

# GP Longitudinal Integrated Foundation Training (GP LIFT) Guidance

## Yorkshire & Humber Foundation School (YHFS)

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## Executive Summary

Longitudinal Integrated Foundation Training (LIFT) training was piloted in the North West Foundation School for their August 2016 cohort of new medical trainees.

Yorkshire and Humber Foundation School (YHFS) started our LIFT pilot in August 2019 for 18 Foundation trainees (6 in the East, 6 in the West, 6 in the South) These trainees were longitudinally attached to primary care with integrated clinical placements within hospital trusts.

Trainees will have 1 day per week in a designated GP practice for their 2 years in post.

The GP will be the Educational supervisor for these trainees for their 2 years in post.

LIFT trainees are no different to FY1 / FY2 trainees, they are just following a slightly different pathway. Instead of having 6 x 4-month training placements, one of which would have been a GP placement at FY2, they have 6 x 4-month clinical training placements but spend 1 day per week at their designated GP practice throughout the 2-year placement.

The majority of the information in this guidance has come from the NW Foundation School, but as we progress with the first cohort of LIFT trainees we will add to this document.

# Contents

Paragraph	Page
1. Purpose	4
2. Introduction A pilot for YHFS Where are the programmes? Where are we now?	4
3. Scope	8
4. Educational Background	12
5. Guidance for the supervision of Foundation Year 1 General Practice trainees in Longitudinal Integrated Foundation Training (LIFT)	13
6. Guidance for the timetabling of trainees in Longitudinal Integrated Foundation Training (LIFT)	15
7. LIFT 'bullet point' summary	20
8. Guidance for GP trainers	21
9. Guidance for Hospital trainers	22
10. Horus	23
11. Duties	23
12. Equality Impact Assessment	24
13. Monitoring Compliance and Effectiveness	24
14. Feedback from the LIFT event 3rd of October 2019, the Met Hotel, Leeds	25
15. Feedback from Placement 1 – August to December 2019	28
16. Useful Links, References and Acknowledgements	37
17. Illustrations	39
18. Definitions	43
19. Appendix A: Information and extracts from a statement by the education committee of the General Medical Council:	44
20. Appendix B: Distribution list & Key contacts	45
21. Appendix C Learning Themes throughout the NW Foundation Training period	46

# 1. Purpose

This document is to help those trainers involved with LIFT and for LIFT trainees understand more about the process and what is required over the 2 years of Foundation training.

## 2. Introduction

### A pilot for Yorkshire and Humber Foundation School

#### Introduction

The typical model of Foundation training is six four-month placements in 1 or two trusts over the 2 years of training. More recently, the Broadening the Foundation Programme (1) initiative has aimed to encourage training away from purely hospital environments.

In an attempt to equip the doctors of the future, integrated training placements are encouraged, but have not yet flourished since traditional models of care persist in the vast majority of NHS services.

The LIFT pilot aims to produce Foundation School graduates who are more rounded, patient centred doctors, who will have more practical knowledge of care pathways to support the future NHS. LIFT will augment a prolonged two-year community placement with six, four-month placements within the hospital setting.

LIFT hopes to embrace the symbiotic learning relationship between trainee, trainer and patient, allowing patients to be followed along care pathways - promoting the trainee to see the patient at the centre of care and in turn the trainee to achieve better learning outcomes. In addition, it hopes to enhance the training relationship between members of the learning multidisciplinary team and, as such, improve the community of learning.

Workforce transformation, in a medical setting, has been difficult to get off the ground. YHFS has commissioned primary care placements for a minimum of 80% of Foundation trainees for several years. We also firmly believe in the 'action learning set' approach whereby trainees meet and develop an esprit de corps, as a group of peers, away from the clinical workplace. Six rotations alone do not make a programme.

It is clear from YHFS quality management activity that many Foundation trainers rarely have the opportunity to meet and we need to support working as a team with the trainee at its hub.

With changes of attending medical teams and rapid turnover of clinical cases, the notion of trainee, trainer and patient having a continuing and symbiotic learning relationship has been largely lost.

In the United States, the work of David Hirsh and others (2) has shown the value of continuity of training (including increased empathy and patient centredness) and the detrimental effect of compartmentalised attachments (such as 'agency syndrome' and ethical erosion). Foundation training could be improved by a realignment of training to a more longitudinal model, based around the patient in their natural environment. Please see Table 1 in the Illustrations.

Hospital attachments should be more akin to “apprenticeships”, with the stated intentions of following patients in and out of hospital through different stages of their illness, whilst increasing contact between trainee and trainer.

Simultaneous primary care experience should reflect the theme of the apprenticeship, sampling related aspects of clinical care. The aim will be for the trainee to accompany the General Practitioner’s (GP) panel of patients through the health care system.

Longitudinal competency themes such as Values, leadership, self-management, patient safety and quality improvement can be continuously targeted and tracked.

The YHFS will pilot this improvement under the name of Longitudinal Integrated Foundation Training (LIFT). The overall aim is to produce Foundation School graduates who are more rounded, patient-centred doctors who will have a thorough working knowledge of many care pathways, including alternatives to hospital admission or A & E department attendance. All Foundation trainees must be equipped to take up any chosen speciality on completion and LIFT will produce better prepared speciality trainees. The increased exposure to primary care, with its consequent role modelling, may improve recruitment in that area.

### **Suggested format of Training for LIFT**

At present trainees within YHFS undertake 6 separate 4 month clinical placements over a two year period, commonly five in a purely hospital setting and one in a General Practice (GP) setting. Educational Supervisors are often hospital consultants who may have limited exposure to the trainee over the two-year period.

Within LIFT, trainees will be Educationally Supervised by a named GP trainer for a two-year period. The Foundation Trainee will 1 day per week in this primary care setting. Alongside these sessions’ trainees will undertake 6 x 4-month hospital attachments themed to the GP patient cohort (4 days per week) over the two years. The themed hospital attachments will augment and consolidate knowledge of the patient pathways by accompanying the GPs chosen panel of patients through the health care system. Learning support will be consolidated within the hospital attachment by the attendance at the formal Foundation Teaching Programme. This will also support professional peer networking.

Each trainee will have a named GP trainer, with 1 day per week being based in the primary care setting. This GP trainer will also fulfil the role of **educational supervisor** set out in the new Guide for Foundation Training 2019 (3) (previously the Reference Guide). At least 1 primary care session will be a general one, dealing with unselected problems from the practice’s panel of patients. Other sessions will be chosen to augment the theme of the 4-month hospital placement operative at the time. Examples of weekly rotas are shown in Table 2 in the illustrations.

Each trainee will have a named specialist trainer for each of the 6 x 4-month, themed time periods. This individual will fulfil the role of **clinical supervisor** set out in the new Guide for Foundation Training 2019 (3). The speciality can be chosen as the theme for the time period, reflected in both primary and secondary care settings. The intention is to promote an “apprenticeship” model, where the trainee is supervised by the named trainer for as much time as possible, depending on the nature of the placement. One requirement is the inclusion of 1-hour weekly face to face 1 to 1 discussion time. Assistance by trainees will be encouraged at operating theatre lists, outpatient clinics and any other activity the trainer chooses for its educational value, commensurate with that theme. The trainees’ level of supervision and responsibility is graded and appropriate to their ability.

The remaining session in the working week will be the compulsory teaching programme with the rest of the year cohort. We will expect an induction to each workplace environment as happens with the other Foundation trainees.

### Timeline

The start date of the LIFT pilot was August 2019, aiming to complete their Foundation training by end of July 2021. Tracking and reporting of progress will be maintained throughout the 2-year programme via Horus, with a full report on a complete cohort available by December 2021.

### Evaluation

Trainees within LIFT will be expected to achieve the requirements of the Foundation Programme Curriculum for each year of the Foundation Programme, as set out by the UKFPO, which will be assessed by their Annual Review of Competency Progression (ARCP). Evidence for their competency will be provided through the HORUS portfolio.

The Longitudinal competency themes such as NHS values, leadership, self-management, patient safety, quality improvement, professional regulation and development will be tracked using the HORUS portfolio and with use of the formal teaching program.

In addition, the success of the LIFT project will be evaluated through local feedback questionnaires from trainees, and supervisors and the GMC national training survey.

## Where are the Programmes?

### South Yorkshire GP LIFT posts – Sheffield

Oriel Number	Placement 1	Placement 2	Placement 3	Placement 4	Placement 5	Placement 6
STH SY094	Gastroenterology	Vascular Surgery	Endocrinology & Diabetes Mellitus	Intensive Care Medicine	Emergency Medicine	Obstetrics & Gynaecology
STH SY095	Endocrinology & Diabetes Mellitus	Gastroenterology	Vascular Surgery	Obstetrics & Gynaecology	Intensive Care Medicine	Emergency Medicine
STH SY096	Vascular Surgery	Endocrinology & Diabetes Mellitus	Gastroenterology	Emergency Medicine	Obstetrics & Gynaecology	Intensive Care Medicine
STH SY133	Geriatric Medicine	Neurology	Urology	Intensive Care Medicine	Endocrinology & Diabetes Mellitus	Acute Internal Medicine
STH SY134	Urology	Geriatric Medicine	Neurology	Acute Internal Medicine	Intensive Care Medicine	Endocrinology & Diabetes Mellitus
STH SY135	Neurology	Urology	Geriatric Medicine	Endocrinology & Diabetes Mellitus	Acute Internal Medicine	Intensive Care Medicine

## East Yorkshire GP LIFT posts – DPOW &amp; Scunthorpe

Oriel Number	Placement 1	Placement 2	Placement 3	Placement 4	Placement 5	Placement 6
<b>DPOW NYEC019</b>	Trauma & Orthopaedics	General Psychiatry	Respiratory Medicine	Otolaryngology	Obstetrics & Gynaecology	Geriatric Medicine
<b>DPOW NYEC020</b>	Endocrinology & Diabetes	General Surgery	Emergency Medicine	Gastroenterology	Geriatrics	General Psychiatry
<b>DPOW NYEC023</b>	Gastroenterology	Geriatric Medicine	General Psychiatry	Emergency Medicine	Paediatrics	Respiratory
<b>Scunthorpe NYEC125</b>	Urology	General Psychiatry	Endocrinology & Diabetes	Intensive Care Medicine	Obstetrics & Gynaecology	Emergency Medicine
<b>Scunthorpe NYEC126</b>	Gastroenterology	Emergency Medicine	General Surgery	Endocrinology & Diabetes	Intensive Care Medicine	Urology
<b>Scunthorpe NYEC127</b>	General Surgery	Gastroenterology	Emergency Medicine	Obstetrics & Gynaecology	Otolaryngology	Intensive Care Medicine

## West Yorkshire GP LIFT posts - Leeds &amp; Mid Yorks

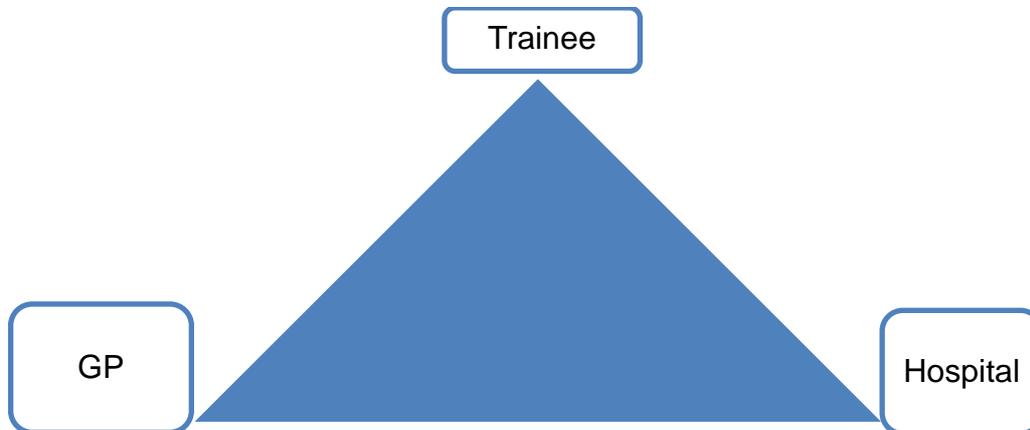
Oriel Number	Placement 1	Placement 2	Placement 3	Placement 4	Placement 5	Placement 6
<b>Leeds F1 Mid Yorks F2 WY053</b>	Geriatric Medicine	Infectious Diseases / Genito-Urinary Medicine	Intensive Care Medicine	Emergency Medicine	Paediatrics	Obstetrics & Gynaecology
<b>Leeds F1 Mid Yorks F2 WY054</b>	Intensive Care Medicine	Geriatric Medicine	Infectious Diseases / Genito-Urinary Medicine	Obstetrics & Gynaecology	Emergency Medicine	Paediatrics
<b>Leeds F1 Mid Yorks F2 WY055</b>	Infectious Diseases / Genito-Urinary Medicine	Intensive Care Medicine	Geriatric Medicine	Paediatrics	Obstetrics & Gynaecology	Emergency Medicine
<b>Mid Yorks F1 Leeds F2 WY095</b>	Geriatric Medicine	Cardiology	General Surgery	Obstetrics & Gynaecology	Acute Internal Medicine	Paediatrics
<b>Mid Yorks F1 Leeds F2 WY096</b>	General Surgery	Paediatrics	Gastroenterology	Obstetrics & Gynaecology	Emergency Medicine	Geriatric Medicine
<b>Mid Yorks F1 Leeds F2 WY097</b>	Gastroenterology	General Surgery	Paediatrics	Geriatrics Medicine	Obstetrics & Gynaecology	Emergency Medicine

## Where we are now?

### Leadership; what makes it effective?

'Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek'.

Barak Obama



### Aim:

"...produce Foundation School graduates who are more rounded, patient-centred doctors who will have a thorough working knowledge of many care pathways, including alternatives to hospital admission or A & E department attendance"

### Gaps in our knowledge

- Geographical
- Timetable/Rota Clash
- Colleague awareness of LIFT in hospital setting
- Inability to follow patient journey across primary and secondary care
- Reduced out of hours/educational experience
- Knowledge of ward patients in hospital
- Achieving foundation competencies?
- GP Supervisor role?
- Handover Arrangements
- Following patients up in GP
- GP placements following secondary care themes

### How do we close the gaps?

- Ensuring proximity of GP and Hospital placements where possible
- Supervisor education to improve awareness of LIFT
- Inclusion of out of hours experience
- Community experience to bridge gaps
- Coordination between hospital / GP and Trainee re rotas, supervision and access to training days
- Understanding and handling emotion
- Relationship building
- Promote leadership
- Share best practice

## 3. Scope

Six main themes were consistently found in the NW pilot:

1. The perceived **benefits** of LIFT in the North West
2. **Learning points** from experiences of LIFT in the NW
3. LIFT trainees' **attitude** to their work
4. The GP: Hospital **weekly split**
5. The impact of LIFT upon **recruitment into GP**
6. **Information and support** for LIFT supervisors.

### 1. The perceived benefits of LIFT in the NW

Through increased time earlier on in GP practice:

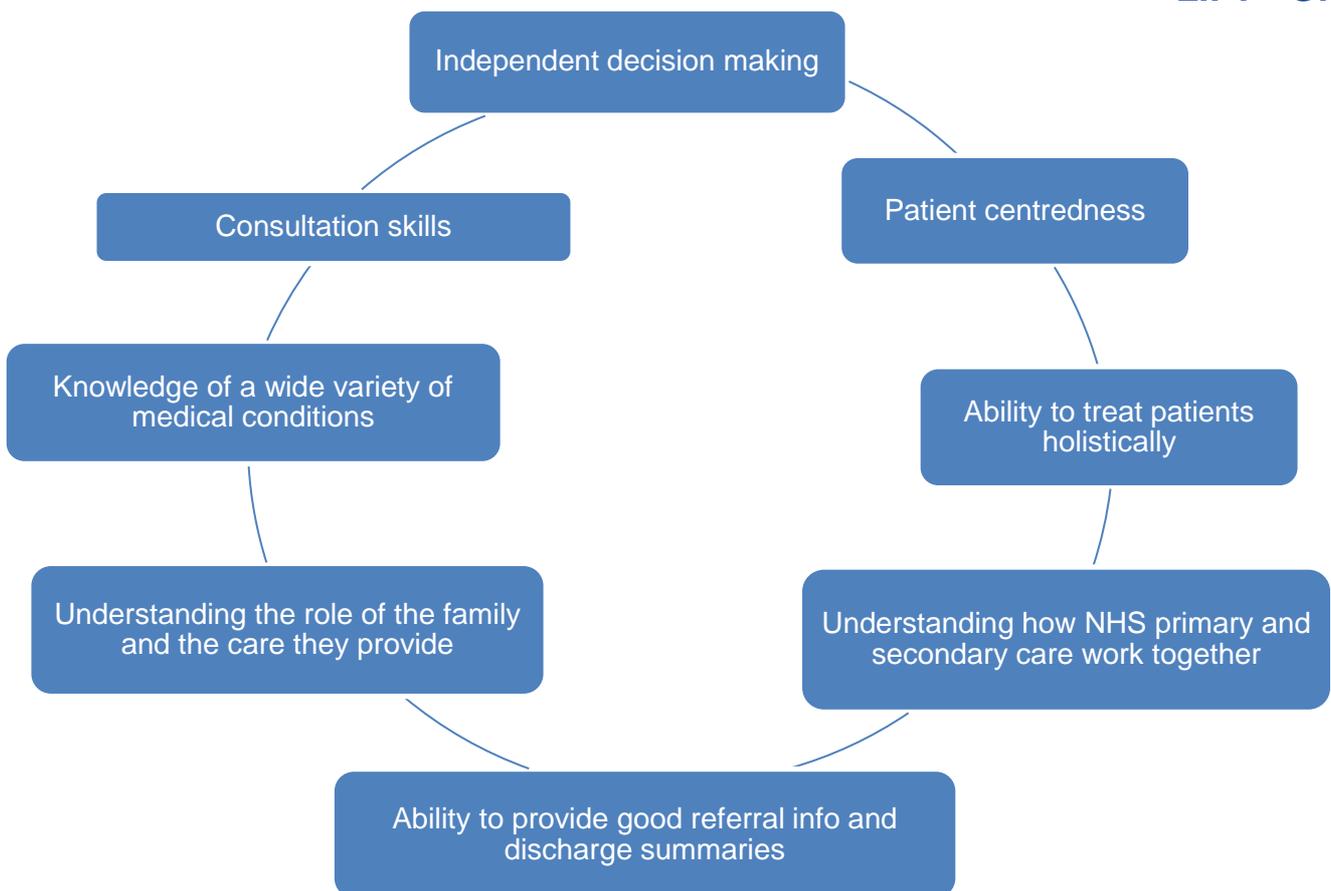
- GPs build a longitudinal supervisory relationship with trainees. Continuity & increased understanding facilitates pastoral support & enables supervisors to provide greater educational challenges.
- LIFT “**provides stability**” and the chance to form working relationships within a general practice which “encourage the trainee to feel part of the team”.
- LIFT trainees are more likely be able to diagnose patients who present at hospital with multiple problems, as well as successfully treat patients who present with additional ailments & conditions outside of the hospital specialty in which they work.

### 2. Learning points from experiences of LIFT in the NW

- Initially, because hospital colleagues did not always understand LIFT, trainees were sometimes viewed as less committed/part-time.
- Supervisors report trainees perceiving themselves during the early months as “behind” due to their reduced exposure in hospital.
- Concerns existed where trainees lacked on-call – despite not being an FY1 requirement & some supervisors feel trainees overvalue it.
- GP supervisors found LIFT trainees' FY1 grade difficult - the supervision required, inability to prescribe, & “low service”.
- It has been difficult for supervisors to provide trainees with cases to follow between primary and secondary care, as LIFT intended.

### 3. LIFT trainees' attitude to their work

- LIFT trainees were often perceived to be higher than average in terms of their motivation, enthusiasm, overall capabilities & calibre.
- Supervisors thought the program had attracted very motivated candidates, or the stringency of the selection process had benefits.
- Supervisors often perceive LIFT trainees as having a positive attitude & “coping better”, possibly due to the variety in their working week.
- In contrast some were struggling with unmotivated / unenthusiastic trainees, showing little commitment to LIFT.



#### 4. The GP: Hospital weekly spilt

- It can be difficult to manage **two concurrent workplaces** – trainees miss team meetings at one place of work when attending the other, handovers can be problematic, and continuity of care for patients can be challenging. Travel can also be difficult.
- **Rotas often clash** and hospitals impinge upon GP time. This continues to be an ongoing and unresolved issue for some.
- Initially there was a **lack of understanding** (particularly by hospital colleagues) of the LIFT trainees' contractual need to be released to attend their "other" workplace.
- Some supervisors felt a **single GP day** would be just as effective, if not more effective, than the day-and-a-half currently in place. (One of the reasons for YHFS only doing 1 day instead of 1 ½ days)

#### 5. The impact of LIFT upon recruitment into GP

- The majority of GPs hope and expect LIFT **will improve** GP recruitment. Hospital supervisors varied in their opinion more.
- Many GPs felt the 2 years of exposure to GP that LIFT provides, offers opportunities to "give general practice a **greater chance**".
- The earlier exposure to GP means LIFT trainees are all well equipped to make **specialty choices**.
- Several supervisors observed LIFT to "**convert**" trainees to general practice.
- Some thought the **purpose** of LIFT "was to improve GP recruitment".

## 6. Information and support for LIFT supervisors

- A number felt they had been **well informed** prior to the start, received sufficient info, had opportunities to ask questions and discuss the program with other supervisors.
- Others felt “**ill-equipped**”, and would have welcomed training, more meetings and greater support in order to reassure them they were providing trainees with the best possible experience.
- Some Trusts have established a **local infrastructure** to provide info / support / training for LIFT supervisors & trainees.
- Elsewhere LIFT supervisors are working in **greater isolation**.
- LIFT trainees are perceived by their supervisors **to have a better understanding of how primary & secondary care work together**.
- In comparison to non-LIFT trainees, those on the LIFT program consider themselves to **more likely to have good work-life balance**
- LIFT trainees are considered to be on a par with their non-LIFT peers in terms of their compassion for patients. Both supervisors and trainees rate LIFT and non-LIFT trainees’ ability to cope at work to be similar. Generally, supervisors rated the support they provide to trainees – higher than trainees rated that support themselves!
- Some NW LIFT trainees rated themselves higher on some aspects of wellbeing than their supervisors rated them.

### Q1: When asked about the amount of opportunity they have to develop consultation skills, who do you think more often rates this highly?

LIFT trainees 96.6% rate this highly  
 Non-LIFT trainees 77.2% rate this highly

### Q2: When asked how able and informed they feel to make specialty choices, who do you think more often rates this highly?

LIFT trainees 89.6% rate this highly  
 Non-LIFT trainees 62.1% rate this highly

### Q3: When asked about the personal/pastoral support they receive, who more often rates this highly?

LIFT trainees 86.1% rate this highly  
 Non-LIFT trainees 63.4% rate this highly

Overall, the findings of the survey supported themes arising through telephone interviews with LIFT supervisors and focus groups with LIFT trainees

## Overall NW recommendations

- Greater communication and coordination between trainees' supervisors.
- Similar coordination in relation to a trainee's GP and hospital rotas.
- A need for supervisor & trainee roles to be standardised.
- Differences in LIFT experiences across Trusts addressed.
- Whole working day considered over 1½ GP days.
- Raising the profile of LIFT within hospitals, to increase understanding of LIFT trainees and their absences in GP.
- Consideration of whether all LIFT trainees could benefit from the experience of on-calls from FY1.
- A LIFT information Pack and additional info / advice opportunities for LIFT supervisors would be beneficial.
- Greater support for all Foundation trainees.
- There is a need to better identify trainees who consider leaving & to support supervisors struggling to help them.
- Lessons can be learned by looking at where the LIFT and traditional programs have advantages over each other, and where the strengths of both could be built upon.

## 4. Educational Background

“Educational Science to Remember”

1. Test-enhanced learning
2. Desirable difficulties
3. Spacing
4. Interleaving
5. Self-theories of Carol Dweck
6. Deliberate practice

Remember

Three requirements for remembering:

Encoding	→	Acquisition
Storage	→	Persistence
Retrieval	→	Later use

Dr. David Hirsh explains the benefits of a Longitudinal Integrated Clerkship

<https://www.youtube.com/watch?v=cKGeWSws1So>

## 5. Guidance for the supervision of Foundation Year 1 General Practice trainees in Longitudinal Integrated Foundation Training (LIFT)

General Practice is an ideal training environment for junior doctors, who can experience holistic and compassionate health care from a range of chronic and acute medical conditions, closer to the patient's own environment. Assessment of patients in this way helps trainees develop clinical judgements and compassionate, patient-centred care values.

This environment provides a rich learning content and context for excellent training, but also carries risk. Our most junior trainees, those in Foundation year 1 (FY1), may well feel isolated from their peers more than their counterparts in the hospital. In addition, the nature of the patient's health care needs may be unpredictable and unfamiliar to them. They will work alongside many professions allied to medicine, many of whom may not themselves be fully versed with the abilities of Foundation trainees. FY1 trainees need to work under supervision - mindfulness to the provision of this supervision is paramount to the success of safe Foundation training in a General Practice setting.

This guidance document is not intended to be exhaustive but covers many of the common questions relating to FY1s working in General Practice.

### General considerations

Patient safety (and that of staff) must always be a top priority. Foundation trainees, as should we all, should only undertake work which they are either competent in, or are learning competence under supervision. FY1s will need the closest support of any trainee doctor.

No-one should be put in a position of working beyond their competence without appropriate support and supervision. Robust processes to ensure this must be in place in the General Practice setting. Clearly, FY1s need to see patients but every patient should be seen again and 'signed off' by a more senior practitioner. Flexibility as to the timing of this second, more senior, review should reflect the complex nature and duration of the health care problem.

FY1 trainees **must** ...

- be aware of the limitations of their practice
- work within their competence
- have access to senior colleagues for clinical advice at all times
- ask for senior help when needed

FY1 trainees **should**...

- take full advantage of the rich GP training environments, including allied health care clinics
- work predominately in the practise itself, where assistance is always available
- refer patients onwards only if discussed with a more senior team member first

FY1 trainees **must not**...

- act if unsure of their ground
- work in an environment where their only assistance is off the premises
- consult patients without appropriate, documented senior review

FY1 trainees should not ...

- be rostered to shifts or duties where no support is available
- be left to deal with an emergency alone
- refer patients to other disciplines alone

## Specific situations

### Prescribing

The legal position of FY1s prescribing is set out in Appendix A. To summarise, FY1s may prescribe only when it is 'necessary' in their role of learning to achieve full registration. This is essentially an exception to the normal prescribing regulations, on the authority of the named supervisor using the organisation's governance mechanisms to ensure safety. Such an exemption would be dangerous to extend outside the hospital to community pharmacies.

Prescribing drugs and other treatment modalities appropriately is specified in Good Medical Practice and is a Foundation curriculum requirement. It is known that in the hospital setting Foundation trainees as a group make the most prescription errors.

Prescriptions generated by FY1 doctors must, be checked and countersigned by a more senior prescribing professional.

FY1 trainees **must**...

- only prescribe within the limits of their competence
- use electronic prescriptions when able
- use governance policies and protocols to inform treatment medication choice
- have all prescriptions checked

FY1 trainees **must not**...

- prescribe on FP10 forms
- dispense medications alone

### Home Visits

FY1 trainees **should**...

- participate in joint or supervised visits in conjunction with other practitioners

FY1 trainees must not...

- carry out acute, unselected home visits
- carry out telephone triage

### Procedures

Many procedures mandated by the Foundation programme curriculum are performed in the GP setting. These can allow for the acquisition and assessment of FY1 competencies. Trainees and trainers should be familiar with these Foundation curriculum requirements.

Minor surgical procedures such as catheterisation or suturing and medical investigations such as peak flow, may be suitable vehicles for FY1 workplace-based assessments, supervised learning events, or the acquisition of curriculum competencies. Such procedures may include suturing, Flu vaccination administration, incision and drainage of abscess, catheterisation, and performance of cervical smear, auditory canal syringing, wound dressing and tissue viability assessment. This is by far from an exhaustive list.

The educational value of repetitive duties across a range of health care service delivery within the practice should not be underestimated. Mindfulness and identification of the educational value of a task can help the trainee and trainer sense of training satisfaction. This in turn can help motivation for learning.

FY1 trainees **should**

- use GP placements to acquire the curriculum requirements mandated by the GMC for FY1
- undertake typical minor procedures, to fulfil GMC competencies

FY1 trainees **should not**

- perform complex procedures unless there is a clear training component and unless supervised by a more senior doctor
- perform reiterative tasks without educational value

FY1 trainees **must not**

- work beyond their competence

**Please also see the “YHFS GP FY2 Handbook - including LIFT”**

## **6. Guidance for the timetabling of trainees in Longitudinal Integrated Foundation Training (LIFT)**

### **Introduction**

Both hospital and General Practice can be great training environments for junior doctors, who can experience health care with a range of chronic and acute medical conditions. Working across two environments also has its challenges, when taking place in fraught and rapidly changing workplace, which is the modern NHS. The Broadening the Foundation Programme (1) initiative has aimed to encourage training away from purely hospital environments. In an attempt to equip the doctors of the future, integrated training placements are encouraged, but have not yet flourished since traditional models of care persist in the vast majority of NHS services. Workforce transformation, in the medical setting, has been difficult to get off the ground.

The LIFT programme run by YHFS aims to connect several such integrated placements in a coherent programme and this paper outlines some of the important considerations. There is no element of LIFT which is new to Foundation training – General Practitioners (GPs) as educational supervisors, FY1s in general practice, integrated hospital/community placements and ‘unbanded’ programmes already existed before LIFT. It is their combination in LIFT which is original.

This provides rich possibilities for learning, but also carries risk. The hospital services will increasingly have no choice but to understand and work with integrated Foundation placements.

This guidance document is not intended to be exhaustive but covers many of the common questions relating to the LIFT format, which have arisen in practice.

### **General considerations**

The specification for trainers in hospital and primary care are ambitious (Appendices 1-3). As well as longitudinal aspects of learning, there are elements of practice more akin to “apprenticeship” – with guaranteed time with trainers – which may be unusual for hospital-based trainees at this level. We anticipated that our most junior trainees in primary care, might feel isolated from their peers more than their counterparts in the hospital.

Since LIFT is new, many trainees had little knowledge of it prior to taking up their posts. Most have said they would have liked more information, at what is a particularly daunting time of change for them. Guidance documents are available on the YHFS website (5), the HEE (North West office) web site (4) and on the UKFPO website (6). Nevertheless, for whatever reason, many trainees have said enough information was not available.

### **On call / Out of Hours work**

Whilst having no out of hours (OOH) work makes timetabling simpler, it is not popular with most trainees. Nearly all of the early negative feedback from trainees in the NW, amongst all the positive comments, was around OOH working – or rather lack of it in three out of five LIFT sites.

First placements in non-acute settings, say in psychiatry or pathology, have always fostered fears in trainees about undertraining in acute skills.

Whilst the perception is real and understandable, experience suggests it is a temporary phenomenon and that trainees quickly catch their peers in what is, after all, a two-year programme. Any lack of OOH working reinforces these concerns amongst affected LIFT trainees, about acquisition of acute competencies.

OOH, and its associated payment ('banding' as it was called), has always been a Trust issue. HEE has never had a view on the presence or absence of OOH work in a Foundation programme, as long as curriculum competencies are delivered. The availability of OOH work is dependent on the service requirements and the availability of resources, since Trusts fund this. HEE has, however, always promoted equitable sharing of banding amongst Foundation training programmes where possible.

OOH working is not a General Medical Council (GMC) requirement for Foundation training and never has been. The GMC require programmes only to deliver the Foundation curriculum and not what time of day it is delivered. Naturally, many would argue that hospitals at night give a different type of experience than during the day. Lack of immediate supervision, with the requirement to stretch skills in prioritisation and decision-making are often stated as desirable elements of OOH work. This also carries risks with patient safety (and that of staff) which must always be a top priority. Foundation trainees, as should we all, should only undertake work which they are either competent in, or are learning competence under supervision. Different rates of pay for LIFT jobs with and without OOH also contribute to the negative feedback.

There are different methods of Programmes addressing the trainees' concerns. As a broad generalisation, these are expressed in likely order of preference for most trainees.

(1) Include all the LIFT trainees in the standard on call at the same frequency as the other FY1s. If the OOH thus provided duties displace a GP session or sessions, then they must replace those GP sessions instead of hospital duties at some other time.

(2) Have no regular rostered OOH work but allow LIFT trainees to internally cover ad hoc OOH shifts in their appropriate departments. Such activity is commonplace and, indeed, necessary for every Trust for service provision.

(3) Have no OOH work, at least in FY1, and counsel the trainees about the HEE, GMC and financial issues discussed above, given the two-year duration of Foundation training.

If the OOH duties displace a GP session or sessions, then they must replace those GP sessions instead of hospital duties at some other time.

Any of the above approaches are more likely to be acceptable to trainees if the training programmes are formulated with a good representation of placements which deliver acute care skills, such as emergency medicine, acute medical units or critical care.

With the new trainee doctor contract, 'banding' is an old term that will not apply - jobs are 40 hours per week with basic pay or whether they have out of hours duties which are paid pro rata. This may well make it easier for OOH work to be rostered in by Trusts.

The advice, therefore, is to provide OOH work for LIFT trainees wherever possible. Whatever the configuration of the job, accurate information should be provided for trainees in time for the national recruitment process.

### **Weekly timetable**

Clearly, written work schedules and timetables are essential. The co-ordination of work across primary and secondary care is a challenging task. Hospital rota co-ordinators may particularly struggle with multiple, complex and competing demands on them.

Typically, general practices are smaller outfits than hospital units, with less flexibility in trainer time. It may be better to have a larger practice with multiple LIFT trainees attached to maximise the timetabling options, when fitting with hospital units. Early (and subsequent) meetings with the postgraduate team, GP and hospital trainers are advised to foster a team approach and address timetabling detail.

### **Primary Care**

Assuming full time working, two sessions per week (on average) are spent in primary care and eight in the hospital. Mandatory training days will also need to be incorporated into the trainees' schedule.

Of the two sessions per week spent in the practice, at least one should be in a conventional surgery with the designated trainer available for supervision, briefing and feedback. The rest are flexible, the intention being that the trainee maintains contact with the practice's panel of patients in some form. Also, they may be able to pursue interests within the theme of the placement e.g. minor surgery. Multi-professional activities are encouraged. Some of this time may be used to follow visit their patients in hospital or in other clinics.

Timetables can be flexible and need not be identical week on week. One session may usefully be rostered with other LIFT trainees in the practice, if this fits in with operational requirements. One-hour face-to-face time with the trainer per week is required and is not usually difficult to arrange in primary care. All off site placements should facilitate attendance at the weekly teaching programme, to allow an 'action learning set' approach and reduce feelings of isolation. Workplace-based assessments should be performed in both environments.

We do appreciate that rotas may be put under pressure with the trainees being out at their GP practice 1 day a week. However, in order for them to receive the best training experience from their LIFT post we would expect them to be released for at least 75% of their GP days.

Where zero days or on call rotas impact the day they are usually at their GP practice, every attempt should be made to reschedule any missed days. We do realise that this may not always be possible, which is why we have put a guide of 75%.

Rotas should be made available to the trainee as early as possible, so they can discuss any pressure points with their GP practice and make alternative arrangements where necessary.

Rotas should be sympathetic to the fact that trainees are out of the trust 1 day a week and where possible it should be the same day every week (Mon, Tues or Wed preferably)

There are 6 trainees in WY, 6 in East Yorkshire and 6 in South Yorkshire.

It is likely that the preferred scenario will be that there will be 1 trainee at each practice on a Mon, Tues or Wed, but some practices are taking more than 1 trainee. (East have 6 different practices, 1 trainee in each. West have 3 different practices with 2 trainees in each and South have 2 different practices with 3 trainees in each)

Mandatory training days also need to be taken into account when preparing the LIFT trainees rota. The dates for these are usually set well in advance.

If it becomes apparent that trainees are continually missing their GP day because of their trust rota, and are going to miss the 75% attendance, this will be escalated by the trainee/practice to the Foundation School Director/Deputy Dean who will look into the reasons behind this. Local arrangements will be taken into consideration as will annual leave, sick leave etc.

### **Hospital**

Assuming full time working, eight sessions per week should be spent on the acute site, one of which represents the regional teaching days. The weekly timetable should facilitate learning and minimise educationally unproductive tasks - at least two of the six weekly sessions in hospital should be where the trainer can reasonably be expected to be present e.g. operating theatre sessions, endoscopy lists, ward rounds. There should be at least one hour per week face to face discussion time with the hospital trainer. The above specification has caused occasional concerns of 'favouritism', expressed by non-LIFT trainees when this occurs. In fact, the specification should be provided for all appropriate Foundation placements but are less often fulfilled. Workplace-based assessments should be done in both environments.

Where possible a pseudo 'job-share' between two LIFT trainees in parallel programmes has many advantages. They can share good practice, and each can be timetabled to be at the hospital when another is in primary care, to enhance continuity. This also allows a constant presence in the hospital unit from at least one of the LIFT trainees when it is necessary for operational reasons, say when a surgical team always does a business round early every weekday morning. Timetabling a handover for the LIFT trainees with their peers is good practice, before and after time away from the hospital unit.

### **Team working**

Working across two sites has the potential to compromise the feeling of being part of a team in either of them. Every effort should be made by both teams to include LIFT trainees in team meetings and other departmental activities. Early feedback suggests that LIFT trainees have more difficulty finding their place in hospital teams compared to the practice, despite their spending twice as much time there and spending more time there than 'less than full time' (LTFT) trainees, which have not caused the same degree of unsettling as some early LIFT posts. Differences in job content, such as OOH and educationally unproductive tasks, between LIFT and non-LIFT trainees should be minimised.

Where one group is felt to be disadvantaged, raising them all to the level of the best would be the desired approach. Continuity of care should be helped, where possible, by handover and elements of job-sharing and timetabling described above.

**Trainer and Trust considerations**

To maximise the benefit of integrated Foundation placements it is essential to foster ownership amongst hospital teams. In difficult working conditions, the urgent drives out the important and this can lead to resistance to LIFT from busy colleagues, focussed on their task in hand.

The long-term benefits of LIFT and other integrated placements may be accepted by Trust Chief Executives and Medical Directors, but postgraduate teams (Foundation Programme Directors, Foundation Programme Administrators, Medical Education Managers, Directors of Medical Education) have more difficulty convincing some hospital trainers and rota managers.

This can lead to resistance from rota coordinators, who if asked to choose between LIFT and normal training formats, would prefer conventional trainees every time. Similar issues are seen with 50% or 60% LTFT trainees.

Similarly, some hospital trainers may have negative feelings about 'losing' trainees for two sessions in a week, and some will be more negative about community experience. Negative feelings from trainers cause negative (and unconstructive) feelings amongst trainees. Early experience suggests, on the whole, GP trainers are positive about the LIFT concept.

Buy-in from trainers and organisations is, therefore, key in maximising the benefit of LIFT. This includes managers, rota masters and Human Resource colleagues as well trainers and board members. Early buy-in from GP and hospital colleagues pays dividends with practical problems around timetabling.

When formulating programmes, it is important to consider the speciality of the hospital placements and the suitability for the LIFT format. Excessively burdensome posts tend not to feedback well for LIFT, probably because they exacerbate the trainees' continuity and inequality issues discussed above. Because the LIFT format uses six instead of five placements, plus primary care, more variety in speciality is possible and in keeping with the ethos of Foundation training. Some of the best feedback comes from trainees who are not in traditional service placements.

## 7. LIFT 'bullet point' summary

- Integrated placements are specified in Broadening the Foundation Programme (1)
- Trusts must produce accurate information about placements, particularly out of hours duties
- Primary care and hospital administrators, managers and trainers should be consulted for buy in, planning and timetabling
- Choose hospital placements carefully for trainer buy-in to avoid negative briefing of trainees
- Every effort needs to be made to make LIFT trainees integral to the hospital part of the placement
- The GMC do not require out of hours duties for Foundation curriculum delivery
- Health Education England has no say in whether out of hours duties are included in placements
- Many trainees value out of hours duties and feedback will be improved if they are included
- Trusts must provide clear, written weekly timetables
- Smaller units have less flexibility and timetabling may have to be scheduled around them
- One third of scheduled sessions should be with trainers supervising.
- Multidisciplinary activities and following the patient journey are to be encouraged.
- If hospital on call duties mean missing GP time, this can be 'paid back' at another time, if suitable to all parties, however this should be negotiated between the trust, the trainee and the practice and we appreciate this may not be possible
- One hour 'one-to-one' discussion with the trainer must be provided each week in both environments
- Workplace-based assessments should be performed in both environments.
- Practices as close to the acute hospital site as possible should be chosen, to minimise travelling.
- HEE provides travel expenses for the use of Foundation trainees in primary care.
- A pseudo 'job-share' between two LIFT trainees in parallel programmes has many advantages

## 8. Guidance for GP trainers

### Primary Care placement specification

The primary care environment and trainers will be pivotal to the success of LIFT. Each LIFT trainee will be in the primary care setting two sessions per week. All the usual conventions of Foundation training will apply; however, LIFT has some additional features.

Foundation Trainees as part of LIFT will: -

- Be part of the practice team
- Be expected to have a placement-specific induction and orientation to HEE standards
- Be allocated to a named GP educational supervisor who will be responsible for their progression within the Foundation Programme Curriculum during their placement, including the required assessment criteria set out by the Annual Review of Competence Progression (ARCP).
- For Horus purposes the GP trainer will be the named ES and a supplementary CS. The hospital trainer will be the main CS (including for Horus purposes).
- Be provided with an individual timetable by the practice to support augmentation of community learning themes and specific training needs for the Foundation doctor (See appendix 1 for example, support from YHFS will be given for this).
- Receive from an individual weekly timetable from the practice to support augmentation of community learning themes and specific training needs for the Foundation doctor
- Have at least one weekly session engaged in duties where the community based Clinical Supervisor can reasonably be expected to be present e.g. GP surgeries, minor procedure sessions.
- Be timetabled flexibly in the other primary care session. These may be with GPs, professions allied to medicine, practice meetings or following the patient along different parts of the care pathway.
- Be timetabled to have at least one hour per week face to face discussion time with the GP supervisor.
- Attend the formal Foundation teaching program at the host Trust.

## 9. Guidance for hospital trainers

### Hospital placement specification

The LIFT trainees will be present in one hospital placement for eight sessions per week. Each placement will be of four-month duration and be themed to the community placement (see Tables in the illustrations). All the usual conventions of Foundation training apply; however, LIFT has some additional features.

Foundation Trainees as part of LIFT will: -

- Be expected to have a placement-specific induction and orientation, to YHFS standards
- Be allocated to a named CS who will be responsible for their progression within the Foundation Programme Curriculum during their placement including the required assessment criteria set out by the Annual Review of Competence Progression (ARCP).
- Have a named hospital trainer who will be the main CS for Horus purposes. For Horus purposes the GP trainer will be the named ES and a secondary CS.
- Be provided with an individual timetable by the CS to support augmentation of community learning themes and specific training needs for the Foundation doctor (See appendix 1 for examples).
- Have at least two of the six weekly sessions engaged in duties where the CS can reasonably be expected to be present e.g. operating theatre sessions, endoscopy lists, ward rounds.
- Be timetabled to have at least one hour per week face to face discussion time with the CS.
- Attend the formal Foundation teaching program at the host Trust.

## 10. Horus

The 3 clinical specialities will be imported for the LIFT trainees in the normal way.

The GP is the ES so will have the overview of the trainee for the full year.

The number of assessments that the LIFT trainees should do over the 2 years is under discussion. We are suggesting that the LIFT trainees do an additional 2 Mini Cex, 2 CBDs and a PSG in the GP practice. We can't mandate this as it is additional to the sign off check list, but we should promote this as best practice.

We will also be asking the trainees, ES and trust faculty to complete a feedback form towards the end of each placement. This can also be uploaded to Horus.

## 11. Duties

This section should give an overview of the individual, departmental and committee duties, including levels of responsibility within the organisation.

YHFS staff supporting the functioning of this pilot study include; -

Craig Irvine	Foundation School Director (also Deputy for East)
Ray Raychaudhuri	Deputy Foundation School Director (South)
Shane Clark	Deputy Foundation School Director (West)
Sue Reid	Programme Support Manager

[Foundation.yh@hee.nhs.uk](mailto:Foundation.yh@hee.nhs.uk)

Trusts are responsible for the trainees as their employer and Clinical Supervisor.

GPs are responsible for the trainees as their Educational Supervisor.

YHFS are responsible for the trainees training.

**Any queries re LIFT posts or trainees / training issues should be sent to the Foundation inbox with **\*\*LIFT PROGRAMMES\*\*** in the subject heading so it can be identified quickly by the team.**

A distribution group is being set up and we are looking at creating WhatsApp groups, support groups either regionally / locally depending on what those involved require.

LIFT trainees annual leave must be approved by both the ES – from the GP practice perspective and the CS – from the trust perspective.

CS / ES need to share feedback especially as the ES is based in the GP practice and the CS is based in the Trust. Good communication between the ES / CS is key to the success of the LIFT posts. It will help to support the trainee and recognise any issues they are having early, helping identify any patterns that are emerging.

Exception reporting should be dealt with by the CS in the trust, but the ES should be informed of any ERs the trainee submits where possible and appropriate

## 12. Equality Impact Assessment (EIA)

Under the Equality Act, the need for public bodies in England to undertake or publish an equality impact assessment of their policies, practices and decisions was removed in April 2011 when the 'single equality duty' was introduced. Public bodies must still give "due regard" to the need to avoid discrimination and promote equality of opportunity for all protected groups when making policy decisions and are required to publish information showing how they are complying with this duty.

All faculty and admin staff have undertaken mandatory Equality and Diversity training.

## 13. Monitoring Compliance and Effectiveness

This section should identify how HEE plans to monitor compliance with the policy. It should include:

- Who will perform the monitoring?
- When will monitoring be performed?
- How is it going to be monitored?
- What will happen if any discrepancies are identified?
- Where will the monitoring results be reported?
- How will learning take place?

### **Who will perform the monitoring?**

YHFS HEE Programme Support / FSD

### **When will monitoring be performed?**

Towards the end of each placement

### **How is it going to be monitored?**

Use feedback forms / away days

LIFT event 3<sup>rd</sup> October 2019 in Leeds, plus plan a further event for April / May 2020.

### **What will happen if any discrepancies are identified?**

YHFS will work with the trusts, GP practices and trainees to resolve any discrepancies or issues

### **Where will the monitoring results be reported?**

YHFS Committee meetings and the YHFS Away Day (Regional and Local)

### **How will learning take place?**

A review will take place after each set of feedback has been received and this will be used to update this guidance and the LIFT processes.

## 14. Feedback from the LIFT event 3<sup>rd</sup> of October 2019, the Met Hotel, Leeds

Content and style of the event	The likely usefulness and impact of the event for you	Your enjoyment of the event	Most useful session	Least useful session	How the event could be developed	The venue/administration of the event	Any other comments?
"The agenda items were all relevant and the style was appropriate as it was more interactive than didactic PowerPoint presentation"	To be aware of the issues with LIFT on system level and personal level and also what issues to expect and how to overcome them and who to contact if you need help, guidance or coordination.	I enjoyed it!!!	All of it. But the interactive and peer discussion was the most useful. Knowing who is who and out names on faces.	None	Wide audience invitation. Maybe have smaller table discussion between acute trusts (clinicians and rota coordinators), LIFT Trainees, GP trainer and/or practice managers.	OK	Excellent event, thanks
I felt it was very good in an environment that was relaxed and focused on key areas.	It helped me to understand the reasons behind the new LIFT and the importance of making it work for all.	I enjoyed meeting other people from various NHS backgrounds.	I felt the session was useful and applicable	There was nothing I did not feel was useful	More attendance with Trainers and Foundation GPs especially those in the first year.	Really good	Nothing further to add apart from those comments made on the day of the event and noted.
Well delivered. Open forum for discussion.	Excellent opportunity to share experiences / problems with other ES / FY1 LIFT trainees.	Good to make contact with secondary care / other clinicians involved in working with our trainee and useful to hear experiences / what other GP surgeries are doing with FY1 so far.	General discussion with other ES / primary care to ensure similar aims / supervision of trainees so far	NA	NA	Central location, Leeds preferred. Difficult to travel to other locations	NA

Content and style of the event	The likely usefulness and impact of the event for you	Your enjoyment of the event	Most useful session	Least useful session	How the event could be developed	The venue / administration of the event	Any other comments?
Good, however, I found the table positioning a bit awkward at times, as I really had to stretch my neck, to look behind me.	Impact: O contacted my LIFT trainee, via email, not heard back (2 weeks later, as I have been on holiday).	Ok, met a nice practice manager and his assistant. Shame there were no more GP's, especially from Grimsby, (I understand Keith Collett, who is vital in my area, indicated he was unable to come on that particular date. I also was not aware, I could have taken my LIFT trainee.	Discussion, shame this was at the end, perhaps a discussion at the beginning and at the end.	Can't remember.	More people, Dr's and trainees.		Was the very long day, including travel, worth it? Not sure, perhaps skype like meetings could be the future for some people?
The event was informal and with no set agenda. We were all introduced, and a positive atmosphere was generated by the facilitator, which enabled delegates to feel able to share issues. A large number of issues were discussed using this method.	Very useful.	Fine	NA	NA	NA	Good	NA
Relaxed style but sensible structure and facilitated useful discussion and networking.	Mainly useful in terms of networking.	Good	Hearing what has happened so far, as I haven't yet had a LIFT trainee (coming in December)	GP timetables (but clearly still useful to hear how it is being done).	Some more formal surveys as to how many days trainees have managed to get in GP vs trust.	Excellent, easy to get to and suitable size and fab food!	NA

Content and style of the event	The likely usefulness and impact of the event for you	Your enjoyment of the event	Most useful session	Least useful session	How the event could be developed	The venue / administration of the event	Any other comments?
Helpful to have an open discussion led by the Director of the FS. Slightly less structured than I was expecting but didn't detract from being able to share information.	Helpful to bring some people together to discuss LTFT locally and regionally. We aim to plan to meet locally with all LIFT supervisors.	Good	The GP timetable examples	Need more trainees to feedback to gain some meaningful idea of what changes may need to be implemented going forwards but that isn't to say that I felt the feedback from the trainee wasn't useful - it was.	As above	Room was a bit cramped. Which is good because lots of people came.	NA

# 15. Feedback from Placement 1 – August to December 2019

## 1. How are you involved with LIFT?

19 Responses

1. Trust - TPD or Clinician / Administrator
2. Trust - TPD or Clinician / Administrator
3. Trust - TPD or Clinician / Administrator
4. Trainee
5. Trainee
6. Trainee
7. Trainee
8. Trainee
9. Trainee
10. Trainee
11. Trainee
12. Trainee
13. GP Practice - GP Trainer / Practice Manager
14. GP Practice - GP Trainer / Practice Manager
15. GP Practice - GP Trainer / Practice Manager
16. GP Practice - GP Trainer / Practice Manager
17. GP Practice - GP Trainer / Practice Manager
18. GP Practice - GP Trainer / Practice Manager
19. GP Practice - GP Trainer / Practice Manager

Trust - TPD or Clinician / Administrator	3
Trainee	9
GP Practice - GP Trainer / Practice Manager	7



## 2. For trainees: Did you find your induction at the GP Practice / Trust adequate for your needs? For trusts/GP practice: Did you have any issues at trainee induction?

10 Responses

1. Too long, broad with unnecessary shadowing of team that I have done throughout medical school
2. No
3. Yes
4. No issues, suitable induction for post
5. By necessity it was very short - I feel that we are really still in the induction period!
6. Yes, although it was quite long and there was a lot of shadowing which wasn't always useful - eg watching a nurse take 10 venepuncture samples.
7. Yes
8. Yes, it was great

9. There was an initial difficulty with induction due to communication between the trust and the practice, meaning the GP surgery were not expecting me on my first visit. There was no specific LIFT induction within the trust.
10. No issues

**3. For the ES & trainee: Did you have any difficulty in arranging to meet with your trainee (for the ES) / trainer in your GP practice (for the trainee)**

16 Responses

1. No - I meet with her every week, either observe/help with consultations, attempt supervised consultations. Also, after lunch my GP supervisor makes time to teach us all (me as an F1, an F2 and a nurse) about different medical topics e.g. contraception, role play consultations e.g. depression or examination e.g. abdo exam. She invests lots of time in our training and development.
2. No - please give more detail below
3. No - please give more detail below
4. No - please give more detail below
5. No - please give more detail below
6. No - please give more detail below
7. No - please give more detail below
8. No - please give more detail below
9. No - please give more detail below
10. No - please give more detail below
11. Yes - please give more detail below
12. It wasn't made clear for a few weeks to my practice and trainer that they were meant to be my ES, but once that was cleared up, there were no problems.
13. No - please give more detail below
14. Hard to meet up in August, as holiday season and lots of inductions going on.
15. No - please give more detail below
16. No - please give more detail below

Yes - please give more detail below 1  
 No - please give more detail below 12  
 Other 3

**4. For the CS / TPD & trainee: Did you have any difficulty in arranging to meet with your trainee (CS/TPD) / trainer in the Trust (trainee)**

15 Responses

1. No - please give more detail below
2. N/A
3. No - please give more detail below
4. No - please give more detail below
5. Yes - please give more detail below
6. No - please give more detail below
7. No - please give more detail below
8. No - please give more detail below
9. No - please give more detail below
10. No - please give more detail below
11. No - please give more detail below
12. No - please give more detail below
13. No - please give more detail below
14. No - please give more detail below
15. No - please give more detail below

Yes - please give more detail below 1  
 No - please give more detail below 13  
 Other 1

**5. For the trainees; Have you had any issues being released from either your trust or your GP practice to attend mandatory training? (This could have been due to on calls / rest days / annual leave for example)**

12 Responses

1. No - My mandatory training is on Tuesdays not Wednesdays which is my GP LIFT day, so no issues here.
2. N/A
3. Yes - please give more detail below
4. No - please give more detail below
5. No - please give more detail below
6. No - please give more detail below
7. No - please give more detail below
8. Yes - please give more detail below
9. No - please give more detail below
10. No - please give more detail below
11. No - please give more detail below
12. No - please give more detail below

Yes - please give more detail below 2  
 No - please give more detail below 8  
 Other 2

**6. For Trusts and GP Practices; What positives have you found with the new LIFT programmes?**

7 Responses

1. Great to welcome an enthusiastic doctor to the team.
2. Trainee seems above average.
3. To have the trainee one day a week for the whole year helps the integration of the trainee to GP team better.
4. Enthusiastic team member. Medical students have benefited from her teaching. Great to have her on board.
5. LIFT trainees seem to be more engaged with their portfolio
6. Looking forward to deepen the relationship with lift trainee now introduction period over. Good thing is now that we have another 8 months to really get going
7. Running as planned

**7. For Trusts and GP practices; what development areas have you found / are still working on? Please describe / list below:**

8 Responses

1. The LIFT trainee does not seem to attend many days in the practice. I think she has only been in for about 4 days in a 3 month period.
2. Issues found: Trainee unable to attend face to face mandatory training in the trust. Even less time spent within trust placement speciality with one day a week in GP practice and all on-calls, zero days, study leave, annual leave etc so trust speciality experience definitely negatively affected.
3. Understanding, influencing the rota in the trust to be coordinated with the days the trainee works in primary care.
4. Continuity of care / follow up of patients
5. Knowing when she is going to be in - we still have yet to receive a rota!
6. Paying days back to GP.
7. A swifter start next time, contact the trainee by text etc if needs be, so feels more involved.
8. Rota coordination

**8. For all: Were there any elements of the placement, either GP or Clinical, that you felt that you (for the trainee), or for your trainee (for the trust/GP practice) could have been more involved in or didn't have access to?**

11 Responses

1. There are some issues with having the trainee one day a week e.g. our trainee cannot attend the primary care MDT meeting which is on Friday whilst the trainee is with us on Tuesdays.
2. Some sort of induction for trainers re: competencies to be covered. timescale of when forms have to be filled, level of supervision etc
3. Sometimes struggle for the practise meetings as I don't work on that day in GP
4. No
5. A rota. Would be very helpful to know when to expect the trainee to be in the surgery.
6. There has been a lot of confusion regarding my role as a LIFT trainee and there was nothing clear at the start of the placement about whether we were meant to attend on our on call days or if we had to make the time up to the GP practice. The communication between the hospital and the practice has been less than ideal and particularly when I was still trying to understand the two, it would have been helpful to have more guidance for everyone involved. It felt like neither the hospital nor the practice knew what to do with me or how the programme worked.
7. Not so far
8. I would like to know earlier whether a trainee is falling below the 75% attendance mark. It is harder to negotiate paying back days with a specialty when you are initially contacting them 2 weeks before the rotation begins. Also, the GP practices need to also be flexible with paying back days i.e. one of the practices couldn't allow pay back of any days, as they did not have the clinicians to supervise the trainees.
9. Not really
10. The coordination of the rotas between surgery and attending GP lift day proved very difficult, and it was left to myself to try to coordinate. I felt this made my working environment in trust difficult, as my day caused problems in the rota with my superiors but also team members who were short on days I was away.
11. No

**9. For Trainees; When selecting your programmes did you have any initial queries about what you would be doing? Can you describe these further / list below?**

10 Responses

1. Yes - I wondered how structured each weekly session would be, if there would be a timetable or list of things to tick off as the weeks go along, or if it would be more relaxed and flexible. I wanted some information about the role of an F1 in GP - this was more difficult to ascertain due to lack of experience and not literature sent to us about expectations, or guidance on what things we can do as an F1s compared to an F2.
2. N/A
3. Yes - please give more detail below
4. Development
5. No - please give more detail below
6. How it would work with the medical rota, if I would get let out for my GP days, would my hospital supervisor be okay with it, would I be missing out on continuity of care of the ward patients.
7. Yes - please give more detail below
8. No - please give more detail below
9. Yes - there wasn't much/any detail on what the LIFT programme would involve. I based my choosing it on things I could find about other LIFT programmes on google.
10. There was minimal information about the programme to begin with, and even upon starting my roll I had to email many times to receive any information about what the role actually involved, when I would be attending and how this would work around my timetable. Consequently, any issues were not sorted prior to my start date.

**10. For the trainees: Have all your queries now been answered?**

## 10 Responses

1. Yes - by my postgraduate coordinator.
2. N/A
3. Yes - please give more detail below
4. Still like med school
5. Yes - please give more detail below
6. Yes - please give more detail below
7. Yes - please give more detail below
8. Yes - please give more detail below
9. Yes - please give more detail below
10. Yes - please give more detail below

**11. How do you feel the LIFT programmes benefit a) your working relationship and b) the patient relationship**

## 10 Responses

1. So far, it's nice to get to know my colleagues, my GPs and nurses in the practice, I look forward to getting to working with them more. Hard to tell yet with patient relationship as I haven't yet seen patients twice/ followed them up just yet.
2. N/A
3. On the whole I would say it has not affected my working relationships in hospital in any way; my colleagues are sympathetic to the fact that I attend GP on Tuesdays and do not appear to have held it against me in any way, even though it can mean they are more short-staffed. There is no impact in a positive way on these relationships within the trust, in fact I would say there is no real impact at all thus far. However one area I would identify is when writing discharge summaries & instructions for follow up for GP; I am much more inclined to spend more time over this having seen how difficult it can be as a GP to pick up a half-baked and rushed discharge summary. In terms of the patient relationship, again I would be dishonest if I said I felt there has been much of an impact thus far. I suppose you could argue that I take a broader approach to patients in the hospital setting when able, however more than often this is dictated by the workload of the day. If time allowed more often, then perhaps it would be a different story.
4. Poorly, having a negative impact
5. Both a and b.
6. Good and helps with general knowledge which is used in hospital medicine also
7. I like the set up in GP and it is very easy to be multidisciplinary, they are very supportive when I have queries. I like having the time pressures on appointments and working to a time limit with a patient. Enables me to be more focussed and quickly formulate a management plan.
8. It has been good to switch between hospital medicine and general practice ways of thinking and greater appreciate the links and difficulties between the two. It's interesting to see how challenging the role of both the GP and hospital doctor is, especially as hospital consultants/trained GPs haven't worked in the respective specialty for sometimes decades and don't appreciate the current concerns/challenges/demands of each other's role. It has been nice to be able to bridge that gap.
9. It is really useful to have the weekly opportunity to experience and improve on one-to-one patient consultations. I think it has improved my patient relationships in hospital and given me a better insight into the types/availability of services in the community (very useful for discharge planning).
10. I feel my relationship with patients is improved through my LIFT programme as I have time during my GPS to speak to my own patients and spend time with them as opposed to the busy nature of the hospital. My working relationship has been strained due to the LIFT program. Other colleagues and seniors are not aware of the scheme and it has not been well incorporated into the normal rota, therefore leaving gaps and having no additional staffing, making the working environment more difficult for other members of my team, and being left feeling as though it is my fault.

**12. Have there been any issues around gaining foundation competencies?**

## 10 Responses

1. No, plentiful opportunities to gain core competencies e.g. IM injections, ECGs, and already have done a CBD with my GP supervisor.
2. I don't know - haven't seen the trainee enough to establish this.
3. Not thus far
4. Have not gained any
5. No, if anything improves them
6. No portfolio is coming along well. Plenty of reflection to complete in GP and as the trainer is my ES doing mini-cex and CBD's are easy as I know exactly where they are on the days I'm in GP (across the corridor from me). Also has blocked off slots to accommodate me asking questions.
7. No
8. None
9. Not yet
10. No

**13. Has there been any changes to rotas?**

## 15 Responses

1. No - please give more detail below
2. I don't know. I have never seen a rota, and don't know when to expect the trainee in the practice.
3. No - please give more detail below
4. Not yet but having to try and organise this to hit criteria
5. Yes - please give more detail below
6. our trainee has been proactive in this. If there was rota change or if can't attend on Tuesday he managed to come in another day, he organises this well in advance.
7. when lift trainee is on call day changes
8. No - please give more detail below
9. No - please give more detail below
10. Yes - please give more detail below
11. I think my rota will have to be adjusted for each placement to accommodate my on-calls and meet GP attendance requirements, as I have a few placements with quite a lot of frequent on-calls. The rota managers at my practice so far seem to be very helpful and organised with this though.
12. No - please give more detail below
13. Accommodation of additional pay back days in GP from Geriatrics.
14. this was the difficulty, the rota was not designed with LIFT trainees in mind, therefore making it very difficult to take a day each week to attend my GP practice.
15. Yes - please give more detail below

Yes - please give more detail below 3  
 No - please give more detail below 5  
 Other 7

**14. For the GP Practice / trainees: NW LIFT trainees had 1 and a half days in a GP practice. On a scale of 1 to 5, Do you feel 1 day a week in a GP practice is adequate**

16 Responses

1. 4
2. 4
3. 5
4. 4
5. 3
6. 3
7. 3
8. 1
9. 2
10. 5
11. 3
12. 4
13. 5
14. 5
15. 5
16. 5



3.81 Average Rating

**15. For the trusts: Have you had any issues due to your LIFT trainee being in a GP practice 1 day a week?**

3 Responses

1. In relation to question 12 - 1 day a week is adequate, but 4 days in 3 months is not!
2. Yes, as above - time within speciality even less now than it was before.
3. No, but it is difficult to pay back days in some specialties i.e. Urology, when they have already written the rota according to the original requirements.

**16. On a scale of 1 to 5, do you feel LIFT has improved team performance and involvement for all involved?**

16 Responses

1. 3
2. 4
3. 1
4. 3
5. 1
6. 3
7. 1
8. 3
9. 1
10. 4
11. 5
12. 5
13. 3
14. 4
15. 1
16. 3



2.81 Average Rating

**17. How do you feel that modern technology might aid LIFT programmes e.g. Skype, facetime etc**

## 17 Responses

1. At this early stage of my career, I would rather focus on face to face interactions. I feel technology might had to hassle and delays especially if things don't end up working/malfunctioning. Keeping things as simple is better in my opinion.
2. Would be helpful to see a rota so that we know when to expect the trainee.
3. Not improve - please explain below
4. Skype for trust mandatory training sessions, ES meetings et.
5. Not improve - please explain below
6. Not improve - please explain below
7. Improve - please give examples below
8. Not improve - please explain below
9. Not improve - please explain below
10. Not improve - please explain below
11. Not improve - please explain below
12. Not improve - please explain below
13. Not improve - please explain below
14. Not improve - please explain below
15. I don't really know how it would aid it at the moment, unless consultations can be done via Skype.
16. I think that would be a good use of time and technology.
17. It would be good to communicate and share tips and tutorials with other LIFT trainees and practices every now and again.

**18. Any other feedback or comments?**

## 9 Responses

1. "Would have liked more guidance about what to expect from LIFT as F1s from the beginning.
2. Would have liked contact email addresses from individuals who have already done LIFT to see how we can make the most of our GP day.
3. I feel that in the hospital, my rate of learning is slower than everyone else because I am away x1/week - this is somewhat added to the stress in the hospital and makes me feel frustrated - sometimes my colleagues/senior doctors aren't aware of my reduced experience in hospital and expect more from me than is possible at this early stage.
4. More guidance to GPs about how to manage rota - often my GP isn't aware when I have annual leave, when I am due to come in - currently lack of communication between rota coordinators and GP practice. At the moment, I email my GP supervisor when I am due to be off because of annual leave.
5. Generally, I enjoy my GP days - I enjoy seeing patients, makes me think carefully about differential diagnoses, red flags etc, and requires different set of skills to the hospital and I look forward to challenging myself in a different way each week. The practice has set me up with SystemOne log ins, Windows logins, and SMART card access so it helps me to work slightly more independently and more with the team of GPs that can then help with each patient after I have seen them. My GP has suggested to record us speaking to patients (confidentially with patient's permission) - I think this is a great learning idea, to make us aware of non-verbal and verbal communication and we can improve and perfect our consultation skills.
6. Would like a bit more structure to each day, or a guide of 'GP competencies' perhaps to cover/learn as the weeks go on. This will help track and record what we have learned and build on areas that are weaker. Also gives us ideas about what areas we have missed, what areas to explore further..."
7. No
8. It is early and difficult to say what sort of impact LIFT has had for me personally so far. I do very much enjoy the days as a break from the ward, and I feel they are a positive in terms of maintaining perspective as to career direction (as someone very keen to become a GP) and as an aid in avoiding being completely beaten-down and burnt-out by the harsh realities of life on the ward as an F1. It has been difficult lately with a string of on-calls meaning that I only worked 2 GP days in 5 weeks, meaning that I have not really had any sense of continuity, however I do not see how this can be altered - ultimately we have a commitment to the on-call rota first and foremost. There is also some difficulty in being released from hospital enough times to hit the minimum criteria for my GP commitments (75%) - for example, with on-call commitments and annual leave (just one GP placement missed due to AL)

I am scheduled for 12 out of 17 potential GP days, 70%. Thus, I am now having to try and convince my hospital rota co-ordinator to release me from my hospital commitments for an extra day in order to be able to hit my target of 75%, or 13 out of 17 GP days. This is probably the most difficult thing about LIFT.

9. We have had good experience so far. I would like to have the placement days to be flexible in primary care, but this again done through better coordination and communication with the local trust.
10. one day a week, with on calls. change in rotas, AL of trainer and trainee - every week is a new challenge, and it's like starting from the beginning.
11. "I would prefer 1 day only as I wouldn't want to miss that much in-patient hospital work. Also, my GP is roughly 45 minutes away so would add another hour 30 on to my travel time which I wouldn't be happy about for only a half day.
12. I think technology wouldn't improve LIFT. I don't know when I'd use it. I know when to turn up, complete my clinic day and then debrief with my supervisor. When would I use Skype? If I have any queries, I bring them up on my clinic days and just call the practice or email my supervisor if there are any other problems."
13. Not sure whether 1 is good or bad on above scales!
14. I think LIFT is working really well but feel that the GP practices and the Trust need to communicate more, as it currently feels like two separate programmes running simultaneously.
15. The idea behind the LIFT programme is great, and when able to attend the GP's I have really learnt a lot and benefitted from the training. However, the cons have far outweighed the benefits so far, as it is new many members of the trust were unaware of the post and what it involved. The busy surgical rota does not allow time to take a day out a week, there was no extra staffing to take my place when I was away, and this had a negative impact on my relationship with team members and the seniors involved in coordinating the rota.

## 16. Useful Links, Acknowledgements and References

### Links:

FY1s and the GMC, good medical practice:

[http://www.gmc-uk.org/doctors/registration\\_applications/uk\\_internships.asp](http://www.gmc-uk.org/doctors/registration_applications/uk_internships.asp)

[http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

<https://www.foundationprogramme.nhs.uk/content/curriculum>

The UK Foundation Programme Office - UKFPO:

<https://www.foundationprogramme.nhs.uk/>

The Northwest of England Foundation School policies and procedures:

<https://www.nwpgmd.nhs.uk/foundation-policies-and-processes>

FY2s in General practice:

<https://www.nwpgmd.nhs.uk/foundation-information-gp-practices-f2>

YHFS:

<https://www.yorksandhumberdeanery.nhs.uk/foundation>

<https://www.yorksandhumberdeanery.nhs.uk/foundation/recruitment-and-retention/longitudinal-integrated-foundation-training-lift>

[https://www.yorksandhumberdeanery.nhs.uk/foundation/curriculum\\_delivery\\_and\\_teaching/fy2\\_gp\\_training/list\\_of\\_practices](https://www.yorksandhumberdeanery.nhs.uk/foundation/curriculum_delivery_and_teaching/fy2_gp_training/list_of_practices)

**\*\*check up to date\*\***

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- Suzanne Gawne, Foundation Programme Director, East Lancs
- Harry Chan, Foundation Programme Director, Wigan
- David Baxter, Director of Medical Education, Stepping Hill, Stockport
- Shahidal Barry, Director of Medical Education, Morecambe Bay
- Gary Saynor, Foundation Programme Director, Bolton

**References:**

(1) Broadening the Foundation Programme

Health Education England, 2014

<https://hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/better-training-better-care-btbc/broadening-foundation-programme>

(2) Dr. David Hirsh explains the benefits of a Longitudinal Integrated Clerkship

<https://www.youtube.com/watch?v=cKGeWSws1So>

(3) Guide for Foundation Training 2019

[https://www.foundationprogramme.nhs.uk/sites/default/files/2019-10/FoundationGuideTraining\\_Sept19\\_Update.pdf](https://www.foundationprogramme.nhs.uk/sites/default/files/2019-10/FoundationGuideTraining_Sept19_Update.pdf)

Operational guide 2019

<https://www.foundationprogramme.nhs.uk/sites/default/files/2019-11/Operational%20Guide%20%2008.11.19.pdf>

(4) Foundation Policies and Procedures

Formal Teaching Programme Guidance

Health Education England (North West Office), 2015

<https://www.nwpgmd.nhs.uk/foundation-policies-and-processes>

(5) HEE YH website:

<https://www.yorksandhumberdeanery.nhs.uk/foundation/recruitment-and-retention/longitudinal-integrated-foundation-training-lift>

(6) UKFPO website

<https://www.foundationprogramme.nhs.uk/>

(7) GMC website

<https://www.gmc-uk.org/>

# 17. Illustrations

**Table 1**

Longitudinal Integrated Foundation Training Model

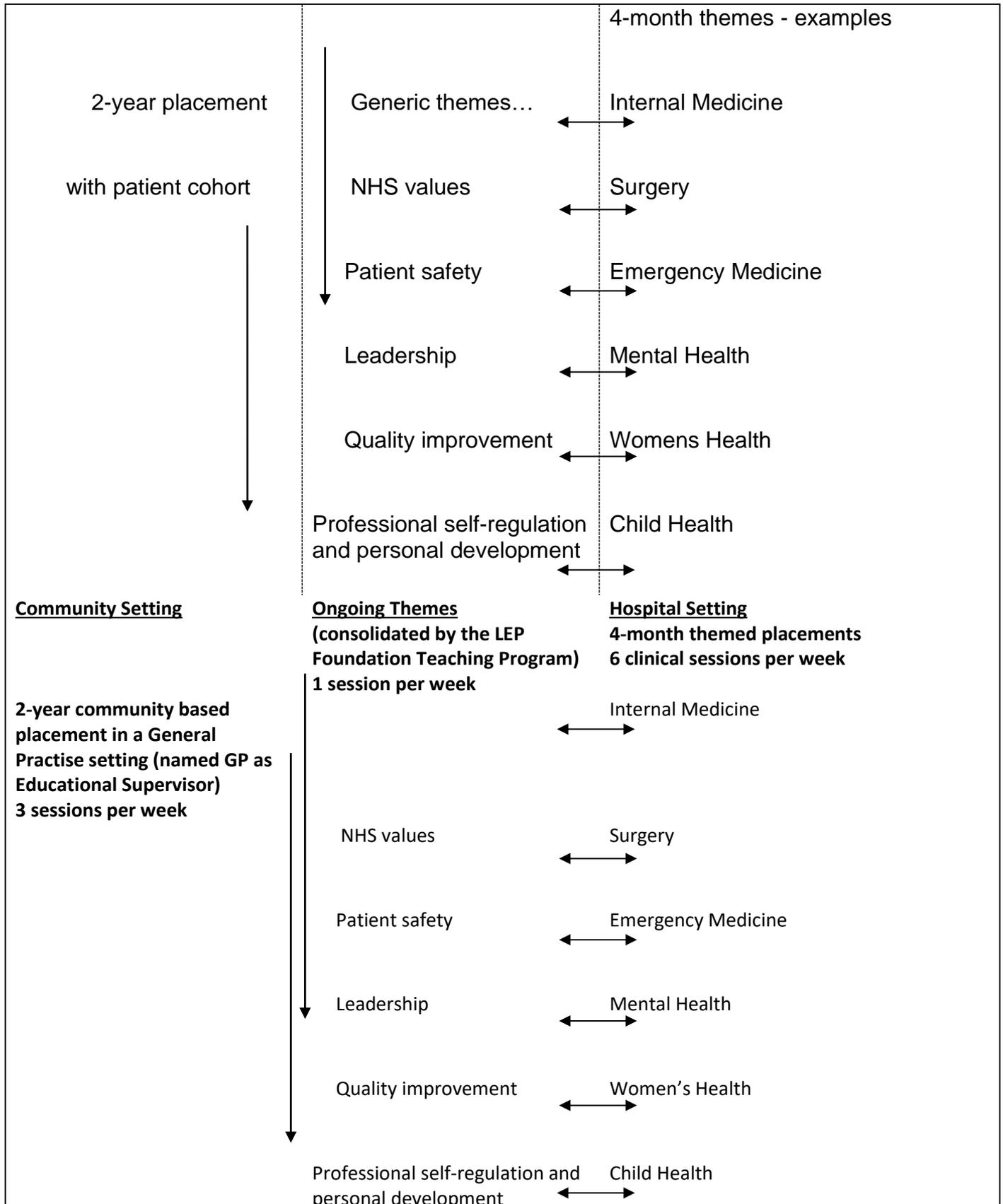


Table 2

## Example weekly timetable

Example FY1 - Trainee 1

	4 days immediately prior to F1 start date	Mandatory Programme Shadowing/Induction	
Placement 1	1st Wednesday August	Departmental Induction - Medicine unit; Respiratory	
Month 1		Placement Theme (Respiratory Medicine)  1 session set teaching  7 clinical sessions weekly  <i>4 direct trainer contact e.g. Thoracic medicine OPD lung function endoscopy Consultant round</i>	GP induction 2 sessions weekly (to continue at trainer's discretion)
Month 2		<i>&lt;3 general sessions e.g.</i>	GP placement (after induction)
Month 3		<i>2 ward work</i>	2 sessions weekly
Month 4		<i>1 MAU session</i>	<i>e.g. General GP session CDM session- asthma clinic Trainer 121/audit/admin</i>
Placement 2	1st day	Departmental Induction - A & E	
Month 1		Placement Theme (Emergency Medicine)  1 session set teaching  8 clinical sessions weekly  <i>on average guidance... &gt;4 direct trainer contact &lt;4 other</i>	GP placement  2 sessions weekly  <i>General GP session Emergency surgery Trainer 121/audit/admin</i>
Month 2			
Month 3			
Month 4			
Placement 3	1st day	Departmental Induction - Surgery	
Month 1	1 session set teaching	Placement Theme (Surgery) 8 sessions weekly  <i>on average guidance... 4 direct trainer contact e.g. surgical OPD, operating theatre</i>	GP placement 2 sessions weekly  <i>e.g.  General session Minor ops Musculoskeletal</i>
Month 2		<i>4 general sessions</i>	
Month 3		<i>e.g. ward work</i>	
Month 4		<i>SAU session</i>	

Table 3

## Example rotas from Chapelgreen Practice – Aug 2019

DAY	DATE	TIME	ACTIVITY	WITH
<b><u>ONE</u></b>	TBC	09.00	Health & Safety Tour & Introductions, at High Green Health Centre, Thompson Hill, High Green, personal checks, etc.	Deputy Manager
		10:00	Computer Based Training on our clinical system Systmone, and a tour round Ardens templates. Bluestream e-learning log in	IT & Finance
		11:00	QOF (Quality and Outcome Framework) background and how it relates to income	DMT
		12:30	Lunch	Lunch
		13:00	Meet Educational Supervisor and discuss training.	
		14.30	Sit and Observe GP afternoon surgery.	As opp
		16.30		
		17.30	Home	
<b><u>TWO</u></b>	TBC	08.00 or 08.30	Sit and Observe GP morning surgery.	As Opp
		11:00	Coffee Meeting	High Green
		12:00	Lunch	
		13:00	Computer Refresher at High Green – Systmone training. Blue Stream E-learning topics that must be covered are; Safeguarding Adults Level 2 / Safeguarding Children Level 3 – <b><u>PRIOR TO OWN SURGERY</u></b> Other e-learning as necessary can be agreed with your supervisor.	
		14.00 or 14.30	Sit and Observe GP afternoon surgery.	As opp
		16.30		
		17.30	Home	

Foundation FY1 - Job Plan 2019

<b>TIME</b>	<u>Monday In Practice</u>	<u>Tuesday In Practice</u>	<u>Wednesday In Practice</u>
09:00	<b>9.00 start finish at 5pm</b>	<b>9.00 start finish at 5pm</b>	<b>9.00 start finish at 5pm</b>
09:30	<b>WARD ROUND Aaron View</b>	<b>WARD ROUND Silver Lodge</b>	<b>LONG TERM CONDITION REVIEWS Nurse Manager or Nurse Practitioners</b>
10:00			
10:30			
11:00	COFFEE MEETING	COFFEE MEETING	COFFEE MEETING
12:00	<b>VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor</b>	<b>VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor</b>	<b>VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor</b>
13:00	Lunch	Lunch	Lunch
13:30	Set Up For pm Surgery/follow up calls	Set Up For pm Surgery/follow up calls	Set Up For pm Surgery/follow up calls
14:00	Joint Surgery (4 Patients) Reviewed by GP after Consultation.	Joint Surgery (4 Patients) Reviewed by GP after Consultation.	Joint Surgery (4 Patients) Reviewed by GP after Consultation.
14:30			
15:00			
15:30			
16:00			
16:30	Admin Time	Admin Time	Admin Time
17:00			

## 18. Definitions

LIFT	Longitudinal Integrated Foundation Training
GP	General Practice / General Practitioner
ES	Educational Supervisor
CS	Clinical Supervisor
TPD	Training Programme Director
ARCP	Annual Review of Competencies
YHFS	Yorkshire and Humber Foundation School
TPD	Training Programme Director
WTE	Whole Time Equivalent
LTFT	Less than full time
FAQs	Frequently Asked Questions

Any to add?

## 19. Appendix A

### Information and extracts from a statement by the education committee of the General Medical Council:

Provisional registration is available under the Medical Act 1983 for the purposes obtaining the experience required to become fully registered with the GMC. The act restricts the practice of medicine and only 'fully registered practitioners' may hold certain posts or sign certain certificates. There are further provisions regarding charging by 'doctors' (defined as 'registered medical practitioners') in the NHS (Charges for Drugs and Appliances) Regulations 2000. There are restrictions placed on the sale and supply of medicines by The Medicines Act 1968 and the Misuse of Drugs Act 1971 restricts supply of medicines but 'doctors' are exempted, under certain circumstances. In both of these cases, the term 'doctor' is also defined as 'registered medical practitioner'.

The term 'registered medical practitioner' is defined under the Interpretation Act 1978 to mean a 'fully registered person' within the meaning of the Medical Act 1983. Therefore, at first sight, the statutory powers of prescription are all reserved to doctors with full registration, and are not available to provisional registrants.

However, there is the facility in the Medical Act 1983 for a provisional registrant to be 'deemed to be registered under so far as is necessary to enable him to be engaged in employment in a resident medical capacity ... in one or more approved hospitals, approved institutions or approved medical practices but not further.' Therefore, a provisional registrant may exercise the powers of a fully registered practitioner so far as this is 'necessary' for the purposes of his employment in a resident medical capacity. The question of to what extent the powers may be exercised will turn on the facts of each case; however, it is worth noting that the use of the powers must be 'necessary', rather than simply 'desirable'.

The term 'resident medical capacity' is defined in the Medical Act 1983. It states that 'References to employment in a resident medical capacity shall be construed as references to employment ... where;

- a. in the case of an approved hospital or an approved institution, the person employed is resident in the hospital or institution where he is employed or conveniently near to it and is by the terms of his employment required to be so resident; or
- b. in the case of an approved medical practice, the person employed satisfies such conditions as to residence as may be prescribed.'

'Resident medical capacity' is therefore a matter to be determined or not by the terms of employment. It is a service requirement, not an educational one and although designed for the old PRHO grade, it can be applied to FY1.

#### Bibliography

The UK Foundation Programme Curriculum (2012) United Kingdom Foundation Programme Office  
 Good practice in prescribing and managing medicines and devices (2013) General Medical Council  
 Good Medical Practice (2013) General Medical Council  
 The Trainee Doctor (2011) General Medical Council  
 The New Doctor (2009) General Medical Council  
 Out-of-Hours Dispensing of Medications by Doctors; Journal of Medical Safety 2013; July;17-23  
 Education Committee Statement about the position of doctors with provisional registration prescribing in General Practice. General Medical Council  
[http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/table\\_of\\_form\\_compatibility.pdf](http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/table_of_form_compatibility.pdf)

## 20. Appendix B

To add the distribution lists / key contacts here

## 21. Appendix C: Learning Themes throughout the NW Foundation Training period

Ongoing teaching and learning during placements (and the formal Foundation Teaching program) can be carried across to the community setting. These should include: -

- NHS values
- Patient safety
- Leadership
- Quality Improvement
- Professional Self-Regulation
- Professional Development

These ongoing vertical themes will help the trainee to meet the ARCP criteria as set out by the UK Foundation Programme. It is expected that the trainees' professional self-development will be supported in the community setting.

Practices are encouraged to think flexibly around the content of the trainees' three sessions in primary care. One should be a conventional GP surgery, but for the remainder of the time, think of the whole range of primary care activity available and different points of care pathways. You should facilitate the trainee accompanying the patient into secondary care and other settings where possible. If travelling with the patient, the trainee should be an observer only and must not be used as medical cover for ambulance transfers. Care must be taken not to disproportionately direct Womens' Health consultations to female LIFT trainees, who may not be comfortable with them at this stage of their training. LIFT trainees may do hospital on-call or emergency shifts, but HEE specify that these must not impinge of practice time.

Flexible timetabling, however, does not mean lax supervision. The LIFT trainees should be supervised as closely as any other trainee. Their location should be known to the trainers at all times.

Make the LIFT trainee(s) part of your team for two years.

### NW Evaluation based on LIFT themes and NHS values

LIFT aims	Corresponding themes from NHS constitution
1. Patient safety	Commitment to quality of care
2. Patient centredness	Working together for patients Respect and dignity
3. Quality Improvement	Commitment to quality of care
4. Self-regulation and personal development	Commitment to quality of care
5. NHS Values	Compassion
6. Leadership and NHS management	Improving lives, Everyone counts

<b>Domain 1</b>	
<b>LIFT aim</b>	<b>NHS value</b>
<b>Patient safety</b>	<b>Commitment to quality of care</b>
<p>Definition of aim: Patients should be treated in a safe environment and be protected from avoidable harm. We want to help NHS providers minimise future patient safety incidents and drive improvements in safety and clinical quality</p> <p>The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the process of healthcare</p>	<p>We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.</p>
<p>Anchor statements: 0 – No or negative evidence to support this domain from free-text comments of assessment tools, supervisor reports and reflective notes. 1 – Some evidence to support this domain. 2 – Considerable evidence to support.</p>	<p>Examples: Evidence of adverse clinical incident affecting patient safety and not adequately reflected. Clinical incident which is reflected upon and demonstrated learning from it Quality improvement project demonstrating improvement in quality of patient care and safety.</p>
<b>Domain 2</b>	
<b>Patient centredness</b>	<b>Respect and dignity Working together for patients</b>
<p>Definition of aim: The Health Foundation has identified a framework</p> <ul style="list-style-type: none"> <li>• Offering coordinated care, support or treatment.</li> <li>• Offering personalised care, support or treatment.</li> <li>• Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.</li> </ul>	<p>We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.</p>
<p>Anchor statements: 0 – No or negative evidence to support this domain from free-text comments of assessment tools, supervisor reports and reflective notes. 1 – Some evidence to support this domain. 2 – Considerable evidence to support</p>	<p>Examples: No or negative comments on TAB, MSF, ESR and SLEs. Some positive comments around patient-centredness In TAB, ESR, and SLEs. Considerable amount of evidence / positive comments in portfolio.</p>

<b>Domain 3</b>	
<b>Quality Improvement</b>	<b>Commitment to quality of care</b>
<p>Definition of aim: The combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. Medical Leadership Competency Framework cites this in terms of</p> <ul style="list-style-type: none"> <li>• Demonstrating Personal Qualities</li> <li>• Working with Others</li> <li>• Managing Services</li> <li>• Improving Services</li> <li>• Setting Direction</li> </ul>	<p>We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes</p>
<p>Anchor statements: 0 – No or negative evidence to support this domain from free-text comments of assessment tools, supervisor reports and reflective notes. 1 – Some evidence to support this domain. 2 – Considerable evidence to support.</p>	<p>Examples: No or little evidence of Quality Improvement work in portfolio. Some evidence of QIP. Excellent QI project leading to better patient outcomes.</p>

<b>Domain 4</b>	
<b>Self-regulation, personal development</b>	<b>Commitment to quality of care</b>
<p>Definition of aim: Personal development is a lifelong process. It is a way for people to assess their skills and qualities, consider their aims in life and set goals in order to realise and maximise their potential. The medical leadership competency framework cites this in the following terms...</p> <p>1.1 Developing Self Awareness 1.2 Managing Yourself 1.3 Continuing Personal Development 1.4 Acting with Integrity</p>	<p>We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes</p>
<p>Anchor statements: 0 – No or negative evidence to support this domain from free text comments of assessments, supervisor reports &amp; reflective notes. 1 – Some evidence to support this domain. 2 – Considerable evidence to support.</p>	<p>Examples: Little or no evidence of learning, CPD in portfolio. Attendance at mandatory teaching poor. Some evidence of additional learning; seeks opportunities and demonstrates positive learning. Good attendance at mandatory teaching. Considerable evidence of self-awareness of learning needs; seeks opportunities independently, self-driven, motivated, demonstrates learning and success from it.</p>

<b>Domain 5</b>	
<b>Compassion</b>	<b>Compassion</b>
<p>Definition of aim: Compassion consists of five elements: recognizing suffering, understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings, and motivation to act/acting to alleviate suffering.</p>	<p>We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering.</p> <p>We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care</p>
<p>Anchor statements: 0 – No or negative evidence to support this domain from free-text comments of assessment tools, supervisor reports and reflective notes. 1 – Some evidence to support this domain. 2 – Considerable evidence to support</p>	<p>Examples: No or few comments of compassion or empathy in TAB, ESR, SLEs. Some comments of compassion and caring in TAB, ESR and SLEs. Significant amount of positive comments around compassion and caring in multiple assessments and reports.</p>

<b>Domain 6</b>	
<b>Leadership and NHS management</b>	<b>Improving lives, everyone counts</b>
<p>Definition of aim: Leadership is about mobilising the attention, resources and practices of others towards particular goals, values or outcomes. Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours.</p>	<p>We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources, we waste opportunities for others.</p>
<p>Anchor statements: 0 – No or negative evidence 1 – Some evidence to support this domain. 2 – Considerable evidence to support</p>	<p>Examples: Nil to support this domain from free-text comments of assessment tools, supervisor reports and reflective notes. Some evidence of experience and development in leadership and management skills Considerable evidence of the above</p>