Supporting Trainers, Supporting Doctors, Supporting Patients: progress since the postgraduate medical foundation programme review.

In 2018–2019 the HEE Foundation Programme Review heard evidence from a wide range of stakeholders, including foundation doctors, about the difficulties faced by those entering foundation training from medical school. A number of recommendations were made and this pack outlines progress and contains practical information to assist with implementation.
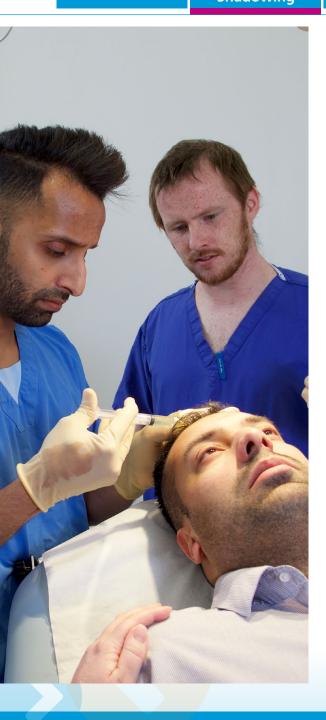
Contents

1. Guide to Foundation Year 1 Shadowing

Recommendation 1 pledged to help improve the transition process in order to better prepare foundation doctors for the next stage of their development. The first section of this pack, the guide to shadowing, is an important part of this effort.

Background

Allowing a new employee to shadow an experienced team member is a widely used approach to help the individual become familiar with their new working environment, understand their responsibilities, absorb the norms of the organisation, build relationships with co-workers and focus their professional skills.

In the context of Foundation Year 1 (F1), the shadowing period aims to help equip recent medical graduates with the local knowledge, skills and attitudes needed to provide safe, high-quality patient care, from their first day as an F1 doctor. It builds on the core professional skills learnt in undergraduate medical education including student assistantships.

We consider this best practice guidance for 2020 but, from 2021 onwards, there is an expectation that the contents of this document will be standards against which Local Education Providers (LEPs) will be measured as part of HEE's Quality processes.

The process is endorsed by NHS Employers and by HEE.

Aims

1) Ease the transition from undergraduate to postgraduate training
2) Improve patient care and safety.

Structure

The F1 programme commences on the first Wednesday in August for the vast majority of F1 doctors. Shadowing takes place in the four working days before this, typically Thursday, Friday, Monday, Tuesday although many Trusts require the F1 to attend a day before this (the last Wednesday in July) to allow the new F1s to complete mandatory training.

Any F1 doctor who, due to exceptional circumstances, cannot be available to undertake the four-day shadowing period must inform their foundation school manager and Local Education Provider (LEP) at the earliest opportunity so that, if at all possible, alternative arrangements can be made.

In England, the four days of shadowing are funded by HEE and should not be used for other purposes, such as statutory/mandatory training.

During the shadowing period, employing organisations should offer a locally tailored programme that includes at least 50 per cent shadowing clinical activity. Where the F1 role requires it, this must include exposure to 'out-of-hours' and/or emergency cover and, whenever possible should include at least one full shift or clinical day during which the F1 should assume a degree of clinical responsibility under appropriate supervision. Where ongoing clinical care is required, a handover of patients and responsibilities must occur between the outgoing F1 and the incoming doctor on the last day of the shadowing period to facilitate safe continuity of care. Any non-ward-based induction component should comprehensively cover those aspects of induction essential to undertake shadowing and fulfil their F1 responsibilities.

Learning objectives for shadowing are given in **Appendix 1**.

Incoming F1s should shadow the current F1 doctor (who is about to leave the post) and Trusts should, where possible, ensure the F1 doctor is available to facilitate the shadowing. If this is not possible, the department must identify a suitable substitute.

Standards of Implementation

Below expected standard	Baseline	Good	Excellent
Less than 16 hours in clinical area

No handover | 16 hours in clinical area

Timetabled handover period on final day of shadowing | 2 full days/shifts in clinical area

Scheduled and protected handover period on final day of shadowing

Out-of-hours experience where necessary

Policy to limit all but essential F1 leave at time of shadowing | Direct involvement/ oversight of Non-Executive Director (NED) with responsibility for education in planning and implementation

Current trainees used in design and delivery of shadowing programme |

Appendix 1:

What knowledge and experience should a new F1 expect to gain in their shadowing period?

General

Employers should allow a reasonable amount of time for the F1s to become familiar with what will be their new working environment and allow them the opportunity to become familiar with the local processes. This should include but is not limited to:

• Knowledge of hospital layout including mess, canteen, rest areas, parking, etc
• Access codes for and training on IT systems
• Meeting the postgraduate team (including the educational supervisor (ES) and clinical supervisor (CS) if possible)
• Meeting the rota coordinator and understanding how to request leave
• Meeting the medical staff/HR leads to understand their contract of employment
• Meeting with payroll to understand payslips and tax. **Please refer to the BMA's understanding of your payslip guidance here.**
• Meeting the Guardian of Safe Working Hours (GoSWH) to understand the protocol if the limit on hours are breached and to understand the exception reporting process
• Understanding how to report incidents and escalate concerns
• Introduction to the eportfolio
• Understanding the local safety procedures – fire, sharps injury procedure, local safeguarding, etc.

More information from NHS Employers about contractual arrangements on shadowing can be found here.

The shadowing experience in the clinical environment should consist of the following:

Meeting the wider team and key clinical staff:

- The consultant who leads the team
- Other doctors who will supervise them (e.g. registrars, core trainees, etc)
- Senior nursing staff
- Administrative staff
- How to access information/guidelines, etc
- Understanding the day-to-day ward routine
- The doctor's role in the team and the arrangements for their workplace supervision, including how to access advice or hands-on support at any time it is needed

Ward rounds

- Compiling lists/assimilating information
- Presenting information
- Writing notes

Routine jobs

- Procedures (including patient identification)
- Ordering investigations and following up results
- Speaking to patients and their relatives
- Prescribing drugs and fluids, including To Take Out drugs (TTOs)
- Routine patient reviews and how to record them
- Preparing for discharge, writing discharge summaries and arranging follow up

- Requesting and understanding feedback
- Attending a departmental meeting/teaching session/multi-disciplinary team (MDT) if possible
- Death certification, mortuary, coroner, bereavement office, do not attempt resuscitation (DNAR)

The hospital out-of-hours (where relevant)

- Roles and responsibilities out-of-hours
- Formal and informal handover arrangements, including at the beginning and end of each shift and, where applicable, the mid-shift huddle
- Reviewing new problems in existing patients
- Foundation doctors required to work during the overnight period should be given information about the arrangements for accessing food and drink
- Where foundation doctors are required to work during the overnight period, information about the location of rest facilities and how to access them should be given

Emergency work (where relevant)

- Carrying a bleep with appropriate supervision
- Assessing and admitting patients
- Recognising comorbidities including mental health issues
- Understanding urgency and accessing senior support
- Formulating management plans
- Reviewing impact of interventions and adapting plans
- Referring to therapists/between team.

Appendix 2:

Preparing for Professional Practice 2020 Programme (Example programme)

(With thanks to Leeds Teaching Hospitals NHS Trust who provided us with a sample in order to create this)

Day 1	
07:30 - 08:30	**Arrival/registration and housekeeping**
08:30 - 09.45	**Welcome talks** Introduction 8.30-8.40am 8.40am Medical Director/Chief Executive 8.50am Medical Education Manager/DME 9.00am Senior HR Advisor (PSU) 9.10-9.45 Fire Officer
09:45:- 10.30	**Hospital tour**
10.30- 11.00	**Take time/guardians of safe working meeting ALL GROUPS**
11.00 - 16.30 (Including breaks)	**Group sessions:** 1) Organising leave Employee contract/disciplinary processes/payslip Incident reporting 2) Meet supervisors and outgoing F1s Visit home ward and meet key staff Understand the escalation procedure Introducing feedback and the eportfolio NB: this might involve meeting with teams from outside the base LEP 3) Using the IT systems/IT access/information governance
16.30-17.00	**The hospital out-of-hours (site practitioner/coordinator)**
18.00 - 20.00 approx	**Curry evening (optional)**

Appendix 2 Continued:

Preparing for Professional Practice 2020 Programme (Example programme)

Day 2	
09:00 - 17:00	**Shadowing on the wards (see below for aims)** **(Exact times to fit with clinical teams)**

Day 3	
09:00 - 17:00	**Shadowing on the wards** **NB: Time should vary to include some out-of-hours if needed** **e.g. 1100-1900** **(see below for aims of out-of-hours/emergency work)**

Day 4	
09:00-13:10	**Training carousel (in groups): (sessions will vary depending on local needs)** Resus refresher Using investigations effectively Prescribing/TTOs Asepsis in procedures and infection control Writing in the notes Death certification Verbal communication and handover Written communication and discharges Local Safeguarding Processes DNAR
13:30-14:00	**'On your way talk' - all groups F1 Training Programme Director (TPD)**
14:00-15:30	**Handover on the ward from clinical teams**

2. Foundation Doctor 'Quality Charter' and Good practice Guidance

Recommendation 4 of the Foundation Programme Review was to develop a 'quality charter' to define how Local Education Providers (LEPs) can support foundation training and which would include best practice and minimum standards. Many of the measures set out in the charter are based on innovations and practices already in place at some trusts. We have also included guidance for employers on how best to implement the charter.

We consider this best practice guidance for 2020 but, from 2021 onwards, there is an expectation that the contents of this document will be standards against which Local Education Providers (LEPs) will be measured as part of HEE's Quality processes.

Ensuring safe and effective care

1. **High quality induction**

It is important that LEPs try and ensure that a thorough clinical induction is provided every time a foundation doctor rotates into a new clinical area. This is particularly so when the FD is rotating between different hospital sites or other providers part way through the training year, for example when moving from a community placement back into an acute trust. Methods to consider are to roster the induction into the foundation doctor's work schedule and to aim for it to take place before the doctor starts clinical work in the new area.

2. **All staff to be familiar with the level of competency of foundation doctors**

LEPs must ensure that staff working with foundation doctors are aware of their limited experience and do not ask them to carry out tasks that are above their level of competence.

3.   Workplace supervision

Foundation doctors need to be made aware of who is available within the workplace to provide them with advice and, if required, hands-on support. This support should always be readily available and easily accessible.

4.   Out-of-hours working

It is a good practice to have a **handover** at the start and end of every shift and that, where appropriate, that handover is multi-disciplinary and confirms the workplace supervision arrangements for the shift.

Where possible, LEPs should promote the use of **a mid-shift 'huddle'** – a pre-arranged time for foundation doctors to meet and touch base with their supervising seniors to discuss workload and any concerns, including arrangements for bleep-free breaks.

The promotion of **hospital-wide coordination** and fair distribution of out-of-hours workload is also beneficial, for example using 'Hospital at Night' arrangements for evenings and weekend daytimes as well.

5.   Adequate support for tasks

It is important that LEPs ensure that the availability of support staff (e.g. phlebotomists and physician's assistants) is matched to clinical need during the main working week and out-of-hours.

6.   Standardisation of equipment

All relevant clinical areas should have an adequate stock of equipment used for simple procedures such as urethral catheterisation, venous cannulation and blood-taking. Solutions such as the use of pre-made packs or easily accessible, clearly organised and well-stocked trolleys should be considered for specific common procedures. The location where this equipment is stored on wards should be standardised across the hospital.

Creating a supportive environment

7. **Appropriate electronic resources to support working**

Whenever possible LEPs should use electronic resources to support the efficient working of foundation doctors, particularly out-of-hours. Examples include use of electronic prescribing and electronic systems, such as smartphone-based task allocation systems, to allocate work out-of-hours.

8. **Facilitation of rest periods when working out-of-hours**

Coordination of the out-of-hours workload should also ensure protected time is identified for foundation doctors to rest, with their bleep being taken by another team member during this time.

9. **Adequate facilities for food and drink available on-site 24 hours per day**

Access to hot and cold food and drink should always be available.

10. **Dedicated quiet areas for rest when working overnight**

11. **Trusts should facilitate the development of peer or near-peer support networks for FDs.**

Improving educational experience

12. **Educational and named clinical supervisors to be trained for the role, proactive and readily available (and need job-planned time for these roles)**

13. Self-development time

Factoring self-development time (SDT) into foundation doctors work schedules is important. SDT is formally rostered time for carrying out non-clinical activities that are essential curricula requirements. It is advised that foundation year 2 doctors should receive on average two hours per week and, where possible, foundation year 1 doctors should be allocated one hour per week.

14. Repetitive tasks

Good practice dictates that foundation doctors are not expected to perform inappropriate or excessively repetitive tasks of little educational value. For example, all FDs expect to write discharge summaries, but it would not be appropriate for them to regularly write large numbers of discharge summaries for day-case patients in whose care they have not been involved.

15. Educational programmes for foundation doctors

Wherever possible, foundation doctors should be involved in the development and annual review of their trust-based foundation teaching programmes.

Teaching programmes should cover the breadth of medical practice, not just hospital-based medicine. Community-based doctors and mental health specialists should contribute to the development and delivery of the programme.

All formal foundation teaching sessions should be bleep-free and where possible departments should endeavour to ensure routine work is suspended at times of departmental educational meetings to allow FDs to benefit from these.

16. Simulation-based training

Foundation doctors should receive simulation-based training at least three times per year. This should have learning outcomes based on the foundation programme curriculum, could encompass both in-situ and simulation centre-based learning and ideally will be part of multi-disciplinary learning.

Good practice Guidance

The good practice guidance set out below are relevant for 2020 but are likely to be updated for 2021. Some of the guidance has been drawn from HEE's **Enhancing Supervision Programme** that engaged with a large number of doctors in training as well as educators.

	Below expected	Baseline	Good	Excellent
Induction/ shadowing	Poor quality or shadowing period less than 16 hours in clinical areas. Poor quality or no hospital induction Poor quality or no departmental induction Alternative arrangements not made for those not rostered to work at time of induction.	Clear introduction to departments in protected time. Shadowing programme with >=50% (16 hours) in clinical areas and handover period on final day. Induction includes introduction to key personnel, supervision arrangements, access to guidelines, appropriate IT training, arrangements for routine and out-of-hours (OOH)/emergency work as well as employment issues such as rota management, booking leave, parking arrangements etc.	Clear induction programme to reflect needs of new doctors including their personal wellbeing. Use of staged training to ensure coverage. Feedback sought on hospital &/or departmental induction, and used to design future programmes Policy to limit all but essential F1 leave at time of shadowing. Shadowing involves out-of-hours time if appropriate to role.	Current trainees used in design and delivery of shadowing &/or induction programme Induction includes introduction to Trust's wellbeing team or equivalent
Workplace supervision/ escalation of concerns	Trainees not clear who to contact immediately in the event of a clinical concern; trainees unable to identify which senior clinician is in supervisory role on each shift	Trainees have clearly identified senior clinician to escalate concerns to during a shift, GP surgery and (specifically for F2s in GP) a home visit Key staff familiar with levels of experience of foundation doctors Guardian of safe working in post	Clear, regularly updated and accessible departmental guidance on how to contact senior responsible clinician Governance structures in place around escalation of concerns about patient safety AND about quality of supervision All staff familiar with levels of experience of foundation doctors	Regular 'check-in' on foundation trainee by those providing workplace supervision Easy access to high-quality SLEs Rostered debrief at end of shift Regular comprehensive and constructive feedback to foundation doctors about their performance from members of the multidisciplinary team

Good practice Guidance (continued)

	Below expected	Baseline	Good	Excellent
Out-of-hours working	No or only ad-hoc handover arrangements No food or drink available No rest areas available	Timetabled handover between shifts OOH food and drink available Dedicated quiet and rest area for those working overnight Specific parking arrangements if required	Supervised handover between shifts Mid-shift huddle Hospital wide coordination of OOH work (e.g. H@N) at night and at weekends. OOH food and drink caters for differing needs (e.g. gluten free, halal, vegetarian)	Organised system of breaks Rostered debrief at end of OOH shift
Adequate support for tasks	Foundation doctors have to perform excessive numbers of repetitive tasks e.g. routine phlebotomy, venous cannulation	Daily phlebotomy service Clinical areas well stocked and standardised layout of equipment PPE available as required Few excessively repetitive tasks Access to adequate administrative support for records management	Good use of electronic resources (smartphone based task allocation, electronic prescribing) Assistance with tasks as needed (e.g. 9-5 phlebotomy service, site practitioners able to undertake cannulation)	Development of roles to help foundation doctors (e.g. doctor's assistants, PAs, nurse practitioners)
First contact with educational supervisor	First meeting takes place more than 6 weeks after starting post	First educational supervisor meeting within 6 weeks of starting post	First educational supervision meeting within 2 weeks of starting post	Supervisor makes personal contact with supervisee before start of post
Frequency of educational supervisor meetings	No evidence of meeting at start and/or end of post	Documented meetings only at start and end of post	Documented meetings at start, middle and end of post	Additional meetings as per trainee needs / request

Good practice Guidance (continued)

	Below expected	Baseline	Good	Excellent
Supervisor training	No evidence of having engaged with formal training in supervision Supervisor not aware of how to support a trainee who has been involved in a serious incident (SI) or complaint	Evidence of all supervisors within department attending an externally accredited educational supervision course specific to foundation training	Additional / ongoing training and evidence of CPD in supervision for all supervisors (1 piece of CPD in one year; 3 different types of CPD in 5 years)	Actively providing developmental opportunities for senior registrars or GP specialty trainees in providing supervision. Supervisors cover all domains of AoME standards each revalidation cycle.
Educational supervisor (ES) role and clinical supervisor (CS) role	ES changes with every rotation No evidence of supervisor having protected time for supervising trainees Supervisor allocated too many trainees to supervise adequately (more than 4 trainees) Trainees / trainers not aware of the difference between educational and clinical supervision roles in terms of support and purpose	Trainee has a consistent ES over the course of one year of equivalent full time training (during which they may change posts more than once) Supervisor has 1 hour allocated in job plan per week, per trainee for supervision NB: each trainee should have equivalent of 1 hour per week, or 4 hours per month, combined educational and clinical supervision time over the course of their placement. This allocation covers meetings, SLEs, portfolio work, ARCPs etc. Use of placement supervision group	Supervisors participate in annual 360 degree appraisal from supervisees Evidence that supervisor is receiving 0.25PA (1 hour per week) per trainee protected time for supervision Where educational and clinical supervision is provided by same individual, trainees signposted to mechanisms by which they can access alternative support if they have concerns about raising an issue that could affect their training progression	Provision for ES / supervisee to maintain longer term supervision relationship (more than one year in duration) Department / training programme has a designated lead for wellbeing or pastoral support that any trainee can approach with concerns they feel unable to raise with their clinical or educational supervisor Group supervision models e.g. Balint Groups, Action Learning Sets used as an additional form of supervision Use of PSG in all placements
Content of meetings (evidenced in trainee's eportfolio)	Bare minimum of documentation in eportfolio	Trainee's training needs documented	Personal development plan created in first meeting, agreed and co-signed by supervisor and trainee Personal development plan referred back to over course of supervision relationship	Holistic approach to trainee's needs – personal goals considered as well as educational and training needs

Good practice Guidance (continued)

	Below expected	Baseline	Good	Excellent
Governance around supervision	No evidence of governance structure for supervision	Supervision (workplace/named clinical/educational) discussed at Local Faculty Group	Mechanisms in place to escalate issues in supervision from Local Faculty Group to DME and Board level Supervisors participate in annual 360 degree appraisal from supervisees Active involvement of NED with responsibility for education	Separate educational appraisal/ meeting for those with educational responsibility or clear structure to include this explicitly in annual appraisal.
Self-development time	None	2 hours/week for F2s	1 hour/week for F1s 2 hours/week for F2s Clear policy to support efficient use of SDT	1 hour/week for F1s 3 hours/week for F2s
Programme of peer or near-peer support	None	Approved trainee lead programme or formal arrangements.	Clear structure of support and training for buddies or mentors.	Constructive feedback sought about buddy/mentor system
Relevant educational programme	Foundation doctors regularly unable to attend teaching programme	Sessions planned and mapped to curriculum and level of training 3 sessions of simulation per year Feedback on sessions sent to those who have been involved in delivery	All FDs able to attend each session (protected time and/or repeated sessions)	Foundation trainees actively involved in design of programme

3. HEE Beyond Foundation website

HEE's Beyond Foundation website puts trainees in touch with resources, information and support for doctors who choose to take time out between foundation and specialty training. This includes links to HEE's Supported Return to Training resources, contacts for health and wellbeing advice, and information on relevant policies and procedures. The information is provided by HEE's local offices, who will be able to help doctors with individual queries.

4. An introduction to the eLfH supervisor modules

The Foundation Programme Review heard that a high-quality, supportive environment with strong supervision ensures the safety of both doctors and patients and guarantees the highest standards of training. Such an environment also improves the recruitment and retention of doctors, and improves the wellbeing of all healthcare staff working on those wards. Although many individuals are involved in the development of a foundation doctor, the educational and clinical supervisor play key roles in terms of guidance and support It is important to ensure that they are trained to identify and meet the needs of those going through this level of medical training.

Recommendation 12 holds that LEPs must ensure that foundation supervisors are valued and have appropriate training and skills and specific time allocated for their roles. This has been explored through many routes. Appreciating that online learning is accessible to all and sets a consistent message, HEE committed to reviewing the online modules available to foundation educational and clinical supervisors that are hosted on eLfH. HEE has been working with eLfH to review the existing supervisor modules to ensure they are appropriate and reflective of what is required and is working to keep them updated. The modules have also been reviewed to see identify gaps in training so that new content can be developed and so that they are accessible to all.

The modules on eLfH appropriate to foundation training are available here.

As well as reviewing the content and developing new modules as above, HEE is working with eLfH to 'repackage' the content so that there is a link within eLfH that is titled 'Foundation Supervisor Modules' and steers those to the most relevant modules. These modules will be reviewed periodically so that they remain up to date over time.

5. Mentorship and Peer to Peer support

The Foundation Programme Review's recommendation 13 proposed that senior trainees should be encouraged to take on the role of mentors with Trusts modelling their programmes on successful schemes already underway. HEE is working with the Academy of Medical Royal Colleges (AoMRC) to advance plans for senior trainees to support more junior colleagues in both a formal and informal way.

Peer and near-peer support

This kind of support is usually given on a voluntary or ad-hoc basis or as part of the 'leadership role' taken on by senior trainees supervising more junior colleagues in the clinical environment and other related areas such as research, QI etc. Alongside this, the support of established peers or near-peers can be beneficial both in terms of ease of approachability and ensuring an understanding of the practical day-to-day issues of which senior clinicians and supervisors may be unaware. Tailored support may also be beneficial in terms of reducing differential attainment for instance because of ethnic background, **as highlighted in this report by the GMC.**

The quality charter suggests that all LEPs establish a programme of peer or near-peer support for foundation doctors. This does not replace good induction or educational supervision and falls short of a full mentorship programme but does have many benefits in terms of helping new FDs 'find their feet' in their new workplace.

There are a number of well-established near-peer or buddying systems already in place and this guide does not attempt to replace these. Rather it aims to offer guidance on the creation of a programme where one does not exist and to provide background to help ensure the process is safe for new doctors and the near-peers who offer them support.

A good example of near-peer support is **www.welldoctors.org** which was established by trainees to support junior colleagues. The advantages of such a scheme in terms of organisational culture and the benefit in terms of professional development for those leading it are obvious. However, while in the majority of cases the relationship between the established doctor (the 'mentor' or 'buddy') and new doctor ('mentee') will be beneficial to both parties, it is possible that, in certain circumstances, a mentor might not have the skills to provide the necessary level of support required by the mentee and one or both parties might be harmed by the relationship.

While these systems are not full mentorship schemes and in many cases may provide purely pastoral support, the provision of a formal structure to the process is recommended with a degree of proper training for those in the mentoring role, clear guidance on the process (possibly including a 'mentorship' contract) and the support for mentors in the form of a senior educator with experience in dealing with trainees requiring extra support is highly recommended (more information on mentoring is given in **Appendix 1**).

Where an LEP does not have a system in place, the following process is recommended as a possible guide establishing the process:

1) To take in the 'mentor' role, trainees should have the approval of their educational supervisor or, in the case of non-training grades, their line manager/supervising consultant.

2) Mentors should be volunteers. The requirements for good mentorship are enthusiasm; a willingness to commit to and develop the role; appropriate knowledge and skills; the ability to listen; good communication skills and a willingness to feedback constructively and challenge; a positive attitude and the ability to be a good role model.

3) Mentors should undergo appropriate training for example the eLfH 'Medical Mentoring' (**Appendix 3** or **https://www.e-lfh.org.uk/programmes/medical-mentoring/**) and a face-to-face induction into the role.

4) Mentors should be allocated to mentees and should each sign a contract (see **Appendices 4** and **5**). Mentors would be expected to have a purely pastoral role and not contribute to any summative judgements on the progress of the foundation doctor they are mentoring.

5) Either party may terminate the contract at any time but a further mentor may be assigned at the discretion of the senior educator supervising the process.

6) A mentor may have one or more foundation doctors as mentees but should not be overburdened with numbers so as to affect their ability to provide good mentorship. It is envisaged that between one and three FDs would be enough for most mentors. Mentoring would take place in existing non-clinical training time.

7) Mentors must have ongoing support either from a senior educator within their employing trust who has experience of dealing with trainees who need extra support and it is advised that mentors have timetabled regular sessions to support them in this role.

8) The process of matching mentor and mentees and arranging meetings with mentors and their senior support will require some administration time.

9) Doctors who take on the role should consider it as part of their professional obligations and be encouraged to undertake further learning/training which should be supported by their own educational supervisor/training Programme Director (GMC domains that would benefit their training are given in **Appendix 2**).

Appendix 1: Mentoring

While this is not a full mentorship programme, the following provides a brief summary on the role of a mentor.

'Mentoring is to support and encourage people to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be.' (Parslow)

Activities of the facilitative mentor:

Regular contact with FD mentee, especially in the first few weeks of any placement
Source of wisdom: provide advice/signposting of resources/local knowledge from personal experience
Providing support: to maximise learning and develop resilience and capability
Critical friend: provide challenge when needed and encouragement to 'push the boundaries'
Developing problem-solving skills
Advice on goal setting and achieving: exploring professional options
Personal advocate: to encourage and support personal development and establish professional networks

More details on the mentoring process can be found here.

Appendix 2: Generic Professional Capabilities (GPCs)

Generic Professional Capabilities that might be enhanced in senior trainees by the role of mentor.

Domain 1: Professional values and behaviours

Doctors have a wide range of professional responsibilities relating to their roles as an employee, clinician, educator, scientist, scholar, advocate and health champion. These responsibilities include demonstrating the following expected professional values and behaviours:

- maintaining trust by showing respect, courtesy, honesty, compassion and empathy for colleagues
- managing time and resources effectively
- demonstrating situational awareness
- reflecting on their personal behaviour and its impact on others
- interacting with colleagues in a way that demonstrates appropriate professional values and behaviours in terms of supporting colleagues
- being able to identify and create safe and supportive working and learning environments
- being a professional role model.

Domain 5: Capabilities in leadership and teamworking
Doctors in training must demonstrate that they can lead and work effectively in teams by:
- supervising, challenging, influencing, appraising and mentoring colleagues and peers to enhance performance and to support development.
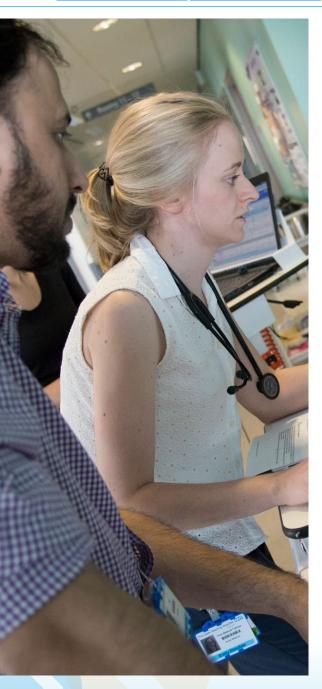
Domain 8: Capabilities in education and training
Doctors in training must demonstrate that they can:
- provide supportive developmental feedback both verbally and in writing to learners and doctors in training
- carry out the roles and responsibilities of a clinical trainer.

There is also opportunity to develop communication and interpersonal skills including empathy and compassion, active listening, cultural and social awareness, communicating effectively and sensitively, being prepared to give clear information, effectively managing challenging conversations and to develop the ability to deal with complexity and uncertainty.

For more on the GMC's expectations on doctors' professional responsibilities, including their duty of care to patients, click here.

Appendix 3: eLfH Module

---

eLfH Module

Title: Medical Mentoring

Description:
This e-learning resource has been created so that as a junior doctor you can complete the training to become a mentor to other junior doctors without the need to travel to a teaching session. It has been split up into two sections so that you can dip in and out whenever it is convenient.

Hierarchy:
Medical Mentoring (MEM) > Medical Mentoring

Keywords:
Mentoring training, mentoring, peer mentoring programme, peer, mentor, mentors, mentee, mentees, mentoring methods, mentoring models

Created:
13 Feb 2018 – **https://www.e-lfh.org.uk/programmes/medical-mentoring**

Appendix 4: Mentoring/Buddying Contract (Mentor) Courtesy of Wye Valley NHS Trust

F1-2 Buddying Scheme

I confirm that I wish to participate as a mentor in the F1 buddying scheme being run at …NHS Trust.

This will run from _____ August 20 __ – _____ August 20 __

I confirm that I am happy to be matched with   1 / 2   F1s for this purpose [please delete].

I have already or will complete the e-learning for health module on Medical Mentoring Part 1 by 1st August.

I agree that throughout this mentorship I will provide an environment that is:

- Challenging, but not critical
- Mutually respectful
- Open and honest
- Trustworthy and discreet
- Supportive

I understand that should there be significant physical or psychological issues brought up, that I must be transparent about the potential need to seek help from the F1 [or F2] Programme Director.

In August, I will ensure to offer as a minimum a meeting every two weeks and then every month for the rest of the first placement. I will check up on my mentee if I have not heard from them in a month.

I will formulate a mentoring agreement proforma as per HEE standards at our first meeting.

I am aware that a formal support group will take place, initially every month. I will attend this if I have any concerns or difficulties, but also to provide support to my fellow F2 mentors.

Signed …………………………….   Date ………………………………….

26

Appendix 5: Mentoring/Buddying Contract (Mentee) Courtesy of Wye Valley NHS Trust

F1-2 Buddying Scheme

I confirm that I wish to participate as a mentee in the F1 buddying scheme being run at …NHS Trust.

This will run from _____ August 20 __ – _____ August 20 __

I will consider completion of the e-learning for Health module on Medical Mentoring Part 1 by the end of August.

I agree that I expect an environment that is:

- Challenging, but not critical
- Mutually respectful
- Open and honest

- Trustworthy and discreet
- Supportive

I understand that should there be significant physical or psychological issues brought up, that my mentor will ask for help from the F1 (or 2) Programme Director.

In August, I will ensure to suggest as a minimum a meeting every two weeks and then every month for the rest of the first placement. I understand my mentor will check up on me if they have not heard from me in a month.

I will formulate a mentoring agreement proforma as per HEE standards at our first meeting.

I am aware that a formal support group will take place, initially every month for the mentors, where commonly faced difficulties will be discussed in a confidential manner.

Signed …………………………. Date ………………………………

6. Self-development time (SDT)

The Foundation Programme Review heard that foundation doctors can often struggle to find time to carry out essential educational activities such as completing their portfolio, reflecting on practice and meeting with their supervisors. Dedicated time, during the working week, for these educational activities and also for considering career pathways would be beneficial. HEE pledged as part of recommendation 14, to engage with key stakeholders to assess how foundation doctors can be given formal time in their working week for non-clinical professional activities which would be called self-development time (SDT).

In August 2020, all English trusts with foundation doctors were required to include self-development time in the work schedules of foundation year two (FY2) and then if possible for foundation year one (FY1) doctors. After evaluating the first year of this scheme listening to feedback from trainees themselves and the system it has been determined that from August 2021 all FY1 and FY2 doctors will have a minimum of 2 hours on average per week of SDT time. The implementation of this has been planned with the wellbeing of doctors in mind, but also with the demands that are being placed upon service provision in mind.

The SDT time is intended to be used for formal meetings with supervisors, reflecting on clinical practice and development needs, use of eportfolio, preparing/delivering teaching, quality improvement activity, career exploration and reflective practice.

For more about SDT and to read the supporting documents explaining its intended uses please visit **www.hee.nhs.uk/our-work/doctors-training/foundation-review** and **https://www.nhsemployers.org/news/2020/06/self-development-time-for-doctors**. This information also covers many of the questions frequently asked by foundation trainees and their supervisors about self-development time.

7. A date for your diary

Foundation Programme Conference 2021

Join us on 25 March 2021 in Birmingham for a major conference for those running and supervising the Medical Foundation Training Programme. The agenda will cover the uniqueness of providing support for foundation doctors, progress on implementing the recommendations of HEE's Foundation Programme Review, what's next for foundation training and provide the opportunity to hear from trainees, educators and other experts in the field. More details will follow, but please save the date in your diary now!

Health Education England
www.hee.nhs.uk

in LinkedIn
@NHS_HealthEdEng
www.facebook.com/nhshee