North West of England Foundation School

Foundation Formal Teaching Guidance (2025)

Foundation Formal Teaching Programme

Advisory Notes for:

Foundation Programme Directors,

Foundation Programme Administrators,

Medical Education Managers,

Directors of Medical Education

Any colleagues involved in delivering Foundation teaching programmes

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1. Background

Foundation teaching programmes are compulsory and are intended to enrich the experiential learning that takes place in the clinical environment. Teaching programmes for Foundation year 1 (FY1) and Foundation year 2 (FY2) should be one weekly 4-hour session or one full day fortnightly. Regularity is crucial to the regular *culture* of each unit and to ensure everyone gets an opportunity to attend. It is accepted that teaching will not occur 52 weeks a year – there are times such as rotation dates and peak holiday periods, where other activities may take precedent. The minimum number of sessions possible during a 12 month is 40 half-day sessions or 20 full days, allowing for these considerations.

Attendance is mandatory. It is a requirement for satisfactory training and this needs to be understood by Foundation resident doctors and trainers, monitored by education staff and enforced by Foundation Program Directors (FPDs). The weekly timing of the teaching session must be timetabled in and agreed. All parties must accept and adhere to the timing. If part of departmental teaching is deemed 'essential', this should either be part of departmental induction or Foundation teaching so all can benefit. If unable to attend, residents must inform education staff of the reason. Poor attendance records will be considered at appraisal, against applications for study leave and ARCP/sign-off.

Both generic and speciality-based clinical teaching is needed for FY1 and FY2, with a variety of teaching methodologies to maintain learner engagement. Evaluation, feedback and evolution are essential. We advocate a *learning set* approach, where the cohort develop together, supporting each other along the way – it is not just about the teaching. Foundation resident doctors should be actively involved in the running and delivery of the teaching programme and should be consulted about the teaching programme to ensure relevance. They should have a consultative role – it remains the responsibility of the Foundation Programme to ensure delivery of teaching. The organisation and administration burden for delivering the programme should not rest with the residents. The teaching programme is something which should be delivered *with* the residents, not *to* them.

This document is issued to supplement the UK Foundation Programme Office (UKFPO) 2021 curriculum's 'Direct Training' guidance in establishing teaching standards for foundation resident doctors in the North West region. It is written for those involved in organising and delivering core foundation teaching, detailing regional policy and contains useful suggestions on what has worked well among trusts. This updated guidance incorporates the latest UKFPO curriculum requirements as well as a response to findings from surveys carried out amongst residents and trainers which require innovative changes. A number of changes have been made since the last guidance issued in 2017 so we recommend that you have a chance to review this document when planning sessions for foundation teaching.

2. National Guidance on Foundation Teaching

The UKFPO 2021 curriculum highlights the need for 'Direct training' or programmed educational activities for all resident doctors in order to complement experiential learning. Such training is done to fulfil hard to encounter curriculum requirements and should not be used to replace experiential learning, but rather to enrich it. Direct training must have clear objectives that are aligned with the curriculum, consisting of 'core' topics which are areas that have been identified by the UKFPO, alongside any relevant material as dictated by local preference.

Currently, foundation resident doctors are required to log a minimum of 60 hours of learning per year, with at least 30 hours of 'core' learning. This is the absolute minimum, below which sign-off should not occur. It is therefore the responsibility of local foundation teams to ensure that a resident has ample opportunities to attend these sessions to meet these requirements. Core foundation learning sessions can be used to better prepare residents for their professional development. There are several instances where formal teaching of the syllabus will be necessary, and these are shown in Figure 1 (on page 5).

Mental health including mental illness	*Integration of acute illness into chronic disease management and multiple comorbidities*
Health promotion and public health	*Teaching skills*
Simulation	*End of life care*
Leadership	*Patient safety*
Quality improvement methodology	*Frailty*
Appraisal of evidence	*Safeguarding*
Careers guidance	*Use of new technologies and digital agenda*
High risk prescribing	

Figure 1: List of topics as identified by the UKFPO curriculum for direct training.

It is advised that such sessions should be designed and delivered according to sound educational principles and carried out by those skilled in facilitating, ideally subject experts. However, the method of teaching as well as what content can be taught apart from the above topics is not specified and is left up to local foundation teams. More information on these individual topics can be found in the UKFPO 2021 curriculum, pages 80-90.

The GMC's *Promoting excellence* sets out the standards that are expected of organisations responsible for educating and training doctors in the UK to meet. It provides the framework for learners, educators and administrators in the delivery of postgraduate medical education. In particular, Domain 5 is clear that the requirements set out in the curriculum as well as that of the GMC's *Good Medical Practice* must be delivered and assessed, with all parties having joint responsibility, including employers, local faculty and residents. We recommend that you are familiar with this document.

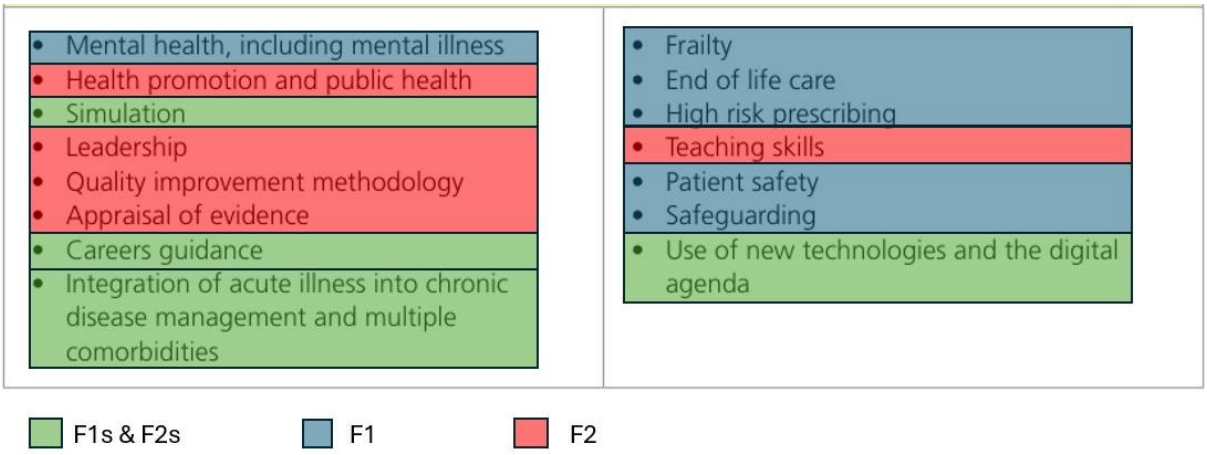

Figure 2: Suggested ways in which UKFPO topics could be distributed between FY1 and FY2 years,

3. Programme Format and Policy

There are important practical considerations when delivering effective teaching programmes. NHS England (North West) requirement is 4 hours of dedicated foundation teaching per week. Our experience is that this is best delivered as one full 4-hour session per week or one full day per fortnight. There are examples of two x 2-hour sessions working well, though tendency of late arrivals and early leaving are doubled.

Teaching programmes of less than a day per fortnight should not be organised. Given normal realistic attendance rates these make the minimum necessary delivery time unfeasible. Regularity is important, as infrequent, or irregular events can get overlooked by departments, and residents may not be able to attend sufficient sessions. Breaks should be regularly scheduled in, with a minimum interval of every 90 minutes recommended. It is also emphasised that the requirement for interactive learning methods is particularly important to maintain attention for a full day (more on methods later).

Foundation resident doctors will evidence longitudinal and spiral learning as the Higher Learning Outcomes (HLO) remain constant throughout the programme, but the level of knowledge required to demonstrate the objectives increases on progression from FY1 to FY2. FY1 teaching has always included strong clinical teaching as per GMC guidance. FY2 resident doctors also require clinical teaching, in keeping with the spiral curriculum concept, where areas are revisited in greater complexity at later levels of training. However, topics on vital non-clinical areas such as career development or leadership training should be included. Please see Appendix 1 and 2 which gives some ideas for teaching content.

Some will argue that ‘classroom’ teaching is not the way to train, and they will learn more in a theatre list/clinic/ward round. If we are honest, in practice this is mainly motivated by service pressures. Whilst the apprenticeship model has great merit, there is the other 90% of the working week to do this. One session i.e. 10% is not excessive for time out for reflection and directed learning in small groups. There is no ideal session of the week for everyone. Some clinical learning opportunities may be missed due to inability to be in two places simultaneously. The Foundation Programme Director (FPD) and foundation trainers need to act as a group to agree the timing of the teaching. Once agreed, all departments need to honour it, accept it and progress with it.

It is important to re-emphasise it is not just about the teaching. Foundation resident doctors working in disparate hospital specialities and in primary care have many common problems but would otherwise never see each other. There is a danger of isolation. The teaching is their chance to share problems as a group, network with their peers and solve housekeeping issues with education staff. They can unconsciously form their own ‘action learning sets’ and deliver their own generic skills training. For instance, the ‘Lessons Learnt’ programme that is seen widely in several North West trusts, is a perfect opportunity to schedule into these mandatory sessions, allowing for group reflection and resident-led teaching. It establishes their esprit de corps which is a very important consideration. They have this for FY1 and then they become independent practitioners, reviewing patients or discharging them, and they can be dispersed to unfamiliar parts of the hospital, or even to primary care – simultaneously the support system often falls away. It is not just about the teaching.

3.1. Attendance and Engagement with the Teaching Programme

Policy for Foundation Resident Doctors

Attendance is mandatory as the teaching programme forms part of the working week and the expectation is that resident doctor will attend, unless they are recorded as being on leave, on call, on nights, on zero days or detained by an occasional emergency. Residents may choose to attend on zero days and claim a day in lieu from their department, but this is discretionary. Minimum attendance rates are difficult to define. Once attained these may accidentally become the maximum. This should be monitored by the foundation education teams, analysed by resident and by placement, with feedback given to residents, trainers and departments.

If not able to attend and sign-in for any reason, residents must give prior notice to the FPD or Foundation Programme Administrator (FPA) of the reason. Poorly performing residents or placements will also be followed up by the FPD. Attendance should be 100%, unless there is a reason. Any unexplained absences should be chased up by the foundation education team and be fed back to trainers, resident, departments and FPD.

It is important to establish a culture of sending apologies and explanations if not attending. Email communication is mandatory – ensure residents give you a reliable address and that check their mail twice weekly. The excuse of 'I didn't get the message' is unacceptable. This needs to be explicit to residents from the outset. Emphasise the importance of communication at your first meeting and follow this up. Appendix 3 is a suggested e-mail to enforce this. Thank and encourage responders. Call in non-responders and leave them in no doubt that their inability to respond to a simple e-mail is unacceptable. Reliance on asking fellow resident colleagues to pass on messages is not appropriate or acceptable.

Many rota or shift arrangements make it difficult to attend all of teaching. FPDs and their colleagues need to make it clear from the outset that failure to attend for unsatisfactory reasons will jeopardise completion and sign off at the end of the attachment. The aspiration should be 100% attendance at sessions *they are able to attend*, just like ward rounds or other sessions. If FPDs do not take this seriously, nor will the residents or departments. Time management and diary keeping are skills the residents should take on board. Attendance should be considered during the annual ARCP process.

Foundation Resident Doctors – Non-attendance and ARCP

If a foundation resident doctor fails to give prior notice of non-attendance at the teaching programme, or turns up late / leaves early, this will be noted as Time out of Foundation Training (TOFT) and will be required to be declared on the Form R at the end of the training year. This will then form part of the review of progress at the Annual Review of Competence Progression (ARCP). The ARCP panel judgment will include review of any concerns or attendance issues which have been submitted by the residents via the Form R, or which have been noted in entries on the portfolio by the FPD/FPA. The panel will then decide whether the doctor has completed all the requirements of the training programme for that year.

Failure to meet the expected requirements of attendance at the teaching programme may result in an extension of training time.

Policy for departments

Departments should be mandated to release residents to all teaching unless on call. Some departments and specialities have made this difficult for foundation resident doctors. This attitude can percolate quickly down from Consultants to SpRs and nursing staff, making the culture of nonattendance acceptable. Occasional emergencies will arise which cause late or nonattendance, but repeated failures are simply due to this culture or lack of planning. The FPD needs to be clear with departments that release of residents for teaching is mandatory. Not to do this should jeopardise their continued presence in that unit. FY1 and FY2 duties can be covered, if given sufficient priority, by other grades or other disciplines, and vice versa.

Some departments may be reluctant to release ‘their’ residents for foundation teaching, especially if it competes with the departmental teaching. This misses the simple point that foundation resident doctors are not speciality resident doctors and have their own curriculum. There is no reason why residents cannot attend both foundation and departmental teaching if they do not coincide. If they can only attend one, they must attend foundation teaching, if they can attend more that is laudable. If there are concerns that missing departmental teaching risks safety, the simple solution is to weave this training into foundation teaching so that everyone can benefit. There are several successful examples of both in the North West.

Protected time

Foundation teaching is protected time where the only purpose during that time is for residents to attend these sessions. As such, it must not be influenced by clinical duties. There should be a clearly defined bleep policy in the Trust. The best way to achieve this is to hand bleeps in/turn off bleeps during teaching. Residents should have their bleep covered by another colleague of a different grade/discipline whilst attending a teaching session. Mobile phones should ideally also be switched off for the duration of the teaching.

3.2. Cancellation and Rescheduling Policy

We accept that there are occasional situations when teaching may need to be cancelled - such as trainer sickness/change of circumstances, industrial action, lack of venue or trust clinical pressures. Discussion with the Postgraduate Dean or representative (Deputy Dean for the School) is needed before cancelling. Cancelled teaching sessions should be rescheduled.

Winter pressures are part of life in the NHS and place considerable systemic pressure on trusts; however, these should be accounted for, and contingency plans put in place on how to ensure foundation teaching is not disrupted. As an example, it would be reasonable to have a break from teaching across the Christmas period, at the discretion of the Trust.

3.3. Catch-up Content

To allow for those who were unable to attend due to rota based clinical commitments (night shifts, zero days, professional or study leave) or annual leave, the gold standard would be to record sessions and/or have a summary document/slide provided to residents with the permission from the facilitator. These can be organised into a secure online storage system such as OneDrive or sent directly by email to residents. The benefit of doing so is not only to provide an opportunity to learn for those who haven't attended, but also frees up residents from excessive notetaking and allows for reflection and consolidation of the material for those who attended. The resource can also be re-used the following year or even shared with other trusts in the region provided they are up to date and have permission granted by the author. Such material served us well during the pandemic, in the form of the ViPER system, hosted by the Preston programme.

3.4. Selection of Facilitators

The education teams must know who the tutors are. A database of them and their credentials should be kept. Whilst consultant doctors are recommended to lead these sessions, there are plenty of foundation resident doctors who would be more than happy to support these educational activities as part of their own training requirements. FPDs and local foundation teams are encouraged to reach out to departments and individuals in their local trust, who may be available to provide this teaching. *Foundation residents should be consulted about the teaching programme to ensure relevance. They should have a consultative role – it remains the responsibility of the Foundation Programme to ensure delivery of teaching. The organisation and administration burden for delivering the programme should not rest with the residents. The teaching programme is something which should be delivered with the foundation resident doctors, not to them.*

Furthermore, the value of peer and near-peer teaching should be recognised (as it is by the UKFPO curriculum) given their expertise in knowing what would be relevant to them at their stage of training but should not be the mainstream and ideally facilitated. Foundation resident doctors provide a huge resource and several trusts have indicated their own success in incorporating them. Those planning the sessions must ensure that teaching is provided in an appropriate manner and in most cases by those skilled in facilitating or who have previous experience. A generic guidance for teachers should be sent out to highlight what is expected of them, and how best to structure their session according to evidence-based educational principles.

It may be difficult to provide teaching on certain topics due to a lack of local expertise. Foundation departments are recommended to seek external speakers who may provide an enriching experience to a resident's educational development. Such speakers can be funded for using the study budget allowance that individual trusts get.

4. Delivery of Teaching

Foundation teaching should be delivered along sound principles of educational theory, and learner needs respected according to Maslow's hierarchy and adult learning theory. The learning environments should also conform to the standards laid down by the GMC's *Promoting Excellence*. The UKFPO has set out a syllabus for teaching which are meant to supplement experiential learning in the clinical environment. However, it cannot be fully relied upon to deliver the vital clinical teaching appropriate for foundation resident doctors (as highlighted by resident surveys) and as such, trusts are urged to implement clinical teaching alongside the UKFPO requirements.

4.1. Teaching Content

The list of topics supplied by the UKFPO are mandatory requirements, although mostly involve non-clinical subject areas which are crucial but often seen as less engaging by foundation resident doctors. There is no way around this, and their importance must be emphasised, however a balance can be achieved where residents can get clinical teaching relevant to doing their job which is particularly desirable for FY1s.

Apart from the aforementioned syllabus, the choice of what is taught is left to individual foundation teams as this will vary based on locally available resources. The UKFPO focusses on the development of generic capabilities as highlighted in their purpose statement: '*The doctor completing foundation training can deliver medical care with indirect supervision in areas covering generalist practice*'. It can therefore be extrapolated that exposure to the fundamentals of a variety of specialities would be appropriate in preparing for higher training. An example list of subjects can be found in Appendices 1 and 2.

Based on the success of some trusts in implementing an effective teaching programme, it may be beneficial to group similar topics and deliver 'themed' sessions such as a 'Cardiology' or 'Care of the elderly' day. This can provide structure; help consolidate information and make it easier to plan for. However, individual trusts might find timetabling such sessions together more difficult due to trainer availability and want to provide a more varied set of topics on the day.

Following on from the previous guidance, it is suggested in splitting the FY1 teaching programme into phases of induction, survival and developmental (Appendix 1). This helps to compartmentalise the process of learning in relation to their stage of training. For instance, certain topics such as ‘Prescribing’ or ‘Pain management’ may be beneficial earlier on, followed by more specialist topics. The opportunity exists to integrate the phases into 2-year programs with FY2. All teaching must be relevant and tailored to the level of the residents at the time which can be decided amongst local educators. Gaps can be timetabled in to allow for requested topics and foundation resident doctors should be seen as an important stakeholder in teaching delivery.

Previous guidance had also recommended repeating ‘mandatory’ topics to allow for all residents to access them. However, this has been seen to result in a reduction in the breadth of topics and repetitive content was highlighted as the main factor affecting engagement in teaching amongst residents in the North West (2023). It is therefore no longer encouraged and should ideally be mitigated with the use of catch-up content. However, we recognise that certain content such as inductions which may directly affect patient care should be repeated for individual residents if for some reason, they have missed it.

4.2. Teaching Techniques

Effective teaching must be at the correct stage of training and pitched at the right level. It needs to be centred on the patient experience where possible, interactive and engage the residents’ attention. Principles of instructional design such as Gagne’s 9 events or the ADDIE model could be utilised to appropriately plan a session.

A variety of delivery methods, not just set-piece lectures, should be used to ensure the teaching is effective. Where possible, teaching should be delivered in a **face-to-face scenario** over distant learning. Some topics may lend themselves to delivery by small group sessions, whilst others require e-learning or lectures.

Learning in facilitated small groups remains the ‘gold standard’. Lectures have their place but should not be exclusively relied upon. Residents have indicated that simulations and small group case-based discussions were seen as the most effective methods of teaching and

should therefore be encouraged. A variety of techniques should be employed to maintain attention, which would include:

- Small groups: Helps to teach reasoning and explore new topics in detail.
- Lectures: Useful in providing an overview for large groups
- Bespoke clinical activities e.g. ‘teaching clinics’
- IT based systems
- Video links to clinical areas e.g. operating theatre
- Simulation
- E-Learning
- Balint groups
- Practical skill sessions and Workshops

Many of these will be limited by technical issues and capacity of accommodation and faculty. Though resource-heavy, the use of simulation, role play, and actors is highly commended. Use of video can provide excellent feedback to residents.

Choice of suitable faculty is important. It may be difficult, for instance due to theatre work, to secure the highly-regarded involvement of senior surgeons in classroom teaching. SpRs or StRs may be entirely suitable alternatives. Choose tutors who are willing to have feedback and adjust their delivery appropriately.

Residents at all levels should present and FY2 residents should be involved in tutoring FY1s. There should be time built in to allow resident presentations and enough flexibility built in to allow speakers or topics requested by the residents. Local teams will deliver the sessions in whatever ways are appropriate and available to them, but two methods of training delivery deserve special mention – simulation and e-learning.

Simulation

Simulation is a broad topic. There are some, but rather few, areas of foundation teaching in where simulation is by far and away the best technique to use. These are mainly around situations which may occur relatively infrequently, but which have to be right at the first time of asking. CPR and ALS training is the exemplar of this which is especially more important now given that ALS training is no longer mandatory for foundation residents. It seems likely that this logic could be applied to a small number of other acute emergency situations, such prearrest conditions, critical care scenarios, shock, anaphylaxis, seizures and haemorrhage.

There are probably many areas which are currently covered by other teaching techniques, which *could* be covered well or better by simulation. If doing themed days, you could have theory taught in one session, and a simulation on that content in another session. The UKFPO curriculum (page 83) provides a useful list of topics that could be covered by simulation.

E-learning

There are many e-learning packages and several are designed for Foundation resident doctor training.
They vary in their format, content, degree of interaction and assessment of learning. As in all IT systems, poor educational design will not be rescued by the fact that it is on-line. Packages which freeze, loose data or seem irrelevant to the resident doctors will not be well received. The elearning for healthcare site (elfh) provides an approved range of courses, which can be linked to the Horus eportfolio.

e-Learning packages can be used as an easy way to deliver mandatory training, without tying up large numbers of staff. They can effectively deliver background learning in topics normally considered dry or uninspiring, which are nonetheless important and necessary, as well as an assessment of knowledge learned. Some induction topics are exemplars of this. The best interaction is gained by facilitated on-line discussions which allow asynchronous but effective dialogue despite modern shift working. This requires skilled, trained and dedicated facilitators.

4.3. Programme stakeholders

Whilst the appendices are a useful template, it is important to involve the residents in the planning of the teaching very early in the programme. Timetable gaps in the programme for planning and consultation sessions, which can also be useful for inserting requested topics at short notice. Whilst the suggestions may not always be feasible or appropriate, they may help guide FPAs/FPDs/DMEs and make the residents feel like they are being listened to. Residents should be represented on the Foundation Board (terms will vary from trust to trust) in the Health Economy.

Role of the Foundation Board in the Health Economy (or equivalent)

The Foundation Board should meet regularly to raise the profile and manage the foundation programme (including teaching) in the LEP. The Foundation Board should have representation from residents, senior trust members, patch associate dean and include medical education colleagues from the wider health economy including, but not exclusively mental health and GP specialties as members.

5. Feedback and Assessment

Foundation resident doctors are encouraged to map their attendance of these teaching sessions to the curriculum which would be particularly useful to evidence HLO 2 and 3 for the purpose of the ARCP. Whilst there are no summative components to the sessions, formative assessments are recommended to further reinforce learning.

Evaluation and feedback is an essential component of the teaching programme. This may be by verbal feedback in designated consultation sessions timetabled as part of the teaching. It may be by written feedback physical/online sheets, such as the one seen in appendix 4, and/or via the e-portfolio. There are successful examples of the provision of a completed evaluation form being used to confirm attendance at a session, but this should be weighed against the loss of anonymity. In theory, those aware of responder details should be independent, not being involved in organising the sessions. Feedback should guide future content and delivery, in consultation with the resident doctors.

Most residents will happily accept the need for structured feedback and persuasion will suffice for the majority. However, the need for feedback is absolute and sadly, compulsion may be needed for a few. The main levers for this would seem to be inclusion in satisfactory appraisal, applications for study leave and the ARCP/sign-off processes at the end of years 1 and 2. Residents need to understand that programmes cannot be run without this information.

The teaching programme itself should be evaluated, not just the individual elements of it. Appendix 5 suggests some indicators which Foundation teams can consider in the quality control of the teaching.

Appendix 1: FY1 teaching programme example

The teaching programme for FY1s has been broken down into phases, with each session grouped into themes were possible. Commonly encountered clinical presentations that a foundation resident should be expected to deal with could be taught early on, followed by more speciality-based topics or subject matters relating to personal and professional development. Topics in bold red are UKFPO requirements. The list of topics here is not exhaustive and can be organised as full days or split between half-days.

Induction (August)	August-December (Survival)	January-July (Developmental)
Health and safety	**Safeguarding**, **Patient safety** **TIPS-QI**	Lessons Learned Surgical day: Acute surgical conditions, Gen surg, Urology, Orthopaedics with BSS
Useful contact details, Exception/Incident reporting	Sepsis, infection control, antimicrobials, microbiology, fluid management, oxygen	Endocrinology day and diabetes, Insulin management
IT logins and **use of new digital technologies**	Geriatrics, **Frailty**, **Palliative care**, Pain management, Confusion	Communication skills, breaking bad news, handovers
UKFPO curriculum introduction, SDT, Horus	**High risk prescribing**, Drug interactions	**Psychiatry including mental health and illness**
Prescribing, Infection control	Cardiology/Cardiothoracics: ACS, Acute heart failure, AF, Cardiac arrest, ECG	Radiology, Pathology
Clinical placement info, Coreprocedures refresher	Respiratory: PE, Asthma, COPD, CAP	Advanced skills: Ultrasound cannulation, Ascitic tap, Lumbar puncture
'Asked To See Patient' course	Advanced Life Support skills	Gastroenterology
	Team building and Wellbeing	**Simulation** (Can be incorporated for most of the above)

Appendix 2: FY2 teaching programme example

FY2s may benefit more from more niche speciality-based topics as well as fundamental nonclinical areas. Career guidance is useful at this stage (or at the end of FY1) as they would be approaching the application season around this time. Quality improvement is a mandatory requirement for both FY1s and FY2s but is expected to be more robustly done for FY2s so a thorough explanation may be needed of the processed involved.

August-December (Career, professional development, clinical)	January-July (Developmental)
Career guidance (Application and interview tips)	Trauma management
Quality improvement day **TIPS - QI**	Paediatrics
Leadership skills	Obstetrics and Gynaecology
Community and **Public health** (including GP)	Neurology/Neurosurgery
Appraisal of evidence and research skills	Anaesthetics/ICU
Bespoke teaching	Renal medicine
Teaching skills	Dermatology, Ophthalmology, Rheumatology etc
Medical Law	Pathology, Microbiology
Simulation	ENT and Max Fax

Appendix 3

Suggested e-mail

(The tone is informal in keeping with the style of the author but this can be adapted to your own)

Subject: Welcome

Welcome to *(insert location here)* . It was nice to meet you all at Shadowing today.

Foundation Training is all about...

- the ill patient *in any setting* and
- generic skills, becoming a *professional*

My main role will be to guide you through the two year programme, which should equip you to take on your chosen career.

So to start with, and these are themes I may need to stress for a while, I need you to simply do two things...

(1) Turn up when you are supposed to, on time, and
(2) Communicate with me (especially if you are unable to do 1.above)

This is the first part of being a professional. If you do 1 and 2, all things are possible and you will have a rewarding time with us. We will get along just fine. We can adapt things to what you need and deal with any problems.

If you don't do these things, trust me you will definitely run into difficulties and we don't want that.

Please note that attendance at teaching is compulsory unless on nights, on leave or on call. Please also note your registration with the GMC will require my signature to certify you have been trained, which I cannot and will not provide if you do not attend training when you can.

The team here will be monitoring things and will help all the way. I will send you regular (or rather irregular, but plenty of them) e-mails so please don't hesitate to ask anything.

Please check your mail at least twice per week.

So let's test the system. **Please reply to this e-mail so I know the account is activated.**

Regards

(Name of FPD)
Foundation Program Director

Appendix 4

Example evaluation sheet

…….. Hospitals NHS Trust Department of Postgraduate Medical Education Foundation Training Session

Title: Facilitator: Date:

In order to continually monitor the success and improve the effectiveness of the training, we would like you to provide feedback on the session you have just attended: On a scale of 1-4, please indicate your satisfaction with the following:

	Low			High
General assessment of the session	1	2	3	4
How would you rate the facilitator/speaker	1	2	3	4
Was the content relevant to your needs?	1	2	3	4
How would you rate the knowledge learned?	1	2	3	4
Opportunity for interaction and participation	1	2	3	4

What information was missing that you would have liked presented?

……..……..……

Please list two examples of how you can apply what you have learned today to your job.

1. ……

2. ……

What other topics would help you to do your job better?

……

Thank you for taking the time to complete this assessment form. Please leave it in the room for collection, or leave in the Medical Education Office.

Appendix 5

Quality Control in Foundation Programme (LEP)

Sufficient amount - 4 hours of dedicated Foundation teaching per week Suitable format - one session weekly/day fortnightly/2x2 hours/other

Facility to hand in bleeps
Teaching bleep – free

Distribution of delivery methods – small group/lecture/workshops/multimedia
Back-up reference material – written or intranet How interactive was session?

Curriculum coverage

Evaluation of sessions – feedback from residents

Sessions cancelled due to teacher availability

Sessions repeated if training mandatory

Teaching programme – a standing agenda item on Foundation Board (Evidence Agenda & Minutes)

Teaching programmes included in annual report