GMC's Role in Regulating Medical Education and Training

1. The GMC is the statutory regulator of doctors in the UK. We protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The Medical Act (1983), as amended, gives us four functions, including promoting high standards of medical education.

2. Basic medical education comprises the undergraduate medical course and clinical experience as a provisionally registered doctor (the first year of the Foundation Programme or F1). Provisional registration allows newly qualified doctors to put into practice under supervision the knowledge, skills and behaviours learned as a student; to gain new knowledge, while fine-tuning professional attitudes; and transition from general to further, specialised training.

3. In the context of undergraduate medical education, we set the standards for the delivery of teaching, learning, and assessment in medical schools and specify the outcomes graduates must achieve, in our guidance *Tomorrow’s Doctors*. We published a new edition of *Tomorrow’s Doctors* in September 2009, and medical schools should be preparing for its implementation from the academic year 2011/2012. Until then, *Tomorrow’s Doctors (2003)* continues to apply.

4. We ensure that the standards and outcomes specified in *Tomorrow’s Doctors* are met through our Quality Assurance of Basic Medical Education (QABME) programme. We have just completed a cycle of QABME visits to all medical schools. In the case of new medical schools we have an ongoing programme of visits to support them in implementing programmes that are consistent with our standards. All reports of our visits to schools are published on our website: http://www.gmc-uk.org/education/undergraduate/medical_school_reports.asp

5. In the context of postgraduate medical education, we regulate the first year of the Foundation programme by setting the duration, content and standard of programmes; determining the bodies that may provide, arrange or be responsible for programmes; and setting arrangements for certification including assessment. *The New Doctor (2009)*, published jointly with PMETB (who are responsible for the second year of the Foundation Programme), specifies the standards for the delivery of the Foundation Programme, and the outcomes for the training of provisionally registered doctors seeking full registration.
6. The Quality Assurance of the Foundation Programme (QAFP) is the process for ensuring that postgraduate deaneries are meeting the standards specified in *The New Doctor*, jointly run by the GMC and PMETB. All reports of our visits to deaneries are published on our website: http://www.gmc-uk.org/education/postgraduate/quality_assurance_qafp_procedures.asp.

**EU Directive 2005/36**

7. The year of clinical experience as a provisionally registered doctor also ensures that UK basic medical education complies with European Directive 2005/36, comprising a total of at least six years of study or 5500 hours of theoretical and practical training provided by or under the supervision of, a university, and with Article 24 (3)(d) which requires suitable clinical experience in hospitals under appropriate supervision. To comply with the Directive, satisfactory completion of a programme for provisionally registered doctors of 12 months’ duration is confirmed by the Certificate of Experience signed by universities, or their designated representative in postgraduate deaneries or foundation schools. Provisionally registered doctors must meet the outcomes for full registration set by the GMC before being eligible to apply for full registration.

**Merger of PMETB with the GMC**

8. On 1 April 2010 the Postgraduate Medical Education and Training Board will merge with the GMC. This means that, for the first time, one body will be responsible for the regulation of all stages of medical education and training including both years of the Foundation Programme, approving specialty training curricula and quality assuring the delivery of those training programmes. This will be in addition to our current responsibilities in respect of undergraduate medical education.

9. The Foundation Programme itself is not explicitly mentioned in the Medical Act 1983 or the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. The decision that PMETB is responsible for the second year of the Foundation Programme (F2) is based on legal advice.

**Lord Patel’s review**

10. In 2008, following the announcement by the Secretary of State that PMETB would merge with the GMC, the two organisations invited Lord Patel to lead a review of the current arrangements for regulating medical education and training and to make recommendations that would inform future policy developments by the GMC. Its 27 recommendations identify where regulation may be enhanced, the quality of training improved and the assurance of it enhanced. The outcome of the consultation will be considered at the Council meeting on 31 March 2010.

**Professional and Linguistic Assessments Board (PLAB)**

11. The PLAB test is the main route by which International Medical Graduates demonstrate that they have the necessary skills and knowledge to practise medicine safely in the UK. It is set at the level expected at the end of F1 which means that the doctor must be capable of performing the clinical and communication skills expected of a doctor who has had one year of clinical experience following graduation.
From the pre-registration year to the Foundation Programme

Development of the pre-registration year

12. The Goodenough Report, in 1944, advocated the introduction of what became known as the pre-registration year, arguing that it was no longer appropriate for newly qualified doctors to enter independent practice without a period of service providing general experience under supervision prior to the acquisition of full registration. This period was an extension of the undergraduate course, still under the authority of the university, with a significant educational component and with gradually increasing responsibility for the care of patients.

13. Provisional registration, covering the pre-registration year, was introduced in 1953.

14. On assuming responsibility for the PRHO year, the GMC issued recommendations on general training at approximately 10 yearly intervals.

15. The Recommendations as to the Medical Curriculum in 1957 emphasised the need for reducing the student’s factual load and for ensuring that “the memorising and reproduction of factual data should not be allowed to interfere with the primary need for fostering the critical study of principles and the development of independent thought”. There was little by way of detail about the PRHO year.

Recommendations as to Basic Medical Education 1967

16. The report reiterated the purpose of the pre-registration year: ‘It is thus the end of the beginning, and is not the beginning of the next stage – that of preparation for vocational practice.’

17. Council noted concern at evidence of the limited educational value of the period under the existing arrangements, and recommended changes. Almost universal disappointment had been expressed to the Council about the pre-registration year. “Too often a pre-registration doctor is excessively occupied with routine activities and his further education is consequently neglected.”

18. Council suggested that all pre-registration appointments be held in posts affording general experience in medicine or surgery, of one year duration, of which (as at present) six months should be in medicine and six months in surgery. The hospitals, and also the posts, would continue to be approved by the university. All posts should be regularly supervised, and the holders of the posts should also receive regular supervision, of an educational nature.

19. There was a suggestion to extend the period to two years but Council’s view was that experience so far with pre-registration year suggested that educational supervision during this period had not yet become so effective as to justifying abandoning the effective control at present exercised by Licensing Bodies over the final year of studies. Proposals were suggested to increase the educational value of pre-registration posts.
20. Council noted the "substantial difficulties arising from the number of students who will hold, as happens at present, posts outside the region which is the responsibility of their own parent Medical School. In these cases the responsibility for the supervision of the post rests with the Medical School associated with the Region". Council felt that in such circumstances, the parent medical school should maintain a close interest in its young graduates, and arrangements should be made between Universities or Medical Schools for the effective supervision of young graduates holding pre-registration posts outside the regions with which their School associated.

21. Council concluded that a considerable degree of University supervision offers the best prospect of major improvement and that it hoped that Universities will regard it as a duty, not only to look after the posts (by way of inspection and supervision) but also to look after the persons, that is the young men and women who are completing their basic medical education in those posts. "There is no substitute for the continued interest of Medical Schools in the welfare of their young graduates in the pre-registration. At the same time the Council recognises that the period needs to be a shared responsibility among Medical Schools, since many of the graduates hold pre-registration posts at a considerable distance from their parent School....Council would welcome the opportunity to collaborate with the Universities and Medical Schools in devising plans for this purpose."

22. Council set out general criteria including, that each pre-registration post should be in the charge of a chief or chiefs who should have not less than four consultant sessions per week in the hospital and should be directly responsible for the training of the holders of pre-registration posts; responsibility should normally not exceed 30 beds some of which should be for acute cases; the educational nature of the post should be fully understood; and the student should be allowed at least six hours weekly for education purposes.

Royal Commission on Medical Education in 1965-68 (Todd Report)

23. The notion of a pre-registration year as part of the continuum of basic medical education and easing some of the pressure on the undergraduate curriculum, was endorsed '...the undergraduate medical course does not provide sufficient training for the immediate practice of medicine...' (Todd Report, 1968). The report also noted its concern about the inadequacies or uncoordinated provision of training for junior hospital doctors¹.

Merrison Report 1975

24. The Merrison Report agreed with the principles upon which the pre-registration year was based but criticised the organisational structure that had developed and the deficiencies in the legislative framework. It found that '...all too often the graduate is treated as a much needed extra pair of hands rather than a probationer doctor still requiring supervision and training at a significant point in his career. Some young doctors find themselves burdened with responsibilities they are not yet in a position to assume; others are given duties not necessarily relevant to their training needs'.

¹ Lister, J. The history of postgraduate medicine education, Postgrad Med J 1994 70:728-731
25. The *Merrison Report* led to the establishment of the Education Committee of the GMC, with the general function of promoting high standards of medical education and co-ordinating all stages of medical education in the *Medical Act 1978*.

1980 Recommendations on Basic Medical Education

26. These recommendations were the first to be produced following the assumption of the statutory function of co-ordinating all stages of medical education by the Education Committee. Council welcomed the long delayed statutory recognition of the essential unity of all stages of medical education.

27. The principal purpose of the re-registration year was reiterated – to afford the graduate balanced clinical experience with increasing responsibility for the care of patients, under supervision of consultants and other senior medical staff who accept the educational nature of the posts held by the graduate. The patterns of experience should prepare the graduate for subsequent specialty training, whether for general practice or for any other specialty. The “educational value of it depends substantially upon the wise exercise of the discretion which the Act and Regulations give to the Universities and Medical Schools”.

28. Considerable disappointment had been expressed to the Council in the past with regard to the pre-registration year. This led to the issue by the Council in 1973 of a Code of Good Practice for Universities and Medical Schools in relation to the pre-registration year and the Education Committee noted that since then the situation had improved. Again the Education Committee emphasised that the graduate should not be excessively occupied with routine activities.

29. Universities and medical schools were reminded that they must accept responsibility for the educational standards of posts, and for guiding and assisting their graduates to obtain suitable pre-registration posts. “The organisational and financial implications of this responsibility must be recognised. While the Dean or Postgraduate Dean may be regarded as exercising this responsibility on behalf of the University, it is important to provide supporting staff with sufficient time and a specific duty to undertake the various tasks necessary to maintain and improve standards”.

30. For the first time, quality assurance activity is referred to. The Education Committee advised that periodic visits to recognised posts should be undertaken by the medical school to keep the University informed of the nature of the clinical load, of the senior staff available for supervision and of the facilities available for PRHOs.

31. The Education Committee was also given powers to appoint persons to visit approved hospitals and institutions.

32. Schools which exported students were advised to establish some liaison with medical schools in receiving regions, and agreement reached about their respective responsibilities.

33. The report noted that it may be desirable to establish regional or national matching schemes, particularly when pressure on posts increases as a result of larger output from schools.
1992 Recommendations on General Clinical Training

34. In February 1992 the GMC issued new recommendations on General Clinical Training, focussing on the PRHO year.

35. The recommendations were primarily intended for universities which had a duty to prescribe the content and supervision of the training given, in terms set by the GMC, in order to complete basic medical education. It noted that ‘for this reason general clinical training statutorily falls under university governance although it is undertaken in a setting that differs from, and is often remote from, that of the medical school.’

36. The key recommendations were:

a. Universities should exercise great control than hitherto over the clinical duties undertaken during general clinical training, over hours of work and rotas, over the educational content of posts, over the supervision of house officers, the general education provided and the monitoring of house officers’ progress. Universities should only approve posts for general clinical training if they are satisfied that all these matters are properly addressed.

b. The pattern of experience during the pre-registration year was set by the GMC at a high level, to include a core of general, supervised experience in medicine and surgery with increasing responsibility for the care of patients.

c. Universities were expected to exercise control over the combination of posts which their graduates may undertake to ensure that the overall pattern of experience is acceptable and should, in principle, allow their graduates to accept any recognised post in any region.

d. Posts must offer breadth and diversity of experience. Care of patients with acute illnesses must form an essential component, but doctors should acquire some experience in the care of patients with chronic illness.

e. The postgraduate dean exercised the responsibility for assuring the education standards of posts and for guiding and assisting graduates to obtain suitable posts of combination of posts on behalf of the university.

f. Training may take place in hospitals or, in general practice, in health centres.

g. Universities have a duty to prescribe for their own graduates the content/list of competences to be achieved by the end of general clinical training and supervision of the training given, implying that there was not a consistent approach to the content of PRHO year for graduates of different schools.

h. Responsibility for approving educational supervisors rested with
universities, and the educational supervisors were responsible for assuring the university that the necessary competence had been acquired.

i. PRHOs must be supervised in each post by a named consultant (or principal in general practice) who is formally designated the educational supervisor and who understands the duties of that role.

j. At all times of the day and night, a consultant or other member of staff in an appropriate specialty senior to the PRHO must be available at the hospital to provide cover and help. No other arrangement is acceptable.

k. It was thought inadvisable for the length of posts to be less than three months.

GMC visits between 1995 – 1997

37. The GMC undertook visits to medical schools between 1995 and 1997 to see how far the 1992 recommendations on general clinical training had been implemented.

38. The GMC found that although the clinical and educational experience of some PRHOs was of a high quality, many posts did not reach the standard expected by the GMC. Issues were:

   a. Educationally inadequate posts

   b. PRHOs not properly supervised or supported by colleagues

   c. Organisational problems within hospitals

   d. Inadequate facilities for personal well-being of PRHOs.

39. The outcome of the visits was to develop revised recommendations to bring the quality of training in all posts up to the standards of the best appointments.

The New Doctor 1997

40. In 1997, the GMC’s Education Committee issued The New Doctor, Recommendations on general clinical training and its Supplement on general clinical training in general practice (1998) outlining recommendations for clinical training of the new graduates (PRHO year). …setting out the clinical, educational and personal needs of PRHOs and making explicit the responsibilities of those concerned with the pre-registration year. Structured appraisal and the role of Postgraduate deans to work with the NHS Trusts to establish organisational frameworks to manage training were specifically referred to for the first time.

41. The Education Committee noted that ‘Greater emphasis will have to be placed on the transition from provisional to full registration at the end of general clinical training. This will require more structured appraisal of PRHOs during their final year of basic medical
education.’

42. The recommendations were to be implemented by April 2000 and emphasised the need for:

a. Proper clinical and educational supervision

b. Training and support for those facilitating PRHO learning and assessment

c. Lines of accountability established by the universities with responsibility for overseeing the pre-registration year, in conjunction with the providers of PRHO training, to involve the postgraduate deans and clinical tutors, as well as the PRHOs educational supervisors.

d. Postgraduate deans, and through them the universities, must work with NHS Trusts and general practices to establish organisational frameworks which will facilitate the provision of high quality PRHO training.

e. Competences to be acquired at the end of the pre-registration year to be set by the university.

f. Development of methods of formative assessments of PRHOs

g. Develop procedures in case of poor performance.

_Implementing The New Doctor: the Education Committee’s informal visits to UK universities (1998 to 2001) published 2002_

43. The GMC found that there had been some improvement in the quality of general clinical training, including some excellent posts introduced in general practice and specialties such as psychiatry, where the educational component had been planned as an integral part of such posts and service commitments were not allowed to affect the education and training provided.

44. Most universities worked with NHS partners to set up systems to provide PRHOs with educational support and feedback about their performance and progress. Trainees told the GMC that relevant, formal educational courses were being provided but that they were not always able to attend. Feedback and support were being offered by educational supervisors in most posts.

45. The introduction of learning agreements was positive.

46. The report identified a number of difficulties with PRHO training. These included:

a. Tension between education and service (shown by a lack of protected or bleep free time to attend educational activities, a lack of staff to provide cover)
b. Workload and work intensity (leading to PRHOs working longer hours than they should have done and a subsequent potential impact on patient care and patient safety)

c. Lack of clarity about responsibility or collaborative and constructive working relationships, such as sharing information about PRHO training to improve posts, between University, Postgraduate Deanery and Health Service organisations.

d. PRHOS carrying out tasks of limited educational value more appropriately undertaken by another member of the healthcare team

e. Inconsistent levels of support and feedback

f. Need for educational supervisors to have greater guidance about their role and responsibilities for training.

47. Further thought was necessary about how to co-ordinate the efforts of those responsible for the education of PRHOs with those overseeing the provision of healthcare.

48. The visits also revealed that further guidance was required to ensure that the principles of professional practice, set out in Good Medical Practice, are put at the heart of this period of training.

49. The problem was recognised that although universities had clear statutory responsibility for the PRHO year the PRHOs themselves no longer have formal association with their universities and are employees of the NHS.

Modernising The New Doctor 2004

50. Before 2007, under the Medical Act the GMC set the patterns of experience for PRHO training and made recommendations on the content of training. A PRHO doctor was required to undertake a period of experience in medicine and surgery before full registration was granted.

51. In 2002, the Education Committee started a review of the PRHO year, including a review of the legislative framework and the recommendations contained in The New Doctor 1997.

52. The aims of the review were:

a. Ensuring that there is an educational continuum between undergraduate medical education, the foundation programme and postgraduate medical training

b. Identifying the added value of PRHO training to a medical graduate

c. Applying modern educational principles to PRHO training

d. Transition to outcomes: a clear set of outcomes to be demonstrated by
medical graduates before being granted full registration

e. Those bodies involved in PRHO training must be given the freedom to
design effective and innovative training programmes which meet the
outcomes set out in *The New Doctor*.

f. The GMC should provide a platform at full registration that the
Foundation Programme can build upon.

g. A system of quality enhancement is necessary to ensure that PRHO
training is effective and to provide a mechanism to allow the aspirations of
contemporary society to be met and good practice to be disseminated and fed
into improved standards.

h. *Good Medical Practice* should be at the heart of the content and
curriculum of PRHO training

53. In developing *Modernising Legislative Policy*, the proposals for legislative
reform, the Education Committee Chairman and Deputy CMO for England agreed
that the current experience based framework was too rigid for the requirements of
contemporary medical education and training.

54. In July 2004, the Education Committee established the *Modernising the New
Doctor Transitional Group* to continue to develop the policy work necessary to
ensure that the legal obligations could be met in 2007.

55. New arrangements were proposed that required legislation and came into
force in August 2007 after a two year transition period from 2005 to 2007. The
transition period allowed training programmes and assessment processes and tools
to develop. A transitional edition of *The New Doctor* was published in 2005.

56. During this period there was *Good Medical Practice* and *The New Doctor*
outcomes for F1 have been mapped to each of the Foundation Programme

57. In 2006 and again in 2009 the GMC approved the Foundation Programme
Curriculum as enabling the outcomes for F1 to be met.

58. In 2007 the Education Committee agreed that postgraduate deaneries would
be responsible for programmes for provisionally registered doctors, recognising the
new Foundation Programme framework with postgraduate deans responsible of
education and training through Foundation Schools within their area. The duration of
such programmes was confirmed as 12 months.

*Quality Assuring the Foundation Programme (QAFP)*

59. Since 2006, when pilots were set up to develop a process to quality assure
the Foundation Programme, there has been a much stronger emphasis on quality
assurance. A QAFP process was agreed and the first postgraduate deaneries were
quality assured under the new QAFP regulatory framework in 2008. The GMC and
PMETB hold postgraduate deaneries responsible for quality managing training by
Local Education Providers.

60. The GMC appoints persons to visit postgraduate deaneries and report back on whether a programme for provisionally registered doctors should be recognised by the GMC. The Quality Assurance of Basic Medical Education Programme (QABME) visits to medical schools questions F1 doctors about how prepared they were for the Foundation Programme. The changed role of medical schools in the governance of the F1 year is evident in QABME where medical schools are no longer asked about the provision or oversight of training for F1 doctors.

61. Six pilot visits were undertaken in 2005 to 2007 to develop and refine the method of quality assuring, jointly with PMETB.

62. Since the new regulatory framework came into force in August 2007, six deaneries have been visited in 2008 and 2009: Kent, Surrey and Sussex (May 2008), London (June 2008), Northern (May 2009), Severn (June 2009), North Western (October 2009) and Oxford (November 2009).

63. QAFP enables us to:
   a. Make a judgement together about whether the Foundation Training provided by the Postgraduate Deanery is meeting the standards and should be approved;
   b. To share good practice and develop and improve Foundation Education and Training with Foundation Programme providers; and
   c. Develop coherence between undergraduate and postgraduate education and training.
   d. The UKFPO has set up a process of peer review to look at notable practice identified in QAFP reports. Representation is from foundation school directors, foundation school managers, foundation training programme directors, foundation doctors and the UK Foundation Programme Office. The group has been tasked with facilitating the process of sharing those aspects of notable practice highlighted in QAFP reports which may have a general relevance and identifying any areas for improvement identified in the report which may have a national relevance.

*Foundation Programme commitment to GP and community places*

64. Community practice experience is not mandatory for foundation doctors. According to data from the UKFPO, during F2 16% of trainees experience general practice and none do so in F1 (UK Foundation Programme Office December 2009).

65. This outcome is very different from the objective envisaged when the Foundation Programme started across the UK from 1 August 2005.

66. The aim in England was to ensure that at least 55% of foundation doctors would have an experience in general practice before the completion of their
Programme. In 2006, it was expected that most of these experiences would be undertaken by F2 trainees. However, further funding in England would mean that it was anticipated that by 2007, 80% of trainees would undertake an experience in general practice. The numbers meant that it would be necessary to undertake some of these general practice experiences in F1 (Alan Crockard, MMC, minutes of PRHO Prescribing Reference Group, 7 December 2005 and MMC The Foundation Programme: the truth, Issue 04 Winter 2005).

67. The Scottish Executive Health Department had not made the same commitment to fund general practice experiences in F1 (Ricky Bhabutta, minutes of PRHO Prescribing Reference Group, 7 December 2005). The intention was that the Foundation Programme include a broad range of experience in mainly acute care settings and a clear aim to provide experience in mental health as well as in general practice (MMC Foundation Programmes, NHS Scotland).

68. In 2005 there were two provisionally registered doctors in general practice in Wales (David Philips, Minutes of PRHO Prescribing Reference Group, 7 December 2005). And there were no provisionally registered doctors undertaking GP experiences in Northern Ireland and there was at present no policy intention to implement them (Kathryn Booth, minutes of PRHO Prescribing Reference Group, 7 December 2005).

Scoping exercise to design a study to evaluate the effectiveness of The New Doctor 1997

69. During the development of The New Doctor 2007, the GMC commissioned a project to design a way of evaluating the effectiveness of The New Doctor 1997, conducted by NHS Education for Scotland and the Northern Deanery at Newcastle.

70. The key issues emerging from interview data were clustered into three broad categories. These are summarised below:

Category A: Educational standards

- A national standard with defined outcomes.
- A widened opportunity for three month placements
- A curriculum was established
- The educational provision improved
- The changes have been slow
- Initiated the move towards assessment

Category B: Delivery

- The Deaneries led on implementation
- Initiated Deanery quality assurance visits
- The major change was PRHO supervision
- Trainers more aware of learning needs
- PRHOs now expect training
Category C: Service tensions and confounding factors

- Tensions between education and service delivery needs remain
- An important concurrent change has been the reduction in working hours
- A culture change has increased the awareness of PRHOs of their own limitations and highlighted patient safety
- The fragmentation of teams reduces informal learning opportunities
- Other factors influence the impact

71. There were no apparent differences between Scotland and England.

72. Overall therefore, the interview data revealed that *The New Doctor* led to important structural changes for the training of PRHOs. However, the real impact in terms of the daily experience of the PRHO is very difficult to assess. The perception is that PRHO education and training has changed but how much of this change is due to *The New Doctor* and how much is due to other important changes would be very difficult to separate out retrospectively.

73. A literature review was conducted for the project.

74. The abstracts reviewed were sub-divided into three headings. These are listed below, along with a summary of the main findings under each.

a. Papers which directly reference *The New Doctor* and/or use it as a basis for research. It is clear from these papers that *The New Doctor* has resulted in important attempts to elevate the PRHO experience and achieve the goals it set out (e.g. educational interventions; new innovative posts). Despite this, some studies have highlighted areas with room for improvement. For example, a lack of formal training for educational supervisors, working excess hours and problems with accommodation and catering were cited.

b. Papers published after 1997 which make no clear reference to *The New Doctor*. The topics covered by researchers who make no explicit reference to *The New Doctor* are similar to those noted above. There have been some large questionnaires aimed at assessing workload and quality of training, as well as research focussing on specific skills, on innovative PRHO rotations and the impact of undergraduate curricula reform on PRHO capabilities. There is an implication in much of the research that the ideals of *The New Doctor* are still not always achieved in reality. Thus there remain challenges for those who are implementing Modernising Medical Careers (MMC).

c. Papers published before *The New Doctor*. Much research carried out pre-1997 indicated that tensions between the service commitment and educational functions of the PRHO year could often result in a less than satisfactory experience. *The New Doctor* arose from a clear need for a review of PRHO training. Its detailed account of the requirements and responsibilities for both PRHOs and their teachers, were intended to act as a basis for future reform.
Introduction

75. Six deaneries have been visited in 2008 and 2009: Kent, Surrey and Sussex (May 2008), London (June 2008), Northern (May 2009), Severn (June 2009), North Western (October 2009) and Oxford (November 2009). A trend has been identified where two or more QAFP reports have requirements, recommendations or notable practice in a similar area.

Overview of requirements, recommendations and notable practice per domain

76. The following graphs illustrate which domains requirements, recommendations and notable practice fall into.

Requirements
Domain one: patient safety

Summary

77. 24 per cent of requirements, 22 per cent of recommendations and 11 per cent of notable practice fall under this domain.
Trends

78. For three deaneries visited teams made requirements regarding the clinical supervision of FDs, which was considered to be inadequate. In two of these deaneries, the teams required immediate action in response to the concerns raised.

79. For two of the deaneries visited teams required the deanery to improve communication of the roles and responsibilities of FDs educational and clinical supervisors to LEPs, the supervisors and the FDs.

80. For two of the deaneries visited teams required the deanery to improve the LEPs understanding of the roles and competencies of F1 and F2. One deanery had a recommendation about this. Effects of this lack of understanding included FDs being asked to perform duties which they were not competent to do and FDs being assigned inappropriate rotas because of incorrect assumptions made regarding their level of experience and competence.

81. For three of the deaneries visited teams required the deanery to make improvements to departmental induction for FDs. Two deaneries had a recommendation about this. In some cases some FDs were not receiving departmental induction at all, in other cases this induction was not considered to be fit for purpose. For some deaneries the frequency of departmental inductions had not been adjusted in accordance with the three or four month foundation rotations, and continued to take place only every six months which historically matched the PRHO and SHO rotations. For two deaneries teams did identify areas of notable practice in induction at particular LEP sites, and suggested that such practice could be of benefit across all LEP sites.

82. For three of the deaneries visited teams recommended that the deanery improve the educational handover for FDs, so that for each three or four month placement the clinical supervisor provided information regarding the FD’s educational progress to the educational supervisor. In some cases where the educational supervisor changes for each placement, such handover was recommended between educational supervisors as well. Effects of a lack of educational handover included educational and clinical supervisors not being aware of concerns raised about the progress of a FD in previous placements.

83. For two of the deaneries visited teams recommended that the deanery improve the dissemination and communication of deanery and LEP whistleblowing policies to FDs.

Domain two: Quality assurance, review and evaluation

Summary

84. 23 per cent of requirements, 22 per cent of recommendations and 18 per cent of notable practice fall under this domain.
Trends

85. One of the most significant trends identified in the six QAFP visits was the need for deaneries to improve their local quality management of the foundation programme. Primarily, the need for deaneries to improve how the findings from quality management activity (including paper-based reporting, visits, and surveys, including the national PMETB Trainee survey) are turned into action plans for LEPs, and how action taken is monitored by the deanery. Five deaneries had requirements or recommendations to this effect.

86. For four of the deaneries visited teams recommended that the deanery collect more quality data from foundation doctors through the use of foundation doctor surveys, representation of foundation doctors on committees, and interviewing of foundation doctors during quality management visits.

87. Teams identified notable practice in quality management systems and processes at two of the deaneries visited. This practice included the use of electronic systems to monitor the quality of the delivery of foundation programmes, and the design and implementation of deanery-level regulations for the delivery of foundation training which are mapped to the GMC and PMETB standards.

Domain three: equality, diversity and opportunity

Summary

88. Nine per cent of requirements, four per cent of recommendations and four per cent of notable practice fall under this domain.

Trends

89. One marked trend has been noted in this domain. For five of the deaneries visited teams required the deanery to develop the collection and analysis of equality and diversity data, and the use of this analysis to inform policy development and the delivery of the foundation programme.

90. Teams have not identified very much notable practice for this domain, however examples of good deanery and foundation school support for foundation doctors requiring adjustments to their training have been noted in three visit reports.

Domain four: recruitment, selection and appointment

Summary

91. Eight per cent of requirements, four per cent of recommendations and three per cent of notable practice fall under this domain.

Trends

92. Two deaneries had recommendations to make improvements to the recruitment of educational supervisors for foundation doctors. These improvements
included more deanery involvement in the recruitment of educational supervisors, which takes place at LEP level, and better dissemination and communication of job descriptions for educational supervisors.

**Domain five: delivery of curriculum including assessments**

**Summary**

93. 11 per cent of requirements, 12 per cent of recommendations and 21 per cent of notable practice fall under this domain.

**Trends**

94. The most significant trend noted in this domain relates to the foundation programme assessments. Three deaneries had requirements and recommendations related to improving the quality of the foundation programme assessments. These improvements included the need to improve the quality of assessments through better training for assessors, through better quality control of assessments, for example to ensure that assessors observed the procedure that they were assessing on that occasion and did not base their assessment on past knowledge of the foundation doctor's performance, and through providing more useful feedback to foundation doctors regarding their performance in assessments.

95. Two deaneries had recommendations to improve foundation doctor's access to bleep free core curriculum teaching. At two deaneries, teams found that foundation doctors were well supported to access protected core curriculum teaching and recorded this as notable practice.

**Domain six: support and development of foundation doctors, trainers and local faculty**

**Summary**

96. 14 per cent of requirements, 23 per cent of recommendations and 28 per cent of notable practice fall under this domain.

**Trends**

97. For three of the deaneries visited teams made requirements and recommendations for improvements in the training and review of educational supervisors. Improvements included ensuring that educational supervisors are appraised for their educational role, ensuring that all educational supervisors receive appropriate training, and improving how training that educational supervisors have undergone is monitored.

98. For two of the deaneries visited teams made requirements for improvements in deanery policy regarding study leave. Improvements included issuing of clearer guidance for study leave to ensure equity of access across the deanery and addressing of inconsistencies in the use of study leave budgets for mandatory training.
99. At three deaneries the teams found notable practice in the provision of careers advice for foundation doctors.

Domain seven: management of education and training

Summary

100. Six per cent of requirements, nine per cent of recommendations and nine per cent of notable practice fall under this domain.

Trends

101. The most significant trend noted for this domain relates to the development of high level plans and strategies for the foundation programme. Three deaneries were required to make improvements in this area and one had a recommendation to this effect. Improvements included the inclusion of strategic objectives for foundation training within the overall deanery strategy, the production of strategic management plans for the delivery of foundation programme in the deanery, and the involvement of LEPs in the development and delivery of strategic plans.

102. At two deaneries teams found notable practice in the relationships that the deaneries had with their Strategic Health Authorities.

Domain eight: educational resources and capacity

Summary

103. Four per cent of requirements, three per cent of recommendations and four per cent of notable practice fall under this domain.

Trends

104. One deanery had a requirement and one a recommendation relating to the need to ensure adequate financial resources for the delivery of foundation training.

Domain nine: outcomes

Summary

105. Three per cent of requirements, two per cent of recommendations and three per cent of notable practice fall under this domain.

Trends

106. Because of the very low number of requirements, recommendation and notable practice made under this domain, there were no trends identified.