseases.

F2

- challenges others who are not observing best practice in infection control
- describes the concept of outbreak management within healthcare settings e.g. diarrhoea on a ward.

**Assessment: MSF, core procedures and DOPS.**

## Knowledge

- risk of infection and ways of minimising, before undertaking any procedure
- principles of appropriate use of antibiotics
- local antibiotic resistance patterns
- appropriate use of isolation facilities and side rooms
- the scientific basis of the importance of aseptic techniques
- the impact of iatrogenic infection on mortality and morbidity
- infection control and means of limiting cross infection
- policies for needle stick injury and bodily fluids contamination.

## 9 Nutritional care

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to assess patients' basic nutritional requirements and the use of procedures to ensure adequate nutrition.

## Competences

F1 and F2

- performs a basic nutritional screen
- identifies major nutritional abnormalities and establishes a management plan, where relevant with other healthcare professional input
- makes nutritional care part of daily practice.

**Assessment: MSF, CBD and mini-CEX.**

## Knowledge

- effects of disease on nutritional requirements
- impact of poor nutrition on susceptibility to, and recovery from, disease
- metabolic response to injury, sepsis, starvation
- options for nutritional support
- safety issues regarding nutritional care.

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## 10 Health promotion, patient education and public health

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to be able to educate patients effectively.

### 10.1 Educating patients

#### Competences

F1

- recognises and uses opportunities to prevent disease and promote health
- explains to patients, as appropriate, the possible effects of lifestyle, including the effects of diet, nutrition, smoking, alcohol and drugs (separately and in combination)
- advises patients on correct use of medicines, including how to recognise emergence of serious adverse effects
- identifies potential 'ready to quit' smokers
- advises on smoking cessation and supportive measures
- advises appropriate drinking levels or drinking cessation

F2

- describes the implications of the wider determinants of health
- describes the impact of health inequalities on the patient.

**Assessment:** *mini-CEX, CBD and MSF.*

#### Knowledge

- natural history of common diseases
- investigation procedures including possible alternatives/choices and methods to encourage concordance with therapies
- importance of occupations and wider social and economic factors in disease, and possibilities for rehabilitation
- patient education on
  - disease and disease prevention
  - investigations
  - therapy.

### 10.2 Environmental, biological and lifestyle risk factors

#### Knowledge

- Risk factors for disease including:
  - genetics
  - diet

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- obesity
- exercise
- social deprivation
- health outcome inequalities among ethnic minority communities
- sexual behaviour and sexually transmitted infections
- occupation
- substance misuse and abuse
- accidents and child/vulnerable person abuse
- awareness of possible pregnancy complications in women of child-bearing age.

See also The New Doctor (GMC) as listed under Professionalism: Behaviour in the workplace.

## 10.3 Smoking

### Knowledge

- effects of smoking on health of smoker and others including the unborn child
- implications of addiction
- smoking cessation strategies.

## 10.4 Alcohol

### Knowledge

- effects of alcohol on health and psycho-social well-being of the patient and family members
- effects of alcohol on pregnancy
- local support groups/agencies.

## 10.5 Epidemiology and screening

### Knowledge

- data collection methods and their limitations
- demographic data collection using ethnicity data to inform health promotion and care planning <http://www.equalityhumanrights.com/>
- principles of prevention, health surveillance and screening
- conditions that are notifiable and how to inform the competent authority.

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## 11 Ethical and legal issues

**Outcome:** demonstrates the knowledge and skills to cope with ethical and legal issues that occur during the management of patients with general medical problems.

### 11.1 Medical ethical principles and confidentiality

#### Competences

F1 and F2

- describes and demonstrates an understanding of the main principles of medical ethics, including autonomy, justice, beneficence, non-maleficence and confidentiality as they apply to medical practice
- ensures privacy when discussing sensitive issues
- uses and shares clinical information appropriately or seeks advice when uncertain (see Professionalism: Behaviour in the workplace)
- seeks timely advice where patient abuse is suspected, while respecting confidentiality
- modifies patients' management plans in accordance with the principles of patients' best interests, autonomy and rights.

**Assessment:** *CBD, MSF and supervisor's report.*

#### Knowledge

- GMC guidance on specific ethical issues and guidance on consent. See [http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp) and refer to the Reference Guide
- principles of patients' best interests
- ethical principles and legal framework in relation to autonomy, medical research and human rights (including advance directives)
- strategies to ensure confidentiality
- functions of Caldicott Guardians
- limits to confidentiality
- Data Protection Act/Freedom of Information provisions.

### 11.2 Valid consent

#### Competences

F1 and F2

- describes the principles of valid consent
- gives the patient appropriate information in a way s/he can understand in order to obtain valid consent
- obtains valid consent after being trained in the process of consent
- refers consent requests/queries to senior colleagues when appropriate
- checks that the patient has understood the relevant information

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- describes mental health legislation in the area of consent.

**Assessment:** *mini-CEX, CBD and DOPS.*

## Knowledge

- process for gaining valid consent and the associated legal framework
- the difference between consent and assent
- capacity and capacity law relevant to the country of practice (see Ethical and Legal Issues: Legal framework of medical practice)
- children's rights including Gillick competency
- use and limitations of mental health legislation in consent issues
- implications of HIV testing.

## 11.3 Legal framework of medical practice

### Competences

#### F1

- discusses the risks of legal and disciplinary action if a doctor fails to achieve the necessary standards of practice and care
- describes and applies the principles of
  - confidentiality
  - child protection procedures
- completes death certificates and liaises with the coroner/procurator fiscal
- completes cremation forms appropriately
- minimises risk of exposing a pregnant woman to radiation
- recognises the need for restraint of some patients with mental illness according to the appropriate legal framework.

#### F2

- discusses the implications of a living will or advance directive
- initiates restraining orders in some patients with mental illness according to the appropriate legal framework.

**Assessment:** *CBD and supervisor's report.*

## Knowledge

- legal framework that relates to medical practice and its application to patient management
- the Mental Health Act (1983) section 5 (2) and Mental Health Care and Treatment (2003) Scotland
- the Mental Capacity Act (2005) England and Wales. Adults with Incapacity Act (2000)

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## Scotland

- the Data Protection Act 1998 and Freedom of Information Act 2002 in Scotland and 2005 in England as well as UK and European legislation relating to access to records
- legal responsibilities for completing death certificates
- types of death to be referred to the coroner/procurator fiscal
- the doctor's role in cremation procedures
- situations where compulsory detention under a section of mental health legislation in the UK would be appropriate
- conditions that patients should report to the DVLA, and doctors' responsibilities if they fail to do so
- the role of medical evidence in the coroner's court and other legal proceedings
- basic knowledge of equalities legislation and its impact on medical practice linked to equality duty in regard to race, disability and gender
- child protection procedures, inter-agency referral routes (e.g. police, social services) and when to involve them
- legal framework surrounding justification of exposure to ionising radiation by referring practitioner.

## 11.4 Relevance of outside bodies

### Knowledge

- the relevance to professional life of:
  - NHS structure
  - Royal Colleges and Faculties
  - General Medical Council (GMC)
  - Postgraduate Medical Education and Training Board (PMETB)
  - UK Foundation Programme Office
  - postgraduate deaneries
  - foundation and postgraduate specialty schools
  - defence organisations
  - British Medical Association (BMA)
  - Medicines and Healthcare products Regulatory Agency (MHRA)
  - National Institute for Health and Clinical Excellence (NICE)
  - European Medicines Agency (EMA)
  - local authorities
  - voluntary organisations.

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## 12 Maintaining good medical practice

### 12.1 Lifelong learning

**Outcome:** demonstrates the knowledge, attitudes, behaviours, skills and competences needed to start self-directed lifelong learning.

#### Competences

F1 and F2

- learns from experience/experiential learning
- reviews professional learning needs and takes step to address these
- maintains a professional development portfolio by recording learning needs and reflections
- uses WPBAs and MSF to get feedback and improve performance
- recognises errors and mistakes and demonstrates measures to learn from them
- arranges and prepares for own appraisal in a timely manner
- contributes to the appraisal, assessment or review of students and other colleagues.

**Assessment:** *CBD and MSF.*

#### Knowledge

- the concept of continuing professional development
- the role of appraisal and revalidation
- the purpose of assessment (formative and summative).

### 12.2 Research, evidence, guidelines and care protocols

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to use evidence and guidelines that will improve patient care.

#### Competences

F1 and F2

- finds and interprets evidence relating to clinical questions
- supports patients in interpreting evidence
- appraises recent research, and discusses findings with colleagues to advocate specific action.

**Assessment** *MSF, CBD and mini-CEX.*

#### Knowledge

- evidence based medicine (EBM)
- guidelines and protocols

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- limitations of the existing evidence base
- advantages and limitations of guidelines and protocols
- methods of determining best practice.

## 12.3 Audit

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to use audit results to improve patient care.

### Competences

F1 and F2

- describes the audit cycle and recognises how it relates to the improvement of clinical care
- has participated in an audit project
- makes audit links explicitly to learning/professional development portfolios.

**Assessment:** *audit project review and e-portfolio.*

### Knowledge

- the audit cycle and relevance to developing patient care, clinical governance and risk management
- data sources for audit
- data confidentiality
- the audit cycle's relationship to the improvement of clinical care.

## 13 Teaching and training

**Outcome:** demonstrates the knowledge, skills, attitudes and behaviours to undertake a teaching role.

### Competences

F1

- undertakes teaching in under or post-graduate education in a one-to-one setting
- assesses students and other non medical colleagues in training
- contributes to the assessment or review of students and other colleagues with whom they work.

F2

- sets educational objectives, identifies learning needs (own and group's) and applies teaching methods appropriately
- demonstrates appropriate preparation for teaching

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- undertakes small group teaching, including a presentation
- provides constructive feedback to others including F1 doctors.

**Assessment: *Developing the clinical teacher.***

## Knowledge

- adult learning theories
- learner-centred approach
- principles of assessment
- principles of feedback
- features of an effective presentation.

## 14 Working with colleagues

**Outcome:** demonstrates effective teamwork skills within the clinical team and in the larger medical context.

### 14.1 Communication with colleagues and teamwork for patient safety

#### Competences

F1

- displays understanding of personal role within the team and is able to support a team leader
- listens to views of other healthcare professionals
- takes leadership role and delegates appropriately in the context of own competence
- demonstrates awareness of local major incident planning and their potential role in any such incident
- meticulously cross-checks instructions and actions with colleagues (e.g. medicines to be injected)
- describes ways of identifying and dealing with poor performance in self and in colleagues.

F2

- shows leadership skills where appropriate and at the same time works effectively with others towards a common goal.

**Assessment: *MSF and CBD.***

## Knowledge

- information requirements of team members
- others' perspectives in contributing to management decisions

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- the role of other team members
- what makes a good leader and how bad leadership can render a team ineffective
- techniques of approaching and managing conflict
- the role of the voluntary sector in supporting patients, carers and families

## 14.2 Interface with different specialties and with other professionals

### Competences

#### F1

- shows an understanding of the challenges of providing optimum care within a variety of clinical settings
- arranges appropriate urgent investigations and chases results when necessary.

#### F2

- consistently seeks effective communication with colleagues in other disciplines
- describes the process of referral from primary to secondary care.

**Assessment: MSF and CBD.**

### Knowledge

- effective team working
- roles and responsibilities of team members and other professionals in patient care
- how good team working sets direction in order to manage and improve services for patients
- *Medical Leadership Competency Framework and Medical Leadership Competency Curriculum* [http://www.institute.nhs.uk/building\\_capability/building\\_leadership\\_capability/project\\_documents.html](http://www.institute.nhs.uk/building_capability/building_leadership_capability/project_documents.html)
- clinical team and support services (e.g. nutrition, dietetics, therapists)
- working relationships of:
  - hospital, primary care and mental health services
  - hospital and other agencies (e.g. social services, local authority services, police)
- information transfer from primary to secondary care on admission
- the role of the voluntary sector in supporting patients and carers
- the principles of providing optimum care within a community setting.

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## Learning in acute care

### Overview

The main themes of the Foundation Programme are competency and satisfactory performance in professional practice. Assessing foundation doctors who are managing acutely ill patients (e.g. rapid assessment of airway, breathing and circulation) will enable overall competency and performance in acute care to be judged. The Foundation Programme will focus on learning in the workplace and much of the assessment of professionalism will occur there. Other learning environments, such as short courses and simulation activities, may also be used.

The foundation doctor should select topics on which to be assessed from the list of clinical conditions/presentations below. A range of assessment tools will be used. The foundation doctor and clinical or educational supervisor should ensure that at least one core problem from each group is formally assessed over the course of the year. More details about the assessment methodology appear in Assessment.

The different environments in which these conditions are managed will need similar competences, but a different approach to their management. For example, the management of chest pain in primary and secondary care have similarities but also important differences. Foundation doctors should be aware of how to manage acutely ill patients in different settings and, where relevant, against a background of chronic illness and co-morbidity.

Similarly, extremes of age will affect the range of conditions and their clinical presentation. Foundation doctors will not be expected to have the same level of clinical skills for managing infants and children as they do for adult patients. If they are responsible for infants they will be expected to know how to recognise serious illness in this younger age group and to be able to initiate paediatric basic life support. The opportunities for assessment below refer to adult patients, unless otherwise specified.

Acute presentations in any of the workplace settings that will be experienced in Foundation Programmes can be grouped in terms of patients who have:

- airway problems
- breathing problems
- circulation problems
- neurological and visual problems
- psychiatric/psychological problems
- pain.

Opportunities for the assessment of competence should be taken when foundation doctors are managing adult patients with the following complaints:

#### **Airway problems, including:**

- situations where the airway may be compromised, including stridor
- performing basic airway manoeuvres using adjuncts
- identification of patients who may require tracheal intubation

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- unconscious patients
- anaphylaxis.

## **Breathing problems, including:**

- assessment of breathing (rate, depth, symmetry, oxygen saturation)
- recognition that a high respiratory rate needs prompt and iterative evaluation
- patients with:
  - asthma
  - COPD
  - chest infection/pneumonia
  - pneumothorax
  - left ventricular failure
  - pulmonary embolism.

## **Circulation problems, including:**

- assessment of the circulation (heart rate, blood pressure, perfusion)
- patients with:
  - hypotension
  - bleeding
  - severe sepsis
  - tachyarrhythmias
  - bradyarrhythmias
  - electrolyte derangement
  - oliguria and acute kidney injury
  - acute coronary syndrome.

## **Neurological and visual problems, including:**

- patients with:
  - collapse or coma
  - seizures
  - meningism
  - hypoglycaemia
  - acute onset of focal neurological signs
  - acute visual impairment.

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## **Psychiatric/behavioural problems, including:**

- situations where the safety of the patient, self or others may be at risk, including underlying mental illness (e.g. depression)
- violence and aggression with particular regard to child and elder abuse
- patient suffering from:
  - overdose/self harm
  - substance abuse
  - delirium or acute confusional state
  - psychosis.

## **Acute pain, including:**

- prompt, safe and effective management of acute and chronic pain, including palliative care
- patients with:
  - chest pain
  - abdominal pain
  - headache
  - large joint pain
  - back pain
  - injuries.

# Investigations and procedures

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**Outcome:** routinely arranges and correctly interprets basic laboratory and radiological investigations in the context of the particular patient with understanding of applicability and limitations.

## Competences

F1 and F2

- requests common investigations appropriate for patients' needs and the clinical context
- discusses (to the patient's level of understanding) the risks, possible outcomes and the results when available
- explains the implications of potential results
- gains informed consent
- recognises the need for an investigation result to impact on patient management
- avoids unnecessary investigations
- ensures results are available in a timely fashion
- interprets results of laboratory tests taking into account their applicability and limitations
- prioritises importance of results
- reviews reports when circumstances change
- obtains consent for a post mortem (PM) examination.

**Assessment:** *mini-CEX and CBD.*

## Knowledge

- investigation reports, which include the opinion of another professional, will need relevant information on the request form
- how biological samples should be sent for histological examination, including the sample-specific quality issues that help the pathologist to make an accurate diagnosis
- when a PM should be requested and the relationship of this process to death certification and the work of the coroner.

## Investigations commonly requested for acutely ill patients

- full blood count
- urea and electrolytes
- blood glucose
- cardiac markers
- liver function tests
- amylase
- calcium and phosphate
- coagulation studies
- arterial blood gases

# Investigations and procedures

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- inflammatory markers
- 12 lead ECG
- peak flow
- chest X-ray
- abdominal X-ray
- trauma radiography
- ultrasound, CT and MRI
- microbiological sampling including blood cultures obtained by good aseptic technique.

## Practical procedures

**Outcome:** performs the common practical procedures listed below. These are needed to diagnose and manage adult patients who present acutely. Foundation doctors who care for children will also learn how to do some of the following common procedures for them.

By the end of F1, you should be able to competently perform and teach undergraduates in the following procedures:

- Venepuncture
- IV Cannulation
- Preparation and administration of IV medication and injections and fluids
- Arterial puncture in an adult
- Blood culture (peripheral)
- IV infusion including the prescription of fluids
- IV infusion of blood and blood products
- Injection of local anaesthetic to skin
- Subcutaneous injection
- Intramuscular injection
- Perform and interpret an ECG
- Perform and interpret peak flow
- Urethral catheterisation (in adult males and females)
- Airway care including simple adjuncts

## Competences

For each procedure doctors should know the indications and contraindications and be able to:

- explain the procedure to the patient (including possible complications) and gain valid informed consent
- prepare the required equipment, including a sterile field
- position the patient and give premed/sedation as required, involving the anaesthetist where appropriate

# Investigations and procedures

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- adequately prepare the skin where relevant, including giving local anaesthetic
- arrange appropriate aftercare/monitoring
- safely dispose of equipment, including sharps
- document the procedure, including labelling samples and giving instructions for monitoring
- recognise, record and be able to undertake emergency management of common complications.

## **F2 Doctors**

During F2, doctors are expected to maintain and improve their skills in the above procedures. By the end of the year they should be able to help others with difficult procedures and guide F1 doctors in teaching others.

Foundation doctors will be able to extend the range of procedures they can do. Each specialty will stipulate an appropriate range of procedures in which foundation doctors will be expected to become proficient when and if attached to that specialty, for example:

- aspiration of pleural fluid or air in emergency or respiratory medicine
- skin suturing in emergency or surgery
- insertion of a central venous pressure line in critical care or similar environment
- aspiration of joint effusion in rheumatology
- insertion of a speculum in gynaecology.

## **How practical procedures are learnt**

It is the expectation that foundation doctors learn procedural skills on simulated models/manikins, prior to undertaking the procedure on patients.

The following steps may be followed:

- reading up the theory, or studying virtual training packages on the internet or DVD
- using a skills laboratory, where available
- learning in simulation centres/with simulated patients
- observing at first hand
- being observed doing the procedure by a competent practitioner with relevant experience of the procedure.

## **How non-technical skills are learnt**

Evidence from recent UK pilot studies has shown that high fidelity simulators have given foundation doctors valuable opportunities to deepen their understanding of the importance of communication skills, human factors and teamwork when managing acutely ill patients. Where simulators are available, the opportunities that they present should be fully exploited.

# Learning

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Learning will occur both in the workplace (experiential) and in the form of structured teaching based on important clinical scenarios. Foundation doctors will be encouraged to engage in reflective practice and to perform self-directed learning from patients, clinical opportunities, electronic learning materials, books, journals and other educational resources.

Foundation doctors should also learn by observing how other people perform. They should not only observe their application of formal knowledge and practical skills, but also they should learn from their mode of engagement and interaction with patients and other professionals.

Although some work may seem repetitive, it still presents a learning opportunity. It is important to recognise variation within common conditions. This could involve taking particularly full notes of perhaps a dozen cases a fortnight and discussing the differences in their treatment and progress. This will create greater expertise and allow the foundation doctors to take more responsibility.

## Clinical learning experiences

Clinical and educational supervisors will be encouraged to identify learner-centred educational opportunities in the course of clinical work (Figure 1).

**Figure 1: Intercollegiate Surgical Curriculum Project: Key characteristics of learning in the clinical setting.**

<b>Defining characteristics of education</b>	<b>Working context</b>
It takes place during professional practice and involves clinical and educational practice.	It demands both patient-centred and learner-centred interaction during the same clinical event, with an emphasis on effective oral communication.
It requires all clinical events to be seen and treated as educational experiences, and also patient-centred.	Learners need to recognise that clinical settings are at all times a learning resource, and that they may provide a negative or positive experience.
Although carried out essentially in the practice setting, it must be complemented by opportunities for reflection (at a distance).	It must involve reflective practice which should be recorded in the e-portfolio in the relevant section.

Source: JCHST (2005)

Doctors and their teachers will recognise the importance of maximising the wide variety of learning opportunities in the clinical workplace. These must be appropriate to the foundation doctor's level of experience afforded by the working environment (Figure 2).

# Learning

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**Figure 2. Work-based teaching and learning methods**

- accounts by patients, service users and carers of their experiences
- analysis of care scenarios supported by literature reviews
- audit
- audio/video recording of one's own practice or someone else's practice
- computer-controlled simulator
- discussion of one's own or another's practice
- e-learning
- group discussion of typical cases
- mock exams
- narrative of one's own case or a case by someone else
- observation of someone else's work and practice
- review of clinical guidelines or protocols
- review of patient's case notes (individual or team)
- simulated patients and/or colleagues
- skills laboratory
- work as a medical professional, including clinical practice, meetings and documentation.

*Source: Modified from Fish and Coles (2005)*

Programmed educational activities are organised during protected time for all foundation doctors (Figure 3):

**Figure 3. Programmed educational activities**

- The foundation educational programme will include:**
- diagnosis and clinical decision-making
  - effective time management, prioritisation and organisational skills
  - clinical accountability, governance and risk management
  - safe prescribing in clinical practice
  - the frameworks needed to ensure patient safety
  - legal responsibilities in ensuring safe patient care
  - understanding how appraisal promotes lifelong learning and professional development including career progression
  - the recognition of diversity and cultural competence
  - decision-making through communication with patients
  - team-working and communicating with colleagues
  - understanding consent and explaining risk

# Learning

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- managing risk and complaints and learning from them
- awareness of ethics and law as part of clinical practice
- using evidence in the best interest of patients
- taking responsibility for the future of medical care by teaching others effectively
- a supervised audit project.

F1 doctors are not entitled to study leave. F2 Doctors will be encouraged to take study leave to support their learning of the Curriculum (refer to the Reference Guide). This might include:

- attending courses relevant to the Foundation Programme e.g. to achieve ALS training or its equivalent
- sampling “taster” career alternatives that were not available within their F1 rotation e.g. public health, laboratory-based specialties, etc.

## Support for learning

**Local education providers (LEPs)** will provide details of the trained educational supervisors and clinical supervisors to the Foundation doctors (refer to Appendix B Responsibilities of trainers).

### Initial appraisal and educational agreements

When foundation doctors start in a new placement, they must arrange a meeting with both their educational and clinical supervisors (these roles may be undertaken by the same person). This is primarily the responsibility of the foundation doctor. The LEP will provide a back-up mechanism to ensure that this meeting takes place. An educational agreement is an essential starting point for negotiating the educational goals and discussing learning opportunities, the assessment process and use of the e-portfolio.

### Supervising and supporting workplace-based learning

Educators need to identify their own professional development needs in order to carry out their roles effectively, and to develop the confidence and expertise to support workplace learning.

The roles of the educators needed to support learning activities include: advisor, appraiser, assessor, clinical supervisor, coach, co-learner, critical friend, educational supervisor, expert, facilitator, mentor, teacher, trainer and tutor.

# Assessment

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Assessment is a crucial component of the *Foundation Programme Curriculum* (the Curriculum). It is the duty of the foundation doctor to demonstrate engagement with the assessment process. This means undertaking appropriate assessments and documenting them in the e-portfolio. Individual assessments are formative and represent an important opportunity for learning and reflection on practice. The end of placement/final supervisor's report will draw on the outcomes of multiple assessments. Participation in the assessment process, coupled with reflective practice, is the best way to demonstrate progression towards the outcomes expected of the programme.

## **i Purpose of assessment:**

- to highlight achievements and areas of excellence
- to emphasise the need for feedback
- to supply and demonstrate evidence of progression linked to the Curriculum
- to identify doctors who may need additional help.

## **ii Assessment methodology**

### **Continuous assessment**

The assessment tools are formative, thus designed to help foundation doctors improve their practice. Foundation doctors are expected to demonstrate improvement and progression during each attachment. Therefore, they should arrange for these assessments to be evenly spread throughout each attachment. Improvement in clinical practice will only happen if regular assessment leads to constructive feedback. Thus continuous assessment is a fundamental part of the Foundation Programme.

The educational/clinical supervisor's overall assessment and judgement of the foundation doctor must be based on multiple assessments by many observers. Within any attachment an individual assessor is unlikely to build up a coherent picture of competences, let alone performance of an individual foundation doctor. Therefore the local Foundation Programme training director/tutor should ensure that there is a local faculty responsible for forming a balanced judgement of a doctor's performance supported by the assessment results. Such an approach will prevent any individual having undue influence over a doctor's progression. To ensure fairness and equality of opportunity, all assessments will be subject to monitoring.

### **Self assessment**

Foundation doctors have a personal responsibility to make self assessment an integral part of their professional life. It is good educational practice for this to be stated clearly and discussed fully during induction.

Foundation doctors, with the support of their supervisor(s), are responsible for arranging performance appraisals, having the outcomes recorded and documenting ways to improve.

# Assessment

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## Assessment differences between F1 and F2

The assessment methods are the same in F1 and F2, but different standards pertain. The judgement about whether or not a foundation doctor has met the required standard for satisfactory completion of F1 or the Foundation Programme will involve a sample of the detailed competences and will not include a formal assessment of each one. Nevertheless, doctors about whom there are concerns, or who are felt to be performing sub-optimally, will need more of their practice sampled than those who are performing consistently well.

### F1

The outcomes recorded following clinical performance reviews or assessments will feed into the overall performance report at the end of the year. This report confirming overall satisfactory performance of the F1 doctor will inform the medical school as to whether they should complete the GMC Certificate of Experience. Once the Certificate is issued, the doctor is eligible to apply for full registration with the GMC. The GMC expect competence in all the domains set out in *The New Doctor* and reproduced in the Syllabus and competences.

### F2

The overall judgement of satisfactory completion of F2 will allow the doctor to be eligible to enter core or specialty training. This judgement will include an assessment of a foundation doctor's ability to take on increasing levels of responsibility.

During assessments, doctors will be expected to discuss or demonstrate achievement in each of the headline competences (see Syllabus and competences). The assessment process is not designed to rank the performance of doctors in training.

## E-portfolio

The e-portfolio is the record of a foundation doctor's assessments, achievements and other evidence demonstrating completed outcomes as specified by the GMC. The deanery will specify which e-portfolio is in use. It is essential that foundation doctors populate the e-portfolio with assessments, achievements and other evidence as it will be used to inform the end of year report by the foundation school director. It may also be used during interviews for appointment to specialty training.

## Assessors

- assessors **must** be trained in giving feedback, understand the role of the tool being used, assessment methodology and be competent in the competence they are assessing
- most assessors should be supervising consultants, GP principals and doctors in training who are more senior than the foundation doctor, experienced nurses or allied health professional colleagues
- foundation doctors should usually agree the timing and the clinical case/problem with the assessor
- assessors should also carry out unscheduled assessments.

# Assessment

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## Assessment Tools

### A. Multi-Source Feedback

Team Assessment of Behaviour (TAB)

- this consists of the collated views from a range of co-workers (previously described as 360-degree assessment). It will be mapped to a self-assessment tool with identical domains
- MSF should usually take place at least once a year. Deaneries have the option of increasing the frequency
- it is suggested that both F1 and F2 TAB be taken in the first four months of the year's training. If there is a risk of "rater fatigue", ie overburdening of a small number of colleagues, then F2 TAB could be undertaken in the second four months of training. If there are concerns about any foundation doctor, TAB can be repeated in the last four months of training.
- for each assessment, the foundation doctor should nominate 15 raters. A minimum of 10 returns are required. No other foundation doctor can be a rater.

Recommended mix of raters/assessors is as follows:

- 2–8 doctors more senior than F2, including at least one consultant or GP principal
- 2–6 senior nurses (band 5 or above)
- 2–4 allied health professionals
- 2–4 other team members including ward clerks, secretaries and auxiliary staff.

### B. Direct observation of doctor/patient encounter

Two tools can be used to assess doctor/patient encounters:

- Mini-clinical evaluation exercise (mini-CEX)
- Direct observation of procedural skills (DOPS).

Foundation doctors are required to undertake a minimum of nine observed encounters in both F1 and in F2. At least six of these encounters each year should use mini-CEX.

#### i Mini-clinical evaluation exercise (mini-CEX)

This is a structured assessment of an observed clinical encounter.

- foundation doctors should complete a minimum of six mini-CEX in F1 and another six in F2. These should be spaced out during the year with at least two mini-CEX completed in each four month period
- a different assessor should be used for each mini-CEX wherever possible, including at least one of consultant or GP level, per four month placement
- each mini-CEX must represent a different clinical problem, sampling one of the acute care, chronic illness, psychiatric care, etc. (categories listed in the Syllabus and competences).

# Assessment

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## ii Direct observation of procedural skills (DOPS)

This is a structured checklist for assessing the foundation doctor's interaction with the patient when performing a practical procedure.

- foundation doctors may submit up to three DOPS as part of the minimum requirements for evidence assessing doctor-patient encounters. However there should also be a minimum of six mini-CEX per annum (see mini-CEX page 52)
- different assessors should be used for each encounter wherever possible
- each DOPS could represent a different procedure and may be specific to the specialty
- although DOPS was developed to assess procedural skills, it's primary purpose in foundation is to assess the doctor/patient interaction.

## C. Core procedures

The GMC requires demonstration of competence in a series of procedures in order for a provisionally registered doctor with a licence to practise to be eligible for full registration. These will be recorded and signed off in a core procedures, which is found in the e-portfolio. A completed core procedures is also required for successful completion of the Foundation Programme.

## D. Developing the clinical teacher

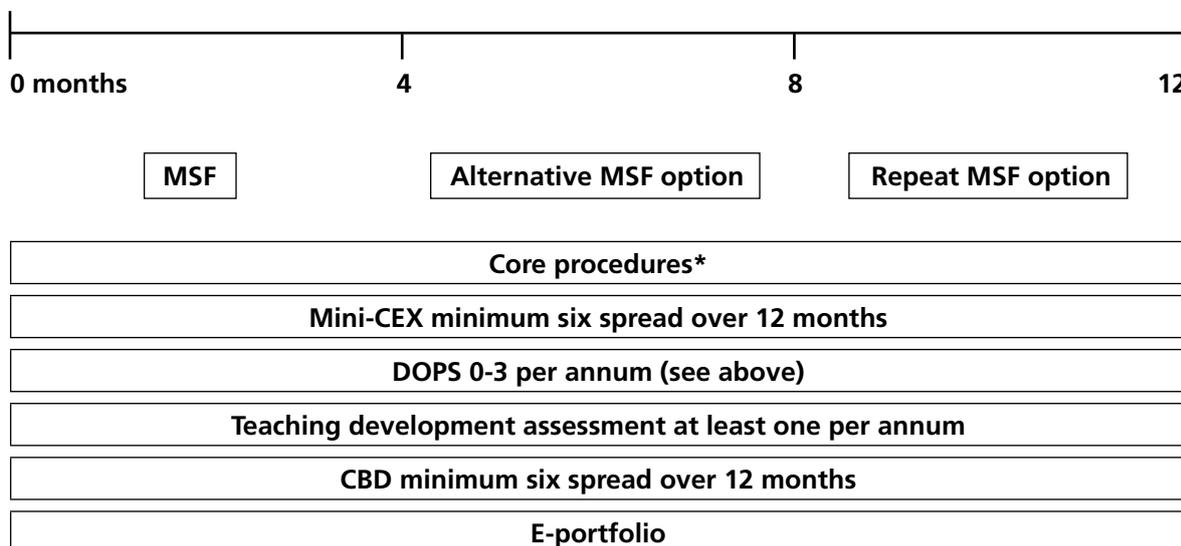
This is a form to aid the assessment of a foundation doctor's skill in teaching and/or making a presentation.

## E. Case based discussion (CBD)

- This is a structured discussion of clinical cases managed by the foundation doctor. Its strength is assessment and discussion of clinical reasoning.
  - a minimum of six CBDs should be completed with at least two CBDs undertaken in any four month period
  - different assessors should be used for each CBD wherever possible
  - assessors should have sufficient experience of the area under consideration, typically higher specialty training, with variations between specialties
  - each CBD must represent a different clinical problem, sampling one of the acute care, chronic illness, psychiatric care etc (categories listed in Syllabus and competences).

# Assessment

Figure 4. Assessment during the Foundation Programme



\* This is to be completed for F1 only. All other assessments will be needed for both F1 and F2.

## F. Feedback and debriefing

Feedback is a key component of the interactions between supervisors and foundation doctors. Giving and receiving feedback and engaging in constructive conversations about learning, successes, difficulties and progress are all part of an effective professional learning environment. Improvement in clinical practice will only happen if regular review leads to constructive feedback. As indicated above, unscheduled assessments are a good opportunity for immediate feedback. This is particularly true of DOPS and mini-CEX which may be opportunistic. It is essential that trainers provide, and foundation doctors receive, structured feedback.

## G. Personal responsibility

The foundation doctor, with the support of the supervisor(s), is responsible for arranging assessments, having them signed off and recording results. The evidence should be used to stimulate immediate or early feedback and to provide a basis for discussion with the clinical and/or educational supervisor.

## Final assessment

Towards the end of a placement, the foundation doctor and educational supervisor will meet again for an overall assessment. They will need to review the e-portfolio and the results of assessments made during the placement. This process will involve reviewing evidence from colleagues who have observed the doctor's performance in practice and/or in individual assessments. If the educational supervisor is different from the clinical supervisor, there should be a robust communication system to ensure a continuous, appropriate, and timely flow of evidence. This should include a 'sign off' document confirming satisfactory performance and progress. It should detail any outstanding issues that still need to be addressed. Refer to section 10 in Reference Guide.

# Assessment

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The educational supervisor's role includes having an overview of the foundation doctors' assessments. The results of these assessments will be drawn together and included in a formal structured educational supervisor's report. This will cover the overall performance of the doctor in a placement. Whilst WPBA will be taken into account, the overall judgement will include a triangulated view of the doctor's performance, which will include their participation in (and attendance at) educational activities, appraisals, the assessment process and recording of this in the e-portfolio.

The outcome of the final assessment discussion should be agreed by both the foundation doctor and the educational supervisor and recorded in the doctor's e-portfolio "End of placement review" form.

Placement reports put together in an annual report will form the basis of the foundation training programme director/tutor's recommendations of satisfactory completion of F1 and the Foundation Programme.

## I. Lack of progress

Most foundation doctors should achieve the required F1 competences by the end of their first year, and the F2 competences by the end of their second year.

Deaneries/foundation schools will make sure that there are systems in place to help doctors who may need additional support. Such doctors may be identified by:

- concerns raised by the doctors themselves, which might include problems relating to their training or assessment
- information transferred from undergraduate schools by foundation doctors (refer to GMC guidance)
- periods of prolonged absence (refer to the Reference Guide for further detail)
- judgments about their practice arising from the assessment tools
- reluctance/failure to take part in educational processes
- reluctance/failure to engage in the assessment process
- concerns raised by educational and/or clinical supervisors
- serious incidents/events/complaints from patients, colleagues or carers.

These issues must be discussed with the doctor concerned. The educational supervisor should follow local processes and seek early advice when necessary. Further work may be needed for the few doctors still experiencing difficulty despite extra support. They may carry out more assessments (of competence, performance or knowledge). Doctors who do not make progress may need more education and training, with further assessments. Training may be extended for up to a maximum of one year (or equivalent for part-time foundation doctors), at the discretion of the deanery/foundation school.

If there is still no progress, then the doctor will be deemed to have failed. This means that the doctor will not have satisfied the requirements of the Foundation Programme. The postgraduate dean/foundation school director will be unable to sign off the doctor for the specific component of training and will initiate career management discussions with the foundation doctor. It should be mutually determined whether medicine is the right career

# Assessment

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for that individual – a change of career may be necessary. Deaneries/foundation schools will have an appeal process for doctors who are unable to satisfactorily demonstrate completion of this stage of their postgraduate medical training. Further information can be found in the relevant section of the Reference Guide and in GMC's *Standards for Training in the Foundation Programme* (in *The New Doctor*).

The employer is also responsible for assessing and determining the employability of the foundation doctor. The individual may not be employable in the foundation post or programme where particular concerns or problems have been identified.

In the above circumstances the employer must inform the deanery, and in normal circumstances an agreement would need to be reached over referral of the doctor concerned to the GMC so that the GMC can determine whether or not the doctor can remain on the professional register.

# Appendix A: Curriculum design and educational framework

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## Curriculum design

Foundation doctors are developing professionals and need to deepen and broaden their understanding and expertise. This means:

- revisiting clinical and professional practice, and studying at increasingly complex levels
- practising with decreasing supervision
- recognising that levels of expertise generally increase with practise and reflection.

When doctors start their professional career they have to work through an explicit set of processes before being able to formulate a hypothesis which leads to a differential diagnosis. They may then use protocols and guidelines to decide on relevant investigations and management. An expert clinician may reach a similar diagnosis and appear to have made an intuitive leap with relatively limited information. However, this will have been based on widespread knowledge and extensive experience. It may take account of the knowledge that 'common things commonly occur', but also rare events are possible and can be suspected when there is something unusual in the patient's presentation.

In medical practice, doctors should never stop learning and continuing their professional development. Doctors should continue to refine their clinical skills and techniques and the quality of their interactions with others. This includes encouraging self care and shared decision-making with patients, relatives and colleagues. It is probably as important for doctors to understand their personal style, assumptions and beliefs, (and changing them when appropriate) as developing their procedural and clinical skills.

## Educational Framework

The Dreyfus model of skills acquisition (see Figure 5) describes different levels and aspects of practice in the spiral curriculum (see Figure 7), from medical school to specialist training.

**Figure 5: Summary of the Dreyfus model of skills acquisition**

### Level 1: Novice

- rigid adherence to taught rules or plans
- little situational perception
- no discretionary judgement.

### Level 2: Advanced beginner

- guidelines for action based on attributes or aspects (global characteristics of situations recognisable only after some prior experience)
- situational perception still limited
- all attributes and aspects are treated separately and given equal importance.

# Appendix A: Curriculum design and educational framework

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## **Level 3: Competent**

- coping with crowdedness
- now sees actions at least partly in terms of longer-term goals
- conscious deliberate planning
- standardised and routine procedures.

## **Level 4: Proficient**

- sees situations holistically rather than in terms of individual aspects (see above)
- sees what is most important in a situation
- perceives deviations from the normal pattern
- decision-making less laboured
- uses maxims (whose meaning varies according to the situation) for guidance.

## **Level 5: Expert**

- no longer predominantly reliant on rules, guidelines or maxims
- intuitive grasp of situations based on deep tacit understanding
- analytic approaches used only in novel situation or when problems occur
- vision of what is possible.

*Source: Eraut, M (1994) Developing Professional Knowledge and Competence.*

Understanding the Dreyfus five levels will enable foundation doctors to manage each stage of a patient's journey more effectively. They will steadily build up their expertise from having specific skills to managing the whole patient experience. They will gradually need less supervision.

Such models will also help supervisors and assessors expand what they look out for in the foundation doctor's work and therefore make better judgements on their progress.

Relevant questions a supervisor/assessor might ask include:

- is the foundation doctor using a more discerning mix of clinical understanding, protocols and guidelines?
- is the foundation doctor carrying out procedures and making decisions more quickly?
- can other team members describe how the foundation doctor has gained confidence in their decisions and their risk assessments?
- are there fewer complaints from patients?
- does the foundation doctor ask for help less often?

# Appendix A: Curriculum design and educational framework

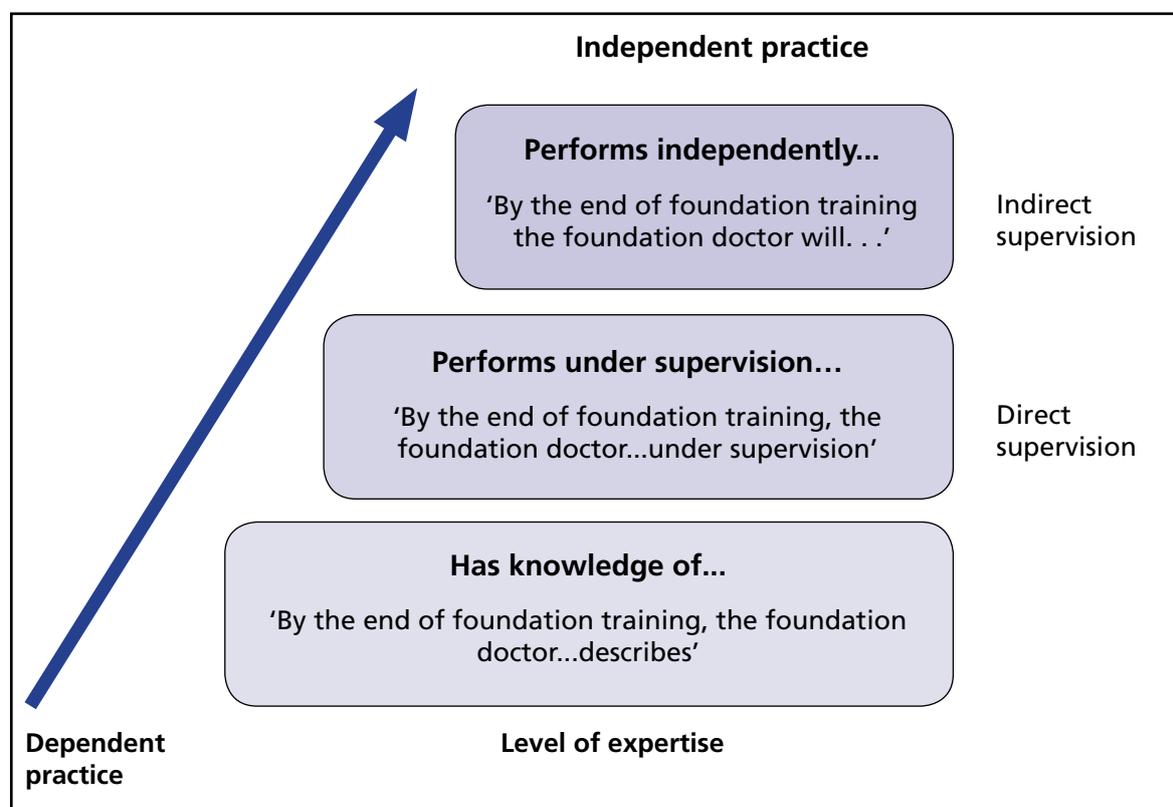
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The following two examples illustrate how this can be applied in intensive care and inserting a chest drain.

## Intensive care

A modification of the intensive care competence development framework is shown below (Figure 6). It illustrates the improvement of clinical practice and different levels of supervision in different aspects of the Foundation Programme. Understanding this progression will enable foundation doctors to assess and reflect upon their clinical management more accurately.

**Figure 6: Development of core competences for the Foundation Programme**

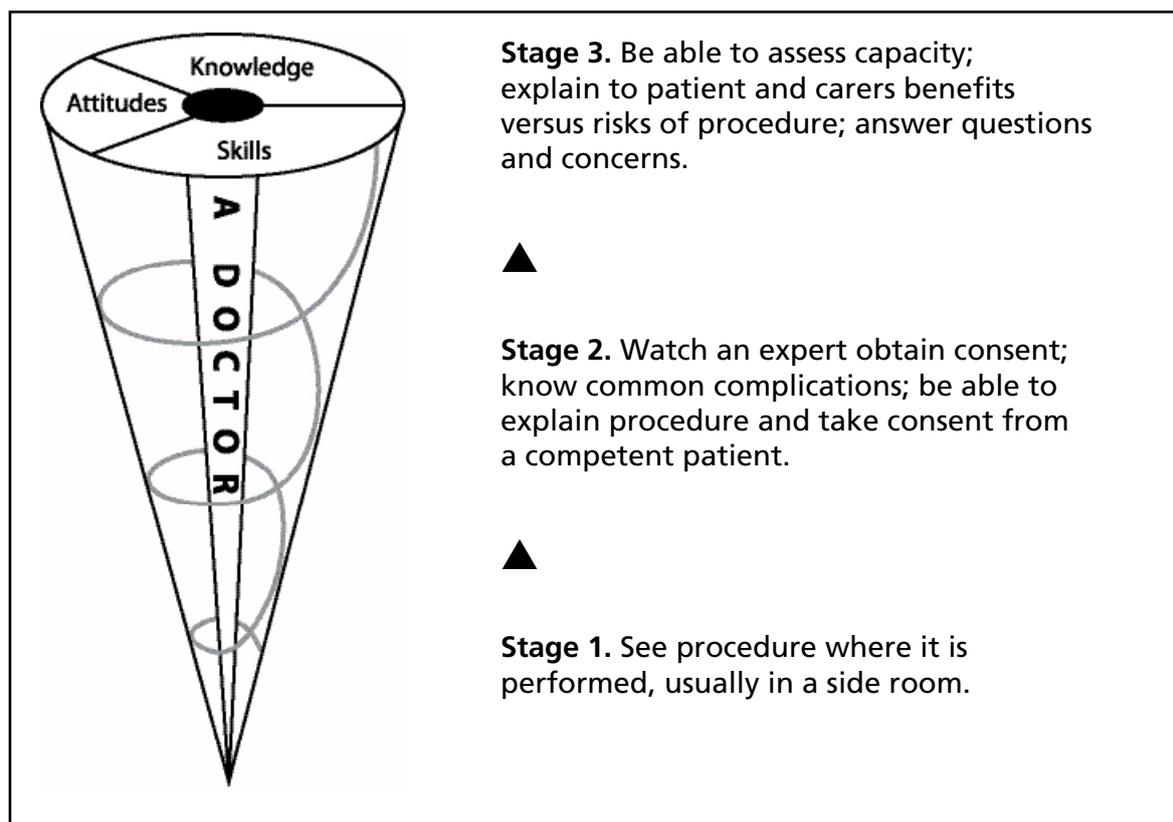


Source: Adapted from The CoBaTrice Collaboration's Intensive Care Steps to Independent Practice model (2006).

# Appendix A: Curriculum design and educational framework

## Example of the spiral curriculum

Figure 7: Consent for inserting a chest drain



Based on: Harden RM, Davis MH and Crosby JR (1997) *Medical Education*; 31, 264.

At the beginning of F1, doctors will find that they have to follow guidelines to complete basic tasks. The aim is to move towards a position where they can carry out much of the day-to-day basic work to a high standard. Foundation doctors start to move towards managing this subconsciously, allowing them to focus on diagnostic accuracy and relevant management of care. This can only be achieved by frequently repeating tasks and by always reflecting carefully on the process and outcome. This approach can be helped by external senior help or facilitation.

### Educational framework

Doctors are responsible for their own learning. At the same time they must understand the needs of the patient and of the organisation in which they work. They should understand the complexities, constraints and opportunities they find in their practice, and be able to choose how to make best use of these. They also need to understand that, as well as engaging in more formal educational activities, they learn by working with other team members. They must learn how to contribute to the safe practice of medicine.

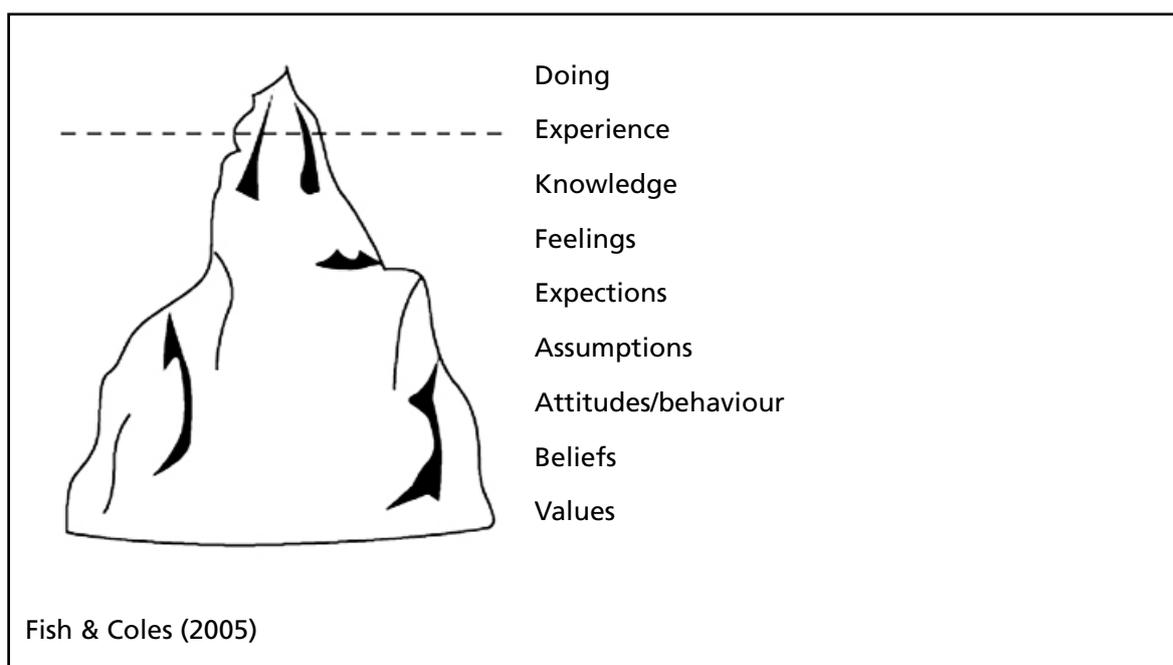
## Appendix A: Curriculum design and educational framework

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Good educational practice acknowledges the private and public aspects of professional development, and gives due importance to the key relationships which inform professional development. Effective learners will achieve their aims, acknowledging that who they are and what they believe affects what they do. Foundation doctors do not live in a vacuum; they may have personal and family difficulties and the most effective learners recognise the impact of these factors and deal with them.

Effective educational practice will help foundation doctors understand the relationship between theory and reality, which will enable them to exercise better judgement in complex situations. They will also be encouraged to understand other roles within the team and show how they can adapt and collaborate in emergency situations. They will need to become aware of the different perspectives and expertise that can improve problem solving, clinical reasoning, patient management and decision making. This depth of understanding and expertise requires study and practice of all the components of professional activity, as outlined in the metaphor of the iceberg (see Figure 8).

**Figure 8: Developing a curriculum for practice**



*Source: Fish and Coles (2005)*

Acquiring expertise that can be adapted to new situations depends on the development of clinical and ethical reasoning and professional judgement. Much learning occurs in teams and much knowledge and expertise is found in groups rather than in individuals. This strengthens the principle that learning in the Foundation Programme should take place in team-based practice. Expertise is more than knowledge or a tool kit of skills. The foundation doctor will learn similar skills in different settings, facilitating the development of transferable skills.

Doctors at the start of their careers seek predictable solutions rather than acknowledging the paradoxes and ambiguities of clinical practice. The following actions should be considered:

# Appendix A: Curriculum design and educational framework

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- exploring new courses of action
- reflecting on what happens
- accepting unpredictability.

Similarly, the acquisition and application of skills and knowledge will vary according to where care is given. General practice will enable foundation doctors to care for acutely ill patients in a different setting from secondary care. Patients will present differently, and their illnesses will be seen at a much earlier stage. Their management will need different clinical and risk assessment skills. Also, primary care offers a unique perspective on how secondary care specialties work. Foundation doctors will be able to follow their patients through the service, from the presentation of acute illness through investigation, diagnosis and management to recovery, rehabilitation or death. They will also be able to see the effect of acute illness on those with a chronic disease.

Consideration will need to be given as to whether the clinical context for learning needs to be more closely prescribed to ensure that foundation doctors acquire generic competences across a range of clinical situations. For example, meaningful competences in child health can be acquired outside paediatric (or general practice) placements.

# Appendix B: Responsibilities of Trainers

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## Roles

When learning in and from practice, it is important to understand that roles may overlap and differ in subtle ways. In these cases, supervision provides essential support. However:

- the needs of the learner should determine which role is adopted, and these change over time and in different situations
- skilled educators move in and among these roles according to identified need
- enough time should be allocated to develop these roles and relationships
- those involved should aspire to mutually negotiated and fair outcomes, but they should also recognise that supervision involves a power relationship
- good educational practice requires a balance of the following aspects:
  - support
  - challenge
  - clarification of the standards to be achieved
  - clarification of the consequences of non-achievement.

### **Educational supervisor**

All F1 and F2 doctors will have an educational supervisor.

A trainer is selected and appropriately trained to be responsible for the overall supervision and management of a specified foundation doctor's educational progress during a training placement or series of placements. The educational supervisor is responsible for the foundation doctor's educational agreement.

Only clinicians committed to and engaged in teaching and training foundation doctors should undertake the role. They must enable foundation doctors to learn by taking responsibility for patient management within the context of clinical governance and patient safety.

Local education providers must ensure that educational supervisors have adequate support and resources to undertake their training role. This will include training in equality and diversity.

The educational supervisor will:

- ensure that the programme is appropriate for the doctor's needs
- meet with the foundation doctor at the beginning of each placement to agree how the learning objectives for this period of training will be met and confirm how formative feedback and summative judgments will be made
- help foundation doctors by reviewing their learning needs in the light of achieved goals
- carry out and/or collate assessments from clinical supervisors, trainers and other assessors
- review the doctor's learning e-portfolio
- conduct appraisals and give supportive feedback on the results of MSF

## Appendix B: Responsibilities of Trainers

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- meet with the foundation doctor to assess whether they have met the necessary outcomes and complete an end of placement review form for each placement
- support the doctor through any difficulties
- tell the clinical director, head of service or medical director and those responsible for training, of serious weaknesses in their supervisee's performance that have not been dealt with, and any other problems an individual has with the training programmes. The supervisor should tell the foundation doctor the content of any information about them that is given to someone else
- ensure that all training opportunities meet the requirements of equality and diversity legislation
- give appropriate handover to the next educational supervisor with the foundation doctor's knowledge.

### Clinical supervisor

A trainer is selected and appropriately trained to be responsible for overseeing a specified foundation doctor's clinical work and providing constructive feedback during a training placement. Clinical supervisors may/will change on a day-to-day basis depending on the rota for each foundation doctor. Some training schemes appoint an educational supervisor for each placement. The roles of clinical and educational supervisor may then be merged.

A clinical supervisor will usually be the consultant or principal in general practice to whom a foundation doctor is directly responsible for their clinical work. There will be frequent contact between them. The educational supervisor may see the foundation doctor much less often.

Only clinicians committed to training foundation doctors should undertake the role of clinical supervisor. They must enable foundation doctors to learn by taking responsibility for patient management within the context of clinical governance and patient safety. It may be appropriate to delegate some supervision to appropriately experienced non-consultant (or non-GP principal) doctors. The clinical supervisor remains responsible and accountable for patient care and for the supervision of the foundation doctor.

Local Education Providers (LEPs) must ensure that clinical supervisors have adequate support and resources to undertake their training role. This will include training in equality and diversity.

The clinical supervisor is responsible for:

- ensuring that the foundation doctor is never put in a situation where s/he is asked to work beyond his/her competence without appropriate support and supervision. Patient safety must be paramount at all times
- guaranteeing suitable induction to the ward/department/practice
- meeting with the foundation doctor at the beginning of each placement to discuss what is expected in the placement, learning opportunities available and the foundation doctor's learning needs
- ensuring that the clinical experience available to the foundation doctor is appropriate and properly supervised
- ensuring that all training opportunities meet the requirements of equality and diversity legislation
- monitoring, supporting and assessing the foundation doctor's day-to-day clinical and

# Appendix B: Responsibilities of Trainers

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professional work

- providing regular feedback on the foundation doctor's performance
- undertaking and facilitating work place based assessments (WPBAs)
- allowing the foundation doctor to give feedback on the experience, quality of training and supervision provided
- discussing serious concerns with the educational supervisor about a foundation doctor's performance, health or conduct
- completing the clinical supervisor's report (which can include assessments for all competences) at the end of the placement.

# Appendix C: Appointment to Foundation Programmes and career management

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## Entry and accreditation

Entry conditions will correspond to the GMC's and the PMETB's standards of recruitment, selection and appointment. This implies that applicants for F1 will have obtained a medical degree but not yet completed the equivalent of an F1 year. F2 applicants will have completed the equivalent of an F1 and usually no further medical training. These processes must be open, fair and effective. Those appointed must have appropriate induction into the training. Refer to the Reference Guide.

The UK Foundation Programme Office (UKFPO) coordinates national recruitment to the Foundation Programme.

## Career management

Effective career planning and management support are an integral part of post-graduate medical education and training.

- As applications for specialty training take place midway through F2, or even earlier, there should be suitable sessions for career support in Foundation Year 1, which can then be built upon in Foundation Year 2. Starting to explore career options in Foundation Year 2 is too late
- Most doctors get their first choice specialty and/or first choice deanery for specialty training
- Foundation doctors should be encouraged to choose a 'plan B' specialty and deanery and early career support sessions will assist this. Exploration of wider career options is encouraged before detailed attention is given to a specific career pathway
- The first stage of career advice and support is with educational and clinical supervisors (who will help doctors tailor their educational plans to the career choice and the specialty they work in). Further sources of support include the director of medical education/postgraduate clinical tutor
- Foundation doctors should be encouraged to adopt a pragmatic, realistic outlook and to recognise that their desired career path may only be attainable within the context of the job market and their personal circumstances
- Foundation doctors are expected to be proactive in the planning and progression of their career, building on careers management skills learnt at medical school
- Doctors are encouraged to develop career planning skills during the Foundation Programme and this can be facilitated by increasing their awareness of personal work values, strengths and attributes
- Foundation doctors should be aware that careers can change direction because of ill health, disability and work life balance issues, and should seek careers support in these circumstances
- Foundation doctors are encouraged to consider their possible career pathways and subsequent specialty training programmes when choosing F1 and F2 taster placements, audit projects and research.

# Appendix C: Appointment to foundation programmes and career management

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## Career management resources for foundation doctors

Careers information is available from the UK Medical Careers website [www.medicalcareers.nhs.uk](http://www.medicalcareers.nhs.uk), the UKFPO website [www.foundationprogramme.nhs.uk](http://www.foundationprogramme.nhs.uk), postgraduate deaneries, the medical royal colleges and faculties (whose websites are good sources of information). Various publications are available in postgraduate medical libraries (e.g. BMJ Careers). Foundation doctors must have access to accurate information on recruitment and selection processes.

Foundation core curriculum programmes should contain specific sessions to develop career management skills. All foundation doctors should have access to a step-wise approach to support, including deanery careers support systems. Foundation doctors should be aware of careers which change due to ill health, disability and work life balance issues and the sources of careers support in these circumstances.

Foundation doctors should have access to local taster programmes.

Information about higher medical specialist training is available from the Joint Royal Colleges of Physicians Training Board ([www.jrcptb.org.uk](http://www.jrcptb.org.uk)). Information about higher surgical training is available from the Joint Committee of Surgical Training ([www.jcst.org](http://www.jcst.org)). Contact details for the medical royal colleges and specialty training bodies can be found on the Academy of Medical Royal Colleges website ([www.aomrc.org.uk](http://www.aomrc.org.uk)).

Doctors who need advice or support should contact the postgraduate medical education staff of their local NHS Trust (in England, Wales and Northern Ireland) or NHS Board (in Scotland). Postgraduate deaneries are developing systems to ensure that trained people are available to give local advice. Foundation doctors should be informed of these as part of their induction. College or specialty tutors within a hospital can advise on careers in their own specialty. Doctors who need guidance on training for general practice should contact the local GP vocational training course organiser, associate director, or director of postgraduate general practice education, who will be a member of the local postgraduate deanery. Doctors who require impartial and confidential advice and support should be informed how to access these services.

E-portfolios will form the basis of all career discussions, so doctors seeking careers information or advice should ensure that they are up-to-date. A career reflection on each Foundation Programme post should be entered into the e-portfolio. All foundation appraisals should contain an element of career discussion between the foundation doctor and their supervisor.

All the royal colleges have updated curricula in 2009/10 for their specialties, accessible through the relevant college or faculty websites.

# Appendix D: Ensuring quality in Foundation Programmes

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Responsibility for the approval of the training provided in the Foundation Programme rests with the General Medical Council (GMC) as the regulator. The GMC is the UK competent authority with regard to EU legislation. The regulator has set in place a robust quality assurance system known as the Quality Assurance of the Foundation Programme (QAFP) in order to:

- ensure that the standards set are being met, and to enable them to decide whether to continue to approve the deanery as a body to provide Foundation Programme training in the UK
- enable the regulator to support the development and improvement of local Foundation Programme education and training by ensuring that useful and innovative educational practices are shared (horizontal connections)
- ensure that foundation training is aligned with undergraduate and postgraduate education (vertical connections).

Until 2010, the Foundation Programme was regulated jointly by the GMC and PMETB; from 2010 this function rests with the GMC and is delegated to the GMC's Postgraduate Board. The quality processes were developed and piloted by the GMC and PMETB. There are three types of quality activity and to avoid confusion they should be used accurately:

## **Quality assurance - carried out by the regulatory authorities**

Quality assurance encompasses all the policies, standards, systems and processes involved with ensuring maintenance and enhancement of the quality of postgraduate medical education in the UK. The regulator undertakes planned and systematic activities to provide public and patient confidence that postgraduate medical education satisfies given requirements for quality within the principles of good regulation.

## **Quality management - carried out by the postgraduate deanery**

Quality management refers to the arrangements by which the postgraduate deanery discharges its responsibility for the standards and quality of postgraduate medical education. The deanery must satisfy itself that local education and training providers are meeting the regulator's standards through robust reporting and monitoring mechanisms.

## **Quality control - carried out at local education provider (LEP) level**

Quality control relates to the arrangements (procedures and organisation) within local education providers (health boards, NHS trusts and independent sector organisations) that ensure postgraduate medical trainees receive education and training that meet local, national and professional standards.

These processes are interdependent. The regulator's QA is a systematic educational audit of the deanery quality management systems; the latter must include review of LEP quality control measures. The regulator has set national standards for the delivery and outcomes of the Foundation Programme and deaneries are required to demonstrate through reports and visits that the standards have been met. There are nine domains of activity described:

- patient safety
- quality assurance, review and evaluation
- equality, diversity and opportunity

## Appendix D: Ensuring quality in Foundation Programmes

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- recruitment, selection and appointment
- delivery of the Curriculum including assessment
- support and development of trainees, trainers and local faculty
- management of education and training
- educational resources and capacity
- outcomes.

In each domain, the regulator has described who is responsible for its achievement, the standard(s) to be reached, and the criteria by which its achievement is judged. The standards set by the regulator are mandatory, but the processes by which deaneries quality manage, and LEP quality control, the programme provision are not specified.

Full information on the quality assurance of the Foundation Programme can be obtained from the GMC website at [http://www.gmc-uk.org/education/assuring\\_quality.asp](http://www.gmc-uk.org/education/assuring_quality.asp).

Examples of 'good practice' in the implementation of the Curriculum can be found on the UKFPO website at [www.foundationprogramme.nhs.uk](http://www.foundationprogramme.nhs.uk).

# Appendix E: Changes since 2007

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The layout of the *Curriculum* has been changed after feedback from PMETB surveys, the Tooke Report and from the results of wide consultation.

## Structural changes

- different layout brings the syllabus, competences and accompanying assessment to the forefront. This will facilitate easier navigation for the principal users, i.e. trainees and trainers
- the whole *Curriculum* has been rationalised with removal of duplication
- Quality assurance, quality management and quality control information has been updated.

## Assessment

- the assessment methodology has been clarified and simplified in response to widespread feedback
- specified assessments have been directly linked to each competence
- a core procedure has been produced to record competence in procedural skills for F1 doctors
- only one form of multi-source feedback (TAB) is recommended for use throughout the four nations
- clarification of educational and clinical supervisor roles and responsibilities
- in the assessment tools, separate descriptors have been written for all grades 1-6
- new tool developed to assess teaching and presentation skills.

## Syllabus and competences

- inclusion of a new professionalism section which underpins all medical practice, bringing together attitudes and behaviours from the previous *Curriculum*
- clinical governance is unified with patient safety
- a new section on medical devices has been added
- expansion of safe prescribing section
- strengthening laboratory requesting systems
- the recognition and management of the acutely ill has been given more prominence.

# Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

## How the Curriculum maps to regulators' requirements: GMC

The *Foundation Programme Curriculum* (the Curriculum) has been mapped to the four domains of the GMC, illustrating where the standards have been met in the Curriculum (Syllabus and competences (SC)).

### Domain 1 – Knowledge, Skills and Performance

Attributes	Generic Standards	Fulfilment in FPC
Maintain your professional performance	Maintain knowledge of the law and other regulation relevant to practice Keep knowledge and skills up to date Participate in professional development and educational activities Take part in regular and systematic audit	SC 11.1, 11.3 SC 12.1 SC 12.1 SC 12.3, Learning (figure 3)
Apply knowledge and experience to practice	Recognise and work within the limits of your competence Follow appropriate national research governance guidelines Apply the skills, attitudes and practice of a competent teacher/trainer Work effectively as a manager Adequately assess the patient's conditions Provide or arrange advice, investigations or treatment where necessary Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately Provide effective treatments based on the best available evidence Take steps to alleviate pain and distress whether or not a cure may be possible Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests Support patients in caring for themselves	SC 1.0 SC 12.2 SC 1.3 NA SC 3.1 SC 2.3 SC 2.4 SC 12.2 SC 3.8 SC 14.1-2 5.0
Keep clear, accurate and legible records	Keep clear, accurate and legible records Make records at the same time as the events you are recording or as soon as possible afterwards Record clinical findings, decisions, information given to patients, drugs prescribed and other information or treatment	SC 2.5 SC 2.5 SC 2.5

# Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

## Domain 2 – Safety and Quality

Attributes	Generic Standards	Fulfilment in FPC
Put into effect systems to protect patients and improve care	<p>Respond constructively to the outcome of audit, appraisals and performance reviews</p> <p>Take part in systems of quality assurance and quality improvement</p> <p>Comply with risk management and clinical governance procedures</p> <p>Co-operate with legitimate requests for information from organisations monitoring public health</p> <p>Provide information for confidential inquiries, significant event reporting</p> <p>Make sure that all staff for whose performance you are responsible, including locums and students, are properly supervised</p> <p>Ensure systems are in place for colleagues to raise concerns about risks to patients</p> <p>Report suspected adverse drug reactions</p> <p>Ensure arrangements are made for the continuing care of the patient where necessary</p>	<p>SC 1.0, Assessment</p> <p>Appendix G</p> <p>SC 7.1-4</p> <p>SC 8.0</p> <p>SC 7.4</p> <p>SC 2v</p> <p>SC 7.1</p> <p>SC 2.4</p> <p>SC 1.3</p>
Respond to risks to safety	<p>Report risks in the health care environment to your employing or contracting bodies</p> <p>Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities</p> <p>Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk</p> <p>Respond promptly to risks posed by patients</p> <p>Follow infection control procedures and regulations</p>	<p>SC 7.1-2</p> <p>SC 1.1</p> <p>SC 14.1</p> <p>SC 3.9</p> <p>SC 8.0</p>
Protect patients and colleagues from any risk posed by your health	<p>Make arrangements for accessing independent medical advice when necessary</p> <p>Be immunised against common serious communicable diseases where vaccines are available</p>	<p>SC 1.2</p> <p>SC 1.2</p>

# Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

## Domain 3 – Communication, Partnership and Teamwork

Attributes	Generic Standards	Fulfilment in FPC
Communicate effectively	<p>Communicate effectively with colleagues within and outside the team</p> <p>Explain to patients when something has gone wrong</p> <p>Encourage colleagues to contribute to discussions and to communicate effectively with each other</p> <p>Listen to patients and respect their views about their health</p> <p>Give patients the information they need in order to make decisions about their care in a way they can understand</p> <p>Respond to patients' questions</p> <p>Keep patients informed about the progress of their care</p> <p>Treat those close to the patient considerately</p> <p>Pass on information to colleagues involved in, or taking over, your patients' care</p>	<p>SC 14.1</p> <p>SC 7.0 (Knowledge)</p> <p>SC 14.1</p> <p>SC 7.1</p> <p>SC 2.3-4, 7.1</p> <p>SC 6.1</p> <p>SC 6.1</p> <p>SC 6.1-2</p> <p>SC 1.3, 3.10</p>
Work constructively with colleagues and delegate effectively	<p>Treat colleagues fairly and with respect</p> <p>Support colleagues who have problems with their performance, conduct or health</p> <p>Act as a positive role model for colleagues</p> <p>Ensure colleagues to whom you delegate have appropriate qualifications, experience</p> <p>Provide effective leadership</p>	<p>SC 1.1, 14.1</p> <p>SC 1.1, 14.1</p> <p>SC 1.1, 14.1</p> <p>SC 1.1, 14.1</p> <p>SC 14.1</p>
Establish and maintain partnerships with patients	<p>Encourage patients to take an interest in their health and take action to improve and maintain it</p> <p>Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research</p>	<p>SC 10.1-4</p> <p>SC 2.2, 2.4, 11.2</p>

# Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

## Domain 4 – Maintaining Trust

Attributes	Generic Standards	Fulfilment in FPC
Show respect for patients	Implement and comply with systems to protect patient confidentiality Respect the rights of patients participating in research Be polite, considerate and honest and respect patients' dignity and privacy Treat each patient fairly and as an individual	SC 2.5 SC 7.1 SC 1.1 SC 6.1, 7.1. 11.1
Treat patients and colleagues fairly and without discrimination	Be honest and objective when appraising or assessing colleagues and when writing references Respond promptly and fully to complaints Provide care on the basis of the patient's needs and the likely effect of treatment	SC 1.1 SC 7.5 SC 2.4
Act with honesty and integrity	Ensure you have adequate indemnity or insurance cover for your practice Be honest in financial and commercial dealings Ensure any published information about your services is factual and verifiable Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence Obtain appropriate ethical approval for research projects Be honest in undertaking research and reporting research results Ensure that your research is audited regularly Inform patients about any fees and charges before starting treatment	SC 12.4 SC 1.1 NA SC 11iii SC 11i NA NA NA

Section/standards	Fulfilment in FPC
Section 1	Appendix E, SC, Core procedures, Assessment, Appendix B
Section 2	See above
Section 3	
1.1	Appendices G, B, How to use the Curriculum, Assessment (assessment methodology)
1.2	Appendix D

## Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

Section/standards	Fulfilment in FPC
1.3	Appendix D
2.1	Assessment, SC. Published on UKFPO website
2.2	Assessment
2.3	Assessment (assessment methodology), Appendix A
3.1	Introduction, How to use the Curriculum, SC (1.1 and 12.1), Investigations and Procedures, Learning (support for learning, Figures 1 and 2), Appendices A, E, G
3.2	How to use the Curriculum, SC (outcomes), Investigations and procedures (outcomes), Assessment (final appraisal)
4.1	SC, Investigations and Procedures, Appendix F and e-portfolio <a href="http://www.foundationprogramme.nhs.uk/">www.foundationprogramme.nhs.uk/</a>
5.1	How to use the Curriculum for trainers and trainees, Appendix D (QC)
5.2	Appendix D
5.3	Appendix D (QC)
5.4	How to use the Curriculum, Assessment, Appendix D
6.1	Syllabus in practice, Learning (figure 3)
6.2	Syllabus in practice, Learning (figure 3), Assessment (final assessment)
6.3	Syllabus in practice, Learning (figures 1 and 2)
7.1	Learning (figure 2 and 3)
7.2	Assessment (assessment methodology) and Appendix B
7.3	Appendix B
8.1	Assessment in Foundation working party utilising AoMRC Improving Assessment, data from Scottish portfolio group and HcAT
8.2	See 8.1 and Assessment
8.3	Appendix D (QC)
9.1	SC (1.0, 2.4, 7), Learning (Figure 2), Appendix B
9.2	Appendix B, Assessment (assessment methodology)
10.1	Learning, Appendix B
10.2	Learning, Appendix B
10.3	Assessment (assessment methodology), Appendices B, D (QC)
10.4	Assessment (methodology)
10.5	Appendix B
11.1	Assessment (continuous assessment), Appendix B
11.2	No formal exams, all are WPBA

## Appendix F: Mapping the Foundation Programme Curriculum to the regulators' requirements

Section/standards	Fulfilment in FPC
11.3	Assessment (purpose and methodology, feedback and debriefing), Appendix B
11.4	Assessment (final appraisal and lack of progress), Appendix B
12.1	Consensus at AFPC and allied working groups
12.2	All WPBA are formative and include feedback
12.3	See 12.2
12.4	Refer to AoMRC Improving Assessment, expansion of gradings previously 1-4, now extended 1-6
12.5	Assessment (final appraisal)
12.6	Assessment (difference between F1 and F2 and lack of progress)
13.1	Assessment (lack of progress final paragraph)
13.2	<a href="http://www.foundationprogramme.nhs.uk/download.asp?file=Learning_PortfolioV3-1.pdf">http://www.foundationprogramme.nhs.uk/download.asp?file=Learning_PortfolioV3-1.pdf</a>
13.3	Appendix F
13.4	Appendices E and F
13.5	E-portfolio is a secure web-based service available anywhere in the UK, but with access controls allowing suitable restrictions by location and by individual allocation of trainees to supervisors
14.1	Appendix G. To be reviewed in 2014 for use in 2015
14.2	Appendix G
15.1	See 10.1-4
15.2	Appendix B
15.3	Assessment, Appendices B and D
15.4	Assessment
15.5	Appendix D (QAFP – national, QM – deanery , QC – local)
16.1	Appendix G
16.2	Lay people are currently not involved in WPBA, however the UKFPO is commissioning a development programme to validate patient surveys of foundation doctors' performance. There is therefore the commitment to patient involvement in foundation doctor assessment. Studies are ongoing and patient assessment will be included when fully validated, at the latest 2014/15.
17.1	Appendix B (educational and clinical supervisor roles)
17.2	Available on <a href="http://www.foundationprogramme.nhs.uk">www.foundationprogramme.nhs.uk</a>
17.3	SC (1.0)

# Appendix G: Curriculum development and list of contributors

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It was stated in the *Foundation Programme Curriculum* (2007) that a revision would take place for 2010.

Comments on the previous version were received from PMETB surveys and the *Tooke Report* (2008). A wide consultation of stakeholders was undertaken. Further advice was sought on the content and layout of various drafts of the *Foundation Programme Curriculum* (the Curriculum). Undergraduate and postgraduate trainers, as well as organisers of training and patient groups, were included in these consultations. The opinion of foundation doctors was sought from the Academy Trainee Doctors' Group, the British Medical Association Junior Doctors Executive Committee, the BMA Medical Students Committee and the UKFPO Foundation Doctors' Board.

Under the AoMRC Foundation Programme Committee's (AFPC) supervision the main work of revising the Curriculum was undertaken by three working groups:

## Assessment in foundation

Ms Lesley Briggs, AoMRC Patient/Lay Group; Dr Stuart Carney, Deputy National Director UKFPO; Dr Alan Connacher, AFPC/RCPE; Ms Manjula Das, AoMRC; Dr Adrian Jennings, Foundation School Director (Eastern Deanery); Dr Matthew Mak, Foundation Doctor; Dr David Marshall, AFPC/RCPSG; Dr Colin Melville, Foundation School Director, (NYEC); Dr Ed Neville (Chair); Mr Manjit Obhrai, AFPC/RCOG and Ms Winnie Wade, RCPL/ Educationalist.

## Competence framework

Professor Julian Bion, IBTICM/AFPC; Dr Andrew Bright, BMA JDC/Foundation doctor; Professor Alison Bullock, Educationalist; Ms Manjula Das, AoMRC; Dr Georgia Jones, Foundation School Director Peninsula; Dr David Long, RCPCH/AFPC; Dr Johann Malawana, BMA JDC; Dr Ed Neville (Chair); Dr Helen Rodgers, Scottish representative and Professor David Sowden, East Midlands Deanery/AFPC.

The revision of competences was based on methodology devised by Professor Julian Bion.

Thanks are extended to the following individuals who added the revision of the competences: Dr Chris Adcock, Dr Tom Anderson, Dr Alistair Billington, Dr Rebecca Borrowman, Dr Jason Goh, Mrs Alison Marshall, Ms Barbara McSween, Mr Douglas McCabe, Dr Bruce Olojede, Dr Nilesh Parekh, Dr Christina Radcliffe, Dr Peter Reid, Mrs Lianne Robb, Mrs Arlene Shaw; Dr Andrew Wight; Dr Beatrice Lyons; Dr Eunice Onwordi; Dr Jaqueline Sims; Dr Jenny Hewlett; Dr Nina Douglas; Dr Ross Cronin; Dr Victoria Digiorgio-Miller; Dr Will Davies and Dr Yassir Iqbal and Ms Maria Flynn; Dr Nick Withers; Dr Richard D'Souza, Dr Peter Riou; Dr Charles Osi-Bempong; Dr Stephanie Gapper; Dr Ken MacLeod, Dr Hannah Stewart; Dr Daisy Lo and Dr Tarek Shirazi.

## Restructuring the Curriculum in accordance with the regulator's requirements

Ms Manjula Das, AoMRC; Dr James Dooley, Foundation School Director; Dr Ian Doughty, RCPCH/AFPC; Professor Michael Eraut, educationalist; Dr David Kessel, RCR/AFPC; Dr Ed Neville (Chair); Dr Edmund O'Connor, Foundation Doctor, Dr Brian Shine, RCPATH/AFPC, Dr Nicholas Ware, Foundation Doctor.

# Appendix G: Curriculum development and list of contributors

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Based on the recommendations of the working groups, the AFPC assembled the draft *Foundation Programme Curriculum* (the Curriculum) which was sent for stakeholder review in 2009. After assimilation of these comments the revised draft was agreed by the AFPC and thereafter sent to the regulators for approval.

## **The following individuals contributed to the current Foundation Programme Curriculum:**

Dr Ed Neville, Chair of the AoMRC Foundation Programme Committee

Members of AoMRC Foundation Programme Committee:

Professor Julian Bion, Critical Care; Dr Alan Connacher, Royal College of Physicians of Edinburgh; Dr Angela Carragher, Northern Ireland Medical and Dental Training Agency; Dr Helen Cugnoni, College of Emergency Medicine; Professor Sir Neil Douglas, President Royal College of Physicians of Edinburgh/Chair of the Academy of Medical Royal Colleges; Professor Derek Gallen, National Director of the UK Foundation Programme Office; Dr Andrew Jeffrey, National Association of Clinical Tutors UK; Dr Ian Doughty, Royal College of Paediatrics and Child Health; Dr David Kessel, Royal College of Radiologists; Dr Malcolm Lewis, Committee of General Practice Education Directors/Wales; Dr John Lowe, Royal College of Psychiatrists; Dr Matthew Mak, foundation doctor; Dr David Marshall, Royal College of Physicians and Surgeons of Glasgow; Mr Sol Mead, AoMRC Patient/Lay Group; Dr Fiona Moss, Conference of Postgraduate Medical Deans; Professor Philip Murray, Royal College of Ophthalmologists; Mr Manjit Obhrai, Royal College of Obstetricians and Gynaecologists; Dr Graham Nimmo, Intercollegiate Board for Training in Intensive Care, Ms Susan Redward, GMC; Ms Patricia le Rolland, Postgraduate Medical Education Training Board; Dr Brian Shine, Royal College of Pathology; Professor David Sowden, East Midlands Deanery; Dr Anthony Starczewski, Associate Dean for SHOs Wales; Ms Winnie Wade, Royal Colleges Physicians of London/Educationalist; Ms Melissa Whitten, Royal College of Obstetricians and Gynaecologists; Dr David Williams, Faculty of Public Health and Mrs Barbara Wood, Academy Patient/Lay Group.

We are extremely grateful to Ms Manjula Das of the Academy of Medical Royal Colleges who supported the committee and all working groups of the AFPC and co-ordinated and managed the technical development of the Curriculum.

Repeated advice was sought on the content and layout of various drafts of the Curriculum. Undergraduate and postgraduate trainers, as well as organisers of training, were included in these consultations. The opinion of foundation doctors was sought from the Academy Trainee Doctors' Group, the British Medical Association Junior Doctors Executive Committee, the BMA Medical Students Committee and the UKFPO Foundation Doctors' Board. A stakeholder review took place prior to this iteration of the Curriculum.

The Academy of Medical Royal Colleges Foundation Programme Committee will continue to review and evaluate the *Curriculum*. A further rewrite is scheduled to take place in 2014, to be in place by August 2015. Evaluation of the Curriculum will be included in each deanery's quality management process and the QAFP mechanism will monitor this.

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