NHS
Health Education England

School of General Practice in the West Midlands

Dear GP Trainees, Trainers, Practice Managers and TPDs,

I hope everyone is keeping well and managing the changes and stress of the current situation. There are a number of issues that need discussing hence this email:

1) Re-deployment:

There are no plans to redeploy any group of trainees as a block. GP trainees and Foundation Doctors who are due to rotate in December will rotate as planned (see comment below affecting some Trusts). Trainees should have therefore undertaken a new Risk Assessment for their new rotation. If there is any disparity between the Trust Risk Assessment and the Lead Employer's Risk Assessment then the trainee should discuss with the Lead Employer.

2) Foundation Doctors:

Some but not all Hospital Trusts have asked for the return of their Foundation Trainees to support the Medical Rotations. This is what has been agreed for those Trusts who have asked:

25% of FY2 to return to support Medical Rotation for each of the next 4 months. So if a FY2 will spend 3 months in GP rather than 4. Exactly which of the months will they be missing from GP will be determined by the Foundation Lead at the Trust. The Trust is responsible for informing both the FY2 doctor and the Host Practice.

To date the Trusts who have asked for the return of the FY2s from GP for 4 weeks are UHB, UHNM, Walsall and Dudley. There may be others over the next few weeks as winter and Covid pressures grow.

If you are a Foundation Training Practice we are desperate not to disrupt the training that you are offering the FY2 doctors as we are very aware how career enhancing a great experience in General Practice can be for Foundation Doctors, hence the GP School were keen not to disrupt the rotations too much but conscious that the Trusts are the employers and are obviously facing unprecedented pressures.

There are increasing number of Foundation Doctors coming through from Medical Schools and it would be great to give as many as possible the opportunity of seeing how challenging and satisfying General Practice really is and help overcome any negative images from secondary care. If any Practice wishes to provide this experience for FY2 doctors please let me or your Area Director know.

3) GP Trainees in Hospital Attachments:

At present 1 trust has asked the Postgraduate Dean about whether GP Trainees in Hospital could be re-deployed to cover Medical Rotation for a week at a time. This has not yet been agreed. It may be that with increasing pressures on medical rotations, other Trusts will be asking for permission to temporarily and for strictly limited periods of time ask for redeployment from less pressurised

attachments. Any redeployment will need appropriate induction, clinical supervision and there should be accessibility to get WPBA completed.

4) GP Trainees in General Practice:

Primary Care has changed dramatically in the last year and GP training has had to change equally quickly as a result. The system is under pressure and as a result there is pressure on every team member including trainee, trainer, programme director and practice manager.

From the perspective of the trainee, what helps with reducing stress are the following aspects:

1) Peer support from colleagues within the practice and at Half-Day-Release. It is important that trainees are able to attend HDR and also not feel isolated within the practice or especially if working remotely.

2) Clinical Supervision needs to be accessible and supportive. Moving to remote consulting on telephone and over video has been challenging for experienced GPs who know the patients but is even more so for GP trainees who do not know the patients. Debriefing is important and is part of the clinical time within the working week. Trainees should be asking for advice on management when needed.

Although de-briefing is part of clinical time, if this leads to a discussion about a clinical subject area which then is an educational activity and would be part of tutorial educational time.

3) Educational Time is meant to be 30% of the working week (allowing for lunch-breaks etc). The 70:30 ratio should be maintained despite pressures on the system. The 3 sessions of educational time are shared between Half-Day-Release, Tutorials and Self-Directed Study.

I appreciate that with increasing clinical pressures it may be challenging for the increasingly busy trainers to provide as much tutorial time but practices should be encouraged to consider how to provide supported-education. It may mean other members of the team are involved to discussion aspects of being a GP, trainees should be involved in other educational activities such as MDTs, Significant Event Meetings or Covid Planning Meetings but may also mean that tutorials become “on the hoof” and spontaneous. Tutorial time should be maintained where ever possible but may become more fragmented or less regimented.

5) Being an integrated and important of the Primary Care Team:

A GP Registrar is an important part of the Primary Care Team and contributes to the clinical capacity of the whole team. The Team should still function if the GP Registrar was absent. Even though there are employment rules protecting trainees from exploitation, there is also the professional capabilities of “Being a GP” which include working with Colleagues and in Teams. It is therefore a balance of working within and contributing to the Practice Team. It is important that everyone within the team feels supported and not pressurised or harassed.

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If there are issues or problems then these are best resolved with discussions between the GP Registrar and Trainer/Practice Manager. Practices want trainees to feel supported but also experience what being a real GP is like.

Any issue should be discussed locally within the practice, involving Programme Directors as necessary before being escalated to Area Director, Lead Employer, Responsible Officer or BMA. Involving higher authority figures, before any local discussion has occurred, can sometimes hamper a satisfactory solution and damage relationships within the practice.

Newly qualified GPs have a steep learning curve after CCT and continue their personal development over the subsequent few years. Trainees who are able to complete CSA/RCA/AKT and then have a few months focussing on the capabilities needed to be a GP are often better prepared for their first job as a newly qualified GP.

6) Vaccination and Locum Work:

Being involved in vaccination clinics has some but limited educational benefit. Practices need to discuss where GP Registrars are best employed and I would suggest they are better placed in a clinical decision making environment consulting with patients. Some involvement may be justified after discussion with the trainee.

Any additional work outside the normal training attachment counts as locum work and would need the approval as previously discussed:

1) Approval of host Clinical Supervisor as potentially outside work affects risk assessment
2) Approval of Educational Supervisor as a trainee should be making good progress to contemplate additional work
3) Approval of the Lead Employer as they need to be aware of additional work

7) Educational Supervisor Review and ARCP:

Most trainees will be due an ESR in the next few weeks. For those that have an ARCP they will need a full ESR but if there is not an ARCP in the next 2 months then this can be an interim ESR provided progress is satisfactory. If there are any concerns then a full ESR should be completed.

The Trainees needs to make it clear whether they are following the new regime for Work Place Based Assessments or the old regime. For ST3 trainees coming up to CCT before Feb 2021, either in normal time or on an extension, it would be sensible to consider remaining on the old regime.

The old regime is very different to the 14F regime. Consider uploading the Guidance of WBPA 2020.

WBPAs were stopped for the period Feb 2020 to end of July 2020 but recommenced in August 2020. It is important to ensure that as a trainee you are adding evidence of development since August by learning logs and WBPAs over the last few months.

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You need to ensure that you are on track with the WBPAs although the absolute total can be quite complicated for those coming up to CCT. It would be best to err on the safe side and ensure that you have more than the minimum and that there is current evidence of your capabilities.

As previously stated, there is no absolute OOHs requirement but there should be evidence of Competence for Urgent and Unscheduled Care. What exactly is required for any individual trainee needs to come from discussion with the educational supervisor.

These are some of the issues raised at recent meetings with trainees and trainers. I hope that offers some clarity and reassurance for everyone involved in Training. Thank you again for your on-going support which has produced a high standard of education at an incredibly challenging time for General Practice. The GP School continues to recruit new trainers and new training practices so please promote training to your colleagues as it is incredibly satisfying and stimulating as well as being vital to sustain the future workforce.

David Palmer

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