Some questions from the F2 curriculum session 18.11.21

Q. ALS

Q. If I've done ALS in F1 can I still use this to link to F2 curriculum? Is ALS mandatory, and if so are there any courses provided through trusts?

Any piece of evidence that is linked to your FPCs in F2 should have been done during your F2 training period, so the short answer is unfortunately no.

ALS is *not* mandatory in this new curriculum, as per the GMC going forward in *all* postgraduate curricula. F2 doctors can still achieve their FPCC if they do not have the ALS/e-ALS. However, it remains valued and recommended, to the extent that The NI Foundation School at NIMDTA will continue to provide funding for those F2 doctors who arrange to do their ALS, but please remember that **NIMDTA will only fund it *once* during your two years of Foundation training.** It can be arranged through your Trust or though Kingsbridge private hospital. Please see separate NIFS ALS guidelines:

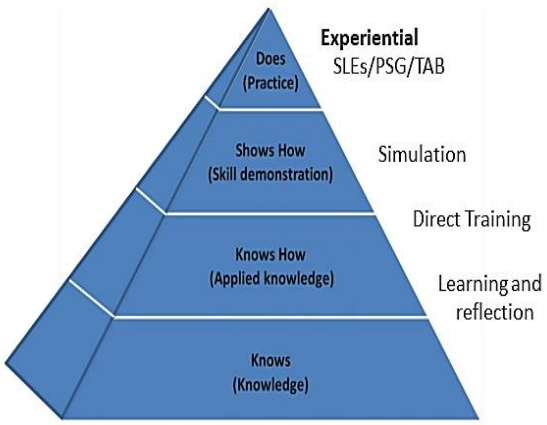
Summary for ALS:

1. It is now NOT mandatory, but remains valued and recommended
2. Funding of up to £300 is available for one ALS/e-ALS course during NI Foundation training
3. ALS/e-ALS certificate is a useful piece of evidence that can be linked to 3 FPCs

Q. Simulation and core topics

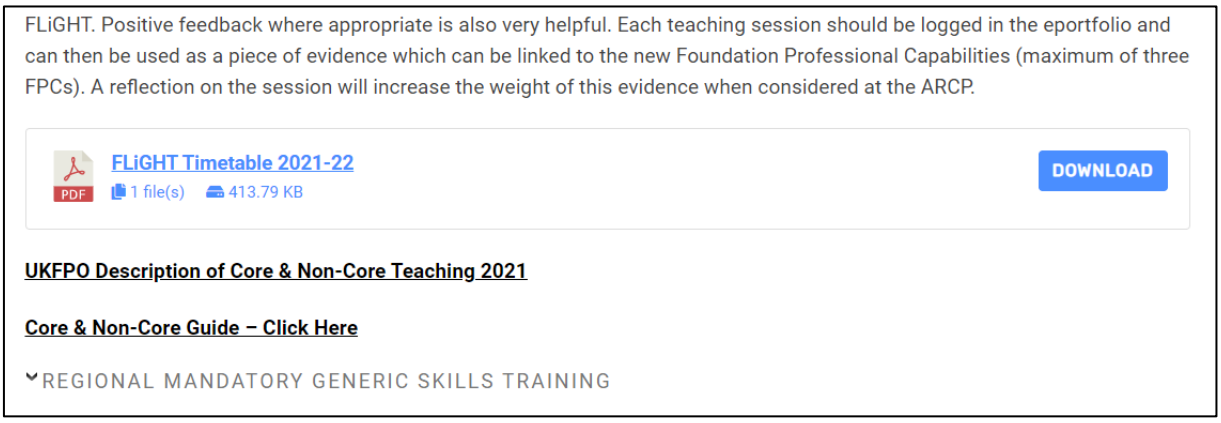
Q. Simulation is that part of core teaching or non-core? Has there been any core simulation organised for us? Would ALS count for some of that simulation? Our trust has simulated teachings for FY1s but not for F2s, are we meant to ask for this to be organized? Is it mandatory or just another way of showing evidence?

The requirement for simulation training for *all* Foundation doctors (FDs) is new in the curriculum. It is listed as one of the 15 core topics which must be taught to all FDs. It is evidence that is most closely associated with FPC 2 Clinical Prioritisation of the deteriorating patient, and can be high fidelity or low fidelity, as long as it is simulating a potentially real situation for you to have to deal with. Time spent in simulation training can be recorded on the new LEARN form and is part of the minimum of 30 hours of **core learning** (as well as time spent attending FLiGHT modules, with the exception of GMC and professionalism module which counts as **non-core learning**). Simulation, which is core learning, needs to be delivered at Trust level, and any simulation session can have F1 and F2 doctors training together. All DMEs/FPDs/Sim leads are aware of this. Like all other pieces of evidence, it can then be linked to a maximum of three FPCs, so depending on the content you might find it can be linked to one or two other relevant FPCs as well. Mental health scenarios are also strongly encouraged as this curriculum emphasises the 'parity of **mental health** and the importance of **social wellbeing** as well as **physical health**. Simulation evidence is the 'shows how' so is next down in weight from experiential (which carries the most weight).



Q. What other things can count as non-core aside from e-learning?

Please see UK & NIFS core and non-core guidance on NIMDTA Foundation website in FLiGHT section:



In summary, non-core includes X-ray meetings Journal clubs Teaching for mixed grades of doctors; M and M; MDTs; peer RV; Departmental teaching; Grand Rounds etc., as well as e-learning, and reflections that show 'internalisation' of material relevant to the FPCs. Specifically for NIFS F2s, this F2 curriculum session and the GMC/professionalism FLiGHT module are also labelled as non-core. All 15 sessions in FLiGHT alone will get you well over your 30 hours of core. The second 30 hours can also be core (or non-core) to reach a *minimum* of 60 hours in total.

Q. CPR training

Q. I have done CPR training within the trust can this count for FPC 2?

Yes, your certificate for this can be linked to FPC2, but like all FPCs it will be very hard to prove you have achieved any capability with just one piece of evidence (despite the fact that there is no minimum number required defined in the curriculum). For FPC 2 you will also specifically need evidence of simulation training (please look at the detail of FPC2 requirements in the full curriculum on p72). Remember that for each FPC, a spread of evidence is what is being looked for. So consider the hierarchy: is there experiential evidence, feedback on my performance, evidence of direct training and of self-directed learning such as reflection or e-learning? Also, does the evidence I have linked show that I have learned about my patients' mental health and social wellbeing, as well as their physical health. And finally overall, do I have evidence of caring for patients in the non-acute and community settings as well as in the acute setting?

Q. LEARN and LEADER forms

Q. Could you quickly explain what a learn and leader form is and if they are compulsory for ARCP? Is a LEADER form mandatory? And if we have spent time teaching/supervising medical students, who do we ask to fill out the LEADER form?

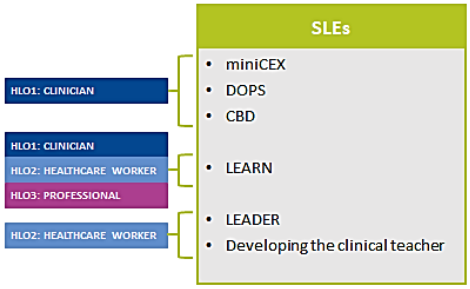
Again, *please see Topic 7* on the UKFPO website New UK Foundation Programme Curriculum 2021 - UK Foundation Programme and scroll down to Topic 7 where you will find a factsheet (just one page) on the new LEARN form. It can be used instead of SLE forms and for simulation teaching. This sheet has

been written by the lead author for assessment herself (Fiona Cameron) for you. It is not compulsory to use a LEARN form, but it is a useful way to record the top weighted evidence and can be used instead of other forms. It is intended to make things easier for you.

Q. *Is LEARN and LEADER another form of SLE?*

Yes

SLES are: Mini-CEX; CbD; DOPs; LEARN; LEADER; DCT and each can be linked to a maximum of three FPCs



Q. Attending a FLiGHT module on a day off

Q. If you can only attend a Generic Skills date on a rota'd day off, can you get a day back in lieu? If we have to do FLiGHT modules on our days off (because study leave days have been declined due to low staffing), can we get a study leave day in lieu for this? Thanks

NIMDTA Study Leave Guidance states, *"Where trainees are granted study leave on non-working days, Trusts will aim to facilitate Time off in Lieu (TOIL)."* In the event of an F2 trainee attending in their own time (e.g. a rostered day off or during annual leave) strictly speaking they would be entitled to a day off in lieu to compensate, but it would be something they would need to discuss with their Trust & Clinical working area. As with all Study Leave, it would only be granted if it can be facilitated within the service. However as 6-7 dates are offered for each of the mandatory FLiGHT modules, it would be reasonable to expect an F2 requesting a day in lieu to provide an explanation of why they had to book to attend on a rostered day off. Finally, just to reiterate that F2 doctors are strongly discouraged from attending Generic Skills/FLiGHT days either pre or post on call, as this is compensatory rest time.

Q. AUDIT and linking evidence such as attendance at a FLiGHT module to FPCs

Q. Is it mandatory to do an audit to complete F2? Does the FLiGHT module cover FPC9? Can flight modules count as core teaching? And how many can I take per rotation? Can you link the flight modules to FPCs?

Strictly no, doing an audit is not mandatory, however FPC 9 is Quality Improvement and so being involved in and completing the audit cycle is strongly encouraged and evidence of completed audits can be linked to the QI FPC. Furthermore, if presented at a local meeting or teaching session it could also be linked to FPC10 Teaching the teacher, teach and present effectively. To prove a Foundation Professional Capability, there needs to be a variety of evidence, from up and down Miller's pyramid (Experiential/Direct training/reflection and e-learning). This curriculum is about the weight of evidence, not the numbers of pieces of evidence (although it does say as a *guide*, the optimum number of pieces of evidence is probably around five, with space for a maximum of ten pieces of evidence per FPC). The NIMDTA FLiGHT modules have been specifically designed to cover the mandatory core topics in the new curriculum, with the exception of simulation training which needs to be offered by the Trusts. These are all Direct Training (core learning) sessions, except the GMC and Professionalism module which has been kept on from the previous Generic Skills course and has labelled as non-core. On attending the QI FLiGHT module, yes this can then be linked to FPC9 as Direct training in Miller's pryamid, but it will not prove the capability by itself. Completing a QI project in the clinical setting could be linked to FPC9 as well, and would carry more weight given the experiential nature of it compared to

a direct training session. A reflection or e-learning on something QI related would then add to these. Please have a look at the expected 'behaviours' for F2 level detailed for each FPC in the 111-page curriculum (download it and skip through p71-p79 F2 expected behaviours). You don't have to prove each of these; they are examples to give an idea of how to prove your achievement of that particular capability.

Q. More AUDIT and linking

Q: Can you explain the requirements around audit? Compulsory to be part of one, or compulsory to design one? And How about audits which started in F1 and are coming to the end of a pdsa cycle this year? Is QIP mandatory? Audit? So we can be involved in a QIP e.g. data collection, and this is sufficient to meet the criteria? Does that mean attending the QI flight module will meet that because you will have awareness of the process? Just to confirm if we have done an audit you can link this to FPC9?

Nowhere in the curriculum says that you must complete an audit, however it would be a useful piece of evidence to link to FPC9 Quality Improvement, along with your QI FLiGHT module (Direct Training) and perhaps a reflection and an e-learning. Please read the F2 behaviours on p71-p79 of the full curriculum. FPC9 is on p78 of the full curriculum. It is not about 'meeting the criteria', you need to look at the example behaviours and consider what evidence you have that you can link to prove you have the capability. **Consider for each FPC: the range of weight of evidence (Miller's pyramid), and the overarching themes of mental health, physical health and social wellbeing, as well as evidence from acute, non-acute and community experience.**

Q. I have a question regarding linking Foundation programme Capabilities 1-5 to SLEs for HLO1 Do I need to evidence 5 SLEs (Mini-CEX/ DOPS) per individual Foundation capability for HLO1? Or is it 5 SLEs in total for Foundation Capabilities 1-5 as well as providing other evidence in the form of reflections and teaching sessions? Also as a guide how many times should I be linking each FPC to evidence in my e-portfolio?

You need to prove each of the 13 Foundation Professional Capabilities, by linking sufficient evidence. You should use evidence from up and down Millar's pyramid, experiential evidence carrying the most weight and being most relevant to HLO1. And overall the 13 FPCs, your evidence needs to show capabilities in mental health as well as physical health, and to be from non-acute and community settings as well as the acute setting. You will not be able to prove you have attained a capability with no evidence, and it will be hard to do so with just one or two pieces of evidence. The *optimum* number of pieces of evidence, outlined in the new curriculum and from experience, suggests around five pieces of good quality evidence (see p37 in the full curriculum) but there is room for up to 10 pieces maximum. So for example in HLO1, you might expect 1-3 SLEs, a simulation, a Direct training (FLiGHT module) and a reflection/e-learning or two. There is less likely to be SLEs in HLO2 but PSG and TAB will be relevant to 'valuable member of the healthcare workforce'. So it's about thinking how you can prove each capability rather than ticking off minimum numbers. You can link each piece of evidence to a maximum of three FPCs. In order to have sufficient evidence to consider where you link them (and this is what you consider and write about in your summary narrative, one for each HLO) again as a *guide*, this curriculum *suggests* you should aim to complete between 5 and 10 SLEs per four-month placement. The authors were asked at the outset to 'take the numbers out' of this curriculum and to 'reduce the burden of assessment that many foundation doctors feel'. Also, no 'named courses' such as ALS. They have managed to achieve all of these GMC requirements.

Q. PSG – Placement Supervision Group

Q. Do we need to complete a placement supervision group for every rotation? Is it required for first rotation? And can the psg be done in the same placement as tab? What does psg stand for? For PSG if the CS organises this, who makes up the PSG and do we need to take action on this or is it up to CS? Is it compulsory to have one PSG per level of training? I was previously informed by ES for F1 that it was not an essential requirement?

The PSG (Placement Supervision Group) is *clearly described in Topic 5 on the UKFPO website*. Google or click on New UK Foundation Programme Curriculum 2021 - UK Foundation Programme then scroll down to Topic 5. It is not needed for every placement, but it can done in more than one, and it is good experiential evidence that can then be linked to up to 3 FPCs. We recommend a TAB in the first placement **(OcTABer)** and a PSG in the second placement, but this is not fixed. PSG/TAB/SLEs are all experiential evidence at the top of the pyramid, and so carry the most weight. The PSG is made up of the people who work with you on a daily basis (nurses, physios, dietitians etc.) and the members are agreed with you and your CS at your initial CS meeting or soon thereafter. The CS organises and initiates it, but there is no reason why you cannot check in with your CS about it any time. It can be used formatively and more than once, but it is now mandatory to have one satisfactory PSG and one satisfactory TAB by the time of the ARCP. Last year, in the 2016 curriculum it was not compulsory, but one satisfactory PSG is now required for successful completion of your ARCP in this new 2021 curriculum. More detailed PSG guidance is likely to be issues by the UKFPO soon.

Q. Educational Supervisors and meetings

Q. Have educational supervisors been re-informed about recommended number of SLEs etc? There have been some issues with ES's asking for minimum of 10+ SLEs per placement, and minimum of X reflections per rotation

Yes, supervisors should be aware, but like everyone they are also under pressure and trying to get to grips with the new curriculum. They may also be simply trying to encourage you to get some evidence into your portfolio, remember the evidence is not just for doing what is required for the ARCP, it is a process of continuous learning and 'self-actualisation'. Feedback and reflection are central to your education and progress as a Foundation Doctor. All supervisors have been offered training in the new curriculum and have also been encouraged to learn from the UKFPO website materials which are excellent and specially designed for busy doctors to dip in and out of to answer specific queries. The two main authors (and some others) have spent many hours writing factsheets, and writing and recording short videos and podcasts in the Topics (1-12) to help everyone, so *please* look at them!

Q. Initial meetings with my ES & CS were delayed well beyond 3 weeks; will this cause problems for my ARCP even though everything else in my portfolio is contemporaneous? ES and my AL and covid isolation delayed things

As long as they are done, it shouldn't, particularly if it's because of the reasons you have stated in your question. But it's likely to have made it more difficult for you having not had the opportunity to meet at an early stage so you can get on with gathering your evidence and learning from the start of your placement by a process of continuous formative assessment and 'self-actualisation.' If everything else is contemporaneous and the CS/ES reports are satisfactory then that should be fine.

Q. TAB – Team Assessment of Behaviour

Q. Can 3 GP/consultants count for TAB instead of 1 senior doctor if none in placement?

If you are in a placement where there are not enough people to respond as required in TURAS, then you will need to do your TAB in a different placement. For a TAB to be released there has to be the minimum numbers of raters as per the UKFPO. Therefore there must be 2 consultants or trained GPs, and a minimum of 1 doctor more senior than F2. Of course the minimum numbers of all of the other raters must be satisfied too otherwise the TAB cannot be released. This cannot be changed. Therefore if the trainee can satisfy the minimum numbers then a TAB can be completed. Unless one of the GPs completes the TAB as a doctor more senior than F2 and ticks the GP trainee box (for example) then the TAB cannot be completed and won't be able to be released. In the situation where a trainee does not have the minimum numbers of colleagues to complete a TAB then a PSG should be performed instead and the TAB completed in the next placement.

Q. FLiGHT modules

Q. Is there a minimum number of flight modules that need to be completed to be signed off? What if I'm not able to get time off to attend? I had this issue in my current rotation where leave was being refused to attend flight modules.

Q. Who do we contact if the isn't opportunity to meet the minimum requirements through lack of opportunity? There is no sim in my hospital/Trust, and I got 2 flight modules only after complaining to my ES and TPD. All the other flight modules are fully booked.

All 15 modules are mandatory. Work with your Trust (CS/ES/FPD) to arrange. If you are having these kind of problems that cannot be resolved locally, then contact us at the foundation school foundation.nimdta@hscni.net at the earliest opportunity and we will liaise with your FPD in the first instance. They are all remote on zoom this year and each one is repeated 6 or 7 times throughout the year in order to give you plenty of choice to arrange.

Q. Acute, non-acute and community experience needed

Q. "Assessment of patients in a variety of settings including acute, non-acute and community" - do you have any suggestions of how I can prove this if I have no community or non-acute placements?

All the FPDs bar one (i.e. 14/15) and all DMEs (Director of Medical Education) attended the FOCUS meeting (Foundation Curriculum Session) in April 2021, just prior to the new curriculum going up on the UKFPO website. All were informed of the need to provide this range of experience, and have been looking at ways to do so. Please contact your ES/FPD and discuss this type of issue at ES meetings beginning and end of placements, you will want to comment in your summary narrative about not just what you have done and linked and why, but also what you need to do. This will also form part of your next placement PDP (Personal Development Plan). The trusts have an obligation to provide you with the required experience, and with simulation training sessions, specifically for FPC2. Simulation training is a core topic and must therefore be taught.

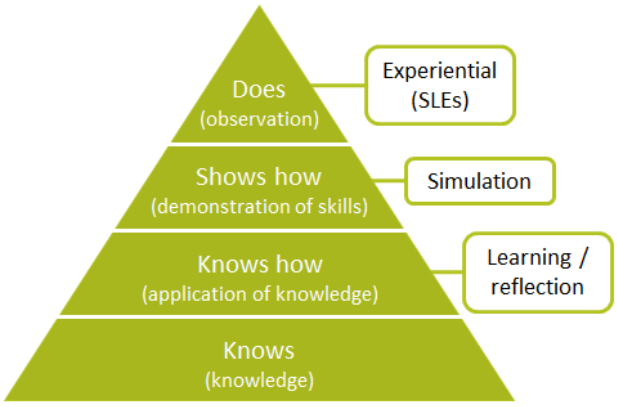
Q. Summary narratives

Q. What is expected in the summary narratives, in terms of format and content? Is there a word limit for this clinical summary narrative?

Summary narratives are new. There will be one for each of the three HLOs (Higher Learning Outcomes) and you should start them towards the end of the first placement. They are intended to be a global reflection on what evidence you have logged in your portfolio, and to consider which FPCs you would be best to link them to, and why. Do you have evidence from each level of Millar's pyramid (experiential/direct training FLiGHT/reflections and e-learning), and what feedback to you have especially from within the workplace (PSG/TAB) to show that you have achieved the individual Foundation Professional Capabilities and therefore the Higher Level Outcome.

Again, *please see Topic 8* on the UKFPO website New UK Foundation Programme Curriculum 2021 - UK Foundation Programme and scroll down to Topic 8 where you will find a short video and a factsheet describing exactly what a summary narrative is and what you should think and write about. It is a changeable narrative, so you might want to keep a word document as you go along. You can make changes to each of the three summary narratives right up until you submit it for the ARCP, at which point each of the three summary narratives should be **no more than 300 words long**. And remember, it is not a summative assessment (pass/fail) rather the intention is to get you to think about what evidence you have, what capabilities you have linked or will link it to and why, and what else you need going forward which you will be able to discuss with your ES at the start of the next placement. It's also important to remember that the third placement is effectively only 2 months long with regard to completing your portfolio for your ARCP.

- Reduced 'assessment burden' on the Foundation Doctor
- Summary narrative to be written by Foundation Doctor for each HLO to show rationale for selecting evidence uploaded and mapped
- No minimum number of SLEs
- Foundation Doctor to link adequate evidence to 13 FPCs in accordance with hierarchy of evidence
- eportfolio will allow up to 10 pieces of evidence per FPC and will allow each



- As the FD progresses through their training, they will undertake activities that will help them develop the 13 FPCs
- The FD will be expected to develop a portfolio of evidence to reflect this progress
- Across each training year the Educational Supervisor (ES) will help to guide their training
- The curriculum defines the role of the ES

Formative assessment	Summative assessment
• Supervised Learning Events • The Personal Learning Log • The Summary Narrative • Portfolio Evidence (Curriculum Linkage) • Placement Supervision Group • Multisource Feedback (TAB)	• Clinical Supervisor Reports • Educational Supervisor Reports • Prescribing Safety Assessment (F1 only)