**Covering the foundation competencies while in general practice**

This is a selection of ideas produced at the trainer’s conference and following experience in the pilot F2 years in Health Education North West.

Many competencies can be achieved during a 4 month general practice placement but we advise focusing on specific areas and covering others if they arise or are required by a specific doctor.

The most appropriate areas are:-

* + Communication
  + Primary secondary care interface
  + Team work
  + Triage and problem solving
  + Clinical governance and risk management
  + Critical appraisal skills
  + Management skills
  + Chronic disease

**Communication skills –**

This encompasses both patient consultation and inter-professional communication. This is an opportunity to build on basic consultation theory covered at undergraduate level and application in practice depending on the level and career plans of the doctor. There is a need to be adaptable depending on assessed need. It is suggested that areas to concentrate on for all doctors are the use of hypothetico-deductive history taking, eliciting patient’s ICE and explanation skills.

Video and role play should be used for feedback and skill development.

**Teamwork –**

We need to use all the opportunities in the PHCT.

It is important to be aware that many Foundation doctors will have sat in and been involved with team members as medical students. It may be better to use attachments but link learning to a specific clinical problem that arises. For example if the patient presents with a leg ulcer the doctor should track the patient to the district nurse.

Everything from reception to nurses and people outside the practice may be appropriate.

The Foundation doctors need time to reflect on the teamwork seen and how it works or does not in relation to the provision of effective patient care

Patients with chronic illness and palliative care problems are a useful resource.

**Triage –**

The processes for introducing and developing these skills could involve knowledge based tutorials, role play, and by observation.

Ideally the doctors should then carry out observed phone advice with feedback and then be able to see the patients they have spoken to in surgery.

There should be reflection on the problems of phone consultations and problem solving.

They need to be specifically exposed to the hypothetico-deductive consulting model in this setting.

**Clinical governance and risk –**

The doctors should see the processes and if possible be involved. The aim is to demonstrate that clinical governance is not just a ‘tick box’ exercise.

Ideally they should carry out an audit and be involved with Significant Event Analysis.

It would be appropriate for involvement in Health and Safety and risk assessment as needed.

**Chronic disease –**

A wide variety of conditions can be seen in the primary care setting.

The doctors need to learn how to manage problems not just collect data.

There are good opportunities to look at protocols, the clinical evidence base and interact with the team.

Foundation doctors can usefully run clinics alongside nurses and complete templates etc.

It has been found that carrying out appropriate chronic home visits are very educational. The time spent in patient’s homes can also help with room allocation problems if space is tight at the surgery.

Both processes also enable development of knowledge about clinical IT systems and templates.

It would be appropriate to introduce the concept of the need for medication reviews, use of formularies and resource issues.

**Primary secondary care interface –**

The doctors can look at communication issues in a variety of ways – traditional written, verbal and IT based.

There is an option to visit patients in hospital and then see them back at home.

Useful tasks include clarification of discharge letters and sorting post hospital medication.

Significant Event Analysis is an important area to be aware of when looking at admissions and discharge.

Review of patients with results and seeing the investigations in hospital if appropriate.

**Critical appraisal –**

Review of new guidelines that come to the practice is very useful especially if this is followed by a presentation to the team.

This can lead to discussions around protocols and change management.

This could arise from RCA or just an interest.

The foundation doctors should be involved in audit and evidence searches.

Review of research papers is a useful skill to develop.

**Management –**

The foundation doctors can be involved in practice management. This will be influenced by perceived need – such as career intentions. The learning objectives need to be clear.

PHCT and LMC meetings may be appropriate.

Presentation skills can be demonstrated and improved with feedback.

Time management, delegation and negotiation can all be covered.

Involvement with staff interviews, induction and training are useful activities in developing an understanding of Primary care as well as acquiring personal skills.

**How can a career surgeon get the most out of a primary care placement?**

The trainers discussed the issues that could be raised by a doctor who had a fixed career plan and did not really want to be based in primary care for 4 months.

This should not really be a problem as primary care is an excellent place to achieve many of the competencies.

However it was felt that the **“I would rather be in Theatre”** scenario could occur.

The doctor needs to be engaged and the supervisor needs to demonstrate the many positive aspects of the primary care experience.

There are a number of ideas that would provide very good learning opportunities.

Looking at the primary - secondary care interface in more detail:-

* Follow the patient through a major surgical procedure and then back home.
* Discharge planning and complications
* Prescribing after surgery
* Involvement with the primary health care team. Specifically in this case the district nurses, palliative care nurses and occupational therapy/physiotherapy services
* Look at preparation for surgery of patients with chronic illness.

Opportunities around minor surgery:-

* Consent
* Clinical governance and risk
* Carrying out procedures.
* GP ‘special interest’ skills

Communication skills:-

* What has the patient been told? – checking understanding
* “Bad news”
* Social and psychological factors pre and post surgery
* Explanation

This plan can obviously be varied for different doctors as the need arises