

Dear Colleague

## FY1 INDUCTION AND SHADOWING ARRANGEMENTS

### Summary

1. This DL advises NHSScotland employers of the arrangements to be applied by NHS Boards in relation to the Foundation House Officer 1 (FY1) mandatory Induction / Shadowing arrangements for the annual intake. The arrangements have been developed in liaison with NHS Board Heads of Medical Staffing, Directors of Medical Education and BMA (Scotland).

### Induction / Shadowing Programme Period

2. NHS Boards will establish appropriate local arrangements for the effective Induction / Shadowing of new FY1 junior medical staff annually from July / August. The arrangements will comprise a minimum 4 day remunerated programme divided approximately 50/50 between a (classroom) Induction Programme and clinical based Shadowing of current FY1 junior medical staff and their clinical teams. At least 50% of the Induction / Shadowing programme period should be spent in shadowing. Guidance on the core content and approach to Induction / Shadowing has been developed by Directors of Medical Education and this is attached as an Annex to this DL.

### Remuneration

3. In completion of the mandatory Induction / Shadowing programme the new FY1 junior medical staff will be remunerated for the 4 days of Induction / Shadowing immediately prior to commencing the full contractual role on the basis of the national FY1 basic salary with no payment of a Banding Supplement.

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**7 June 2016**

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### Addresses

#### For action

Chief Executives,  
Directors of Finance,  
Directors of Human  
Resources  
NHS Boards and  
Special Health Boards,  
NHS National Services  
(Scotland) (Common  
Services Agency and  
Health Improvement  
Scotland (HIS)  
Medical Staffing  
Departments

#### For information

Members, Scottish  
Partnership Forum (SPF)  
Members, Scottish Terms  
and Conditions Committee  
(STAC)  
Members, Scottish  
Workforce and Governance  
Committee (SWAG)  
Management Steering  
Group (MSG)

#### **Enquiries to:**

Daniel MacDonald  
Scottish Government  
Health Directorates  
St Andrew's House  
Regent Road  
Edinburgh EH1 3DG

Tel: 0131-244 3016

Fax: 0131-244 3465

Point of contact

[daniel.macdonald@gov.](mailto:daniel.macdonald@gov.scot)

[scot](mailto:scot)

[www.gov.scot](http://www.gov.scot)

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## **Contract Start Date and Associated Matters**

4. For the annual FY1 intake the contract start date will be the date on which the Induction / Shadowing begins with the new FY1s being remunerated for attendance at the local mandatory Induction / Shadowing Programmes.
5. In future years, the contract start date will be the Thursday preceding the FY1's date of taking up full duties and responsibilities.
6. Contracts of Employment will clearly indicate that the new FY1's will have no entitlement to payment of a Banding Supplement until they take up the full contractual role expected of an FY1. In future years rotational dates will be detailed in an appropriate CEL.
7. Paragraph 121 of the Terms and Conditions Medical and Dental Staff Scotland (2002) Handbook will apply in relation to the establishment of the incremental date for the new FY1s, i.e. the date from which the new FY1s are remunerated.
8. It should be noted that the incremental date for FY1 junior medical staff is re-set on appointment as an FY2.

## **GMC Registration**

9. Through planned timeous communication with the new FY1 junior medical staff they will be informed that GMC Provisional Registration is required for the mandatory Induction / Shadowing programme. They will also be reminded of the significance of making timeous application to the General Medical Council for Provisional Registration to achieve this.

## **Compulsory Pre-Employment Checks**

10. Compulsory Pre-Employment Checks for PVG and Occupational Health will require to be completed prior to the Induction / Shadowing period and on the corresponding date in future years.
11. Mutual obligations on this will be reinforced through effective communication with the new FY1 junior medical staff. This forms part of the agreement within the Code of Practice.
12. NHS Boards will inform Disclosure Scotland and their local Occupational Health Services in relation to the earlier dates of peak demand.

## **Supervision of the New FY1s**

13. The status of the new FY1 junior medical staff during Induction / Shadowing is that they are on supernumerary attachment to the clinical team without allocation of any clinical responsibilities.
14. The new FY1s will not be included on rotas and will not work unsupervised during the Induction / Shadowing period.
15. This status will be made clear to all concerned.

## Accommodation

16. It is recognised that in some NHS Boards the provision of accommodation for the new FY1 junior medical staff may be problematic due to levels / double demand.

17. The new FY1s will be notified of this in advance and where necessary will be supported in making local short term alternative arrangements, in accordance with the recruiting NHS Board's local policy.

## Communications

18. It is recognised that early and effective ongoing communication with the new FY1 junior medical staff is important and will assist greatly in personal and organisational preparations to deliver the most positive experience and benefits from the mandatory Induction / Shadowing Programme.

19. Early communication with the new FY1 junior medical staff will be actioned through The Foundation Programme web site: [www.foundationprogramme.nhs.uk](http://www.foundationprogramme.nhs.uk), through Scottish Medical Schools and through the GMC roadshow meetings.

## Action

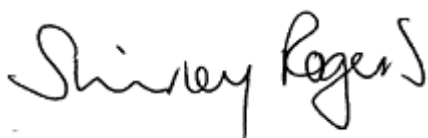
20. NHS Boards and Special Health Boards are required to:

- a) apply the agreed arrangements;
- b) ensure that all relevant staff are aware of the new arrangements; and
- c) employers are asked to make their own arrangements for making copies of this DL which is available on the SHOW website at:  
<http://www.scot.nhs.uk/publications/asp>

## Enquiries

21. Employees should direct their personal enquiries to their employing Board, Special Health Board, NHS National Services Scotland (the Common Services Agency) or Health Improvement Scotland.

Yours sincerely



**SHIRLEY ROGERS**

Director of NHS Workforce

## ANNEX 1

### INDUCTION AND SHADOWING FOR NEW FOUNDATION DOCTORS IN YEAR 1

#### 1. INTRODUCTION

1.1 Tomorrows Doctors (2009 para 110) sets out a requirement that medical students must be properly prepared for their first allocated F1 post. It suggests that they should, wherever practicable, have a period working with the F1 who is in the post they will take up when they graduate.

1.2 Supplementary GMC guidance on “Clinical placements for medical students” (Feb 2011) states: “Shadowing is a period of time when a medical student goes to the site where they will be working as an F1 doctor and assists the F1 whom they will replace when they start employment. This time period should ideally take place as near to the date that they will start their F1 position as possible.”

1.3 In 2012 the Workforce Availability Policy and Programme Implementation Group (WAPPIG) issued guidance [WAPPIG Shadowing guidance note - final.pdf](#) to Strategic Health Authorities in England on implementation of a period of paid shadowing in the week prior to new F1 doctors taking up their first post. While this guidance was widely circulated in Scotland, Health Boards took individual decisions about how to implement a paid shadowing period and the content of that period.

1.4 From 2013 the Management Steering Group, representing NHS Employers in Scotland, has agreed that all NHS Boards will offer a minimum four days paid induction and shadowing to all new Foundation doctors in this and subsequent years.

1.5 This paper sets out guidance on the intended learning outcomes and suggested content of the shadowing period.

#### 2. CONTENT TO BE INCLUDED:

##### ***Familiarisation***

2.1 UKFPO annual report (2010) shows that only 58% of graduates are recruited to the Foundation Programme most closely associated with their medical school. A large minority of F1 doctors will therefore commence their first post in a hospital that they may have had little or no association.

2.2 The shadowing and induction programme should therefore be set at a level that assumes at least some of the doctors will be completely new to the hospital(s) concerned and to the area.

##### ***Induction***

2.3 This component needs to address the areas of induction that are essential to undertake shadowing and then fulfil responsibilities of an F1 doctor by the first Wednesday of August.

##### ***Shadowing***

2.4 Should allow the new doctor to become familiar with the environment and working pattern of those in the ward, department or practice in which they will be working. This requires sufficient time working directly with the relevant F1 doctor over the course of a shift or shifts. Where possible it is recommended that shadowing should be for full days or shifts.

##### ***Outcome***

2.5 The new F1 doctor should, on first day of their first job, be familiar with their environment and the work that will be expected of them. They should be able to describe their responsibilities in ensuring safe and effective patient care and know where to turn for supervision and support. They

should also be aware of any further expectations for induction that will be required during the early weeks of their employment.

### **3. PRINCIPLES IN SETTING THE CONTENT FOR PROGRAMME**

3.1 Foundation doctors should participate in the induction / shadowing programme arranged by the Board in which they will be undertaking their first foundation programme placement from the first Wednesday in August each year.

3.2 The content of the induction programme for F1 doctors in Scotland should be agreed within each Health Board with Director of Medical Education taking a lead in approving the structure and content of the programme.

3.3 The induction and shadowing programme should comprise of four days which will be paid and be mandatory for all F1 doctors. The programme should be divided 50/50 between a (classroom) Induction Programme and shadowing of current FY1 Junior Medical Staff and their clinical teams. At least 50% of the programme period should be spent in shadowing. Where NHS Boards run additional non-mandatory shadowing arrangements these may continue on a voluntary, unpaid basis.

3.4 As a guideline 16 hours during the four mandatory paid days should be spent shadowing Foundation doctors in the clinical area in which the new doctor will first commence work.

### **4. SUGGESTED CONTENT OF INDUCTION**

4.1 The induction section of the programme will vary between Health Boards but is likely to contain most or all of the following.

- Fire safety
- Personal Well-Being
- Management of Risk / Incident reporting
- Communication / Handover/ Hospital at Night
- Use of Laboratories and Radiology
- Infection Control and Anti-Microbial guidelines
- Safe prescribing
- Blood Transfusion
- Do Not Attempt CPR / Death in Hospital
- Simulation training / managing medical emergencies
- IT security and induction on local IT systems
- Annual, Maternity, Paternity Leave
- Remuneration
- Occupational Health and Safety
- Data Protection / Information Governance
- Whistleblowing
- Sickness Absence
- Social Media Policy
- How to use a bleep

4.2 Additional basic level training can be delivered through online systems (e.g. learnPro) during the early weeks of first placement e.g. Adult Support and Protection, Child Protection, Prevention and Management of Violence and Aggression, Manual Handling, Equality and Diversity, Safer use of insulin.

4.3 Set out below is a list of Procedures which the GMC suggest that Foundation Doctors should be able to carry out safely and effectively (Tomorrow's doctors 2009);

### **Diagnostic Procedures**

- |   |  |
|---|--|
| 1. Measuring body temperature                                     | ... using an appropriate recording device  |
| 2. Measuring pulse rate and blood pressure                        | ... using manual techniques and automatic electronic devices.  |
| 3. Transcutaneous monitoring of oxygen saturation                 | Applying, and taking readings from an electronic device which measures the amount of oxygen in the patient's blood.  |
| 4. Venepuncture   | Inserting a needle into a patient's vein to take a sample of blood for testing or to give an injection in the vein.  |
| 5. Managing blood and samples correctly                           | Making sure that blood samples are placed in the correct containers and that these are labelled correctly and sent to the laboratory promptly in the correct way. Taking measures to prevent spillage and contamination. |
| 6. Taking blood cultures  | Taking samples of venous blood to test for growth of infection organisms in the blood. Requires special blood containers and laboratory procedures.  |
| 7. Measuring blood glucose  | Measuring the concentration of glucose in the patient's blood at the bedside using appropriate equipment and interpreting results.   |
| 8. Managing an electrocardiograph (ECG) monitor                   | Setting up a continuous recording of the electrical activity of the heart. Ensuring the recorder is functioning correctly and interpreting the tracing.  |
| 9. Performing and interpreting a 12-lead electrocardiograph (ECG) | Recording a full, detailed tracing of the electrical activity of the heart using a machine recorder (electrocardiograph).  |
| 10. Basic respiratory function test                               | Carrying out basic tests to see how well the patient's lungs are working (for example, how much air they can breathe out in one second.)   |
| 11. Urinalysis using Multistix                                    | Testing a sample of urine for abnormal contents such as blood or protein. The urine is applied to a plastic strip with chemicals which change colour in response to specific abnormalities.                              |
| 12. Taking nose, throat and skin swabs                            | Using the correct technique to apply sterile swabs to the nose, throat and skin.   |
| 13. Nutritional assessment  | Making an assessment of the patient's state of nutrition. This includes an evaluation of their diet, their general physical condition and measurement of height, weight and body mass index.                             |

14. Pregnancy testing	Performing a test of the urine to detect hormones which indicate that the patient is pregnant.
15. Administering oxygen	Allowing the patient to breathe a higher concentration of oxygen than normal, via a face mask or other equipment.
16. Establishing peripheral intravenous access and setting up an infusion; use of infusion devices	Puncturing a patient's vein in order to insert an indwelling plastic tube (known as a "cannula"), to allow fluids to be infused into the vein (a "drip"). Connecting the tube to a source of fluid. Appropriate choice of fluids and their doses. Correct use of electronic devices which drive and regulate the rate of fluid administration.
17. Making up drugs for parenteral administration	Preparing medicines in a form suitable for injection into the patient's vein. May involve adding the drug to a volume of fluid to make up the correct concentration for injection.
18. Dosage and administration of insulin and use of sliding scales	Calculating how many units of insulin a patient requires, what strength of insulin solution to use and how it should be given (for example into the skin, or into a vein). Use of a "sliding scale" which links the number of units to the patient's blood glucose measurement at the time.
19. Subcutaneous and intramuscular injections	Giving injections beneath the skin and into muscle.
20. Blood transfusion	Following the correct procedures to give a transfusion of blood into the vein of a patient (including correct identification of the patient and checking blood groups). Observation for possible reactions to the transfusion and correct actions if they occur.
21. Male and female urinary catheterisation	Passing a tube into the urinary bladder to permit drainage of urine in male and female patients.
22. Instructing patients in the use of devices for inhaled medication	Providing instructions for patients about how to use inhalers correctly, for example, to treat asthma.
23. Use of local anaesthetics	Using drugs which produce numbness and prevent pain, either applied directly to the skin or injected into skin or body tissues.
24. Skin suturing	Repairing defects in the skin by inserting stitches (normally includes use of local anaesthetic).
25. Wound care and basic wound dressing	Providing basic care of surgical or traumatic wounds and applying dressings appropriately.
26. Correct techniques for "moving and handling", including patients	Using, or directing other team members to use, approved methods for moving, lifting and handling people or objects, in the context of clinical care, using methods that avoid injury to patients, colleagues, or oneself.
27. Giving information about the	Making sure that the patient is fully informed, agrees to

procedure for obtaining and recording consent and ensuring appropriate aftercare

the procedure being performed and is cared for and observed appropriately after the procedure.

28. Hand washing (including surgical “scrubbing up”)

Following approved processes for cleaning hands before procedures or surgical operations.

29. Use of personal protective equipment (gloves, gowns, masks)

Making correct use of equipment designed to prevent the spread of body fluids or cross-infection between the operator and the patient.

30. Infection control in relation to procedures

Taking steps necessary to prevent the spread of infection before, during or after a procedure.

31. Safe disposal of clinical waste, needles and other “sharps”

Ensuring that these materials are handled carefully and placed in a suitable container for disposal.

## **5. IMPLEMENTATION**

5.1 Directors of Medical Education will agree arrangements for mandatory attendance at induction and shadowing programmes with HR leads in each Board. They will also liaise with Foundation Programme Directors and/or Foundation leads within Boards to ensure the content of the induction and shadowing programme meets clinical requirements.



## **ANNEX 2**

**The undernoted guidance is for use by Medical Staffing / HR colleagues in the wording of offer letters and contracts of employment to Foundation House Officer Year 1 appointments:**

### **1. MANDATORY INDUCTION / SHADOWING ARRANGEMENTS**

#### **1.1 Purpose**

You are required to participate in a mandatory four day / 32 hour programme of Induction / Shadowing. Remuneration for attendance at this programme will commence on dd/mm/yyyy. The purpose of this programme is to ensure that on commencement of your Foundation House Officer Year 1 (FHO1) post on dd/mm/yyyy you are able to:

- Demonstrate that you are familiar with the working environment for your FHO1 post;
- Understand your responsibilities for safe and effective patient care, including how to seek supervision;
- Demonstrate familiarity with the relevant IT systems and procedures in your area of work; and
- Understand the responsibilities and limitations of your FHO1 post.

During the mandatory Induction / Shadowing period you will be attached, on a supernumerary basis, to a clinical team. You will not have any clinical responsibilities or undertake any unsupervised work.

#### **1.2 Pay Arrangements**

Remuneration for attendance at the Induction / Shadowing programme will commence dd/mm/yyyy. You will be paid on the basic pay point of the FHO1 salary scale currently, £XX,XXX per annum. You will not receive any banding supplement during the Induction / Shadowing programme.

#### **1.3 Other provisions**

With the exception of provisions contained at section 2.3 below all other terms and conditions of the contract will apply and accrue during the period of attendance at the mandatory Induction / Shadowing programme.

### **2. POST INDUCTION / SHADOWING PERIOD PAY ARRANGEMENTS**

#### **2.1 Pay Scale/Point**

You will be paid on the Foundation House Officer Year 1 payscale.

Your base salary will be £XX,XXX per annum, paid monthly and will progress by annual increments in accordance with the current, nationally agreed, salary scale for your grade. These rates are subject to amendment from time to time.

#### **2.2 Incremental Date**

Your incremental date will be dd/mm/yyyy.

## 2.3 Pay Banding

With effect from August 20XX , in addition to your base salary, you will receive a xx% banding supplement for duty contracted at pay band xx. This supplement will be payable monthly and is non-superannuable.