

Foundation Doctor Role and Responsibilities within the Local Education Provider and Minimum Requirements for Clinical Supervision of Foundation Doctors

Introduction

1. Foundation Doctors (FDs) carry out many 'clinical' and 'non-clinical' duties, most of which are essential for their further education and training. It is essential that the role and responsibilities of the FD are clear, tasks assigned to them are appropriate, and clinical supervision is provided at all times.
2. This document has been produced to:
 - a) define the role and responsibilities of FDs
 - b) guide LEPs on appropriate and inappropriate duties for FDs
 - c) define the minimum requirements of clinical supervision for all FDs working within the three London and KSS foundation schools.
3. LEPs should review their adherence to this policy and take immediate action if variations in practice are identified.
4. It is important that all supervisors and other staff working with FDs are familiar with the policy before they are assigned to supervise and assess a FD.
5. The policy applies to both years of training, with advice if it differs between F1 and F2.
6. The three London and KSS foundation schools will monitor LEP adherence to this policy through their quality management processes.

The Purpose of the Foundation Programme

7. The programme is designed to bridge the gap between undergraduate and specialist medical training. The ethos of training is to provide a generic learning environment in different specialties which builds upon undergraduate training and allows FDs to demonstrate overall performance in the workplace rather than competence in isolated test situations.
8. The programme aims to allow FDs to develop the competences, attitude and clinical skills of good medical practice (<http://www.gmc-uk.org/guidance/index.asp>) and allow them to achieve the outcomes required to enter the professional register at the end of F1 (<http://www.gmc-uk.org/doctors/index.asp>) and enter specialty training at the end of F2.

Role and Responsibilities of FDs

9. It is a LEP responsibility to ensure that all staff involved in training FDs are aware of the defined roles and responsibilities of FDs.
10. It is also a LEP responsibility to provide a written job/placement description which specifies the roles and responsibilities of FDs completing the placement.
11. Changes of department or employer: Foundation doctors new to a department and/or trust must receive adequate induction before starting work, including starting at night. Individual arrangements should be made as necessary to enable this, especially when a doctor is

working up to the end of their contract at one trust and starting immediately elsewhere. The overall hours worked should continue to be compliant with the Junior Doctor contract.

12. The main role of the FD is to deepen and broaden their knowledge and clinical skills through a mixture of teaching opportunities, hands-on experience on the wards/in the community and series of assessments to achieve the competences outlined in the FP Curriculum (<https://foundationprogramme.nhs.uk/curriculum/>). To fulfil this role FDs are responsible for:
- ✓ revisiting clinical and professional practice, and studying at increasingly complex levels
 - ✓ practising with decreasing supervision
 - ✓ building on existing levels of understanding
 - ✓ recognising that levels of expertise generally increase with practice and reflection
 - ✓ practising in a way which makes patient safety paramount
 - ✓ working closely with doctors in specialty teams and with nurses and other associated healthcare professionals
 - ✓ attending all mandatory professional development teaching sessions and attending FP-specific teaching arranged by their LEP
 - ✓ completing all the assessments outlined in the Assessment Guide for FDs: <https://foundationprogramme.nhs.uk/curriculum/assessments/>
 - ✓ meeting supervisors on a regular basis to identify personal learning needs and discuss plans on how to meet them
 - ✓ ensuring that their own health does not pose a risk to patients in accordance with the GMC's Good Medical Practice
 - ✓ managing their own learning, using the support structures within their LEP and the Foundation Programme Horus e-Portfolio
 - ✓ supporting the quality of training, by completing surveys and attending quality management visits

Learning Priorities for FDs

13. FDs are required to obtain theoretical and practical knowledge and competences in the following areas:
- ✓ Good Clinical Care
 - ✓ Maintaining Good Medical Practice
 - ✓ Relationships with Patients and Communication
 - ✓ Working with Colleagues
 - ✓ Teaching and Training
 - ✓ Professional Behaviour and Probity
 - ✓ Acute Care
14. The main learning priorities for F1 Doctors should be:
- ✓ diagnosis and clinical decision making
 - ✓ effective time management, prioritisation and organisational skills
 - ✓ clinical accountability, governance and risk management
 - ✓ safe prescribing in clinical practice
 - ✓ the frameworks needed to ensure patient safety
 - ✓ legal responsibilities in ensuring safe patient care
 - ✓ the recognition of diversity and cultural competence
15. The main focus for F1 doctors should be training in the assessment and management of the acutely ill patient.

16. The main additional learning priorities for F2 Doctors should be:
- ✓ decision making through communication with patients
 - ✓ team-working and communicating with colleagues
 - ✓ understanding consent and explaining risk
 - ✓ managing risk and complaints and learning from them
 - ✓ being aware of ethics and law as part of clinical practice
 - ✓ using evidence in the best interest of patients
 - ✓ understanding how appraisal works to promote lifelong learning and professional development
 - ✓ undertaking small group teaching, including a presentation
17. It is expected that LEPs and individual departments consider the above when assigning duties to FDs or designing educational teaching programmes.

General and Clinical Duties Expected of FDs

18. Taking into account the above, FDs are expected to carry out clinical duties which include:
- ✓ history taking, examination and differential diagnosis
 - ✓ management of acute and chronically ill patients and diagnostic testing
 - ✓ clinical skills e.g. venepuncture, arterial blood gas sampling
 - ✓ assessment of patients arriving for elective admission
 - ✓ effective communication skills and counselling including breaking bad news
 - ✓ co-ordinating treatment and investigative procedures
 - ✓ discharge planning
19. FDs should note that they may occasionally be required to perform duties in emergency and unforeseen circumstances at the request of their supervising consultants but these are exceptional and should not be required for prolonged periods or on a regular basis.

Tasks Considered to be beyond the Competence of FDs

20. FDs should only assume responsibility for or perform procedures in areas where they have sufficient knowledge, experience and expertise.
21. Specific conditions apply to the following procedures/duties in relation to FDs:
- a) **Site or side marking for procedures to be carried out by others**
It is the responsibility of every supervisor and other medical professionals to ensure that FDs are never asked to site or side mark. This is the responsibility of the person carrying out the procedure.
 - b) **Prescription, transcription and administration of drugs**
It is the LEP's responsibility to ensure that FDs and their supervisors are fully aware of the risks and responsibilities associated with the prescription, transcription and administration of drugs. The following should be noted:
 - ✓ F1 Doctors are not allowed to prescribe, transcribe or administer cytotoxic drugs or immunosuppressants (excluding corticosteroids).
 - ✓ F2 Doctors should never initiate or administer cytotoxic drugs or immunosuppressants (excluding corticosteroids). Specialist units which provide training for FDs may apply for an exceptional variance of this directive to the Foundation School Director. Variances for the administration of cytotoxics will **not** be granted which would permit a FD's

participation in administrations via the intrathecal route, nor, without evidence, that for other routes:

- The experience forms part of a defined programme of training and is not a routine duty
 - Agreed protocols are in place, which include formal, supervised and certificated experience
 - An appropriately trained senior doctor or nurse is always present
 - The delivery of treatment is during the day and does not depend upon the presence or absence of the FD.
- ✓ It is the responsibility of the LEP to ensure that the F2 Doctor has been trained in the relevant procedure, and his/her competency has been proved through assessments, before being allowed to prescribe or transcribe cytotoxics.

c) **Obtaining consent for procedures**

Consent is the responsibility of the doctor undertaking an investigation or providing treatment. If this is not practical, responsibility can be delegated to someone else but the following must be taken into account when asking FDs to obtain consent:

- ✓ F1s are not allowed to take consent for procedures that they cannot/do not perform (for example endoscopy, radiological procedures, surgical operations)
- ✓ If a F2 is not capable of carrying out a procedure, s/he may **only** obtain consent for it when documented as trained to do so, under direct supervision, or under specific delegation from the experienced doctor carrying out that procedure. It should be also ensured that the role of the FD in the consent process has been discussed and is clearly understood.
- ✓ The doctor who delegates the obtaining of consent will still be responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent before any investigation or treatment starts

The three London and KSS Foundation Schools expect LEPs to have formal policies in place governing consent, and to audit compliance at regular intervals.

Appropriate and inappropriate duties for FDs

22. It is the responsibility of every supervisor and other medical staff member to ensure that FDs only undertake appropriate duties and those with no educational value (e.g. portering) are not assigned to them.
23. It is expected that the LEP and individual departments have a defined training process and a method of assessing and recording competency, in addition to the list of competences in the Foundation Programme Curriculum, for clinical procedures which may be appropriate for improving general practical clinical competence during the particular placement. Such procedures, however, may be deemed inappropriate if they are a little more complex and the FD is unlikely to need that skill again.
24. The following procedures are considered **appropriate** for FDs (see also paragraphs 25 and 36) after they have been trained to do so:
 - ✓ Urethral catheterisation
 - ✓ Venepuncture
 - ✓ Cannulation
 - ✓ Blood culture taking

- ✓ ECG taking
- ✓ IM injections
- ✓ SC injections
- ✓ IV injections (note: not cytotoxics etc.)
- ✓ Arterial blood gas sampling
- ✓ Oxygen therapy (starting on nasal specs, to venture masks, to 15L non-rebreather)
- ✓ Starting and administering nebuliser therapy
- ✓ Performing spirometry
- ✓ Taking all basic observations including HR, temperature, BP and oxygen saturation
- ✓ BM testing (only if confirmed as competent within the LEP)
- ✓ Setting up an IV infusion
- ✓ Performing CPR
- ✓ Using airway protection devices
- ✓ Nasal packing for haemorrhage
- ✓ Straightforward suturing
- ✓ Bladder scanning
- ✓ Femoral venous blood sampling
- ✓ Femoral arterial blood sampling
- ✓ Femoral nerve blocks
- ✓ Joint aspiration (knee only)
- ✓ Skin biopsy

25. Locums: Provisionally registered (F1) doctors may only do locums/additional shifts within their employing trust and in a unit or specialty in which they are currently working or have previously worked. Adequate on-site supervision must be available at all times, and overall hours compliant with the Junior Doctor contract.

26. The following may be undertaken by FDs **if appropriately supervised:**

- ✓ Pleural fluid tube drainage under ultrasound guidance
- ✓ Ascitic drainage (therapeutic)
- ✓ Sigmoidoscopy
- ✓ Central line insertion under ultrasound guidance
- ✓ Inserting a naso-gastric tube or naso-gastric enteral feeding tube and confirming safe placement
- ✓ Ascitic tap (paracentesis) for diagnosis
- ✓ Pleural tap for diagnosis
- ✓ Removal of chest drains
- ✓ Femoral lines
- ✓ Arterial lines
- ✓ Lumbar puncture
- ✓ Proctoscopy
- ✓ Virtual patient reviews by tele-medicine

27. It is expected that supervisors and other personnel working with FDs ensure that a number of routine duties which provide the basis for the development and refinement of essential clinical skills do not feature **to an inappropriate extent.** Where the following duties do not make an essential contribution to the education of the FD, the duties should not be assigned to them:

- Venesection
- Siting and resiting cannulae
- Phlebotomy support for dynamic endocrine function tests

- Clerking patients attending for day case surgery or outpatient procedures such as endoscopy/angiography - limited involvement would be permitted where there is a demonstrable educational component such as attending the procedure.
- Supervising ECG exercise stress tests. - In appropriate circumstances, FDs may supervise tests being carried out on their own in-patients, but only after appropriate training in observation, interpretation and resuscitation.
- Lengthy discharge summaries, over and above an initial discharge letter
- GP home visits, unless there is an educational purpose.

28. The following duties are **not the responsibility of FDs** and should never be assigned:

Clinical duties

- Routine phlebotomy, or compensating for regular shortfalls in the phlebotomy service
- Administering contrast media, unless the FD has been directly involved with the assessment of the patient, and only after training in the management of anaphylaxis
- Warfarin level assessments in coagulant clinics

Non-clinical duties

- Routinely collecting or delivering requests and results of investigations
- Finding beds for emergency and routine admissions/portering duties
- Filing and other strictly clerical work
- Explaining cancellation of admissions
- Negotiating patient placements with social service departments unless this is part of their training on discharge arrangements as part of a Multi Disciplinary Team

Minimum Requirements for Clinical Supervision of FDs

29. FDs should never be left without adequate on-site clinical supervision which must be immediately available in person and not just by telephone or telemedicine.
30. Out of hours working, including nights, can provide useful experience for both F1 and F2 doctors. The required on-site supervision can be provided by the trainee working as part of a well-constituted hospital at night team. (As shift working often impacts on daytime educational opportunities, no more than 2x4 month placements of the year should include frequent night shifts).
31. Every FD must have a CS allocated for each placement who is responsible for ensuring that the FD is appropriately supervised, supported and is only assigned appropriate duties.
32. All CSs must have had adequate training and be aware of their responsibilities for patient safety. The FTPD should be notified in writing if the CS will be absent for more than 2 weeks and assign an alternative CS.
33. If the CS is temporarily unavailable, supervision should be transferred to a trained practitioner but the CS will retain overall responsibility/accountability for patient care and the FD.
34. The CS should link the level of supervision to the competence and experience of the FD.
35. The CS must assess and deem FDs competent before allowing them to perform procedures without direct supervision.

36. The CS (including GP CS) is responsible for ensuring that:
- ✓ There is always appropriate cover (e.g. middle-grade doctor or specialist nurse) available for the FD. Individuals providing cover should be competent in the activities being supervised, available and comfortable with this responsibility.
 - ✓ FDs have access to the clinical guidelines
 - ✓ FDs have access to a consultant/GP for help and advice on the management of a patient at all times and there is a back-up system in place for supervision and support
35. The GP CS should only ask a FD to undertake a home visit alone when competent to do so, the safety risk is low, and the FD has appropriate clinical equipment and a fully charged mobile.

Quality Control of Clinical Supervision, Support Provided and Duties Allocated to FDs

36. The LEP has ultimate responsibility for compliance with this policy. There must be clear mechanisms in place to monitor and thereby ensure that FDs are adequately supervised and supported at all times and only undertake duties they are competent to perform and which have educational value. This responsibility extends to all placements delivered in and out of the main hospital (e.g. GP placements).
37. Feedback on the clinical supervision and support provided, as well as duties allocated, should be sought from FDs on a regular basis and considered at Local Faculty Groups. At Foundation School and LETB level compliance will be monitored during LEP Quality Management Visits, feedback from LEP F1 and F2 trainee representatives and via questionnaires – national, pre-visit and end-of-placement.
38. The LEP must take immediate action if a lack of clinical supervision or support for FDs is reported or discovered.