

# **A Guide to Psychiatry in the Foundation Programme**

**for Supervisors and  
Foundation Trainees**

**2015**

## **Introduction from the President of Royal College of Psychiatrists, Professor Sir Simon Wessely**

The expansion of the Foundation Programme in psychiatry is, I believe, a heaven sent opportunity for us to get serious about ensuring that the next generation of doctors are better prepared for life in the health service, than frankly was the case for my generation. Admittedly, that is not hard, given that back in my generation when myself, and probably many of you, qualified it was considered that all you needed to start you on your career was experience in medicine and surgery, irrespective of your own intentions and irrespective of what were the true needs of the population. So now we have a chance to get it right.

Psychiatry foundation training offers specific opportunities for trainees to develop transferable skills that are appropriate for managing the patient in any setting. Words like "patient centred", "whole patient" or "holistic" have all become clichés these days- but no matter how you phrase it, the truth is that good care depends on being familiar with both the physical and psychological in illness. Patients now expect more of doctors than just high intelligence and technical skills – although neither of these will ever go out of fashion. Patients now expect that their doctor will show equal skills of self-awareness, reflection, caring with compassion and an empathic understanding of patients. All of us are now familiar with the lessons of the Francis Report. What had failed in that setting was not technical knowledge, but deficiencies in caring and compassion – whole patient care. A small prize is available to anyone who can find a better word than that, but you all know what I mean. Psychiatry foundation placements, I hope, will also help to reduce some of the stigma which is still associated with mental illness, and also counter some of the rather daft myths that still exist around psychiatry.

The purpose of increasing the exposure of the next generation of doctors to psychiatry is not to persuade them to become psychiatrists. Even if not a single extra junior doctor opts for a career in psychiatry, provided that they have learned something from their placement that will ensure that they are better equipped to meet the challenges of the future NHS, it will be a job well done. But it would be disingenuous to pretend that this is also not an opportunity to improve recruitment to our own speciality.

We really need to embrace this opportunity to ensure that we are offering high quality foundation training in psychiatry to our doctors. The stakes are high – the rewards even higher – for patients, for the next generation of doctors, and for our profession.

## **Introduction**

Welcome to this guide to foundation training in psychiatry for trainees and supervisors. This guide is designed to give an overview of the Foundation Programme, specifically focusing on placements in psychiatry. It sets out important **quality guidance** on how to ensure high quality foundation posts.

This guide has been designed by Dr Ann Boyle (Foundation Programme Lead) and Dr Jen Perry (FMLM Clinical Fellow in Leadership and Management) using multiple sources of information, which are listed in the reference section.

## **Key Contacts**

<b>Name</b>	<b>Role</b>	<b>Contact</b>
UK Foundation Programme Office (UKPFO)	Facilitate the operation and continuing development of the Foundation Programme	Website: <a href="http://www.foundationprogramme.nhs.uk/pages/home">http://www.foundationprogramme.nhs.uk/pages/home</a> Email: <a href="mailto:enquiries@foundationprogramme.nhs.uk">enquiries@foundationprogramme.nhs.uk</a>
Nikki Cochrane	Head of Training & Workforce Operations Royal College of Psychiatrists	<a href="mailto:careers@rcpsych.ac.uk">careers@rcpsych.ac.uk</a>
Dr Ann Boyle	Specialist Adviser for Foundation, Royal College of Psychiatrists	<a href="mailto:careers@rcpsych.ac.uk">careers@rcpsych.ac.uk</a>

If you would like the contact details of the Foundation Psychiatry Lead within a specific LETB or Foundation School please contact Alexandra Menzies.

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## **Background to the Foundation Programme**

### What is the UK Foundation Programme?

The Foundation Programme is a two-year structured, supervised programme of workplace-based learning for medical school graduates. It exists to prepare junior doctors for specialty training by providing them with the medical knowledge and skills to meet the requirements of the Foundation Programme Curriculum<sup>i</sup>. Foundation Year 1 (FY1) is the pre-registration year and Foundation Year 2 (FY2) is a post registration year of generic training.

The Foundation Programme aims to:

1. Build on undergraduate education by instilling recently graduated doctors with the attributes of professionalism and the primacy of patient welfare
2. Provide generic training that ensures Foundation Doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing both acute and long term conditions
3. Provide the opportunity to develop leadership, team working and supervisory skills
4. Provide each Foundation Doctor with a variety of workplace experience in order to inform their career choice<sup>ii</sup>.

All Foundation Doctors must make patient safety paramount and must practise with professionalism. They must learn how to empathise with patients' conditions and develop professional attributes in accordance with the GMC's Good Medical Practice<sup>iii</sup> and The Trainee Doctor<sup>iv</sup> including:

- Integrity
- Compassion
- Altruism
- Aspiration to excellence via continuous improvement
- Respect of cultural and ethnic diversity
- Regard to the principles of equity
- Ethical behaviour
- Probity
- Honesty
- Leadership

At all times Foundation Doctors must promote patient safety by:

- Practising within their competence
- Practising in accordance with prevailing professional standards and requirements including those expected in their placement
- Seeking advice from more experienced clinicians whenever appropriate in the workplace
- All doctors must ensure that they have adequate indemnity insurance for their practice

## How is the Foundation Programme organised?

The Foundation Programme is Quality Assured by the GMC. The Local Education and Training Boards (LETBs) are responsible for ensuring they meet or exceed the standards for training for the Foundation Programme in The Trainee Doctor as set by the GMC.

Health Education England has set up LETBs which are responsible for the training and education of doctors within their area. LETBs deliver foundation training through Foundation Schools.

The FY1 and FY2 programmes consist of a series of placements which last 4-6 months (4 months minimum). The programmes are usually hosted by Acute Trusts and can include experience in a wide variety of areas, including community placements (Psychiatry, general practice, community paediatrics), medicine and surgery. Foundation doctors will complete a 'Preparing for Professional Practice Programme' or shadowing period prior to starting their placements.

The national co-ordinating body for the Foundation Programme is the UK Foundation Programme Office which is commissioned by the four UK health departments.

## **Foundation Doctors in Psychiatry**

### Changes to the Foundation Programme and what this means for psychiatry

The Broadening the Foundation Programme (BTFP) Report<sup>y</sup> details how the UK's health and social care landscape is changing and recognises the need for a more patient centred, integrated model of care. It recognises that more care should be community based and that doctors' training needs to change to reflect this.

The recommendations from the BTFP report are:

- 1) Educational Supervisors should be assigned to Foundation Doctors for at least one year, so they can provide supervision for the whole of FY1, FY2 or both years.
- 2) Foundation Doctors should not rotate through a placement in the same specialty or specialty grouping more than once, unless this is required to enable them to meet the outcomes set out in the Curriculum.

However, where the experience will be significantly different between the posts, then two posts within a specialty grouping will be permitted (e.g. Acute Internal Medicine (admitting) posts and General Medicine (ward-based) posts). In such circumstances, the sub-specialties should not be the same.

- 3) a) At least 80% of Foundation Doctors should undertake a community placement or an integrated placement from August 2015.

**b) All Foundation Doctors should undertake a community placement or an integrated placement from August 2017.**

Psychiatry posts in mental health hospitals which are not on the site of an acute hospital will be counted as being community posts. Posts located within the acute hospital where the trainee will have the opportunity to look after patients with long-term conditions, work with community services/MDT will also be counted as community posts. Liaison psychiatry would fall under this definition.

The target set by the psychiatry taskforce is to have **22.5% of all FY1 and 22.5% of all F2 posts in psychiatry**. This means that nearly half of all doctors will participate in at least four months of postgraduate psychiatry training, which represents a significant increase.

Key Definitions:

**Community placement:** This is primarily based in a community setting (e.g. community paediatrics or community psychiatry).

**Community-facing placement:** This is primarily based within an acute setting; however, the placement should also include opportunities to develop skills in the care of the total patient, long-term conditions and the increasing role of community care.

**Integrated placement:** The doctor is primarily based in a community setting, which crosses traditional care boundaries and supports the development of capabilities in the care of patients along a care pathway.

What is the difference between Foundation Year 1 (FY1) and Foundation Year 2 (FY2)?

FY1 enables Medical Graduates to begin to take supervised responsibility for patient care and consolidate the skills they have learned at medical school. Satisfactory completion of FY1 allows the relevant university (or their designated representative in a Postgraduate Deanery or Foundation School) to recommend to the GMC that the Foundation Doctor can be granted full registration<sup>i</sup>. It is worth noting that this may change in the future as the Shape of Training Report<sup>vi</sup> has recommended that full registration should move to the point of graduation from medical school.

**Most FY1 doctors when they first start will be very inexperienced and will require a substantial amount of support from their supervisors and the team.**

This will change as the year goes on and they move into FY2, as they will start to develop skills, knowledge and confidence in their clinical work.

FY2 doctors remain under clinical supervision but take on increasing responsibility for patient care. They begin to make management decisions, develop their core generic skills and contribute more to the education/training of the wider healthcare workforce. At the end of FY2 they will have begun to demonstrate clinical effectiveness, leadership and decision-making responsibilities. Satisfactory completion of FY2 will lead to the award of a Foundation Achievement of Competence Document (FACD) which indicates that the Foundation Doctor is ready to enter a core, specialty or general practice training programme<sup>ii</sup>.

What is the difference between Foundation Training and Psychiatry Specialty Training?

The Foundation Doctor is NOT learning to be a psychiatrist. The aim of the rotation is to give Foundation Doctors a meaningful experience in psychiatry and to allow the doctor to achieve the Foundation Programme competencies. However, if Foundation Doctors have an interest in psychiatry, they should be supported in accessing other additional learning opportunities.

All trainees play a key role in the delivery of NHS care and are not supernumerary to service requirements. It is important that Foundation Doctors 'learn by doing', as they

will learn more effectively when they are responsible for their actions. However, it is important to remember that FY1 doctors are new Medical Graduates and will be inexperienced compared with psychiatry Core Trainees. Therefore they need to be well supervised to allow them to develop as doctors whilst ensuring patient safety.

After completing foundation training the doctor may wish to apply for GP, core or specialty training. The current process within psychiatry is that doctors apply for three years of core training (CT1-3) during which they complete their membership exams. Following this, the doctor will then apply for specialty training in one or more of the following specialties; general adult, CAMHS, forensics, old age, psychotherapy and learning disability. At the end of this, doctors will be awarded a Certificate of Completion of Training (CCT).

#### Are Foundation Doctors able to prescribe?

The safety of patients must be paramount at all times. Foundation doctors must not be put in a position where they are asked to work beyond their competence without appropriate support and supervision. Technically F1s can prescribe in any setting including the community. The College has concerns about the possibility of unsupervised prescribing in community settings and for this reason would recommend that F1s only prescribe in inpatient settings. Any derogation from this would need to be negotiated locally with the deanery/foundation school and will depend on supervision and other safeguards.

#### Can Foundation Doctors do out of hours shifts and what level of supervision is required?

Foundation Doctors can do out of hours shifts, however FY1 doctors should not be on Core Trainee rotas. Any on-call for FY1s must be separate from core rotas and be carefully designed.

FY1s are not allowed to do locum shifts.

The Royal College of Psychiatrists (RCPsych), in discussion with the GMC, has agreed the following guidance in relation to Foundation Doctors undertaking out of hours experience<sup>vii</sup>:

- Availability of robust clinical supervision should be considered in the planning and development of all foundation posts in psychiatry. Arrangements should include supervision in the in hours placement and any associated out of hours work/on-call responsibilities.
- A review of the supervisory roles and relationships should be considered as part of the quality control of new placements at a Local Education Provider (LEP) level informed by the Foundation School/School of Psychiatry
- Trainees must be supervised according to their experience and competence, and must only undertake tasks in which they are competent or are learning to be competent, and with adequate supervision. Trainees must never be put in a situation where they are asked to work beyond the limits of their competence without appropriate support and supervision from a Clinical Supervisor.
- Foundation doctors must always have direct access to a senior colleague who can advise them in any clinical situation. Foundation doctors must never be left in a situation where their only help is outside the hospital or the place where they work.



- **A senior colleague does not have to be a doctor but can be a senior nurse, provided they have the necessary knowledge and skills to advise the trainee appropriately.**
- If immediate supervision at the place of work comes from a nurse the trainee must also have access to a senior doctor who can attend if necessary.
- FY1 doctors should not be on Core Trainee rotas; any on-call for them must be separate from core rotas and be carefully designed.
- The level of supervision necessary may be different at the beginning of the four month placement to the end of the four months and different at the beginning of the year and the end. Employers need to undertake a 'risk assessment' to ensure that the appropriate clinical cover is in place for the number and level of complexity of the patients that the doctor may be required to see .This is not an exhaustive list and should include: decision making about emergency inpatient admissions, CPR and medical emergencies in an inpatient setting, work in Emergency Department and the responsibilities delegated OOH to them as the on-call doctor under the relevant Mental Health Act.
- The Foundation Doctor must feel they are adequately supported by the clinician on site.

How much study leave are Foundation Doctors entitled to? What are the requirements of their generic Foundation Teaching Programme?

LETBs/Foundation Schools will have their own study leave policies. Generally speaking FY1 doctors are not eligible for study leave, however, local arrangements may exist to enable them to undertake tasters. FY2 doctors may request up to 30 days study leave. The majority of this is allocated to the teaching programme, taster sessions and Advanced Life Support.

FY1 and FY2 doctors are entitled to three hours a week of protected in-house, formal education which is organised by the LEP. This may be aggregated to form whole days of generic training. Supervisors should release the Foundation Doctors so they can attend. This teaching offers the opportunity to meet with their other FY1/FY2 colleagues and is usually held at the host Trust.

Further information can be found here: The UK Foundation Programme Office. The UK Foundation Programme Reference Guide, July 2012, Updated for August 2014 (2) p33-34

Please see Appendix 1 for a sample generic teaching programme timetable

## **How to Organise Training**

### Introduction

The RCPsych has produced guidance to support the development of high quality psychiatry foundation placements. The guidance is not intended to be prescriptive although there are some requirements in any training placement which should be considered to be mandatory.

There is no single model of post/placement as service models present different strengths and learning opportunities across different sub specialties in psychiatry and the geographies across the four UK nations. The RCPsych has contributed to the development of the Foundation Programme curriculum<sup>i</sup>, which covers generic and mental health specific learning outcomes. The quality control and quality management of all foundation posts and programmes is at an LEP and Foundation School level. The role of the College is an advisory one only and this guidance should be viewed as national best practice.

## Quality Guidance

### **Post development and curriculum delivery**

Foundation posts in psychiatry must provide significant practical experience to enable doctors to achieve and maintain clinical and generic competencies. Posts must enable doctors to demonstrate the knowledge, skills and behaviour required by the foundation curriculum.

Ideally, psychiatry posts included in a 2 year Foundation Programme should be subject to a curriculum mapping exercise. This will ensure that the outcomes delivered in each post integrate well into a proposed 2 year Foundation Programme.

### Working within an MD

All foundation psychiatry posts should aspire to give a Foundation Doctor a high quality experience of MDT working. This could include attendance at CPA meetings as a gold standard of multi-professional working in mental health. Foundation Doctors should be supported in making useful contributions to the MDT meeting. The environment should allow other team members to make reliable judgements about the Foundation Doctor's ability and performance.

### Communication skills

Foundation psychiatry posts should provide excellent learning opportunities for Foundation Doctors to acquire and develop communication skills. This should be through working with patients, their families and other professionals in both straightforward and more complex situations.

### Reflective practice

The development of reflective ability is a Foundation Programme outcome. This can be developed in psychiatry with 1 hour face-to-face weekly supervision with a named clinical supervisor. There may also be the opportunity to attend a specific Balint Group developed for Foundation Doctors.

### Working across services

There will be opportunities to allow the Foundation Doctor to experience working across the health and social care boundaries. Doctors will be able to maximise learning opportunities across acute and mental health services, primary and secondary care services, social care and voluntary sector services.

### Experience of holistic care and patients with long-term conditions

Community visits are not an absolute requirement of a Foundation psychiatry post. However, opportunities to have experience of holistic care in both acute presentations and in long-term conditions are likely to be widely available in all psychiatry placements. Home visit selection is the responsibility of the trainee's named Clinical Supervisor and should be undertaken at their discretion, with careful patient selection and due oversight of the LEPs lone worker policy. Appropriate and timely debriefing for the Foundation Doctors should be available immediately following the visits.

### History taking, mental state examination and core medical skills

A Foundation Doctor should have the opportunity to develop skills in history taking and mental state examination in their placement. There should be opportunities available to doctors to acquire core medical skills within their day-to-day clinical work (for example, physical health assessment of new admissions in an inpatient setting). Placements could also be developed which have timetabled sessions in an acute medical setting (for example, one day a week on-call in a co-located acute trust).

### Recognising and managing the acutely unwell patient

Learning opportunities could include both recognising and managing acutely ill patients in a mental health setting. This would include experience of managing acute mental disorder and self-harm both in routine and out of hours work. It would also include managing patients with long-term conditions, and recognising the interplay between long-term physical illness/psychological factors/mental disorder. This would enable the trainee to appreciate the implications for both patient management and outcomes.

### Medico-legal issues

Psychiatry posts are well placed to deliver Foundation Programme experiential learning opportunities. Foundation Doctors will be able to acquire an understanding of medico legal and ethical issues within healthcare through teaching and clinical work. There are specific opportunities within psychiatry to develop an understanding of the Mental Capacity Act and experience of using it. Specific support for FY2 doctors who are on-call out of hours and are deputising for the Responsible Clinician under the Mental Health Act should have supervision around the powers of detention for an on-call junior doctor. These competencies should be acquired prior to participation in any out of hours work. FY1 doctors should never be the only doctor on site out of hours.

### Tasters

In order to complement any clinical exposure in a psychiatry foundation placement, the RCPsych suggests that LEPs and Foundation Schools develop posts which include 5 taster days. The taster days should be within other sub-specialty areas of psychiatry. They should be bespoke, compliment trainees' interests and ideally inform future career intentions within and outside of specialty training in psychiatry. For example, an FY2 may wish to be a paediatrician in the future and so could do a taster in CAMHS.

FY2 doctors can use study leave to undertake tasters. FY1 doctors are not eligible for study leave; however, local arrangements may exist to enable them to undertake tasters towards the end of the FY1 year.

Further information can be found here: UK Foundation Programme Office. Specialty Tasters in the Foundation Programme: Guidance for Foundation Schools. March 2011<sup>viii</sup>  
[www.foundationprogramme.nhs.uk/download.asp?file=Tasters\\_guidance](http://www.foundationprogramme.nhs.uk/download.asp?file=Tasters_guidance)

### Teaching Opportunities

All Foundation Doctors should be presented with opportunities to teach others. For Foundation Doctors in psychiatry this could include teaching undergraduate Medical Students or teaching a medical topic to the MDT. It may be helpful for the foundation doctor to do this in conjunction with a senior colleague who can provide supervision and support.

### Attendance at generic teaching programme

Foundation Doctors must be supported to attend their generic foundation teaching programmes. Attendance at this teaching programme is a mandatory requirement for the Annual Review of Competence Progression (ARCP) for Foundation Doctors.

### Attendance at local site psychiatry teaching

Trusts may wish to consider developing opportunities for Foundation Doctors which are integrated into local existing specialty training opportunities; for example Journal Club, Case Conferences and targeted attendance at MRCPsych teaching sessions.

### Development of specific mental health teaching programmes

LEPs and Foundation Schools should consider the development of specific mental health teaching programmes for all Foundation Doctors. Not all Foundation Doctors will have had the opportunity to complete a psychiatry post in the course of their 2 year Foundation Programme.

### Audit and Quality Improvement (QI)

Foundation Doctors should have time protected to engage in audit and QI work. It is recommended that one half day per week is embedded in all foundation psychiatry placement timetables to support this activity.

### Induction

All placements need to be developed with due regard for appropriate induction for Foundation Doctors to ensure patient safety.

There are at least three levels of induction:

- Deanery/Foundation School;
- Employer/Local Education Provider (LEP);
- Departmental/workplace.

How to prepare for the arrival of a Foundation Doctor in your place of work:

Ensure the whole team/ward is informed and involved in the Foundation Doctor's placement. Members of the team should be engaged in the process and will be able to support the doctors' training. FY1 doctors should normally undertake a "shadowing" period of the FY1 job that they will be taking up at the start of their year. This ensures

they will have the necessary local knowledge and skills to provide safe patient care<sup>ii</sup> It is important to ensure that the Clinical Supervisor is present for the FY1s shadowing period to provide the necessary support.

It is important to describe to the team the level of training the FY1 or FY2 has. It should be explicitly stated to the team what should and should not be expected from the Foundation Doctors and what support they will require. This is particularly relevant if psychiatry is the FY1s' first placement.

Identify a workplace induction process and timetable for your trainee. The induction should ensure that the doctor is introduced to all team members, familiarised with the working environment (including health and safety procedures) and should involve a period of shadowing/observation.

The doctor should also be provided with a thorough handover of patients (see Appendix 4 for a sample workplace induction programme). More information can be found on the different types of induction here: The UK Foundation Programme Office. The UK Foundation Programme Reference Guide, July 2012, Updated for August 2014 (2) p24.

### Experience beyond the curriculum

There are a proportion of Foundation Doctors in psychiatry who may wish to acquire competencies beyond the Foundation Programme over the course of their placement. This will include Foundation Doctors who have already committed to a career in psychiatry, who may have a particular aptitude and interest in exploring options beyond the curriculum. There are also doctors whose final career intentions are unclear or who have chosen another speciality, who may wish to maximise any learning opportunities within their psychiatry placement. A list of possible additional achievements /learning opportunities could include:

- 1) Additional psychotherapy experience. For example, observation/undertaking individual/group psychotherapy training or participation in a psychotherapy supervision group.
- 2) Additional emergency experience. For example, involvement/observation of a 136 assessment or seclusion review.
- 3) Additional medico-legal experience to include observation of a Mental Health Tribunal or Mental Health Act Assessment. See Appendix 2 for a guide for Foundation Doctors who are observing tribunals.
- 4) Other experience. For example, presentation of a project at a regional or national meeting.
- 5) Attendance at a prison visit, court diversion or visit to a secure mental health unit.
- 6) Observation or undertaking of ECT

A weekly timetable should be designed to try and incorporate these experiences where possible. See Appendix 3 for sample timetables.

## **Learning environment and culture**

It is critical that any psychiatry placement in the Foundation Programme should be in an environment that is safe and delivers a good standard of care for patients. The clinical environment should be intrinsically multi-professional to allow Foundation Doctors to learn with and from a range of clinical staff.

Foundation Schools, with LEPs, need to identify suitable learning environments for foundation posts in psychiatry. Most established psychiatry posts in the Foundation Programme exist in general adult psychiatry. Other clinical environments such as old age psychiatry, liaison psychiatry and some community settings are also likely to be able to effectively deliver the foundation curriculum outcomes. The potential of other learning environments, such as CAMHS and learning disability psychiatry, have yet to be completely explored.

Hospital based placements have a number of advantages as foundation placements in psychiatry. An inpatient environment allows for a high degree of senior and multidisciplinary team support. There is co-location with other trainees, particularly when the mental health unit is co-located on an acute hospital site. An inpatient environment provides more potential for Foundation Doctors to achieve physical healthcare competencies. Inpatient placements should be complemented with supervised community exposure. This could be facilitated, for example, by utilising the links a specific inpatient area has with a Community Mental Health Team (CMHT), which would allow doctors to follow patients along a care pathway.

Multi-professional teams which can provide a high level of support for FY1 doctors are particularly suitable placements. Teams with a relatively stable caseload which do not have an acute undifferentiated take (for example early intervention, assertive outreach and treatment and recovery services) are suitable. Ideally there should be a consultant who is familiar with the patients and can ideally provide supervision. In FY2, doctors are more experienced and may be able to benefit greatly from the potential learning opportunities in a CMHT setting. Careful consideration and planning should be given to enabling a community based Foundation Doctor to make a smooth transition back to the general hospital setting. There is also a need to be mindful of mitigating against the potential of Foundation Doctor isolation, particularly if the doctor is the only early years trainee in a community team.

Trainees should receive 1 hour face-to-face supervision from a senior clinician each week. This should be timetabled and considered a mandatory requirement for any placement to deliver. Further detail is given on this in 'Supporting Foundation Doctors and Trainers' (below).

## **Educational governance**

There needs to be effective, transparent and clearly understood educational governance systems and processes for quality management and quality control of foundation training. The co-located speciality school for psychiatry may be involved in this arrangement. Accountability for educational governance at a LETB level between the Foundation School and co-located specialty school for psychiatry must be clearly assigned. Ideally, consideration should be given for a named individual at an LEP level. It is recognised that in smaller LEPs this may not be feasible and that different models of educational governance have the potential to work very well.

The role of the RCPsych in the Foundation Programme educational governance is involvement in the development of the curriculum through the Academy of Medical Royal Colleges (AoMRC). The RCPsych has an advisory role to help identify and disseminate good practice. The College can provide support to LEPs and Foundation Schools in improving the quality of training in psychiatry foundation placements.

### **Supporting Foundation Doctors and Trainers**

All Foundation Doctors must have the appropriate educational and pastoral support so they are able to achieve the curriculum outcomes over the 2 year programme. Psychiatry placements contribute to this by providing learning opportunities to enable the acquisition of knowledge, skills and behaviour consistent with the FY1 and FY2 outcomes.

A Foundation Doctor should have a named Clinical and a named Educational Supervisor. A **Clinical Supervisor** is responsible for overseeing a specified Foundation Doctor's clinical work and providing constructive feedback during a training placement. An **Educational Supervisor** is responsible for the overall supervision and management of a specified Foundation Doctor's educational progress during a training placement or series of placements.

At an LEP level, named Clinical Supervisors must be clearly identified, competent to supervise and have had specific training to equip them with supervision skills. **Foundation doctors should receive 1 hour face to face supervision from a senior clinician each week.** This should be agreed at the start of each placement, timetabled and considered a mandatory requirement. There should also be clear lines of supervision identified when the named Clinical Supervisor is absent, for example this could be from a higher trainee. LEPs should be mindful that FY1 doctors require onsite access to a dedicated supervisor with the required knowledge and skills to deal with problems that might arise in any clinical situation. Due to the multi-professional nature of mental health services this may not always be a doctor. Arrangements should be made so that foundation doctors have the contact details of those who are supervising them.

Any rota at an LEP level that includes Foundation Doctors must enable appropriate supervision and provide learning opportunities to meet the foundation curriculum requirements.

All consultant supervisors in psychiatry for the Foundation Programme need to have a commitment to developing this group of doctors. Supervisors need to be selected, inducted, trained and appraised to reflect the responsibilities of Foundation Supervisors. Mental health LEPs will need to work in partnership with the Foundation School and the co-located acute trusts within a geographical location. Together they will need to ensure that psychiatrists involved in the Foundation Programme are part of an integrated faculty of Foundation Educators.

Named Clinical Supervisors and Educational Supervisors for foundation placements need to be provided with support, resources and time to deliver effective training. In light of the greater requirement for direct supervision of these doctors, especially early in the FY1 year, the time requirement is likely to exceed 0.25PA per week. Medical Directors and Directors of Medical Education need to be mindful of this. There is a need to clearly allocate time in consultant job plans to provide this. This will help ensure a high quality education and training experience and will enable patient safety.

Supervisory arrangements for locum consultants who are supervising Foundation Doctors need to be agreed by the Trust Director of Medical Education/Trust Foundation Lead and FTPD.

One of the particular strengths of psychiatry is that the majority of Supervised Learning Events (SLEs) are consultant led. This is in great contrast to other specialties in secondary care. FY1 and FY2 doctors must have opportunities to receive regular constructive and meaningful feedback on their performance. The model of clinical supervision of psychiatry, with 1 hour face to face supervision with a senior consultant, should maximise the opportunity for constructive developmental feedback to occur.

Further information on the roles and requirements of clinical/educational supervisors can be found here: The UK Foundation Programme Office. The UK Foundation Programme Reference Guide, July 2012, Updated for August 2014, P16-18

## **The Foundation Programme E-Portfolio, Curriculum and Assessment Process**

### What is the e-portfolio?

All Foundation Doctors must maintain an e-portfolio and use it to support their educational and professional development and career planning. There are two providers of the e-Portfolio; NES and Horus.

The e-portfolio includes personal development plans, summaries of feedback from the Educational Supervisor, Clinical Supervisors' reports, significant achievements or difficulties, reflections of educational activity, career reflections and the results of the Foundation Programme assessments.

The e-portfolio is reviewed to inform the judgement about whether a Foundation Doctor has met the requirements for satisfactory completion of FY1 and FY2<sup>ii</sup>.

### What is the role of supervisors in relation to the e-portfolio?

Supervisors should know what Foundation Doctors' e-portfolios should contain and should have an awareness of the foundation competencies.

Supervisors should take an active interest in the Foundation Doctors' work and check their portfolios regularly within supervision.

Supervisors should complete Supervised Learning Events (SLEs) with doctors and complete their supervisor reports **Error! Bookmark not defined..** At start of placements, supervisors should take active role in timetabling in SLEs with the foundation doctor.

### What are Supervised Learning Events (SLEs)?

A SLE is an interaction between a Foundation Doctor and trainer which leads to immediate feedback and reflective learning. SLEs are not summative and there is no numerical marking; the focus is on narrative formative feedback.

SLEs use the following tools:

- Mini-clinical evaluation exercise (Mini-CEX)



- Direct observation of procedural skills (DOPS)
- Clinical based discussion (CBD)
- Developing the clinical teacher

The SLE process is described in further detail in the Curriculum: Academy of Medical Royal Colleges. The UK Foundation Programme Curriculum, July 2012 updated for 2014, P56

What is the recommended minimum number of SLEs per placement? (Based on a clinical placement of four month duration)

- Direct observation of doctor/patient interaction: Mini-CEX, DOPS-3 or more.
- Case-based discussion (CBD)- 2 or more
- Developing the clinical teacher -1 or more<sup>i</sup>

What is the frequency of assessments?

- E-portfolio -Contemporaneous
- Core procedures -Throughout FY1
- Team assessment of behaviour (TAB- Multisource feedback tool) -Once in first placement in both FY1 and FY2, optional repetition
- Clinical Supervisor end of placement report -Once per placement
- Educational Supervisor end of placement report- Once per placement
- Educational Supervisor end of year report- Once per year<sup>i</sup>

What are procedures?

There are a number of core and clinical procedures which Foundation Doctors need to get signed off during their training. Foundation Doctors may find opportunities to undertake the following during their psychiatry placements:

- Venepuncture
- Perform and interpret ECGs
- Perform and interpret peak flows
- Intramuscular injection
- Blood culture (peripheral)

There needs to be an appropriate level of supervision in place for Foundation Doctors undertaking these procedures. For example, the Foundation Doctor could be supervised in performing and interpreting ECGs by a Core Trainee who is experienced in this area.

Foundation Doctors should not be expected to perform procedures such as IV cannulation, arterial punctures, IV preparation/administration of medications/fluids/other infusions whilst doing their psychiatry placements. Patients requiring this level of medical intervention should be transferred to a general hospital and should not be managed in a psychiatric setting<sup>i</sup>.

What are the key themes from the curriculum?

The key message from the curriculum<sup>i</sup> is that Foundation training is underpinned by two central concepts:

- Patient safety
- Personal development

There are two sections to the curriculum. The first is on 'The Foundation Doctor as a professional and a scholar' which has generic outcomes and competencies. The second section is entitled; 'The Foundation Doctor as a safe and effective practitioner' which has clinical outcomes and competencies.

The vast majority of competencies from the curriculum can be developed in a mental health setting. Specific learning opportunities in foundation psychiatry are highlighted in the **quality guidance** section 1 ('Post development and curriculum delivery')

The South Thames Foundation School has developed the following psychiatry competencies<sup>ix</sup>:

During a foundation placement, the doctor should obtain the following competences, with the relevant competency assessment completed on the e-portfolio.

1. Elicit a basic clinical history for a common psychiatric disorder
2. Perform a mental state examination (MSE) for a common psychiatric disorder
3. Perform a cognitive screening assessment
4. Perform a risk assessment
5. Make a concise case presentation and initial management plan for a common psychiatric disorder
6. Write an accurate and concise report, assessment or referral

### What is an ARCP?

Towards the end of FY1 and FY2, the Foundation Training Programme Director/Tutor, under the guidance of the Foundation School, should convene an ARCP panel to review the progress of all Foundation Doctors in their programme. The ARCP provides a formal process for reviewing Foundation Doctors' progress, which uses the evidence gathered by them and supplied by their supervisors.

Doctors are given an outcome from their ARCP which can be;

Outcome 1- Satisfactory completion of FY1/FY2

Outcome 3- Inadequate progress - additional training time required.

Outcome 4-Released from training programme

Outcome 5- Incomplete evidence presented – additional training time may be required

(Note; no outcome 2)

After a doctor has successfully passed their ARCP they are able to proceed to the next stage of their training<sup>ii</sup>.

## **Frequently Asked Questions (FAQs)**

### 1) What are the benefits of having an increased number of psychiatry foundation posts?

All doctors will come into contact with patients suffering from mental illness throughout their careers. It is important therefore that doctors develop the knowledge and skills to deliver good quality care to this patient group early on in their training and this has been recognised by the Broadening the Foundation Programme Report. Foundation Doctors working in psychiatry will have the opportunity to meet patients with mental illness, particularly those with long term conditions and those in community settings. They will gain experience of navigating the boundaries of acute and mental health services, inpatient and outpatient services and primary and secondary care. They will learn more about working with social care services and the voluntary sector.

Psychiatry foundation training offers specific opportunities for trainees to develop transferable skills that are appropriate for managing the 'whole' patient in any setting. Doctors will develop skills of self-awareness, reflection, caring with compassion and an empathic understanding of patients. This is extremely important in light of the Francis Report which highlighted the need to have a caring and compassionate medical workforce. Psychiatry foundation placements will help to reduce some of the stigma which is still associated with mental illness.

Mental illness does not have parity of esteem with physical illness. 23% of the UK population will suffer with mental ill health at some point in their lifetimes. This can have a wide variety of consequences, including increased physical health problems, increased health risk behaviours (e.g. smoking, drug and alcohol use) and reduced life expectancy amongst some groups. Vice versa, physical illness can also lead to mental illness. At present, there is a funding gap between mental health and other medical specialities. Increasing the number of psychiatry foundation posts so that doctors, early in their careers, are able to understand the relationship between physical and mental illness is a key step in achieving parity of esteem.

There is evidence to show that recruitment at foundation level encourages recruitment into psychiatry as a specialty. It is well recognised that there have been serious problems in psychiatry recruitment. In 2011, only 78% of the 478 core trainee year 1 (CT1) vacancies were filled in England and Wales. A study was carried out by Kelley et al<sup>x</sup> in which a survey was distributed to all FY2 doctors in the UK. This was to determine what proportion had exposure to psychiatry before specialty applications and whether such exposure correlated with choosing psychiatry as a career. The study showed that 14.6% of Foundation Doctors had exposure to psychiatry prior to specialty applications. Of these, 14.9% chose psychiatry as a career in contrast to only 1.8% of those who did not have psychiatry exposure. It is important therefore that Foundation Doctors have high quality psychiatry placements.

These changes to training will also offer multiple benefits to supervisors and organisations. For the consultant psychiatrist, having Foundation Doctors is an opportunity to expand their trainer experience, contribute to their own professional development and promote their specialty. There will be opportunities for other psychiatry doctors of different grades to teach Foundation Doctors and to enhance their teaching skills.

## 2) How do graduates apply for foundation training and who decides which placements foundation doctors get?

Applicants register on the Foundation Programme Application System (FPAS). They then complete an online application form and sit a situational judgement test. Applicants are given a score based on educational performance (this is based on two elements: medical school performance and educational achievements) and the results from their test. Applicants are allocated to a Foundation School and matched to programmes based on their scores and personal preferences.

More details can be found here: The UK Foundation Programme Office. FP/AFP 2015, Applicants Handbook, June 2014<sup>xi</sup>.

## 3) What are Academic Foundation Programmes?

Foundation schools in partnership with universities offer a small number of Academic Foundation Programmes. They provide doctors with the opportunity to develop their research, teaching and/or leadership skills and explore academia as a career alongside their clinical work.

The programmes typically last two years although occasionally vacancies arise at FY2. Academic training, whether structured as a stand-alone placement or regular time throughout the programme, should not exceed one third of the time allocated to training in FY2.

As Academic Foundation Programmes typically provide less time for the development of clinical and generic skills, there is a different application process to identify applicants who are likely to be able to meet all of the clinical and academic requirements.

All doctors appointed to academic programmes must have an Academic Supervisor or equivalent with whom they should agree learning outcomes.

Further information can be found here: The UK Foundation Programme Office. The UK Foundation Programme Reference Guide, July 2012, Updated for August 2014, P9-10

## 4) How can Foundation Doctors who have not managed to do a psychiatry placement, but are interested in the specialty, get experience?

Foundation Doctors can undertake external tasters, for example a Foundation Doctor undertaking an orthopaedic placement who is interested in psychiatry may wish to undertake 2-5 days in a CMHT.

## 5) What about Foundation Doctors who have concerns/negative views about placements within psychiatry?

Doctors may have pre-conceived negative views about foundation psychiatry placements. These include fears about a lack of exposure to acute care or procedural experience relevant to the curriculum. An overview of the literature suggests that concerns about psychiatry placements being of little value are common but are almost always universally overturned once the placement is completed. The BTFP report (5) highlights that there is overall a high level of satisfaction amongst those who do psychiatry placements (BTFP).

It is important that all stakeholders are mindful of this concern and welcome any models to support Foundation Doctors in maintaining acute skills in a mental health setting.

6) Can Foundation Doctors do home visits?

Yes Foundation Doctors can do home visits. Home visit selection is the responsibility of the trainee's named Clinical Supervisor and should be undertaken at their discretion, with careful patient selection and due oversight of the LEPs lone worker policy. Suitable patients would include those who have already been seen and risk assessed by the service. Foundation Doctors should not undertake home visits alone, home visits should be undertaken jointly with another team member. Appropriate and timely debriefing for the Foundation Doctors should be available immediately following the visits.

7) Who holds the Contract of Employment for Foundation Doctors?

The Contract of Employment for Foundation Doctors is held by the Lead Employer which is usually the Acute Trust; although in some circumstances may be another body such as the LETB.

8) How much sick leave/annual leave are Foundation Doctors entitled to?

It is worth highlighting that the maximum period of permitted absence from training, other than annual leave, during the FY1 year is four weeks. Further details on sick leave and annual leave can be found here:

The NHS Careers guide: 'Welcome to the medical team'  
<http://www.nhscareers.nhs.uk/media/1916250/2902505-hee-welcome-brochure-final.pdf><sup>xii</sup>

## **Appendix 1: Sample generic foundation teaching programme**

### FY2 Teaching Programme Day 4 October 4<sup>th</sup> 2014

- 09.00 – 09.15 Welcome and learning objectives for the day
- 09.15 – 10.30 Managing the septic patient
- 10.30 – 11.30 Antibiotic prescribing
- 11.30 – 12.15 Working in acute care
- 12.15 – 13.00 LUNCH
- 13.00 – 14.00 DNAR and End of Life issues
- 14.00 – 15.00 Managing palliative care patients/ Use of the Liverpool Care Pathway
- 15.00 – 15.30 BREAK
- 15.30 – 16.45 Teaching Presentations e.g. Managing a patient with chronic renal failure
- 16.45 – 1700 Reflective practice of learning objectives

## **Appendix 2: Mental Health Tribunals**

### A Guide for Foundation Doctors who are observing tribunals

#### **Background to the Mental Health Tribunal**

A patient with a mental disorder who is presenting risks to themselves or others, and who is unwilling to be treated, can be detained in hospital for treatment using the Mental Health Act, often referred to as 'being sectioned' (due to sections of the MHA being relied

upon to do this). Patients detained under the Mental Health Act have a right of appeal to the Tribunal (the full title is First Tier Tribunal –Mental Health); the time at which a patient can apply depends on the section. Patients who appeal are entitled to free legal representation at their tribunal.

### Process of a tribunal hearing

The tribunal is a panel that is made up of three people – a Judge (who chairs the hearing), a Tribunal Doctor who is a Consultant Psychiatrist, and a Specialist Lay member who has knowledge of mental health care. The panel’s powers depend on the section of the Mental Health Act that the patient is detained under. The panel comes to the hospital for a meeting with the patient, their legal representative and clinical team which is a formal meeting called a hearing.

### Seating plan at the hearing

Tribunal doctor	Judge	Specialist Lay member (SLM)
Clinical team doctor	Patient’s legal rep	Patient Nurse Care Co-ordinator

Before the hearing starts, the panel and (separately) the patient’s legal representative reads the reports from the clinical team (a medical report, nursing and a report from the care co-ordinator who is usually a social worker or community psychiatric nurse) and discusses issues such as order of evidence: if the patient is agitated, they will be encouraged to give their evidence first.

After the patient’s **legal representative** says what the patient is requesting, the panel question the **clinical team**: i.e. the doctor, nurse and care-co-ordinator, and take notes. These questions cover the *statutory criteria*: these are the legal criteria on which the patient’s detention under section is justified, and typical answers are shown below.

Q. Is the patient suffering from a mental disorder?	A. The actual diagnosis may not yet be confirmed; the two most common diagnoses for detained patients are paranoid schizophrenia and schizo-affective disorder.
Q. Is the patient’s disorder of a nature that requires detention?	A. Nature includes diagnosis, pattern of illness i.e. relapsing and remitting, response to treatment, perpetuating factors, including compliance and insight
Q. Is the patient’s disorder of a degree that requires detention?	A. Current mental state so delusions, hallucinations, depression or mania, and negative symptoms such as self neglect.
Q. What is the appropriate treatment for the patient?	A. Includes medication, nursing care, occupational therapy, psychology, input from other teams, accommodation, benefit advice, carers support, employment support AND follow up arrangements when the patient leaves hospital e.g. community mental health team or Crisis/Home Treatment team
Q. What is the risk if the Section is lifted? There are three categories of risk: risk to the patient’s health, risk to the patient’s safety, and risk to others by the patient’s actions	A. Risk to health: mental (distress), physical (self care, neglect of medical conditions) Risk to safety: self harm, suicide attempts, putting self in risky situations and vulnerability, retribution from others, road safety. Protection of others e.g. from physical assaults

The patient's legal representative questions the clinical team with an aim to show that the patient either: does not meet the criteria above, is willing to stay in hospital and take treatment as a voluntary patient or will accept treatment in the community, and that any risks can be managed.

Sometimes hearings do not proceed (the panel will adjourn) if there is missing information that would mean it would not be in the interests of justice for the patient to proceed.

### **The patient's evidence**

The patient may wish to give evidence first or wait to see what their clinical team say first in order to respond to the clinical team's concerns with the help of their legal representative

After this the panel discuss the evidence privately and decide their options, which are:

- Immediate discharge from section if the criteria are not met- the patient may leave immediately or may agree to stay voluntarily in hospital
- Deferred discharge: section is to be lifted at a specified date in the future – usually a few days- to allow time for follow up arrangements
- Not discharged but recommendations are made to clinical team regarding care such as considering a community treatment order or a move to another hospital nearer the patient's home
- in restricted cases, conditional discharge

The patient, their representative and the clinical team are told the decision and a written version of the decision is sent to the hospital and to the patient's legal representative within a set time scale (a few days) as a record of the hearing.

The practice direction specifies the contents of reports: <http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Practice+Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf>

Readable information about Mental Health Act: A Clinician's brief guide to the Mental Health Act, 3<sup>rd</sup> Ed. 2014 Tony Zigmond RCPsych publications ISBN 978-1-909726-24-6

### **Appendix 3: Sample timetables**

#### FY1 Old Age Inpatient Psychiatry Placement

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Ward Work	Supervision (1 hour)  FY1 Generic Teaching (3 hours)	Ward work  Journal Club (1 hour)	Ward Round	Academic Meeting (1 hour)  Audit (1 hour)  Bailint Group (1 hour)
PM	Ward Round	Speciality experience	Ward Work	Specialty Experience	Ward Work

This is an FY1 placement on a functional old age psychiatry ward. There are two consultants and 3 early years trainees (GP, CT, FY2) working alongside the FY1. The FY1 will have the opportunity to:

- Gain experience of working on an old age psychiatry ward through clerking new patients, assessing patients' mental and physical healthcare needs, attending ward rounds.
- Attend their specialty experience twice a week, such as supervised community and outpatient experience (e.g. memory clinic), liaison old age psychiatry
- Attend 2 hours/week postgraduate psychiatric learning experience (Academic meeting, Journal club)
- Attend 3 hours weekly FY1 generic teaching (protected)
- Undertake 1 hour audit/quality improvement work each week
- Have weekly supervision with their clinical supervisor
- Attend Balint group (reflective practice group)

This model can be adapted for general adult psychiatry

#### FY2 Crisis Resolution/Home Treatment Team

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Home visits/new assessments	Home visit/new assessments  Journal Club (1 hour)	Home visits/new assessments	Home visits/new assessments	Home visits/new assessment  Academic meeting (1 hour)
PM	MDT Handover	Speciality Experience	Balint Group (1 hour)  Audit/QI (1 hour)  Supervision (1 hour)	MDT Handover  Generic FY2 teaching ( 3 hours)	MDT Handover

This is an FY2 placement in the Home Treatment team. The FY2 will be working alongside a Consultant Psychiatrist (supervisor) and an ST5 Psychiatry Trainee. The FY2 doctor will have the opportunity to:

- Undertake home visits and new patient assessments, as well as attending MDT handovers
- Undertake 1 session each week in 'specialty experience', this could include attending a general adult outpatient clinic or working on an inpatient ward
- Attend 2 hours protected postgraduate psychiatry teaching (academic meeting, journal club)
- Attend the FY2 generic teaching programme (protected time)
- Have weekly supervision (1 hour) with their consultant psychiatrist supervisor
- Undertake 1 hour audit/quality improvement work each week
- Attend the Balint Group (reflective practice group)



## **Appendix 4: Sample local workplace induction timetable**

### Inpatient ward with some community experience

	<u>Mon</u>	<u>Tues</u>	<u>Wed</u>	<u>Thurs</u>	<u>Fri</u>
<u>AM</u>	Introductory meeting with supervisor (1 hour)  Introduction to team members (include ward staff, CMHT, pharmacy, MHA office etc) (2 hours)	Attend ward round	Shadow CT3  Attend Balint Group (1 hour)	Attend ward round  Supervision (1 hour)	Academic teaching (2 hours)  Teaching from Psychiatry SHOs (1 hour)
<u>PM</u>	Observe outpatient clinic	Shadow ward CT3	Go out on home visits with CPN	FY2 teaching programme	Shadow ward CT3

## **References**

- 1) <sup>i</sup> Academy of Medical Royal Colleges. The UK Foundation Programme Curriculum, July 2012 updated for 2014
- 2) <sup>ii</sup> The UK Foundation Programme Office. The UK Foundation Programme Reference Guide, July 2012, Updated for August 2014
- 3) <sup>iii</sup> GMC Good Medical Practice. [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)
- 4) <sup>iv</sup> GMC. The Trainee Doctor. 2011
- 5) <sup>v</sup> Health Education England. Broadening the Foundation Programme Report. February 2014
- 6) <sup>vi</sup> Greenway D. Shape of Training Report: Securing the future of excellent patient care. 2013
- 7) <sup>vii</sup> RCPsych. Foundation Trainees and supervision out of hours in Psychiatry Guidance. September 2014.
- 8) <sup>viii</sup> UK Foundation Programme Office. Specialty Tasters in the Foundation Programme: Guidance for Foundation Schools. March 2011
- 9) <sup>ix</sup> Marcus Hughes (South Thames Foundation School), Educational and Clinical Supervision in the Foundation Programme Presentation. July 2014

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- 10) <sup>x</sup> Kelley T, Brown J and Carney S. Foundation Programme psychiatry placement and doctors' decision to pursue a career in psychiatry. *Psychiatric Bulletin* (2013) 37: 30-32
  - 11) <sup>xi</sup> The UK Foundation Programme Office. FP/AFP 2015, Applicants Handbook, June 2014
  - 12) <sup>xii</sup> The NHS Careers guide: 'Welcome to the medical team'  
<http://www.nhscareers.nhs.uk/media/1916250/2902505-hee-welcome-brochure-final.pdf>