UK Foundation Programme

UK Foundation Programme Curriculum 2021

Academy of Medical Royal Colleges

Northern Ireland mdta Medical & Dental Training Agency

GIG CYMRU NHS WALES Addysg a Gwella Iechyd Cymru (AaGIC) Health Education and Improvement Wales (HEIW)

NHS Education for Scotland

NHS Health Education England

Introduction

The Foundation Programme (FP) curriculum is the only part of the continuum of medical education common to all UK medical graduates. It ensures that newly qualified doctors have the opportunity to work and learn in the UK healthcare environment, where they will use their knowledge and skills to meet the needs of the population.

The programme is usually delivered over two years, although those working less than full time or requiring longer training for other reasons may take longer than two years to complete it.

New graduates from UK medical schools (and some from overseas) enter F1 as doctors via a national recruitment process with 'provisional' registration from the GMC. They progress through (usually) 3 x four-month placements in different healthcare settings, beginning on the first Wednesday in August. At the end of F1, assuming the foundation doctor (FD) successfully completes the requirements of the programme, they are eligible for 'full' GMC registration and progress to F2. On completion of F2, the FD is awarded the FPCC (Foundation Programme Certificate of Completion) and may progress to specialty or GP training, or work in other healthcare settings.

A number of international medical graduates (IMGs) also benefit from the programme, usually by entering at F2 level via a 'standalone' recruitment process.

As a result of their stage of training, most FDs have limited experience in the healthcare workplace and usually require considerable supervision and support, particularly in the early stages of their foundation training.

The FP is thus designed to build on the knowledge and skills, behaviours and attitudes gained in undergraduate training, allowing the doctor to develop their generic clinical and professional capabilities in a workplace environment that is supportive for the doctor and safe for the patient. It also provides a mechanism for assessing the FD's capabilities and behaviours, providing extra support if needed and, if necessary, preventing progression to higher levels of training.

The full Purpose Statement of the FP can be found here.
An introduction to the FP for the FD can be found here.
An introduction to the FP for educators/ trainers can be found here.

The FP must constantly evolve if it is to provide a useful introduction to the ever-changing landscape of medicine, equipping the doctor to work safely and effectively as part of the multidisciplinary caring team, acquire the skills needed to be able to develop in the evolving healthcare environment, and prepare for a successful, satisfying career. This 2021 iteration of the FP curriculum has been rewritten to meet the requirements of the GMC's 'Excellence by Design'. It builds upon, updates and streamlines previous successful and groundbreaking versions.

A summary of the changes can be found here.

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The Role of the Doctor

The role of the doctor as healer of the sick remains core to the practice of medicine. However, over time the practice of the doctor has changed, broadening to include the prevention of disease as well as advocacy for and partnership with our patients. The work we do is now based mostly on scientific evidence and the methods by which we care are in many cases clearly defined by established guidelines. With the development of clear pathways of care, many of the tasks formerly carried out solely by the doctor are now performed by any one of a number of other professionals. This has led to a blurring of professional boundaries but also helps to define what is specific about the role of the doctor.

The doctor, uniquely, is the healthcare professional who holds ultimate responsibility for the patient under their care, obtaining and analysing information regarding the patient's condition or that of the population for which they care, diagnosing and deciding, along with the patient(s) where possible, what is the best course of treatment, if any, to follow: prevention, cure, long-term control, palliation or none.

In many situations in which the doctor finds themselves, uncertainty will likely exist and it is the role of the doctor to understand this; to make decisions on care based on sound ethical principles using personal knowledge and skills, evidence and scientific training; and by consulting with colleagues or seniors where necessary, bearing in mind that the right course of action might be to deviate from the standard pathway, sometimes even to develop or trial new therapies and sometimes to do nothing but offer explanation and support.

Along with all healthcare professionals, to underpin their role the doctor must have a sound and up-to-date knowledge of the underlying scientific principles and approaches to medical care, an understanding of the professional responsibilities that make patient care paramount, the necessary skills for their role, and a willingness to share their knowledge with those practitioners and students alongside whom they discharge their professional responsibility.

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Theme 1: Purpose

The UK Foundation Programme is designed to support the transition from medical student to doctor. It thus covers a crucial stage in the medical training, marking:

- the acceptance of professional responsibility for the care of patients and their families/carers;
- the beginning of the doctor's working life as a qualified healthcare professional who will be a valued member of the multidisciplinary team, go on to provide leadership, and ultimately take overall responsibility for their patients' care;
- the start of the doctor's career as an independent, self-directed professional.

The Foundation Programme must therefore provide the opportunity for newly qualified doctors to deliver the care required to meet population healthcare needs in an environment that supports the doctor's development and protects patients. To achieve this, the programme places doctors in a series of complementary medical environments, including both acute and community settings where they work under supervision, to develop the generic capabilities that underpin the provision of both acute and long-term healthcare. In particular, they will learn the importance of integrating with the multidisciplinary team and of delivering patient-centred care. The use of varied placements offers the opportunity to acquire an essential knowledge of the breadth of modern healthcare and an understanding of the equal importance of physical, mental and sociocultural needs to health and wellbeing.

The FP is unique in that it is common to the majority of doctors entering postgraduate training in the United Kingdom. The programme thus has a role in ensuring an equitable standard of healthcare across all four nations, contributing to the ongoing development and modernisation of healthcare, and the training of doctors with the necessary capabilities to enter UK specialist training and meet the challenges of providing healthcare as it evolves. To ensure this, the FP curriculum is endorsed by the health departments of the four nations of the UK and supported by the Academy of Medical Royal Colleges.

The purpose of the UK FP is to establish the newly qualified doctor as:

1. an accountable, capable and compassionate clinician;
2. a valuable member of healthcare workforce and;
3. a professional, responsible for their own practice and portfolio development.

These form the three Higher Level Outcomes (HLOs) of the Foundation Programme.

The outcome of foundation training is to reach a level of practice at which the doctor completing the programme can be entrusted to deliver safe, compassionate care, with indirect supervision in areas covering generalist practice, and be prepared to develop more specialist skills. The doctor completing FP will also know how to make a useful contribution to the quality and development of healthcare, show the ability to work within a team, appreciate the breadth of medical practice, be able to care for their own wellbeing and understand how to plan a career.

To fulfil the requirements of the curriculum, the doctor is expected to deliver front line care on a day-to-day basis alongside other healthcare professionals, establishing them as a key member of the healthcare workforce and providing an important service to the population. The curriculum is designed to ensure doctors are trained and assessed to a common standard across the UK in posts distributed across a wide range of medical specialties, geographic locations and care settings.

The FP comprises two distinct levels:

F1: In supporting the doctor through this transition from undergraduate to postgraduate training, the F1 year builds on undergraduate values, behaviours, skills and knowledge by placing the newly qualified doctor in an environment where they are employed to provide patient care with the direct supervision needed for their level of experience. The length of F1 is currently set at one year by the GMC and the standard required for progression is entrustment to work safely in a supervised environment.

F2: The remainder of foundation training provides an opportunity to consolidate and build on the generic skills learnt in F1 and, importantly, to develop more independent practice, particularly decision-making skills and the ability to deal with the variability and uncertainty that is part of everyday clinical practice. Attainment of F2 capabilities is likely to take a minimum of one year.

In providing the necessary supervision, the Foundation Programme also provides an opportunity to identify doctors who are not fully prepared for the workforce, to provide them with remedial training and, where necessary, to ensure they do not progress further.

'This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.'

Theme 2: Governance and Strategic Support

2.1 Curriculum design

The Foundation Programme aims to develop generic capabilities and the term 'pluripotency' has been widely used to describe this, implying that the doctor completing FY2 will have the skills to enter any chosen UK training pathway. The level to which these generic capabilities are required is clearly defined in the purpose statement: "The doctor completing foundation training can deliver medical care with indirect supervision in areas covering generalist practice."

All UK graduates and many doctors entering the UK workforce from overseas pass through the FP, and the curriculum is designed to ensure doctors are trained and assessed to a common standard across the UK in posts distributed across a wide range of medical specialties, geographic locations and care settings.

The curriculum was developed by the **AoMRC Foundation Programme Committee** (AFPC), taking into account the views of a **wide variety of stakeholders**, including lay representatives and experts who considered the learning needs of doctors at this crucial stage in their training to ensure they are equipped with the appropriate knowledge, skills, behaviours and attitudes to deliver safe and effective frontline healthcare that meets the needs of the UK health service. The curriculum builds on the existing model that has proved to be **feasible, practical and sustainable** in terms of training and assessment, and has been developed with input from experts in curriculum design and **assessment**. There has also been consultation with **employers and service providers**.

In designing the curriculum, the committee has considered the diversity of the workforce, sought advice on **equality and diversity** from experts including the GMC, and worked closely with the UKFPO in attempts to reduce differential attainment.

More on curriculum design can be found here.
The timeline for the consultation can be found here.

Curriculum delivery will be monitored by the AFPC, via key stakeholders including the UKFPO, the GMC trainee survey and the e-portfolio to allow further refinement/development and ensure currency with appropriate reference to GMC requirements.

The committee, along with the UKFPO, will also monitor the impact of diversity and differential attainment among learners . This is discussed in more detail on **Theme 5** (Quality Assurance and Improvement).

2.2 The 'parity of mental health' and the importance of social wellbeing

During the consultation, a variety of stakeholders raised the vital importance of mental health training for today's medical workforce. Thus, in designing the curriculum, the committee has endeavoured to emphasise the importance of mental and social wellbeing on physical health and to **list explicitly the areas of mental health in which FDs should acquire knowledge and skills.**

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Theme 3: Programme of Learning

Modern medical practice is very broad, with multiple specialties and subspecialties. In the future, it is likely to become broader still with the development of techniques that are as yet unknown. The FP thus seeks to prepare the FD with a generic set of capabilities, although the programme will contain exposure to a variety of specialties and even subspecialties.

In providing training for a large number of doctors from widely varied backgrounds, the FP seeks to embrace the diversity of those undertaking the programme and to treat all fairly and equitably. Behaviour of any type, including speech or written words, whether private or public, that is likely to cause offence, or be unlawful itself, will not be tolerated and will be acted upon as appropriate.

The specific curriculum outcomes can be found here.

3.1 Educational Approach
3.2 Educational Methods
3.3 Recording Learning
3.4 Breadth of Experience
3.5 Critical Progression Points
3.6 Learning Outcomes
3.7 Standards for Educators
3.8 Feedback

The programme is based around the capabilities all doctors in postgraduate training must demonstrate, which are contained within the nine domains of the Generic Professional Capabilities (see list overleaf), published by the GMC, which form the basis of Good Medical Practice **https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf** and, for F1, encompass the GMC Outcomes for Provisionally Registered Doctors **https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-provisionally-registered-doctors**.

GMC Generic Professional Capabilities

Domain 1: Professional values and behaviours

Domain 2: Professional skills

- Practical skills
- Communication and interpersonal skills
- Dealing with complexity and uncertainty
- Clinical skills

Domain 3: Professional knowledge

- Professional requirements
- National legislative requirements
- The health service and healthcare system in the four countries

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team working

Domain 6: Capabilities in patient safety and quality improvement

- Patient safety
- Quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

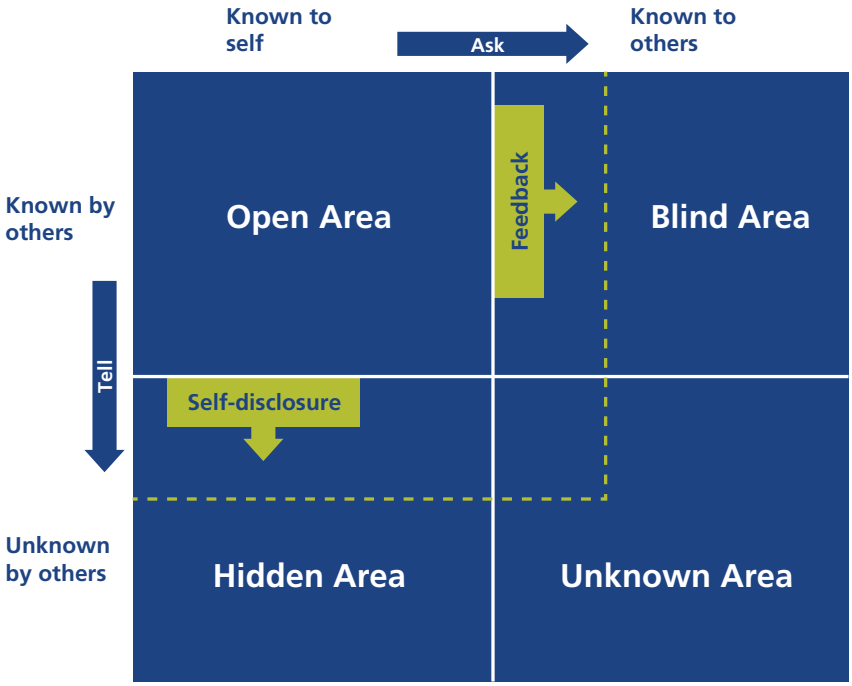
Domain 9: Capabilities in research and scholarship

3.1 Educational approach

In line with the purpose statement above and the generic learning outcomes expected, the educational approach taken in the Foundation Programme uses practical, experiential learning, augmented by direct training and supported by self-development, including reflection.

This fits into a simple, two-dimensional model of professional development that can be represented by an adaptation of the JoHari window (see diagram below) where the FD is encouraged to demonstrate (disclose) the required capabilities through their behaviour in the workplace and develop these by a process of reflection and further learning, augmented by the feedback of others.

More information on the JoHari window is found here.



The above two axes' approach to learning maps to the assessment process, whereby the FD demonstrates a readiness to progress at ARCP, based on capabilities demonstrated (disclosed) in their portfolio and augmented by the summative assessment of experienced educators.

More on assessment can be found here.

It is vital that FDs and those supervising them understand that the process requires a proactive approach from both learner and trainer and that development will not occur without an opportunity for the doctor in training to perform and reflect, and the supervisor to observe and provide feedback. Almost by definition, some of the feedback will reveal errors or weaknesses in the performance of the FD from time to time. FDs must be ready to accept this and act upon it, and those training them should be able to deliver it honestly and with sensitivity to the doctor receiving it.

More on feedback can be found here.

The importance of keeping a record of professional development activities and reflecting on them forms part of the GMC's Good Medical Practice, and the seeking of and reflection upon the feedback of others are the cornerstones of strengthened medical appraisal, required of doctors at all levels and in all roles by the GMC in order to demonstrate ongoing fitness to practise.

The importance of reflection is discussed here.

In line with this, the FP seeks to instill the process of reflection through the creation of a 'narrative', cataloguing the FD's journey through the programme, and reflecting on strengths and weaknesses to facilitate self-development. This process allows the FD to celebrate excellence and identify areas for development.

Within the Foundation Programme, the record of practice is maintained within the foundation e-portfolio through input from the foundation doctor, workplace colleagues and supervisors, and this is submitted at the end of each training year for review at the ARCP in the same way as doctors at all levels of medical training.

More information on recording learning can be found here.

When considering the evidence submitted to the ARCP, the demonstration of capabilities via behaviour in the workplace is considered the most important kind of evidence (equating with 'does' in Miller's Pyramid), with evidence from other sources being considered when this is not available.

Miller's Pyramid is explained here.

Although this process is used widely in training in the UK, some FDs will be unfamiliar with the method and it is the responsibility of those supervising them to ensure they understand the process.

More about supervision and the performance of educators can be found here.

3.2 Educational methods

To develop the FD, the FP uses a blend of:

a) experiential learning,

b) direct training,

c) self-development.

These align approximately with the hierarchy of evidence required by the ARCP, the most important of which is experiential learning.

The hierarchy of evidence can be found here.

(Note the term 'service-based learning' is sometimes used as an alternative, but the FP prefers experiential learning as it implies the full experience of the placement rather than simply the service element.)

More on service-based learning can be found here.

a) Experiential learning

In order for FDs to gain generic skills, the FP places them in a sequence of working environments under a level of supervision appropriate to their abilities. Programmes are planned to ensure exposure to environments that provide a significant range of experience in different settings conducive to acquiring the curriculum outcomes.

Most placements should involve significant patient contact in a manner that is patient-focused rather than task-focused.

The outcomes of the curriculum cannot be met purely through patient-facing activities. To achieve the other outcomes of the curriculum, the placements must offer an opportunity to undertake non-patient facing activities that allow the FD to demonstrate the capabilities of Higher Level Outcomes 2 and 3.

Examples of non-patient facing activities that should be provided by the majority of foundation placements can be found here.

All placements must conform to the standard required by the GMC in Promoting Excellence. https://**www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715_pdf-61939165.pdf**

Good experiential learning can only be achieved with good educational support and it is vital that, as the FD undertakes experiential learning, they have an opportunity to demonstrate (disclose) skills and to receive feedback from competent professionals. With current arrangements of service often provided by large teams splitting work across shifts, those supervising FDs will often change regularly, meaning that ongoing supervision can become fragmented. Similar issues can arise in community and primary care settings.

This places significant emphasis on the FD to take responsibility for, and a proactive approach towards, their learning on a day-to-day basis, and on the educational supervisor to guide and support them. It also requires all healthcare professionals who work alongside the FD to understand their capabilities and provide feedback on their performance both formally and informally.

More information on the expected levels of performance of medical educators can be found here.

Feedback should be formative, although, in the interests of patient safety, summative judgements of performance may occasionally need to be made at an early stage in an FD's progress through the programme. In a good educational environment, regular feedback should be routine, but some of it will need to be recorded in the doctor's portfolio as an SLE so that it can be used as evidence of progress against curriculum capabilities.

More information on feedback can be found here.
More information on SLEs can be found here.

By providing direct feedback on behaviour in the workplace, such evidence provides the highest level of personal evidence, i.e. 'does'.

The hierarchy of evidence can be found here.

Alongside the FD's own portfolio of evidence, gathered through experiential learning, the FD will be assessed by the healthcare professionals and educators who they work with.

More information on assessment can be found here.

A word about 'service-based learning'	Important non-patient facing activities
This term is frequently used in postgraduate medical training and is based loosely on the traditional apprenticeship model of medical training, although it is not clearly defined and the curriculum uses the term 'experiential learning'. The term 'service learning' is widely used in education to mean a form of experiential learning in which learners gain benefit from their interaction with the community they serve, and thus it fits to some degree with the experiential learning of the Foundation Programme. The term 'service' also risks a focus on 'getting the job done' and thus detracting from the broader range of activities that the FD must undertake to cover the breadth of the FP curriculum. Examples of important non-patient facing activities that are undertaken by the multiprofessional team, which should, where possible, involve the FD, are listed in the adjacent column. There is also a risk that 'service' can become task-based rather than patient-focused – something that potentially reduces the value of learning opportunities by stripping them of context.	Although the most important aim of the FP is to allow the FD to gain broad experience in direct patient care, there are a multitude of professional activities undertaken by the multiprofessional team, many of which are vital to the provision of safe professional care and continuing professional development. Though not directly patient facing, these fall within the role of 'service provision': • Departmental teaching sessions • M&M and peer review meetings • Journal clubs • Grand rounds • Schwartz rounds • Balint groups • Multiprofessional meetings, including practice meetings and those with social care. Where these are of direct educational value to the FD, they should be logged as 'non-core learning' with a brief note to justify their inclusion where this is not self-evident. (NB: The FD is required to log 60 hours of learning at each level of training, of which up to 30 hours can be 'non-core learning'.)

b) Direct training

Even across multiple placements, there will be parts of the curriculum that cannot be demonstrated by all FDs in the workplace. This may be because there are insufficient numbers of placements to accommodate all FDs in a given specialty where a practice is more common, or because desired outcomes are not yet embedded widely across the healthcare system and FDs will not necessarily encounter them in their everyday practice. Where curriculum requirements cannot be met by experiential learning, they can be fulfilled by evidence of learning in formal sessions, and LEPs must make provision for this training to ensure their FDs can satisfactorily complete the curriculum.

Currently, FDs are required to log a minimum of 30 hours of such 'core' learning.

The curriculum lists topics that should be covered in the core teaching programme unless LEPs can clearly show that they are embedded within the experiential learning of placements.

Such core training sessions that should be delivered are listed below.

Other core sessions can be composed of material relevant to the curriculum, as dictated by local preference and, ideally, with the involvement of FDs in planning the sessions.

This direct training must be delivered alongside experiential learning to better prepare the FD for their experiential learning and to enrich it. However, such training should not replace experiential learning, and those planning programmes must weigh the value they provide against the need to remove the FD from the primary (experiential) training environment. In line with educational principles, direct training must have clear objectives that align with the FP curriculum and be delivered in a modality that is appropriate to those goals.

A guide to the educational principles underlying good training can be found below.

By performing in simulation or interacting in training, the FD can provide evidence on the second level of the hierarchy of evidence, i.e. 'shows'.

The hierarchy of evidence can be found here.

Core Foundation learning sessions	Principles of education
Core Foundation learning sessions should be delivered alongside experiential learning at the LEP or Foundation School level and, as noted above, can be used to better prepare the FD for their experiential learning and to enrich it. Although the curriculum is largely delivered through an experiential approach, there are a number of instances where formal teaching of areas of the syllabus will be necessary if they cannot be delivered to all FDs through experiential learning. At the time of publication, these are: • **Mental health including mental illness** • **Health promotion and public health** • **Simulation** • **Leadership** • **Quality improvement methodology** • **Appraisal of evidence** • **Careers guidance** • **Integration of acute illness into chronic disease management and multiple comorbidities** • **Frailty** • **End of life care** • **High-risk prescribing** • **Teaching skills** • **Patient safety** • **Safeguarding** • **Use of new technologies and the digital agenda** Such sessions should be delivered along sound Principles of Education (see adjacent column) but their method of delivery is not specified. For example, mental health capabilities may be taught in general practice or more formal 'core learning' sessions; genomics may be covered in a specific online learning module or by participation in a MOOC etc. Safeguarding may be taught as part of an employer's mandatory programme but TPDs should ensure that the full scope of issues covered encompasses current safeguarding requirements (e.g. modern slavery, human trafficking, female genital mutilation, 'county lines' etc.). The curriculum does include specific requirements for simulation. FDs are required to log at least 30 hours of such 'core' learning alongside their 30 hours of 'non-core' learning.	The training of FDs must be designed and delivered along sound educational principles, and the needs of FDs respected according to the principles of Maslow's hierarchy and 'adult' learning theory. Learning environments must conform to the standards laid down by the GMC's Promoting Excellence. Similar principles apply to direct training where it is used to augment and consolidate experiential learning. Those planning sessions, including 'Core Learning' must ensure that when direct training is provided it is carried out in an appropriate manner and by those skilled in facilitating, as well as, in most cases, by subject experts. Examples might include: • Lectures, including online sessions, to provide structure and overview for large groups, • Practical sessions to teach and drill skills, • Small group workshops to consolidate knowledge, teach reasoning and explore new topics in more detail, • Simulation teaching to develop complex practical skills, situational awareness and professional skills, including leadership and teamworking. – **Simulation scenarios for the FP can be found here.** • Open discussions, Balint groups and action learning sets to explore attitudes. The value of peer and near-peer teaching should also be recognised.

c) Self-development

Individuals learn in different ways and many models have been used to describe different approaches to learning and teaching (e.g. **Kolb's learning cycle**). However, to fully master a subject, individuals need to see the context of what they are learning and internalise the material, ideally by using the learning in practice to reinforce it. It is a myth that all FDs, as 'adult learners', can fully guide their own learning. It is the role of the supervisor to signpost the context and organisation of material and, to some degree, its relevance. However, internalisation can only be achieved by personal effort on the part of the FD.

Self-development will largely be self-directed but may be instigated at the suggestion of an educator or as the result of feedback. It may involve enhancing knowledge and exploring areas of interest. This sort of activity should be recorded in the e-portfolio as 'non-core' learning, mapped against the areas of the curriculum, with suitable evidence of that material being internalised through reflection on the learning.

By reading and recording learning, the doctor in training can provide evidence on the lowest level of the hierarchy of evidence, i.e. 'tells'. However, by putting this learning into practice and demonstrating (disclosing) the behaviours in line with the curriculum capabilities, the evidence will move up the hierarchy to 'does'.

The hierarchy of evidence can be found here.

3.3 Recording learning

The FP curriculum has three Higher Level Outcomes (HLOs) based on the GPCs. To complete the FP, the FD must provide evidence to the ARCP panel at the end of each training year to show they have achieved these outcomes. The Higher Level Outcomes state that the FD must have demonstrated that they are:

1) an accountable, capable and compassionate clinician;
2) a valuable member of the healthcare workforce and;
3) a professional, responsible for their own practice and portfolio development.

For convenience, the three Higher Level Outcomes are each divided into a number of capabilities (between three and five), known as Foundation Professional Capabilities (FPCs), that can be demonstrated by the FD via their actions/behaviour in the workplace, supported by evidence of learning both from formal training sessions ('shows') and personal study ('tells'). The number of pieces of evidence required is not specified. However, the e-portfolio will allow up to ten pieces of evidence to be linked to each FPC and the use of each piece of evidence up to three times. The requirement is to robustly demonstrate that they are ready to be entrusted at the next level of training.

Most of this evidence should be from the top of the hierarchy of evidence, i.e. demonstrating the capabilities in practice by behaviours in the workplace.

NB: Some evidence can be used for more than one capability.

The hierarchy of evidence

Those developing the curriculum felt strongly that, in the context of the purpose of FP, the best evidence to demonstrate the capabilities required of the curriculum was through appropriate behaviour in the workplace. If this were not possible then demonstrating the values, behaviours, skills and knowledge for some of the outcomes in simulated settings would be an acceptable alternative. In a small number of cases, and with adequate reference to clearly demonstrated attitudes and behaviours elsewhere, evidence of knowledge and understanding is acceptable.

This can be rendered simply by a hierarchy developed from **Miller's Pyramid**:

Does
Shows
Tells

This hierarchy maps approximately to the methods of learning:

Experiential
Direct training
Self-directed learning

When feedback (via SLEs) is used by FDs to demonstrate capability, that which comes from more senior professionals will carry more weight as evidence than that from less experienced colleagues, and FDs must present evidence from consultants and other senior professionals within their e-portfolio for consideration at ARCP.

Evidence at the top of the hierarchy ('does') is expected to form the vast majority of that which is provided to support the capabilities listed under HLO 1 (accountable, capable and compassionate doctor), and would be expected to provide a significant amount of that required for HLO 2 (a valuable member of the healthcare workforce). However, demonstration of HLO 3 (a professional responsible for their own practice and portfolio development) may, aside from the provision of a portfolio, be largely evidenced by teaching records, particularly the 'core' teaching and, perhaps, by reflection.

The evidence provided by the FD in their e-portfolio will be triangulated with reports from supervisors and that obtained via multisource feedback ("TAB") and from the Placement Supervision Group (PSG).

Reflection

The GMC states that:

> Medicine is a lifelong journey, immensely rich, scientifically complex and constantly developing. It is characterised by positive, fulfilling experiences and feedback, but also involves uncertainty and the emotional intensity of supporting colleagues and patients.
>
> Reflecting on these experiences is vital to personal wellbeing and development, and to improving the quality of patient care. Experiences, good and bad, have learning for the individuals involved and for the wider system.

https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/the-reflective-practitioner---guidance-for-doctors-and-medical-students

The FP endorses the importance of reflection by FDs as a means of internalising learning and improving the care they provide to their patients.

Reflection can be carried out in a number of ways and some evidence of this should be recorded in the e-portfolio.

Further advice on reflection can be found on the UKFPO website.

The AoMRC has produced a toolkit on reflective practice:
http://www.aomrc.org.uk/wp-content/uploads/2018/08/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf

Although FDs are encouraged to record reflection on individual events, the main form of reflection required by FDs is a 'summary narrative', providing insight into their progress and areas for future development.

More about this is can be found in the 'assessment' section.

3.4 Breadth of experience

As noted previously, the purpose of the FP is to establish the FD as an accountable, capable and compassionate clinician within the multiprofessional team, and as an independent professional in their own right. The curriculum is thus about establishing generic and transferable capabilities rather than specific skills.

Most FP rotations will take the form of 6 x four-month placements although, where other formats have proved successful or appear promising, alternative approaches may be approved by the FSD. This allows the FD to experience a small but significant variety of medical environments. Programmes must be planned to ensure that an FD has exposure to environments that are conducive to achieving the curriculum outcomes and will therefore, by necessity, include experience in recognising and managing mental health conditions as well as some exposure to community-based medicine and to health promotion.

Placements involved in the training of FDs must conform to the standards laid out by the GMC in Promoting Excellence: **https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence**.

3.5 Critical progression points

There are only two progression points in the FP:

- Completion of F1, allowing application for full registration with the GMC and progress to F2 training,
- Completion of F2, allowing the FD to access specialty or GP training.

F1

In F1 training, the FD will require close and often direct supervision when making decisions around patient management and may have some limitations placed on their practice around prescribing, use of the Mental Health Act, and transfer of care from one location to another. To progress, the F1 must demonstrate behaviours consistent with the outcomes of the curriculum at the level where they can be entrusted to work safely with less direct supervision, starting to take responsibility for making routine day-to-day decisions around patient management in non-specialist medical environments. This implies a readiness to begin to take decisions with an understanding of the variability and uncertainty of clinical practice, and therefore to recognise situations where more senior support is required.

The breadth and depth of experience required for completion of the programme will not be expected of the F1 doctor.

The GMC stipulates that to obtain full registration the F1 doctor must have completed one year of training.

The UKFPO currently specifies that to complete F1 the FD must pass the Prescribing Safety Assessment.

As with other levels of training, readiness for progression will be made by assessment of evidence in the e-portfolio at the ARCP.

F2

To satisfactorily complete F2, the FD must demonstrate behaviours consistent with the outcomes of the curriculum at the level where they can be entrusted to work safely with indirect supervision in non-specialist medical environments, leading care on a day-to-day basis, recognising and understanding the context and variability of clinical presentations.

Evidence that the outcomes have been achieved and the Foundation Professional Capabilities (FPCs) demonstrated is provided using a portfolio of evidence supported by summative evidence from established healthcare professionals who provide reports on clinical and professional behaviours demonstrated by the FD in the workplace.

The syllabus covering the Higher Level Outcomes (HLOs) and FPCs can be found here.

The level of performance expected in order to complete foundation training is where the doctor can be entrusted to deliver safe, compassionate care with indirect supervision in areas covering generalist practice, and is prepared to develop more specialist skills.

The doctor completing FP will also know how to make a useful contribution to the quality and development of healthcare, show the ability to work within a team, appreciate the breadth of medical practice, be able to care for their own wellbeing and understand how to plan a career.

Table 1. Summary of the Dreyfus model of skills acquisition

The Dreyfus model is an educational model that gives a summary overview of progression from novice to expert. In terms of overall practice, particularly in 'generalist' clinical areas, it is likely that the doctor completing F2 will demonstrate an overall level of practice that can be described by this model as 'competent'. In some areas, particularly in the management of less common conditions in the 'generalist' arena where they have limited experience, they may remain at the 'advanced beginner' stage. In specialist areas, where the FD has no experience, it is likely they will remain a 'novice'. In other areas, where the FD has gained significant exposure to practice and in the management of common 'generalist' medical conditions, it is possible that FDs will be beginning to show 'proficient' practice.

Level 1: novice
- Rigid adherence to taught rules or plans
- Little situational perception
- No discretionary judgement

Level 2: advanced beginner
- Guidelines for action based on attributes or aspects (global characteristics of situations recognisable only after some prior experience)
- Situational perception still limited
- All attributes and aspects are treated separately and given equal importance

Level 3: competent
- Coping with crowdedness
- Now sees actions at least partly in terms of longer term goals
- Conscious deliberate planning
- Standardised and routine procedures

Level 4: proficient
- Sees situations holistically rather than in terms of individual aspects (see above)
- Sees what is most important in a situation
- Perceives deviations from the normal pattern
- Decision-making less laboured
- Uses maxims (whose meaning varies according to the situation) for guidance

Level 5: expert
- No longer predominantly reliant on rules, guidelines or maxims
- Intuitive grasp of situations based on deep tacit understanding
- Analytic approaches used only in novel situation or when problems occur
- Vision of what is possible

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

3.6 Higher Level Outcomes and the Foundation Professional Capabilities

To successfully complete the UKFP, the FD will be able to demonstrate that they are:

1. An accountable, capable and compassionate doctor,
2. A valuable member of the healthcare workforce,
3. A professional, responsible for their own practice and portfolio development.

These will be demonstrated by behaviour in the workplace and training programme, in line with the 13 Foundation Professional Capabilities (FPCs). A summary of the FPCs is given below and **examples of behaviours that demonstrate the FPCs can be found here.**

While the programme can be considered a two-stage programme with two critical progression points, FDs will evidence longitudinal and spiral learning as the HLOs remain constant throughout the programme, although the level to which the FPCs must be demonstrated increases.

Successful completion of F1 marks the successful transition from student to fully registered doctor, while the F2 year is designed to build on F1 learning and encourage excellence, the development of clinical knowledge and skills, and to support the FD to become an independent professional and conscientious lifelong learner.

The doctor is not expected to demonstrate every example of behaviour listed under each FPC (except for the life support requirements*) but must demonstrate that capability in a positive way. It is possible that, in some placements, the FD will have a very limited opportunity to demonstrate one or more of the FPCs. This should not affect progress, but where performance does not give a clear indication that the behaviour has been demonstrated when it should have been, or indicates that undesirable behaviours have been observed, then this should be addressed. In a specific placement, it is the role of the clinical supervisor to address failure to demonstrate expected behaviours by providing feedback to the FD and, where this may impact on overall progress against the HLOs, to record this information in the e-portfolio. It is the role of the ES, with support from the FTPD, to decide whether all the FPCs have been sufficiently demonstrated in the overall context of the training year. Failure to satisfactorily demonstrate all the FPCs over the training year, or the demonstration of repeated undesirable behaviours, should trigger an extension to training or, in some cases, termination of training. A similar consideration may be warranted even if such behaviour has not been repeated but has been very significant (for example, if the FD has received a written warning from the employing organisation or has been directly involved in an incident where they have been shown to have acted carelessly or dishonestly).

Extensions to training may also be required to allow completion of curriculum requirements for other reasons, such as time out of training for health reasons.

* Where an FD cannot physically perform a certain skill, those assessing it should consider whether reasonable adjustments should be made and the FD allowed to explain the process.

The 13 Foundation Professional Capabilities

HLO 1: An accountable, capable and compassionate doctor

1. **Clinical assessment:** assess patient needs in a variety of clinical settings including acute, non-acute and community.
2. **Clinical prioritisation:** recognise and, where appropriate, initiate urgent treatment of deterioration in physical and mental health.
3. **Holistic planning:** diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient.
4. **Communication and care:** provide clear explanations to patients/carers, agree a plan and deliver healthcare advice and treatment where appropriate.
5. **Continuity of care:** contribute to safe ongoing care, both in and out of hours.

HLO 2: A valuable member of healthcare workforce

6. **Sharing the vision:** work confidently within the multiprofessional team and, where appropriate, guide the team to deliver a consistently high standard of patient care based on sound ethical principles.
7. **Fitness for practise:** develop the skills necessary to manage own personal wellbeing.
8. **Upholding values:** act as a responsible employee, including speaking up when others do not act in accordance with the values of the healthcare system.
9. **Quality improvement:** take an active part in processes to improve the quality of care.
10. **Teaching the teacher:** teach and present effectively.

HLO 3: A professional, responsible for their own practice and portfolio development

11. **Ethics and law:** demonstrate professional practice in line with the curriculum, GMC and other statutory requirements, through development of a professional portfolio.
12. **Continuing professional development:** develop practice, including the acquisition of new knowledge and skills through experiential learning; acceptance of feedback and, if necessary, remediation; reading and, if appropriate, through research.
13. **Understanding medicine:** understand the breadth of medical practice and plan a career.

3.7 Levels of performance of educators

The standards for foundation training are laid out in the **Guide for Foundation Training in the UK**, which defines the roles of educational and clinical supervisors. Broadly speaking, the ES takes responsibility for the FD's overall progression through one or more training years, while the named CS is responsible for training within a specific placement. In some areas, different titles are used for these roles.

The ES must be a medical professional and must be recognised in that role by the GMC. To maintain professional credibility and competence in this role, the ES must undertake CPD that is aligned to the supervision of FDs and, in line with the 'pluripotential' nature of foundation training, should have an understanding of the breadth of medicine. The ES is expected to be accessible and approachable, should meet the FD on a regular basis, and should aim to inspire excellence in the FD they supervise.

In the vast majority of placements, the CS will also be medically qualified and thus subject to the same form of recognition by the GMC as the ES. Where the CS is not medically qualified (e.g. in certain public health placements), it is the responsibility of the local FTPD to ensure the CS has the required skills comparable to those laid down by the **Academy of Medical Educators and adopted by the GMC**.

It is the role of the CS to guide the FD's development within an individual placement. At the very minimum, the CS must meet with the FD formally at the start and at the end of a placement, and at a point part way through the placement to review progress and provide feedback. Where only this minimum standard is met, the CS must ensure that other suitably experienced educators are available to provide support and feedback to the trainee during the placement.

GPs who undertake these roles may do so at the discretion of the FTPD but must receive an induction into the role, demonstrate ongoing CPD in the supervision of FDs, and be familiar with the FP curriculum.

All those supervising FDs must be up to date with equality and diversity training and **undergo training that raises awareness of differential attainment in some groups of the FDs they supervise, and must seek to reduce unconscious bias.** They must also be aware that some FDs, particularly those who have trained outside the UK system, may be unfamiliar with the training system in the UK and that FDs from differing backgrounds (including some of those that entered their medical training via widening participation schemes) or with certain health needs may need additional support with certain parts of the training programme. Supervisors should actively seek to support these groups and consider additional face-to-face meetings to ensure they are progressing against the curriculum.

It is widely recognised that a variety of professionals contribute to the supervision of FDs on a day-to-day basis (workplace supervisors). These include prescribing pharmacists, nurse practitioners, senior nurses, more senior trainees and doctors who are not recognised trainers. These individuals are recognised as professionally capable and competent by their professional qualifications and registration with their professional bodies. FDs can learn significantly from these professionals and should value the training they receive from them. However, at all times on shift, the FD must be responsible to a nominated consultant and should know how to contact them. In general practice, this will be the GP who is supervising them.

All supervisors should be familiar with the principles of good supervision and training, e.g.:

HEE **Enhancing Supervision**
HEIW **Support for Trainers**
NES **Scottish Trainer Framework**
NIMDTA **Recognition and Approval of Trainers**

Those supervising FDs should be sensitive to the specific needs of newly qualified doctors, recognising their limited experience and the role of the FP in supporting the transition from UG to PG training. In particular:

- FDs will not necessarily be familiar with experiential learning in the context of service provision and will, despite exposure to the working environment in apprenticeships and shadowing, be naïve in certain areas that established professionals take for granted. This may be particularly true of IMGs.

- Many FDs are, understandably, daunted by the professional responsibility of the PG role and many may face this new responsibility in a situation where they are working away from established support networks. Shift working may also undermine their resilience and lead to fragmented contact with supervisors and colleagues. Furthermore, some FDs will, because of placement on sites away from the main Trust/LEP or because of less than full time working, have less opportunity to develop peer or near-peer relationships in the workplace. Supervisors should thus be proactive in the offer of pastoral care to FDs.

- Educators used to a particular clinical specialty must remember the 'pluripotential' nature of foundation training, the need to guide FDs in the acquisition of generic professional skills, and the need to provide careers support.

More information on the role of the clinical supervisor (CS) in the FP can be found here.
More information on the role of the educational supervisor (ES) in the FP can be found here.

Educators and assessment

As well as providing supervision and support to FDs whom they supervise, those undertaking ES and CS roles will be required to provide summative judgement on the performance of the FD against the curriculum outcomes.

It is key to delivering feedback for learning and assessment that the assessors have an understanding and knowledge of the foundation curriculum and expected standards required at the two levels of training within the FP.

It is also vital that ES and CS reflect on their performance in both training and assessment and engage in strategies used by the LEP and deanery/local office to monitor these processes.

More on strategies to monitor performance can be found here.

Educators should particularly consider the impact of the training environment on differential attainment and, where necessary, seek to support FDs from differing backgrounds. Educators must strive to ensure that all FDs, regardless of any protected characteristics, their undergraduate institution or background, have full understanding of the educational requirements and assessment types of the FP. Current equality and diversity training is thus core to recognition of trainers, along with understanding of the curriculum and assessment processes.

More on the assessment strategies of the curriculum can be found here.
More detail on the curriculum for educators can be found here.

3.8 Feedback to learners

Good feedback is timely, accurate, honest, fair, specific, constructive, and should take into account the expected level of performance of the trainee.

Feedback must be delivered sensitively and should recognise cultural differences in the way it is delivered. However, it is vital that all doctors, whatever their background, understand the importance of the feedback process, and supervisors must make this explicit at introductory meetings.

Feedback should be given verbally as a regular part of day-to-day experiential learning, and is invaluable in this form as a measure of current-against-previous performance. Good feedback will include an action plan for future development that, in view of the FD's inexperience, should take the form of advice or 'directive feedback'.

Some feedback should be recorded in the e-portfolio as **SLEs using the relevant forms, or the generic LEARN form** to be used as evidence of learning. Such feedback encounters would generally occur in private to provide the FD an opportunity to reflect on the encounter and the feedback itself, and to ask questions if needed. It should be noted, however, that the feedback conversation is often more detailed and nuanced than the written record, and the encounter is therefore likely to be more useful to the FD than the written record in terms of professional development.

Advice on feedback can be found at **https://www.aomrc.org.uk/reports-guidance/improving-feedback-reflection-improve-learning-practical-guide-trainees-trainers/**.

More formal written feedback will be given at the end of each placement. This is obtained from the **Placement Supervision Group (PSG)** and collated in the CSR, and via multisource feedback (**Team Assessment of Behaviour** - TAB). This feedback will guide the summative judgement against curriculum outcomes.

In some cases, particularly where the FD's performance is poor, the feedback being given may be unsettling to the FD and lead to anger, upset or denial. In situations where this is likely, the use of a 'second' in the room (for one or both parties) is often considered good practice. However, the provision of this support should not significantly delay the delivery of important feedback, which should always follow the 'rules' of good feedback above. Timely, honest and constructive feedback is vital to the development of all those in training programmes and, for those who are required to show significant improvements in their practice, early feedback is particularly important to allow progress to be made without the need to extend the training period.

Supervised Learning Events (SLEs)

Supervised Learning Events (SLEs) have been used for some time in medical education. Their role in the FP is as a more formal way of recording feedback, and to allow it to be presented within the e-portfolio at ARCP as evidence to support the FD's progress against the curriculum. As such, the use of SLEs to demonstrate capabilities in the workplace is more valuable than simply demonstrating isolated skills or knowledge.

In FP, the following SLEs are used:

- **Mini-CEX** – mini clinical evaluation exercise: direct observation of the FD undertaking an interaction while at work on the ward;
- **CBD** – case-based discussion: the discussion of a case presentation after an (unobserved) encounter in the workplace environment;
- **DCT** – developing the clinical teacher: used for feedback on a formal teaching session or presentation the FD has delivered;
- **DOPS** – direct observation of procedural skills: completion of which should, ideally, include observation of the explanation to the patient of why the procedure is being performed, the process of consent including an understanding of complications, and technical capability of the procedure itself;
- **LEARN** – learning encounter and reflection note: a form for recording the above and other forms of evidence, such as performance in simulation;
- **LEADER** – for recording feedback following an event where the FD has used leadership skills.

An SLE should thus put the encounter recorded into context, providing feedback on the FD's understanding of the purpose of the encounter as well as information on how it was carried out. Isolated feedback relating solely to how the skill was performed fits largely into the 'shows' category of evidence, and feedback from a discussion of the case fits into the 'tells' category in the **hierarchy of evidence**.

It is therefore likely that most SLEs in the FD's portfolio will be from observation of clinical encounters either directly, such as obtaining a history, examining a patient (mini-CEX) or performing a procedure (DOPS). Some might include a discussion that reveals the FD's understanding of a patient episode, such as those that may occur in the outpatient clinic, morning surgery or post-take ward round (CBD).

It should be noted that some specialties use Workplace Based Assessments (WBAs), which have a similar format to SLEs, but SLEs are not assessments. However, a series of SLEs submitted by the FD as evidence against various FPCs that all suggest significant need for improvement in performance in the workplace would not provide evidence to support attainment of curriculum outcomes. On the other hand, evidence of improved performance after following the advice given by a supervisor would be powerful evidence to support not only the development of practice but also a professional approach.

In selecting SLEs to be used as evidence of capability against the curriculum, FDs can thus choose examples of good performance from among those documented in the e-portfolio but must draw on examples from practice across all the foundation year placements.

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Theme 4: Programme of Assessment

The purpose of assessment is to judge the learner's attainment of curriculum outcomes and, in the context of postgraduate medical training, assessments used must promote trust in the public that registered doctors have reached a required standard.

Assessment must: be able to identify when a learner has achieved the curriculum requirements; be fair, achievable, and proportionate; and discriminate those who have not achieved the required learning outcomes or behaviours who cannot progress to the next level of training.

4.1 Overview

The UK Foundation Curriculum is an outcomes-based curriculum with three Higher Level Outcomes (**HLOs**), as defined in the **Purpose Statement**, underpinned by 13 Foundation Professional Capabilities (**FPCs**). By the end of the two-year programme, the FD will be expected to have evidenced achievement of the HLOs by demonstrating knowledge and skills, behaviours and attitudes through a programme of assessment, which is detailed in this section of the curriculum.

The FP is a two-stage programme with **two critical progression points**. However, FDs will evidence longitudinal and spiral learning as the HLOs remain constant throughout the programme, although the level of performance required to demonstrate the FPCs increases on progression from F1 to F2.

Satisfactory completion of F1 confirms successful transition from student to a doctor who is eligible to apply for full GMC registration.

The F2 year is designed to build on the learning of F1 and encourage excellence, develop clinical knowledge and skills, and support the FD to become an independent professional and a valued and conscientious lifelong learner. The end of F2 is a critical progression point that will satisfy the FD's readiness to enter specialty or general practice training by demonstrating that they are ready to practise with indirect supervision in generalist areas of practice.

Successful completion of the two-year programme will result in achievement of the Foundation Programme Certificate of Completion (FPCC), which is a requirement for specialty and/or GP application.

As a consequence of the above, it is logical to assess the doctor according to the capabilities/behaviours they exhibit in the workplace, taking into account the professional judgements of established healthcare professionals to provide summative assessment that will be used at ARCP. This process is clearly established in the UKFP, and the proposed new curriculum will continue to reflect this.

All FDs should meet the same standard of assessment. However, deaneries/local offices may be required to make suitable adjustments to ensure that every FD can meet the HLOs, irrespective of their background or disability.

4.2 Programme of assessment

The principles of assessment are based on the same **educational approach** as the training programme, with evidence of capability against the 13 FPCs provided by the FD via the e-portfolio triangulated with feedback from those supervising/working alongside them.

Throughout the training year the FD will demonstrate learning and engagement with the programme by:

- undertaking and recording formative learning events;
- keeping a 'learning log' of core learning sessions attended, including simulation and, where required, performing to an acceptable standard;
- taking part in and recording other learning activities including non-core learning and self-directed learning;
- undertaking reflections including summary narratives;
- maintaining a contemporaneous e-portfolio, engaging with feedback on training and completing the necessary records for revalidation;
- providing feedback on the training programme;
- undertaking multisource feedback.

The F1 will provide evidence of completing the **Prescribing Safety Assessment** (PSA).

These formative learning events will be recorded in the e-portfolio and may then be mapped by the FD to the FPCs, which in turn will provide evidence of completion of the Higher Learning Outcomes.

Those supervising/working with the trainee will provide formative assessment/feedback in the form of:

- **Team Assessment of Behaviour** (TAB) - multisource feedback
- **Placement Supervision Group** (PSG) feedback

And summative assessment in the form of:

- **Clinical Supervisor Reports** (CSRs)
- **Educational Supervisor Reports** (ESRs)
- Records of additional meetings and discussions as necessary

The use of reports from experienced clinicians in supervisory roles is widely used as a process to make judgements on the progress of doctors in postgraduate training and has been used since the inception of the FP in 2004. There is evidence to show that the **TAB** and **PSG** add information to this process and, although they are largely used formatively, these assessments are also used as part of the ARCP processes.

Spread over a variety of healthcare settings and a variety of assessors, this approach of recording achievements by the FD and assessment by established healthcare professionals will allow a robust assessment of the FD's capabilities against the HLOs of the programme.

At the end of each level of training, the ES will provide a summary report to the ARCP panel (the ES end of year report). NB: In Scotland this role is taken on by the FTPD.

To ensure the assessment process is fair, it is vital that those training and assessing FDs have undergone recent equality and diversity training and are aware of the impact that protected characteristics, an FD's background and training arrangements can have on performance in the workplace and others' perception of that performance.

'Specialised' programmes

FDs work in a range of care settings, including primary and secondary care, community placements and academic medicine.

Foundation rotations vary in post content, and opportunities are available to some foundation doctors as additional incentives. These include opportunities such as fellowships in leadership, quality improvement, education etc. Research programmes, psychiatry fellowships and GP longitudinal programmes are examples of the variety of opportunities available within the UK Foundation programme.

Irrespective of the type of programme, the assessment strategy will be used for all foundation doctors.

FDs following all programmes will gather formative evidence that can be linked to the FPCs and used as evidence for completion of the HLOs at summative assessments. Using this outcomes-based curriculum and assessment strategy will allow every FD, irrespective of the rotations and incentives/ fellowships, to demonstrate their completion of foundation. This supports the pluripotency of the output of the UK Foundation programme. Specialised programmes are provided to 'add value' to the FP by encouraging the development of excellence in specific capabilities.

Reasonable adjustments

In some cases, reasonable adjustments to training programmes will be made under the GMC Guidance 'Welcomed and Valued' (**https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued**), and relevant national legislation. Where it has been considered appropriate to make these adjustments to support the training of doctors with disabilities, such adjustments should also be made to the assessment process. This is most likely to apply to doctors with physical disabilities who may be unable to complete certain practical skills. For example, the life support manoeuvres detailed in FPC2, or common 'ward-based' procedures such as those required to demonstrate FPC4. There is also the provision within the programme to grant extensions to training for those unable to complete the requirements in the usual timescale due to health problems.

It is outwith the scope of this document to identify specific adjustments that may be required. When considering adjustments to evidence in the curriculum it must be remembered that each FD must achieve the curriculum outcomes.

Differential attainment and widening access

The assessment process must be fair to all foundation doctors. Access to the UK Foundation Programme is from UK medical schools via undergraduate and graduate entry programs, including EU and non-EU graduates. However, the majority of FDs are from UK undergraduate programmes and will be thus be familiar with the concepts of reflective practice, supervision and feedback in the form of SLEs, and will have been assessed on common practical procedures.

Irrespective of their backgrounds, FDs should have information detailing the purpose of the formative learning events, how they should be performed and what they should expect from those who supervise them and provide feedback/ advice. Educational induction must therefore include training in completion of SLEs and other assessments (both summative and formative) to ensure all are familiar with the process and any standards required. Induction must also include use of the e-portfolio with clear guidance on recording progress within it. Extra support mechanisms must be in place to ensure that those who need additional training in assessment and use of the e-portfolio are not disadvantaged.

It is likely that the ES and CS may need to arrange additional meetings with FDs from non-UK backgrounds to ensure they understand the processes and the requirements.

To ensure all supervisors understand the needs of diverse FDs, they must all have undertaken recent E&D training, which should include the concept of unconscious bias.

Some curriculum outcomes may be evidenced by attendance at external courses, and the UKFP recognises the value of these in training FDs. They are also valued by trainees. All FDs should have equal opportunities to attend such courses and not be disadvantaged by costs or travelling distances. Equity of access to relevant and appropriate training opportunities must be considered and signposted to all foundation trainees.

Where simulation is used for learning and assessment it should be recognised that this form of learning may be unfamiliar to some FDs, particularly those who obtained their primary medical qualification outside the UK, and additional support and explanation may be required particularly with regard to the process and purpose of the debrief.

4.3 Formative learning and the e-portfolio

The educational approach described above requires the FD to record their learning in the e-portfolio. Much of this learning will be formative, allowing reflection. However, at the end of each training year, the FD will be required to present evidence of some of this learning to the ARCP panel to demonstrate performance against the curriculum outcomes.
There is no fixed number of pieces of evidence required for each FPC, as different FDs will have different opportunities and experiences. The requirement is only that the FD will provide sufficient evidence to demonstrate each of the FPCs.

Although SLEs undertaken in the workplace are formative and their presence in the e-portfolio is primarily for reflection, FDs will be expected to choose some to include as evidence against the FPCs in summative assessments.

When SLEs are used as summative evidence they must largely be drawn from those that correspond to the top level of **Miller's Pyramid** ('does'), meaning that the SLEs chosen will mostly represent direct observation and 'real-time' discussion of patient encounters in the workplace. **This is explained in greater detail below.**

FDs should provide a suitable variety of evidence.

Supervised Learning Events

Supervised Learning Events (SLEs) have been widely accepted by postgraduate and undergraduate curricula as methods of allowing the learner to demonstrate progress in the clinical environment. They sit at the top of Miller's Pyramid ('does'). The learner can demonstrate that they have embedded theoretical knowledge into practice. There is strong evidence that they provide valid confirmation of the acquisition of clinical skills, communication skills and theoretical knowledge (M. Patel, Agius, Wilkinson, L Patel, Baker. June 2016) **https://doi.org/10.1111/medu.12996**.

SLEs should always be performed as formative assessments. However, a selection of them will be used by the foundation doctor as evidence of progress against the FPCs, which in turn will support sign-off of the HLOs. These selected SLEs will thus be used summatively. To demonstrate the FPCs, the FD will need a number of SLEs performed in different settings and dealing with a variety of encounters most of which will need to be patient-related. To achieve this, the FD will need to undertake SLEs regularly and in all placements that will also allow feedback from a variety of clinicians. SLEs should be carried out with the outcomes of the curriculum in mind and, to ensure full curriculum coverage, the FD will need to plan when and where certain SLEs should be undertaken with support from their clinical and/or educational supervisor if necessary.

The clinical or educational supervisor may also direct the FD to carry out certain SLEs to aid development or, if necessary, to support remediation.

In selecting the SLEs they include within the summative assessment, FDs will need to consider the curriculum requirements and ensure they select appropriate examples from a variety of encounters that have been undertaken with a range of clinicians or other healthcare professionals. Those selected must include physical health, mental health and social issues, and be carried out across a range of settings, including inpatient, non-acute and community.

Details of the range of SLEs are described earlier in this document.

Personal Learning Log

Alongside SLEs, the Personal Learning Log (PLL) provides a record of learning and therefore of curriculum coverage. The Foundation Programme has a syllabus that builds on undergraduate learning and is wide ranging to ensure the foundation years prepare doctors for future healthcare needs, although no programme of learning can cover the whole range of medical practice and knowledge that continues to develop.

Within the PLL, FDs should record their attendance at delivered education, provided to support their curriculum ('core' learning), and also record any non-core learning that they have attended either in the LEP or other venues. **Details of training that is considered suitable are given here**. The learning can be face-to-face (which may be via videoconferencing), or may be via online modules or personal reading.

As with SLEs, learning activities from the PLL can be linked to the FPCs and submitted to summative assessments when this is appropriate. However, when evidencing clinical capabilities, SLEs will be a much more powerful form of evidence, as they sit higher in Miller's Pyramid/the **hierarchy of evidence** and cannot be used as the sole form of evidence when used to support attainment of clinical capabilities.

To support trainee wellbeing, the UKFPO clearly takes the position that, in completing the Personal Learning Log, the FD would largely be expected to record learning delivered in the workplace or on approved study courses rather than rely on learning undertaken outside working hours.

Summary narrative

The summary narrative is a form of written reflection that encourages the doctor to reflect on their overall practice and development. The concept is currently used by non-training grades, including consultants, when preparing for annual appraisal to review practice against the four domains of Good Medical Practice, and thus seeks to encourage reflective practice and prepare the FD for future requirements.

At the completion of each level of training, prior to the final meeting with the ES, the FD is required to complete a written summary of their progress against each HLO (maximum 300 words), referring, if appropriate, to their choice of evidence to support progress against – or achievement of – the FPCs. The FD should be encouraged to start preparing a short summary of their progress with each of the HLOs at the end of each placement. This short summary should encourage them to critically review their curriculum achievements and consider if they are making sufficient progress to demonstrate the HLOs.

Consideration should be given to whether each FPC has the appropriate evidence, particularly feedback on performance in the clinical environment (SLEs, PSG feedback, TAB etc. corresponding to 'does' in Miller's Pyramid and representing **experiential learning**). Other evidence may be in the form of evidence of core and non-core learning (**direct training**) where the FD has played an active role ('shows' in Miller's Pyramid), or reference to **self-directed learning** as recorded in the Personal Learning Log ('tells' in Miller's Pyramid).

The ES should provide feedback on progress with the narrative and help guide the preparation for the PDP for the next post. At the end of the next post, the summary narrative may be built upon as evidence of further progress. The FD should be encouraged not just to comment on fulfilling curriculum requirements and future training needs but also to identify where they have exceeded the requirements and demonstrated excellence.

For those trainees who require remediation for any reason, they can use the narrative as a method of identifying progress.

Detailed guidance on how to write the summary narrative is available in the appendix and will be also provided in the e-portfolio guide.

This form of reflection and the way it is recorded is new to FP but is used in other PG curricula. It is designed to encourage reflection on progress globally and seeks to strengthen the benefits of

positive reflection, which can be overlooked when focusing on the details of specific cases/incidents. In using this process, the FP does not seek to undermine the benefits of reflecting on specific cases, but acknowledges that this is often better done in a group setting/debrief or privately/with a supervisor. Where the FD has reflected on a specific incident either to consolidate good practice or to record lessons learned, there is opportunity to do this in the e-portfolio and, if appropriate, use this record as evidence against the FPCs.

The summary narrative is used for:

- tracking progress to achieve HLOs,
- demonstrating excellence,
- supporting doctors when they are required to demonstrate progress against poor performance.

More on reflection in FP can be found here.

Portfolio evidence (curriculum linkage)

To satisfy the curriculum, the FD will be required to provide evidence demonstrating complete coverage of the curriculum and thus achievement of the HLOs. To achieve this, the FD will be expected to link a range of evidence selected from their e-portfolio to each FPC. The gathering of portfolio evidence is a formative process but, as with much of the formative assessment used throughout the year, selected examples are used summatively.

For each FPC, the FD should aim to provide a range of linked evidence, which should be from a range of learning experiences including SLEs, classroom or self-directed learning, reflective practice and formative feedback. However, at least some of this must comprise evidence from the top of Miller's Pyramid, i.e. 'does', in the form of SLEs where the FD has demonstrated the required capabilities and multisource feedback via the TAB or PSG. Some will, however, come from other levels, for example where the FD has 'shown' competence (e.g. simulation). Demonstration of behaviours can be underpinned by evidence that the FD 'knows' through attendance at learning/teaching events and self-directed learning. Such lower-level evidence can be strengthened by reflection.

In selecting which evidence to link, the FD must remember that they have to:

- show capabilities across different healthcare settings, i.e. acute, non-acute and community;
- include examples pertaining to both physical and mental health, and an understanding of the effect of social needs on health;
- provide a range of examples, some of which must be from directly observed encounters with patients to confirm clinical capabilities and communication skills.

Quantity of evidence required

To fulfil the requirements of early iterations of the curriculum, individual FDs linked widely varying quantities of evidence to the curriculum outcomes, from the 'bare minimum' numbers linked to multiple capabilities, to over a thousand linkages of which many added little extra information. This was rationalised under the previous curriculum to limit absolute numbers of pieces of evidence and the number of times a piece of evidence could be used. This was designed to achieve a balance in which assessment burden was limited, while ensuring the breadth of the curriculum was evidenced.

The current curriculum does not specify exact numbers for pieces of evidence submitted. However, experience with previous curricula suggests that about five pieces of good quality evidence for each capability appears to be sufficient. The e-portfolio puts a cap on evidence linkage of 10 pieces per FPC. Previous experience also suggests that cross-linking evidence to a number of FPCs should not be excessive and, drawing on previous limits of cross-linkage for 20 FPCs, this version of the curriculum limits the use of a particular piece of evidence to support three FPCs.

Team Assessment of Behaviour (TAB)

The multisource feedback process used in FP is the Team Assessment of Behaviour. This has four domains and provides good evidence for HLO 1 and 2, as well as some for 3. It is a validated approach (**https://www.tandfonline.com/doi/full/10.1080/01421590701302951**) when completed by an appropriate group of raters and reviewed by a suitably trained supervisor. TAB was used in previous versions of the FP curriculum.

The TAB is used formatively to develop professional behaviours but a satisfactory TAB is a requirement to complete the ARCP process and the contents of the TAB inform the summative ESR.

Domains in the TAB on which FDs are rated include:

– maintaining trust/professional relationships with patients,
– verbal communication skills,
– teamworking/working with colleagues,
– accessibility.

The FD must complete a self-TAB that is mapped to the same domains before inviting raters to contribute to the process. This is a good example of personal reflection and, if it differs from the outcome of the TAB, provides a good starting point for discussion with the ES.

Approximately 15 raters are chosen by the FD and responses requested via the e-portfolio. A valid TAB must have a minimum of 10 responses and, unless the placement precludes it, these must be selected from particular staff groups (**https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2923.2009.03333.x**).

The mix of raters/assessors must include at least:

- two consultants or trained GPs, and the named clinical supervisor should normally be used as an assessor;
- one other doctor more senior than F2;
- two senior nurses, including practice nurses and nurse practitioners (band 5 or above);
- two allied health professionals/other team members, including ward clerks, secretaries, practice managers, other administrative and auxiliary staff.

All responses must be gathered from a single placement and the TAB would normally be done in the first placement of F1 and then repeated in the first placement of F2. The results of the TAB are then discussed with the ES at the end of the first placement at each level of training.

The TAB is completed via a structured form to help guide feedback from other professionals who may not be as familiar with the FP as educators directly involved in the training of FDs. Those reviewing the outcome of the TAB must ensure the feedback is appropriate, fair, non- judgemental, and is free from bias.

Possible TAB responses from raters are:

- No concern
- Some concern
- Major concern

TAB outcomes include:

- Satisfactory
- Incomplete (within time limit – usually considered to be two weeks after the end of the placement to which the TAB pertains)
- Invalid (incorrect number or mix of assessors)
- Unsatisfactory: anything other than a single rater recording 'some concern' for one or more domains

When reviewed by the ES, usually at the meeting marking the end of the first placement, any TAB that is not deemed 'satisfactory' must be repeated in the next placement and should lead to an action plan recorded within the ESR.

All FDs must have a 'satisfactory' TAB on at least one occasion in each level of training. However, even those with a satisfactory TAB can be asked to repeat the assessment if a concern about progress is raised or if the FD requires an extension to their training.

Placement supervision group (PSG)

Constructive multiple-rater feedback has been accepted as an effective method of driving improvements in performance and learning. The purpose of the PSG is to provide constructive senior feedback on the FD's clinical performance. It is expected that all healthcare professionals will be in a position to support and guide the FD, providing feedback on performance to the FD and CS. However, the named clinical supervisor (CS) identifies a nominated group of senior healthcare professionals who work alongside the FD to make up the **placement supervision group**. Where possible, the clinical supervisor should identify these individuals to the FD.

The makeup of the PSG will vary depending on the placement but is likely to include:

- doctors more senior than F2, including at least one consultant or GP principal;
- senior nurses, including practice nurses or nurse practitioners (band 5 or above);
- ward pharmacists;
- allied health professionals.

In a general practice placement, the PSG may be limited to one or two GPs.
The roles of the PSG are:

- observing the foundation doctor's practice in the workplace;
- undertaking and facilitating supervised learning events (SLEs);
- providing contemporaneous feedback on practice to the foundation doctor;
- providing structured feedback to the clinical supervisor;
- raising concerns immediately if unsatisfactory performance by the foundation doctor has been identified.

In compiling his or her report, the named clinical supervisor should use feedback from the PSG. This process is important because, within any placement, an individual healthcare professional is unlikely to build up a coherent picture of the overall performance of an individual foundation doctor.

The PSG feedback is given via a structured form to help guide other professionals who may not be as familiar with the FP as educators directly involved in the training of FDs. Those reviewing the outcome of the PSG must ensure the feedback is appropriate, fair, non- judgemental, and is free from bias.

Where possible, a PSG should be involved in each of the FD's CSRs but, at a minimum, formal PSG feedback must be involved in one report for each level of foundation training.

Where there are significant concerns raised by the PSG about an FD's performance in one placement, at least one more CSR supported by evidence from a PSG must be completed before the next critical progression point.

Feedback from the PSG and TAB

The PSG is available in the e-portfolio and is being used increasingly where performance has been identified as requiring improvement. It provides information on clinical skills as well as professional skills and is complementary to TAB.

- Placement Supervision Group Tool: A useful aid in identifying those trainees requiring additional support. Van Hamel, Burton, Meikle 2019, NACT March 2018, Poster Presentation at DEMEC 2019.

- Using the Placement Supervision Group Feedback Tool for Foundation Doctors in England. K. Várnai, March 2020 Ottawa Conference.

It also provides additional information where excellence has been achieved and demonstrated by the FD.

The PSG has been incorporated into other postgraduate curricula as the Multiple Consultant Report.

4.4 Summative assessments

In line with the two axis (JoHari) approach to learning, the assessment process requires the FD to demonstrate a readiness to progress at ARCP, based on capabilities demonstrated (disclosed) in their portfolio and triangulated with the summative assessment of experienced educators.

Summary of assessments against HLOs

HLO 1: An accountable, capable and compassionate doctor	HLO 2: A valuable member of the healthcare workforce	HLO 3: A professional, responsible for their own practice and portfolio development
1. **Clinical assessment:** Assess patient needs in a variety of clinical settings including acute, non-acute and community 2. **Clinical prioritisation:** Recognise and, where appropriate, initiate urgent treatment of deterioration in physical and mental health 3. **Holistic planning:** Diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient 4. **Communication and care:** Provide clear explanations to patients/carers, agree a plan and deliver healthcare advice and treatment where appropriate 5. **Continuity of care:** Contribute to safe ongoing care both in and out of hours	6. **Sharing the vision:** Work confidently within the multiprofessional team and, where appropriate, guide the team to deliver a consistently high standard of patient care based on sound ethical principles 7. **Fitness for practise:** Develop the skills necessary to manage own personal wellbeing 8. **Upholding values:** Act as a responsible employee, including speaking up when others do not act in accordance with the values of the healthcare system 9. **Quality improvement:** Take an active part in processes to improve the quality of care 10. **Teaching the teacher:** Teach and present effectively	11. **Ethics and law:** Demonstrate professional practice in line with the curriculum, GMC and other statutory requirements through development of a professional portfolio 12. **Continuing professional development:** Develop practice including the acquisition of new knowledge and skills through experiential learning; acceptance of feedback and, if necessary, remediation; reading and, if appropriate, through research 13. **Understanding medicine:** Understand the breadth of medical practice and plan a career
CSR ESR TAB PSG e-portfolio evidence PSA certificate – F1 only	CSR ESR TAB PSG e-portfolio evidence	CSR ESR e-portfolio evidence Learning log Engagement in feedback on training Form R/SOAR

The types of summative assessment used are discussed in more detail below.
CSR, **ESR**

Supervisor assessments

Within each post, the FD will be required to demonstrate satisfactory progress against the curriculum outcomes. This will involve an educational review from both the clinical and educational supervisors. The CS and ES will complete regular reports on the progress of the FD, which provide a summative assessment of their progress and are subsequently used to inform the educational supervisor's end of year report (FTPD report in Scotland), which in turn informs the ARCP panel. These reports are global assessments of the trainee's performance and can only be completed by a recognised trainer. The supervisor is required to comment on whether the trainee meets the expected outcomes for the stage of training. In order to make this judgement, the CS and ES will evaluate the formative learning and assessments: SLEs, personal learning log, reflection including summary narrative, portfolio evidence, feedback from the placement supervision group (PSG), team assessments of behaviour (TABs), and progress mapped to the domains of good medical practice (that is, the 13 FPCs). Practice will be reviewed and a record of discussion regarding the progress will be recorded.

The **role of the CS is described here** and the **CS end of placement report (CSR) is described here**.
The **role of the ES is described here** and the **ES end of placement report (ESR) is described here**.

These reports will monitor educational progress as FDs move through the programme, to ensure the provision of feedback to the FD and to support learning linked to the learning outcomes. The standard for each of these reports should pertain to the FD's progress with respect to the curriculum requirements at their current stage of training, and the expectation of achieving the outcomes required when they reach the next critical progression point.

The information that will inform the clinical and educational supervisors will be:

- pro-rata completion of SLEs to demonstrate learning;
- satisfactory attendance at delivered 'core' learning;
- satisfactory record of non-core learning;
- satisfactory reflection/summary narrative;
- attendance record;
- engagement with the programme, including maintenance of a contemporaneous e-portfolio, participation in feedback on training, and completing the necessary records for revalidation;
- team assessment of behaviour (TAB) in at least one placement at F1 and one at F2;
- Placement supervision group assessment (PSG) in at least one placement at F1 and one at F2.

At the end of each training year the ARCP panel will make a summative judgement based on achievement of the curriculum outcomes.

The following summative assessments will be used at each critical progression point:

- Clinical supervisor end of placement reports – 1 per post
- Educational supervisor end of placement report – 1 per post (except final post)
- Educational supervisor end of year report (provided for final post) (NB: In Scotland this report is completed by the FTPD)
- Team assessment of behaviour – minimum of 1 per training year
- Placement supervision group report (minimum 1 per year)
- Prescribing Safety Assessment (PSA) valid on entry or passed by the end of F1
- Reports of any additional meetings between the FD and supervisors
- Attendance record
- Any specific national requirements approved by the UKFP Board
- The e-portfolio evidence provided by the FD, which must demonstrate:
  - A contemporaneously completed e-portfolio, engagement with feedback on training, and the necessary records for revalidation
  - Curriculum coverage with range of evidence to confirm achievement of each of the 3 HLOs
    - evidence linked to each FPC (including the specific skills in FPC2)
    - evidence of passing the PSA (F1 only)
    - reflective practice including summary narratives for each HLO

Clinical Supervisor end of placement report (CSR)

The CSR is probably the most important assessment used in the FP. Its purpose is to provide information on the performance of the FD in the workplace against the FPCs (and thus GPCs), and it sits at the highest point on Miller's Pyramid. It is informed by multiple pieces of evidence and multi-rater assessments. Over the course of the FP, the CSRs in the e-portfolio thus provide robust evidence of capability in a broad range of clinical settings.

Towards the end of each placement (and, in the final placement, before the ARCP), the FD and named CS will meet to complete a review of the FD's performance and progress in the placement.

The CSR is a judgement by the CS of whether the FD will achieve the Higher Level Outcomes (HLOs) for that training year.

The judgement will be based on a review of several sources of evidence, including:

- direct observation of practice in the workplace by the clinical supervisor (CS);
- feedback from the placement supervision group (PSG) (this is mandatory at least once for each level of training), which should be used formatively during the training year, however it is expected that by the ARCP the trainee should have a satisfactory PSG that has been used summatively to inform the CSR;
- evidence of achievement of curriculum outcomes recorded in the e-portfolio, including pro-rata completion of SLEs to demonstrate learning;
- evidence of engagement with the learning process recorded in the e-portfolio;
- the FD's attendance record;
- any incidents or investigations in which the FD has been involved.

The CSR will use the following ratings: no concern, some concern, major concern.

These ratings are defined as:

- No concern: the FD is on track to satisfy the requirements of the programme at the next critical progression point.

- Some concern: there are some indicators that suggest the FD may not have achieved all the curriculum outcomes by the next critical progression point. This is likely to include FDs who have few entries in their portfolio or have demonstrated behaviours in the workplace that have required more formal discussion.

- Major concerns: there are multiple indicators that suggest the FD will not have achieved all the curriculum outcomes by the next critical progression point or evidence that the FD's practice presents a significant risk to patients or colleagues or, in some cases, where the FD has been found guilty of misconduct.

Explanatory comments must be entered to justify the rating.

The clinical supervisor's report should comment specifically on:

- evidence of the FD's personal and professional development as a result of feedback and reflection,

- any demonstration of excellence in the FD's practice,

- any concerns regarding this FD's practice (these must be supported by specific examples),

- targets for future development including a plan to address any concerns.

If there is any concern that the FD's performance will not meet the expected minimum requirements for sign-off for any of the FPCs, this must be discussed, support offered, and a remedial action plan with specific outcomes recorded in the e-portfolio. The CS should also inform the ES.

More guidance on the CSR can be found here.

Educational Supervisor Reports (ESRs)

The educational supervisor is responsible for monitoring the overall progress of the FD through a particular level of training (either F1 or F2). The ESR is a summative assessment of the educational achievements and progress throughout the training year.

At the end of each placement, the ES should meet the FD and complete a report (the ESR) to indicate whether the foundation doctor's trajectory is likely to meet or exceed the expected minimum levels of performance required to be able to demonstrate the 13 foundation professional capabilities at an appropriate level at the end of the year of training. (NB: In Scotland this role is taken on by the FTPD).

The judgement of the ES will be based on review of several sources of evidence, including:

- Clinical supervisor's report (the ES will sometimes also be the clinical supervisor and then will complete both reports)
- Team assessment of behaviour (TAB)
- Evidence the FD has engaged with the training e-portfolio to show progress against the 13 FPCs
- Pro-rata completion of SLEs to demonstrate learning
- Satisfactory attendance at delivered 'core' learning
- Satisfactory record of non-core learning
- Satisfactory reflection including the summary narrative
- Satisfactory engagement with feedback to the programme
- Attendance record
- Any involvement of the FD in investigations or significant events
- Progress against any remedial action plan

In line with the CSR, the ESR will use the following ratings: no concern, some concern, major concern. Explanatory comments must be entered to justify the rating.

If there is any concern that the FD's performance will not meet the expected minimum requirements for sign off for any of the FPCs, this must be discussed, support offered, and a remedial action plan recorded in the e-portfolio. The ES may need to consider informing the FTPD.

In the third placement, instead of the end of placement ESR, the ES will complete the 'ES end of year report', which uses the same sources of evidence as the ESR but also takes into account:

- the FD's completed summary narrative on their progress,
- any specific nationally agreed ARCP requirement dictated by a national government that differs from the standard UKFP ARCP outcomes,
- evidence submitted by the FD via the e-portfolio as evidence of achieving the 13 FPCs.

In this report, the ES is making a recommendation to the ARCP panel on whether or not they should award the FD a successful ARCP outcome, based on whether the FD has shown that they have demonstrated the 13 FPCs to a sufficient level and are on track to fulfil the three HLOs of the FP.

More guidance on the ESR can be found here.

Prescribing Safety Assessment (PSA)

Prescribing is a fundamental part of the work of Foundation Year 1 doctors, who write and review many prescriptions each day. It is a complex task, requiring knowledge of medicines and the diseases they are used to treat, and careful judgement of risks and benefits of treatment, as well as attention to detail.

As well as offering the potential for improving health, it is an activity associated with potential hazards: a GMC-sponsored study found that nine per cent of hospital prescriptions contain errors ('**An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education - EQUIP study**'). It is also apparent in other research that this is the area of the foundation doctor role that new graduates find the most challenging (**The state of medical education and practice in the UK report: 2014** and **Be prepared: are new doctors safe to practise?**). As a result, in **Outcomes for graduates** (originally published in Tomorrow's Doctors), the GMC defined the prescribing competencies required of new medical school graduates.

The Prescribing Safety Assessment allows candidates to demonstrate their competencies in relation to the safe and effective use of medicines.

The British Pharmacological Society and MSC Assessment are working together to deliver a Prescribing Safety Assessment (PSA) that allows all students to demonstrate their competencies in relation to the safe and effective use of medicines. **https://prescribingsafetyassessment.ac.uk/**
To complete F1, the FD must have passed the PSA within the two years prior to entering into the programme, or hold a valid pass certificate on completion of F1.

4.5 Patient feedback

The AFPC discussed the incorporation of formal patient feedback into the assessment process. A systematic approach to this was piloted previously by the UKFP, and the outcome showed it to be of limited value, placing quite significant burden on FDs. (Collecting Patient Feedback on Foundation Doctors (A pilot test amongst Foundation Year 1 and 2 doctors, Academy of Medical Royal Colleges (AoMRC)). Picker Institute Europe. September 2013).

Direct patient feedback is thus not currently used in the summative assessment of FDs.

The AFPC does acknowledge the importance of capable and compassionate interactions with patients and their carers, and encourages FDs to use any examples of suitably anonymised patient feedback received as evidence within the e-portfolio if it provides evidence of the FPCs.

4.6 Annual Review of Competence Progression (ARCP)

The ARCP provides a formal process that reviews the evidence presented by the FD and their supervisors, relating to the trainee's progress in the training programme. It enables the trainee, the postgraduate dean/deputy, and employers to document that the capabilities required are being gained at an appropriate rate and through appropriate experience. For the vast majority of FDs, the panel will convene in June, which will usually coincide with the approaching end of a training year. Where an FD has undertaken an extension or is working LTFT, the panel will still conduct a review annually but a further panel will need to convene when the FD is approaching a critical progression point.

The decision about whether or not an FD's performance in each of the 13 FPCs has met or exceeded the minimum required standard for satisfactory completion of F1, or the foundation programme as a whole, will involve an overall judgement based on the ES end of year report, a review of the other summative assessments, and the contents of the e-portfolio presented to the ARCP panel. The ARCP panel judgement will include review of any concerns that have been raised, submitted by the FD via 'Form R' or equivalent, and the attendance record. Although the FP is UK-wide, there are a small number of regional differences, based on the requirements of the devolved governments, which mean the criteria used for ARCP vary slightly between the four nations of the UK. FDs and educators should ensure they are familiar with these in good time to ensure FDs are fully prepared for the ARCP process.

Full guidance on the ARCP process, including the management of FDs who receive unfavourable outcomes is available in the '**Guide for Foundation Training in the UK**'. There is an appeals mechanism for foundation doctors who have not satisfied the requirements and/or are disputing judgements of performance.

Foundation year 1 (F1)

A satisfactory ARCP will indicate that the F1 doctor has met or exceeded the minimum expected level of performance required for sign-off for each of the 13 foundation professional capabilities. This will lead to the award of a Foundation Year 1 Certificate of Completion (F1CC), which will inform the medical school as to whether they should complete and issue the GMC Certificate of Experience. Once the certificate is issued, the foundation doctor is eligible to apply for full registration with the GMC. The GMC expects satisfactory achievement of all domains set out in 'Promoting excellence: standards for medical education and training', and reproduced in the Foundation Programme Curriculum syllabus outcomes.

If an F1 doctor appeals the outcome of an unsuccessful ARCP, the appeal may involve the medical school if the FD is a UK graduate.

Foundation year 2 (F2)

The overall judgement of satisfactory completion of F2 will indicate that the F2 doctor has met or exceeded the minimum levels of performance required for sign-off for each of the 13 foundation professional capabilities. This will lead to the award of a Foundation Programme Certificate of Completion (FPCC), which will allow the foundation doctor to be eligible to apply to enter core, specialty or general practice training.

The ARCP process contains monitoring metrics and local teams across the UK report ARCP outcome data to the GMC, which is available in the GMC's online reporting tool **https://www.gmc-uk.org/education/reports-and-reviews/progression-reports/annual-review-of-competency-progression**.

As with all feedback, the outcome of the ARCP panel should be reported to the FD in a timely manner, with clear guidance on any action needed if an unsuccessful outcome has been issued.

The ARCP panel should also consider the quality of evidence and reports submitted to support their decision-making, and a process should exist to ensure that supervisors receive feedback on the quality of their reports.

The ARCP Checklist

Requirement	Standard
Provisional registration and a licence to practise with the GMC (F1 only) Full registration and a licence to practise with the GMC (F2 only)	To undertake the first year of the foundation programme, doctors must be provisionally registered with the GMC and hold a licence to practise. In exceptional circumstances (e.g. refugees), a fully registered doctor with a licence to practise may be appointed to the first year of a foundation programme. To undertake the second year of the foundation programme, doctors must be fully registered with the GMC and hold a licence to practise.
Completion of 12 months' (WTE) training (taking account of allowable absence)	The maximum permitted absence from training, other than annual leave, is 20 days (when the doctor would normally be at work) within each 12-month (WTE) period of the foundation programme. Where a doctor's absence goes above 20 days, this will trigger a review of whether they need to have an extra period of training (see GMC position statement on absences from training in the foundation programme – June 2013).
A satisfactory educational supervisor's end of year report	The report should draw upon all required evidence listed below. If the FD has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the FD has met the requirements for progression.
Satisfactory educational supervisor's end of placement reports	An educational supervisor's end of placement report is required for all FD placements EXCEPT for the last FD placement at each level of training. The educational supervisor's end of year report replaces this.
Satisfactory clinical supervisor's end of placement reports	A clinical supervisor's end of placement report is required for ALL placements. At least one CSR in each level of training must make use of PSG feedback. All of the clinical supervisor's end of placement reports must be completed before the doctor's Annual Review of Competence Progression (ARCP).
Satisfactory team assessment of behaviour (TAB)	Minimum of one per level of training.
Satisfactory placement supervision group report (PSG)	Minimum of one per level of training.
Satisfactory completion of all curriculum outcomes	The FD should provide evidence that they have met the 13 foundation professional capabilities, recorded in the e-portfolio. Evidence to satisfy FPC1-5 must include direct observation of at least five clinical encounters in the form of SLEs, and the specific life support capabilities specified in FPC2.

Requirement	Standard
Satisfactory engagement with the programme	Personal learning log of core/non-core teaching/and other learning Reflection including summary narrative Contemporaneously developed portfolio Engagement with feedback on training programme Completion of relevant probity/health declarations including Form R/ SOAR or equivalent
Successful completion of the Prescribing Safety Assessment (PSA) (F1 only)	The F1 doctor must provide evidence that they have passed the PSA within two years prior to entry to the programme or on completion of the programme.
Evidence of completion of additional requirements set by HEE/NES/NIMDTA/HEIW and approved by UKFP Board	

4.7 Management of poor performance

There is recognition that failure to progress at each stage of assessment has significant impact on the FD. It is important to establish where weaknesses and areas for development lie to enable the FD to address them and progress. The assessment strategy needs to be robust and provide appropriate constructive feedback and advice for development. It must be free from bias and come from a range of assessors.

It has been shown that multi-rater feedback (including TAB) and the clinical and educational supervisors' reports are the most reliable at identifying doctors in difficulty. Work is starting to emerge on the validity of the PSG. These summative assessments, formative interactions in the form of day-to-day contact and more formally in the use of SLEs, also provide strong evidence to assess progress in the acquisition of clinical skills, communication skills and theoretical knowledge (Patel et al).

Regular structured assessment (both formative and summative) and feedback allow regular monitoring of the FD's progress and provision of clearly identified objectives to be set for ongoing progress that will support training and subsequent progression. In some cases, extra, remedial or targeted training will be required. To achieve this, it is vital that those supervising the FD have a clear understanding of their roles, and that those guiding training, including the CS and ES, know the requirements of the FP curriculum and of the processes available to support learners who are not progressing as expected through the programme.

Concerns about poor performance should be raised as soon as possible with an FD, to ensure that any remedial action can be taken. **More information on giving feedback can be found here.**

ES and CS must, in particular, have an understanding of the difficulties that may be faced by FDs from certain backgrounds, including doctors from overseas, those training LTFT, and those with protected characteristics who may need specifically targeted support. **More information on these groups can be found here.**

Those FDs who do not meet the required learning outcomes at critical progression points may be offered extensions to their training, as detailed in the '**Guide for Foundation Training in the UK**'.

In certain cases, the performance of FDs may be such that it raises concerns that they may be a risk to the safety of patients in their care. This may occur at any stage in a placement and the CS, usually in consultation with the ES or FTPD and clinical or medical director, may have to make a decision to remove them from that environment. Where this situation exists, the supervisor should ensure that the FD is supported through the process and that any investigation is conducted as swiftly as possible. Where necessary and appropriate, remedial training should be provided.

The suspension of any postgraduate trainee should be discussed with the PG Dean or their representative as soon as possible.

A record of any additional meetings that pertain to the need to provide any extra support to an FD, or remove the FD from a training environment, should be made in the e-portfolio. Action plans for remediation should be specific, measurable, achievable by a doctor capable of meeting the outcomes of the programme, realistic and time bound.

4.8 Assessors

By the nature of the assessment process, those involved in education will be involved in assessment. Both these roles require an understanding and knowledge of the foundation curriculum and expected standards of an FD. **The roles of educators with regard to assessment within the FP are detailed here.**

Assessors must be aware of the potential impact on assessment created by unconscious bias, and ensure they support all judgements of performance with clear evidence. In the case of the ES and CS, this evidence should wherever possible be triangulated with that provided by others in the MDT. Similarly, assessors must understand the need for reasonable adjustments to be considered in the assessment of a doctor with a disability and, if necessary, seek advice in situations where these may be appropriate.

4.9 Monitoring the quality of the assessment programme

Deaneries/local offices should collect data on trainee and trainer demographics with the expectation that they will consider the impact of the training environment on those with protected characteristics and, if necessary, support trainees who are subject to widening access strategies. Detailing these processes is not within the remit of the curriculum, but the review of this data should prompt careful consideration and, if necessary, adjustments to a training organisation's educational induction and education programmes to ensure that all FDs regardless of their background or undergraduate institution have full understanding of the educational requirements and assessment types of the FP.

Core to the performance of educators, alongside the requirements of the GMC, is current equality and diversity training and understanding of the curricula and assessment types pertinent to the doctors they supervise. It is therefore vital that deaneries/local offices and LEPs develop strategies to feed back to individual ES and CS on their performance, both as trainers and assessors.

Guidance on the quality assurance of the ARCP process is given in the **Guide for Foundation Training in the UK.**

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Theme 5: Quality Assurance and Improvement

The FP curriculum will be reviewed on an ongoing basis by the AFPC, which meets three times per year in the light of feedback from stakeholders, including FDs as well as trainers.

The membership of the AFPC is listed here.

The AFPC regularly receives requests for additions to the curriculum and will continue to consider these and make requests to the GMC in the case of larger-scale changes, and when it considers items should be removed. The committee hopes that the HLOs and FPCs will not change significantly for some time, as they are based on the GPCs, but acknowledges the need for evolution over time.

In particular, the committee plans to review and update the areas suggested as 'core' teaching, which will provide the opportunity to highlight new or evolving areas of practice that should be introduced to FDs but which they may not encounter in day-to-day practice, and of which it is likely those supervising them will have only limited knowledge. Similarly, the AFPC will remove areas that have become standard practice and will be thus be covered in experiential learning (or, indeed, have become out-of-date practice).

The time specified for core teaching and other learning will also be kept under review.
The AFPC will also monitor the impact of the **changes to the curriculum**.

5.1 Introducing the FP Curriculum

The 2021 curriculum is available on the UKFPO website and is valid from August 2021. A 'countdown' approach taken over the months prior to its introduction is to ensure wide dissemination and understanding of changes via 'training champions', webinars and slide presentations made available on the UKFPO website.

Doctors starting F2 in August 2021 change to the new curriculum at the same time as new F1s start the programme.

The transition for the small numbers of doctors training out of sync or LTFT will be managed on a case-by-case basis.

5.2 Evaluation and monitoring of the 2021 curriculum

Foundation schools monitor regular trainee surveys, including:
- GMC national trainee survey (NTS),
- NETS (in England) and equivalent in other nations running the programme.

The results of these are reviewed by FSDs and FSMs, and patterns can be identified and shared via the UKFPO. Each year, the UKFPO suggests additional questions for the GMC survey and, if accepted, these could be used to evaluate the changes, particularly as viewed by the F2s who have completed a year under the 2016 curriculum. Each foundation school holds regular board meetings and management committees attended by representatives of all LEPs, including trainees, where feedback from FDs and educators around deliverability can be escalated.

The GMC publishes ARCP/outcome data from foundation schools, which is collated nationally and contains E&D data.

The UKFPO runs a Foundation Doctor's Advisory Board (FDAB), which is chaired by two senior FSDs and made up of FD representatives from all the UK foundation schools. Attendees at this meeting can represent the views of their fellow FDs on training issues, including the FP curriculum.

Oversight of evaluation and monitoring will be provided by the UKFP Board, with feedback on the curriculum delivered to the AFPC via a standing item on the committee's agenda.

5.3 Doctors with protected characteristics

It is widely recognised that doctors from certain backgrounds can be disadvantaged in their training because of those backgrounds. This can be true of doctors with protected characteristics, those who have entered medicine via widening access arrangements, those who have trained in non-UK medical schools, and those undertaking LTFT training.

In designing the curriculum and in reviewing the assessment process, the AFPC has consulted widely and openly and taken advice from an expert in equality and diversity. This expert support will be sought as needed during the time this curriculum is in use.

In terms of equitable treatment, the committee acknowledges and supports the AoMRC statement on race inequality. **https://www.aomrc.org.uk/wp-content/uploads/2020/06/200622_Race_inequality_NHS_statement.pdf**

The AFPC and the UKFPO are committed to reducing differential attainment, to supporting the widening participation agenda and to supporting flexible working.

This version of the curriculum states the expectation of equitable treatment of all FDs. We have also clearly stated the need for reasonable adjustments to be made in the demonstration of physical skills so that doctors with disabilities who are unable to perform them will not be automatically prevented from progressing, and highlighted the provision of extension to training time for doctors requiring it, including those with health problems.

UKFPO has embarked on a programme to better understand the needs of – and provide support to – those with protected characteristics, and now invites FP applicants to enter demographic information on:

- age,
- disability,
- gender reassignment,
- marriage and civil partnership,
- pregnancy and maternity,
- race,
- religion or belief,
- sex,
- sexual orientation.

Although entry of this data cannot legally be mandated, when entered this can be related to outcome data for monitoring purposes.

The curriculum advocates that similar data should be gathered from those supervising and assessing FDs.

Projects undertaken by the UKFPO and ongoing are listed here.

Some of this monitoring information is available via the GMC NTS and this outcome data will also be monitored.

The AFPC and UKFPO will remain engaged in work by the AoMRC and GMC in exploring and addressing differential attainment.

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Appendices

Appendix 1: Introduction and Purpose

Summary of changes to the 2021 FP curriculum

- Written to link explicitly with **GMC's GPCs**.
- Clear statement of the expectation of equitable treatment for all FDs.
- Number of Higher Level Outcomes (previously 'Sections') reduced from four to three.
- Number of **foundation professional capabilities** (FPCs) to be demonstrated reduced from 20 to 13.
- There is no specific number of **formative SLEs** that need to be undertaken (previously 16) but to demonstrate the HLOs, examples of practice must be submitted as summative evidence against learning outcomes across a variety of placements.
- Importance of **placement supervision group** (PSG) emphasised and made mandatory to ensure a broader range of healthcare professionals provide feedback to foundation doctors.
- The curriculum introduces a more formal **hierarchy of evidence** to emphasise the importance of direct observation in the workplace as the most crucial evidence that the FD has fulfilled the HLOs.
- Specific **'core' teaching sessions** make explicit the need for training programmes to provide teaching in certain areas, including simulation.
- The curriculum endorses current practice for the recording of a '**personal learning log**' of 'core' and 'non-core' teaching and learning, both as evidence of engagement with the programme and for use as evidence for the acquisition of FPCs.
- The new curriculum defines the **role of the doctor**.
- The new curriculum makes a specific statement regarding the **importance of mental health** and specifies a syllabus covering this important area of medical practice.
- A '**summary narrative**' provides additional opportunities to reflect on progression and curriculum achievement to complement to current reflective practice.
- The review has provided an opportunity to develop a curriculum that considers and incorporates recent work in the area of **differential attainment** and highlights the importance of monitoring it.
- The curriculum explicitly allows for **reasonable adjustments** to the assessment of performance.

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Introduction to FP for foundation doctors

The Foundation Programme is designed to develop your generic clinical and professional skills (the 13 foundation professional capabilities (FPCs)) and prepare you for a medical career by providing an introduction to a number of different healthcare workplace settings within the foundation school, through which you will rotate as you progress in the programme.

More on the purpose and outcomes of the FP can be found here.

What you need to do to complete the FP is laid out in this curriculum, which has been approved by the GMC. Most of the **FPCs** you need to gain will be achieved during your day-to-day work and the curriculum uses the term '**experiential learning**' to describe this. This experiential learning will be enhanced by 'core' foundation teaching and by personal study and reflection that you undertake.

For convenience, the 13 FPCs are grouped into three 'Higher Level Outcomes' (**HLOs**).

As you progress through the programme you will need to gather evidence that you have demonstrated the capabilities and keep a record of this in an electronic portfolio (Horus in England and Turas in NI, Scotland and Wales). This evidence will take the form of supervised learning events (**SLEs**) – **reflection** on your training and feedback from those supervising you in the workplace. You will need to provide sufficient evidence to demonstrate that you have achieved each of the 13 FPCs. As many of the FPCs are based on performance in the workplace, SLEs where someone supervising you has directly observed you at work are the most useful form of evidence. As a guide, most FDs need to accrue at least 5 to 10 SLEs per four-month placement to ensure they have sufficient amounts and variety of evidence to show that they have covered the whole curriculum. You should discuss with your supervisor at the start of each placement how many SLEs you aim to achieve and how you plan to achieve this. The number will be based on which outcomes you plan to evidence in the placement.

Evidence of progress must be presented from all the clinical settings in which you have undertaken training, and you must therefore keep your portfolio up to date as you progress through the year.

Each year, usually at the beginning of June for most FDs, your e-portfolio is submitted to the Annual Review of Competence Progression (ARCP) panel, which will decide if you have made sufficient progress to move to the next level of training. Assuming you complete F1 successfully, you will be eligible to apply for full GMC registration and move on to F2. If you fulfil the requirements of F2 you will be awarded the Foundation Programme Certificate of Completion (FPCC) and be eligible to apply for specialty, core or GP training.

Throughout the programme, your progress will be monitored and supported by those assigned to supervise you. In each placement, you will have a named clinical supervisor (CS) who will usually be a specialist in the area in which you are training. The CS will meet you at the start, middle and end of the placement and will complete a report on your work with the help of other healthcare professionals alongside whom you have worked. These professionals make up your 'placement supervision group' (**PSG**). The CS report (**CSR**) will go into your e-portfolio alongside the evidence you have entered.

At least once in each year (usually in your first placement), you will be asked to carry out a multi-source feedback exercise, which in the FP is called team assessment of behaviour (**TAB**).

As an FD, those working alongside you should be aware that you will have limited experience and you should thus be closely supervised and supported. As you gain confidence, the level of supervision may not need to be as great; however, it is important that you feel confident to seek advice and, if necessary, direct support. Your CS should ensure the necessary support is provided and, if you feel it is lacking, then you should raise this with them.

When you are working clinically, there should always be a senior doctor available to you from whom you can seek advice and, if necessary, physical support. You should always know how to contact this individual and if this is not the case you should report this via the clinical risk systems of the organisation in which you are working and, if necessary, via your foundation training programme director (FTPD) or foundation school director (FSD).

Across each level of training (F1 and F2), you will also be assigned an educational supervisor (ES) who will oversee your progress in a long-term manner (the titles of these posts may vary across the devolved nations). They will meet you regularly and discuss what you have done and what you need to do and, at the end of each training year, will make a recommendation to the ARCP panel in the form of an ES report (**ESR**).

As you train, you should have the opportunity to develop your skills and to demonstrate them in the workplace. You should also receive feedback on your performance and advice on how to improve it. Although most doctors have good insight into their strengths and weaknesses, all of us have 'blind spots' and, as well as reinforcing good practice, the purpose of feedback is to highlight areas of practice that need development to improve performance. You should therefore not be disheartened if you have performed less well than you expected and are given advice that will improve your performance. You should actively seek out feedback in all areas of your training and key elements of this should be recorded by your supervisors in your portfolio as SLEs. The more times you seek out and obtain formal feedback, the more evidence you will have in your e-portfolio to demonstrate that you have achieved the 13 FPCs.

Each year, some FDs will not be able to demonstrate the FPCs. This can sometimes be due to poor performance in the workplace and sometimes due to inadequate evidence presented to the ARCP panel. Sometimes it is due to ill health or other issues meaning they miss too much training time to complete the requirements. If you are experiencing difficulties that may prevent you from progressing in your training or are unclear of the requirements of the programme, it is vital that you engage with your ES as early as possible so they can help you address the problems or make supportive adjustments to your training so that you are able, if possible, to progress with your career.

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Introduction to FP for educators

The Foundation Programme is designed to develop generic clinical and professional skills and prepare newly qualified doctors for a medical career by providing an introduction to a number of different healthcare workplace settings within the foundation school through which they rotate as they progress in the programme. This curriculum outlines the requirements of the FP and is approved by the GMC.

More on the purpose and outcomes of the FP can be found here.

To achieve the Higher Level Outcomes (**HLOs**) of the FP, the FD needs to demonstrate the 13 Foundation Professional Capabilities (**FPCs**).

Many of the FPCs will be demonstrated during the FD's day-to-day work and the curriculum uses the term '**experiential learning**' to describe this. This experiential learning will be enhanced by **'core' foundation teaching** and by **personal study** and **reflection**.

Evidence of progress in and achievement of the FPCs is recorded by the FD in their e-portfolio and each year, usually at the beginning of June for most FDs, the e-portfolio is submitted to the Annual Review of Competence Progression (ARCP) panel, which will decide if they have made sufficient progress to move to the next level of training. Assuming they complete F1 successfully, they will be eligible to apply for full GMC registration and move on to F2. If they fulfil the requirements of F2, they will be awarded the Foundation Programme Certificate of Completion (FPCC) and be eligible to apply for specialty, core or GP training.

As they train, FDs must be given the opportunity to develop their skills and to demonstrate them in the workplace. They must receive **feedback** on their performance and advice on how to improve it. Although most doctors have good insight into their strengths and weaknesses, like all of us they have 'blind spots' and, as well as reinforcing good practice, the purpose of feedback is to highlight areas of practice that need development to improve performance.

All those supervising FDs should therefore actively seek to provide feedback in all areas of training and record some of this formally in the FD's portfolio as supervised learning events (SLEs). Some of these SLEs will be used by the FD as evidence that they have achieved each of the 13 FPCs. As most of the FPCs are based on performance and behaviours in the workplace, these records provide the most useful evidence for their e-portfolios. As a supervisor you should review the FD's portfolio progress and agree how many SLEs should be achieved to evidence the learning outcomes.

The Hierarchy of Evidence is given here.

More information on the **programme of learning**, the **educational approach** and **assessment processes** used in the FP are given here.

When supervising FDs, all those involved should bear in mind that most FDs will have limited experience and should thus ensure that any for whom you have responsibility are closely supervised and supported. As they gain confidence, the level of supervision may not need to be as great; however, FDs should always have support immediately available to them and be able to seek advice when needed.
As a result of the limited experience of FDs, supervisors should remember that some may be unfamiliar with the environment in which they have been placed and that this might be compounded in FDs from certain backgrounds. This can adversely affect their performance and supervisors must ensure they take steps to help them understand better the requirements of the programme to reduce any differential attainment as a result of this.

More information on differential attainment can be found here.

Each year, some FDs will not be able to demonstrate the FPCs. This can sometimes be due to poor performance in the workplace and sometimes due to inadequate evidence presented to the ARCP panel. Sometimes it is due to ill health or other issues meaning they miss too much training time to complete the requirements. If you are aware that an FD is experiencing difficulties that may prevent them from progressing in their training, it is vital that you raise this early with their ES.

More on levels of supervision and requirements of educators can be found here.

To provide support and guidance for the FD, they will be assigned specific supervisors: the clinical supervisor (CS) for each placement and the educational supervisor (ES) for each training year.

More information the role of the Clinical Supervisor (CS) can be found here.
More information the role of the Educational Supervisor (ES) can be found here.

The Clinical Supervisor

In each placement, the FD will have a clinical supervisor (CS) who will usually be a specialist in the area in which they are training for that period. The CS should meet the FD at the start of the placement to ensure they are familiar with their work environment, responsibilities, the other staff with whom they will be working, and to advise them on how to obtain the most from the placement. A further meeting should take place in the middle of the placement to provide feedback, highlight areas of good practice and address any areas of weakness. At the end of the placement, the CS should meet the FD to complete the CS end of placement report (CSR), which forms a vital part of the FD's assessment. Evidence of all meetings and the end of placement report should be recorded in the FD's e-portfolio. At least once in each training year, the end of placement report must include formally recorded comments from other healthcare professionals alongside whom they have worked. These professionals make up the placement supervision group' (PSG).

The CS should be familiar with the **programme of learning**, the **educational approach** and the **assessment processes** used in the FP in the context of the four domains laid down by the **Academy of Medical Educators and adopted by the GMC in the recognition of trainers as** they relate to FDs. They should also demonstrate ongoing CPD related to the supervision of FDs.

During placements, the CS should ensure the FD is fully integrated into the work of the team and given the opportunity to demonstrate their abilities and receive feedback on their performance, some of which should be recorded in the e-portfolio as supervised learning events (**SLEs**). Where possible and appropriate, the FD should attend and ideally play an active part in team meetings, mortality reviews, departmental training sessions etc., particularly where they support the achievement of curriculum outcomes. **More explanation about this is given here.**

It is the responsibility of the CS to provide clear feedback to the FD on their performance in the placement, to highlight good practice and to guide developments. Where there are concerns about the FD's progress, these must be recorded and addressed and, where they are significant, should be brought to the attention of the FD's educational supervisor (ES).

More information on giving feedback is given here.
More information on the CSR is given here.

It is also the responsibility of the CS to listen to feedback from doctors in training for whom they are responsible and, where necessary, respond to this.

The Educational Supervisor

Across each level of training (F1 and F2), the FD will be assigned an educational supervisor (ES) who will support and monitor the FD's progress in a long-term manner and help guide their personal and professional development. The ES should meet the FD regularly and discuss what they have done and what they still need to do to complete the training year. At a minimum, these meetings should be at the start of the year, at the end of each placement, and at the end of the year (before the ARCP takes place).

At the end of each training year the ES will make a recommendation to the ARCP panel in the form of an ES end of year report.

The ES must be familiar with the **programme of learning**, the **educational approach** and the **assessment processes** used in the FP in the context of the six domains laid down by the **Academy of Medical Educators and adopted by the GMC in the recognition of trainers** as they relate to FDs. They should also demonstrate ongoing CPD related to the supervision of FDs.

The ES should regularly review the FD's e-portfolio and provide clear feedback to the FD on their progress against the three HLOs and 13 FPCs, reviewing evidence entered by the FD, CS reports, and the outcome of the multisource feedback (Team Assessment of Behaviour (TAB)) used in FP.

The ES should use each contact with the FD as an opportunity to reinforce good practice and guide development in areas that require it. It is the role of the ES to challenge the FD to strive for excellence and signpost developmental opportunities.

Where there are significant concerns about the FD's progress, these should be explored sensitively and support offered, with an action plan drawn up and recorded in the e-portfolio. Where necessary, these concerns should be brought to the attention of the FTPD.

More information on the ESR is given here.

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Appendix 2: Governance and Strategic Support

AoMRC Foundation Programme Committee Membership

The FP curriculum is developed and reviewed by the AoMRC Foundation Programme Committee, which has wide representation from:

- the UKFPO and foundation schools,
- various medical Royal Colleges and Faculties,
- NHS Employers,
- GMC,
- other organisations including NACT,
- doctors in training,
- lay representatives.

Curriculum design

The AoMRC Foundation Programme Committee developed the curriculum with input from a wide range of **stakeholders**.

The 2021 curriculum is developed from the highly regarded 2016 curriculum.

The 2016 FP curriculum has been successful because it is capability/outcome-based and therefore was able to deliver a significant reduction in the numbers of higher level outcomes to four, and professional capabilities to 20. The four outcomes were designed to align with Good Medical Practice. The 2021 curriculum refines these to three Higher Level Outcomes and 13 Foundation Professional Capabilities in a structure where the three Higher Level Outcomes broadly align to the three Outcomes for Graduates (**https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates**):

– the doctor responsible to the patient;
– the doctor as part of the healthcare workforce;
– the doctor as an independent professional.

The structure takes into consideration the GMC's recently published Generic Professional Capabilities (GPCs) framework and the outcomes required for provisionally registered doctors.

- Good clinical care
- Maintaining good medical practice
- Teaching and training, appraising and assessing
- Relationships with patients
- Working with colleagues
- Probity
- Your health
- Core clinical and procedural skills for provisionally registered doctors

Curriculum design timeline

At the start of the process, the curriculum was reviewed by the AFPC and potential changes were discussed.

The online stakeholder consultation was run alongside stakeholder events with employers, trainers, foundation doctors and education managers (Sept-Dec 2018).

The new curriculum was drafted.

Draft changes were taken to educators in the four nations, including foundation school directors (FSDs) (Jan-April 2019).

The new curriculum was revised by the AFPC and the assessment strategy considered.

The new curriculum and assessment strategy were presented at DEMEC (Dec 2019) to a wide range of stakeholders, and to FSDs and FSMs.

Further revisions were made by the AFPC and agreed (Feb 2020).

The curriculum was submitted to the Academy Patient and Lay Committee, and the UKFP Trainees' committee (March-April 2020). In view of the COVID-19 pandemic these consultations were carried out using an online process.

Further revisions were made by the AFPC and agreed in the light of the above comments (May 2020).

The curriculum was reviewed by an expert in equality and diversity (June 2020).

A final review was conducted by the AFPC and submitted to the AoMRC Council (July 2020).

The final draft was prepared for submission to the GMC (Aug 2020).

Stakeholder engagement

The structure of the 2021 curriculum takes into account the opinions of a wide range of stakeholders. Stakeholder consultations included meetings with:

- representatives of NHS Employers,
- current foundation trainees,
- UKFP foundation school directors and managers,
- TPDs from Wales, Northern Ireland and Scotland,
- Royal College representatives, both directly and via the AoMRC Foundation Programme Committee, many with experience of curriculum design in their own specialties.

There was direct engagement with many stakeholders involved in the HEE MERP review, including representatives of the devolved nations. Online consultation yielded responses from a number of medical colleges and faculties, and individuals from a range of specialties including general practice, different geographic locations and organisations, and from individuals of different grades and professions.

During development, the UKFPO, FSDs and FSMs were regularly updated, and feedback was sought. When nearing completion, the 2021 curriculum, including the assessment strategy, was showcased at DEMEC in an open forum to allow feedback from experts in medical education and further refinements were made.

These consultations were used to refine the proposal further with the aim of providing as concise a curriculum as possible that supports the training of generic skills, which allow doctors to meet the requirements of the 21st century health service.

Equality and diversity

The AoMRC, UKFPO and Royal Colleges/Faculties have E&D policies that govern those working on the curriculum. The involvement of the AoMRC's lay representatives via the AFPC has ensured patient involvement, and it is hoped that the wide consultation goes some significant way towards ensuring due consideration to equality and diversity. The process invited comments from a variety of stakeholders, some of whom share protected characteristics, and an E&D expert attended a number of meetings of the committee to provide advice. In particular the trainee group that reviewed the curriculum represented a notable diversity of ethnic backgrounds. The UKFPO continues to explore differential attainment as part of the ongoing monitoring of the FP.

Strategic workforce support

To ensure the curriculum is feasible, practical and sustainable, one of the earliest stakeholder consultations took place with NHS Employers and this session was used largely to discuss service need with respect to foundation doctors and their professional development, which will lead to them becoming the senior doctors and medical leaders of the future. Along with the input from expert groups and stakeholder events that formed part of the HEE review (supported by appropriate devolved nation input), this formed the basis for the development of the curriculum capabilities and outcomes. There was a strong feeling among all stakeholders that newly qualified doctors must undertake service-based learning and that the care they deliver must be patient-centred not task-based.

Further consultations with a wide range of stakeholders, including patient representation via the AoMRC FP Committee and a repeat meeting with employers, refined the model. The new curriculum centres on the necessity for F1s to be given the opportunity to develop by delivering direct patient care under supervision appropriate to their level of ability, and to integrate fully into the healthcare workforce. This must be done on a background of general personal and professional development that will form the basis of continuous professional development.

Armed with the capabilities established in FY1, doctors entering F2 training should be given the opportunity to take more responsibility for patient care, learn decision-making skills, and deal with diagnostic uncertainty. F2 should also provide an opportunity for further self-development in a way that will benefit future career choices and the wider healthcare workforce.

Assessment strategy

As a consequence of the above, it is logical to assess the doctor according to the capabilities/behaviours they exhibit in the workplace, taking into account the professional judgements of established healthcare professionals to provide summative assessment that will be used at ARCP. This process is clearly established in the UKFP and the 2021 curriculum reflects this.

Details of the assessment strategy are found here.

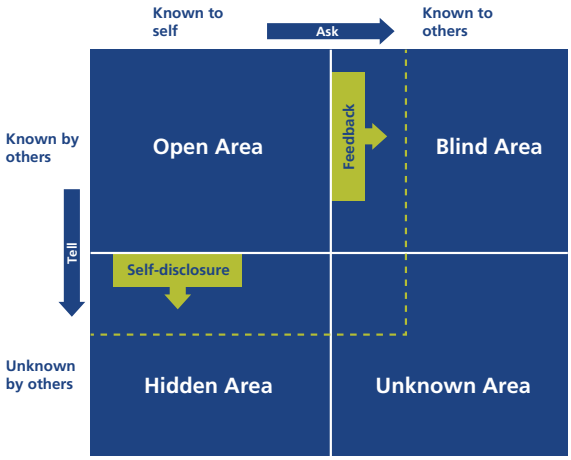
Appendix 3: Programme of Learning

a) Educational models

A number of educational models are referred to in the design of the curriculum.

JoHari Window

The JoHari Window is a commonly used model in medical education. It was created in the 1950s by two psychologists as a tool to explore group dynamics and is useful for the development of self-awareness. It is ideally suited to the concept of the FD as someone who is undertaking experiential learning in a team environment, and although often associated with interpersonal skills, it is, in this context, extended to include the more practical skills required of the FD.

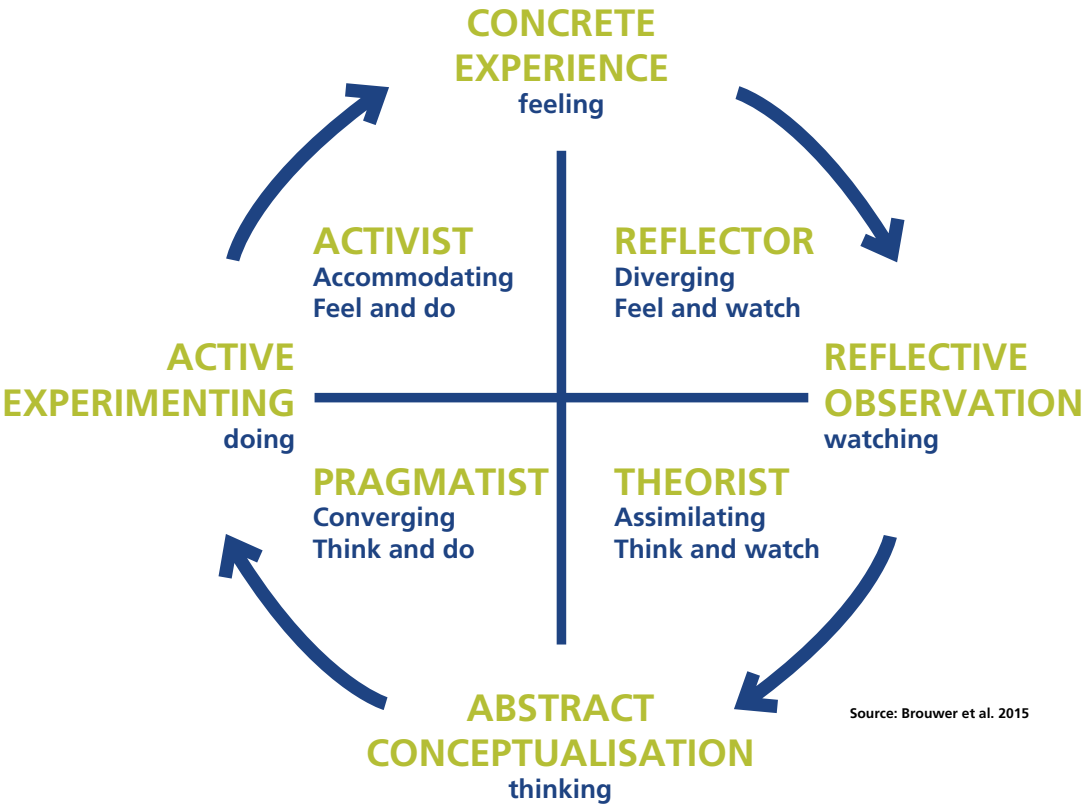


Miller's Pyramid

Miller's Pyramid is an educational model that provides a hierarchy to the performance of skills.

Where possible, FDs should demonstrate their capabilities to the level of 'does' which equates with performance in the workplace. Where this is not possible then 'shows' in simulation is an acceptable level of evidence where it is accompanied by other evidence of workplace performance in related skills.

Kolb's Learning Cycle



Source: Brouwer et al. 2015

Dreyfus Model

Table 1. Summary of the Dreyfus model of skills acquisition

Level 1: novice
- Rigid adherence to taught rules or plans
- Little situational perception
- No discretionary judgement

Level 2: advanced beginner
- Guidelines for action based on attributes or aspects (global characteristics of situations recognisable only after some prior experience)
- Situational perception still limited
- All attributes and aspects are treated separately and given equal importance

Level 3: competent
- Coping with crowdedness
- Now sees actions at least partly in terms of longer term goals
- Conscious deliberate planning
- Standardised and routine procedures

Level 4: proficient
- Sees situations holistically rather than in terms of individual aspects (see above)
- Sees what is most important in a situation
- Perceives deviations from the normal pattern
- Decision-making less laboured
- Uses maxims (whose meaning varies according to the situation) for guidance

Level 5: expert
- No longer predominantly reliant on rules, guidelines or maxims
- Intuitive grasp of situations based on deep tacit understanding
- Analytic approaches used only in novel situation or when problems occur
- Vision of what is possible

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

b) Syllabus

To successfully complete the UKFP, the FD will be able to demonstrate that they are:

1. an accountable, capable and compassionate doctor (FPC1-5),

2. a valuable member of the healthcare workforce (FPC6-10),

3. A professional, responsible for their own practice and portfolio development. (FPC11-13).

These will be demonstrated by behaviour in the workplace and training programme, in line with 13 Foundation Professional Capabilities (FPCs), listed below, along with examples of the behaviours expected to demonstrate them. (NB: the doctor is not expected to demonstrate every behaviour in each FPC but must demonstrate that capability.)

FPCs

The following section gives examples of behaviours the FD may exhibit that would show evidence of the required capability.

Click on the number to view the example behaviour for each FPC. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13.

FPC1

Clinical assessment: assess patient needs in a variety of clinical settings including acute, non-acute and community.	
F1 Behaviours	**F2 Behaviours**
• Communicates with patients sensitively and compassionately to assess their physical, psychological and social needs. • Understands that presentation, including some physical signs, will vary in patients of different backgrounds at different ages and sometimes between men and women. • Uses collateral history and alternative sources of information when appropriate. • Examines the physical and mental state of patients sensitively, with a chaperone where necessary, eliciting and interpreting clinical signs including those elicited by the mental state examination. • Recognises vulnerable individuals including those at risk of abuse or exploitation, and demonstrates appropriate consideration of safeguarding issues.	• Is confident in patient interactions in acute, non-acute and community settings. • Appropriately instigates a range of standardised assessments routinely (e.g. mental state, suicide risk scores, confusion assessments, pain scores, continence, VTE, nutritional assessments etc.). • Actively seeks symptoms and clinical signs that confirm or refute diagnostic possibilities. • Demonstrates focused assessments in an appropriate context and in a safe manner.
GPCs: 1, **2**, 4, **7**	

FPC2

Clinical prioritisation: recognise and, where appropriate, initiate urgent treatment of deterioration in physical and mental health.	
F1 Behaviours	**F2 Behaviours**
• Recognises the need for urgent intervention to treat both mental and physical health problems.* • Demonstrates the skills needed to initiate immediate management in the critically ill patient.* • Knows when to seek advice and/or physical support as required. • Provides comfort and support to the dying patient. *To complete F1, the FD must demonstrate the following in the simulated environment: – identify the causes and promote the prevention of cardiopulmonary arrest; – recognise and treat the deteriorating patient using the ABCDE approach; – undertake the skills of quality CPR and defibrillation (manual and/or AED) and simple airway manoeuvres; – utilise non-technical skills to facilitate initial leadership and effective team membership.	• Takes responsibility for initial management of critically ill patients, seeking advice and/or physical support as required.* • Demonstrates the knowledge and skills required to manage a variety of common urgent care scenarios, including mental health presentations and the ability to take a leading role in these situations. • Recognises 'the dying patient' and ensures comfort and support. *To complete F2 the FD must demonstrate the following in the simulated environment: – recognise and treat the deteriorating patient using a structured ABCDE approach; – deliver standardised CPR in adults; – manage a cardiac arrest by working with a multidisciplinary team in an emergency situation; – utilise non-technical skills to facilitate strong team leadership and effective team membership; – communicate with and manage a disturbed or challenging patient with a mental health condition.
NB: Where an FD is not able to perform certain skills, it may be appropriate to allow reasonable adjustments to be made, including affording the opportunity to describe rather than demonstrate the skill.	
GPCs: 1, **2**, 3, **5**, 6	

FPC3

Holistic planning: diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient.	
F1 Behaviours	**F2 Behaviours**
• Clearly communicates the findings of the physical, psychological and social assessment, including any uncertainties, to more senior doctors and the wider multiprofessional team. • Recognises the importance of coexisting conditions, including mental health conditions, in assessment and management and understands that many patients are experts on their own condition(s). • Recognises the patient who is likely to die within hours or days. • Obtains consent for investigation and, where appropriate, intervention based on an understanding of the principles of capacity and knows how to act when this is not present. • Undertakes investigations appropriately and safely; interprets the results of these investigations and acts accordingly. • Synthesises information to formulate a diagnosis and management plan based on professional knowledge, established guidelines and legislative requirements, and individual patient needs, where necessary in the context of diagnostic uncertainty.	• Shows initiative in providing patient care and an increasing ability to make diagnostic and management decisions. • Makes rational use of investigations and is confident to omit them or wait if appropriate. • Understands the importance of coexisting conditions and their impact on the patient's general wellbeing and adapts plans of care to accommodate these, including consideration of the burdens and benefits of treatment. • Recognises patterns of presentation in different settings, makes rational use of guidelines in treatment, and recognises when patients fall outside these, bringing this to the attention of more senior doctors. • Shows confidence in the face of uncertainty and prioritises care in a logical and considerate manner.
GPCs: 1, **2**, 4, **7**	

FPC4

Communication and care: provide clear explanations to patients/carers, agree a plan and deliver healthcare advice and treatment where appropriate.	
F1 Behaviours	**F2 Behaviours**
• Delivers care including humane interventions*, in an appropriate and safe manner including physical interventions, procedures**, safe prescribing***, blood transfusion and use of medical devices. • Uses available technology and medical devices to facilitate care. • Shows an understanding of the importance of non-pharmacological therapies. • Communicates diagnosis and potential treatment plans to patients and their carers, where necessary explaining uncertainty; communicates prognosis with an understanding of the impact this may have on the patient and their carers; establishes a shared approach where possible that is sensitive to the patient's beliefs and background; educates patients in management of their condition and provides health promotion advice (e.g. making every contact count). * The GMC defines these as: nutrition, hydration, symptom control, pain control, end of life care and CPR if and when appropriate. * NB Reasonable adaptations may be appropriate for the doctor who has difficulty with physical care. ***By completion of FY1 must have passed the Prescribing Safety Assessment.	• Actively seeks opportunities for health promotion and/or demonstrates a commitment to improving population health/ resolving health inequality. • When initiating treatment, routinely seeks to involve the patient as an equal partner in their care pathway. • Demonstrates confidence in the use of non-pharmacological therapies including, where appropriate, re-enablement; counselling; physical, occupational and psychological therapy; and social prescribing. • Prescribes anticipatory medications for the last days of life. • Demonstrates an understanding of guidance around consent and, where appropriate, obtains consent for more complex procedures and, if appropriate, for research purposes. • Shows ability to initiate and undertake procedures in more challenging settings and/ or develops capabilities in more complex procedures. • Communicates effectively in more challenging situations, such as: the communication of poor or uncertain prognosis in a manner that provides support for patients and their carers; initiation of DNAR discussions; situations where an error has occurred or conflict has arisen and/or where communication is more difficult, e.g. because of physical impairment, lack of capacity, immaturity or learning disability, or language barriers, and uses an interpreter or other professional including IMCA or IMHA as appropriate. • Demonstrates an ability to prescribe that is consistent with the standard required to pass the PSA.
GPCs: 1, **2,** 3, **4,** 6, 7, 8, 9	

FPC5

Continuity of care: contribute to safe ongoing care both in and out of hours.	
F1 Behaviours	**F2 Behaviours**
• Prioritises tasks and takes responsibility for their completion, seeking help if required. • Demonstrates an understanding of the processes to ensure correct patient identification. • Ensures continuing care in an appropriate, safe environment, which may include acute admission, arranging safe discharge, organising further contact, and onward or specialty referral, including mental health or palliative care. • Hands over care effectively both verbally and in writing and with due respect for confidentiality. • Conducts patient reviews in a timely manner. • Escalates concerns to more senior doctors (or other appropriate healthcare professionals) as needed. • Keeps clear contemporaneous records. *****By completion of FY1 must have passed the Prescribing Safety Assessment.**	• Works to facilitate patient flow in the context of the healthcare environment in which they work. • Takes appropriate responsibility for care when under indirect supervision. • Directs less experienced doctors in their work. • Demonstrates an ability to direct/lead handover, showing some ability to anticipate problems that may arise and plan solutions to them. • Is competent in written communication when making referrals and in summarising consultations, for example in creating letters in the outpatient setting and/or referring for admission.
GPCs: 1, **2**, **5**, 6, 7, 8	

FPC6

Sharing the vision: work confidently within and, where appropriate, guide the multiprofessional team to deliver a consistently high standard of patient care based on sound ethical principles.	
F1 Behaviours	**F2 Behaviours**
• Demonstrates an understanding of personal values and the effect that personal behaviour and attitude has on others. • Works as part of a team by showing an understanding of the role of a doctor: managing time effectively, communicating clearly with team members, accepting the leadership of others and challenging this where appropriate. • Understands and respects the differing roles of individual team members and care groups and develops skills to interact with them effectively. • Values diversity and understands the risks posed by unconscious bias. • Clearly communicates the findings of the biopsychosocial assessment, including any uncertainties, to the wider multiprofessional team. • Liaises with agencies outside the employing organisation and, where necessary, outside healthcare to ensure biopsychosocial needs, including the safeguarding of vulnerable patients, are met.	• Acts in a way that shows honesty and integrity and supports a just, open and transparent culture that fosters learning and critical enquiry. • Demonstrates the ability to understand and influence the actions of others in an appropriate manner and recognises that different professionals may prioritise work in a different way. • Leads the multiprofessional team when appropriate (e.g. directs FY1s in day-to-day work, prioritises care tasks for self and team). • Provides support to colleagues (including mentoring FY1s as necessary) and seeks to mitigate the effects of differential attainment on the performance of others. • Recognises when others are not performing and offers support/seeks advice appropriately.
GPCs: **1**, 2, 3, 4, **5**, 6, 7, 8, 9	

FPC7

Fitness for practice: develop the skills necessary to manage own personal wellbeing.	
F1 Behaviours	**F2 Behaviours**
• Recognises the importance of personal wellbeing for safe patient care (e.g. takes breaks appropriately, understands 'sleep hygiene' if working shifts, registers with a GP, understands how to seek help for personal issues if needed).	• Recognises the importance of protecting patients and colleagues from risks posed by personal and health issues. • Understands personal wellbeing in the context of planning a future career.
GPCs: **1**, **3**, 4, 5, 6	

FPC8

Upholding values: act as a responsible employee, including speaking up when others do not act in accordance with the values of the healthcare system.	
F1 Behaviours	**F2 Behaviours**
• Takes responsibility for own actions. • Demonstrates an understanding of the need for 24-hour care in the acute setting, including the need to ensure safe cover in unexpected situations and the concept of scheduling planned care to facilitate safe and efficient use of resources. • Works within their healthcare organisation, conforming to values, policies, training requirements etc. • Demonstrates by application an understanding of the principles of the national healthcare system in which they practice, including conforming to legislative requirements. • Notices and reports failures in care or situations where care is substandard.	• Takes a proactive approach with employing organisation to ensure clear cover arrangements, effective personnel management, booking leave etc. • Recognises and reports failures in care, understands causes of medical error and contributes to the systems that prevent/rectify systematic errors.
GPCs: **1**, 3, 4, 5, **6**, 7, 8	

FPC9

Quality improvement: take an active part in processes to improve the quality of care.	
F1 Behaviours	**F2 Behaviours**
• Engages with QI initiatives through activities such as collecting data for audit purposes, attending QI meetings and following recommendations to improve the quality of care.	• Takes an active part in ongoing QI work including active involvement with QI processes and encouragement of others to follow recommendations to improve the quality of care. • Where appropriate, instigates and carries out QI project within framework of employing organisation. • Adopts new patterns of working, including the use of new technologies (e.g. virtual consulting, genomics) and philosophies (e.g. a sustainable healthcare approach) to enhance patient care.
GPCs: 1, 2, 3, 5, **6**, 8, 9	

FPC10

Teaching the teacher: teach and present effectively.	
F1 Behaviours	**F2 Behaviours**
• Provides clear explanations in the clinical setting including the ability to educate patients about their conditions and therapies. • Plans and delivers a formal teaching session using an appropriate teaching method.	• Delivers teaching in the clinical setting to students or less experienced doctors, other healthcare professionals and/or trainees. • Provides appropriate feedback to students, FY1s and/or other healthcare workers on performance. • Expands teaching repertoire by teaching/ presenting in other settings and/or using other techniques.
GPCs: 1, 2, 4, 5, 6, **8**, 9	

FPC11

Ethics and law: demonstrate professional practice in line with the curriculum, GMC and other statutory requirements through development of a professional portfolio.	
F1 Behaviours	**F2 Behaviours**
• Regularly develops and maintains a portfolio of evidence that demonstrates practice in line with the requirements of the foundation curriculum that can be used to show the FD's readiness to progress to further training, apply for full GMC registration and move on to undertake more independent practice. • Demonstrates initiative. • Participates in quality assurance of training programmes, including national and local surveys.	• Develops and maintains a portfolio of evidence that demonstrates practice in line with the requirements of the foundation curriculum that can be used to show the FD's readiness to practise with indirect supervision and move on to further training. • Actively seeks learning opportunities and proactively develops portfolio to demonstrate skills in line with career expectations and/or future professional development.
GPCs: 1, **3**, 4, 5, 6, 8, 9	

FPC12

Continuing Professional Development (CPD): develop practice, including the acquisition of new knowledge and skills through experiential learning; acceptance of feedback and, if necessary, remediation; reading and, if appropriate, by research.	
F1 Behaviours	**F2 Behaviours**
• Demonstrates an ability to appraise new knowledge and knows how to incorporate any findings into practice. • Learns from experience, seeks out feedback, both positive and negative; and demonstrates an ability to understand criticism and, where necessary, adapts practice appropriately. • Actively engages with foundation training, completes curriculum requirements and participates in core foundation and departmental teaching programmes.	• Keeps practice up to date. • Actively engages with foundation training. • Demonstrates an ability to understand criticism and, where necessary, adapts practice appropriately. • Demonstrates an ability to seek out and appraise new knowledge and, where appropriate, recruits for and/or conducts original research and incorporates any findings into practice.
GPCs: **1**, 2, **3**, 8, 9	

FPC13

Understanding medicine: understand the breadth of medical practice and plan a career.	
F1 Behaviours	**F2 Behaviours**
• Demonstrates an exploration of the breadth of medical practice to broaden knowledge and understand the variety of care available to the patient, and to inform career development. • Understands the impact of personal values on career selection.	• Demonstrates an understanding of a variety of different healthcare environments. • Demonstrates an understanding of career options available.
GPCs: 1, 2, **3**, 4, 5, 6, 7, **8**, 9	

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Specific areas of core learning

While the curriculum is by definition generic, there are some areas of practice to which some FDs will have limited exposure, and in which those supervising them will, by the nature of their specialties, have limited knowledge and/or skills. It is thus not possible or even desirable to include some of these topics as curriculum outcomes in their own right, as the demonstration and assessment of capabilities in these areas is not consistently feasible and may vary significantly across regions or countries where the programme is delivered. However, those developing the curriculum felt it appropriate to give positive discrimination to these areas to highlight them to FDs and their trainers and to give guidance/signpost resources to ensure that FDs develop their practice appropriately. These include areas of medical practice that are expanding or are new, or which have historically received limited coverage.

As noted above, it is expected that these areas be covered in foundation core training and/or specifically signposted by FTPDs where they are not universally available in settings where they can be assimilated experientially. Furthermore, those planning core teaching should consider the variation in healthcare delivery and the needs of different populations across the UK, and endeavour to ensure FDs are equipped to work in different areas of the UK by highlighting different presentations and prevalence of disease in different populations.

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

Mental health in the FP curriculum

Mental health disorders are common and frequently go unrecognised and untreated. The FP curriculum explicitly emphasises the need for physical and mental health to be considered in tandem (see the statement on: **The 'Parity of Mental Health' and the importance of social wellbeing).**

The following topics must be included in the FD core training programme if they are not available to all FDs, either via direct presentations or recognition of these disorders in patients presenting with other conditions.

Training should cover the recognition and assessment of:
- Depression
- Mania
- Psychosis
- Anxiety/panic
- Personality disorder
- Delirium
- Chronic cognitive impairment/dementia
- Eating disorders
- Substance use disorder
- Somatisation disorders, including functional syndromes

FDs also need to develop skills in managing clinical scenarios where they may be required to apply knowledge of mental health legislation/treatment to a patient with a physical health presentation:

- assessing capacity and using Mental Capacity Act;
- Mental Health Act 1983 (or equivalent, e.g. Mental Health Scotland Act 2015) including but not limited to 5(2)*;
- relevant ethical framework around difficult decision-making, e.g. treating patients with eating disorders or self-harm;
- understanding that physical disease can present with psychiatric symptoms (e.g. multiple sclerosis, Cushing's, hypothyroidism) when ordering and interpreting investigations;
- serious adverse effects of common psychotropic medications, e.g. neuroleptic malignant syndrome, QTc prolongation, serotonin syndrome;
- communicating with and managing a disturbed or challenging patient, and understanding the risks some patients with mental health conditions pose to themselves and to others;
- explaining a diagnosis to a patient (or carer) who has Medically Unexplained Symptoms (MUS) or a non-organic cause for their symptoms, e.g. panic disorder presenting as chest pain.

* The limitations on practice for pre-registration doctors in this area should form part of this discussion.

FPC 1, 2, 3, 4, 5

Health promotion and public health	
Successive reviews of healthcare in the four UK nations have identified the need to embed health promotion within practice to improve population health. Training may include:	
Examples for F1	**Examples for F2**
• Making Every Contact Count (MECC) or equivalent and delivering appropriate health promotional advice. • Ensuring an understanding of antibiotic 'stewardship', including following local policies and avoiding unnecessary prescription. • Recognition that mental health conditions and social issues have a significant impact on physical health, quality of life and long-term survival.	• Providing the opportunity to engage in a local public health intervention project (e.g. #HealthinSchools). • An introduction to social prescribing to avoid pharmacological treatment. • A workshop on the benefits of immunisation programmes. • A QI project to embed the use of MECC, social prescribing as part of daily care, or to encourage better recognition of mental health conditions such as depression or eating disorders in those presenting with physical illness.
FPC 3, 4, 13	

Simulation

Simulation has a well-established role in the training of healthcare professionals. It has a role not only in the development of clinical skills in a safe environment but also non-technical and teamworking skills, such as situational awareness and leadership.
Foundation doctors should have the opportunity to take part in simulation.

NB: The requirements for FPC2 specify the need for the FD to demonstrate proficiency in certain life support capabilities in the simulated setting.

The table below lists the scenarios to which FDs should be exposed during their training and the attached programme is an example of how simulation training might be organised in three sessions over the two levels of FP. The programme allows some flexibility for both local needs, and should be adapted to fit with established local teaching patterns, especially where some scenarios are covered in other training.

Those facilitating simulation training must be aware of the varying backgrounds of FDs and ensure all are familiar with the purpose and process of simulation exercising, including the use of the debrief which may be unfamiliar to some participants.

Asthma/COPD	**Drug/blood admin error**
PE	DKA
CCF	**Trauma**
Bleed	Seizure/reduced consciousness
Sepsis	**Ischaemic stroke**
End of life/bad news	Anaphylaxis
Cardiac arrest/ACS	**SVT**

Example F1 Programme	Example F2 Programme
Session 1 Reduced consciousness – asthma/COPD Acutely ill patient – sepsis Cardiac arrest – ACS **Session 2** Frailty – fall/CVA Transfusion reaction Drug error – insulin **Session 3** Anaphylaxis Major haemorrhage Local incident training – learning from incidents	**Session 1** Breaking bad news Palliative care/end of life Mental health – acute mental disorder **Session 2** Acutely ill patient – SVT/DKA/PE Reduced consciousness/seizure – trauma/head injury Cardiac arrest **Session 3** Primary care scenario Local incident training – learning from incidents x2

FPC 2, 6, 8, 10

Learning to teach/present

Doctors are frequently required to present information in formal and informal situations. Part of the doctor's role is to educate others, including patients.

Training in this area should include:

- basic adult learning theory,
- designing a teaching session,
- the 'teaching toolbox'
  - teaching in the clinical setting
  - lecture – including the use of slides
  - small group tutorial/PBL
  - open discussion
  - teaching a practical skill
  - creating a poster/infographic
  - online/remote teaching

FPC 10

Leadership

Doctors remain important healthcare professionals and are frequently called upon to lead the clinical team. The groundwork for this should be laid in Foundation, if not acquired before.

Training in leadership should be focused on the first two tiers of the Medical Leadership Competency Framework: demonstrating personal qualities and working with others. **https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf**

Where FDs show a specific interest, training may include managing service and setting direction. They can also be signposted to the resources of the NHS Leadership Academy **https://www.leadershipacademy.nhs.uk** and the Faculty of Medical Leadership and Management **https://www.fmlm.ac.uk**.

The leadership involved in improving services can be introduced as part of QI training.
The LEADER form can be used to facilitate discussion of leadership in the workplace.

FPC 6, 9

Quality improvement methodology

The application of Quality Improvement (QI) methodology is vital to the development of healthcare and patient safety. FDs should be involved in the embedded QI processes of the departments and/or healthcare providers in which they are training.

Where good quality, sustainable QI processes are not widely available, then FDs can be supported to undertake small-scale QI projects. However, this must be done with the intention of 'closing the audit loop' by implementing and embedding change.

The UKFP supports training in the capabilities endorsed by the AoMRC document, 'Training for Better Outcomes: Developing QI into Practice' (June 2019):

- Understanding the system
- Human elements of change
- Measurement of change
- Implementing change
- Sustainability and spread
- Leadership and teamworking

https://www.aomrc.org.uk/wp-content/uploads/2019/06/Developing_QI_into_practice_0619.pdf

FPC 6, 9

Appraisal of evidence

The vast scope of modern medicine means that much knowledge is acquired by reference to established guidelines and their implementation based on sound scientific principles. However, the ability to appraise new evidence or to research a clinical question is vital to ensure the development of practice and to improve patient care.

There are a variety of tools available for use in the appraisal of evidence and a variety of sources from which information can be obtained.

Where FDs have not learned these skills at undergraduate level, they should be introduced to standard approaches to interrogate trustworthy databases and review the evidence obtained from them.

Where FDs have answered a clinical question they should, if appropriate, be supported in the publication of this evidence.

FPC 3, 12

Careers

One of the purposes of the Foundation Programme is the exploration of potential careers for FDs.

With continual advances in medicine and changes in the healthcare system, the landscape of medical careers is constantly changing and, while educational supervisors should be able to offer at least a basic level of careers advice, the core training programme must also provide careers guidance.

The MDRS careers strategy, available on the **COPMeD "Strategies, policies and guidance" webpage**, provides some structure to the approaches required.

Some FDs already have a clear career plan but many will not, and even those with clear plans must be challenged appropriately to ensure their goal is realistic.

The provision of careers advice will not be a 'one-size fits all', but in most cases it should take the form of a careers audit or cycle, beginning with an evaluation of personal values. An example of the steps, described in the e-LfH "**Career Planning - Foundation Trainee Doctors**" course, is:

- Where am I now?
- Where do I want to be?
- How do I get there?
- What support do I need?
- How can I keep improving?

The use of 'taster' sessions should be encouraged and facilitated.

FPC 13

Integration of acute illness into chronic disease management and multiple comorbidities
FDs, particularly F1s, spend a lot of time delivering care for acute episodes to consolidate their acute care skills, which are an important component of the FP curriculum. However, many acute presentations form part of an ongoing chronic illness and all have an impact on the psychological and social wellbeing of the patient and their family or carers. Similarly, mental health disorders can impact on physical health. All FDs should understand the concept of multimorbidity and offer an approach to care that focuses on how the person's health conditions and treatments interact and affect quality of life, the person's individual needs, preferences for treatments, health priorities, lifestyle and goals, adverse events, unplanned care, and the benefits and risks of following recommendations from guidance on single health conditions and improving QOL by reducing treatment burden. FDs must understand this and the importance of the interface between primary and secondary care. Where GP placements are not available to all FDs, the FP should offer training to FDs on the interface between secondary and primary care. All FDs must have an opportunity to take part in outpatient clinics.
FPC 3, 4, 12, 13

Frailty
All FDs must be familiar with the principles of dealing with frail elderly patients. This includes, but is not limited to, an understanding of: • methods of identifying frailty, • a comprehensive 'geriatric' assessment, • the members of the multidisciplinary team and their roles, • assessment and management of delirium, • assessment of capacity, • best interests decision-making, • the risks posed by hospital admission.
FPC 1, 2, 3, 4, 5, 6, 13

The dying patient

All FDs should understand the principles of compassionate care of the dying patient and those important to them.

Teaching should provide the FD with an approach to managing the last hours of life and introduce the concept of caring for patients who have entered the 'last year of their life'.

Teaching on this topic should align with the six ambitions for palliative and end of life care **http://endoflifecareambitions.org.uk/**, with emphasis on:

- recognising the dying patient;
- sensitive communication, including 'talking about death';
- involving and supporting the patient and those important to them;
- planning, coordinating and delivering individualised care to maximise comfort and wellbeing.

FPC 1, 2, 3, 4, 5, 6, 13

High-risk prescribing

This should be guided by local incident reporting/risk processes, but is likely to include:

- Warfarin
- Insulin
- Analgesia and pain management (for example the 'Recognise Assess Treat' approach of the Faculty of Pain Management: **https://fpm.ac.uk/events-professional-development/epm-uk**)
- 'Enforced' sedation

FPC 2, 3, 4

Patient safety

Describes how organisational culture and working systems impact on patient safety; understands a systems-based approach to incident investigation.

Applies a proactive systems approach to identifying, evaluating and managing risks to patients.

Outlines how knowledge of human error and human factors improves clinical practice; continually monitors and acts to improve patient safety.
https://www.aomrc.org.uk/patientsafety/

An understanding of professional responsibilities and GMC FTP processes.

FPC 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13

Safeguarding

Along with other healthcare staff, foundation doctors should be trained to a level of competence commensurate with their role, in line with the recommendations of the intercollegiate documents:

- Safeguarding Children and Young People: Roles and Competencies of Healthcare Staff (RCN Jan 2019) **https://www.rcn.org.uk/professional-development/publications/pub-007366**
- Adult Safeguarding: Roles and Competencies of Healthcare Staff (RCN Aug 2018) **https://www.rcn.org.uk/professional-development/publications/pub-007069**

Those overseeing the training of foundation doctors must ensure that, if used for this purpose, established local training programmes are commensurate with the current understanding of abuse and exploitation, including topics such as female genital mutilation, modern slavery, human trafficking, and 'county lines' exploitation.

FPC 1, 2, 3, 4, 5, 8, 11, 13

Use of new technology and the digital agenda

In the rapidly expanding subject of healthcare, new advances are constantly introduced and as FDs progress in their careers, many of these will become commonplace. However, changes take time to enter everyday clinical practice and FDs should at least be introduced to the concepts of new technologies. Many of the digital technologies to which this pertains are discussed in the HEE review by Eric Topol **https://topol.hee.nhs.uk**, although where specific references and technologies pertain to a particular region of the UK or nation these should be included.

As a minimum, FDs should:

- be made familiar with the IT systems they are required to use,
- be able to apply the principles of genomics at an 'end user' level,
- understand the principles of data analytics and AI,
- Be familiar with the safe use of non face-to-face consulting technology including 'remote prescribing',
- be familiar with sustainable healthcare.

Other technologies that may be relevant for inclusion are:

- sensors, wearables and the use of healthcare smartphone apps;
- higher-level understanding of genomic medicine;
- interventional and rehabilitative robotics;
- speech recognition and natural language processing.

FPC 12

Appendix 4: Blueprint of Assessments

Suggested blueprint of assessments mapped to general professional capabilities.

Programme of assessment

HLOs

HLO 1: An accountable, capable and compassionate doctor		**HLO 2: A valuable member of the healthcare workforce**	**HLO 3: A professional, responsible for their own practice and portfolio development**
Summary narrative		Summary narrative	Summary narrative
Summative assessments	CSR, ESR, PSA	CSR, ESR,	CSR, ESR, Form R/SOAR
Formative learning	Learning log, reflective practice, SLEs, TAB, PSG	Learning log, reflective practice SLEs, PSG, TABs	Learning log, reflective practice, SLEs, e-portfolio engagement

FPCs

FPC1

Clinical assessment: assess patient needs in a variety of clinical settings, including acute, non-acute and community.	
F1 Behaviours	**F2 Behaviours**
• Communicates with patients sensitively and compassionately to assess their physical, psychological and social needs. • Understands that presentation, including some physical signs, will vary in patients of different backgrounds at different ages and sometimes between men and women. • Uses collateral history and alternative sources of information when appropriate. • Examines the physical and mental state of patients sensitively, with a chaperone where necessary, eliciting and interpreting clinical signs including those elicited by the mental state examination. • Recognises vulnerable individuals, including those at risk of abuse or exploitation, and demonstrates appropriate consideration of safeguarding issues.	• Is confident in patient interactions in acute, non-acute and community settings. • Appropriately instigates a range of standardised assessments routinely (e.g. mental state, suicide risk scores, confusion assessments, pain scores, continence, VTE, nutritional assessments etc.). • Actively seeks symptoms and clinical signs that confirm or refute diagnostic possibilities. • Demonstrates focused assessments in an appropriate context and in a safe manner.
GPCs: 1, **2**, 4, **7**	

Summative assessments	ESR √	CSR √	PSA (F1) √		
Formative learning	SLEs √ TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC2

Clinical prioritisation: recognise and, where appropriate, initiate urgent treatment of deterioration in physical and mental health.

F1 Behaviours	F2 Behaviours
• Recognises the need for urgent intervention to treat both mental and physical health problems.* • Demonstrates the skills needed to initiate immediate management in the critically ill patient.* • Knows when seek advice and/or physical support as required. • Provides comfort and support to the dying patient. * To complete F1, the FD must demonstrate the following in the simulated environment: – identify the causes and promote the prevention of cardiopulmonary arrest; – recognise and treat the deteriorating patient using the ABCDE approach; – undertake the skills of quality CPR and defibrillation (manual and/or AED) and simple airway manoeuvres; – utilise non-technical skills to facilitate initial leadership and effective team membership.	• Takes responsibility for initial management of critically ill patients, seeking advice and/or physical support as required.* • Demonstrates the knowledge and skills required to manage a variety of common urgent care scenarios, including mental health presentations and the ability to take a leading role in these situations. • Recognises 'the dying patient' and ensures comfort and support. * To complete F2, the FD must demonstrate the following in the simulated environment: – recognise and treat the deteriorating patient using a structured ABCDE approach; – deliver standardised CPR in adults; – manage a cardiac arrest by working with a multidisciplinary team in an emergency situation; – utilise non-technical skills to facilitate strong team leadership and effective team membership; – communicate with and manage a disturbed or challenging patient with a mental health condition.

NB: Where an FD is not able to perform certain skills, it may be appropriate to allow reasonable adjustments to be made, including affording the opportunity to describe rather than demonstrate the skill.

GPCs: 1, **2**, 3, 5, **6**

Summative assessments	ESR √	CSR √	PSA (F1) √		
Formative learning	SLEs √ TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC3

Holistic planning: diagnose and formulate treatment plans (with appropriate supervision) that include ethical consideration of the physical, psychological and social needs of the patient.

F1 Behaviours	F2 Behaviours
• Clearly communicates the findings of the physical, psychological and social assessment, including any uncertainties, to more senior doctors and the wider multiprofessional team. • Recognises the importance of coexisting conditions, including mental health conditions, in assessment and management and understands that many patients are experts on their own condition(s). • Recognises the patient who is likely to die within hours or days. • Obtains consent for investigation and, where appropriate, intervention based on an understanding of the principles of capacity, and knows how to act when this is not present. • Undertakes investigations appropriately and safely; interprets the results of these investigations and acts accordingly. • Synthesises information to formulate a diagnosis and management plan based on professional knowledge, established guidelines, and legislative requirements and individual patient needs, where necessary in the context of diagnostic uncertainty.	• Shows initiative in providing patient care and an increasing ability to make diagnostic and management decisions. • Makes rational use of investigations and is confident enough to omit them or wait if appropriate. • Understands the importance of coexisting conditions and their impact on the patient's general wellbeing and adapts plans of care to accommodate these, including consideration of the burdens and benefits of treatment. • Recognises patterns of presentation in different settings, makes rational use of guidelines in treatment, and recognises when patients fall outside them, bringing this to the attention of more senior doctors. • Shows confidence in the face of uncertainty and prioritises care in a logical and considerate manner.

GPCs: 1, **2**, 4, **7**

Summative assessments	ESR √	CSR √	PSA (F1) √		
Formative learning	SLEs √ TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC4

Communication and care: provide clear explanations to patients/carers, agree a plan, and deliver healthcare advice and treatment where appropriate.

F1 Behaviours	F2 Behaviours
• Delivers care, including humane interventions*, in an appropriate and safe manner, including physical interventions, procedures**, safe prescribing***, blood transfusion, and use of medical devices. • Uses available technology and medical devices to facilitate care. • Shows an understanding of the importance of non-pharmacological therapies. • Communicates diagnosis and potential treatment plans to patients and their carers, where necessary explaining uncertainty; communicates prognosis with an understanding of the impact this may have on the patient and their carers; establishes a shared approach where possible that is sensitive to the patient's beliefs and background; educates patients in management of their condition and provides health promotion advice (e.g. making every contact count). *The GMC defines these as: nutrition, hydration, symptom control, pain control, end of life care, and CPR if and when appropriate. **NB Reasonable adaptations may be appropriate for the doctor who has difficulty with physical care. ***** By completion of FY1 must have passed the Prescribing Safety Assessment.**	• Actively seeks opportunities for health promotion and/or demonstrates a commitment to improving population health/resolving health inequality. • When initiating treatment, routinely seeks to involve the patient as an equal partner in their care pathway. • Demonstrates confidence in the use of non-pharmacological therapies including, where appropriate, re-enablement; counselling; physical, occupational and psychological therapy; and social prescribing. • Prescribes anticipatory medications for the last days of life. • Demonstrates an understanding of guidance around consent and, where appropriate, obtains consent for more complex procedures and, if appropriate, for research purposes. • Shows ability to initiate and undertake procedures in more challenging settings and/or develops capabilities in more complex procedures. • Communicates effectively in more challenging situations, such as the communication of poor or uncertain prognosis, in a manner that provides support for patients and their carers; initiation of DNAR discussions; situations where an error has occurred or conflict has arisen and/or where communication is more difficult, e.g. because of physical impairment, lack of capacity, immaturity, learning disability or language barriers, and uses an interpreter or other professional including IMCA or IMHA as appropriate. • Demonstrates an ability to prescribe that is consistent with the standard required to pass the PSA.

FPC4 (continued)

Communication and care: provide clear explanations to patients/carers, agree a plan, and deliver healthcare advice and treatment where appropriate.					
GPCs: 1, **2**, 3, **4**, 6, 7, 8, 9					
Summative assessments	ESR √	CSR √	PSA (F1) √		
Formative learning	SLEs √ TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC5

Continuity of care: contribute to safe ongoing care, both in and out of hours.	
F1 Behaviours	**F2 Behaviours**
• Prioritises tasks and takes responsibility for their completion, seeking help if required. • Demonstrates an understanding of the processes to ensure correct patient identification. • Ensures continuing care in an appropriate, safe environment which may include acute admission, arranging safe discharge, organising further contact, and onward or specialty referral including mental health or palliative care. • Hands over care effectively both verbally and in writing, and with due respect for confidentiality. • Conducts patient reviews in a timely manner. • Escalates concerns to more senior doctors (or other appropriate healthcare professionals) as needed. • Keeps clear contemporaneous records. *****By completion of FY1, must have passed the Prescribing Safety Assessment.**	• Works to facilitate patient flow in the context of the healthcare environment in which they work. • Takes appropriate responsibility for care when under indirect supervision. • Directs less experienced doctors in their work. • Demonstrates an ability to direct/lead handover, showing some ability to anticipate problems that may arise and plan solutions to them. • Is competent in written communication when making referrals and in summarising consultations, for example in creating letters in the outpatient setting and/or referring for admission.
GPCs: 1, **2**, **5**, 6, 7, 8	

Summative assessments	ESR √	CSR √	PSA (F1) √		
Formative learning	SLEs √ TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC6

Sharing the vision: work confidently within and, where appropriate, guide the multiprofessional team to deliver a consistently high standard of patient care based on sound ethical principles.	
F1 Behaviours	**F2 Behaviours**
• Demonstrates an understanding of personal values and the effect that personal behaviour and attitude has on others. • Works as part of a team by showing an understanding of the role of a doctor: managing time effectively, communicating clearly with team members, accepting the leadership of others and challenging this where appropriate. • Understands and respects the differing roles of individual team members and care groups, and develops skills to interact with them effectively. • Values diversity and understands the risks posed by unconscious bias. • Clearly communicates the findings of the biopsychosocial assessment, including any uncertainties, to the wider multiprofessional team. • Liaises with agencies outside the employing organisation and, where necessary, outside healthcare to ensure biopsychosocial needs are met, including the safeguarding of vulnerable patients.	• Acts in a way that shows honesty and integrity and supports a just, open and transparent culture that fosters learning and critical enquiry. • Demonstrates the ability to understand and influence the actions of others in an appropriate manner, and recognises that different professionals may prioritise work in a different way. • Leads the multiprofessional team when appropriate (e.g. directs FY1s in day-to-day work, prioritises care tasks for self and team). • Provides support to colleagues (including mentoring FY1s as necessary) and seeks to mitigate the effects of differential attainment on the performance of others. • Recognises when others are not performing and offers support/seeks advice appropriately.
GPCs: **1**, 2, 3, 4, **5**, 6, 7, 8, 9	

Summative assessments	ESR √	CSR √			
Formative learning	SLEs √ (e.g. LEADER) TAB √ PSG√	Learning log √	Reflective practice √	Summary narrative √	

FPC7

Fitness for practise: develop the skills necessary to manage own personal wellbeing.					
F1 Behaviours			**F2 Behaviours**		
• Recognises the importance of personal wellbeing for safe patient care (e.g. takes breaks appropriately, understands 'sleep hygiene' if working shifts, registers with a GP, understands how to seek help for personal issues if needed).			• Recognises the importance of protecting patients and colleagues from risks posed by personal and health issues. • Understands personal wellbeing in the context of planning a future career.		
GPCs: **1**, **3**, 4, 5, 6					
Summative assessments	ESR √	CSR √	Form R/SOAR √		
Formative learning	Learning log √	Reflective practice √	e-portfolio engagement		

FPC8

Upholding values: act as a responsible employee, including speaking up when others do not act in accordance with the values of the healthcare system.	
F1 Behaviours	**F2 Behaviours**
• Takes responsibility for own actions. • Demonstrates an understanding of the need for 24-hour care in the acute setting, including the need to ensure safe cover in unexpected situations and the concept of scheduling planned care to facilitate safe and efficient use of resources. • Works within their healthcare organisation, conforming to values, policies, training requirements etc. • Demonstrates by application an understanding of the principles of the national healthcare system in which they practice, including conforming to legislative requirements. • Notices and reports failures in care or situations where care is substandard.	• Takes a proactive approach with employing organisation to ensure clear cover arrangements, effective personnel management, booking leave etc. • Recognises and reports failures in care, understands causes of medical error and contributes to the systems that prevent/ rectify systematic errors.
GPCs: **1**, 3, 4, 5, **6**, 7, 8	

Summative assessments	ESR √	CSR √	Form R/SOAR √		
Formative learning	Reflective practice √	Quality √ improvement	Summary narrative √	Engagement in quality assurance processes/ survey	

FPC9

Quality improvement: take an active part in processes to improve the quality of care.					
F1 Behaviours			**F2 Behaviours**		
• Engages with QI initiatives through activities such as collecting data for audit purposes, attending QI meetings, and following recommendations to improve the quality of care.			• Takes an active part in ongoing QI work, including active involvement with QI processes and encouragement of others to follow recommendations to improve the quality of care. • Where appropriate, instigates and carries out QI project within framework of employing organisation. • Adopts new patterns of working, including the use of new technologies (e.g. virtual consulting, genomics) and philosophies (e.g. a sustainable healthcare approach) to enhance patient care.		
GPCs: 1, 2, 3, 5, **6**, 8, 9					
Summative assessments	ESR √	CSR √			
Formative learning	Reflective practice √	Learning log √	Quality improvement √	e-portfolio engagement	

FPC10

<table>
<tr><td colspan="6">Teaching the teacher: teach and present effectively.</td></tr>
<tr><td colspan="3">F1 Behaviours</td><td colspan="3">F2 Behaviours</td></tr>
<tr><td colspan="3">• Provides clear explanations in the clinical setting, including the ability to educate patients about their conditions and therapies.
• Plans and delivers a formal teaching session using an appropriate teaching method.</td><td colspan="3">• Delivers teaching in the clinical setting to students or less experienced doctors, other healthcare professionals and/or trainees.
• Provides appropriate feedback to students, FY1s and/or other healthcare workers on performance.
• Expands teaching repertoire by teaching/ presenting in other settings and/or using other techniques.</td></tr>
<tr><td colspan="6">GPCs: 1, 2, 4, 5, 6, 8, 9</td></tr>
<tr><td>Summative assessments</td><td>ESR √</td><td>CSR √</td><td></td><td></td><td></td></tr>
<tr><td>Formative learning</td><td>Learning log √</td><td>Summary narrative √</td><td>e-portfolio engagement</td><td>SLEs √ (e.g. Developing the clinical teacher)</td><td></td></tr>
</table>

FPC11

Ethics and law: demonstrate professional practice in line with the curriculum, GMC and other statutory requirements through development of a professional portfolio	
F1 Behaviours	**F2 Behaviours**
• Regularly develops and maintains a portfolio of evidence that demonstrates practice in line with the requirements of the foundation curriculum that can be used to show the FD's readiness to progress to further training, apply for full GMC registration and move on to undertake more independent practice. • Demonstrates initiative. • Participates in quality assurance of training programmes, including national and local surveys.	• Develops and maintains a portfolio of evidence that demonstrates practice in line with the requirements of the foundation curriculum that can be used to show the FD's readiness to practise with indirect supervision and move on to further training. • Actively seeks learning opportunities and proactively develops portfolio to demonstrate skills in line with career expectations and/or future professional development.
GPCs: 1, **3**, 4, 5, 6, 8, 9	

Summative assessments	ESR √	CSR √			
Formative learning	Reflective practice √	Learning log √			

FPC12

Continuing professional development (CPD): develop practice including the acquisition of new knowledge and skills through experiential learning; acceptance of feedback and, if necessary, remediation; reading and, if appropriate, by research.	
F1 Behaviours	**F2 Behaviours**
• Demonstrates an ability to appraise new knowledge and knows how to incorporate any findings into practice. • Learns from experience, seeks out feedback, both positive and negative; and demonstrates an ability to understand criticism and, where necessary, adapts practice appropriately. • Actively engages with foundation training, completes curriculum requirements, and participates in core foundation and departmental teaching programmes.	• Keeps practice up to date. • Actively engages with foundation training. • Demonstrates an ability to understand criticism and, where necessary, adapts practice appropriately. • Demonstrates an ability to seek out and appraise new knowledge and, where appropriate, recruits for and/or conducts original research and incorporates any findings into practice.
GPCs: **1**, 2, **3**, 8, 9	

Summative assessments	ESR √	CSR √			
Formative learning	e-portfolio engagement	Learning log √			

FPC13

Understanding medicine: understand the breadth of medical practice and plan a career.					
F1 Behaviours			**F2 Behaviours**		
• Demonstrates an exploration of the breadth of medical practice to broaden knowledge and understand the variety of care available to the patient, and to inform career development. • Understands the impact of personal values on career selection.			• Demonstrates an understanding of a variety of different healthcare environments. • Demonstrates an understanding of career options available.		
GPCs: 1, 2, **3**, 4, 5, 6, 7, **8**, 9					
Summative assessments	ESR √	CSR √			
Formative learning	Learning log √	Summary narrative √	Reflective practice √		

Appendix 5: Quality Assurance and Improvement

Unconscious bias and differential attainment

As well as standard equality and diversity training covering legal aspects around discrimination associated with their role, those supervising and assessing FDs should have received training that raises awareness of differential attainment and seeks to reduce unconscious bias. They should thus be aware not only of legally protected characteristics but of other groups that might be affected by indirect discrimination, such as those doctors who obtained their primary medical qualification overseas or those who have entered a medical career via widening participation initiatives. At present there is no national consensus on such training but it should include:

- the 'success factors' raised in: **https://www.gmc-uk.org/-/media/documents/gmc-da-final-report-success-factors-in-training-211119_pdf-80914221.pdf**,
- access to GMC Progression Report data **https://webcache.gmc-uk.org/analyticsrep/saw.dll?Dashboard**,
- the findings of work so far to understand the needs of doctors with protected characteristics or other specific backgrounds (see below).

LEPs and deaneries/local offices should take steps to collect data on the demographics of their educational and clinical supervisors.

Progress so far…

Work so far to understand the needs of doctors with protected characteristics or other specific backgrounds:

- UKFPO supported a qualitative research project focusing on the experience of BAME foundation doctors and has encouraged sharing of the findings both internally and externally;
- the UKFPO has used data from the induction survey, data from the careers destination survey, and recruitment data to consider the potential impact on BAME FDs;
- the UKFPO has explored the feedback from the NTS to consider BAME trainees' experiences;
- the UKFPO is considering how to best identify supervisor demographics and any impact this might have on BAME FDs;
- analysis of medical student applications to FP shows no correlation between reported sexual orientation and region of application, and this survey can be repeated over future years;
- ongoing work with the HEE MERP to review support for those entering medicine under widening participation initiatives and those working LTFT;
- the UKFPO has analysed success in applications to Foundation Priority Programmes.

References

GMC Standards for Doctors

- https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf
- https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-provisionally-registered-doctors
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GMC Standards for Placements

- https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-0715_pdf-61939165.pdf
- https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence

Guidance on Reflection

- https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/the-reflective-practitioner---guidance-for-doctors-and-medical-students
- http://www.aomrc.org.uk/wp-content/uploads/2018/08/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf
- https://foundationprogramme.nhs.uk/resources/reflection/

Supervision

- https://www.hee.nhs.uk/enhancing-supervision
- https://www.nimdta.gov.uk/faculty-development/approval-of-trainers/
- https://www.scotlanddeanery.nhs.scot/trainer-information/scottish-trainer-framework/
- https://heiw.nhs.wales/support/support-for-trainers/
- http://www.nact.org.uk/documents/job-descriptions/
- https://foundationprogramme.nhs.uk/curriculum/ ('Guide for Foundation Training in the UK')
- https://www.gmc-uk.org/education/how-we-quality-assure/medical-schools/recognition-and-approval-of-trainers

Feedback

- https://www.aomrc.org.uk/reports-guidance/improving-feedback-reflection-improve-learning-practical-guide-trainees-trainers/

Role of the Doctor

- https://www.medschools.ac.uk/media/1922/role-of-the-doctor-consensus-statement.pdf

Operational Documents

- https://foundationprogramme.nhs.uk/curriculum/ ('Guide for Foundation Training in the UK')

Diversity

- https://www.gmc-uk.org/education/reports-and-reviews/progression-reports/annual-review-of-competency-progression
- https://www.gmc-uk.org/-/media/documents/gmc-da-final-report-success-factors-in-training-211119_pdf-80914221.pdf
- https://www.aomrc.org.uk/wp-content/uploads/2020/06/200622_Race_inequality_NHS_statement.pdf

Patient Care Standards

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- https://prescribingsafetyassessment.ac.uk/
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- https://www.leadershipacademy.nhs.uk
- https://www.aomrc.org.uk/wp-content/uploads/2019/06/Developing_QI_into_practice_0619.pdf

Careers

- https://www.copmed.org.uk/information-for-those-advising-doctors-in-training/strategies-policies-and-guidance ('MDRS Medical Careers Strategy')
- https://portal.e-lfh.org.uk/Component/Details/514229 ('Career Planning - Foundation Trainee Doctors')

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Glossary

AoMRC – Academy of Medical Royal Colleges
AFPC – Academy (of Medical Royal Colleges) Foundation Programme Committee
BAME – Black, Asian, Minority Ethnic
CS – Clinical Supervisor
CSR – Clinical Supervisor's (end of placement) Report
ES – Educational Supervisor
ESR – Educational Supervisor's (end of placement) Report
FD – Foundation Doctor
FP – Foundation Programme
FPC – Foundation Professional Capability
FSD – Foundation School Director
FSM – Foundation School Manager
FTP – Fitness to Practise
GMC – General Medical Council
GPC – Generic Professional Capability
HEE – Health Education England
HEIW – Health Education and Improvement Wales
HLO – Higher Level Outcome (of the curriculum)
LEP – Local Education Provider
M&M – Mortality and Morbidity
MDRS – Medical and Dental Recruitment and Selection
MDT – Multidisciplinary Team
MECC – Making Every Contact Count
MERP – Medical Education Reform Programme (HEE)
NES – NHS Education for Scotland
NIMDTA – Northern Ireland Medical and Dental Training Agency
QA – Quality Assurance
QI – Quality Improvement
QOL – Quality of Life
UKFPO – United Kingdom Foundation Programme Office
WTE – Whole Time Equivalent

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