Developing people for health and healthcare

Broadening the Foundation Programme

Recommendations and implementation guidance

February 2014

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Contents

Foreword

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

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

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

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

Sir Jonathan Michael
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Introduction

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

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

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

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

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

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

Executive summary

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

Changing patient needs

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

Changing healthcare provision

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

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

Changing education and training

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

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

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

Key messages from the results

Better Training

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

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

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

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

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

- As integrated care models emerge, there are exciting placement opportunities for foundation doctors.

- There is a high level of overall satisfaction among trainees with regard to general practice and psychiatry placements.

- Views that community placements are of limited value are relatively common, but are almost universally overturned once these placements have been experienced.

Better Care

- The redistribution of posts has happened in some parts of the country without adverse effects on patient care or on training in the acute setting.

- Where successful redistribution of posts has occurred, it has been the result of planning, pacing and partnership-working, and where stakeholders have been persuaded of the rationale for and benefits of redistribution.

- Service responses to redistribution of posts have varied and are context-specific but substitution models have typically involved staff-grade doctors, nurse practitioners and physician associates.

- Lack of planning for redistribution or sudden removal of posts can result in weaker substitution models, such as agency locum doctors.

- There is reluctance in some areas to engage fully with the necessary planning, both for new posts and for reconfiguration or substitution models within the acute setting.

- Leadership is key in winning hearts and minds in and across organisations, and in developing collaborative solutions and initiatives.

- Negative attitudes towards some substitution models in acute settings have significantly altered once those models have been experienced. Exploration of the development and deployment of alternative healthcare professionals such as physician associates is happening increasingly.

Recommendations

Recommendation 1

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

Recommendation 2

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

Recommendation 3

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

b) All foundation doctors should undertake a community placement or an integrated placement from August 2017. It should be noted that both community and integrated placements are based in a community setting, and that an acute-based community-facing placement is not a substitute.

Implementation and impact

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

Innovative approaches

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

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

Summary

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

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

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

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

11 Collins J (2010)

Chapter 1: Background

1.1 Introduction: Building a stronger foundation

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

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

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

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

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

1.2 The challenges

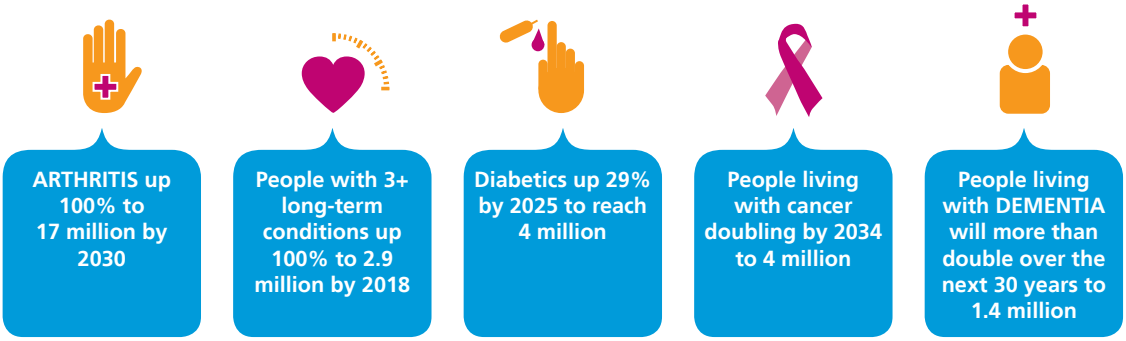
1.2.1 An increasing burden of long-term conditions

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

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

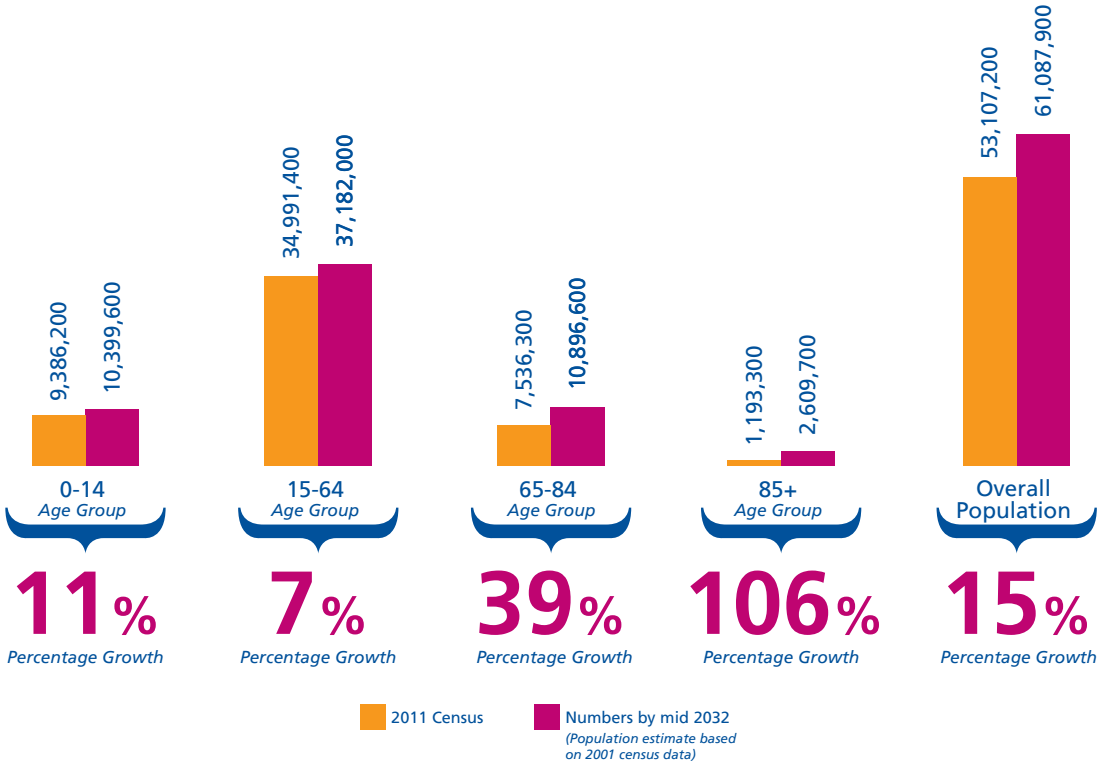
12 Temple J (2010)
13 Collins J (2010)
14 Department of Health (2010)

Figure 1: A rise in chronic disease



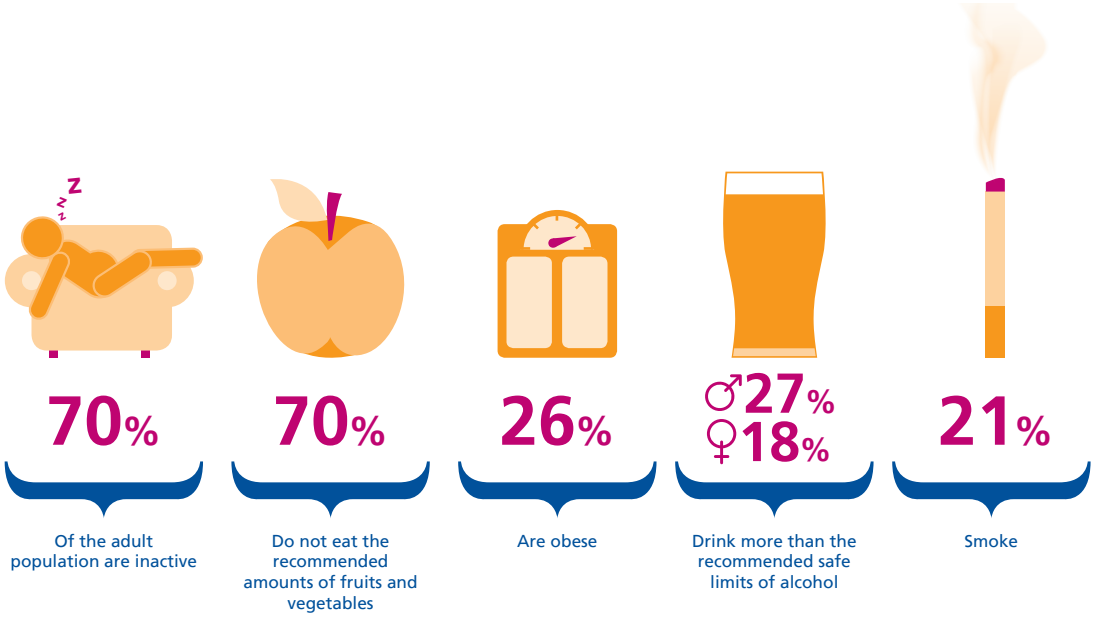
Source: Department of Health (2012a)

Figure 2: Ageing population



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

Figure 3: Population lifestyles present significant risks to health



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

1.2.2 Achieving parity of mental and physical health

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

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

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

Figure 4: Mental illness in the UK

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

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

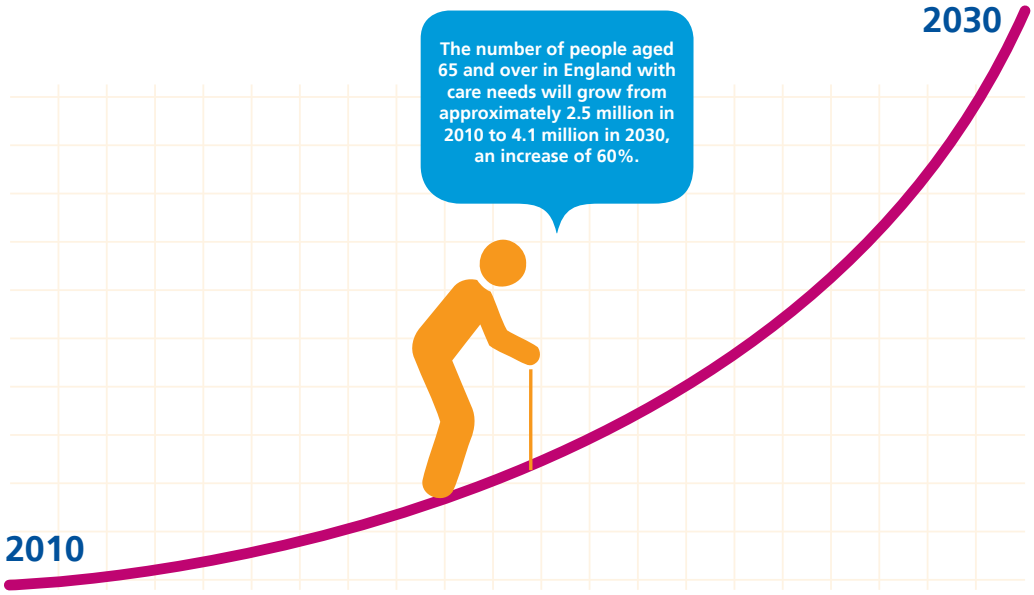
Source: Department of Health (2012a)

1.2.3 Fragmented systems

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

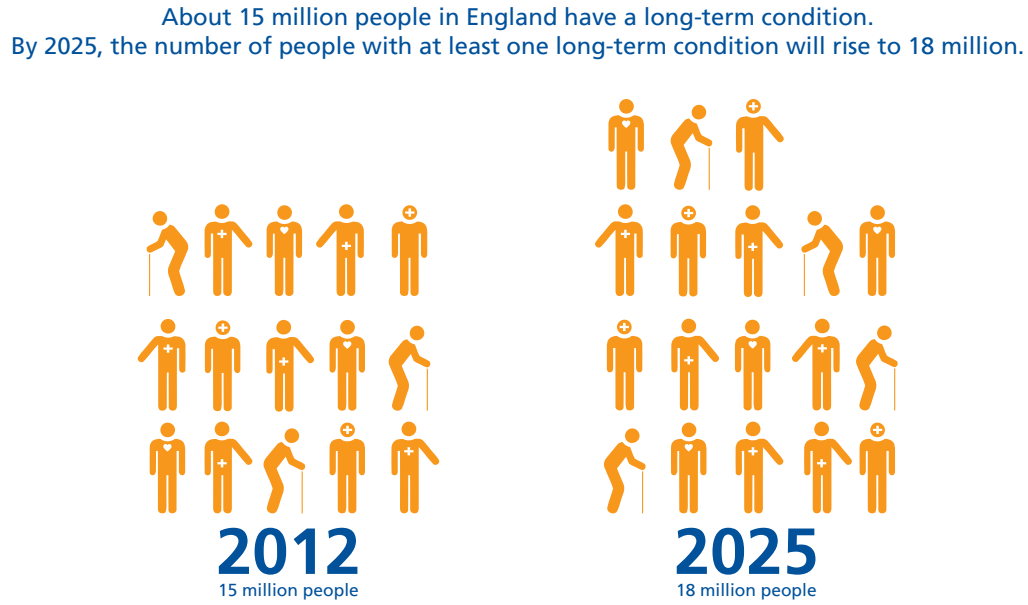
However, a vulnerable and ageing population, including patients with mental illness and patients with multiple, complex long-term conditions, requires health and social care that is coordinated, seamless, and closer to home.

Figure 6: Over 65s with care needs



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

Figure 7: More people with long-term conditions



Source: Department of Health (2012a)

1.2.4 Putting the patient at the heart of everything we do

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

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

1.2.5 Broadening medical training and education

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

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

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

1.3 Integrated care

1.3.1 The move towards integrated care

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

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

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

1.3.2 Achieving integrated care

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

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

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

Figure 8: An integrated care model

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

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

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

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

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

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

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

1.5 In summary

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

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

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

Chapter 2: Methodology

2.1 Working groups[38]

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

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

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

2.2 Methods

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

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

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

39 Collins J (2010)

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

- the experience of trainees with regard to placements, person-centred care, supervision and any experience of interface working across traditional healthcare settings
- trainer and trainee perspectives on current placements, including integrated and community-facing placements, with regard to training as well as patient safety and care
- plans for, and responses to, any redistribution of foundation doctors' posts from specific specialties into community or integrated placements, with regard to the real or potential impact on patient safety and care, and indicative costs around any substitution or reconfiguration plans.

The groups undertook:

- a literature review
- General Medical Council (GMC) data analysis of the GMC trainee survey results
- a consultation exercise with deaneries, foundation schools and trusts
- a request to deaneries for plans for the provision of community and psychiatry placements over the next two to three years
- face-to-face and telephone interviews with a range of healthcare professionals across the country in order to create detailed case studies[41]
- two focus groups with training doctors[42]
- a consultation exercise with trusts to establish existing or planned activity around the redistribution of foundation doctor posts.

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

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

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

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

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

Chapter 3: Overview of the evidence

3.1 Current situation

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

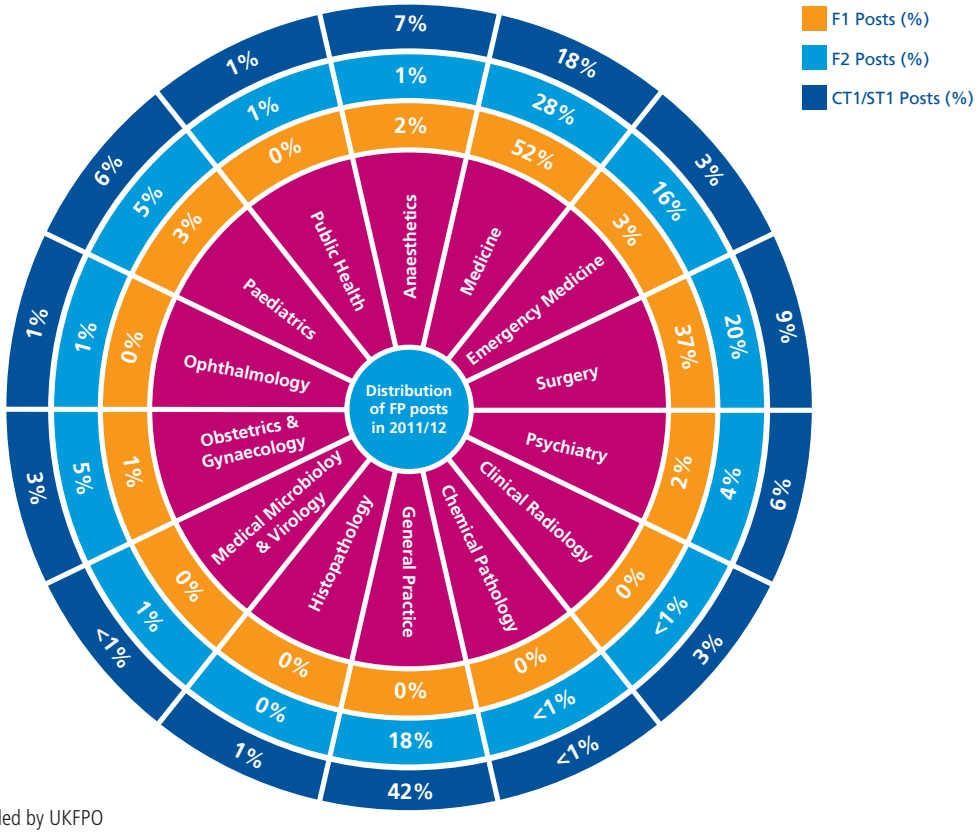
3.1.1 The Foundation Programme today

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

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

3.1.2 The current distribution of Foundation Programme posts

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



Data provided by UKFPO

3.2 The results

3.2.1 Quality of supervision

3.2.1.1 Evidence from working groups, focus groups and case studies

Placements in general practice

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

Placements in psychiatry

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

Integrated placements

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

Community-facing placements

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

43 See Appendix 5

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

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

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

Specific/unique learning opportunities for the foundation doctor

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

Supervision

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

This case study in full can be found in Appendix 5

3.2.1.2 GMC analysis of supervision

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

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

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

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

3.2.2 Foundation doctor satisfaction

3.2.2.1 The literature review[44]

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

44 The full literature review can be found in Appendix 8

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

Placements in general practice

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

Placements in psychiatry

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

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

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

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

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

This case study in full can be found in Appendix 5

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

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

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

3.2.3 Knowledge, skills, competence and attitude

3.2.3.1 The literature review

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

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

3.2.3.2 Evidence from working groups, focus groups and case studies

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

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

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

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

Placements in psychiatry

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

Integrated placements

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

Community-facing placements

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

46 See Appendix 5

3.2.4 Patient satisfaction/experience/outcomes

3.2.4.1 The literature review

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

3.2.4.2 Evidence from working groups, focus groups and case studies

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

3.2.5 Career choices

3.2.5.1 The literature review

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

3.2.5.2 Evidence from working groups, focus groups and case studies

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

3.2.6 Financial considerations for trainees

3.2.6.1 The literature review

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

3.2.6.2 Evidence from working groups, focus groups and case studies

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

3.3 Consultation exercise

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

3.3.1 Community placements

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

- split general practice/community specialty, with three days in general practice and two in another community setting, such as substance abuse medicine, contraception and sexual health, palliative care, public health
- psychiatry, with one month spent in acute medicine and the following three in psychiatry
- an eating disorder unit, with some acute work in an emergency assessment unit.

3.3.2 Community-facing placements

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

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

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

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

This case study in full can be found in Appendix 5

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

3.3.3 Integrated placements

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

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

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

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

3.4.2 Views on challenges in meeting targets

3.4.2.1 Impact on service

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

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

47 See Appendix 8

3.4.2.2 Educational impact

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

3.4.2.3 Supervision

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

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

3.4.2.4 Negative attitudes

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

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

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

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

3.4.2.5 Unrealistic expectations

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

3.4.2.6 Learning outcomes

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

3.4.2.7 Environment

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

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

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

3.4.3 Views on progress towards the targets

3.4.3.1 Impact on service

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

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

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

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

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

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

3.4.3.2 Educational impact

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

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

3.4.3.3 Supervision

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

3.4.3.4 Negative attitudes

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

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

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

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

3.4.3.4 Learning outcomes

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

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

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

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

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

3.5 Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

48 See Appendix 8

Chapter 4: Recommendations

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

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

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

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

4.1 Principles for broadening the Foundation Programme

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

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

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

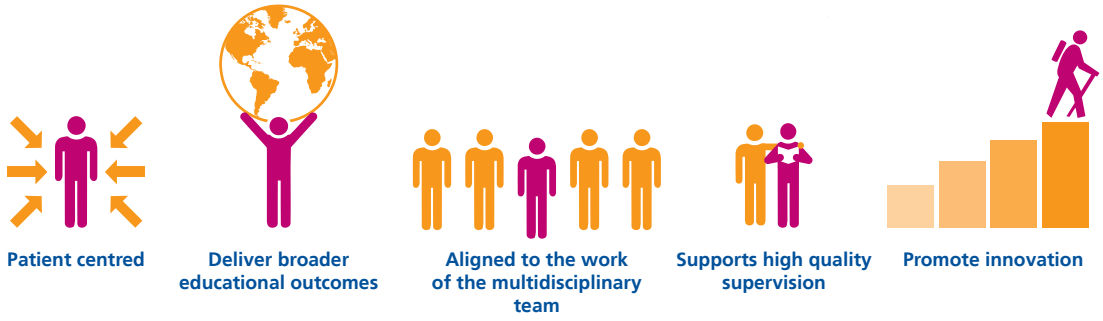
Align to the work of the multi-disciplinary team – the arrangements must ensure that the foundation doctor becomes a member of the multi-disciplinary team.

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

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

49 www.foundationprogramme.nhs.uk

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



4.1.2 Patient-centred

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

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

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

4.1.3 Delivering broader learning outcomes

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

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

50 www.foundationprogramme.nhs.uk

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

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

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

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

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

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

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

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

4.1.4 Supervision and multi-disciplinary team working

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

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

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

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

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

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

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

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

4.1.5 Promote innovation

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

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

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

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

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

59 Collins J (2010, p72, Recommendation 10)

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

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

4.2 Recommendations

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

4.2.1 Recommendation 1

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

4.2.2 Recommendation 2

Foundation doctors should not rotate through a placement in the same specialty or specialty grouping more than once, unless this is required to enable them to meet the outcomes set out in the Curriculum. Any placements repeated in F2 must include opportunities to learn outside of the traditional hospital setting, for example, a programme might include a general medicine placement in F1 followed by an integrated F2 placement in geriatrics.

4.2.3 Recommendation 3

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

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

4.3 Reporting and monitoring

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

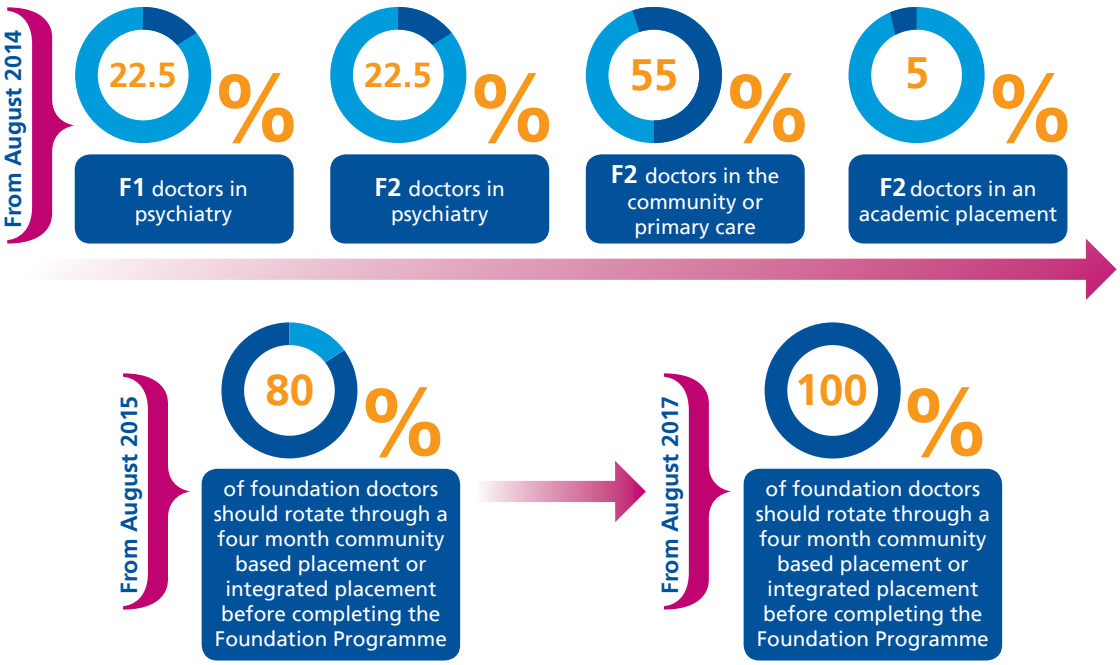
Medical Foundation Programme

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

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

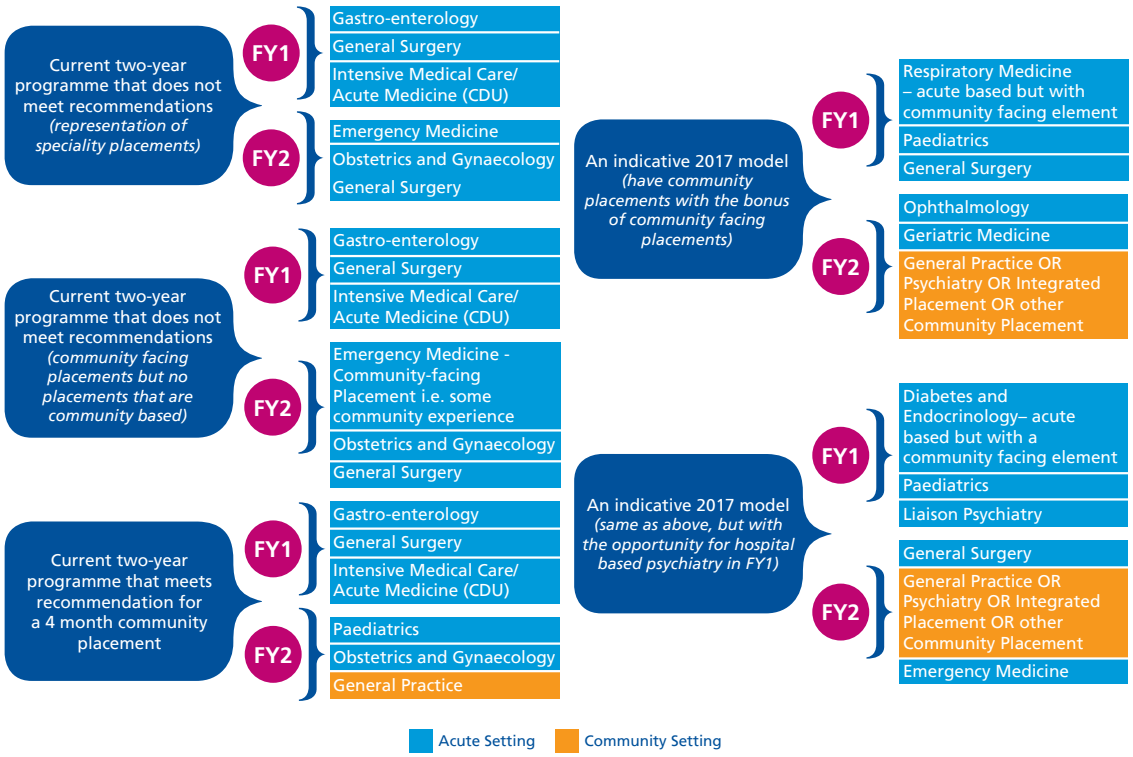
LETBs should also indicate what plans they have to provide a four-month community placement or integrated placement for all foundation doctors, starting in August 2017.

Figure 11: Recommendations for 2014-15



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

Figure 12: Indicative foundation programmes – current and future



Chapter 5: Implementation

5.1 Implementation and impact

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

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

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

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

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

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

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

60 Collins J (2010, p86, Recommendation 17)

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

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

Case Study 4: East Midlands

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

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

This case study in full can be found in Appendix 5

5.2 Innovative approaches

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

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

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

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

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

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

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

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

This case study in full can be found in Appendix 5

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

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

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

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

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

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

This case study in full can be found in Appendix 5

Appendices

Appendix 1: Guidance for LETBs

By 2014, LETBs should have demonstrated credible progression towards existing targets for placements in general practice and psychiatry, in both F1 and F2:

- 22.5 per cent of F1 doctors in psychiatry
- 22.5 per cent of F2 doctors in psychiatry
- 55 per cent of F2 doctors in the community or primary care
- 5 per cent of F2 doctors in an academic placement.

By 2017, all foundation doctors should rotate through a four-month community-based placement or integrated placement before completing the Foundation Programme:

- From August 2015, 80 per cent of foundation doctors
- From August 2017, 100 per cent of foundation doctors

There is a significant challenge for healthcare providers to ensure that, during redesign of services, educational experiences and learning opportunities and outcomes are not compromised. There is a similar challenge for acute providers in ensuring that any redistribution of Foundation Programme posts does not impact adversely on patient care or safety, or on trainees' education and training in the acute setting. Implementation provides opportunities and challenges across the country and will vary according to specific contexts. Partnership working, planning and pacing will be essential in implementing recommendations.

As LETBs develop their own integrated approach to education and training at regional level, it is anticipated that new ways of working, new partnerships and new alignments between service, and education and training, will support the planning of programmes that will best deliver the learning objectives and outcomes as reaffirmed in this report.

Working in partnership, LETBs should take a lead, where necessary, in supporting providers through transitional stages to the targets and recommendations as set out in Chapter 4.

Principles around reconfiguration and redistribution

LETBs will need to plan for the reconfiguration and/or redistribution of posts over the next three years, according to the following principles:

a) Foundation doctors should undertake a community or integrated placement during their two-year programme. Placements must be primarily based in a community setting, with their named clinical supervisor being based in the community. An acute placement

with elements of community experience is not considered a substitute for a community or integrated placement.

b) Existing targets regarding the numbers of doctors undertaking psychiatry placements stand, with specific guidance as below:

i) Experience of increasing the proportion of foundation doctors in psychiatry placements suggests that it is important to achieve a critical mass of such placements.

ii) Hospital-based placements in general adult psychiatry, older adult psychiatry and liaison psychiatry are generally best suited to F1, although some supervised community working experience is valuable.

iii) Given the trainees' additional experience, F2 lends itself more to community mental health team working.

iv) F1 doctors who do undertake community psychiatry placements face particular challenges. If F1 doctors have community psychiatry placements, it is recommended that:

i. they have the opportunity to undertake a shadowing period in preparation for their return to the general hospital setting

ii. due consideration is given to the potential for isolation; for example, placing trainees in pairs or groups may mitigate this

iii. in certain contexts, and with due regard for patient and trainee safety, it may be possible to create community psychiatry placements that offer medical on-call activity for doctors.

c) Foundation doctors should only undertake one placement per specialty or sub-specialty during their two-year programme. Given the range of sub-specialties in medicine, some trainees will rotate through more than one medical placement during the programme and in such cases, one of those should be a community-facing placement.

d) All placements, in any setting, should have clearly specified educational outcomes.

e) All placements should provide trainees with appropriate, effective supervision.

f) Community placements, integrated placements and community-facing placements should offer unique opportunities for trainees to develop competence in whole-patient care, in multi-disciplinary working and in working in and across different settings.

Placements in acute settings should be re-evaluated, with a view to:

a) removing barriers to whole-patient care

b) assessing any potential for reshaping it into a community-facing placement or one incorporating community-facing elements. Community-facing placements should be in addition to community or integrated placements, and should ensure that, as with all placements, they have defined criteria and are structured around appropriate supervision and clear learning outcomes with regard to the community experience elements

c) identifying ways to support trainees in medicine and surgery, for example, reconfiguring services or developing support roles such as physician associates

d) ensuring that trainees' workloads do not increase in the acute setting as a result of any redistribution of posts

e) retaining trainees, particularly in surgery, by converting some of their placements into integrated and community-facing placements

f) providing a broader range of learning opportunities to strengthen foundation doctors' capabilities in the following areas:

i) A multi-disciplinary approach to patient-centred care

ii) Coordination of care across traditional boundaries in partnership with patients and their carers

iii) Identification, assessment and management of acutely ill patients in community settings

iv) Assessment and management of patients with long-term conditions, including patients with long-term mental disorders.

Innovative responses and initiatives

LETBs should be proactive in the creation of innovative placements that are based in the community and that sit within integrated care models and systems as they emerge. There is a need to ensure that the right people are involved in those strategic service discussions and partnerships that are moving ahead with new models of integrated care delivery. For example, emerging healthcare economies and partnerships with varied and appropriate membership need to have representation from LETBs.

LETBs are already helping or planning to help LEPs look at reconfiguration and substitution models. It would be useful for LETBs to offer guidance regionally about local and national reconfiguration and substitution arrangements with examples of best practice, and to support pilot initiatives that explore these models.

Whilst the default position remains the four-month community-based placement (community or integrated), HEE welcomes innovation in developing additional models that support the development of specific competencies that need to be acquired in a community setting. For example, this could include a day a week in general practice across the whole of the two-year programme, or two to three full week blocks in general practice every quarter.

LETBs, working in partnership, should explore ways of piloting innovative approaches to the whole Foundation Programme, as well as individual placements, to achieve the broadest range of learning opportunities and outcomes.

Appendix 2: Guidance for LEPs

The level of challenge for individual LEPs will vary considerably across the country and will depend upon the local context. LEPs need to plan, working in partnership with LETBs and others, for the reconfiguration and/or redistribution of posts over the next three years in order to safeguard and promote the highest standards of patient care, patient safety, medical education and training.

Principles around reconfiguration and redistribution

LEPs will need to plan for the reconfiguration and/or redistribution of posts over the next three years, according to the following principles:

a) Foundation doctors should undertake a community or integrated placement during their two-year programme. Placements must be primarily based in a community setting, with their named clinical supervisor being based in the community. An acute placement with elements of community experience is not considered a substitute for a community or integrated placement.

b) Existing targets regarding the numbers of doctors undertaking psychiatry placements stand, with specific guidance as below:

i) Experience of increasing the proportion of foundation doctors in psychiatry placements suggests that it is important to achieve a critical mass of such placements.

ii) Hospital-based placements in general adult psychiatry, older adult psychiatry and liaison psychiatry are generally best suited to F1, although some supervised community working experience is valuable.

iii) Due to the trainees' additional experience, F2 lends itself more to community mental health team working.

iv) F1 doctors who do undertake community psychiatry placements face particular challenges. If F1 doctors have community psychiatry placements, it is recommended that:

i. they have the opportunity to undertake a shadowing period in preparation for their return to the general hospital setting

ii. due consideration is given to the potential for isolation; for example, placing trainees in pairs or groups may mitigate this

iii. in certain contexts, and with due regard for patient and trainee safety,

it may be possible to create community psychiatry placements that offer medical on-call activity for doctors.

c) Foundation doctors should only undertake one placement per specialty or sub-specialty during their two-year programme. Given the range of sub-specialties in medicine, some trainees will rotate through more than one medical placement during the programme and in such cases, one of those should be a community-facing placement.

d) All placements, in any setting, should have clearly specified educational outcomes.

e) All placements should provide trainees with appropriate, effective supervision.

f) Community placements, integrated placements and community-facing placements should offer unique opportunities for trainees to develop competence in whole-patient care, in multi-disciplinary working and in working in and across different settings.

Placements in acute settings should be re-evaluated, with a view to:

g) removing barriers to whole-patient care

h) assessing any potential for reshaping it into a community-facing placement or one incorporating community-facing elements. Community-facing placements should be in addition to community or integrated placements, and should ensure that, as with all placements, they have defined criteria and are structured around appropriate supervision and clear learning outcomes with regard to the community experience elements

i) identifying ways to support trainees in medicine and surgery, for example, reconfiguring services or developing support roles such as physician associates

j) ensuring that trainees' workloads do not increase in the acute setting as a result of any redistribution of posts

k) retaining trainees, particularly in surgery, by converting some of their placements into integrated and community-facing placements

l) providing a broader range of learning opportunities to strengthen foundation doctors' capabilities in the following areas:

i) A multi-disciplinary approach to patient-centred care

ii) Coordination of care across traditional boundaries in partnership with patients and their carers

iii) Identification, assessment and management of acutely ill patients in community settings

iv) Assessment and management of patients with long-term conditions, including patients with long-term mental disorders.

Innovation responses and initiatives

LEPs should be proactive in the creation of innovative placements that are based in the community and that sit within integrated care models and systems as they emerge. As an integrated approach to education and training emerges in all healthcare settings, there is a need to ensure that those involved in medical education are involved in strategic and operational service discussions, especially with regard to new models of integrated care delivery.

Many LEPs are looking at reconfiguration and substitution models, and those that have not yet done so are advised to explore these possibilities as a way of informing their decision-making in this area. LETBs can provide them with guidance on regional and national examples of best practice. LEPs should approach LETBs with pilot initiatives that support early adoption of and innovation in the creation of programmes and placements that support these models.

Appendix 3: Guidance for trainees

1. The Foundation Programme needs to provide the broad-based education and training that will prepare doctors for any specialty, and for a 40-year career that will undoubtedly see many changes in healthcare provision. Trainees need to be mindful of this in exploiting every learning opportunity during their two-year programme.

2. Trainees should exploit the specific learning opportunities offered in community settings to the full. These opportunities are detailed in the Foundation Programme Curriculum and in post descriptions, but can also include:

    a. the opportunity to develop high-level, critical skills in managing conversations with patients around self-management of conditions and the promotion of general health and wellbeing

    b. working with other service providers and the third sector to gain an understanding of how they contribute to health outcomes

    c. working with patients, families and carers in a longitudinal way that enables learning about relationship and management continuity as well as clinical competence in the management of long-term conditions.

3. Foundation doctors should exploit all specific learning opportunities with regard to working with patients with mental health problems. These may include formal placements in psychiatry or placements in other settings that afford these opportunities, such as acute settings or general practice.

4. Foundation doctors should involve themselves actively with quality improvement projects and seek opportunities, both individually and within multi-disciplinary teams, to develop leadership and management competencies.

5. Foundation doctors should engage in efforts to identify and reduce risk and continuously improve patient care.

6. Foundation doctors should approach all placements with a positive attitude and a determination to identify and exploit the specific ways in which that placement contributes towards their development as a doctor able to practise in any setting.

7. All foundation doctors should seek information and guidance that will allow them to plan for and make informed career decisions.

Appendix 4: Case study template

HEE case study: Broadening the Foundation Programme
Background: As part of HEE's work on the Broadening the Foundation Programme workstream, which will result in a report later in 2013, the groups are collecting data in the form of case studies that will form part of the report. Case studies will focus on community placements, placements within emerging integrated care models and community-facing placements; they will also consider the impact of the redistribution of foundation doctor posts on service in acute settings.
Title of case study:
Location: *E.g. trust, unit, surgery etc (please list all locations mentioned in the case study)*
Interviewees: *Please provide names and roles of all interviewees*
Interviewer:
Type of placement(s) discussed: *E.g. community placement, integrated placement, community-facing placement. Case studies may consider existing, planned or aspirational placements.*
Focus of interview: Please tick all that are relevant. •Training perspective: •Patient satisfaction/experience/outcome •Placement quality/supervision, e.g. who supervises, regularity of meetings, assessment etc •Foundation doctor/supervisor(s) satisfaction •Change in knowledge, skills, perception, attitudes, competence •Mapping to the curriculum •Cost •Career choice •Impact on service/other specialties: •Patient experience/satisfaction/outcomes/safety •Challenges in replacing foundation doctors •Solutions to foundation doctors moving into community settings •Costs associated with 'loss'/substitution/reconfiguring of service •Benefits to new arrangements •Logistical considerations: •Location of placement •Filling roles •Organising supervision (closeness/distance, who, meetings, where, frequency etc.)
Description: *Main features of the placement, how it is organised etc.*

HEE case study: Broadening the Foundation Programme
Analysis: *Key questions for consideration will depend of the exact nature of the placement(s), on the people available for interview and on whether the placement(s) exist, are planned for, or are aspirational. However, they should focus around some or all of these questions:* •What are the benefits to patients (both current and future) in foundation doctors being in this placement? •How does this placement meet supervision requirements in terms of quality, continuity, safety and satisfaction? What are the unique educational and training opportunities afforded to foundation doctors in this placement? •What are the main challenges presented by this placement, with regard to issues such as training, supervision and patient safety? •How have the challenges around redistribution of foundation doctor posts been met, solved or planned for? •What are training doctors' views and attitudes regarding such placements? (These can be both pre and post placement, and can be provided by trainees themselves and others.)
Conclusions: *Conclusions may, for the purposes of the report, be added to/amended by the members of the Broadening the Foundation Programme groups but interviewers are asked to provide any tentative thoughts or conclusions if they feel able.*

Appendix 5: Case studies

Background

As part of HEE's work on the Broadening the Foundation Programme workstream, which will result in a report later in 2013, the groups are collecting data in the form of case studies that will form part of the report. Case studies will focus on community placements, placements within emerging integrated care models and community-facing placements; they will also consider the impact of the redistribution of foundation doctor posts on service in acute settings.

Case study 1

Title of case study: F2 foundation doctors in Oxfordshire's Emergency Multidisciplinary Unit (EMU), Abingdon
Location: Oxfordshire University Hospitals NHS Trust; Oxford Health NHS Foundation Trust; EMU, Abingdon
Interviewee(s): Dr Daniel Lasserson, GP and Senior Clinical Researcher; James Price, Consultant Physician and Clinical Director, Acute Medicine and Rehabilitation, Oxford University Hospitals Trust; Pete McGrane, Emergency Nurse Practitioner and Clinical Director, Community Services, Oxford Health Foundation Trust; plus members of EMU staff
Interviewer: Susan Kennedy
Type of placement(s) discussed: F2 integrated placement

Focus of interview:

Training perspective:

- Patient satisfaction/experience/outcome
- Placement quality/supervision, e.g. who supervises, regularity of meetings, assessment etc.
- Foundation doctor/supervisor(s) satisfaction
- Change in knowledge, skills, perception, attitudes, competence
- Career choice

Logistical considerations:

- Location of placement
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.

Description

The Emergency Multidisciplinary Unit (EMU) sits within the Abingdon Community Hospital with its own entrance. The unit is staffed by consultants, GPs, nurses, occupational therapists, social workers, healthcare assistants and an F2 doctor. EMU gives urgent care patients access to speedy investigations and diagnosis in the community. In the first

instance, EMU operated Monday to Friday from 8am to 6pm. In the last six months, this has been extended to provide a seven-days-a-week service and now extends into the evenings.

Typically, patients are referred to EMU via their GP but can also receive referrals from the 'Single Point of Access' phone line, the ambulance services, emergency departments, medical assessment units, wards at local hospitals and community healthcare professionals (including Hospital at Home). Patients are typically ambulatory but not always. EMU has its own transport and is able to take patients to and from the unit. EMU makes clinical decisions about whether patients need to go into an acute or community hospital, or if they can have their care at home via Hospital at Home community-based services. It also facilitates discharge from acute hospitals.

Senior clinicians within the team take phone call referrals. If it is decided that a patient is coming to the unit, the senior will discuss a preliminary action plan with other staff.

On arrival at EMU, patients are clerked, often by the F2, assessed and preliminary observations can be undertaken. Nursing staff are all trained in procedures such as phlebotomy and cannulation. ECGs and blood transfusions are possible. A variety of typical scenarios are listed below:

- Patient is assessed in EMU, remains there for a period of time and is then considered to be safe to send home with the support of either family, carers or community-based services. Patients can go home but with a prebooked option of coming back to EMU, for example the next day, for further assessment.
- Patient is assessed in EMU and requires a bed. EMU has five dedicated beds on the wards in the community hospital. If EMU patients occupy these beds, they continue to be cared for by EMU staff. If the patient remains in an EMU bed for more than 72 hours, they can be admitted to the community hospital and will occupy a generic bed. They may be admitted to an acute bed at the John Radcliffe hospital at this stage, if appropriate. If patients are admitted into an acute setting, they bypass A&E and are admitted straight to a ward.
- Patient is assessed urgently but rapidly judged by the team to be unwell to an extent that would benefit from transfer and admission to an acute hospital. The team arrange emergency transport from the unit and initiate stabilising interventions that may include, for example, intravenous access, fluid resuscitation, oxygen therapy and airway support.

EMU can receive patients from an acute setting or the community hospital.

Four F2 doctors are based at Abingdon Community Hospital and three rotate through EMU. The F2 doctor in EMU is supervised by the consultant in this setting.

The principles of EMU are generalisable across contexts and settings. Specifically in Oxfordshire, the 'technology' is being rolled out across the county and is being delivered in November 2013 from an additional community hospital site (Witney) and from the two major acute hospitals in Oxford and Banbury.

The principles include:

- integration across multiple dimensions – healthcare and social care, inter-professional, inter-specialty, all adult ages (not solely 'geriatric' care, but complex adult care) and primary/community/secondary
- frontloaded complex assessment
- 'specialist generalists' adept at managing clinical complexity across physical, social and psychological domains
- frontloaded diagnostics, including point-of-care blood testing
- emphasis on the 'postmodern' value of clinical diagnosis, balancing the sustained 'modern' trend to greater reliance on tests
- rapid determination of the optimal patient pathway, based on consideration of patient preference, clinical outcomes (quality) and economic considerations (value)
- unfettered access to a range of responsive domiciliary health and social resources
- an embedded process of evaluation and continual service development.

Update: EMU was named as Best Service Delivery Innovation at The Guardian Healthcare Innovation Awards on 24 October 2013. The team of judges – drawn from prominent national figures in healthcare policy, innovation and leadership – selected EMU from nationwide projects and highlighted it as an innovative service in 'interface healthcare'.

Analysis

Unique or particular educational and training opportunities

- Significant amounts of direct patient contact.
- Clear understanding, and experience, of clinical decision-making within a multi-disciplinary team.
- Small team size, offering more meaningful and real opportunities to be seen as an equal member of that multi-disciplinary team.
- Direct relationships with primary care colleagues – in an acute setting, much of a junior doctor's relationship with these colleagues is via email or phone; in EMU, it's by the bedside.
- Working right next to seniors regularly – even when a senior is not at the bedside with the trainee, they are close by and easily accessed.
- Different cultural relationship in managing risk – an acute setting brings awareness of the proximity of specialists within the same building, which can influence decision-making; this setting requires the trainee to think through risk in a different way but in a safe context within a multi-disciplinary team and with seniors to hand.
- Development of the 'softer side' – trainees get to see how patients value the local

delivery of services; how they, generally, don't want to be in hospital; and how they value choice, differing plans, and so on. By developing relationships with patients and carers in a different setting, they will get to co-production much more quickly.
- Experience of effective gate-keeping/filtering – the NHS needs to offer nuanced and consistent gate-keeping, at different levels, and EMU can offer real experience here.
- Experience of seniors and the multi-disciplinary team making the case for patients to be treated in a variety of settings, such as Hospital at Home, EMU and acute settings.
- Experience assessment of the chronically ill, the acutely ill, and the frail and elderly in a more appropriate setting than A&E or an acute setting. These acute environments can be distressing and disorientating, and trainees gain invaluable experience in being able to experience assessment and management in both.

Supervision
- The supervisor is an experienced senior used to working in an interface role.
- The supervisor is in close proximity.
- In terms of delegated supervision, the trainee is working in a small unit within a team and is never alone.
- The relative quiet and calm of the unit offers the time and opportunity for high-quality, close supervision.

Benefits to patients
- The trainee is able to manage patients with a high degree of autonomy but with direct support.
- There is time to talk with patients and their families or carers – trainees have spoken about the value of this in terms of seeing the whole patient; in appreciating social, psychological and economic issues.
- Patients appreciate the trainee as part of a team working towards the best care for them.
- Trainees take back into the acute setting a better understanding of patients' lives before and after any acute episode.

Challenges
- Trainees were initially quite sceptical but have quickly come to appreciate the benefits and value of the placement.
- The placement must be structured in such a way that trainees do see it as valuable, and feel sufficiently busy and productive. Co-location is important in EMU in terms of the community hospital and Minor Injuries Unit.
- None of the interviewees, including the current F2, could think of any disadvantages or significant challenges.

Trainee attitudes

- These were very positive; all have enjoyed their placement and reported it as very valuable.
- One F2 trainee spoken to on the day had intended a career in surgery and was not looking forward to this placement, but was now very enthusiastic about it. He felt it provided an invaluable experience that would be of real benefit once he went into surgery, and was looking forward to going into patients' homes later that week with the occupational therapist.

Conclusions

All interviewees were incredibly positive about the integrated care model itself, and about the role of the training doctor within it. The placement appeared to offer some unique learning opportunities that cannot be easily replicated in the acute setting and to offer learning around interface roles, decision-making around the best place for treatment, care and management of patients, working in a multi-disciplinary team, and working with colleagues and patients in a variety of settings.

Case study 2

Title of case study: F1 Psychiatry Placements, Leicestershire Partnership NHS Trust
Location: Bennion Centre, Glenfield Hospital, Leicester
Interviewee(s): Dr Christian Labib and Dr Sophina Hissaund
Interviewer: Susan Kennedy
Type of placement(s) discussed: F1 placement – mental health services for older patients, inpatient care

Focus of interview:

Training perspective

- Patient satisfaction/experience/outcome
- Placement quality/supervision, e.g. who supervises, regularity of meetings, assessment etc.
- Foundation doctor/supervisor(s) satisfaction
- Change in knowledge, skills, perception, attitudes, competence
- Career choice

Logistical considerations

- Location of placement
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description

Glenfield Hospital is part of the Universities of Leicester NHS Trust. The hospital has approximately 415 beds and provides a range of services for patients, including nationally recognised medical care for heart disease, lung cancer and breast care.

The Bennion Centre has approximately 40 beds, generally for the over 65s, specialising in the assessment and treatment of functional mental illness, including depression, anxiety disorders and psychotic illness.

There are five foundation doctor posts that include a four-month psychiatry placement. Two F1 doctors who had both undertaken two previous four-month placements in acute settings were interviewed. Once at the Bennion Centre, they each had a consultant psychiatrist as their clinical supervisor.

Analysis

What are the benefits to patients (both current and future) in foundation doctors being in this placement?

- Patients benefit from the medical skills of the foundation doctors. Nurses and other healthcare professionals look to these doctors for medical diagnosis since they lack recent medical experience themselves and are not able to undertake medical procedures.
- Patients benefit from these doctors having the time to spend with them. For example, history-taking can take up to two hours. There is continuity of treatment and personnel, and relationships with patients and their families and carers are built.
- The foundation doctors interviewed felt that the experience here had equipped them with a wide variety of skills and a depth of knowledge and understanding that would enable them to offer better care to patients in the future, such as the ability to more easily recognise mental health symptoms, issues, contributing mental health factors and so on; the ability to see 'beyond' physical conditions and see the whole patient.
- Doctors felt they had learned the importance of a holistic approach, and gained a much better understanding of patients' needs and health, and their lives at home, with less focus on 'the disease, the problem, the physical'.
- Both doctors expressed the view that, when they next went into an acute setting, they would feel able to take a good history and build real rapport with the patients, whereas doctors who had not experienced a psychiatry placement might respond by simply "calling for Psychiatry". They felt they had developed real skills in picking up information from body language, speech and so on. Both felt they were more empathetic.
- Both expressed the view that they were "a better doctor now".

How does this placement meet supervision requirements in terms of quality, continuity, safety and satisfaction? What are the unique educational and training opportunities afforded to foundation doctors in this placement?

- Both doctors rated the supervision that they had received in this placement as superior to any they had had to date:
  - "Supervision here is top notch."
  - "I didn't have [this level of] supervision in my other jobs."
  - "Something I've never experienced before, the opportunity to sit down with my consultant for an hour every week, talking about whatever, having the ability to ask someone senior…"
  - "I was shocked when I heard it [the frequency of supervision]."
  - "Consultants give you their mobile numbers so you can contact them."
  - "My consultant is just down the corridor; I can discuss the patient, the management, then go and see the patient and then go back to him."
  - Both trainees felt that completing e-portfolios with supervisors was easier, that there was plenty of time for case-based discussions and so on.

What are the main challenges presented by this placement? (with regard to training, supervision, patient safety, etc.)

- The trainees had not been part of any on-call rota whilst on this placement and were therefore financially worse off during these four months. Neither regarded this as a particular problem, but they expressed the view that it would have been good to do on-calls. They recognised that psychiatry on-calls would probably present a problem for F1 doctors who lack the experience to be able to perform well in this role, although they would have liked this experience. As an alternative, they would have liked the opportunity to do medical on-calls whilst in this psychiatry placement.
- Trainees felt that there was the potential to feel 'de-skilled' during this placement, and both appreciated the fact that they had already completed two placements in acute settings. They felt that the placement would be improved by allowing Foundation Programme doctors to undertake the medical procedures that they are able/competent to perform, but this is not allowed at the Bennion Centre and patients requiring rehydration or catheters, for example, have to be transferred to the main hospital. Both doctors expressed frustration at this. With regard to de-skilling, both trainees acknowledged that colleagues who had undertaken this placement earlier in the year had experienced similar concerns when approaching their next clinical placement but had said that those fears were unfounded. Both trainees felt that, had this been their first placement, they would have felt considerably more worried when approaching a second placement.

What are training doctors' views and attitudes regarding such placements?

- Both doctors expressed the view that more F1s need to undertake a psychiatry placement. Neither is intending a career in psychiatry but they have valued this placement, and feel it has given them unique skills and that it will improve their care of patients in the acute setting. Both recognise now that, in the acute setting, a lot of patients have chronic pain and are medicated heavily rather than being treated through unpicking anxiety and depression. The view was expressed that "pain is not recognised as a proper problem".
- They have found the placement offers a much better interface with community and have experienced much more varied and frequent interface working in multi-disciplinary teams, such as community psychiatric nurses and social workers coming on ward rounds. They had never encountered these roles before. For example, in the acute setting, it is left to the nursing staff to liaise with social workers. "This is my first real experience of multi-disciplinary working."
- There was a lot of praise for the team working at the centre, and feeling that they were an integral and valued part of this. "People look at you as the doctor. In other specialties, they know you are the junior; they don't expect you to know or may disregard you. There is a lot of respect here. A lot of mutual respect. Everyone brings a lot to patient care. The occupational therapists are amazing. The nurses are amazing. They'll do jobs for you that they don't have to. It's a nice environment. Team work."
- The doctors recognised that they had not felt any isolation, when questioned about this, because there were five of them. They covered each other; there was a lot of team working.

Conclusions

- Placements offer unique learning opportunities.
- F1 doctors really valued these placements and recommended them whole-heartedly to other F1s. Appropriately supported, supervised and thought-through placements can be entirely suitable for F1 doctors.
- F1 doctors would appreciate the opportunity to do medical on-call work in order to maintain their clinical skills but the problem of de-skilling was not considered a real issue. However, they expressed some concern around a new F1 going into this as a first placement, although colleagues who had been in this position reportedly have not suffered. Opportunities for trainees to maintain clinical skills would be desirable.

Case study 3

Title of case study: The role of physician associates (PA, formerly physician assistant)
Location: Shrewsbury and Telford Hospital NHS Trust; Queen Elizabeth Hospital in Birmingham (University Hospitals Birmingham NHS Trust); University of Birmingham
Interviewee(s): Kate Straughton, PA in acute medicine; Professor Jim Parle (PA Course Director at University of Birmingham and Chair of the UK and Ireland Universities Board for Physician Associate Education); James Whitehouse, PA in elderly care; Sarah Russell, PA in neurosurgery; Teresa Dowsing, PA in acute geriatrics; Rachel Mail, PA in cardiology; Pete Jenkins, PA in vascular surgery; and Shane Apperley, PA in trauma and orthopaedics
Interviewer: Susan Kennedy
Type of placement(s) discussed: PA

Focus of interview:
Impact on service/other specialties

- Patient experience/satisfaction/outcomes/safety
- Challenges in replacing foundation doctors
- Solutions to foundation doctors moving into community settings
- Costs associated with 'loss'/substitution/reconfiguring of service
- Benefits to new arrangements

Logistical considerations

- Location of placement
- Filling roles
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description
The interviewer visited three locations and spoke with a range of interviewees in each setting:

- Shrewsbury and Telford Hospital NHS Trust, where they took on eight PAs in January 2013
- Queen Elizabeth Hospital, where they employ PAs
- University of Birmingham, where they have recently relaunched their Physician Associate (was Physician Assistant) Studies Programme from January 2014. The programme is being re-opened in partnership with the Queen Elizabeth Hospital (University Hospital Birmingham NHS Foundation Trust), and with other hospitals and practices in the Midlands.

PA is a rapidly growing healthcare role in the UK, working alongside doctors in hospitals and general practice surgeries. PAs support doctors in the diagnosis and management of patients. Some of the competencies discussed with the interviewees included: taking medical histories, performing examinations, analysing test results and diagnosing illnesses

under the direct supervision of a doctor. The role originally developed when a GP practice in search of a recruitment solution invited American PAs to work in the UK. Only around ten of the 25 members of the original US cohort still remain, and the majority of the 250 PAs practising in the UK are now 'home-grown'.

The interviewer spoke to seven PAs, who were working in the following specialties:

- Stroke/HCOOP
- Neurosurgery
- Cardiology
- Orthopaedics
- Acute medicine
- Geriatric medicine
- Vascular surgery

PAs come to the course with an existing life sciences degree, such as bioscience or biomedical science. Some come to the postgraduate diploma straight from their degree; others come from a variety of backgrounds. Some come from other healthcare professions, nursing and pharmacy, while others may have worked in other fields.

PA courses involve intensive training over two years, with students studying for 46-48 weeks each year. The curriculum includes many of the same elements as the standard four- or five-year medical programme that doctors study. However, it focuses principally on general adult medicine in hospital and general practice settings, rather than specialty care. As well as significant theoretical learning in the key areas of medicine, the course also includes 1,600 hours of clinical training in a range of settings, including general hospital medicine (350 hours) and typically 80 hours in each of mental health, surgery, obstetrics and gynaecology, and paediatrics.

As well as academic achievement, applicants for PA courses should be able to demonstrate experience of working with the public, an interest in health or social care and excellent communication skills.

The aim of the profession is to have statutory registration in the future. This would enable PAs to prescribe as well as authorise imaging requests.

Some of the duties and skills of PAs, discussed in conversation with them, include the following:

- Clerking/history-taking
- Phlebotomy/cannulation
- EDNs
- Putting together job lists for ward rounds
- Requesting ECGs

- Inter-specialty referrals
- Writing discharge letters
- Identifying a deteriorating patient
- Educating patients
- Holding own clinics
- Trauma calls
- Assisting in theatre (opening and closing)
- Educating nursing staff and medical students
- Auditing
- Post-operative clinics
- Working in a team caring for frail and complex patients, with occupational therapist, physiotherapist and consultant

Analysis

All PAs interviewed, along with the course leaders at the University of Birmingham, doctors in training and consultants working alongside them, were extremely enthusiastic about the role and its potential for the future.

Patient experience/outcomes/safety

- The repeated emphasis was that PAs work within careful parameters. They are always working under the direction/supervision of a senior doctor.
- The view was that patients get seen quicker and that they appreciate this. In discussion, there had only ever been two instances of a patient saying that they would rather see a doctor (patients are always made aware of the fact that the PA is not a doctor).
- Patients appreciated the continuity, in many settings, of seeing the same person every day.
- Nursing staff can use the PA as a filter; they will ask whether a patient should be seen by the PA or whether they should go straight to a doctor.

Challenges and solutions with regard to replacing foundation doctors

- In Shrewsbury and Birmingham, it did not appear that the PAs had been employed to replace any deficit in foundation doctors. However, in Shrewsbury, their employment did appear to be linked with difficulties in recruitment to specific posts.
- PAs are able to undertake work to the level of a mid-grade doctor but cannot undertake prescribing or request imaging. A registrar at Shrewsbury commented on this with some frustration, saying that it would be extremely beneficial if they were able to do so.

Costs of PAs

- Most PAs around the country are part of Agenda for Change and are on Band 7. In some instances, immediately after qualification, they may be on Band 6 for a year.

Benefits to PA role

- Continuity – there were lots of comments about changeovers and the continuity provided by PAs, particularly at times of the year when doctors are rotating into new posts and may be very inexperienced.
- Complementing and supporting foundation doctors. PAs commented on how they were able to support foundation doctors in their learning, in induction, and in freeing them to attend clinics, theatre, teaching and so on. Feedback from foundation doctors is that they find the role very beneficial to themselves and to patients.
- PAs are trained as generalists but can then go on to acquire very specialised skills, depending on where they work. However, they are obliged to resit general exams covering all areas every six years. This ensures that they remain a flexible workforce that can be redeployed rapidly in different areas if so required.
- PAs are trained in the medical model, trained by doctors, are less protocol guided and more medically minded, and can employ a wide range of decision-making skills. Initially, nearly all PAs reported some friction or tension towards the role, however all felt that this very quickly disappeared and that all other healthcare professionals soon came to appreciate the role.
- The eight-strong PA team at Shrewsbury has been nominated for a Trust Excellence Award this year. The advantages of having the PAs seem evident and it is thought unlikely that, even if a full complement of doctors was now reached in Shrewsbury, the PAs would leave.
- Consultants and registrars spoken to during the day were extremely positive about the role.

Some quotes from interviews

- "If I know a patient is very sick and is likely to need something prescribing, I will ensure that they are seen by the doctors first. However, I am able to see any patient that comes in the door."
- "Junior doctors can focus on the things they need to learn and know about."
- "Nurses and nurse practitioners are very happy to have us on the wards as permanent members of staff."
- "It feels like an evolving role. The more people see what we can do, the more they want us to do [in terms of higher level skills and responsibility]."
- "It's really good that there is a group of us, there is real peer support. It wouldn't work so well with just one PA on their own. We can provide cross cover in the hospital."
- "There was some friction initially but now people are like, 'What would we do without them?'".
- "I'm looking beyond the 'snapshot' of patient pathways now and, in my new job, I'm going to be much more involved in continuity of care, looking holistically – which actually was part of our training."
- "Consultants in Scotland have a lot of experience in working with the initial US PAs and the one I'm going to is keen to develop her 'own' PA. She wants me to get Advanced Life Support (ALS), etc."

- "Saves a lot of money and energy – we offer a triaging service, surgery, post -operative etc ... the consultant doesn't have to see everyone who walks in the door."
- "In the States, PAs take outpatient clinics – this is being developed here but there needs to be the support and training."
- "Working in geriatric medicine, I deal with a lot of dementia, fallers, social admissions etc. I get to look at the whole patient, for example, a patient who has come in with a fall but actually has a whole range of issues ... work closely with the acute medical team too ... I've done research around frailty."
- "The push is coming from consultants and they are convincing management."

Conclusions

- When questioned, none of the PAs or doctors involved with them felt that they contributed to any de-skilling of foundation doctors. "There are no procedures that are now only undertaken by PAs that junior doctors don't get to do any more." The feeling was that they helped Foundation Programme doctors in covering all they needed to in their curriculum, rather than taking learning opportunities away from them.
- A consultant representative at the open evening expressed the view that this was an extremely valuable and flexible role. His hospital is about to take on eight PAs – two in A&E, two in the Medical Assessment Unit, two in vascular and two in surgery. He spoke of being able to maintain continuity of service in uncertain times ahead. It may be that the role is one that can offer some substitution options to trusts.

Case study 4

Title of case study: Moving towards integrated care models
Location: South Devon Healthcare NHS Trust, Torbay Hospital
Interviewee(s): Dr Matt Halkes, Director of Education; Jess Piper, Head of Medical Education and Development
Interviewer: Susan Kennedy, Heather Penny
Type of placement(s) discussed: Integrated care models and planning for integrated placements

Focus of interview:
Impact on service/other specialties

- Challenges in replacing foundation doctors

Logistical considerations

- Location of placement
- Filling roles
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description

There is wide-ranging discussion at Torbay Hospital about the way their service is being reconfigured, and they are considering how training can fit into this.

Key themes

- The need to develop a service through reconfiguration that is not so dependent on trainees, in order that trainees can be best directed and deployed in terms of their training requirements.
- Working closely with workforce and operations colleagues can provide data, for example, around use and cost of locums, that can help build business cases for the redeployment of monies within a trust, even if no new monies are available.
- Education and training needs to be seen to be in line with service requirements and therefore the two are balanced. In this way, cases can be made, without compromising training and learning outcomes, for educational resources, posts, initiatives etc.
- A holistic approach to education and training and the monies attached to that needs to be adopted. For example, undergraduate monies might be reducing but budgets for nurse training might be increasing. This can help shape business cases around developing new service and educational models.
- The need to help colleagues understand what change might mean and how it might not be as negative as initial perceptions might suggest. For example, trauma and orthopaedic colleagues with experience of surgical care practitioners can talk to general surgeons and explain that this type of substitution can work well, if not better.
- People 'outside' medical education, such as service, operations and executive colleagues, all need to be on board – they are aware of national drivers and the importance of things like the GMC survey and trainee voice, in light of the Francis Report[1] and the Keogh Review[2]. They are also receptive to changes in education and training that can support service.
- Learn from others – for example, intensivists are looking at the role of advanced critical care practitioners, as utilised in Exeter and Newcastle.
- There is a need to build strong relationships with operations directors, managers etc.
- If the 'service' team percieves the medical education team to be trying to provide solutions to service problems, they will 'jump on board'.
- Develop as a training organisation, following a holistic approach.
- Integrated models are being set up, but because they are not all fully developed, there is not yet sufficient and appropriate supervision in place to allow for foundation doctors. Supervision arrangements need to be secure and carefully planned.

1 The Stationery Office (2013). The Francis Report. February 2013. HC 947. London: The Stationery Office. Available at: http://www.midstaffspublicinquiry.com/report [accessed 8 November 2013].

2 NHS (2013). The Keogh Review. July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf [accessed 8 November 2013].

- It is important to look at ways to support integrated care models and systems; to support junior doctors in terms of their supervision, especially in surgery; and to look at potential substitution models:
  - Torbay have created two trust fellow posts (one in education and one in innovation). They will spend six months in medicine and six months in surgery. Around 30 per cent of their time will be educational, such as research, but they are trying to build generalists (ST1/2 equivalents). Part of this is to plug the supervision gap for Foundation Programme doctors whose supervisors are in theatre, for example. There is the hope that the jobs will evolve in terms of consistent presence on the wards with links to outreach and critical care teams, linking to ortho-geriatricians. Torbay were able to create the two posts by extracting data from a workforce review, looking at where the gaps were, considering how to reduce locum costs and so on, and then presenting a business case, which was accepted. They are very keen to create more generalist posts.
  - Intensivists are looking at the use of critical care practitioners in other parts of the country. The surgery team is aware that they will/may lose posts, hence their observations of surgical care practitioners elsewhere. Surgical care practitioners are not doing ward-based care but will be doing work that training doctors would have done, such as pre-op, consent and discharge.
  - Taunton have used medical assistants (unclear as to whether this is the same as physician associate) – essentially creating a post alongside junior doctors in the critical setting. Foundation doctors receive support and time is saved. Torbay are looking at the more traditional model of physician associates, and is very keen to consider this and other similar roles.
- There has been a wide range of opinions expressed among consultant colleagues, such as concern about devaluing traditional medical roles: "Where is my team?", "Where are my doctors?". However, these concerns have died down. "It has got quieter – I think they are realising that it works in practice." It is important to discuss with teams what they want, and what they value.

Analysis

Torbay are fully committed to reconfiguring services around integrated care, and feel that these emerging models have real learning outcomes that would benefit foundation doctors. The shift to integrated care brings about real benefits to patients, both now and in the future.

Conclusions

Torbay are considering how they might integrate foundation training into their emerging models of service/care.

- Aware of potential redistribution, financial pressure and the need for generalists and specific service requirements demanded in integrated models, Torbay Hospital are actively looking at complementary and substitution models.

- Torbay Hospital have invested a lot of time and energy into engaging with a wide variety of stakeholders in order to secure engagement and support, and to build multi-disciplinary approaches to reconfiguring services and thinking about education and training. Their new centre, the Horizon Centre for Research, Education and Innovation, offers an integrated approach to education and training. Planning for integrated models that can include foundation doctor placements requires in-depth consideration and an integrated, multi-disciplinary approach.

Case study 5

Title of case study: Redistribution of posts in the East Midlands
Location: Face-to-face interview, telephone interviews, email communication
Interviewee(s): Dr Bridget Langham; Dr Nick Spittle, Associate Foundation School Director (Trent); Dr Subodh Dave, Clinical Teaching Fellow and Consultant Psychiatrist; Foundation Training Programme Director, Chair, Trust Medical Advisory Committee, Radbourne Unit, Royal Derby Hospital
Interviewer: Susan Kennedy, Heather Penny, India Peach
Type of placement(s) discussed: Community and psychiatry placements

Focus of interview:

Training perspective

- Placement quality/supervision, e.g. who supervises, regularity of meetings, assessment etc.

Impact on service/other specialties

- Challenges in replacing foundation doctors
- Solutions to foundation doctors moving into community settings

Logistical considerations

- Location of placement
- Filling roles
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description

Health Education East Midlands is already working towards 100 per cent of Foundation Programme trainees undertaking a community placement. The two foundation schools are working closely with the Foundation Programme training directors based within the trusts to identify two types of posts: those that can be redesigned to include a significant community element; or those that have limited educational value and can be converted to community placements (either general practice or community psychiatry).

All the Foundation Programmes in the region are curriculum mapped and adjustments have been made with rotations to ensure that some trainees do not undertake two

community placements whilst others do not undertake any. Rotations that had no community placements were then identified. The schools then considered the community placement and the psychiatry targets together and ensured that enough community psychiatry placements were allocated to reach the psychiatry target of 45 per cent of all foundation trainees completing a psychiatry placement. The remaining placements were identified for general practice placements.

In addition, each LEP was asked to consider how they could work innovatively to make placements more community based. In Derby, the diabetes and rheumatology posts were identified as potentially being community based, and a new programme of working has been developed that allows the trainees to work in the community with the consultants in these specialties, but also to maintain acute skills by taking part in the out-of-hours rota in the hospital. This also happened for genitourinary medicine.

In another LEP, it was recognised that there was a need to move trainees out of trauma and orthopaedic posts, but that this could have a negative impact on service delivery in the LEP if this happened as a 'big bang'. Therefore a phased approach has been developed over a three-year period.

In Leicester, the LEP has been developing a unit to care for frail and elderly patients that incorporates both acute and community care, and the school has worked with the trust to adjust rotations so that six Foundation Programme trainees will work in this unit at any one time.

In Nottingham University Hospital, placements in healthcare of the elderly are being redesigned to incorporate a community element. They are setting up community or integrated placements to care for the elderly, which will be 75 per cent in the community and 25 per cent acute based.

Analysis

- The redistribution of posts, mostly from surgery, did not come as a surprise. Previously, the quality of training had generally been highlighted as an issue.
- Redistribution seemed 'fair' as it was region-wide.
- Directors of medical education initially questioned redistribution but recognised that there were national targets to be met, and that it was also happening to their 'neighbours'.
- A phased approach was adopted in order to minimise any potential negative impact on service or training.
- In terms of impact on those trainees remaining in acute placements, the feedback has not indicated any negative impact on their training or service.
- In some acute settings, there were 'gains' in that general practice specialty training 1/2s were substituted for Foundation Programme posts as part of the expansion of the general practice training scheme.

- Together with redistribution of posts to allow the creation of additional community placements, there has been a push to get LEPs to review their posts with a view to creating more that have community elements, such as community-facing placements in paediatrics (acute based but with significant community elements).
- New community geriatric posts have been created in Nottingham (although not yet in place). This will involve two F2 doctors 'sharing' a four-month placement in geriatrics – spending two months in a hospital setting with a consultant geriatrician and two months in a community setting with that consultant geriatrician (two consultants rotate in and out of acute and community settings). In this way, trainees will be able to see the links and the interfaces between settings, and better understand patient pathways.
- General practice placements – there is a consensus that these are valuable.
- Psychiatry placements – trainees can sometimes worry that they are not meeting their curriculum requirements, however feedback shows that they do get a lot out of their psychiatry placement. Some offer very good opportunities for FP doctors to practise their medical skills, as they may be the doctor with the most recent medical/clinical experience. Those who have undertaken a psychiatry placement view the specialty more positively as a branch of medicine and also as a career option.
- Most hospital consultants recognise the changing healthcare landscape, and the benefits of community placements. Their concern is still about 'losing' their doctors, "however, there is time within a four-month acute placement to learn the appropriate skill sets, providing they are not bogged down in administrative tasks".
- "The two-year programme needs to be looked at as a whole, there is one curriculum and each placement needs to help deliver that curriculum over the two years."
- Psychiatry consultants have been delighted to be involved in foundation training and have also enjoyed the opportunity to act as educational supervisors for foundation trainees, as this gives them a perspective for the entire year of foundation training. Psychiatry consultants have benefited in gaining an understanding of what foundation doctors encounter in acute settings. Trainees have fed back that they appreciate the quality of supervision provided by psychiatry consultants, which they have felt to be of very high quality.
- Training (workshop) for psychiatry consultants has enabled them to highlight the specific and generic competencies that trainees can gain during psychiatry placements. There can be negative perceptions about these placements and fears about not being able to acquire the necessary competencies, however these concerns can be allayed. Once trainees have undertaken a psychiatry placement, they are very positive about the value of the experience.

Summary analysis by interviewees
Implementation should:

- be a coordinated, regional approach that spreads the load
- be perceived as fair
- be presented as meeting national targets towards delivering the healthcare, education and training needs that are required
- make decisions around sub-optimal acute placements
- incorporate community elements into hospital placements where possible
- construct posts and placements with a view to a coherent, two-year programme that delivers the Curriculum
- emphasise that learning is a continuum and that learning objectives not met in one placement need to be gained in others.

Impact can:

- be minimised if a phased approach is taken
- be minimised if trusts are encouraged to look at their own posts and placements, and reshape them
- be minimised if trusts are given time to think and plan for redistribution.

Case study 6

Title of case study: Integrated care in Leeds
Location: Telephone interview
Interviewee(s): Dr Manjit Purewal, GP and Integrated Care Lead at North Leeds Clinical Commissioning Group
Interviewer: Susan Kennedy
Type of placement(s) discussed: n/a

Focus of interview:
Commissioning and wider-ranging education issues

Description
There is a real move in Leeds towards the creation of integrated care models. Part of the 'bigger' picture in Leeds has been the establishment of the Leeds Medical Senate Development Programme, a ten-month programme for the 26 doctors at the 'top' of the Leeds Trusts and CCGs. Evaluation of the programme has demonstrated the development of more effective relationships between senior doctors across commissioning, primary and secondary care. One of the significant reported changes as a result of the programme with direct benefits to patients has been improved commissioner-provider relationships, which are enabling pathway redesign.

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

A recent visit by the Medical Senate team to Utah – Intermountain Healthcare – focused on clinical leadership training and the need to break down 'silos'.

There is a need for foundation trainees to learn about leadership at an early stage in their career. They would benefit from spending time with commissioners. Dr Purewal has organised this for a recent F2 trainee in order that the trainee can gain an insight into management, commissioning, finance and so on.

"Foundation doctors need to feel that they can help 'shape' their organisation."
"In the NHS we don't engrain a sense of 'one' organisation … there is too much silo working … we need to change attitudes."
"We need to be better at identifying future leaders, about exploiting the enthusiasm, ideas and innovation of younger doctors. We need to sell innovation positively."

The Leeds experience: "The CCGs want more representation. There is a need to have commissioners and providers sitting and talking together, brainstorming ideas together. We need to ensure that LETBs are engaged with commissioners. Everybody needs to be round the table discussing education and training."

Case study 7

Title of case study: Planning for an integrated placement in Buckinghamshire
Location: Stoke Mandeville Hospital
Interviewee(s): Dr Syed Hasan
Interviewer: Susan Kennedy
Type of placement(s) discussed: Planned integrated placement

Focus of interview:
Planning for new integrated services and foundation training might be incorporated within an emerging service model

Description

- Buckinghamshire Healthcare NHS Trust has both acute and community hospitals, which are not co-located:

- **Acute:** Stoke Mandeville and Wycombe. They have no surgical or medical take but receive acute cardiac and stroke patients through a dedicated Cardiac and Stroke Receiving Unit (CSRU). In addition, elective surgery and orthopaedics are based there. There is also a 20-bed step-down unit for medical patients who have had their initial hospital treatment at Stoke but live locally and can be stepped down for ongoing care.

- **Community:** Amersham, Buckingham, Marlowe and Thame. Size and capabilities vary; Amersham has clinics, a day hospital and two wards, which will form the community

geriatrics ward. Together they have 46 beds – a good critical mass to have trainees with consultant supervision. Marlowe has only six to ten beds, which is too small to meet demand'.

- Dr Syed Hasan is setting up a community geriatrics service and is currently the lead until the new appointment is made. There is a real move towards integrated services, with the trust actively promoting this model. As the service emerges, Dr Hasan recognises the potential for a foundation doctor placement and feels that there are unique learning opportunities within this setting.

Integrated model

- There is a very small acute footprint at Stoke Mandeville: two Medicine for Older People wards (patients admitted from front door). They don't all require admission, so part of the service is interface geriatrics – a geriatric liaison service based in the clinical decision unit.

- A consultant and matron are there every morning – signposting, looking at who needs to be admitted and who can be better served elsewhere. That interface is critically important; for example, some people can return home following physiotherapy, return for review in 48 hours or be treated with home intravenous antibiotics.

- The work began with ad hoc funding, and commissioners have now provided funding for a substantive consultant geriatrician post with a special interest in community and interface geriatrics. The need is to be as close to the patient as possible at the front door. GPs with special interest in older people will be part of the model, which could offer a real interface, multi-disciplinary working environment for a trainee.

- At Wycombe, the Medical Unit Day Assessment Service (MUDAS) enables the department to see elderly patients who are deteriorating in their homes, either the same or the next day. This service combines with day hospital services, and includes specialists performing procedures such as lumbar puncture, transfusions and infusions. GPs can call the nominated consultant from Monday to Friday, between 9am and 5pm, and their patient can be reviewed the same or next day. This supports the 'front door policy' and the GP arranges transport, which provides a very quick response.

- MUDAS has been up and running for six months, and the criteria system is working and evolving. Originally it was intended primarily for local GPs but it is now being used more widely, including consultants doing on-calls at Stoke Mandeville.

- Commissioners are keen that geriatric liaison service should expand. The vision is that there should be a geriatrician of the day and services to which they can signpost, such

as MUDAS. The geriatrician of the day could be a consultant geriatrician, GP, senior nurse or physiotherapist, among others.

- Funding for a community geriatrician is confirmed and the post holder will move between Stoke Mandeville and Amersham, although doing the multi-disciplinary team meetings and ward rounds at Amersham. This person, ideally with a foundation trainee working alongside, will assess Wards 8 and 9, looking at which patients can be treated more appropriately somewhere other than in hospital. In this way the boundaries start to be broken down.

- The new community geriatrician will have clinic time built into the job plan, which would focus on admission avoidance – for example, A&E might send someone with a first seizure, who could be considered safe to go home but who needed to be seen fairly quickly, just to make sure that they were alright. Or there could be someone who came into the acute setting; a heart attack could be ruled out but they are still presenting with shortness of breath and needing to see someone within a couple of days. This would be possible, rather than the longer traditional wait. This clinic time might be used also as time for GPs to have a discussion with the consultant about patients – two senior colleagues discussing patients together, both with notes to hand and able to plan care and pathways for those patients. This would also be an ideal professional interface situation for a trainee, in terms of learning about planning, patient pathways and so on.

Analysis

Opportunities for trainees in MUDAS:

- The junior doctor would clerk, take bloods, ECGs, request X-rays and so on. These patients would be reviewed by the consultant and receive a multi-disciplinary assessment from physiotherapists, occupational therapists and nurses: "Ideally, this is a one stop shop."
- This would provide an ideal opportunity for trainees to be trained on the shop floor: "They need to be trained in the day-to-day management of patients, in multi-disciplinary work, in working with families and carers, and in active discharge planning."
- "Trainees need to know that the silos are gone. They need to learn, as part of their training, that traditional boundaries and silo working are a thing of the past."

Case study 8

Title of case study: Portsmouth Hospital NHS Trust
Location: Telephone interview
Interviewees: Aileen Sced, Consultant Anaesthetist, Foundation Programme Director, Associate Director of Medical Education
Interviewer: Heather Murray
Type of placement(s) discussed: General practice community placement, community-facing placements in elderly care

Focus of interview:
The nature of placements being created

Description
In Portsmouth Hospital there are 50 F1 and 62 F2 trainees.

The Foundation Programme has been unhooked to give trainees the flexibility to choose a community-facing placement. In March and April, a competition process takes place for trainees to apply for their F2 posts, incorporating a ten-minute interview.

Around nine trainees are imported from Wessex, with some guaranteed two years in one place and others two years in different places.

The placements are structured as follows:

Community placements

- General practice placements involve F2s and consist of:
  - i) Straightforward general practice posts
  - ii) One general practice post, with time spent in substance misuse
  - iii) One general practice post, with two days in palliative care where they spend time in a hospice
  - iv) One public health placement, which consists of two days in Portsmouth City Hospital, and another day based in sexual health/contraceptive clinics

Both the substance misuse and palliative care posts tend to attract those that are interested in becoming a GP, as well as those with an interest in secondary care.

The supervision can vary in these posts, dependent on the practice, but it is more than adequate with time taken to sit down with the trainees for feedback, particularly in the substance misuse, palliative care and sexual health placements.

There are plans in place to increase the number of posts in public health, palliative care and general practice next year.

Community-facing placements

- There is an elderly care placement, which consists of two months in the acute ward and two months in an outlying/rehab ward.
- Rheumatology and Diabetes placements provide the opportunity to gain experience of outpatient clinics.

Psychiatry placements
The psychiatry placements are currently at F2 only, with an increase of two posts this year to give a total of five.

Case study 9

Title of case study: Substitution of physician associates (PAs) at St George's Healthcare NHS Trust
Location: Telephone interviews
Interviewee(s): Mr Dominic Neilson, Consultant Orthopaedic Surgeon; Dr Cleave Gass, Consultant Anaesthetist and Director of Medical Education
Interviewer: Susan Kennedy
Type of placement(s) discussed: N/A

Focus of interview:
Impact on service/other specialties

- Challenges in replacing foundation doctors
- Solutions to foundation doctors moving into community settings

Logistical considerations

- Location of placement
- Filling roles
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description

- PAs have been at St George's for about four to five years. They were recruited initially in trauma and orthopaedics, as recruitment into training posts was difficult and the service was using transient locums, so there was an urgent need to improve the situation.
- The trauma and orthopaedic trainees were often deployed on the wards instead of undertaking appropriate training opportunities in theatre and clinics. This meant there was the risk of having the posts pulled by the former deanery owing to their insufficient quality in terms of education and training.
- Trainees were moved out of trauma and orthopaedics as part of the redistribution of posts (creating some community psychiatry posts) and PAs were substituted.
- PAs were also placed in oncology and ENT.
- Some core surgery trainees were replaced with advanced nurse practitioners (ANPs). This option was expensive, and they work fewer hours (a 37-hour week as opposed to 48 hours). However, there was no real alternative – core specialty trainees had been

lost and it was impossible to run the rota. ANPs working at night are the single point of contact, while during the day, each is in their own dedicated team.

- Trauma and orthopaedics started with two PAs and now have four working with a pharmacist (because they currently can't prescribe) and one trust-grade doctor. Given the experience and expertise they have now, they probably need the doctor less and less. This team is responsible for looking after inpatient care on the wards.
- PAs are now present in paediatric ITU, oncology and ENT. Each is used in vastly different ways – in ENT and oncology they are used in clinics, while in paediatrics they are used in a shift model.
- The vascular team are now considering the PA model or having surgical assistants.
- PAs are able to use a wide variety of skills and are highly versatile. They tend to be more mature and with previous experience, which makes them very useful.
- There was no real resistance (from some) to them coming in, as the level of care before their arrival was unsatisfactory and their introduction was seen as the way forward: "They were brilliant at getting people on board."
- The PAs were supervised more through a mentoring system than day-to-day supervision.
- The consultant orthopaedic surgeon interviewed had worked with UKAPA to develop an appraisal model for PAs, which has been adopted nationally.
- In terms of capabilities, PAs are more expert and more useful than Foundation Programme doctors. They have all the experience and expertise of a nurse practitioner but a broader range of skills. For example, in trauma and orthopaedics they can offer medical input.
- The consultant orthopaedic surgeon interviewed is in no doubt that they are the way forward.

Analysis

- PAs have 'revolutionised' some areas of service.
- Resistance was huge in some specialties, to begin with, but has eroded quite significantly. Some of the most resistant have become quite evangelical.
- There is no evidence of Foundation Programme doctors 'losing out' or becoming de-skilled as a result of having PAs.
- Foundation Programme doctors and other trainees are no longer compromised. Previously, trainees would be pulled away from training opportunities to undertake ward work, which leads to the risk of losing posts. Having the PAs in post has improved the training for trainees.
- There are no fears of de-skilling trainees, as the department is busy enough for them to be able to get plenty of practice in core procedures etc.
- Once people have seen what the PAs can do, they are impressed and won over.
- There is a need to manage the expectations of Foundation Programme doctors – they can have unrealistic expectations in terms of their career development and the resourcing requirements of the service.

Conclusions
- PAs offer a viable substitution model for Foundation Programme doctors.
- PAs can prove highly skilled, mature, adaptable and very useful in a wide variety of clinical contexts.
- Initial resistance from some is quite quickly overturned once PAs are in place.
- PAs can provide very useful support to Foundation Programme doctors.
- PAs do not compromise the training of Foundation Programme and other doctors.

Case study 10

Title of case study: Foundation doctors in psychiatry placements at St George's Healthcare NHS Trust, and South West London and St George's Mental Health NHS Trust
Location: Telephone interviews
Interviewee(s): Dr Nicola Walters, Foundation Training Programme Director, St George's Healthcare NHS Trust; Dr Stuart Adams, Director of Medical Education, Clinical Systems Safety Officer and Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust
Interviewer: Susan Kennedy
Type of placement(s) discussed: F1 liaison psychiatry placement in an acute setting

Focus of interview:
Training perspective
- Patient satisfaction/experience/outcome
- Foundation doctor/supervisor(s) satisfaction
- Change in knowledge, skills, perception, attitudes, competence
- Career choice

Logistical considerations
- Location of placement
- Organising supervision (closeness/distance, who, meetings, where, frequency etc.)

Description
The existing F1 liaison psychiatry placement is 'based' at the Springfield Hospital (part of South West London and St George's Mental Health NHS Trust) but the doctors work on site at St George's Hospital. The placement is in an acute setting and the doctors do not go out into the community. The placement is completely psychiatry focused – they are not part of the medical or surgical rota.

From August 2013, the placement structure will also include:

Child/adolescent psychiatry placement

This placement will be based at Springfield Hospital, which is a ten-bedded inpatient unit with outpatient clinics and is a 15-minute walk from St George's Hospital. Trainees

will return to St George's one day a week to do acute medicine, in order to ensure that they are up to speed with clinical competencies. They will be linked with a paediatric placement so that the rotation will consist of child/adolescent psychiatry, paediatrics and one other.

Community-based psychiatry placement

This placement will see the trainee within a mental health team (Home Treatment Team (HTT)), assessing patients in their own homes. An HTT typically consists of a consultant psychiatrist, sometimes a registrar, team manager (usually a senior nurse), nurses/nurse practitioners, social workers, and occupational therapists. Mornings will typically see the trainee undertaking home visits after handover, and they will be involved in care planning meetings for three afternoons a week. The trainee will be supervised by the consultant and the registrar. The Foundation Programme doctors will not see first-time patients and will not assess new patients but will see 'appropriate' patients depending on the level of skill they have acquired, and on the basis of both they and the patient being safe. The training doctor will have accommodation on site at St George's and will still be part of the Foundation Programme doctor community. They will come back to St George's one day a week to do acute medicine and will also come back for Foundation Programme teaching.

Peri-natal/liaison psychiatry placement

This placement will consist of two days of peri-natal and three days of liaison psychiatry, and will be based at St. George's.

With all three of these placements, the initiative was taken by the mental health trust. The foundation school emailed all mental health trusts asking if they wanted to create new F1 posts, and South West London and St George's was very proactive and enthusiastic.

Analysis

Unique and/or particular educational and training opportunities

- Existing liaison psychiatry placement:
  They are dealing with medical and surgical inpatients with psychiatric and mental health issues and concerns, and the Foundation Programme doctor is often the first person to see these patients with regard to their mental health. This enables them to see the acutely ill patient from a different, specifically mental health perspective. They are very involved with the team and are well supported within that team.
  The placement offers a particular value in working in a multi-disciplinary team that includes psychiatric nurses, the drug and alcohol liaison team, the acute medical team and others.

  The Foundation Programme doctor is very well supported in doing audit during this placement. It offers real and prolonged exposure to mental health issues of the kind that they will be exposed to in whatever career they follow. The trainee is

able to work closely with community-based healthcare colleagues, and there are excellent opportunities for building good, independent record-keeping skills. It raises issues relating to dealing with patients with learning disabilities and offers a lot of opportunity to develop knowledge, skills and understanding, and also to consider issues such as ethical and moral concerns.

- Anticipated community-based psychiatry placement:
  The Director of Medical Education at South West London and St George's Mental Health NHS Trust has a lot of experience in training F1s in the community at St Helier Hospital, where they rotate through urology, cardiology and community psychiatry. He has devised the new St George's placement with reference to this experience, and comments here refer to that experience. Trainees gain real community experience in a variety of settings including patients' homes; they have opportunities to work across boundaries by working with the HTT and by liaising closely with the inpatient consultant, and there is the opportunity to go onto the wards. The posts are supernumerary and so can be tailored to their needs and what they want to gain from the experience; they can follow patient pathways and see the same patient in both a domiciliary and acute setting.

  The trainee gains real experience in assessing patients with the consultant present, who can provide the summary care plan for the patient at the end of the assessment and also feedback for the trainee. The team is briefed carefully on the competence and limits of the Foundation Programme doctor, but then the training doctor can be quite autonomous; interviewing and making decisions within a safe environment is of real benefit to the trainee and the F1 doctor manages the case from start to finish. They also gain from the opportunity to do a two-week crossover with the liaison psychiatry placement, where two Foundation Programme doctors do a swap for a fortnight.

Supervision

- Existing liaison psychiatry placement: the supervisor is the consultant psychiatrist.
- Anticipated community-based psychiatry placement/existing St Helier placement: the Director of Medical Education commented that supervisors have to recognise the real commitment required in ensuring proper and safe supervision of Foundation Programme doctors. Real emphasis is put on this to ensure that the right people undertake supervision. The consultant is with the trainee whilst undertaking assessments.

Benefits to patients

- Existing liaison psychiatry placement: the trainee is often the first point of contact but has the support of the multi-disciplinary team close at hand. The Foundation Programme doctor gains solid experience of assessing and managing medical

and surgical patients with mental health issues, which enables them to gain real confidence and competence that will serve patients well once they are in their future roles and careers (if they do not go into psychiatry).
- Anticipated community-based psychiatry placement/existing St Helier placement: the Foundation Programme doctor is interviewing and making decisions in a safe environment with a consultant to hand. Patients are seen along care pathways – this benefits them in terms of being seen, interviewed and assessed in more appropriate environments.

Challenges
- There is a need to ensure that anyone taking on a supervisory role recognises what the role entails.

Trainee attitudes
- Existing liaison psychiatry placement: trainees have really enjoyed the placement – not only those who have been intending a career in psychiatry but others too.
- Anticipated community-based psychiatry placement/existing St Helier placement: In the first two years, six doctors have rotated through. Of these, three have gone on to do psychiatry (not all having intended to do so in advance of this placement), one became very interested in psychiatry but ultimately chose general practice, and the remaining two went into other specialties. All have been very enthusiastic about the post and found it valuable.

Conclusions

Both interviewees were very positive about existing and planned placements in psychiatry. The Foundation Training Programme Director at the acute trust was highly appreciative of the very enthusiastic and proactive stance taken by the mental health trust, and saw the new posts as very welcome and exciting additions. The proximity of the trusts was of clear benefit and trainees were easily able to move between the two. Both interviewees were clear that there are particular training benefits to the existing and planned placements. The community placement seems to offer real opportunities in that, whilst being community based, it offers more of an integrated care model with the trainee being able to follow patient care pathways and see patients in a variety of settings. In both existing and planned placements, there is the opportunity for trainees to work in a properly integrated fashion as part of a multi-disciplinary, inter-dependent team.

Appendix 6: Focus group evidence

Overall analysis of discussions in focus groups

Whole-patient care/challenges and opportunities

- There need to be more rounded and varied training experiences to enable trainees to understand how to care for the whole patient and to be more clinically competent.
- Trainees expressed frustration over difficulties in organising discharge, which resulted in some patients, particularly the elderly, remaining in hospital when they were clinically well enough to return home. They felt that systems and relationships across traditional boundaries are not always 'joined up' or fully understood on either 'side', which can lead to tensions and frustrations.
- Trainees would appreciate a more rounded training experience so that they can deal with the whole patient, for example, including mental health issues.
- There was consensus that there is too much silo working.
- Views were expressed by some trainees that a better understanding of the NHS, the wider healthcare system and beyond needs to be taught at medical school. It was felt that a good understanding of the whole system is essential to clinical competence and that, to be able to care for patients holistically, doctors need to understand their wider care.
- Many trainees felt that, whilst they may be considered part of a multi-disciplinary team within the acute setting, this did not always seem to be the case in practice.
- All trainees felt they lacked knowledge about alternative systems and services beyond the hospital. They felt that a greater understanding here would improve their decision-making around admissions and discharges.

Community experience

- There was recognition that a general practice placement was valuable for those intending a career in the acute setting, due to greater understanding of that setting, that specialty, and so on. The opportunity to establish better links and networks with community colleagues and services also proved very valuable.
- Most trainees acknowledged that they and colleagues often had concerns in advance of undertaking community placements. Typically these were around 'being cut off' and not being able to develop or practise clinical competencies. All those trainees who had experienced a community placement, and others who had discussed it with friends who had done so, agreed that these placements were beneficial, that as trainees they had become more 'rounded', and that such placements did still offer opportunities to use and develop clinical skills.
- General practice placements were valued as opportunities to understand the interfaces between primary and secondary care. A view was expressed that "people who don't have community as an option don't have the full picture". One trainee had a general practice placement where there was a nearby community hospital, which helped them gain more and different exposure to the community: "A rich learning experience."

- There was consensus that perceptions of particular specialties (general practice, psychiatry) need to change, that stigma is a problem. It was felt that negative perceptions can start being formed in medical school and that there should be more education and training on and in community-based practice.
- From personal experience and anecdotally, trainees commented on fears in advance of psychiatry placements that these would not be as valuable as an acute setting placement, and that their clinical skills might suffer. Views expressed suggested that these concerns were subsequently overturned and that the experience was found to be very valuable and enjoyable: "Have enjoyed … have had to make decisions and had some autonomy … makes you grow and develop."

Supervision

- There was consensus that supervision in community placements was excellent. There was particular praise for GPs in terms of support and proactivity with regard to supervision. One trainee referred to having a daily mentor and being able to go through her list of queries every day.
- There was consensus that supervision in the acute setting was not always as good as it could/should be, although trainees were keen to point out that they had experienced excellent supervision in the acute setting also. Views were expressed that supervision was very dependent on individuals but that workload was also a factor.

Focus group comments

Barriers to whole-patient and whole-system care

- "There is a variety of experience within the Foundation Programme, it is not the same for everyone. Even though I don't want a career as a GP, I have found my placement so helpful when I came back into the hospital setting as it helped me understand the pressures they are under, and provided me with the necessary links in and out of the hospital."
- "Surgeons have to focus on surgical problems but there are lots of elderly patients that need to be cared for more fully. The 'ortho-geri' model is effective but doesn't happen in general surgery, which it should."
- "There was a case of a patient with a broken hip – the hip was easy to fix but the patient had immobility issues and the case was not necessarily managed as well as it could have been – there were a lot of issues around getting the patient home."
- "It would be much better to create a more rounded training experience so that trainees can deal with the whole patient, such as mental health issues."
- "There are so many cases where wards are full of fractured hips … the patients are still 'whole' people but can be seen just as hips."
- "In order to be clinically competent, you need to understand the whole system and this needs to be taught at medical school. Also, doctors are not always part of the multi-disciplinary team, which they should be."
- "There needs to be more joined-up working and planning to be able to manage the

whole patient, such as with social services and the nurses. It will help prevent patients staying in hospital for longer than they need to when they are clinically able to go home."

- "There is a lack of knowledge about alternative systems and services available, other than hospital-based services. If juniors were utilised to go out into the community we could perhaps prevent admissions."
- "Within A&E, patients can be assessed as fairly well and can go home but may need some support, such as an occupational therapist. The problem is that we don't always know about the services or how to promote them and then the patient will end up in a medical ward and just stay there."
- (Commenting on RACE – Rapid Access Consultant Evaluation) "Two elderly care consultants are responsible for community links in old-age psychiatry placements, which helps teach you about making the best decisions around admissions. This is very good."

Supervision

Supervision in community

- "Some trainees may worry that, in a psychiatric placement, they wouldn't have a solid-enough base in medical knowledge. But colleagues of mine that have completed a placement in community psychiatry have really loved it, because they have enjoyed being thrown in at the deep end and have had to make decisions and had some autonomy, which makes you grow and develop."
- "The supervision in general placement training is really good because the GP is around to ask questions and dedicated time is given for this."

Acute supervision

- "Sometimes it can be very difficult as people don't know who you are."

Appendix 7: Broadening the Foundation Programme to move more placements into the community – a review of the literature by James Heaney and Anna Perkins

PA Consulting Group

Background

In recent years, the health policy of successive governments in England has aimed to shift at least some health services into the community. As outlined in the NHS Next Stage Review,[34] NHS services need to evolve to reflect changes in healthcare and society. Changes in the age profile of the population, combined with technological advances, have meant that many types of healthcare can be delivered more effectively in the community. As society lives longer and there are increasing challenges from complex 'lifestyle diseases', more focus is to be put on prevention, and on managing the complications of ageing and long-term health conditions, including diabetes and heart disease, in the community.

Therefore, the health service needs to train future doctors capable of delivering safe and effective medical care in this changing environment. Training must take account of the shift to the community and ensure foundation doctors are sufficiently prepared for their future roles.

As part of the review of the Foundation Programme, Professor John Collins' report, *Foundation for Excellence*,[1] found that "… a greater share of healthcare is now delivered in the community, with successive governments supporting a model in which this will expand. The balance of placements in the Foundation Programme does not reflect this change". The review went on further to recommend that "the Foundation Programme Curriculum should be revised to give greater emphasis to the total patient, long-term conditions and the increasing role of community care". This builds on the current commitment in England to ensure that at least 55 per cent of all foundation doctors undertake part of their training in general practice.

In his review of the impact of the European Working Time Directive (EWTD),[2] Professor Sir John Temple highlighted that training and the delivery of patient care are inextricably linked. The review also detailed what high-quality training should look like, including that it should be well supervised, structured and competency based, have appropriately skilled trainers with sufficient time and facilities and enable practical experience to be gained, but protect foundation doctors from excessive service pressures.

It is vital that training is aligned with the needs of the modern NHS, ensuring those within the Foundation Programme are being taught technical and professional skills applicable to their future working roles, which will be impacted by society and its changing demographics.[1,2]

The Better Training Better Care project was developed to deliver the recommendations from the reports by Professor John Collins and Professor Sir John Temple. The recommendations are made in the context of improving patient care, the needs of the foundation doctor and the changing healthcare environment. It is this broadening of the Foundation Programme element of the project that seeks to address the specific recommendations made by Professor John Collins[1] for more foundation doctors to undertake community placements. Within these, particular emphasis is placed on general practice and psychiatry amongst other community placements.

PA Consulting was commissioned by HEE to carry out a literature review to support the wider Better Training Better Care project.

Methods

The review considered two main questions:

1. What are the benefits and challenges of community placements in the UK medical Foundation Programme?
2. What lessons can be learned from other countries?

The review focused on the impact of community placements in the UK medical Foundation Programme (specifically general practice, community psychiatry and community paediatrics) on:

1. Placement quality and supervision
2. Foundation doctor satisfaction
3. Changes in knowledge, skills, competence and attitude
4. Patient satisfaction/experience and outcomes
5. Career choice
6. Cost

The review aimed to identify good practice, risks and costs, and also identify any further areas for research where appropriate.

Types of study

The review searched for many types of literature, including randomised controlled trials, cohort studies, case-control studies, cross-sectional studies, ecological surveys, case studies and opinion pieces. This document provides a systematic review of the articles found.

Inclusion and exclusion criteria
Owing to the volume of results expected using the agreed search terms, further inclusion and exclusion criteria were developed. Only results published in the last ten years were considered as this aligns with the original pilots for the Foundation Programme. Articles that met the inclusion criteria but were not written in the English language were not considered.

Search strategy
Electronic databases were searched and the reference lists of identified articles checked. Experts were also contacted for details of any additional papers.

The search terms were selected so as to give as much coverage across the aims of the literature review as possible. They captured the participants, interventions, comparisons and outcomes being considered. The search terms used for the systematic review of the UK literature were foundation doctor, Foundation Programme, F1, F2, trainee doctor, final year medical, community, general practice, psychiatry, paediatrics, career, supervision, cost, skills, competence, capability, workload, satisfaction, patients, patient care, benefits, objectives and career. These terms were agreed with HEE. The search was completed by the Bloomsbury Healthcare Library, using these key databases: Medline, HMIC, AMed, EmBase, PsycInfo, BNI, Cinahl and Health Business Elite.

Additional search methods included hand-searching bibliographies and citations of retrieved publications.

Process for data extraction
Two members of the review team independently considered the search results and agreed which articles were to be requested and included in the review. Two individuals also agreed what data could be extracted from the literature – participants, interventions and outcomes.

Results

The review considered a total of 31 articles, of which 21 UK-based studies were selected for the systematic review and seven for the international comparison. The breakdown of articles considered is included at Appendix 7a. Other sources have also been utilised, including trainee surveys. Three retrieved articles were excluded.

The results are presented in two parts: the systematic review of the UK literature and the international comparisons.

A systematic review of the UK literature

Of the 21 UK articles considered, there was one cohort study, ten surveys, four interview-based studies and six reports (three from supervisors or course organisers and three from foundation doctors).

Placement quality and supervision
Of the literature considered, two articles made reference to placement quality and, in particular, supervision. Of the two studies, one was survey based and one drew on qualitative information from interviews and focus groups.

During interviews in the study by Firth and Wass[20] in the North Western Foundation School, where all F2 doctors rotate through a four-month general practice placement, it was found that foundation doctors felt they had ready access to senior support in a general practice placement. Respondents stated that feedback from supervising GPs was particularly appreciated and often contrasted this against experience in hospital rotations. The study also found that, despite initial concerns from foundation doctors aspiring to surgical careers that the posts would have little educational value, it was markedly apparent that the experience was regarded, on reflection, as being a source of valued learning experiences with more feedback provided than in other foundation training posts.[20]

A study in Wessex,[19] using results from surveys completed by foundation doctors, found the educational feedback and support received from the trainer and other partners in the practice was important. The study reported that foundation doctors felt the community placement offered the required mix of self-initiative working with the knowledge of good supervisory support and back up if required.

In terms of other placement quality measures from a general practice placement, the study in Wessex also found that there were incentives for the practice. General practice trainers stated the benefits of bringing in 'refreshing new doctors' to the surgery.[19] Other benefits included sharing and gaining up-to-date knowledge of modern hospital treatments and hospital education in general. Teaching F2s also stimulated a renewal for knowledge and skills in some trainers, who felt they were "expanding one's own teaching skills in a new area".[19] Some trainers, however, felt that supervising their F2s might sometimes be to the detriment of their patients as it could happen in between surgeries. The article does not expand on the detriment referred to.

The two articles considered show that supervision is a highly regarded element of the foundation placement and that, whilst there is the scope to work on one's own initiative, regular feedback from supervising GPs is appreciated by foundation doctors.

Foundation doctor satisfaction
Ten articles considered foundation doctor satisfaction; five were surveys, three were drawn from interviews and two were opinion pieces from foundation doctors.

The GMC Trainee Survey 2012[31] found that general practice is associated with the highest satisfaction rating of all specialty placements in the Foundation Programme. In 2012, general practice as a specialty placement returned a satisfaction score of 87.8 (range 76.2 to 87.8).

Experiences from Coventry and Wessex in particular provided qualitative support and context around the high satisfaction scores of general practice placements. There were a number of themes identified from qualitative comments: [11,12,19]

- They provide an excellent foundation to becoming a good GP.
- They offer a varied/broad placement.
- The experience gained in dealing with ambiguity will help in their future career, not just the general practice placement.
- The placement improved skills in addition to technical/medical skills, including communication and patient-foundation doctor interaction, which can only be of benefit to the patient.
- The patients are seen as 'people' and not just 'diseases to be cured' so the doctor-patient interaction was appreciated.
- The placement allows for greater lifestyle flexibility.

The interviews conducted by Poon and Toon found that general practice placements allow for greater work life balance.[5] Although not community specific, the surveys completed in the study by Goldacre et al[7] found that 'hours/working conditions' were rated as influential by a higher percentage of doctors who chose psychiatry than those who chose other hospital specialties. An article written by an F2 doctor also stated that motivating factors included lifestyle as well as patient contact.[11]

The literature also considered potential challenges to foundation doctor satisfaction. Despite the high satisfaction scores, one of the potential risks of a community placement is foundation doctor isolation. A respondent of a study in Wessex highlighted that they felt isolated from their peers in the hospital.[19] Although this is a single view within the literature considered, it is a potential negative aspect of a community placement for which provisions should be made.

The issue of isolation was also considered within psychiatry placements, in particular, for F1 doctors. A study at the South Thames Foundation School[33] found that a doctor may find themselves on a site away from their peers and without the immediate opportunity to reinforce the medical skills they have learned. This situation could be exacerbated by a lack of close supervision. However, the findings of the same study also stated that "current isolation will also be reduced if, in line with Professor John Collins' recommendations,[1] more training posts are developed within community settings such as psychiatry". Firth and Wass[20] also found that fears that were held regarding lack of clinical exposure and irrelevance were unfounded.

The interviews considered in the study by Firth and Wass[20] also found that the lack of banding in terms of payment could impact satisfaction with the general practice placement. In contrast, the surveys completed in the field of paediatrics showed that financial considerations are not an overriding concern.[6] This was evidenced by only a low percentage of those choosing paediatrics saying that 'future financial prospects' influenced their choice 'a great deal.'

Change in knowledge, skills, perception and attitude
Five articles considered the knowledge and skills that a foundation doctor can gain through a community placement. One study drew from interviews and focus groups, two from survey results and two were reports by foundation doctors.

The literature showed that foundation doctors often find community-based placements offer them better and sometimes unique opportunities to develop specific foundation competencies. It is stated within the Foundation Programme Curriculum that "those competencies relating to long-term care are usually best experienced in community-based placements".[39]

The survey results of the study completed in Coventry[12] concluded the cohort of F2 doctors felt that, of all the specialties they had experienced, general practice had given them the skills they had expected from the Foundation Programme to a greater extent than other placements – 16 (55 per cent) out of 29 ranked general practice in first position for giving the experience and skills expected of the Foundation Programme.

In summary, it stated that benefits included experience of the interface between general practice and the hospital, the effect of illness on family and community, communication skills, letter- and summary-writing, decision-making and dealing with uncertainty.

The results of a study by Lambert, Surman and Goldacre[42] offered a different perspective on the benefits of experiencing wider skills. Whilst the study was not community-placement specific, there was a majority agreement amongst the doctors that they had to undertake, in their view, an excessive amount of non-medical work that could have been performed by staff without medical training. However, the most recent graduates surveyed in the study had less negative views on this than their predecessors a decade earlier.

Firth and Wass[20] also considered knowledge and skills during the interviews in their study at the North Western Foundation School. They found that generic, transferable learning outcomes were identified, such as improved communication skills, both with patients and fellow healthcare professionals. Also apparent was a greater understanding of the role of primary care as the gatekeeper of the NHS.

Participants in the study by Firth and Wass[20] provided specific examples of where a community placement may improve their performance in other specialties. For example, foundation doctors often described a greater understanding as to why referrals that

were made from primary care occasionally lacked information. The placements improved communication between primary and secondary care as, following the posts, those completing discharge summaries described how they had experienced first-hand what information was relevant and necessary and what could be reasonably expected from primary care in terms of follow up. One participant stated: "I'll be making more of an effort to provide a bit more detailed information on discharge summaries, because I appreciate completely that GPs can't actually do anything with, you know, nothing written on a discharge summary."[20]

The findings in the Wessex study[19] showed that, as a result of the general practice placement, foundation doctors were more comfortable working on their own initiative and also in managing uncertainty. This was aided by the increase in their clinical knowledge and experience.[19] However, no study quantified whether there was a change in knowledge, skills or level of competence following a placement in the community.

The reports by foundation doctors completing general practice placements[10,11] provide further context and texture to support the high satisfaction scores detailed in the trainee surveys[30,31] and make the link to skillsets. They suggest that a general practice placement provides a broad set of skills that are applicable to other areas of practice, including the acute setting.

The literature considered attitudes towards community placements. Three articles in particular showed that the general perceptions of, and attitudes towards, general practice placements are negative initially.

In general practice, initial perceptions ranged from considering the placement would be easy on the basis of the reduced hours and reduced pay, to the posts not being beneficial in terms of learning outcomes.[11,20]

Firth and Wass[20] concluded that there was a striking contrast between perceptions of general practice before and after undertaking F2 rotations in the specialty. Comments by the interviewees showed that initial negative perceptions of general practice placements were based on poor experiences as a student and/or being influenced by their role as hospital doctors over the preceding months, which was reinforced or generated through their interaction with senior colleagues. Initial concerns were also expressed by interviewees that the time spent in general practice impacts the amount of clinical education they receive, of which they are "not getting enough". The results of the study showed that overall, the impact of the posts in influencing trainees' perceptions of general practice for the better was close to unanimous.

An article written by a foundation doctor six weeks into a general practice placement also demonstrated a change in attitudes towards the specialty.[11] The general practice placement was initially 'dreaded'. However, six weeks into the placement, the change of

attitude was 'tremendous'. Reasons for the change included gaining an understanding and appreciation of what GPs do day to day, and being astounded by the complexity of the issues dealt with.

One other article, a systematic review in the field of psychiatry, showed that a clinical attachment can result in a more positive attitude towards the specialty.[35] However, it is noted that this study also considered international literature so is reviewed as part of the international section later in the paper.

Patient satisfaction, experience and outcomes

Only one article considered, albeit briefly, the impact of foundation doctors in community practice on patient satisfaction, experience and outcomes. The study completed in Wessex,[19] drawn from survey results, stated that patient feedback on foundation doctors was reported as being 'excellent'. The findings also demonstrated that patient care was catered for in clinical and non-clinical areas, contributing to the building of a broad picture of patient care and health in the community.[19]

One article considered patient safety specifically and focused on attitudes of foundation doctors towards it.[14] Overall, the study demonstrated a positive attitude towards patient safety among foundation doctors, although these findings were not community-placement specific.

No study looked specifically at the impact of a community placement on patient safety, experience or outcomes.

Career choice

There was considerably more literature available on career choice in comparison to other outcomes considered. In total, 12 articles considered the impact a community placement may have on career choice, to some degree. Of the 12 studies, there was one systematic review in the field of psychiatry, although this also considered international data, one cohort study, seven studies which used surveys, two which were interview based and one article which was a report by a foundation doctor.

The Foundation Programme Annual Report 2012 showed that the number of foundation doctors taking on general practice placements is increasing in comparison to other specialties. In 2012, 43.8 per cent of F2 doctors experienced a general practice placement, more than any other specialty.[38] The data showed that numbers are not as high for other community specialties. For example, currently, less than 20 per cent of foundation doctors have a Foundation Programme placement in psychiatry.[36]

The National F2 Career Destination Survey 2012[16] showed that 36 per cent of doctors appointed to UK specialty training in 2011 progressed to GP training.

The results of a study by Kelley et al[36] showed that among the 14.6 per cent of foundation doctors (of 6,913 respondents) who had exposure to psychiatry prior to specialty application, 14.9 per cent chose psychiatry as a career in contrast to only 1.8 per cent of those that did not have psychiatry exposure. In the paediatrics specialty, it was found that medical students who experience enthusiastic and stimulating training in paediatrics may be more likely to become paediatricians.[6]

The literature linked the high satisfaction scores and change in attitudes of general practice placements to increased motivation towards general practice as a career choice. In particular, a study completed in Coventry and Warwickshire[12] found that not only would 34 of the 35 foundation doctors who completed a questionnaire recommend a general practice job to a friend, there was also an increase in the number of foundation doctors considering general practice as a career. Prior to the F2 placement, 60 per cent had planned a career in general practice, but a total of 77 per cent wanted a career as a GP post-placement.

The 2011 study completed by Firth and Wass also found that some foundation doctors developed career preferences in general practice following the placement.[20] The study at the North Western Deanery found that several participants clearly stated that their change of career preference was directly attributed to their F2 general practice exposure.

The study by Irish and Lake[22] showed that 38 per cent of their 1,825 respondents chose general practice as their specialty, during their foundation training. Although the study acknowledged that foundation training can positively influence career intentions,[19,22] it states that a "measurable positive effect on future recruitment to general practice specialty training remains elusive", pointing to the need for further exploration of this area.

Cost

The literature available on the cost of community placements is minimal. Where financial comment was available, the literature focused on the impact to the foundation doctor when completing a community placement. Only four articles considered the cost of community placements within the Foundation Programme. Of the four articles, two were drawn from the results of interviews, one was based on surveys and one was a report written by course organisers. Foundation doctors in a community setting, for example, a GP practice, are expected to work a maximum of 40 hours per week.[21]

The literature, in particular, the qualitative text, showed that the advantages of community-based settings include work-life balance and an increased opportunity to undertake further educational courses and self-directed learning. However, the negative impact of a community placement is that foundation doctors only receive a basic salary. In contrast, F2 doctors in an acute setting may receive a banding supplement for working

antisocial hours.[21] One of the foundation doctors in Wessex expressed concern over the lack of banding, which was associated with a significant reduction in pay.[19]

The results of the Firth and Wass[20] study in the North Western Foundation School had similar findings, in that posts having no banding meant greater discontent amongst foundation doctors.

In a recent GMC study,[37] one respondent stated that they had registered with a locum agency to earn extra money outside of their community placement hours.

The study by Poon and Toon[5] found that foundation doctors experienced financial difficulties from the lack of banding payments in general practice posts, and that low payment is a disincentive for doctors when choosing their rotations. It was stated that doctors in other F2 posts work up to 48 hours per week, including shifts, and receive an extra banding payment of between 20 and 50 per cent of the basic salary.

None of the studies considered the financial benefits of community placements in the Foundation Programme on the patient or the health service.

International comparisons

This literature review considered seven articles from international sources. They were selected to understand if any findings from other jurisdictions are applicable to community placements for foundation doctors in the UK. It is acknowledged that, owing to differences in structure and demographic, direct comparisons cannot be made, but there may be findings and learning that could be considered.

Of the seven articles selected, one was a systematic literature review covering the UK, Europe, North America, Australia and New Zealand. Three articles were from Australia (two survey-based studies and one based on interviews), one from Japan (survey based), one from Israel (survey based) and one from Singapore (also survey based).

Change in knowledge, skills, competence and attitude

A 2013 systematic review[35] of 46 studies found that clinical attachments in psychiatry did result in more positive attitudes towards the specialty and increased career interest. Other factors were found that influence attitudes, including attachment, setting and duration. It is noted that there is limited information available on the long-term follow up. However, a study from Israel found that a psychiatry placement had no statistically significant impact on changing attitudes.[28]

The need for medicine to be delivered in rural placements is increased in Australia owing to the geography of the country. The results of an Australian study[23] found that students considered a rural placement more comprehensive than expected, both clinically and

socially. The ability to be more 'hands on' was one of the key attractions of the rural placement, as was enhanced patient access – similar to the whole-patient and long-term care findings in domestic studies. Other benefits experienced by the doctors included an increased sense of camaraderie amongst peers, and enhanced levels of supervision when compared to the metropolitan hospital setting.

A Japanese study[25] completed in 2011 showed that student attitudes about the importance of and confidence in practising community healthcare increased after a community clerkship. It also showed that the positive change was associated with the health education activity during the clerkship. The findings of the study indicated that the degree of readiness to change was increased by learning about community practice.

A Singapore study suggested that exposure to a geriatric medicine post during residency may positively influence doctors' attitudes towards older adults.[27]

Career choice
Qualitative analysis drawn from 38 interviews in Australia[24] found that, whilst exposure to a general practice placement can impact career choice, it is the quality of the experience that is key. As well as quality of placement, students stressed the importance of early exposure to general practice and of GPs having a high profile throughout medical school.

The study found that participants reported general practice is often seen as "an inferior type of choice", but that this view can be countered following completion of a placement. The findings also showed that for individuals who had not previously considered general practice as a career, a positive placement experience is likely to change that view.

The key satisfaction triggers of a career in general practice are recorded as similar to the findings from domestic studies. The potential for an improved lifestyle, continuity of care, variety and working with people were key attractions of such a career.

Discussion

The key themes emerging from the literature include the following points:

- General practice placements are the most satisfying of all placements for foundation doctors.
- Exposure to community placements can increase a foundation doctor's motivation for pursuing a career in general practice and/or psychiatry.
- A community placement helps provide a broad transferable skill base as per the Foundation Programme Curriculum, which equips doctors for work in any specialty.
- A community placement helps foundation doctors to better understand and manage the interfaces between primary and secondary care.

The literature also raised some potential risks, including:

- loss of banding
- sense of isolation
- variable supervision in some community placements
- potential for loss of some acute clinical skills.

Both Professor John Collins and Professor Sir John Temple write of the need to align the training of doctors to the future requirements of the patient, society as a whole, and the service.[1,2] This includes ensuring there is safe and effective community care to respond to an ageing population and an increase in long-term illnesses that can be treated outside of the hospital setting. Those in community care have a crucial role to play in providing some of the most personalised care, particularly for children and families, older people and those with complex care needs, and in promoting health and reducing health inequalities.[34]

Data about the impact of community placements on patient satisfaction, experience and outcomes is lacking. The Health Foundation findings[32] suggested that community placements could lead to increased patient satisfaction. However, their study focused on the wider issue of community care, not specifically foundation doctors in community care. When asked during the study, patients expressed greater satisfaction with treatment-at-home regimes than hospital inpatient care. Similarly, patients were generally more satisfied with community-based minor surgery compared with hospital treatment, typically citing ease of access, travel and shorter waiting times as key factors. However, the study was caveated with an acknowledgment that many of the studies that evaluated community-based interventions were highly selective in terms of who was offered the service, and assumptions should not be made on the basis of the evidence review alone.

The literature showed that community placements, in particular in general practice, can help foundation doctors overcome initial negative perceptions of the specialty. Whilst it is positive that the negative views can be overcome by completion of a rotation, it appears that there remains an opportunity to address the negative perceptions ahead of a foundation doctor's community placement.

Foundation doctors can expect highly satisfying placements and it is recognised that broad and more general skills can be developed during a community placement, particularly one in the general practice specialty. The North West Deanery[21] also state in their document, *The Simple Guide to Foundation Programme Training in General Practice*, that some competencies are more likely to be met in general practice than in some other rotations and offered examples of relationships with patients and communication. The literature also showed that these are very much transferrable skills, which can further support a foundation doctor both in the acute setting, and also in their wider career.

The article written by Lambert, Surman and Goldacre[42] assessed how foundation doctors rated their first year of training. Whilst not community-placement specific, it considered the quality of training and also the impact on work-life balance. Only one in five of the students surveyed disagreed with the view that "training was of a high standard". The findings on job enjoyment also supported the generally positive views UK graduates had about their F1 year.

It appears that the changing society will require more generalists with high levels of people skills to provide patient care effectively in the future. Whilst the need for specialists remains and technical skills must continue to be supervised appropriately, the need for the wider skillsets, which can be developed in community settings, is very much apparent. These skillsets are transferrable to acute settings and can help support foundation doctors to better manage and treat the elderly and patients with mental health illnesses, in addition to physical conditions.

There was only anecdotal evidence to suggest what the financial impact of community placements may be on the patient or the service. In their report, the Health Foundation[32] stated that most of the costs of community-based services are staff costs. Daily costs tend to be lower and different studies have found that total costs are either lower or no different to inpatient costs, once longer durations of community-based care are taken into account. Following any initial outlay on equipment and set up, the majority of costs associated with community care are staff costs. Another study referred to by the Health Foundation stated that staffing amounted to 60 per cent of Hospital at Home costs for cancer treatment.[32]

Community care can also be seen as an investment in the wider sense, in that it could improve patient satisfaction and also continue to support the future trajectory of the NHS. This is required, as identified in the GMC's *State of Medical Education and Practice in the UK* report, which stated: "There is a continuing debate about the distribution of doctors across specialties, particularly whether we have an appropriate balance between specialists and generalists, and if we have enough doctors in the right specialties to care for an ageing population."[40] Under the assumption that community care is clinically effective and desirable for patients, an increase in such care may help reduce hospital admissions and re-admissions.

Whilst the literature showed that community placements may help support the future needs of patients in society through positive career choice impact, this review did not find any studies which assessed the impact on patient satisfaction, particularly in comparison to acute care. Assumptions can be made, however, that if patients prefer community-based treatment, increasing the amount of foundation placements will increase patient satisfaction, assuming the foundation doctors are appropriately supervised. If foundation doctors can assist in delivering appropriate patient care in the community, work should

continue in identifying which treatments and services are suitable for out-of-hospital settings. Certain illnesses and requirements as a result of the changing demographics, such as care of the elderly, obesity and diabetes, have already been recognised as areas where community care may be more suitable than continued care in an acute setting.

However, it also acknowledged that society cannot just 'switch' to a community-based care system overnight. This may also be true for foundation doctors entering more community placements, given the apparent initial negative perceptions towards general practice, for example. Despite the documented benefits, in particular around whole-patient care, the transition needs to be supported by effective communication and continuous learning and improvement.[41] Given the findings around the acquisition of general skills, in particular communication, from community placements, foundation doctors could play a key role in helping the changing patient demographic benefit from community care. There is also potential for foundation doctors to act as the bridge between the community and hospital settings, given their exposure to both during their placements. Findings have suggested that experiences in a community placement can improve skills in the acute settings so there appears to be potential for foundation doctors being the positive voice to support the change. After all, it is the foundation doctors who will eventually be delivering such services in the community, in line with the NHS goals, in their future careers.

The poverty of data in certain areas suggests that there are opportunities for further research. In particular, more information is required on the impact of community placements in the Foundation Programme on patient satisfaction, including the approach to the whole patient. There was minimal information on the financial impacts of community placements. Further research should consider if there are any opportunities for cost savings, particularly in relation to a potential reduction in hospital re-admission rates, and also assess the initial cost of setting up community placements. Future research should also look at the causes of initial negative perceptions of general practice placements and how these can be addressed. The literature also focused primarily on general practice placements, so more research should be done into other community specialties, including psychiatry and paediatrics.

Conclusions

The volume of literature available for the specific outcomes considered as part of this review is limited, although there are key findings that can be drawn from the articles considered. The literature suggests that community placements are highly satisfying for foundation doctors, even though there may be financial disadvantages in comparison to other specialty rotations/placements. It suggests that those in a general practice placement can develop a broad skillset to benefit other specialties and their careers overall. The literature acknowledges that the changing demographics of society will require a greater number of GPs to deliver the increasing care needed in community

settings. Studies considered suggest that community placements may positively impact career choice to support general practice and possibly psychiatry.

Limitations of the literature review

The research data is limited. Further high-quality research is needed, especially around specific types of community placement and how they can improve competence, career choice and patient outcomes.

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Appendix 7a: Articles selected for review

Reference number	Title	Author	Published	Study type	Participants	Outcomes
3	Developing a set of quality criteria for community-based medical education in the UK	Cotton P, Sharp D, Howe A, Starkey C, Laue B, Hibble A, Benson J	2009	Interviews	3 GP undergraduate teachers, 4 postgraduate deanery (GPs), an undergraduate teaching administrator, 5 students and 1 individual working in a Strategic Health Authority	Patient outcomes
5	Banding in F2 general practice posts	Poon Y, Toon D	2009	Interviews	5 doctors interviewed as part of a BMedSci project to explore their experiences of F2 GP placements	Foundation doctor satisfaction Career choice Cost
6	Career choices for paediatrics: national surveys of graduates of 1974-2002 from UK medical schools	Turner G, Lambert TW, Goldacre MJ, Turner S	2007	Survey/ questionnaire	Qualifiers from all UK medical schools in nine qualification years since 1974 (over 24,000 respondents)	Foundation doctor satisfaction Career choice
7	Choice and rejection of psychiatry as a career: surveys of UK medical graduates from 1974 to 2009	Goldacre M, Fazel S, Smith F, Lambert T	2013	Survey/ questionnaire	All newly qualified doctors from all UK medical schools in 12 qualification years between 1974 and 2009 (33,974 respondents)	Foundation doctor satisfaction Career choice
8	Cost and quality of education for general practice	Howard J, Gibbs T, Walsh K	2011	Report	N/A	Cost

Reference number	Title	Author	Published	Study type	Participants	Outcomes
9	Educational supervision and the impact of workplace-based assessments: a survey of psychiatry trainees and their supervisors	Julyan TE	2009	Survey/ questionnaire	21 junior doctors and 21 educational supervisors in one UK psychiatry training scheme were surveyed before and after the introduction of Workplace Based Assessments. Response rate of 70 per cent	
10	Foundation programme in general practice	Abusin S	2006	Report (Foundation doctor)	One F2 doctor	Competence
11	Foundation Year 2: changing attitudes towards general practice	Woodcock I	2006	Report (Foundation doctor)	One F2 doctor	Foundation doctor satisfaction
12	General practice and the Foundation Programme: the view of Foundation Year Two doctors from the Coventry and Warwickshire Foundation School	Walzman M, Allen M, Wall D	2008	Survey/ questionnaire	35 doctors who experienced a four-month general practice placement from August 2004 to August 2005 at the Coventry and Warwickshire Foundation School	Foundation doctor satisfaction Career choice Competence
13	Is more interest needed for us FY1 doctors in general practice?	Mirza, A	2009	Report (Foundation doctor)	One F1 doctor	Foundation doctor satisfaction
14	Junior doctors and patient safety: evaluating knowledge, attitudes and perception of safety climate	Durani P, Dias J, Singh HP, Taub N	2013	Survey/ questionnaire	527 respondents made up of foundation trainees, general practice trainees, and hospital core and specialty trainees via the East Midlands Deanery distribution lists.	Patient outcomes (not community specific)
15	Medical careers and societal needs	Irish B, Munro N, Plint S	2010	Report	N/A	Career choice
16	National F2 Career Destination Survey	Carney, S	2012	Survey/ questionnaire	All 25 foundation schools provided data	Career choice

Reference number	Title	Author	Published	Study type	Participants	Outcomes
17	Specialty choice in UK junior doctors: is psychiatry the least popular specialty for UK and international medical graduates?	Fazel S, Ebmeier KP	2009	Cohort study	Over 80,000 applications to specialty training posts in England in 2008	Career choice
18	The effect of modernising medical careers on foundation doctor career orientation in the Northern Ireland Foundation School	O'Donnnell ME, Noad R, Boohan M, Carragher A	2010	Survey/ questionnaire	147 F2 doctors participating in the Northern Ireland Foundation Programme	Career choice
19	The Foundation Programme in general practice: the value added of the attachment – a Wessex experience	Zolle O, Odbert R	2009	Survey/ questionnaire	43 trainers and 76 F2s were contacted in Wessex. The response rate for this study was 56%	Foundation doctor satisfaction Patient outcomes Supervision
20	The impact of general practice attachments on foundation doctors: achieving the goals of Modernising Medical Careers - North West Deanery	Firth A, Wass V	2011	Interviews	25 foundation doctors	Foundation doctor satisfaction Competence Career choice Supervision Cost
21	The Simple Guide to Foundation Programme Training in General Practice	North West Deanery	2012	Report	N/A	Competence Cost
22	When and why do doctors decide to become general practitioners? Implications for recruitment into UK general practice specialty training	Irish B, Lake J	2011	Survey/ questionnaire	1,825 applicants to round 1 of national recruitment into the general practice specialty recruitment process	Career choice
33	Improving psychiatry training in the Foundation Programme	Welch J, Bridge C, Firth D and Forrest A	2011	Interviews	21 foundation doctors	Foundation doctor satisfaction
36	Foundation Programme psychiatry placement and doctors' decision to pursue a career in psychiatry	Kelley T, Brown J, Carney S	2013	Survey/ questionnaire	6,913 F2 doctors	Career choice

Appendix 7b: Articles selected for international comparisons

Reference number	Title	Author	Published	Based	Study type	Participants	Outcomes
23	Rural placements are effective for teaching medicine in Australia: evaluation of a cohort of students studying in rural placements	Birden HH, Wilson I	2012	Australia	Survey/questionnaire	21 students who had completed a rural placement during their final year of the UWS medical programme	Satisfaction (international)
24	Enhancing the choice of general practice as a career	Thistlethwaite J, Kidd MR, Leeder S, Shaw T, Corcoran K	2008	Australia	Interviews	38 medical students, junior doctors, general practice registrars and GPs	Career choice (international)
25	Does community-based education increase students' motivation to practice community health care? - A cross sectional study	Okayama M, Kajii E	2011	Japan	Survey/questionnaire	693 fifth-year medical students taking a 2-week clinical clerkship in Japan	Career choice (international)
26	To teach or not to teach? A cost-benefit analysis of teaching in private general practice	Laurence CO, Black LE, Karnon J, Briggs NE	2010	Australia	Survey/questionnaire	GPs who taught medical students, junior doctors and general practice	Cost (international)
27	Junior doctors' attitudes towards older adults and its correlates in a tertiary-care public hospital	Lui NL, Wong CH	2009	Singapore	Survey/questionnaire	51 house officers, medical officers and registrars	Patient outcomes (international) Change in attitudes (international)
28	The attitude of medical students to psychiatric patients and their disorders and the influence of psychiatric study placements in bringing about changes in attitude	Aker S, Aker A, Boke O, Dundar C, Sahin AR, Peksen Y	2007	Israel	Survey/questionnaire	172 final year medical students	Patient outcomes (international) Change in attitudes (international)
35	Are medical students allergic to psychiatry? A systematic review of the clinical psychiatry attachments on attitudes to psychiatry	Qureshi H, Carney S, Iversen A	2013	Mixed	Systematic review	N/A – systematic review of 46 articles	Change in attitudes (international)

Appendix 8: Department of Health MPET SLA 2012-2013

Extract from Department of Health (2011/2012), MPET SLA 2012-2013, page 9

SHAs should ensure the provision of training placements and programmes for F1 and F2 doctors. This should include four month placements for at least:

- 55% of F2 doctors with community or primary care placements;
- 5% of F2 doctors with academic placements;

SHAs should indicate what plans they are putting in place to provide at least:

- 22.5% of F1 doctors with a four month F1 placement in psychiatry from August 2013;
- 22.5% of F2 doctors with a four month placement in psychiatry from August 2014.

SHAs should also indicate what plans they have to provide community experience for all F2 doctors from August 2014.

Progress to date

% foundation doctors rotating through general practice and psychiatry in England - foundation year ending August 2013	F1	F2	Total
General practice	0.1%	44.1%	44.3%
Psychiatry	4.8%	10.9%	15.7%

Information provided by UKFPO, www.foundationprogramme.nhs.uk

Appendix 9: The working groups

In September 2012, a 'Broadening the Foundation Programme' Task and Finish Group was established, chaired by Anne Eden, CEO of Buckinghamshire Healthcare NHS Trust, to take forward key recommendations from *Foundation for Excellence*[3]. The overarching Task and Finish Group would provide a steer and oversee the activities of two sub-groups, Better Training and Better Care. Each sub-group had a specific focus: Better Training on the educational aspects of foundation training; Better Care on the changes needed to broaden the Foundation Programme.

The chair of the Better Training group was Professor Stuart Carney, Senior Clinical Adviser for HEE, Deputy National Director for UKFPO and Dean of Medical Education at King's College London. The chair of the Better Care group was Stuart Bell, CEO for the Oxford Health NHS Foundation Trust. Membership of all three groups was deliberately wide-ranging across all stakeholders, and had strong lay and trainee representation. Full institutional and individual membership of the groups can be found in Appendix 10.

The sub-groups typically met on a monthly basis, with the Task and Finish Group meeting quarterly and reporting to the Better Training Better Care Taskforce. Meetings were generally held in London with dial-in facilities to allow for the widest participation. The groups were supported by a HEE project team, which included a project director, project manager, project support and communications manager, and was steered by HEE Director of National Programmes, Patrick Mitchell.

3 Collins J (2010)

Appendix 10: Broadening the Foundation Programme – terms of reference

1 Task and Finish Group

1.1 INTRODUCTION

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

1.1.2 It has been developed at the request of the Secretary of State for Health to meet the aspirations, recommendations and key themes arising from Professor Sir John Temple's report, *Time for Training*,[4] Professor John Collins' review, *Foundation for Excellence*,[5] and related initiatives.

1.1.3 The Better Training Better Care Taskforce has agreed to establish a Broadening the Foundation Programme Task and Finish Group, which is part of Better Training Better Care Workstreams 4 and 7 (Foundation Programme delivery).

1.2 PURPOSE OF THE TASK AND FINISH GROUP

1.2.1 The Task and Finish Group will make recommendations, engage partners and provide guidance to enhance the breadth of training experiences available in the Foundation Programme. This will necessitate some redistribution of posts from the predominant specialties.

1.2.2 Reporting to the Better Training, Better Care Taskforce, the group will provide initial findings and propose draft recommendations by April 2013. A final report detailing recommendations for action and guidance for delivery will be completed by September 2013.

1.3 OBJECTIVES

1.3.2 To develop options for change and provide detailed guidance and an implementation plan which enhances the breadth of training opportunities, improves the delivery of the Foundation Programme Curriculum and meets the recommendations of the Collins report[6]

1.4 SCOPE OF WORK

1.4.1 The 'Broadening the Foundation Programme' Task and Finish Group is responsible for delivering Recommendations 13, 16 and 17 (key issues highlighted in bold) from

4 Temple J (2010)
5 Collins J (2010)
6 Collins J (2010)

Foundation for Excellence,[7] as follows:

Recommendation 13
"Flexibility must be accompanied by actively addressing the current mismatch between expectation and reality which exists in the minds of some trainees about career prospects in different specialties. Flexibility must also take into account the importance of ensuring that foundation doctors undertake community placements."

Recommendation 16
"The successful completion of the Foundation Programme should normally require trainees to complete a rotation in a community placement, e.g. community paediatrics, general practice or psychiatry. The GMC should consider whether this aspiration should be reflected in The New Doctor (due in 2011) and be able to obtain evidence of its implementation by 2012."

Recommendation 17
"The distribution of specialty posts in the Foundation Programme is predominantly in two specialties and this must be reviewed by 2013 to ensure broader based beginnings, to share the supervision of trainees among a wider number of supervisors and to ensure closer matching with current and future workforce requirements. Transitional arrangements may need to be put in place – at least in the short term – to ensure that service delivery is not adversely affected by such change."

1.4.2 The key focus areas for the Task and Finish Group separate into improving training and ensuring safe and effective clinical care. There will be two sub-groups to address these two main workstreams, with the main Task and Finish Group considering the recommendations, developing a coherent plan and directing stakeholder engagement.

1.4.3 The two sub-groups will focus on:

Better Training

- Analyse current allocation of posts in the Foundation Programme by specialty.
- Assess training capacity that may be available from 2013/2014 in under-represented specialties and in particular community-based placements, as recommended in *Foundation for Excellence*[8].
- Assess what additional community-based placements are required and recommend how high-quality placements might be commissioned and brought into practice.
- Demonstrate that the proposed recommendations will enhance the training experience of foundation doctors to deliver the necessary outcomes set out in the revised Foundation Programme Curriculum.

7 Collins J (2010)
8 Collins J (2010)

Better Care

- Take evidence from affected specialties as to the impact of these changes on both current Foundation Programme training and the delivery of clinical service.
- Provide guidance detailing good practice where clinical service has adapted and adopted new ways of working to accommodate the loss of foundation placements.
- Make recommendations on potential provision models and the ways in which transition to those models might be managed, in order that deaneries meet national targets regarding under-represented specialties.
- Provide best practice models and ideas for innovative, integrated approaches to community provision within the Foundation Programme that focus on community paediatrics and healthcare of the older person.

1.4.4 It will be necessary to develop a communications strategy and engagement plan.

1.5 MEMBERSHIP

1.5.1 The chair of the Task and Finish Group is still to be determined. The proposed stakeholder representation is as follows:

Academy of Medical Royal Colleges
Royal College of Psychiatry
Royal College of Surgeons
Royal College of General Practitioners
Royal College of Physicians
LETB representative
Two foundation school directors
Foundation school manager
UKFPO
Conference of Postgraduate Medical Deans (COPMed)
Committee of General Practice Education Directors (COGPED)
GMC
Trainee representative
NHS medical director
Acute chief operating officer
Acute trust chief nurse
Lay representative

1.5.2 The Better Training Better Care team members are:

Patrick Mitchell
Heather Murray
Susan Kennedy
Anna Eastgate
India Peach
Megan Storey

1.6 GOVERNANCE

1.6.1 The Task and Finish Group will report directly to the Better Training Better Care Taskforce.

1.7 MEETING ARRANGEMENTS AND FREQUENCY

1.7.1 The group will meet as many times as required. The arrangements are to be confirmed at the first meeting of the Task and Finish Group.

1.8 QUORUM

1.8.1 The quorum necessary for the transaction of the business of the Task and Finish group is 13 members, plus the chair.

1.8.2 Where a member is unable to attend a meeting, a nominated representative can deputise. Members are asked to inform the secretariat of their designated deputy.

1.9 TASK AND FINISH GROUP: SUB-GROUP MEMBERSHIP

1.9.1 Better Training

Academy of Medical Royal Colleges
Foundation school director
Foundation school manager
Foundation Training Programme director
Royal College of Psychiatry
Royal College of Paediatrics
Royal College of Physicians
LETB representative
Clinical director – community
Trainee
COPMeD
COGPED
GMC

National Association of Clinical Tutors (UK) (NACT-UK)
Acute trust DME
Lay representative

1.9.2 Better Care

NHS medical director
NHS chief operating officer
Royal College of Surgeons
Royal College of Physicians
Chief nurse
Trainee
COPMeD
Royal College of Nursing or Nursing Directorate representative
SHA director of workforce/LETB representative
Clinical Commissioning Group
Clinical director – surgery
GMC
Lay representative

2 BETTER TRAINING SUB-GROUP

2.1 INTRODUCTION

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

2.1.2 It has been developed at the request of the Secretary of State for Health to meet the aspirations, recommendations and key themes arising from Professor Sir John Temple's report, *Time for Training*,[9] Professor John Collins' review, *Foundation for Excellence*,[10] and related initiatives.

2.1.3 The Better Training Better Care Taskforce agreed to establish a Broadening the Foundation Programme Task and Finish Group, which is part of Better Training Better Care Workstreams 4 and 7 (Foundation Programme delivery).

9 Temple J (2010)
10 Collins J (2010)

2.1.4 To support this work, two sub-groups have been established to deliver key components, reporting to the main Task and Finish Group.

2.1.5 The Better Training sub-group will focus on the educational aspects, and the Better Care sub-group will look at issues affecting clinical service.

2.2 SCOPE OF WORK

2.2.1 Better Training

- Analyse the current allocation of posts in the Foundation Programme by speciality.
- Assess training capacity that may be available from 2013/2014 in under-represented specialties, and in particular community-based placements, as recommended in *Foundation for Excellence*[11].
- Assess what additional community-based placements are required, and recommend how high-quality placements might be commissioned and brought into practice.
- Demonstrate that the proposed recommendations will enhance the training experience of foundation doctors to deliver the necessary outcomes set out in the revised Foundation Programme Curriculum.

2.3 MEMBERSHIP

2.3.1 The chair of the Better Training sub-group is still to be determined. The proposed stakeholder representation is as follows:

Academy of Medical Royal Colleges
Foundation school director
Foundation school manager
Foundation Training Programme director
Royal College of Psychiatry
Royal College of Paediatrics
Royal College of Physicians
LETB representative
Clinical director – community
Current trainee
COPMeD
COGPED
GMC
NACT-UK
Acute trust DME
Lay representative

11 Collins J (2010)

2.3.2 The Better Training Better Care team members are:

Patrick Mitchell
Heather Murray
Susan Kennedy
India Peach
Megan Storey

2.4 GOVERNANCE

2.4.1 The Better Training sub-group will report directly to the Task and Finish Group, which reports directly to the Better Training Better Care Taskforce.

2.5 MEETING ARRANGEMENTS AND FREQUENCY

2.5.1 The group will meet as many times as required. The arrangements are to be confirmed at the first meeting of the sub-group. Members will be expected to lead on specific areas of work, which may include delivering workshops and engaging with stakeholders.

2.6 QUORUM

2.6.1 The quorum necessary for the transaction of the business of the Better Training sub-group is ten members, plus the chair.

2.6.2 Where a member is unable to attend a meeting, a nominated representative can deputise. Members are asked to inform the secretariat of their designated deputy.

3 BETTER CARE SUB-GROUP

3.1 INTRODUCTION

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

3.1.2 It has been developed at the request of the Secretary of State for Health to meet the aspirations, recommendations and key themes arising from Professor Sir John Temple's report, *Time for Training,*[12] Professor John Collin's review, *Foundation for Excellence,*[13] and related initiatives.

12 Temple J (2010)
13 Collins J (2010)

3.1.3 The Better Training Better Care taskforce agreed to establish a Broadening the Foundation Programme Task and Finish Group, which is part of Better Training Better Care Workstreams 4 and 7 (Foundation Programme delivery).

3.1.4 To support this work, two sub-groups have been established to deliver key components, reporting to the main Task and Finish Group.

3.1.5 The Better Training sub-group will focus on the educational aspects, and the Better Care sub-group will focus on issues affecting clinical service, and patient care and safety, both current and future.

3.2 SCOPE OF WORK

3.1.1 Better Care

- Take evidence from affected specialties as to the impact of these changes on both current Foundation Programme training and the delivery of clinical service.

- Provide guidance detailing good practice examples of ways of overcoming challenges, where clinical service has already adapted and adopted new ways of working to accommodate changing Foundation Programme placements.

- Offer recommendations on potential provision models and the ways in which transition to those models might be managed, in order that deaneries meet national targets regarding under-represented specialties.

- Provide best practice models and ideas for innovative, integrated approaches to community provision within the Foundation Programme that focus on community paediatrics and healthcare of the older person, particularly those who are mentally frail.

3.3 MEMBERSHIP

3.3.1 The proposed stakeholder representation is as follows:

NHS medical director
NHS chief operating officer/CEO
Royal College of Surgeons
Royal College of Physicians
Chief nurse
Current trainee
COPMeD
Royal College of Nursing or Nursing Directorate representative
SHA Director of Workforce/LETB representative

Clinical Commissioning Group
Clinical director - surgery
General Medical Council
Lay representative
NHS employers
Medical Schools Council
NHS Commissioning Board
A trust HR director

3.3.2 Better Training Better Care team members are:

Stuart Bell
Patrick Mitchell
Susan Kennedy
Anna Eastgate
India Peach
Heather Murray
Megan Storey

3.4 GOVERNANCE

3.4.1 The Better Care sub-group will report directly in to the Task and Finish Group, which reports directly into the Better Training Better Care Taskforce.

3.5 MEETING ARRANGEMENTS AND FREQUENCY

3.5.1 The group will meet as many times as required. The arrangements are to be confirmed at the first meeting of the sub-group.

3.6 QUORUM

3.6.1 The quorum necessary for the transaction of the business of the Better Care sub-group is 11 members, plus the chair.

3.6.2 Where a member is unable to attend a meeting, a nominated representative can deputise. Members are asked to inform the secretariat of their designated deputy.

Appendix 11: Definition of terms

It has been agreed that there needs to be an agreed definition of terms for the workstream and the final report. Where existing definitions exist and are widely in use, these have been provided. Some need discussion within the groups in order to finalise an agreed definition. The Task and Finish Group have asked that both groups discuss and complete those definitions highlighted.

Trainer

1. A trainer is an appropriately trained and experienced health or social care professional who has responsibility for the education and training of medical students and/or postgraduate medical trainees, which takes place in the clinical environment.

2. A trainer provides supervision appropriate to the competence and experience of the student/trainee and training environment. S/he is involved in and contributes to the learning culture and environment, provides feedback for learning and may have specific responsibility for appraisal and/or assessment.

Provider

Postgraduate education providers of placements as part of a programme, for example trusts, Health Boards or general practices. There should be an SLA or equivalent between LEPs and the deanery or commissioner of education.

Post

This is the term used to describe a single managed learning opportunity offered by an LEP. Depending on the length of the placement, a post provides two to three placements for two to three foundation doctors in any year.

Placement

A four to six-month managed training opportunity with defined learning outcomes and a named clinical supervisor.

Programme

A series of placements, grouped together, that make up either an F1 or F2 rotation, or a two-year Foundation Programme.

Contract

An education contract is provided through the foundation school, for the duration of the Foundation Programme.

A contract of employment is provided by the LEP for the duration of the period of employment, which could be for a placement, series of placements or programme.

Clinical supervisor[14]
A doctor who is selected and appropriately trained to be responsible for overseeing a specified foundation doctor's clinical work and training, and providing constructive feedback during a training placement.

Educational supervisor[15]
A registered and licensed medical practitioner who is selected and appropriately trained to be responsible for the overall supervision and management of a specified foundation doctor's educational progress, typically for a minimum of one year.

Supervision
Supervision can be delegated by the named clinical supervisor to wider members of the multi-disciplinary team. The named clinical supervisor is responsible and accountable for ensuring the wider members of the team have the competencies to deliver quality training and patient care.

Taster
A taster is a period of time, usually two to five days, spent in a specialty in which the foundation trainee has not previously worked. This enables the development of insight into the work of the specialty and promotes careers reflection.[16]

Community placement[17]
This is a four- to six-month placement with a named clinical supervisor, which is primarily based in a community setting such as general practice, community paediatrics, palliative care, public health or community psychiatry. The learning outcomes will typically include the care of the total patient, the care of patients with long-term conditions and the increasing role of community care.

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

14 Taken from The Foundation Programme Reference Guide, 2012, p84
15 Taken from The Foundation Programme Reference Guide, 2012, p84
16 UKFPO (March 2009), www.foundationprogramme.nhs.uk
17 Community-Experience in the Foundation Programme Reference Guide, 2012, p 35 is defined as: Community experience - The FP should equip foundation doctors with the skills they need to manage the whole patient. This includes assessing and managing patients with acute physical, long-term physical, mental health and multiple health conditions across different healthcare settings. As part of a balanced programme, this could be delivered by providing a placement in a community setting e.g. general practice, public health, palliative care, community paediatrics, psychiatry. In addition, a broader, 'community-facing' experience can also be provided for foundation doctors as part of hospital-based placements e.g. emergency department, outpatient clinics, community clinics, domiciliary visits.

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

Appendix 12: Case studies and focus groups

Case studies

- The aim was to recruit case study sites that could provide more detailed data in the areas sought.
- Case study sites were identified through members of the Broadening the Foundation Programme groups, through The King's Fund and through an online consultation exercise.
- Case studies were undertaken or overseen by an experienced researcher/ educationalist and a Senior Trust Liaison Manager on the Better Training Better Care Programme.
- The Better Training and Better Care sub-groups agreed a template for the areas of focus for interviews with case study participants. Those areas of focus were:
  - patient benefit/safety
  - supervision
  - unique/specific learning opportunities and outcomes
  - challenges in specific placements
  - the challenge of redistribution
  - the views/attitudes of training doctors towards different placements.

Focus groups

- Two focus groups were recruited, on a volunteer basis, through an associate dean and a Foundation Training Programme director in different regions.

- Participants were specifically to be asked about what they saw as the challenges and opportunities in any placements to whole patient and patient-centred care, but discussions were free ranging in order that qualitative data pertaining to various areas of focus could be gained.

- Focus group interviews were facilitated by an experienced qualitative researcher/ educationalist and a programme manager on behalf of the Better Training Better Care Programme.

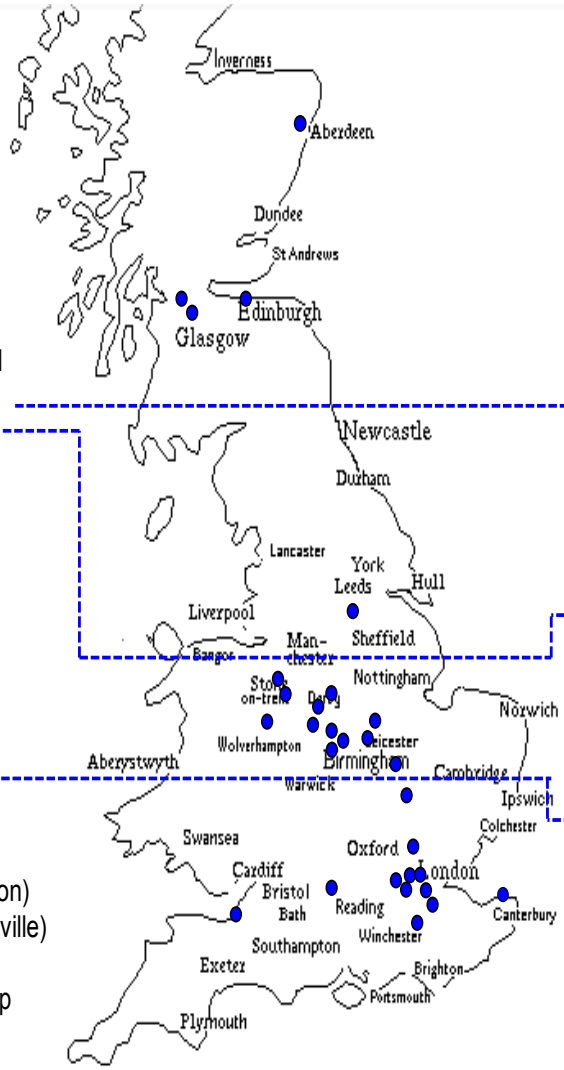
- With both case studies and focus groups, reflexivity and potential researcher bias were a consideration and interview notes were written up and presented in the agreed case study template for analysis and discussion by the Broadening the Foundation Programme groups.

Appendix 13: Physician associate posts in UK hospitals

Scotland
Aberdeen Royal Infirmary
Lothian University Hospital
Hairmyres Hospital: Lanarkshire
Golden Jubilee National Hospital

Midlands
B'ham & Solihull Mental Health
University Hospitals B'ham
Sandwell & W. B'ham Hospitals
Walsall Healthcare
Dudley Group of Hospitals
Mid Staffordshire
Shrewsbury & Telford Hosps

South & London
Weston Area Health (Somerset)
Great Western Hospitals (Swindon)
Bucks Healthcare (Stoke Mandeville)
Bedford Hospital
Royal National Orthopaedic Hosp
Surrey & Sussex Healthcare
NHS Trust (Redhill)



North
Wakefield Hospital

University Hospitals of Leicester
George Eliot Hospital
Royal Derby Hospital
Northampton General Hospital

St George's Healthcare
North West London Hospitals (Northwick Park)
Kingston Hospitals
Barnet & Chase Farm Hosps
Epsom & St Helier University Hosp
Kings College Hospital
East Kent Hospitals University NHS Trust (Margate)

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