NHS England

Yorkshire & Humber Foundation School (YHFS) General Practice Longitudinal Integrated Training (GP LIFT) Guidance

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Executive Summary

The work of David Hirsh and others 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).

It was felt that Foundation training could be improved by a realignment of training to a more longitudinal model, based around the patient in their natural environment. The YHFS programmes have been developed with this in mind.

Dr. David Hirsh explains the benefits of a Longitudinal Integrated Clerkship
https://www.youtube.com/watch?v=cKGeWSws1So

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

YHFS started a LIFT pilot in August 2019 for 18 Foundation doctors (6 in the East, 6 in the West, 6 in the South) These doctors were attached to a GP Practice with integrated clinical placements within hospital trusts.

15 of these posts remain in 2025, with the East Yorkshire posts being paused at this time

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

The GP Practice will provide the Educational supervisor for these Foundation Doctors for their 2 years in post.

LIFT Foundation Doctors are no different to FY1 / FY2 Doctors, 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 their 2-year placement.

LIFT will augment a two-year community placement, one day per week, with six, four-month placements within the hospital setting.

Purpose

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

Introduction

The typical model of Foundation training is six four-month placements in 1 or two trusts over the 2 years of training. They have an Educational Supervisor based in the Trust.

In a LIFT Programme, the Foundation Doctor will have 1 day per week in this primary care setting.

The Educational Supervisor will be a named GP trainer for a two-year period. The Clinical Supervisor will be based in the Trust.

Alongside the sessions' in a GP Practice, Foundation Doctors will undertake 6 x 4-month hospital attachments themed to the GP patient cohort (4 days per week) over the two years.

GP LIFT Doctors will attend the Foundation Mandatory teaching programme with the rest of their cohort in the Trust.

We will expect an induction to each workplace environment as happens with the other Foundation Doctors.

The LIFT programme 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 hopes to embrace the symbiotic learning relationship between Foundation Doctor, trainer and patient, allowing patients to be followed along care pathways - promoting the Foundation Doctor to see the patient at the centre of care and in turn the Foundation Doctor 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.

Evaluation

Foundation Doctors 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 logged using the HORUS portfolio and with use of the formal teaching program.

Where are the Programmes?

2-year linked posts (FY1 & FY2) – 1 day per week GP (Oriel programme numbers)

Sheffield	**DPOW** - paused	**Scunthorpe** - paused	**Leeds F1 Mid Yorks F2**	**Mid Yorks F1 Leeds F2**
2025FPP - SY001	~~EY019~~	~~NYEC125~~	2025FPP – WY001	2025FPP – WY004
2025FPP - SY002	~~EY020~~	~~NYEC126~~	2025FPP – WY002	2025FPP – WY005
2025FPP - SY003	~~EY023~~	~~NYEC127~~	2025FPP – WY003	2025FPP – WY006
2025FPP - SY004				
2025FPP - SY005				
2025FPP - SY006				
2025FPP - SY007				
2025FPP - SY008				
2025FPP - SY009				

LIFT Foundation Doctors' attitude to their work

- LIFT Foundation Doctors 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 Foundation Doctors as having a positive attitude & "coping better", possibly due to the variety in their working week.
- In contrast some were struggling with unmotivated / unenthusiastic Foundation Doctors, showing little commitment to LIFT.

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 Foundation Doctors are all well equipped to make **specialty choices**.
- Several supervisors observed LIFT to "**convert**" Foundation Doctors to general practice.
- Some thought the **purpose** of LIFT "was to improve GP recruitment".

FY1 GP LIFT Supervision Guidance

General Practice is an ideal training environment for Foundation 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 Foundation Doctors 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 Foundation Doctors, 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 Doctors.

FY1 Foundation Doctors 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 Doctors, 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 Foundation 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 Doctors **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 Foundation Doctors **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 Foundation Doctors **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 Foundation Doctors **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 Doctors 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 Foundation Doctors **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 Foundation Doctors **must not**…

- prescribe on FP10 forms
- dispense medications alone

Home Visits

FY1 Foundation Doctors **should**…

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

FY1 Foundation Doctors **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. Foundation Doctors 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 Foundation Doctor and trainer sense of training satisfaction. This in turn can help motivation for learning.

FY1 Foundation Doctors **should**

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

FY1 Foundation Doctors **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 Foundation Doctors **must not**

- work beyond their competence

Please also see the "Foundation GP Handbook - 2025"

Timetabling Guidance

Introduction

Both hospital and General Practice can be great training environments for Foundation 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 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.

Please see some example timetables in Appendix 1 at the end of this document.

General considerations

The specification for trainers in hospital and primary care are ambitious. 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 Foundation Doctors at this level. We anticipated that our most junior Foundation Doctors in primary care, might feel isolated from their peers more than their counterparts in the hospital.

Guidance documents are available on the YHFS website, the NHSE (North West office) web site and on the UKFPO website (Links at the end of this document).

On call / Out of Hours work

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

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

OOH, and its associated payment, has always been a Trust / Foundation Doctor discussion.
It is not required for the completion of the Foundation Programme, but can impact an FDs salary.
The availability of OOH work is dependent on the service requirements and the Trusts available resources, as Trusts fund the OOH payments.
The GMC require programmes only to deliver the Foundation curriculum. 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 Doctors, as should we all, should only undertake work which they are either competent in, or are learning competence under supervision.

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

- Include all the LIFT Foundation Doctors 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**.
- Have no regular rostered OOH work but allow LIFT Foundation Doctors to internally cover ad hoc OOH shifts in their appropriate departments. Such activity is commonplace and, indeed, necessary for every Trust for service provision.
- Have no OOH work, at least in FY1, and counsel the Foundation Doctors about the NHSE, GMC and financial issues discussed above, given the two-year duration of Foundation training.

Any of the above approaches are more likely to be acceptable to Foundation Doctors 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.

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 Foundation Doctors 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 Setting

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 Foundation Doctors' schedule. The dates for these are usually set well in advance.

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 Foundation Doctor 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 Foundation Doctors 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 Foundation Doctors 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 70% 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 70%.

Rotas should be made available to the Foundation Doctor 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 Foundation Doctors 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)

If it becomes apparent that Foundation Doctors are continually missing their GP day because of their trust rota, and are going to miss the 70% attendance, this will be escalated by the Foundation Doctor/practice to their ES / TPD / Foundation School Deputy 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. This could be via direct communication or by Exception reporting.

Hospital Setting

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 if possible.

Workplace-based assessments should be completed in both environments.

Where possible a pseudo ‘job-share’ between two LIFT Foundation Doctors 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 Foundation Doctors 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 Foundation Doctors 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 situation. Every effort should be made by both teams to include LIFT Foundation Doctors in team meetings and other departmental activities. Early feedback suggests that LIFT Foundation Doctors 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) Foundation Doctors, 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 Foundation Doctors should be minimised.

Where one group is felt to be disadvantaged, raising them all to the same level 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 Foundation Doctors every time. Similar issues are seen with LTFT Foundation Doctors.

Some hospital trainers may have negative feelings about ‘losing’ Foundation Doctors 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 Foundation Doctors. 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 managers 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 Foundation Doctors' continuity and inequality issues discussed above. Because the LIFT format uses six placements, with 1 day a week in primary care, more variety in speciality is possible and in keeping with the ethos of Foundation training. Some of the best feedback comes from Foundation Doctors who are not in traditional service placements.

LIFT 'bullet point' summary

- 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 Foundation Doctors
- Every effort needs to be made to make LIFT Foundation Doctors integral to the hospital part of the placement
- The GMC do not require out of hours duties for Foundation curriculum delivery. Many Foundation Doctors value out of hours duties and feedback will be improved if they are included.
- Trusts and Practices 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 Foundation Doctor and the practice and we appreciate this may not be possible. FDs should preferably attend their practice for at least 70% of the time.
- 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 should be as close to the acute hospital site as possible, to minimise travelling requirements
- Travel expenses for the Foundation Doctors in primary care should be claimed back from the employing trust.

Guidance for GP trainers

Primary Care placement specification

The primary care environment and trainers will be pivotal to the success of LIFT. Each LIFT Foundation Doctor 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 Doctors as part of LIFT will:

- Be part of the practice team
- Be expected to have a placement-specific induction and orientation to NHSE 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. The hospital trainer will be the main CS.
- 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 mandatory Foundation teaching program at the host Trust.

Guidance for hospital trainers / FTPDs

Hospital placement specification

The LIFT Foundation Doctors 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 Appendix 1). All the usual conventions of Foundation training apply; however, LIFT has some additional features.

Foundation Doctors 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. (the GP trainer will be the named ES)
- 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.

Horus

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

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

The number of assessments that the LIFT Foundation Doctors should do over the 2 years is under discussion. We are suggesting that the LIFT Foundation Doctors 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 promote this as best practice.

YHFS faculty

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

GPs are responsible for the Foundation Doctors as their Educational Supervisor.

YHFS are responsible for the Foundation Doctors training.

Any queries re LIFT posts or Foundation Doctors / training issues should be sent to the Foundation inbox (England.foundation.yh@nhs.net) with **LIFT PROGRAMMES in the subject heading so it can be identified quickly by the team.**

LIFT Foundation Doctors 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 Foundation Doctor 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 Foundation Doctor submits where possible and appropriate

Useful Links & Acknowledgements

Links

FY1s and the GMC, good medical practice:
Home - GMC
First year of the Foundation Programme (F1) - GMC
Good medical practice - professional standards - GMC

The UK Foundation Programme Office - UKFPO:
UK Foundation Programme - UK Foundation Programme
Curriculum - UK Foundation Programme

The Northwest of England Foundation School policies and procedures:
Foundation Policies and Processes | Health Education North West

YHFS:
Foundation Home | Health Education Yorkshire and Humber
Longitudinal Integrated Foundation Training (LIFT) | Health Education Yorkshire and Humber

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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

Appendix 1 – Example Timetables

Table 1

Example weekly timetable

		Example FY1 - Foundation Doctor 1	
	4 days immediately prior to F1 start date	Mandatory Programme Shadowing/Induction	
		Departmental Induction -	
Placement 1	1st Wednesday August	Medicine unit; Respiratory	
		Placement Theme (Respiratory Medicine)	
Month 1		1 session set teaching	GP induction 2 sessions weekly (to continue at trainer's discretion)
		7 clinical sessions weekly	
		4 direct trainer contact *e.g. Thoracic medicine OPD* *lung function* *endoscopy* Consultant round	
Month 2		*<u>≤3</u> general sessions* *e.g.*	GP placement (after induction)
Month 3		*2 ward work*	2 sessions weekly
Month 4		*1 MAU session*	*e.g.* *General GP session* *CDM session- asthma clinic* *Trainer 121/audit/admin*
Placement 2	1st day	Departmental Induction - A & E	
Month 1		Placement Theme (Emergency Medicine)	GP placement
	1 session set teaching	8 clinical sessions weekly	2 sessions weekly
		on average guidance… *<u>>4</u> direct trainer contact*	*General GP session* *Emergency surgery*
Month 2		*<u><4</u> other*	*Trainer 121/audit/admin*
Month 3			
Month 4			
Placement 3	1st day	Departmental Induction - Surgery	
Month 1		Placement Theme (Surgery)	GP placement
	1 session set teaching	8 sessions weekly	2 sessions weekly
		on average guidance… *4 direct trainer contact* *e.g. surgical OPD, operating theatre*	*e.g.* *General session*
Month 2		*4 general sessions*	*Minor ops*
Month 3		*e.g. ward wark*	*Musculoskeletal*
Month 4		*SAU session*	

Table 2

Example rotas from Chapelgreen Practice – Aug 2019

DAY	DATE	TIME	ACTIVITY	WITH
ONE	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	
TWO	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 – ***PRIOR TO OWN SURGERY*** 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

TIME	Monday In Practice	Tuesday In Practice	Wednesday In Practice
09:00	**9.00 start finish at 5pm**	**9.00 start finish at 5pm**	**9.00 start finish at 5pm**
09:30	**WARD ROUND Aaron View**	**WARD ROUND Silver Lodge**	**LONG TERM CONDITION REVIEWS Nurse Manager or Nurse Practitioners**
10:00			
10:30			
11:00	COFFEE MEETING	COFFEE MEETING	COFFEE MEETING
12:00	**VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor**	**VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor**	**VISIT (Post hospital discharge or GP follow up visits ONLY) Debrief with Supervisor**
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			

Table 3

Blackburn Road Medical Centre. Example Timetables – June 2025

FY1

	Monday		Tuesday		Wednesday		Thursday		Friday	
	clinic 08.30 - 10.30	2	clinic 08.30 - 10.30	2	joint Tutorial 8:30-10:30	2	clinic 08.30 - 11.00	2.5	Clinical Meeting/admin 08.15 -0 09.15	1
	visit or clinic 10.30 - 11.30	1	visit or clinic 10.30 - 11.30	1			debrief 11.00 - 11.30	0.5	clinic 09.30 - 11.30	2
	admin/debrief 11.30 - 12.00	0.5	admin/debrief 11.30 - 12.00	0.5	CLINIC 10.30 - 12.30	2	visit of clinic 11.30 to 12.30	1		
	lunch 12.00 - 13.00	1	lunch 12.00 - 13.00	1			lunch 12.30 - 13.30	1	debrief 11.30 - 12.00	0.5
	Clinic 13.00 - 16.00	3	Clinic 13.00 - 16.00	3	lunch 12.30 - 13.30	1			lunch 12.00 - 13.00	1
	Admin/Debrief 16.00 - 16.30	0.5	Admin/Debrief 16.00 - 16.30	0.5			clinic 13.30 - 16.00	2.5		
					Clinic 13.30 - 16.00	2.5			Clinic 13.00 - 16.00	3
					Debrief 16.00 - 16.30	0.5	debrief 16.00 - 16.30	0.5	Admin/Debrief 15.30 - 16.00	0.5
		8		**8**		**8**		**8**		**8**
	2 clinical sessions		2 clinical sessions		1 study 1 clinical		2 clinical		2 clinical	
									WEEKLY TOTAL HOURS	40

FY2

	Monday		Tuesday		Wednesday		Thursday		Friday	
	clinic 08.30 - 10.30	2	Private Study		joint Tutorial 8:30-10:30	2	clinic 08.30 - 11.00	2.5	Clinical Meeting/admin 08.15 -0 09.15	1
	visit or clinic 10.30 - 11.30	1					debrief 11.00 - 11.30	0.5	clinic 09.30 - 11.30	2
	admin/debrief 11.30 - 12.00	0.5			Tutorial	2	visit of clinic 11.30 to 12.30	1		
	lunch 12.00 - 13.00	1					lunch 12.30 - 13.30	1	debrief 11.30 - 12.00	0.5
	Clinic 13.00 - 16.00	3			lunch 12.30 - 13.30	1			lunch 12.00 - 13.00	1
	Admin/Debrief 16.00 - 16.30	0.5	HDR				clinic 13.30 - 16.00	2.5		
					Clinic 13.30 - 16.00	2.5			Clinic 13.00 - 16.00	3
					Debrief 16.00 - 16.30	0.5	debrief 16.00 - 16.30	0.5	Admin/Debrief 15.30 - 16.00	0.5
		8		**8**		**8**		**8**		**8**
	2 clinical sessions		2 study		1 study 1 clinical		2 clinical		2 clinical	
									WEEKLY TOTAL HOURS	40

Blackburn Road Medical Centre. Example Induction – June 2025

					Wednesday -		**Thursday**		**Friday**		
							clinic 08.30 - 12.30 - Sit with HCA		clinical meeting 08.00 - 09.00		
					08:30 - clinical and non clinical Induction						
									09.00 - 1200 - Sit with GP		
					Lunch 12.30 - 13.30		Lunch 12.30 - 13.30				
					13.30 - 16.00 - sit with GP						
							private study				
									Lunch 12.30 - 13.30		
									13.30 - 15.30 - Sit with Coders		

	Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		
	08.30 - 12.30 - Sit with reception		08.30 - 12.30 - Sit with Secretaries		joint Tutorial 08:30 - 10:30		08.30 - 12.30 - Sit with GP		clinical meeting 08.00 - 09.00		
					10:30 - 12.30 - Sit with NURSE						
									09.00 - 12.30 - Sit with HCA		
	Lunch 12.30 - 13.30		Lunch 12.30 - 13.30		Lunch 12.30 - 13.30		Lunch 12.30 - 13.30				
	1400 - 150 - Tutorial with GP		HDR -13.30 - 17.00		13.30 - 16.30 - Sit with PHARMACY TEAM		private study				
									Lunch 12.30 - 13.30		
									13.30 - 15.30 - Sit with EGP		