Northern Ireland

General Practice Specialty Training

F2 Induction

Starting In General Practice

Version 6 (July 2023)
Produced by GP Specialty Training Team

Welcome to GP Training

Welcome to General Practice (GP). We hope you enjoy a wonderful opportunity to learn about patients and how to *share* their health management.

The doctor patient *relationship* is at the core of GP; indeed the doctor is often the most powerful drug. Learning different consultation and communication skills greatly enhances "*therapeutic rapport*". There is no point prescribing a wonderful drug if the patient doesn't believe in it and comply. Discovering a patient's *ICE* (ideas, concerns & expectations) is a great start to developing a relationship. If a patient has confidence in your diagnosis and management plan through shared discovery they are far more likely to commit.

Time management is a major challenge. We remain so accessible and available to our patients; they often have multiple complaints and need "fitted-in" at short notice. This requires us to be ever flexible to their needs to keep general practice running smoothly and efficiently in a cordial manner. So you will need to look after your own emotional health in GP!

There are so many *guidelines* (some conflicting!) that we must keep abreast of. I believe the knowledge base required in GP for daily practice is greater than any other discipline in medicine.

Polypharmacy is an enormous challenge; you will encounter some patients on more than 30 different drugs. Just imagine all the possible interactions if you have to add another. Anyone can start a drug but it takes a special doctor to be able to stop one.

Primary care and secondary care complement each other. It is the role of the *specialist* to reduce error and uncertainty through extensive and invasive investigations thus minimising danger to the patient from *possible* disease. However given the lower prevalence of disease in the community, GPs must deal in *probability* rather than possibility. This means less investigations and greater use of time as a management tool – in other words *tolerating uncertainty*.

Health is better in areas with more primary care doctors. A 1% increase in hospital doctors was associated with 186 fewer deaths; the same increase in GPs is associated with 575 fewer deaths.

I hope you have a developing, rewarding and enjoyable time in GP; many trainers report after 20 years service that they have never been bored or lacked challenge.

Dr Fergus Donaghy, GP

As a trainee in general practice, I was humbled to have been given such privileged insights into patients' lives, their stories and their expectations. I feel it is just not possible to gain this direct experience, to the same extent, in any other area of clinical medicine.

Getting to know patients, their families, their communities, and indeed being invited into their homes, is a truly rewarding, eye opening and developing opportunity. Looking beyond the traditional therapeutic doctor patient relationship to the wider remit of genuinely holistic care also broadened my horizons and thinking.

Working in some of the most economically and socially disadvantaged parts of Belfast brought home to me the real impact and importance of the wider determinants of health such as education, employment and housing. The disproportionately high mortality and morbidity associated with smoking, excess alcohol consumption and obesity in more deprived populations further fuelled my desire to 'work upstream', to reduce health inequalities and advocate for the most vulnerable in our society.

My frustrations at the sometimes challenging interfaces between primary and secondary care also prompted me to think about the 'bigger picture' and how different parts of the system can work together better to support our patients, families and staff.

For these reasons on completion of my training in general practice, I applied and was successful in gaining a place on the Public Health specialty training programme. I find working on interventions aimed at improving health at the population level really satisfying and I continue to remember that this strives to improve the health and lives of as many people as possible at the individual level.

I whole heartedly believe that all medical trainees should undertake a postgraduate placement in general practice, for me this represents a golden opportunity to gain perspective. I hope you enjoy it!

Dr. Rachel Doherty, ST Public Health

For many of you this rotation will be your first non-hospital based job and with the change of location comes many uniquely refreshing experiences that you will only experience in GP land. For the first time you will see the early stages of disease, and experience continuity of care - including having your own “regulars”. In hospital you may have been called to see patients who have become acutely unwell but whilst in GP you will be presented with the initial symptoms of many chronic illnesses, and take the first part of that journey with them. And the medical conditions encountered cover specialties that most of you will not have worked in prior to starting GP e.g. ENT, Ortho, Paeds, Obs and Gynae and the big one – Psychiatry. This is in many ways the most difficult aspect of the job.

Within 4 month hospital rotations you tend to deal with mostly one area and can get relatively comfortable with that area. This won’t be the case for the next 4 months, but you will learn more about such a wide array of conditions that looking at it from a purely training point of view it is second to none. I think there is a common misconception amongst Foundation Doctors that a GP rotation is in many ways a “break” from the stresses of the acutely unwell patients and terrible rotas that are part of working in a hospital. And yes, having 4 months of free evenings and weekends is nice, but in many ways it will be one of the toughest jobs you will do. It can be quite relentless, with a different patient coming in every 15 minutes with a completely different issue to the previous. Only advice would be to not shy away and to throw yourself into it, sounds clichéd but you’ll get the most out of it that way – Good luck!

Dr Niall McBride, F2

Foundation Training Contacts

Staff Name	Telephone No.	Area of work / Title
Dr Lorraine Parks		Director of Foundation School (Northern Ireland)
Ms Lynn Wilson		Foundation Deputy Director
Dr Ruth Eakin		Foundation Deputy Director
Karen Moore		Foundation School Manager
Laura Wright	02895360222	Foundation Training Co-ordinator
Rebecca Anderson	02895360222	Foundation Executive Officer
Charlene Boyle	02895360222	Foundation Executive Officer

All contacts direct to : foundation.nimdta@hscni.net Please include your name and GMC number in subject box

When you arrive in GP ...

MUST bring to your trainer:

- Evidence that - GMC, Medical Protection & Hepatitis titres are currently satisfactory.
- ENSURE YOUR MEDICAL PROTECTION COMPANY KNOWS YOU ARE WORKING IN GENERAL PRACTICE
- You will need your own stethoscope, auroscope.
- Ensure your motor car insurance is valid for home visits and carrying drugs.

You can expect the practice to provide written information on:

- Local support agencies.
- Local Hospitals & Consultants & Referral guidelines.
- Local Phone numbers.
- Map/Guide of the area.
- Practice Policies, Procedures & Protocols.
- Duty timetable & rota.
- House visit rota.
- Arrangements for annual leave.

Ground Rules between Trainees & Trainers

- Prompt start of surgery sessions–refreshments with Ancillary team before each session.
- If you open a window or door or turn on electric fire – make sure **you** close it!
- Bring lists of questions to Trainer – shows you are thinking & enables structuring. Questions impress – they give an insight to your thinking processes & curiosity. If there are no questions – why? Who has a problem Trainer or trainee?
- Learning log – keep a jotter of lists, points of discussion, revision issues
- House Visits – you must mention every one with your trainer - don't complete Practice Notes till HV written up.
- Assessment – will be through monitoring your computerised data entry, observation on video, the type of questions you ask
- Self Directed Learning must be SMART & have a plan with objectives.
- Dress code – needs to be appropriate and not distracting
- Wash your own dishes afterwards

What do you say about yourself & others you work with on Face book?

Always be careful to “log off” your computer terminal.
Time management is essential for consulting & learning sessions
All sick leave must be reported to NIMDTA and the Single Lead Employer Team.

Complete audit or QI

Quality Improvement is about embedding a cultural change in our processes through PDSA by using Primary & Secondary Drivers - please scrutinise this RCGP link for An introduction to QI in GP

an-introduction-to-quality-improvement-in-general-practice

1 Aim & Title
2 Criteria
3 Standards
4 Preparation & Planning
5 Data Collection 1
6 Changes Implemented
7 Data Collection 2
8 Conclusions

What to expect during your GP attachment - Foundation

- Induction should last one week before you start seeing patients in F2
- The working week is ten sessions.
- 30 minute appointment slots initially, reducing to 15 minutes later for F2F.
- Debriefing to cover the cases managed during each surgery session at least thrice weekly.
- Group tutorials on Friday afternoon 2.00pm to 4.00pm - rotating about the local trainers via Zoom
- If Foundation FLiGHT modules are scheduled on a Friday this will be co-ordinated with your GP tutorial organiser and GP F2 doctors may attend.

- As soon as you arrive in GP tell your trainer of the Deanery days that you need to attend in the following 4 months.

- You may take up to 8 days of your annual leave allowance during the 4 month GP attachment - please give due consideration to the Practice Leave policy.

- You are permitted reasonable time out of practice to attend Deanery Interviews for ST & Core training – subject to the advance approval of your Trainer.

- GP Recruitment Stage 2 and Stage 3 (equivalent of interviews each lasting approximately half a day) - it would be recommended that F2 doctors should be allowed leave for Stage 2 and Stage 3.

- F2 doctors are now employed by the Single Lead Employer Team, but will still remain 'linked' to their trust and the policies provided

- Try to get a number of different professionals to complete your SLEs. Do not rely solely on your named Trainer.

- There will be up to 16 Zoom Friday afternoon teaching sessions.

- During the first F2 Placement a TAB should be completed. During the second F2 placement a PSG report should be completed. However, in some practices there will not be enough colleagues to fulfill the minimum responder requirements for a TAB. In these circumstances a PSG can be completed instead and a TAB completed in your next hospital placement.

Indemnity for Foundation Doctors during non-hospital placements

FAO F2 doctors in GP

When F2 doctors are informing their Medical Protection that they are entering GP be sure the Medical Protection know this is as a Foundation doctor not as a Specialty Trainee.

Working hours

The working week for F2 in GP is ten sessions over 40 hours.

After working four hours any day F2 are entitled to a paid 30 minute break.

There are large variations in start and finish times in GP surgeries depending on local demographics, thus the training practice and the F2 should negotiate daily working hours without exceeding the contracted forty hours.

Teaching and Learning

F2 can expect to have EIGHT days study leave during their GP attachment - There are up to 16 Friday afternoon tutorials organised and they should receive some in-house sessions of

Self Directed Learning. These SDL sessions should ideally be free from booked patients to focus on a topic agreed between trainer and trainee that is pertinent to General Practice.

Workload

There is an inevitable and a considerable variation in workload between practices. When established in practice, F2 may consult with thirty to sixty patients a week depending on case complexity and local needs and confidence. It is important that F2 are exposed to a wide range of cases including F2F, by phone, video and home visits to experience a true sense of general practice.

Tips for your GP attachment

GP is often a series of well-rehearsed reflexes. Get to know your top twenty consultations and develop a safe & efficient pattern of assessment and documentation. Here's a few thoughts. Safety is our number one priority but we also need to be caring and efficient. In General practice the prevalence of serious illness is dramatically lower than in secondary care thus we often find ourselves reassuring patients rather than diagnosing and prescribing. We encounter many symptoms at a very early stage of undifferentiated medical presentations.

A few brief tips below– but always remember GMC & Medical Indemnity & NICE guidance!
Home Visits—Always let the practice know where and when you are going.

Sore throat
Sore throats seldom need antibiotics; patients usually just need to gargle hot salted water for ten minutes thrice daily – physiotherapy to the pharynx. Save the antibiotics for those unable to swallow, history of quinsy, or systemically unwell. Try using the validated CENTOR criteria – https://en.wikipedia.org/wiki/Centor_criteria or fever pain score.

Road Traffic Collisions
Patients involved in minor road traffic accidents often present later to their GP with aches and pains – often there is just muscular-ligamentous inflammation. It is important to document certain facts for legal purposes

1. The date, time & location of accident.
2. Where was the patient sitting in the car?
3. Were they wearing a seat belt.
4. What injuries were sustained – was there any bruising or bleeding or loss of consciousness
5. Were they able to exit the car themselves.
6. Did they need to go to casualty?
7. Have they lost any time from work or missed any sports/hobbies?
8. Consider CT Brain scan if significant head injury

Starting Combined Hormonal Contraception – CHC
CHC all contain oestrogen and a progestogen. The standard oestrogen is ethinyl oestradiol (EE) 30mcg strength; we can consider a lower dose as the patient ages and a higher dose if break through bleeding occurs. Other oestrogens can be considered in individual cases but can be more expensive and less of a track record for safety.
Progestogens are second, third or fourth generation. We usually choose to start with a second generation progestogen such as levonorgestrel (LNG) as they appear to be less risky for thromboembolic disease.
We prescribe one packet for 3 months then review annually thereafter if there are no complications. Reviews concentrate on weight, blood pressure and compliance. For guidance on contraindications see http://www.fsrh.org/documents/ukmec-2009/
We regularly use

- Rigevidon LNG 2ndGeneration Progestogen & 30mcg EE
- Marvelon Desogestel 150mcg & 30mcg EE &

Tips for your GP attachment

Starting the Progesterone only Pill (POP)

Cerazette is now by far the commonest used POP; it needs to be taken every day and can't be more than 12 hours late. We prescribe one packet for 3 months then review annually thereafter if there are no complications. Reviews concentrate on weigh, blood pressure and compliance. There are very few contraindications – see http://www.fsrh.org/documents/ukmec-2016/

CHC - Pill review

Check BMI & BP & compliance & understanding of "missed pill rules"

Need to check for any new contraindications since last assessed – BMI rising, started smoking, irregular bleeding patterns that could suggest infection or dysfunctional uterine bleeding.

Morning After Pill request - EHC

We commonly use Levonelle for the first 72 hours, but Ella One can be more effective during this time and also has a 120 hour license.

Where are they in their pill packet determines the need for EHC

It is important to document

1. LMP
2. Date & reason for UPSI
3. Offer the copper coil as it is the most reliable method
4. Directions in the event of vomiting EHC
5. Plans for contraception until next period
6. Review date
7. Pregnancy test at 3 weeks incase of EHC failure.
8. If >70kg, BMI >26 double the dose of levonelle

Low back pain

Commonest cause in GP is lumbago & muscular skeletal (MSK); but also need to seek out cases of true sciatica (typically when the pain radiates all the way down the leg into the ankle) Important to demonstrate you have excluded cauda equina syndrome so document the sphincters, numb gluteal and the nerve roots L345S12 – knee & ankle jerks and extensor hallucis longus EHL

Asthma review

Three questions are most important to document

1. Does your breathing interfere with sleep?
2. Does your breathing interfere with day time activities?
3. Does your breathing interfere with work?

Check PEFR and inhaler technique. Seek opportunities to step up – or down! inhalers.

Request for antibiotics for simple adult urinary tract infection

There is no need for urine dipstick testing if two or more symptoms are present – frequency, dysuria, fever, abdominal pain. The typical antibiotic used is nitrofurantoin MR for three days.

Men need a seven day course and best to send MSU to lab for O&S as men often need referred to urology for follow up.

Children and pregnant mothers need MSU rather than dipstick.

If there is a high fever, rigors or renal pain think of pyelonephritis; which may need ciprofloxacin.

If using Nitrofurantoin for a UTI be sure to check if renal function is adequate. If on methotrexate avoid trimethoprim and consider stopping MTX during undercurrent infections. Avoid trimethoprim in first trimester of pregnancy. Avoid nitrofurantoin at the term time in pregnancy.

Tips for your GP attachment

NICE traffic lights
https://www.nice.org.uk/guidance/cg160/resources/support-for-education-and-learning-educational-resource-traffic-light-table-189985789
Use these for any sick children, always remember to document the salient findings.

Other Tips

NI Primary Eyecare Assessment
For urgent visual problems consider PEARS.

GP Notebook is a very useful and succinct resource the first few items each day are free but after that you need to register.
Phone calls are becoming much more important in GP. "Phone triage" can be a very efficient form of managing demand. Patients can be "signposted" to other professional allied to medicine or even secondary care without waiting or needing to see a GP, or they may be invited to attend for a consultation. "Telephone consultations" are also used to consult with patients. Doctors and trainees in particular often find this quite challenging without the visual cues but it is a skill we all need to learn. Coming our way next are email consultations.

Home visits are an integral and challenging part of GP. More often nowadays for frail elderly and palliative patients. These visits are highly valued by patients and wonderful learning opportunities. Always bring a printed summary sheet with you as this could then become the referral if casualty is needed. Always have a system to ensure you record all visits on the computer when you return to the surgery. You should also bring a few blank prescriptions with you.

Antibiotic requests by patients over the phone.
We try to avoid giving antibiotics over the phone so we train our staff to ask some questions before passing the request to us – duration of illness, colour of spit, any blood in the sputum, and shortness of breath.

Child protection
Please seek the opportunity to attend a "case conference" as this is a valuable learning opportunity and helps introduce you to the legislation & requirements
http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

QUB GP Podcasts area a great source for updates

COVID
Please be aware of the latest guidance on wearing PPE at work

Inventory

This inventory consists of over 100 tasks that should be completed within the first week of entering GP. You should organise with your trainer & practice manager to be show each of these tasks and then tick off. You can then practice each in your own time as revision.

Orientation & Administration - Practice Manager
Received a tour of the Premises & catering arrangements
Introduced to all members of the Practice team
Have spent time observing in the Waiting Room, Reception area & Treatment Room
Shown how to use the Telephones & Intercom system
Received advice on Fire Safety & evacuation policy
Learning & Consulting - Trainer
Undergone assessment of Learning Needs / styles
Select tutorials to prepare in advance.
Tutorial on the "Doctors Bag"
Have received a stocked Doctors Bag
Have a tutorial on "Medical certification"
Agree "Ground Rules"
Observe the Trainer consult
Accompany the Trainer on Home Visits
Observe another partner of the practice consult
Observe the Practice nurse at work
Familiarise with the resuscitation facilities
Dealing with Medical Emergencies in Primary care
• **Computer**
Viewing the Medical Record - Ancillary team
Log on with password and user ID
View Consultations, past & present
View Summary list - Diseases & Operations
View Immunisations
View previous "Patient Notes"
View Medication acute & repeats, past & present
View Referrals
View Family History
View Attachments
View Templates
View Allergies
View all previous Blood Pressures
View all previous Cholesterols
View all previous PEFR values

Consultation Mode
Enter a test patient "mickey mouse"
Add details under History, Examination & Action Plan (SOAP)
Prescribe paracetamol
View blood results, previous practice notes, summary list, values,

Save the consultation and transfer to another test patient.

Enter another test patient and record a "Home Visit"

Save & transfer back to previous patient and enter a "Telephone Consultation"

Enter that patient & record 1st baby vaccination

Record consent, site & batch numbers

Print a Patient Information Leaflet for Back pain & ensure it is recorded in Consultation

Record the giving of a Hepatyrix vaccination - site, batch number

Record a value for BP, Height, weight, PEFR, alcohol intake.

Record a fluvaccination

Record the issue of a Med 3 detailing the duration & reason

Record smoking status & smoking cessation advice given

- **Prescribing**

Issue a private prescription for viagra, record it as "acute" rather than repeat

Find a drug & convert it to generic

Look at all the previous issues of a drug, how many in the last year?

Cancel the paracetamol that you just issued.

Using Templates & entering values

Provide a printed list of all computer templates used by the practice

Use each template in turn and enter data

- **Appointments**

View the list of appointment schedules

Add a patient

Denote a patient as arrived

Call for that patient

Finish that patient

- **Referring**

Enter a test patient in consultation mode & create a referral – both on Computer software & CCG

Choose the Hospital & speciality

Merge the details to import clinical & administrative data

File & Save & Print

Viewing attachments

View previous attachments on a test patient

- **Patient notes**

Send a patient note to yourself reminding you to "look at their cholesterol"

Denote the cholesterol level and send this Patient note to your trainer

Send another patient note to yourself and this time action it as complete and close it

- **Printing documents.**

Print a referral letter that has already been created

Print an attachment

Print a label for blood samples

- **Laboratory results**

Enter test patient and review previous results in chronological order

Look at all previous cholesterols in a real patient to see the trend

Access your " EDI in-box" & file results as per practice protocol

Trainee / Foundation Doctors bag - for discussion

Ampoules

Furosemide 40mg
Benzylpenicillen sodium 600mg
Water 5mls
Diamorphine & naloxone
Chlorpheniramine10mg
Hydrocortisone 100mg
Diclofenac 75mg
Diazemuls 5mg
Adrenaline amp 1/1000
Cyclizine 50mg
Glucogel 80g
Stesolid 5mg & 10mg
ceftriaxone

Tablets

Omeprazole 20mg tabs
Co-codamol tabs
Aspirin Soluble 75mg
Paracetamol 500mg tabs
Amoxycillin Caps 500mg
clarithromycin
Prednisolone tabs 5mg
Trimethoprim tabs 20mg
Ciprofloxacin 125mg *12 tabs
GTN Spray
Glyceryl trinitrate

Equipment

Thermometer
Green needles
Orange needles
10ml syringe
Urine bottles
Butterfly
Green Venflon
Pink venflon
Mouth mask resusc
Spacer device & SABA MDI
Multistix GP
Mims book
Glucometer
Pulse oximeter
Sphyg & Stehoscope
opthalomo/auroscope
CDs & Defib & Nebs Need discussed

Prescribing

Each practice has its own guidelines - a typical example - see HSC web site for full list

To Promote Generics invariably, EXCEPT for

- sustained release preparations
- contraceptive combinations
- "preferred" branded products
- Controlled drugs
- multi-ingredient products
- drugs with a narrow therapeutic index
- epilepsy & transplant drugs
- specific indications – Duloxetine (Yentreve & Cymbalta), Sildenafil (Viagra & Revatio)
- Buprenorphine (Subutex & Temgesic)
- Insulins
- Antipsychotic depots

To Reduce

- Co-codamol effervescent
- Opioid compound analgesics
- COX2
- Benzo's & Z's – Zolpidem, Zopiclone, Zaleplon.
- Antibiotics
- Dihydrocodiene
- Quinilones as a % of antibiotics
- Co Amoxiclav as a % of antibiotics

Prescribing Guidelines — We don't -

Add hypnotics or anxiolytics to the repeat prescribing screen.
Give effervescent Co-Codamol
Give branded Co-Codamol 30/500 – Tylex / Kapake
Issue NRT - unless they attend a smoking cessation clinic or palliative.
Issue RED listed drugs.
Issue warfarin tablets in the 5mg or 0.5mg strength
Issue Methotrexate in any strength other than 2.5mg

We tend to avoid -

Black triangle drugs
Anxiolytics
Tricyclic antidepressants
Magnapen, Augmentin & Ciproxin – unless specifically indicated
Sunscreens (unless specifically indicated)
HRT for >5yrs if >50yo unless specifically indicated
Initiating Cholinesterase / Dementia drugs without Consultant approval.
Prescribing items not in the formulary – unless justification exists.

We usually prefer –

Nitrofurantoin for UTI
Amoxicillin for RTI
To issue drugs in cycles of 28 days (occasionally 84days)

We always -

Document on the computer any item prescribed – even House Visits – denote by hand

Prescribing

ACEi	Lisinopril Ramipril Perindopril		
CCB	Amlodipine		
ARB	Candesartan cilexitil or Losartan		
Diuretics	Thiazide – Indapimide/chlortalidone	Loop – Furosemide	Spironolactone
PPI	Lansoprazole (omeprazole can interact		
NSAID	Ibuprofen / Naproxen	Diclofenac ?? Not if CVD	
Analgesics	Paracetamol	Co-Codamol 8 or 15 or 30 mg	
Laxatives	Laxido		
Antiplatelets	Aspirin dispersible 75mg		
Statin	Atorvastatin		
Hypnotics	Zopiclone		
SSRI	Fluoxetine / Citalopram / Sertraline		
Antiviral	Aciclovir		
Bisphosphonate	Alendronate		
OHA	Metformin	Gliptin or SGLT2	
COC	COC Rigevidon		
Steroids (topical)	mild - Hydrocortisone	moderate - Clobetasone butyrate	
	potent - Betamethasone	very potent - Clobetasol	
Respiratory	MDI	BAI	Powder
SABA	Salamol	Salbutamol CFC free	Bricanyl
LABA	Salmeterol		
Steroid	Clenil		
Combo	Fostair		Budenoside/formoterol (symbicort)
LAMA	Atrovent / Tiotropium		

Generics	Best Brands
Nifedipine SR	Adipine
Tramadol	Maxitram SR
Fentanyl	Mezolar
Vit D & Ca+ Supp	Adcal D3
Nitrates	ISMO & Monomax
Oxycontin	Longtec
Venlafaxine	Vensir

Dressings	Ask for the Nurse
Alginate	Kaltostat
Hydrocolloid	Activheal hydrocolloid
Non adherent	Askina Pad
Polyurethane foam	Activheal foam

Antibiotics

Public Health Agency & Health and Social Care Board NI

DOWNLOAD THE MICROGUIDE APP

Acne	Topical Benzyl Peroxide then retinoid or Epiduo	Oxytetracycline or tetracycline or Lymecycline	then Doxycycline
Bites	Co-amoxiclav	Doxycycline & Metronidaxzole if allergic (clarithromycin in kids)	
Ac/Ch bronhitis	Amoxycillin	Clarithromycin/doxycycline if allergic	2nd line co-amoxiclav
BacterialVaginosis	Clindamycin cream 2%	Topical Metronidazole	
Candidiasis	Clotrimazole topical	Fluconazole systetemic	Topical only if preg
Cellulitis	Flucloxacillin	Doxycycline	
CAP	Amoxycillin	Doxycycline	
Chlamydia	Azithromycin 1g stat or Doxycycline 100mg bd 7days		
Conunctivitis	Bathe	Chloramphenicol drops 2hrly	
Croup	No Abx	? Dexamethasone	
Dental Abscess	Dentist—Provide Analgesia		
Dermaphyte nails	Terbiafine		
Dermaphyte skin	Miconazole crream	Terbinafine cream	
Epididymo-orchitis	Ciprofloxacin		
Gynae- till sensitivities	Co-amox	Metronidazole 2nd line	
Helicobacter Pylori	Omeprazole/Lansoprazole + 2 Abx from Amoxycillin/clarithromycin/metrondiazole		
Impetigo	Fucidin or Crystaside if small localised lesions	Flucloxacillin	Clarithromycin
Meningitis	Benzylpenicillin iv/im	Cefotaxime if allergic	
Otitis Media	Amoxycillin	Clarithromycin if allergic	1g tds for adults
Prostatitis	Ciprofloxacin or Trimethoprim		
Shingles	Aciclovir	Famciclovir if compliance a problem	
Sinusitis	Amoxycillin or doxycycline		
Pharyngitis	Pen V	Clarithromycin if allergic	
UTI	Trimethoprim or Nitrofurantoin 100mg MR		male 7d
UTI Preg	Nitrofurantonin MR for 7 days		

Limited evidence list - Omacor, Quinine, Probiotics, Multivitamins, Methocarbamol, Lidocaine

Don’t Forget the Pharmacy First Scheme

Home visits

Guidance for F2 & Trainers in GP Home visits (HV)

All F2 should be given the opportunity to undertake HV
HV should be a mix of acute and chronic care
Chronic HV - Care in the community - Reviews of Diabetes/Dementia/COPD/Learning Disability
Palliative care HV are a wonderful learning opportunity that captures the ethos of GP
Aim for an average of three HV per week
All HV should be discussed with Training Supervisor before undertaken & debriefed on return to practice.
Visits to any mentally ill or potentially violent patents must be accompanied with Trainer

Safety

Home visits are an integral part of GP & it is expected every F2 and ST will participate. The visits will reflect more of an educational rather than service commitment. Trainers are responsible for assessing the suitability of a home visit and organising briefing before & debriefing afterwards.

Safety is paramount – trainers organise a risk assessment – especially regarding visiting in the dark, and visiting patients with a history of violence, alcohol or drug problems.

Be careful with your car keys & phone when consulting – these can be targeted by people whilst you leave the consulting room momentarily.

A secure door leading to the consulting and treatment rooms means staff can monitor the flow of patients throughout the surgery.

Consulting and treatment rooms should be fitted with panic buttons; or a coded telephone call to reception staff can alert them.

In the event of a patient having a history of violent behaviour, alert reception staff and fellow doctors to the situation prior to consultation.

See potential threatening patients in consulting rooms close to reception area for added safety.

During consultations where the doctor feels unsure about his/her patient propensity to violence, have a colleague enter the room during the consultation on the pretence of seeking advice on a medical matter.

The doctor's desk should be positioned in such a way as to allow him/her easy access to the door without having to pass a patient in the case of an emergency.

All sharp instruments that could be used in an attack by a patient should be removed from the desk and the surrounding area.

During consultations with possible problem patients don't sit with your legs under a desk, if a patient launches into an assault he/she can trap you in the position, a chair on casters can help you move more quickly away from a patient.

In the event of an assault taking place, stay as calm as possible, speak to the patient while trying to alert other members of staff to the situation, hold your hands up in front of your chest in the position of readiness to take evasive action.

Security measures while doing house calls

Leave your car in an area close to streetlights so you can see if anyone is acting suspiciously around your vehicle.

Have your car keys in your hand ready to open the vehicle quickly. They can also be used as an item of self-protection if the need arises.

Place your medical bag on the floor or in the boot of the vehicle away from prying eyes and opportunistic thieves.

Lock all your car doors when travelling at night or when travelling in busy city areas.

When you have to speak to someone from inside the car that you do not know or are unsure of, roll your window down enough to allow you to speak but not enough for someone to reach in and attempt to grab you or open the car door.

If you are unsure of your route to the patient, ring them on your mobile and if possible have a relative meet you, stay in your car until you reach your destination.

In an area that you are not comfortable leaving your car unattended, have a relative of the patient stay with the car until you finish your consultation.

In the event that someone attempts to steal your medical bag while you are carrying it, let him/her have it. You can replace a bag and its contents easily enough, your life and your safety is more important.

Finally, when travelling at night, always make sure you have enough fuel in your car and that someone knows where you are going.

Ground Rules among F2 Doctors for day release group work

What do you do with people who often

- Arrive a little late?
- Seem to need to leave a little early?
- Talk too much?
- Contribute too little?
- Don't seem to have prepared their work?
- Don't want to lunch with the rest of the group?

Your Rules !! – you must have some? Let us know !!! Please
If ground rules are agreed at the start problems seldom arise, if problems arise its usually too late for Ground rules!

Passwords

You will need for

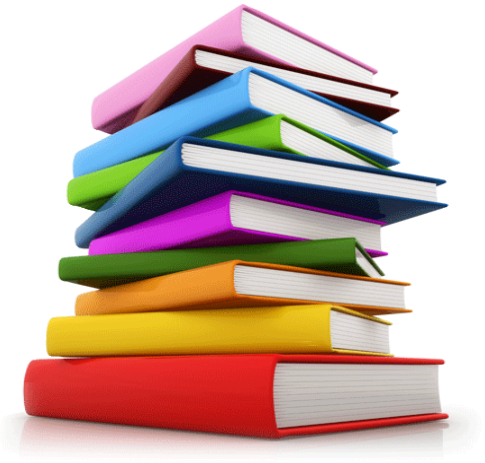
- EMIS/Vision/Healthy
- Docman/Apollo
- CCG
- Intranet
- ECR
- AccuRx

Desired reading before entering GP

Desired reading before entering GP –
Compass Therapeutic notes – may be completed on line
www.medicinesni.com
Infections, Respiratory, Minor ailments, Depression, Dyspepsia, CVD
OA & Rheumatoid arthritis, Women's Health, Epilepsy, Obesity, Pregnancy
And then complete the attached MCQ for accreditation

MIMS give wonderful one page summaries for COPD, Asthma, HT, JBS,

Optional extra reading:
The Inner Consultation - Roger Neighbour. Radcliffe Press
The Doctors' Communication Handbook. – Peter Tate.



Guidance for Taster Modules

Northern Ireland Foundation School

GUIDANCE FOR TASTER MODULES

Foundation Year 2 Doctors can use Study Leave to experience a minimum of two and a maximum of five consecutive days in a specialty that was not available in their F1 year or that they will not be placed during their F2 year.

As a Taster Module requires study leave, completion of the standard F2 Study Leave form is required.

The Taster Module should be well planned with agreed aims and objectives.
Taster Modules should take place in the hospital/trust in which the F2 doctor is based, unless the specialty is not available within that hospital/trust. ***Taster Modules cannot be facilitated outside Northern Ireland.***

Taster Modules should not be planned in the week in which a new four-month Foundation placement begins or ends.

A maximum of one Taster Module will be considered per placement. Trainees should not complete more than two Tasters during their F2 training.

A reflective report on the taster module should be completed promptly and included in the Foundation Portfolio detailing objectives and outcomes.

To arrange a Taster Module please email: specialty.nimdta@hscni.net or gpspecialtytraining.nimdta@hscni.net.

Applications will only be processed when fully completed; all forms should be returned to studyleave.nimdta@hscni.net.

Guidance for Study Leave

Northern Ireland Foundation School

GUIDANCE FOR STUDY LEAVE

Foundation Year 2 doctors are entitled to a maximum of 30 days study leave. At the start of your F2 year you will receive an email from the Study Leave department at NIMDTA to clarify that Generic Skills Modules days will be automatically deducted from your Study Leave allowance.

The 30 days Study Leave is utilised as follows:

10 Days = Regional Generic Skills Programme (mandatory)

8 Days = GP Weekly Teaching Programme (if in a GP Placement)

These days do not require a study leave application.

An additional 2 Days can be used for ALS / e-ALS as detailed below however you are required to submit a Study Leave application for this course

- 2 Days = ALS / e-ALS (optional)

The maximum funding allowance for ALS/e-ALS is £300. Please note that we are not in a position to fund courses in excess of this amount. You must submit an expense claim form (www.nimdta.gov.uk) with receipts for any ALS/e-ALS course to business.management@hscni.net. Only one attempt during foundation training will be reimbursed.

The remainder of Study Leave may be used for:

- Taster Module
- Training Course
- Educational Conference/Meeting
- Poster/Oral presentation
- Private Study Leave toward postgraduate medical exams
- Other relevant educational events.

All of these requests require submission of a Study Leave Application. The education placement provider should be given 6 weeks notice and NIMDTA requires 4 weeks notice for study leave applications. Please note the following information in relation to each of the above listed options:

Guidance for Study Leave Continued….

GUIDANCE FOR STUDY LEAVE

Training Course

F2 Doctors who have completed a recommended training course during their F2 year may be considered for retrospective funding if they enter a NI Specialty/GP Training Programme immediately after completion of Foundation Training within Northern Ireland.

This must be claimed within 3 months after entering Specialty/GP Training. Please note the amount reimbursed will be in line with the NIMDTA Study Leave Policy. Claims for retrospective funding must be submitted to studyleave.nimdta@hscni.net who will liaise with the relevant Hospital Specialty.

Educational Conference/Meeting and Poster/Oral presentation

A maximum donation of £250 towards expenses will be considered for Foundation Doctors presenting at reputable educational conferences within UK and Ireland only. In order to be considered for this funding towards poster/oral presentations, please make sure you include the following along with your Study Leave application:

- Poster/oral presentation slides or abstract
- Copy of conference programme with your name / presentation section highlighted
- Letter or email correspondence confirming your acceptance to present at this conference
- Confirmation in writing that no funding is available from any other source
- Inclusion of the NIMDTA and/or the NIFS logo on your presentation slides or poster

Upon submission of the above requirements, please make sure that all receipts and necessary expenses are attached to your subsequent claim

Private Study Leave

Under the NIMDTA "VALUED" strategy, we allow a maximum of 5 days private study leave *on one occasion only* towards a recognised postgraduate medical exam, provided the F2 doctor gives evidence of entry to the exam.

Please note Private Study Leave is not to be utilised for any other purpose such as Interviews or recruitment related processes.

Applications will only be processed when fully completed. All forms should be returned to studyleave.nimdta@hscni.net 4 weeks prior to the event. Any late or retrospective applications will **not** be considered.

Foundation Curriculum

"Contemporaneous completion of your portfolio" is on the ARCP checklist. If you have no entries in your first four-month placement, you will not get a satisfactory outcome 6 in your ARCP at the end of your F2 year.

At a bare miniumum you probably need to get around 5-6 SLEs (mini-CEX/DOPs/CbD/LEARN/ LEADER/DCT) to give yourself a chance to have enough experiential evidence (that is evidence from within the workplace, which carries the most weight). Please see **Topic 6** in UKFPO New Curriculum: New UK Foundation Programme Curriculum 2021 - UK Foundation Programme (and then scroll on down). These numbers are a *guide* only, but they are useful nonetheless. In fact, while you're there have a look at several of these videos/factsheets if you haven't already.

Please look at the any/all of the videos on the UKFPO website (link above) specifically **Topics 3, 5, 8 10,11 and 12.** Most of the short videos are from the authors themselves and are excellent!

Finally please remember, this is *your* training and you must take ownership. Your supervisors/ FPDs/UKFPO website and ourselves at NIMDTA are all there to support you and answer your questions, and achieving HLO3 is of course all about showing that you are a "Professional, responsible for your own practice and portfolio development".

Any issues, difficulties or questions, *please* contact your F2 reps/CS/ES/FPD or Dr Ruth Eakin direcly, sooner rather than later. But for now, whether you have an overall grasp of the new curriculum or not, it is important to realise that you **must get some experiential evidence (SLEs/ PSG/TAB) into your portfolio**, PRONTO!! (i.e. during your first placement). Overall, the evidence should show and reflect that you can care for your patients' mental health and social wellbeing as well as their physical health, *and* be from the acute, non-acute and community settings across all of your placements over the full training year. You will also need to have some Direct Training and Self Development (Personal learning log) to link to the FPCs, but it is the experiential evidence that carries most weight especially for HLO1.

Guidance for F2 Generic Skills Teaching (FLiGHT)

GUIDANCE FOR F2 Generic Skills Teaching (FLiGHT)

The FY2 generic skills teaching programme has been revised to include as many of the 'core topics' in the 2021 version of the Foundation curriculum as possible and has been renamed:

FLiGHT – Foundation Learning in Generic Hot Topics.

The 2021 version of the Foundation curriculum mandates that all Foundation Doctors must attend and log a minimum of 30 hours of 'core' teaching, with a minimum of 60 hours of core and non-core in total (which can include extra 'core' teaching) per training year. NIMDTA will continue to provide 'core' teaching within this new programme for FY2 doctors, but there will also be simulation teaching provided within the Trusts. Some of the previous F2 Generic Skills sessions will remain, such as Quality Improvement methodology, Safeguarding and Careers guidance, but a number of new topics have been added. Although these new topics will be mostly delivered as 2-hour zoom sessions, each Foundation Doctor will be allocated study leave for a half day so that there will be time for reading before the session and then reflecting and recording in the eportfolio afterwards. All sessions are mandatory, although only one is non-core (GMC and professionalism). Constructive feedback is a vital component of programme development and is therefore a required part of participation in the Foundation programme and attendance at FLiGHT. Positive feedback where appropriate is also very helpful. Each teaching session should be logged in the eportfolio and can then be used as a piece of evidence which can be linked to the new Foundation Professional Capabilities (maximum of three FPCs). A reflection on the session will increase the weight of this evidence when considered at the ARCP.

The FLiGHT timetable information can be found on the NIMDTA website here or alternatively please follow the below link—

F2 Generic Skills Teaching (FLiGHT) – Northern Ireland Medical & Dental Training Agency (nimdta.gov.uk)

2022-23 Portfolio Checklist F2 in GP

By the end of Placement 1

• **Completion of 4 months WTE training** (with 20 days or less permitted absence)

• Satisfactory CS End of Placement report

• Satisfactory ES End of Placement report

• **1 x TAB** (team assessment of behaviour). Ideally started in month 2 **OR**

• **Satisfactory Placement Supervision Group (PSG) report** (to be included in a CSR) if not enough colleagues in GP practice to perform TAB.

Satisfactory and contemporaneous completion of curriculum outcomes.

- Evidence of attaining the 13 FPCs (FPC descriptors page 65-79 in Foundation Curriculum)

Curriculum Links achieved (suggested **minimum** 5 links)

HLO1 _____ links (suggested min 5 per placement & min 25 for the year)

HLO2 _____ links (suggested min 5 per placement & min 25 for the year)

HLO3 _____ links (suggested min 5 per placement & min 15 for the year)

Evidence of experience in

- Acute setting
- Chronic disease
- Community setting

- **Evidence to satisfy FPC 1-5 must include clinical encounters in the form of SLEs**

CBD_____ MiniCEX _____ DOPS _____ LEARN _____ LEADER _____

◊ FPC2 requires evidence of the demonstration of the skills needed to initiate immediate management in the critically ill patient.

◊ Evidence of experience in mental health and social well being

- **Total of 60 hours of teaching recorded in learning log per year**

Minimum of 30 hours Core teaching per year. The remainder of hours can be core or non core to make up to the total.

◊ **Minimum of a total of 20 hours teaching per placement**

- **F2 – FLiGHT sessions**

◊ **Record of non-core teaching in learning log**

- **Evidence of reflection**

◊ Summary narrative commencement for HLO 1

◊ Summary narrative commencement for HLO 2

◊ Summary narrative commencement for HLO 3

- **ES progress report**

2022-23 Portfolio Checklist F2 in GP

By the end of Placement 2

- **Completion of 8 months WTE training** (with 20 days or less permitted absence)
- **Satisfactory CS End of Placement report**
- **Satisfactory ES End of Placement report**
- **Satisfactory Placement Supervision Group (PSG) report** (to be included in a CSR)
- TAB should have been completed and released in Placement 1.

Satisfactory and <u>contemporaneous</u> completion of curriculum outcomes.

- Evidence of attaining the 13 FPCs (FPC descriptors page 65-79 in Foundation Curriculum)

Curriculum Links achieved (suggested **minimum** 5 links)
HLO1 _____ links (suggested min 5 per placement & min 25 for the year)
HLO2 _____ links (suggested min 5 per placement & min 25 for the year)
HLO3 _____ links (suggested min 5 per placement & min 15 for the year)

Evidence of experience in

- Acute setting
- Chronic disease
- Community setting

- **Evidence to satisfy FPC 1-5 must include clinical encounters in the form of SLEs**

CBD_____ MiniCEX _____ DOPS _____ LEARN _____ LEADER _____

◊ FPC2 requires evidence of the demonstration of the skills needed to initiate immediate management in the critically ill patient.
◊ Evidence of experience in mental health and social well being

- **Total of 60 hours of teaching recorded in learning log per year**

Minimum of 30 hours Core teaching per year. The remainder of hours can be core or non core to make up to the total.

◊ **Minimum of a total of 20 hours teaching per placement (should have 40 hours by end of P2)**

- **F2 – FLiGHT sessions**

◊ **Record of non-core teaching in learning log**

- **Evidence of reflection**

◊ Summary narrative commencement for HLO 1
◊ Summary narrative commencement for HLO 2
◊ Summary narrative commencement for HLO 3

- **ES progress report**

2023 ARCP Requirements F2 in GP

By ARCP deadline (31st May 2023)

- **Completion of 12 months WTE training** (with 20 days or less permitted absence)
- **Satisfactory ES End of Year Report** (to be completed at the end of the last placement).
- **Satisfactory ES End of Placement report for *each* placement** (except for last placement where ES End of Year Report is completed).
- **Satisfactory CS End of Placement report for *each* placement.**
- **Satisfactory Placement Supervision Group (PSG) report** – should be completed in P2.
- **1 satisfactory TAB** – should be completed in P1.

Satisfactory completion of all curriculum outcomes.

Evidence of attaining the 13 FPCs (FPC descriptors page 65-79 in Foundation Curriculum)
Curriculum Links achieved (suggested **minimum** 5 links)
HLO1 _links (suggested min 5 per placement & min 25 for the year)
HLO2 _links (suggested min 5 per placement & min 25 for the year)
HLO3 _inks (suggested min 5 per placement & min 15 for the year)

Evidence of experience in

- Acute setting
- Chronic disease
- Community setting

- **Evidence to satisfy FPC 1-5 must include clinical encounters in the form of SLEs**

CBD_____ MiniCEX _____ DOPS _____ LEARN _____ LEADER _____

◊ FPC2 requires evidence of the demonstration of the skills needed to initiate immediate management in the critically ill patient.
◊ Evidence of experience in mental health and social well being

Satisfactory engagement with programme

- **Contemporaneous completion of portfolio**
- **Total of 60 hours of teaching recorded in learning log**

◊ Record of **core** teaching in learning log (30 hours minimum)

- F2 – FLiGHT sessions

◊ Record of **non-core** teaching in learning log **.**

- **Evidence of reflection**

◊ **Summary narrative completion for HLO 1,**
◊ **Summary narrative completion for HLO 2**
◊ **Summary narrative completion for HLO 3**

- **ES progress reports**
- **Completion of Form R**
- **Completion of Probity & Health Declarations**
- **Evidence of completion of additional requirements set by NIMDTA and approved by the UKFPO**

Single Lead Employers (SLE)

SICKNESS

In the event of any sickness days please inform your SLE your practice and email NIMDTA Foundation Team

F2 trainees: foundation.nimdta@hscni.net
F2 should report any absence due to sickness at the earliest opportunity to all four sources

1. Single Lead Employers
2. Their GP practice
3. NIMDTA
4. Their co-ordinator if missing a Friday tutorial

I am off due to sickness/COVID illness/COVID Isolation etc.
Who Do I need to Contact?

If you have been informed to Self-Isolate click here to view a **helpful flyer** on who you need to inform (**this will apply to other forms of leave as well**) and guidance on what to do during your isolation period.

You can also find the absence form here which is required to be completed and sent along with your rota to foundation.nimdta@hscni.net

Have you a query regarding:
Payslips?
Copy of Contract or Confirmation of Employment?
Query regarding your salary?
Please contact the Single Lead Employer team on DDIT-NIMDTA@hscni.net

Travel Expenses

Are you a Foundation Trainee wanting to Claim Travel Expenses?

Those who need to travel more than 40 miles to their place of work might be eligible for some reimbursement of travel costs. If you are a F2 Trainee in a GP Based Placement please refer to the Foundation Finance Guidance, Bank Mandate Form and Travel Expense Claim Form. Please follow the below link for further guidance -

https://www.nimdta.gov.uk/foundation-training/f2-guidance/foundation-finance-guidance/

If you are a F1 or F2 Trainee in a Hospital Based Placement, your expenses need to be submitted through HRPTS – please contact the Single Lead Employer Department for more information – DDIT-travel@hscni.net

Valuable websites

Valuable web sites

GP Notebook gives precise succinct answers to most clinical conditions encountered in GP; it has excellent sections on prognosis, treatment and management easily used during a consultation. http://www.gpnotebook.co.uk/homepage.cfm

www.patient.co.uk Very useful for printing off patient information leaflets and directing patients to.

NICE bites - www.elmmb.nhs.uk

The Northern Ireland formulary at niformulary.hscni.net

GP Team—Staff Name	
Dr Michele Stone	GP Director
Dr Paul Carlisle Dr Andrew Leitch Dr Kathryn Potter Dr Marie King	GP Specialty Training Associate Directors
Prof Nigel Hart	Associate Director - Quality Improvement
Lauran Morrow	GP Training Manager
Natasha Hunter Jane Haslett	GP Training Coordinators
Mandy Boyle Susie Nelson Suzanne Enticott Helen Rowan Jordan Lemon Alexandra Patterson Katharine Miller Ciaran Hamill Oscar Gallagher	GP Specialty Training Administration Team