# The Foundation Programme in General Practice Handbook

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## Additional Resources
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- Job Description for F2 Doctors in GP  
- Key Contacts during the F2 Programme  
- European Working Time Directive  
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A. INTRODUCTION AND BACKGROUND

The Foundation Programme has been fully operational since August 2005 when it became mandatory for all graduates from UK medical schools to demonstrate competence across the Foundation Curriculum on completion of a two year Foundation Programme. This is a requirement for all doctors before specialty training can begin.

The Foundation Programme is an outcome-based educational process. It has defined competences to be achieved and a defined process of assessment with defined assessment tools.

It has a dedicated website: www.foundationprogramme.nhs.uk. The Foundation Programme website provides a wealth of information about foundation training and what trainees should expect throughout their training. There is information about recruitment, assessments, learning portfolios and resources to help trainees with the future career choices.

The NHS Foundation e-portfolio is available on www.nhseportfolio.org.uk. The Trusts will arrange log-in details for trainees and their supervisors.

This Guide to Foundation Programme Training in General Practice is intended to be exactly that. Every practice is different and will offer different learning opportunities for their Foundation doctor. This guide is not intended to be either definitive or prescriptive but a framework that you can build on and adapt to suit your circumstances.

The Programme is designed to train doctors in the following areas:

1. Acute clinical care
2. Professional skills

It emphasises the following:

1. The programme is trainee led
2. Experience of the primary-secondary interface is important
3. There is a programme of assessment which the trainee organises
4. The trainee engages in Continuing Professional Development (CPD) and becomes familiar with the process of life-long learning in their professional life
5. The programme is organised by the Foundation School and a network of Educational and Clinical Supervisors support the trainees’ activities and under-pin the Foundation Programme philosophy
6. Supervisors and trainees are trained in the use of the assessment tools and the Foundation Programme activities

Fifty per cent of all Foundation doctors in Wessex have the opportunity to experience a 3 or 4-month placement in general practice. In accordance with the Collins Report (2010) we aim to increase these numbers.
The content of these guidelines is drawn from:

- experiences of Wessex Foundation Doctors
- experiences of GP Clinical Supervisors
- experiences of the Foundation School team working on the Foundation Programme
- national guidelines and directives

Many readers are already experienced teachers of GP Registrars or Medical Students. For others this is a very new undertaking but we hope that everyone will find it helpful in one way or another.

For the purpose of this guide the terms ‘trainer’ or ‘GP Supervisor’ or ‘Clinical Supervisor’ refers to the person nominated by the practice (and agreed by Health Education Wessex) to have responsibility for the Foundation Programme doctor who is learning in General Practice.
B. THE CURRICULUM & COMPETENCES

The new Foundation Programme Curriculum came into effect in August 2012 and is being used by those doctors who entered their F1 in or after August 2012.

The full syllabus and competences can be downloaded from the Foundation Programme website: http://www.foundationprogramme.nhs.uk/pages/home/keydocs

The 2012 curriculum defines outcomes and competences under the following headings:

1. Professionalism
2. Good Clinical Care
3. Recognition and management of the acutely ill patient
4. Resuscitation
5. Discharge and planning for chronic disease management
6. Relationships with patients and communication skills
7. Patient safety within clinical governance
8. Infection control
9. Nutritional care
10. Health promotion, patient education and public health
11. Ethical and legal issues
12. Maintaining good medical practice
13. Teaching and training
14. Working with colleagues

It is important to remember:

- The rotation in your practice is part of a programme.
- The Foundation doctor will not cover all competences during his/her time in General Practice. It is intended that the Foundation doctor will work through the curriculum during the 2 year Programme.
- Some competences may well be more readily met in General Practice than in some other rotations e.g. relationships with patients and communications.
- The GP Supervisor and the F2 doctor should work together to identify the areas most appropriately covered in the Primary Care setting and in their unique Practice
C. THE CURRICULUM (2012) AND ASSESSMENT

The Foundation Year 2 assessment programme is intended to provide objective workplace-based assessments of the progress of the Foundation doctor through the Programme. The assessment will be used by the Foundation School to decide whether the doctor can be signed up as satisfactorily completing the programme. The Foundation competencies must be achieved prior to commencing specialty training.

- The assessments are designed to be supportive and formative.
- The Foundation doctor can determine the timing of the assessments within each rotation and to some degree can select who does the assessment.
- It is important that all assessments are completed within the overall timetable for the assessment programme.
- Each F2 doctor is expected to keep evidence of their assessments in their eportfolio. These will then form part of the basis of the discussions during appraisals.
- The F2 doctor is an adult learner and it will be made clear to them that they have responsibility for getting their assessments done and for getting their competences signed off.

Supporting documents are available on the UK Foundation Programme website:


Mandatory Meetings:

Doctors who are undergoing training during their Foundation years may expect to be involved in a series of meetings. Details of these are also available as web links on the FP Curriculum web pages.

Overview of meetings

Induction meeting with clinical supervisor

Initial meeting with educational supervisor

Combined: induction meeting with clinical supervisor and initial meeting with educational supervisor

Mid-placement review

Mid-year review of progress
Supervised Learning Events (SLEs) and Assessments

FAQs:

What is a supervised learning event (SLE)?

A SLE is an interaction between a foundation doctor and a trainer which leads to immediate feedback and reflective learning. They are designed to help foundation doctors develop and improve their clinical and professional practice and to set targets for future achievements.

What is the purpose of a SLE?

SLEs aim to:

- support the development of proficiency in the chosen skill, procedure or event
- provide an opportunity to demonstrate improvement/progression
- highlight achievements and areas of excellence
- provide immediate feedback and suggest areas for further development
- demonstrate engagement in the educational process.

Participation in this process, coupled with reflective practice, is an important way for foundation doctors to evaluate how they are progressing towards the outcomes expected of the Foundation Programme Curriculum 2012 (the Curriculum).

Are SLEs assessments?

No! SLEs are not assessments. However, the clinical supervisor’s end of placement report, which forms part of the assessment, will draw upon evidence of engagement in the SLE process but NOT the SLE outcomes.

Can a SLE be failed?

No! SLEs are not assessments; foundation doctor cannot pass or fail.

Which tools do the SLEs use?

Supervised learning events with direct observation of doctor/patient encounter use the following tools:

- Mini-clinical evaluation exercise (mini-CEX)
- Direct observation of procedural skills (DOPS).

Supervised learning events which take place remote from the patient use:

- Case-based discussion (CBD)
Developing the clinical teacher.

Supervised learning events with direct observation of doctor/patient encounter

Foundation doctors are expected to undertake three or more directly observed encounters in each placement. They are required to undertake a minimum of nine directly observed encounters per annum in both F1 and in F2. At least six of these encounters each year should use mini-CEX.

1. **Mini-clinical evaluation exercise (mini-CEX)**

   This SLE is an observed clinical encounter. Mini-CEX should not be completed after a ward round presentation or when the doctor/patient interaction was not observed.

   Foundation doctors should complete a minimum of six mini-CEX in F1 and another six in F2. These should be spaced out during the year with at least two mini-CEX completed in each four month period

   There is no maximum number of mini-CEX and foundation doctors will often complete very high numbers of SLEs recognising the benefit they derive from them.

2. **Direct observation of procedural skills (DOPS)**

   The primary purpose of DOPS in the Foundation Programme is to provide a structured checklist for giving feedback on the foundation doctor’s interaction with the patient when performing a practical procedure.

   Foundation doctors may submit up to three DOPS in one year as part of the minimum requirements for evidence of observed doctor-patient encounters

   Different assessors should be used for each encounter wherever possible

   Each DOPS could represent a different procedure and may be specific to the specialty (NB: DOPS may not be relevant in all placements)

   Although DOPS was developed to assess procedural skills, its purpose in the Foundation Programme is to support feedback on the doctor/patient interaction

   DOPS cannot be used to provide evidence of satisfactory completion of the GMC core procedures required in F1

   There is no maximum number of DOPS and foundation doctors will often achieve very high numbers of SLEs recognising the benefit they derive from them.

3. **Developing the Clinical Teacher**

   At least once during FY2 the doctor should demonstrate involvement in a teaching event. This may be the presentation to colleagues of a project, an audit, or an item of
research. The placement in general practice provides an ideal opportunity to do a useful piece of work and to present this to the practice team.

**Supervised learning events which take place remote from the patient**

**Case-based discussion (CBD)**

This is a structured discussion of a clinical case managed by the foundation doctor. Its strength is investigation of, and feedback on, clinical reasoning.

A minimum of six CBDs should be completed each year with at least two CBDs undertaken in any four month period

Different teachers/trainers should be used for each CBD wherever possible

There is no maximum number of CBDs and foundation doctors will often achieve very high numbers of SLEs recognising the benefit they derive from them.

**Developing the clinical teacher**

This is a tool to aid the development of a foundation doctor’s skills in teaching and/or making a presentation and should be performed at least once a year. The foundation doctor will be encouraged to develop skills in preparation and scene-setting, delivery of material, subject knowledge and ability to answer questions, learner-centredness and overall interaction with the group.

**How frequently should SLEs be done?**

SLEs do not necessarily need to be planned or scheduled in advance and should occur whenever a teaching opportunity presents itself. Foundation doctors are expected to demonstrate improvement and progression during each placement and this will be helped by undertaking frequent SLEs. Therefore, foundation doctors should ensure that SLEs are evenly spread throughout each placement.
How many SLEs should be done?

**Recommended Number of SLEs**

<table>
<thead>
<tr>
<th>Supervised learning event</th>
<th>Recommended minimum number*</th>
</tr>
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<tbody>
<tr>
<td>Direct observation of doctor/patient interaction:</td>
<td></td>
</tr>
<tr>
<td>Mini-CEX</td>
<td>3 or more per placement*</td>
</tr>
<tr>
<td>DOPS</td>
<td>(minimum of nine observations; at least six must be mini-CEX)</td>
</tr>
<tr>
<td>Case-based discussion (CDB)</td>
<td>2 or more per placement*</td>
</tr>
<tr>
<td>Developing the clinical teacher</td>
<td>1 or more per year</td>
</tr>
</tbody>
</table>

*based on a clinical placement of four month duration

**Frequency of assessments**

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-portfolio *</td>
<td>Contemporaneous *</td>
</tr>
<tr>
<td>Core procedures</td>
<td>Throughout F1</td>
</tr>
<tr>
<td>Team assessment of behaviour (TAB)</td>
<td>Once in first placement in both F1 and F2, optional repetition</td>
</tr>
<tr>
<td>Clinical supervisor end of placement report</td>
<td>Once per placement</td>
</tr>
<tr>
<td>Educational supervisor end of placement report</td>
<td>Once per placement</td>
</tr>
<tr>
<td>Educational supervisor's end of year report</td>
<td>Once per year</td>
</tr>
</tbody>
</table>

**The Assessment Tools**

**E-Portfolio**

- Your **E-portfolio** enables you to provide evidence of what you have been doing during your placement and to become a personal log of your experiences and learning. It forms a major vehicle for your assessment so pay attention to making thorough contemporaneous entries.

- Your **E-portfolio** is your record. Use it to record details of cases, teaching sessions, and assessments. Use it to record your reflections upon what you have learned and relate your learning to the personal experiences that you encounter in your place of work.
Team Assessment of Behaviour (TAB) also known as Multi-Source Feedback (MSF)
This is a shortened form of 360° appraisal. It takes place at 2 specified times in the year for all trainees. The trainee completes a self-assessment form and nominates 10 (minimum) colleagues to anonymously complete the form. Feedback is normally given to the trainee and their Educational Supervisor within 6 weeks of the assessment.

Clinical Supervisor’s Report (CSR)
In General Practice you will work very closely with your Clinical Supervisor who will complete a formal report which is an assessment based upon your experience, competencies and learning throughout the attachment.

A well ordered and detailed reflective E-portfolio will aid the Clinical Supervisor in completing the report.

The CSR is an extremely important part of the overall assessment.

What are the issues in assessment?

- This is a supportive but formative developmental process for the trainee.
- The supervisor should be competent and trained to carry out the assessment and able to give structured feedback.
- The F2 doctor determines the timing of assessments within an agreed overall framework for the year. They have some choice of assessor.
- The assessments do not have to be carried out by the doctor who is the nominated trainer.
- You can and should involve other doctors, nurses or other health professionals that are working with the F2 doctor.
- It is important that whoever undertakes the assessment understands the assessment tool they are using.

The assessments are not intended to be tutorials and although protected time is required, assessments can be completed at the beginning, end or even during a surgery.

Each Foundation doctor will keep a learning portfolio/e-portfolio. It will be the means by which they will record their achievements, reflect on their learning experience and develop their personal learning plans. This is an excellent opportunity to develop the habit of keeping an electronic ‘Learning Log’ which are now an essential component of future appraisals and re-validation.

Further information is available in the Foundation Curriculum and on our website pages: http://www.wessexdeanery.nhs.uk/foundation_school/assessment.aspx
The Induction and Working Week

This is really an orientation process so that the Foundation doctor finds his/her way around the practice, understands a bit about the practice area, meets doctors and staff, learns how to use the computer and knows how to get a cup of coffee! This is very similar to the induction programme used for GP ST3s (Registrars) but will probably last about a week. It should be planned for the first week of their 3 or 4-month rotation with you. It is also very helpful if you have an introduction pack for the Foundation doctor, which again is similar to that which you might use for a locum or GP ST1 or ST2. An induction week might look something like the timetable below but this is only a guideline and should be adapted to suit your learner and your practice.

**F2 Induction Programme**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Meeting doctors/ staff 9-10</th>
<th>Sitting in the waiting room 10-11</th>
<th>Surgery &amp; Home visits with trainer 11-1</th>
<th>Working on Reception desk 2-3</th>
<th>Surgery with trainer 3-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>Treatment Room 9-11</td>
<td>Chronic Disease Nurse clinic 11-1</td>
<td>Computer training 2-3</td>
<td>Surgery with another doctor 3-6</td>
<td></td>
</tr>
<tr>
<td>Day 3</td>
<td>District Nurses 9-12</td>
<td>Computer training 12-1</td>
<td>Local Pharmacist 2-4</td>
<td>Surgery with another trainer or Partner</td>
<td></td>
</tr>
<tr>
<td>Day 4</td>
<td>Health Visitors 9-11</td>
<td>Admin staff 11-12</td>
<td>On Call with GP. Assisting with triage/ acute patients/ managing incoming demand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 5</td>
<td>Surgery and home visits with another doctor 9 – 12</td>
<td>Practice meetings 12-1</td>
<td>Computer training 2-3</td>
<td>Surgery with trainer 3-6</td>
<td>Meet trainer to debrief on the first week</td>
</tr>
</tbody>
</table>

Sitting in with other members of the team exposes the learner to different styles of communication and consultation.

Of course this will not necessarily fit into neat hourly blocks of time and you may have several other opportunities that you feel your Foundation doctor would benefit from in this initial phase.

**The working and learning week**

Every experience that the Foundation doctor has should be an opportunity for learning. It is sometimes difficult to get the right balance between learning by seeing patients in a formal surgery setting and learning through other opportunities. The table below is an indicator as to how you might plan the learning programme over a typical week with a doctor who is in your surgery on the standard 4-month rotation. (The next section will look in more detail at each of

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1 See section on – Home Visiting Guidance
The working/learning week for a Foundation doctor is **10 sessions** (regardless of your practice working week arrangements). The F2 is not expected to do out of hours work during their General Practice rotation. The Foundation doctor must have a named clinical supervisor at all times. This will usually be you, but you may share this responsibility with suitably experienced colleagues, usually another Partner in the Practice.

The 10 session week comprises sections A+B + (C or D)

| A. Surgeries | These will usually start at 30 minute appointments for each patient and then reduce to 15-20 minute appointments as the Foundation doctor develops their skills, knowledge and confidence.  
| Minimum of Seven sessions of Surgeries and Home Visits per week | The F2 doctor must have access to another doctor (not a locum doctor) but not necessarily the trainer in the practice.  
| | The F2 doctor does not need to have their own consulting room and can use different rooms so long as patient and doctor safety and privacy is not compromised. |

| B. 2 x sessions in other learning Opportunities | This could be  
| | 1:1 session with the trainer or other members of the practice team. (i.e. a Tutorial)  
| | Small group work with other learners in the practice  
| | Small group work with F2s from other practices  
| | Shadowing or observing other health professionals or service providers e.g. outpatient clinics pertinent to primary care, palliative care teams, voluntary sector workers |

| C. 1 x session on project work or directed study | Your F2 may wish to undertake a project or audit during their time with you. They should have protected time to do some research, collect the data, write up the project and present their work to the practice team. They need not do a full audit but must understand the process. |

| D. 1 x session Private study (optional) | The GP Supervisor will plan with the F2 doctor those areas where study related to Primary Care will be beneficial. |

**Tutorials**

- Short Tutorials can be given either on a 1:1 basis or as part of a small group with their learners. (recommend 45-60 minutes weekly)
- Any member of the practice team can and should be involved in giving a tutorial.
- Preparation for the tutorial can be by the teacher or the learner or a combination of both.

Examples of possible tutorial topics are attached at Appendix 3.

**Chronic Disease Management**

- Although the emphasis is on acute care it is also important for Foundation Programme doctors to realise how much ‘acute illness’ is due to poorly controlled chronic disease.
The importance of exposure to chronic disease diagnosis and management should not be overlooked.

Classroom taught sessions
In addition to the weekly timetable organised by the practice, the Acute Trusts and Health Education Wessex will organise training that amounts to about 12 days during the year.

It is the F2 doctor’s responsibility to ensure that they liaise with their Clinical Supervisor to book the time out of practice.

F2 doctors are not expected to attend the GP vocational training days.
E. FREQUENTLY ASKED QUESTIONS

Q. What is a Foundation Programme Year 2 doctor (F2)?
- The majority of doctors will have completed Foundation Year 1 and move automatically to Foundation Year 2 in a UK training scheme.
- During F1 they will have gained 12 months clinical experience as a doctor in the secondary care setting where they will have undertaken three or more different rotations.
- As an F2 doctor they will have full GMC registration.
- A few doctors are appointed directly to a FY2 programme after completing an internship elsewhere.

Q. How is an F2 doctor different from a GP registrar?
- The F2 doctor is fundamentally different from a GP Registrar.
- The F2 doctor is not learning to be a GP.
- You are not trying to teach an F2 doctor the same things as a GP Registrar but in a shorter time.
- The aim of this rotation is to give the F2 doctor a meaningful experience in General Practice with exposure to patients in the community, which will enable them to achieve the required competences.
- The F2 doctor will not attend the VTS whole or half-day release sessions.

Q. Who decides which doctor will come to my practice?
- Each F2 programme usually consists of 3 rotations. There are numerous combinations.
- F1 doctors list their choice of rotations and are then allocated as far as possible to their preferred options. Trust medical personnel and the local GP offices liaise to match trainees to GP practices.

Q. Does the F2 doctor in GP need to be on the Medical Performers List?
- Your Foundation Doctor is not required to be on the Performers List of the relevant Primary Care Trust (PCT), however, the Acute Trusts are required to notify PCTs that a doctor will be undertaking part of his/her Foundation Training Programme in the PCT area at least 24 hours prior to the Foundation Doctor commencing work within the PCT. The Acute Trusts are to provide the PCT with evidence that the doctor is undergoing post-registration training.

Q. Does the F2 require a contract with the Practice?
- You do not need a contract of employment because the F2 is employed and paid by the Acute Trust. However, in addition to the hospital trust contract they should sign an Honorary Educational Contract with the GP practice.

Q. Is there a Trainer’s Grant?
- Yes. This is known as the “F2 GP supervision payment”. The level of the supervision payment for the F2 doctor will be based on the available funding to Health Education Wessex. Currently it is a pro-rata payment of the GP-Trainer’s grant. The Wessex Foundation Programme manager can confirm the amount valid for each training year.
Q. How many F2 doctors can be trained simultaneously in Practice?
   - The Practice may host more than one F2 doctor simultaneously provided that the Surgery has sufficient space and time to provide Clinical teaching and supervision.

Q. How will I supervise the F2 during my surgeries?
   Some Training Suggestions:
   Patient appointments should initially only be booked with ½ hour slots; The attachment is to enable learning through closely supervised delivery of service commitment in the Practice. Time should be allowed for them to write up and reflect on the social / psychological aspects of the encounter as well as the medical model for feedback to the trainer. You may wish to book every third 10-min appointment with the F2 doctor’s patient so that you can supervise, teach and discuss issues without reducing your own surgery.

Q. What about medical defence cover?
   The employing trust provides indemnity cover for the F2 trainees. However it is recommended that the trainee takes out individual indemnity cover with a defence organisation in addition to Crown indemnity provided by the acute trust. No costs will be reimbursed by the acute Trust or the Deanery.

Q. Can an F2 doctor sign prescriptions?
   Yes. An F2 doctor has full GMC registration and is therefore able to sign a prescription. (Refer to Appendix 8 for guidance on prescribing in General Practice)

Q. What about their Contract of Employment?
   - The Contract of Employment is held by the Acute Trust to which the Foundation doctor has been allocated to for their foundation training. The Acute Trust is responsible for paying salaries and other HR related issues.

   - Salary payments:
     The Trusts are responsible for paying the F2 doctor’s salary throughout the year, though at present, during the GP attachment, the trainee's salary will normally be at the basic rate with no intensity supplement as may be paid in a trust F2 slot.

   - In addition to this legal contract we do suggest that each practice has an Honorary Educational Contract with each of its Foundation Doctors. A specimen copy is attached at Appendix 1.
Q. Are travel costs reimbursed?
- Eligible travel claims are reimbursed by the employer (the host trust). Money has been included in the non-pay element of funding to trusts from Health Education Wessex to cover this, but the amount provided for travel is limited.
- Only additional actual costs are reimbursed. The F2 doctor may claim for any cost of travel from their home to the practice in excess of the cost of their normal travel to the trust (e.g. if driving they may claim any extra mileage over that normally travelled to the trust, if travelling by public transport they may claim the additional cost)
- They may claim for expenses incurred if they have to travel between the practice and their base trust during the working day (e.g. if they have to attend meetings or educational sessions).
- They may also claim for the mileage incurred while doing home visits in the Practice area.

Q. What about Study Leave?
- The F2 doctor is entitled to 30 days study leave during the year. However about 12 of these days will be used as part of the ‘class-room’ teaching programme organised by the Acute Trusts and Health Education Wessex. Trusts do vary slightly on this allocation.
- Normally no more than a third of the study leave should be taken in each four month rotation or a quarter during a 3 month attachment.
- The study entitlement will be about 6 days in each 4-month post and must be approved and recorded by the Trust.

Q. Should an F2 doctor do out of hours’ shifts?
- They are not expected to work out of hours’ shifts during their general practice rotation.
- Some F2s have asked to experience out of hours as a means of exposure to a different type of acute illness. This can be a useful learning opportunity but must be properly supervised.
- Trust OOH work
  F2 doctors may do extra work in the Trust during the GP attachment, such as an evening shift, and this may enable them to attract a banding supplement during the GP component. They may not exceed an average working week in excess of 48 hours.
- Any OOH work should not impact on the Foundation doctor’s working week at the Practice.

Q. Should the F2 doctor contact the GP Practice prior to their attachment in GP?
- We recommend that the F2 should contact their Practice about a month before the attachment and arrange to meet their GP Clinical Supervisor and the Practice Manager.
- Most F2s do find it useful to contact their Practice in advance of starting work there.

The overall working week must comply with the EWTD and during the GP F2 post should be no greater than 48 hours commitment per week.
THE ROLE OF A SUPERVISOR OF F2 DOCTORS IN GP

- All F2 doctors will have one Educational Supervisor for the year.
- You will fulfil the role of the Clinical Supervisor for the doctor whilst they are in your practice.
- If the first rotation is in general practice you will need to carry out an initial appraisal and work with the F2 to identify their learning needs and discuss with them how to maintain their portfolios, Personal Development Plans and keep appropriate records of their assessments.
- For second and third rotations you will need to start by going through the portfolios and discuss their learning to date in order to help them identify the learning needs they wish to address during the rotation with you.
- In the Hub and Spoke models (see later) the F2 may have a Clinical Supervisor who will supervise clinical activity ensuring that the Foundation doctor only performs tasks without supervision that they are competent so to do. This is part of the spoke with a GP Educational Supervisor forming part of the hub.

Induction Meeting and Review Forms

At the start to the F2 placement, you will need to conduct an ‘Induction Meeting’ with the F2 trainee and record this on an Induction Meeting form.

A ‘Mid-point Meeting’ can be carried out halfway through the placement; this is not compulsory, but strongly advised.

The Clinical Supervisor’s Report must be completed 2 weeks before the end of placement and forwarded to the trainee’s Educational Supervisor.

These meetings are recorded on standard forms available within the Foundation E – Portfolio.

GP Access to E-Portfolio

GP Clinical Supervisors should ask to be set-up as a Clinical Supervisor (CS) on the Foundation E-Portfolio. This enables access to the trainee’s E-Portfolio. The F2 will ‘ticket’ other GPs and Practice Staff to receive e-mail copies of the assessment forms for completion.

The GP Clinical Supervisor must record the Clinical Supervisor’s report on the FY2 doctor’s E-portfolio at the end of the attachment. It is recommended that the CS also records the Induction Meeting and comments on progress throughout the attachment.

Performance issues

The vast majority of F2 doctors will complete the programme without any major problems. However some doctors may need more support than others, for example due to ill-health,
personal issues, learning needs or attitude. If you feel at any time that the doctor under your clinical supervision has performance issues you should contact the trainee’s Educational Supervisor or trust Foundation Programme Director who will work with you to ensure that the appropriate level of support is given both to you and the F2 doctor.

It is very important that you keep written records of the issues as they arise and that you document any discussions that you have with the F2 doctor regarding your concerns, ideally on the E-portfolio. CSs should also keep their own records in a secure format.

**Non-standard Foundation Programme Year 2 rotations**

We said at the beginning of this guide that the standard F2 rotation in general practice was for 4 months. However there are some innovative variations to this within the Foundation School but even within these variations all of the principles outlined in the guide will still apply.

Examples of other rotations may be:

- A four month rotation in general practice but with one to two days each week spent in a speciality such as Medical Education (academic programme), Public Health (academic programme) Public Health (clinical), sexual health or psychiatry
- A six month rotation.

**The Supervision Payment/Trainer’s Grant**

The level of the supervision payment is based on the available funding to the Health Education Wessex.

- You can if you have sufficient capacity in terms of space and resources have more than one F2 at any one time.
- To claim the supervision payment, complete and submit the appropriate invoice during the final month of the F2 placement. The current supervision payment Invoice can be obtained by contacting the Wessex Foundation Programme Manager (currently Amelia Isaac: amelia.isaac@wessex.hee.nhs.uk)
G. THE ROLE OF THE CLINICAL SUPERVISOR IN GENERAL PRACTICE

The Clinical Supervisor is the doctor supervising the clinical work with the F2 doctor in the practice. The supervisor will be able to:

- Organise the clinical attachment and be directly involved with the trainee in organising their assessments.
- Supervise the clinical work of the F2 or arrange for this to be covered by a colleague.
- Ensure that there is always appropriate cover available to the F2 doctor.
- Enable the practice to facilitate the learning necessary to fulfil the objectives of the Foundation Programme.
- Liaise with the trainee’s Educational Supervisor regularly and promptly if any difficulties are emerging during the training.
- Sign relevant employment related paperwork on behalf of the Trust while the trainee is working in the practice.
- Demonstrate that they have a level of competence in training and education and be able to apply this to the appraisal and development of an appropriate PDP for the trainee.
- Complete the Foundation Clinical Supervisor’s report at the end of the placement.

THE ROLE OF THE EDUCATIONAL SUPERVISOR DURING THE F2 DOCTOR’S ATTACHMENT IN GENERAL PRACTICE

- This person will supervise the F2 doctor for the whole year and is responsible for the overall development of the programme through all three placements. At present, this is usually a nominated consultant at the acute NHS trust.
- The Educational Supervisor MAY also be the Clinical Supervisor for one post in the rotation. (This is normally the case though).
- The Educational Supervisor has regular meetings with the trainee and should be in contact with each Clinical Supervisor when the trainee is in post. He/she is responsible for signing the Foundation Achievement of Competency Document (FACD) at the end of the F2 programme.
- The Educational Supervisor liaises with the Foundation Programme Director in the Trust. There is an expectation that they will have experience of managing trainees in training posts and have some knowledge of educational theory. They should have completed a course to qualify as an Educational Supervisor.
Honorary Educational Contract

Honorary contract between Foundation Programme Doctors in General Practice and their GP Supervisors

This Agreement is made on ................................................................. [date]

between

.................................................................................................................................

(GP Supervisor)

and

.................................................................................................................................

(Foundation Programme Doctor in General Practice)

The terms and conditions of this honorary contract are as follows:

A. All medical practitioners covered by this contract will be fully registered with the General Medical Council (GMC)

B. GP Supervisors will be so recognised by the General Practice Directorate within Health Education Wessex.

C. This contract will cover that part of Postgraduate Medical Training, known as the Foundation Programme, and will regulate the General Practice component of that programme. It will form part of the supplementary regulations enabling that training period.

D. This document will act as a supplementary/honorary contract between the above parties. The principal contract will be held by a host Acute Trust within Health Education Wessex for the duration of the Foundation Programme.

General:

1 The GP Supervisor will supervise and organise the period of training within General Practice for the purpose of teaching and advising on all matters appertaining to general medical practice for a period of four months from .................................[date placement commences] unless this agreement is previously terminated under the provision of clause 2.

2 This agreement may be terminated by either party by giving one month's notice in writing. Such notice may be given at any time.

3 Salary will be paid by the host trust at the agreed rates as determined by the Doctors and Dentists Review Board.
4 Both parties may become and remain members of a recognised medical defence body at their own expense for the period of this agreement.

5. The Foundation Doctor will not be required to perform duties which will result in the receipt by the practice of private income.

6. Any specific or pecuniary legacy or gift of a specific chattel shall be the personal property of the Foundation Doctor.

7. The hours worked by the Foundation Doctor in the practice, the practice programme and regular periods of tuition and assessment will be agreed between the GP Supervisor and the Foundation Doctor and make provision for any educational programme organised by the acute trust and as advised by Health Education Wessex.
   a) The hours of work shall comply with the European Working Time Directive legislation, or any subsequent Working Time legislation.
   b) The Foundation Doctor is supernumerary to the usual work of the practice.
   c) The Foundation Doctor may be required to accompany their GP Supervisor or another member of the practice team on out of hours work.
   d) The Foundation Doctor should not be used as a substitute for a locum in any practice.
   e) Time spent in practice by the Foundation Doctor should be no more than the average time spent on practice work by a full time member of the practice.

8. The Foundation Doctor shall be entitled to five weeks holiday during a 12 month period and pro rata for shorter periods, and also statutory and general national holidays or days in lieu.
   a) The Foundation Doctor is entitled to approved study leave for educational activities considered appropriate by the GP Supervisor and Foundation Programme Director.
   b) If the Foundation Doctor is absent due to sickness, they must inform the practice as early as possible on the first day of the sickness. Statutory documentation shall be provided as required for any illness lasting more than 7 days. Any accident or injury arising out of the Foundation Doctor’s employment in the practice must be reported to the Practice Manager, duty doctor in the practice or their GP Supervisor.
   c) A Foundation Doctor in General Practice who is absent on maternity leave will comply with the terms of their Principal Contract.
   d) If a Foundation Doctor is chosen or elected to represent the profession, or Foundation Programme Doctors at any recognised body or to attend an Annual Conference of Representatives of Local Medical Committees, the Foundation Doctor in General Practice will be given facilities including special paid leave to undertake such functions and to attend appropriate meetings. The Foundation
Doctor must obtain the consent of their GP Supervisor for such absence from duty, but consent shall not be withheld unless there are exceptional circumstances.

9. The GP Supervisor will provide or organise any message taking facilities that will be required for the Foundation Doctor in General Practice to fulfil their duty requirements.

   a) The GP Supervisor will provide cover or arrange for suitably qualified cover to advise the Foundation Doctor at all times.

   b) The Foundation Doctor shall undertake to care for, be responsible for and if necessary replace and return any equipment that may have been supplied by the Practice or GP Supervisor at the end of the training period.

   c) The Foundation Doctor will apply himself/herself diligently to the educational programme and service commitments and other matter as directed by the GP Supervisor in accordance with the advice of the Health Education Wessex Foundation Programme and its Directors.

   d) The Foundation Doctor will keep an educational log and records such that they may be able to develop a Professional Learning Plan. These records will enable them to fulfil any requirements of the General Medical Council for appraisal, or professional revalidation in their career.

   e) The Foundation Doctor shall keep proper records of attendances or visits by and to any patients in handwritten or electronic format as advised by their GP Supervisor.

   f) The Foundation Doctor shall preserve the confidentiality of the affairs of the GP Supervisor, of the partners in the practice, of the patients and all matters connected with the practice. The exception shall be where information may be required by the Director of GP Education of Health Education Wessex or their nominated officer.

   g) The Foundation Doctor will make suitable provision for transporting themselves in order to carry out the above duties satisfactorily. Appropriate expenses may be reclaimed from the host Trust.

10. Any dispute between the Foundation Doctor and the GP Supervisor should be brought to the attention of the local Associate Dean for General Practice. If the matter can not be resolved at this level it will then proceed through the appropriate channels.

11. The terms of this contract will be subject to the terms of service for doctors as set out from time to time in the National Health Service (General Medical and Pharmaceutical Services) Regulations.
I have read and understand the terms of this honorary contract

Signature……………………………………………………….[Foundation Programme Doctor]
Name…………………………………………………………………………………
Date………………………………………………………………………………..

In the presence of………………………………………………………..[Witness Name]
Signature…………………………………………………………………………
Date………………………………………………………………………………

Signature……………………………………………………….[GP Supervisor]
Name………………………………………………………………………………
Date………………………………………………………………………………

In the presence of………………………………………………………………[Witness Name]
Signature…………………………………………………………………………
Date………………………………………………………………………………
Core Competences for the Foundation Years

1 Good Clinical Care
1.1 History Taking, Examination and record keeping skills
   i. History taking
   ii. Conducts examinations of patients in a structured, purposeful manner and takes full account of the patient’s dignity and autonomy
   iii. Understands and applies the principles of diagnosis and clinical reasoning that underline judgement and decision making
   iv. Understands and applies principles of therapeutics and safe prescribing
   v. Understands and applies the principles of medical data and information management: keeps contemporary accurate, legible, signed and attributable notes

1.2 Demonstrates appropriate time management and decision making

1.3 Understands and applies the basis of maintaining good quality care and ensuring and promoting patient safety
   i. Always maintains the patient as the central focus of care
   ii. Makes patient safety a priority in own clinical practice
   iii. Understands the importance of good team working for patient safety
   iv. Understands the principles of quality and safety improvement
   v. Understands the needs of patients who have been subject to medical harm or errors, and their families

1.4 Knows and applies the principles of infection control

1.5 Understands and can apply the principles of health promotion and public health

1.6 Understands and applies the principles of medical ethics, and relevant legal issues
   i. Understands the principles of medical ethics
   ii. Demonstrates understanding of, and practises appropriate procedures for valid consent
   iii. Understands the legal framework for medical practice

2. Maintaining Good Medical Practice
   i. Learning: Regularly takes up learning opportunities and is a reflective self-directed learner
   ii. Evidence base for medical practice: knows and follows organisational rules and guidelines and appraises evidence base of clinical practice
   iii. Describes how audit can improve personal performance

3. Relationships with Patients and Communication
   i. Demonstrates appropriate communications skills

4. Working with Colleagues
   i. Demonstrates effective team work skills
   ii. Effectively manages patients at the interface of different specialities including that of Primary Care, Imaging and Laboratory Specialities
5. Teaching and Training
   i. Understands principles of educational method and undertakes teaching of medical trainees, and other health and social care workers

6. Professional Behaviour and Probity
   i. Consistently behaves with a high degree of professionalism
   ii. Maintains own health and demonstrates appropriate self-care

7. Acute Care
   i. Promptly assesses the acutely ill or collapsed patient
   ii. Identifies and responds to acutely abnormal physiology
   iii. Where appropriate, delivers a fluid challenge safely to an acutely ill patient
   iv. Reassesses ill patients appropriately after initiation of treatment
   v. Requests senior or more experienced help when appropriate
   vi. Undertakes a secondary survey to establish differential diagnosis
   vii. Obtains an arterial blood gas sample safely, interprets results correctly
   viii. Manages patients with impaired consciousness including convulsions
   ix. Safely and effectively uses common analgesic drugs
   x. Understands and applies the principles of managing a patient following self-harm
   xi. Understands and applies the principles of management of a patient with an acute confusional state psychosis
   xii. Ensures safe continuing care of patients on handover between shifts, on call staff or with ‘hospital at night’ team by meticulous attention to detail and reflection on performance
   xiii. Considers appropriateness of interventions according to patients’ wishes, severity of illness and chronic or co-morbid diseases
   xiv. Has completed appropriate level of resuscitation training
   xv. Discusses Do Not Attempt Resuscitation (DNAR) orders/advance directives appropriately
   xvi. Requests and deals with common investigations appropriately
Suggested Learning Areas suitable for Tutorials

The list below is a suggestion for tutorial topics. It is by no means prescriptive or definitive.

**GP Supervisors should agree a realistic programme early in the attachment to meet the needs of each individual F2 in GP.**

- Managing the practice patient record systems – electronic or paper
  - History taking and record keeping
  - Accessing information
  - Referrals and letter writing
  - Certification and completion of forms

- General Practice Emergencies
  - The doctors’ bag
  - House visits
  - Physical, Mental and Social aspects of Acute care in GP

- Primary Healthcare Team working
  - The doctor as part of the team
  - Who does what and why
  - The wider team

- Clinical Governance and Audit
  - Who is responsible for what
  - What is the role of audit
  - What does a good audit look like

- Primary and Secondary Care interface
  - Developing relationships
  - Understanding patient pathways
  - Care in the Community

- Interagency working
  - Who else is involved in patient care
  - What is the role of the voluntary sector
  - Liaising with Social Services

- Personal Management
  - Coping with stress
  - Dealing with Uncertainty
  - Time Management

- Chronic Disease Management

- The sick child in General Practice

- Palliative Care

- Social issues specific to your area which have an impact on health
Foundation Programme Year 2 placement in General Practice in Health Education Wessex

Job Description

Job Title: Foundation doctor in General Practice
Reports To: GP Supervisor or trainer
Location: (name of practice, contact details including website and trainer e-mail)
Hours: 40 hours per week\(^2\)
Contract Type: Full time
Background: See below
Key Working Relationships: GP Supervisor, Educational Supervisor, Foundation Programme Director.

Background

There has been a strong feeling that exposing all new doctors to a placement in General Practice would enhance their generic and clinical skills for any future career. The GP placement introduces the doctor to General Practice and to a range of skills that are transferable to a career in any speciality. The 3 or 4 month placement will be based in a training practice or a practice that has a well established educational background and is likely to fulfil the criteria for qualification as a training practice.

Job Purpose

The basic principles of the Foundation Programme form the focus of the timetable for this placement. These are an emphasis on work-based learning to develop clinical and professional skills, skills in acute medical care, understanding of the primary – secondary care interface and the development of personal life-long learning skills and continuing professional development.

Main Duties and Responsibilities

- Induction to practice
- Observed surgeries

\(^2\) No more than 40 hours per week are to be spent in the GP placement. The employing Trust may offer up to 8 hours per week additional duties, back in the Trust, to remain compliant with European Working Time Directives but will need to be negotiated and agreed outside this contract.
- Supervised surgeries
- Attendance at practice meetings
- Individual study and preparation of case studies and written work
- Joint study in tutorials with GP Supervisor and other members of the primary health care team
- Joint surgeries with another GP
- Communication skills

The F2 doctor should maintain their portfolio and make regular entries as evidence of their learning.

Travel to the practice from the Trust base and travel related to work in the practice is reimbursed from the Acute Trust.

An Educational contract should be signed with the practice at the beginning of the placement.

Example of timetable

The working week is 40 hours between 08.00 and 18.30. There is no funded work outside these hours. The place of work is [add name of practice]

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30-11.00</td>
<td>surgery</td>
<td>surgery</td>
<td>Joint surgery and tutorial</td>
<td>surgery</td>
<td>surgery</td>
</tr>
<tr>
<td>coffee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.30-13.00</td>
<td>Minor illness clinic</td>
<td>visits</td>
<td>Project work</td>
<td>visits</td>
<td>Chronic illness clinic</td>
</tr>
<tr>
<td>lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.45-18.00</td>
<td>Paperwork 2 hour surgery</td>
<td>Video surgery 1 hour. Work with on call GP</td>
<td>Surgery and paperwork</td>
<td>Half day</td>
<td>Special interest clinic</td>
</tr>
</tbody>
</table>

There will be core training days which occur monthly and are covered by study leave. The practice will have their own programme of educational meetings and practice meetings that you will be expected to attend.

Outcomes of the GP placement

1. Work effectively within the Primary Health Care team understanding the roles of each member of the team

2. Have a working knowledge of the role of the GP and to be able to work under supervision in that role

3. To have worked at the primary/secondary care interface in primary care and be able to identify good practice in referral and discharge of patients from hospital
4. To have undertaken supervised surgeries and identified management plans for the patients.

5. To have identified personal learning needs from the working in General Practice and to have an up-dated personal development plan.

6. To have completed a piece of work on a practice related topic.

7. To have seen and treated patients with illnesses in their own homes and to understand the management issues related to this.

*****************************************************************************
Health Education Wessex /Foundation Programme Contacts

Doctors embarking on the second year of the Foundation Training Programme are advised to make a note of the Education & Training personnel with whom they are likely to encounter during the year.
(Please update your records as personnel do change periodically)

The Foundation doctor should obtain these details from his/her employing Trust at the time of appointment to the Foundation Programme.

<table>
<thead>
<tr>
<th>Postgraduate Dean</th>
<th>Dr Simon Plint</th>
<th>Contact Amelia Isaac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Foundation School</td>
<td>Dr Mike Masding</td>
<td>Contact Amelia Isaac</td>
</tr>
<tr>
<td>Foundation Programme Manager</td>
<td>Mrs Amelia Isaac</td>
<td>01962 718442 <a href="mailto:amelia.isaac@wessex.hee.nhs.uk">amelia.isaac@wessex.hee.nhs.uk</a></td>
</tr>
<tr>
<td>Foundation Programme Administrator</td>
<td>Mrs Lucy Wyatt</td>
<td>01962 718565 <a href="mailto:lucy.wyatt@wessex.hee.nhs.uk">lucy.wyatt@wessex.hee.nhs.uk</a></td>
</tr>
<tr>
<td>Foundation Programme Administrator/PA</td>
<td>Mrs Natasha Patel</td>
<td>01962 718438 <a href="mailto:natasha.patel@wessex.hee.nhs.uk">natasha.patel@wessex.hee.nhs.uk</a></td>
</tr>
<tr>
<td>GP Associate Dean for Foundation Programme</td>
<td>Dr Reg Odbert</td>
<td>Contact Amelia Isaac</td>
</tr>
<tr>
<td>GP Programme Manager (non-foundation)</td>
<td>Mrs Fenella Williams</td>
<td>01962 718447 <a href="mailto:fenella.williams@wessex.hee.nhs.uk">fenella.williams@wessex.hee.nhs.uk</a></td>
</tr>
</tbody>
</table>

Acute Trust / Hospital Contacts

| Foundation Programme Director |
| Educational Supervisor |
| Name of rotation |
| Placement 1 Clinical Supervisor |
| Placement 2 Clinical Supervisor |
| Placement 3 Clinical Supervisor |
| Trust HR contact |
European Working Time Directive

This applies to all workers and, from August 2004, it was extended to include doctors in training. The provisions were phased in, with a maximum hours’ requirement reducing from 58 hours in 2004 to 48 hours in 2010.

The hours are averaged over 13 weeks.

EWTD maximum = 48 hrs per week (averaged over a reference period)

Continuous = 13 hrs per day (11 hrs continuous rest in 24hrs)
             = 24 hrs continuous rest in 7 days
             = 20 minute break in work periods over 6 hrs

Night workers = no more than 8hrs work in 24hrs
Title: Home Visiting for Foundation Doctors in General Practice – (Revised paper)

Summary:

Home visits are an important part of British General Practice representing 10% of all patient contacts. Visiting patients alone exposes the doctor to a personal safety risk. Home visits provide useful experience in many of the Foundation and nMRCGP competencies, and provide material for workplace based assessments. In assessing the suitability home visits for trainees the trainer needs to consider learning needs, clinical competence, patient safety and trainee safety. A simple risk assessment is recommended.

This paper is written as a position paper as general recommendations for all Foundation Schools.

Recommendations for COGPED:

1. All Foundation Trainees should be able to improve their foundation competencies using experience of home visiting during their attachment to general practice.
2. The number of home visits undertaken should be related to educational and not service delivery needs.
3. The trainer is responsible for assessing the suitability of the visit for a Trainee in terms of learning needs, clinical competence (patient safety) and personal safety.
4. The trainer is responsible for ensuring arrangements to brief the Trainee before, making suitable arrangements for clinical supervision during and debriefing after the visit.

<table>
<thead>
<tr>
<th>Author:</th>
<th>Martin Wilkinson</th>
<th>Contact Details:</th>
<th><a href="mailto:martin.wilkinson@westmidlands.nhs.uk">martin.wilkinson@westmidlands.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
<td>DPGPE West Midlands</td>
<td>Date:</td>
<td>22nd December 2008</td>
</tr>
</tbody>
</table>
GUIDANCE ON HOME VISITING FOR FOUNDATION DOCTORS IN GENERAL PRACTICE

Home visiting by general practitioners is an important feature of British General Practice. Home visits represent 10% of contacts with general practitioners although the rate of home visiting has declined over the past 30 years\(^1\)\(^-\)\(^6\). The average annual home visiting rate is 299/1000 patient years, with the majority in the elderly with an average of over three a year over 85 (3009/1000 patient years over 85 years compared to 103/1000 age 16-24). Home visiting rates show a J shaped relation with age and twice as high in people from social class V as in people from social class I. The commonest diagnostic group is disease of the respiratory system. In the older age groups disease of the cardiovascular system is also a common diagnostic group\(^7\).

When visiting patients in their own homes a lone doctor is exposed to the potential but small risk of injury due to a violent patient or relative, or assault whilst travelling in the community. Most reports of violence against GPs occur in the surgery as opposed to home visiting, but risk to community workers is well known. A number of factors increase the risk of violence associated with home visiting including deprivation, type of accommodation, the locality, time of day, alcohol or drugs, mental health problems, and previous history of violence\(^8\),\(^9\). General Practitioners have responded to the risk of home visits by providing transport and a driver to out-of-hours calls, or strongly discouraging home visits in favour of assessment at the surgery.

Foundation Doctors
Home visiting is an essential part of British General Practice providing an opportunity to gain experience in many of the foundation competencies. Useful experience can be gained in the areas of respiratory disease, circulatory disease, infections, musculoskeletal disease, and pain management. These patient contacts can be used for workplace based discussions including cased based discussion and direct observation of procedural skills. Most trainers are keen to introduce their trainees to home visits early into their attachment with the practice. GP trainers have many years of experience of accompanying GP trainees on home visits and only allowing them to visit alone when the trainer is satisfied with clinical competence and after careful selection of the proposed visit.

COGPED recommends that all Foundation have the opportunity to improve their foundation competencies using the experience of home visiting during their attachment to General Practice. Before allowing a Trainee to visit alone a number of areas need to be considered: learning needs, clinical competence, clinical supervision and the safety of the risk patient and the trainee.

Learning Needs and Clinical Competence
The problem presented by the home visit request may not be suitable for the learning needs of all foundation doctors. The management of the acutely ill patient in the areas of respiratory disease, circulatory disease, infections musculoskeletal disease, and pain management are the most suitable cases.

Clinical Supervision
Early in the attachment it is recommended that the trainer accompany the trainee on home visits. Visiting alone only occurs when, and only if, the trainer feels that the trainee is competent to do so. The trainer has a responsibility to screen home visit requests as suitable for the foundation trainee, who will be briefed before, and debriefed after the visit. At all times both the trainer will be contactable by mobile telephone.
Risk Assessment
Trainees will have less experience of home visiting and may not fully appreciate the safety aspect. It is recommended that all training practices undertake a general risk assessment of trainee safety before becoming a foundation practice. This risk assessment to include practice premises, and home visiting arrangements. This should form part of the practice accreditation process.

Normally foundation doctors should only be allowed to go alone on home visits where the trainer assesses the safety risk to be “low”. Where a “high risk” is identified a clinical supervisor or security personnel should accompany trainees. Some inner-city practices may deem that no foundation trainees visit alone due to personal safety issues.

Trainers must take responsibility for identifying suitable home visits within the competence of the trainee and assessing the risk of injury or assault. The trainee must be equipped with the appropriate clinical equipment to undertake the home visit and carry a fully charged mobile phone.

Examples of increased risk of violence to health professionals on home visits

- Visiting in the dark
- Tower Blocks
- Female doctors visiting lone male patients
- Patients with known alcohol misuse or drug misuse history
- Patients with previous violent behaviour to NHS workers.
- Patients with acute psychiatric problems.

Recommendations:

1. All Foundation doctors should be able to improve their foundation competencies using experience of home visiting during their attachments to general practice.
2. The number of home visits undertaken should be related to educational and not service delivery needs.
3. The trainer is responsible for assessing the suitability of the visit for a trainee in terms of learning needs, clinical competence (patient safety) and personal safety. Normally only “low risk” visits are suitable for Foundation trainees visiting alone, and “high risk” visits are not suitable.
4. The trainer is responsible for ensuring arrangements to brief the trainee before, making suitable arrangements for clinical supervision during and debriefing after the visit.

References

Dr Martin Wilkinson
Director Postgraduate GP Education West Midlands.
Martin.wilkinson@westmidlands.nhs.uk
Prescribing in General Practice

Here are some suggestions that may be useful for doctors to consider when they join a General Practice to gain experience during the Foundation Programme and when starting in Specialty Training.

Documentation

It is good practice, and medico-legally essential, to document all encounters with patients. This includes every item of medication prescribed, and every consultation, even telephone calls and House Visits.

Some general rules:

- Prescribe Generics (except SR preps, and branded anti-convulsants)
- Normally Issue repeat medication in 28-day quantities
- Remove un-used drugs from patients’ medication lists
- Aspirin dispersible instead of enteric coated
- Use the PCT-agreed ‘Preferred drug’ as first choice, when possible
- Never issue hypnotics or anxiolytics as repeat prescriptions
- When you increase drug doses, make the previous dosage dormant on the computer.
- Do not initiate PCT ‘Red and Amber’ drugs. D/w trainer.

Aim to reduce:

- Combination drugs
- Topical NSAIDS
- COX2
- Dosage of PPIs – step down or stop treatment when possible
- Repeat prescribing – consider whether drug is necessary: particularly benzodiazepines, Z drugs (Zopiclone, zolpidem)
- Antibiotics – particularly Co-amoxiclav
- Dihydrocodeine
- Quinolones (cipro / ofloxacin)
- Expensive dressings

Try to Avoid:

- Specialist drugs (Examples: Aricept and cholinesterase drugs for dementia / Pergolide / Pregabalin, and trial drugs – unless these are issued under written instructions from a consultant)
- Second and third-line Antibiotics (without bacteriology to support decision)
- Warfarin tablets in 5mg dosage (beware of risk of confusion between 0.5mg and 5mg doses)
- HRT over age 55 (there are exceptions)
- Oestrogen & progesterone contraception over 40 (exceptions apply)
- Weight – reduction drugs (unless on a supervised programme)
- Opiate analgesia (d/w trainer)
- Food supplements and Sun – block (special rules apply)
Example of a Typical Practice Formulary:

**Antibiotics (orally)**
1. Respiratory
   - 1\textsuperscript{st} Amoxicillin
   - 2\textsuperscript{nd} Erythromycin if Pen sensitive
2. Skin infection
   - 1\textsuperscript{st} Flucloxacillin or Pen V
   - 2\textsuperscript{nd} tetracycline
3. UTI
   - 1\textsuperscript{st} Trimethoprim 2nd Nitrofurantoin
     (Await MSU before using other Abs)

**Antibiotics (topical)**
- Fusidic acid
- Gramicidin & neomycin
- Metronidazole

**Pain Relief**
- Paracetamol
- Codeine phosphate
- Avoid combinations where possible
- NSAIDS
  - 1\textsuperscript{st} Ibuprofen
  - 2\textsuperscript{nd} Diclofenac

**GIT**
- **Antacids**
  - Peptac and Gaviscon
- **Anti-emetic**
  - Metoclopramide
- **Laxative**
  - Magnesium hydroxide mix.
  - 2\textsuperscript{nd} Lactulose
  - 3\textsuperscript{rd} Senna 15mg
  - (keep movicol for complex problems)
- **PPI**
  - Lansoprazole

**Respiratory**
- **SABA**
  - Salbutamol (CFC-Free) MDI Ventolin evohaler
  - Dry powder Ventolin accuhaler
  - Terbutaline (Bricanyl MDI or dry powder turbohaler)
- **LABA**
  - Salmeterol (aerosol and dry powder)
- **Steroid**
  - Beclomethasone (Qvar)
  - Budesonide (Pulmicort)
- **Steroid/ B agonist combinations**
  - Seretide (Fluticasone and Salmeterol)
  - Symbicort (Budesonide & formoterol)
- **Anticholinergic**
  - 1\textsuperscript{st} choice Ipratropium (Atrovent)
  - 2\textsuperscript{nd} Tiotropium (Spiriva – long acting)

**CVS**
- **A** **ACEI**
  - Lisinopril / Ramipril
- **B** **B-blocker**
  - Atenolol (caution DM) / Bisoprolol cardioselective
- **C** **CCB**
  - Amlodipine (as maleate) / Felodipine
- **D** **Diuretics**
  - Thiazide
  - Bendroflumethiazide
  - Loop
  - Furosemide
  - K-sparing Spironolactone
GTN

Statins        Simvastatin and build dose

Antiplatelet  Aspirin 75mg disp tabs
    Clopidogrel as per NICE (remember to set a ‘stop date’)

HRT    Get to know a series of
    1. solo oestrogen (no uterus)       eg Premarin
    2. combined sequential            eg Premique cycle
    3. continuous combined            eg Premique

Bisphophonates  Alendronic acid 70mg weekly or Ibandronic acid 150mg monthly

Calcium        Adcal D3 bd

COC            Microgynon 30
POP            Micronor        (reserve Cerazette for when other pills contraindicated)

Emergency Contraception Levonelle 1.5mg (asap, but up to 72 hours)
    Copper iucd up to 120 hours (test for STDs)

Parenteral progestogen  Depo-provera im every 12 weeks

Steroid creams: Hydrocortisone (weak),  Clobetasone butyrate (moderate),
    Betamethasone (strong),  Clobetasol (very strong)

Mental Health
    SSRI          Fluoxetine
    Hypnotic      Temazepam (short course)
    Anxiolytic    Diazepam (minimum script)

Diabetes (T2DM)  
    Metformin
    Glimepiride
    Rosi / Pioglitasone (caution heart failure / IHD)

Antivirals  
    Aciclovir tabs 800mg x5 daily x 7
    Aciclovir ointment

Food supplements  special rules apply - see BNF
Practice Manager FY2 Checklist

Acknowledgement: This document has been adapted from an original paper written by Dr Joanna Robinson for her own Practice.

2 months prior to commencement:

1. E-mail or telephone FY2 with welcome and introduction and offer of a visit to the practice to meet new colleagues ahead of their placement. Most will want to do this.

2. Confirm contact details to include:
   - Email (home and work)
   - Address
   - Tel numbers (home and mobile)
   - Any special needs, requirements or information (religious beliefs and practices, travel arrangements to and from work, commitments outside of work, what they like to be called etc). This sort of information is invaluable in our experience, and helps us to plan for their placement appropriately.
   - Provide them with contact details of their trainer if they do not already have this, including email and tel numbers.

3. Check with the FY2 the date of their latest enhanced CRB check, indemnity insurance arrangements and GMC certificate. Ask the FY2 to provide the documents (where relevant) for inspection on their first day at the Practice. (Take copies for their file on their first day, if appropriate)

1 month prior to commencement:

4. Prepare honorary contract for the FY2 using the standard template – see pages 20-23.

5. Prepare induction timetable for the first two weeks, we include sitting in with GPs and other clinicians in the first week of their placement and virtually all GP sessions in the second week. Check with the FY2 if there are any areas of particular interest or training needs and accommodate if this is possible and appropriate.

6. Once a standard timetable for the FY2 has been agreed (to include their half days, taking account of any On-call commitments and compulsory training) get the appointments for the FY2 set up on the clinical or appointment system at 30 minute intervals to start with.

7. Send electronic or paper copies of timetables, staff handbook (if you have one), prescribing formulary, copy of the honorary contract and FY2 Frequently asked questions to the FY2, reassure FY2 Doctor that all will be well, nothing to worry about and looking forward to having them working at the practice. Remind them about a visit to the practice if they have not already done so.
8. Prepare induction pack for the FY2 to include:

- Timetables
- Tel directories for internal and external contacts
- How to guides (clinical system processes, appointment system, using electronic protocols etc)
- Fire evacuation plan
- Floor plan of the building showing hazards, fire exits and extinguishers
- Copy of the honorary contract
- Prescribing formulary
- FAQs for FY2s
- We always give a welcome to the practice card to each new starter at the practice on their first day.

2 weeks prior to commencement:

9. Prepare and stock the FY2s room, including stationary, clinical consumables, paper, leaflets etc. Arrange nameplate for the door of their room. Update website with doctors details and duration of their placement. Prepare a sign for patients alerting them that the FY2 will be sitting in with doctors and other clinical staff for the induction period.

10. Ensure all staff are aware of the imminent arrival of the new FY2 doctor, in our practice they always forget so we keep reminding them!

11. Prepare access to all IT systems via passwords and logons including, clinical system, appointments, ICE requesting, radiology, scanning system, smart card set up (and remind them to bring it with them), hospital PAS, email, windows etc. We find it’s a good idea to check it all works as well by logging on as the FY2 and checking each system is usable (this can waste literally days trying to get it sorted out if you don’t).

12. Make contact with the FY2, 2-3 days before their placement just to touch base, reassure, reassure, reassure that all will be well and we are all looking forward to their arrival and working with them. Reaffirm to contact you with any troubles or difficulties or worries so that we can rectify with them.

On the day:

13. The morning should be blocked out for the trainer and the practice manager. We advise FY2s to arrive between 9 and 9.30 just to miss the crazy 8.30 rush.

14. Warm welcome, (it helps if the receptionists at least look like they are expected), PM gives tour of the premises, covering health and safety hazards, fire exits, extinguishers, panic alarm locations and procedure for responding to these.

15. Introduction to all staff as part of the above

16. GP Trainer or practice manager to go through the induction pack paperwork with the FY2

17. Show FY2 to their room and the location of all the essentials, ensure they know where they will be next i.e. going out on visits with a GP, and take them along and introduce them to the person they are working with that day.
18. Show them the staff room and cover places of local interest, good places to eat or find lunch etc

19. During the two week induction period, ensure adequate IT training on all clinical and appointment systems, we usually start with 2 x 2hr sessions, with how to guides for each item we cover, and then arranged follow ups as and when required. We also have staff available to problem solve IT and clinical system issues as and when required.

20. Check documentation and photocopy, and store in their personnel file.

Process for submitting claims for F2 Supervision payments

The current invoice template that must be used for submitting claims can be obtained by emailing the Foundation School Manager (currently Amelia Isaac).

The GP F2 Supervision payment amount for 4 month placements can be confirmed by the Wessex Foundation School Team:

Payment queries should be sent to: amelia.isaac@wessex.hee.nhs.uk or natasha.patel@wessex.hee.nhs.uk

Completion of the Invoice

- Invoices must be submitted during the last month that you have the trainee in post with you
- The deadline for invoice submission is 2 months after completion of the F2 trainee supervision period. Retrospective payments can no longer be considered.
- The invoice must have a reference number
- Please submit the invoice on practice headed notepaper
- Include the name of the F2 Supervisor
- Include the name of the F2 doctor
- Please state the placement date from / date to
- Include payee and bank account details

Please send the invoice directly to this address in Wakefield:

XXAISAAC
Health Education England
Wessex LETB
T73 Payables F485
Phoenix House, Topcliffe Lane
Wakefield,
WF3 1WE