Guidance on undergraduate clinical placements

General Medical Council

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Introduction

Purpose of this guidance and who it is aimed at

This guidance applies to everyone involved in undergraduate clinical placements and assistantships. This includes medical schools, placement providers and medical students. Where appropriate and relevant it can also be used by educators and placement providers involved in clinical placements for physician associates.

It aims to support medical schools and placement providers to meet our standards linked to clinical placements. It also gives guidance on addressing issues which impact on placements or student welfare. Students can use this guidance to learn what's expected of them on their placements.

It brings together the key standards and requirements linked to clinical placements in *Outcomes for graduates*, *Promoting excellence: standards for medical education and training* and *Promoting excellence: equality and diversity considerations*.

The role of clinical placements and those involved

Clinical placements are important within an undergraduate medical programme. Placements give medical students (students) practical experience in different healthcare settings. This experience plays a vital role in preparing students for medical practice. It's important to plan placements with the most learning potential. Students should be integrated and valued within clinical teams. Organisations responsible for the education and training of medical students should deliver high-quality educational and clinical supervision. Supervisors should be well trained and compassionate.

Students

Students are responsible for their own learning and should meet our *Outcomes for graduates* and be able to carry out the necessary *Practical skills and procedures* by the time they qualify. They should feel prepared and supported, which helps to create good learning opportunities. Throughout this guidance we refer to students as one group, but they all bring different skills and experience. Diversity across medical school cohorts diversifies the medical field, which benefits patient care and should be supported.

Medical schools

Medical schools should work with placement providers to arrange placements that have genuine educational value. They should give students the opportunity to experience what it's like working in a range of healthcare settings including primary, secondary, community or other health and social care settings.

Placement providers

Placement providers should work with medical schools to effectively manage clinical placements. Placement providers should make sure students can build on their knowledge and practical experience as required in *Outcomes for graduates*. Placement providers should be knowledgeable about raising concerns procedures. They should also understand equality, diversity and inclusion policies that concern students' welfare.

How the clinical placements guidance relates to our other standards and guidance

Through *Outcomes for graduates*, we set the learning outcomes for UK medical students to make sure they have the skills, experience and behaviours needed to join our register. Combined with *Practical skills and procedures* we make sure those qualifying in the UK are safe to begin work as a foundation doctor.

Promoting excellence: standards for medical education and training sets out the requirements for the management and delivery of undergraduate and postgraduate medical education and training. As part of this, we expect education providers to prepare students to make the transition from medical school to professional practice.

This guidance brings together the key standards and requirements in Outcomes for graduates, Promoting excellence and *Promoting excellence: equality and diversity considerations* that relate to clinical placements and student assistantships. It includes professional values and behaviours in *Good medical practice*, and links them to the planning and management of undergraduate clinical placements. The guidance was also produced in line with *Caring for doctors, Caring for patients*. Please read these documents if you're planning a clinical placement or assistantship.

This guidance includes key themes from the documents. They're shown in the four theme headings:

- Patient safety
- Quality of placements

- Medical students should feel prepared, supported, and safe
- Medical students should feel part of a team

What we mean by…

Clinical placement

A clinical placement can be defined as any arrangement where a student is present, for educational purposes, in an environment that provides healthcare or related services to patients or the public. Placements can take place in primary, secondary, community or other health and social care settings (with some aspects being undertaken remotely such as consultations) and are not confined to the working environment of doctors but should include the wider multidisciplinary team. Students can be actively involved and contribute to patient care as part of the team

Student assistantship

A student assistantship is a type of clinical placement, undertaken towards the end of the student's undergraduate course. It should be designed to prepare the student to start practice as an F1. Although some direct care of patients is implicit and necessary, it is primarily an educational experience. It should provide a number of hands-on learning experiences that allow the student to work within clinical settings and to practise clinical skills. The students should be fully integrated within a clinical team and should be responsible for carrying out specified duties under appropriate supervision.

Shadowing

Shadowing is a period of time that should be provided to all graduates to help them get to know the site of their Foundation Year 1 training and assist the F1 who they will replace when they start employment. This time period should ideally take place as near to the date as possible that they will start their F1 position.

Named educational supervisor

A named educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specific student's educational progress during a placement. They can be based within the medical school or placement provider. The named educational supervisor should regularly meet with the student to help plan their training and review progress against agreed learning outcomes. They should bring together

all relevant evidence to form a summative judgement about the student's progression at the end of a placement. They should also facilitate the student's reflective learning by discussing with them the patients and procedures they have experienced during their placement.

Named clinical supervisor

A named clinical supervisor is a trainer who is responsible for overseeing a specific student's clinical work throughout a placement in a clinical or medical environment and is appropriately trained to do so. The named clinical supervisor leads on providing a review of the student's clinical or medical practice throughout a placement and contributes to the educational supervisor's summative judgement at the end of a placement.

Clinical governance

Clinical governance is the system through which National Health Service (NHS) and Health and Social Care (HSC) organisations are accountable for continuously monitoring, improving and safeguarding the quality of their care and services.

Supervisors

Different grades of doctors and senior healthcare professionals can provide different levels of supervision for students. These are explained in full in section 8 – Supervision.

Patient safety

1. Patient safety

Good students and doctors make the care of their patients their priority, so should the organisations that educate and train them. In non-clinical learning environments, there should also be a culture of promoting patient safety.

The professional learning environment is very important for students' development and patient safety. Patients should be safe, their care and experience should be good, and education and training should be valued.

'Preparedness for practice' means the readiness of students to work in clinical practice. It includes not only clinical skills but also behavioural, emotional, and attitudinal aspects. The purpose of undergraduate education and training is to meet the learning outcomes required for provisional registration with us. Students should meet the required standards of knowledge,

skills, and professional attributes. In particular, putting the interests of patients first at all times. They should assess their own capabilities and limitations, act within these boundaries, and know when to request support and advice.

a. The safety of patients should be the primary concern of medical schools, placement providers and students. Our *Promoting excellence* guidance outlines several key points on page 5 relating to patient safety during clinical placements.

b. For the safety of patients and students, students should be aware of the following guidance and follow it while on a clinical placement.

- Our guidance *Good medical practice* and our other guidance relating to issues such as consent, confidentiality and end of life care
- Our *Raising and acting on concerns about patient safety* guidance. Medical schools should give students transparent guidance on how to raise concerns and the necessary steps involved
- The guidance *Achieving good medical practice: guidance for medical students*, which we publish in collaboration with the Medical Schools Council
- The guidance *Professional behaviour and fitness to practise*, which we publish in collaboration with the Medical Schools Council
- Guidance issued by the UK health departments on professional practice
- Guidance and protocols used in the specific placement to protect patient and student safety.

2. Patients' rights

a. Patients should be informed via accessible formats that students are present for learning at the site. For example, patient leaflets, admission leaflets and outpatient letters. This should also include information about their right to object to the involvement of students without prejudice to their care.

b. As part of the consent taking process the doctor, or other healthcare professional, should explain to the patient how the student will be supervised and emphasise that they are part of the clinical team.

c. Students should have opportunities to observe the consent process.

d. Where students are more directly involved in patient care, for example being present in consulting rooms or observing treatment, specific consent should be obtained from the patient to make sure that they are comfortable having a student present. This consent should be obtained by the doctor or other registered healthcare professional responsible for the treatment.

e. Students with appropriate clinical experience may, under supervision, be responsible for explaining to patients what will happen to them. In some cases, they may take consent for minor procedures such as taking a blood sample or a blood pressure reading. For further information please refer to *Decision making and consent*. However, students should not take written consent for any procedures.

f. Medical schools should be aware of our supplementary guidance, *Confidentiality: disclosing information for education and training purposes*, in particular sections 4, 5 and 6.

Quality of placements

3. Planning clinical placements

a. There should be a person or team based at the placement provider responsible for organising the clinical placement. This should happen in conjunction with the medical school. The medical school lead or team should communicate with the departmental lead and supervisors for the placement. They should make sure the teams are aware of the details of the placement.

b. Medical schools should make sure all placements are adequately resourced for all settings. They should be mindful of requirement 5.4 in *Promoting excellence* and the requirement highlighted in theme 1 of the *Promoting excellence: equality and diversity and equality considerations*.

c. All placements should have clearly defined learning outcomes. These should be linked to those set out in *Outcomes for graduates*. These learning outcomes should be communicated to those responsible for delivering teaching in the placement. Their individual roles in helping students to achieve the outcomes should be clearly defined.

d. Medical schools should make sure clinical placement providers are aware of the learning outcomes required for each placement. This includes the knowledge, skills and behaviours students will need to acquire in order to complete their logbooks.

e. Medical schools should give students clear guidance on what responsibilities they can expect to have on a placement. They should outline the duties students will be asked to carry out. If any reasonable adjustments are needed, these should be addressed in advance. Before they start, all students should have time to review the placement setting and duties.

f. Medical schools must give details about students to the person or team based at the placement provider responsible for organising the clinical placement. For example, their level of competence. These details should be passed to the supervisors and should happen well in advance of the placement. Supervisors are then responsible for passing on this information to individual clinical team members to allow effective organisation of teaching opportunities, clinical activities and supervision for the students.

g. Medical schools should offer students continual training and support during placements. Key topics include:
   - harassment, including micro-aggressions, ally-ship and being a bystander
   - mental health support
   - discrimination
   - speaking up. A raising concerns policy should be shared with students before or at the start of the placement. It should be quality assured and regularly evaluated by medical schools.

h. Our report *Caring for doctors Caring for patients* describes how medical schools should work collaboratively with students to:
   - get feedback to meet their specific needs
   - offer confidential services tailored to the needs of students
   - make sure students have an effective way to feedback and speak up about concerns, eg bullying and undermining.

4. Equality, diversity and inclusion

It is clear that clinical placements are an area of particular difficulty for medical students in terms

of witnessing and/or being the subject of discriminating behaviour. The points below are some actions medical schools can consider to improve the quality of placements for students from all backgrounds. There is further guidance from The Medical Schools Council as detailed in their framework *Active Inclusion: Challenging exclusions in medical education*.

a. Medical schools should understand and address equality, diversity and inclusion challenges. They must anticipate rather than react to student's diverse needs.

b. Medical schools and placement providers should create an inclusive culture and fair training environment at placements. They should respect different values, beliefs and perspectives.

c. When medical schools arrange placements for students, they should;
   - consider the student's culture or religious values and how to respect them in different areas of practice. Students should be given guidance or policies before the placement. For example, dress code or religious observance
   - be aware of any specific requirements the student has for their placement. The placement provider should be told about this
   - remember their obligations under the Equality Act 2010. There must be no unfair discrimination on the grounds of religion or belief, age, sex or gender, marriage and civil partnership, race, sexual orientation and disability as they organise clinical placements
   - take action to actively prevent and address racial harassment. There are recommendations in the BMA's Racial harassment charter for medical schools. Medical schools should ensure that robust reporting measures are in place but expand the coverage, so it is inclusive for all students who have protected characteristics.

d. Medical schools should make reasonable adjustments for students with disabilities. They should have the same placement opportunities as other students. Refer to Chapter 3 of our *Welcomed and valued* guidance - What is expected of medical education organisations and employers.

   Organisations must take positive steps to make sure disabled learners can fully take part in education and other benefits, facilities and services. This includes:

   - anticipating needs of disabled learners
   - avoiding substantial disadvantage for disabled learners

- thinking again if an adjustment has not been effective.

e. Placement providers should make sure students are protected from discrimination, abuse or violence, as they would for any NHS or HSC staff members. If students experience discrimination, they should have support available. Actions to prevent and address discrimination should be documented.

f. If the placement provider has an equality and diversity officer, the student should be given their contact details. Medical schools should make sure agreements with placement providers are consistent with *Promoting excellence: equality and diversity considerations*.

5. Providing enough capacity for learning

a. Medical schools should make sure there is enough capacity for learning on clinical placements, and students can meet their learning outcomes.

b. Medical schools, allied health professions trainers and placement providers should consider new ways to deliver placements. For example, combining clinical placements for medical students with other health profession students. This increases learning opportunities between these professions. Or running placements in the third sector if funding is available.

c. Medical schools should make sure placement providers are well prepared to receive students. They should work with other schools to address issues like capacity where placements overlap geographically.

d. Placement providers should plan sessions, so all students are given equivalent learning opportunities. This is especially important when a large number of students attend a placement.

e. Medical schools should make sure that all students have access to planned teaching sessions and lectures. The location of the placement shouldn't affect this. Students should receive the standardised level of teaching to meet the curriculum.

6. Offering a variety of placements

a. Medical schools should be aware of points R5.3 (b) and (d) in *Promoting excellence: standards for medical education and training*. It says students should experience a variety of settings, specialties and patient groups within areas servicing diverse communities.

b. Medical schools should make sure students experience a variety of placements. For example, urban and rural, tertiary and district general hospitals, and community and third sector settings.

c. Medical schools should balance an increasing variety of placements (which can mean shorter placements) with longitudinal placements. This gives students a better understanding of the patient journey. It also gives them time to integrate into the clinical team.

d. Medical schools should provide students with clinical placements and direct patient contact in the early years of the programme.

e. Medical schools should work with placement providers in general practice and hospitals. This helps students understand the patient journey from primary care to secondary care and then to community and social care.

f. Medical schools and placement providers should make sure students can recognise and know how to manage acute mental health issues in all patients. For example, eating disorders or a mental health crisis.

7. Relationships with clinical placement providers

a. Medical schools should have formal, written agreements with all placement providers. This should cover the provision of education and training to provide students with the knowledge, skills and behaviours as set out in *Outcomes for graduates*. They should have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements. These agreements should be easily accessible. For example, on the school's intranet.

b. The process for the allocation of financial resources for undergraduate medical education varies across the four countries of the UK. Medical schools will be aware of the processes in their own areas and should keep up to date with any developments or changes in the way that funding is allocated. Placement providers in NHS, Health and Social Care (HSC) system in Northern Ireland, and non-NHS settings should be adequately funded to carry out high quality clinical placements.

c. The agreement should clearly state who at the medical school is responsible for coordinating clinical placements for their students. These individuals should be available as a point of contact for placement providers if there's a problem with a placement. The agreement should

state who is responsible for organising clinical placements at the placement provider. If placements are across more than one site, the medical school should have a named individual who is responsible for clinical placements for students at each site.

d. Agreements between medical schools and placement providers should set out a process for raising concerns. For example, about the way the placement is being run, the content of the placement or the behaviour/conduct of the supervisors and students. The agreement should contain a clear series of steps for raising a concern and explain the appropriate action to address the situation.

e. Agreements between medical schools and placement providers should state clearly how students can access pastoral care and be supported throughout their clinical placement. This should include supporting students with mitigating circumstances, personal life challenges, wellbeing issues and students speaking up on issues such as bullying and harassment.

f. There should be regular feedback and communication between the medical school and placement providers about the quality and delivery of placements. Placement providers should participate in medical school quality assurance programmes, support data collection, and review relevant actions from the medical school's student placement evaluation.

g. Medical schools should consider whether their agreement with placement providers allows them to effectively quality manage placements. These processes should identify any concerns about individual placements. Any concerns identified should be discussed with the placement provider. The agreement for that placement could be amended with extra provisions which rectify the concerns. If there isn't enough improvement, the medical school should suspend placements to that provider and make alternative provision.

h. Medical schools should make sure their agreements with placement providers are consistent with their equality, diversity and inclusion action plans and policies.

i. Medical schools should consider including the following details in their agreements with placement providers for all settings:

- Expectations around induction processes for students
- details of clinical supervision with consultants and senior medical staff. This should include duration, frequency, teaching activities and opportunities

- timetable for students detailing formal teaching episodes and experiential teaching opportunities and locations. Timetables should be given to students as soon as possible so they can prepare
- student access and training for the placement providers' IT systems, patient information, ward access cards, library and journal access and simulation
- information about medical school processes for the management of concerns about student progress, conduct, or wellbeing. This should include information about how placement providers should notify the medical school about any concern
- information about the medical school policy on student leave and attendance, and details of the agreement with placement providers to support accurate recording and regular reporting of student leave and attendance
- emphasis of the importance of students being integrated into clinical teams, obtaining clinical and practical experience and a range of working hours. For example, out of hours such as night shifts and weekends. Medical schools may want to list the experiences and practical procedures they want students to carry out during each clinical placement
- agreement between the medical schools and placement provider for regular, centralised teaching available to all students while completing each placement in addition to bedside teaching. The agreement should state who is responsible for delivering the centralised teaching
- clarification on indemnity cover for students if they are under the supervision of an independent contractor
- details about the Director of Medical Education, or equivalent, representation at Board level within the placement provider
- details about how funding for education is visible and accounted for at Board level within the placement provider
- arrangements for regular non-clinical time for private study so students can consolidate their learning on clinical placements.

8. Supervision

a. Placement providers should monitor the diversity of the cohort of clinical placement supervisors. They should make sure there is appropriate representation, considering both the

diversity of the clinical workforce and the student cohort.

b. Placement providers should comply with our requirements around the recognition and approval of trainers.

c. Performance of supervisors should be regularly reviewed and appraised (Standards 4.1 and 4.2 in *Promoting excellence: standards for medical education and training*).

d. The development of a student on a placement should be overseen by a named educational supervisor (although job titles may vary). The expectations of a named educational supervisor are detailed in paragraphs 60–65 of our *Leadership and Management for all doctors*.

e. Each student should have a named clinical supervisor who oversees a student's clinical work throughout a placement.

f. Different grades of doctors and senior healthcare professionals can provide different levels of supervision for students.
   - Consultants and GPs should be the doctors who have overall clinical responsibility for the supervision of students. They can make informed judgements on the day-to-day supervision that a student needs. This is based on the previous experience of that student and the types of tasks they may have to complete.
   - Specialty trainees, and specialty and associate specialty (SAS) doctors can support students by providing educational and coaching opportunities. Along with registered senior healthcare professionals they can provide supervision to students where the named educational or clinical supervisor has approved for them to do so.
   - Doctors in Foundation Year 1 (F1) and Foundation Year 2 (F2) can oversee students in carrying out simple tasks but they shouldn't have overall responsibility for supervision of the student. F1 and F2 doctors should act in this limited capacity only where they are fully competent to carry out the task they're observing themselves. Other registered healthcare professionals, for example advanced nurse practitioners (ANPs) can observe the work of students in a similar way to an F1 or F2 doctor.

g. In a third sector setting, students can be supervised by a registered senior healthcare professional. They should have oversight of the placement setting and how the educational needs of students can be met.

h. All those responsible for supervising, coaching or overseeing students should be trained, supported and briefed to carry out this role.

i. Medical schools should make sure students know to stop work immediately if they're concerned about supervision. For example, if they aren't receiving enough supervision and are working beyond their level of competency. Concerns should be fed back to their named clinical supervisor and their medical school.

j. Medical schools should also make sure students know to immediately talk to their named clinical supervisor if they believe they may have acted inappropriately. Or if they have any reason to think a complaint may be made about them by a patient.

k. Schools and placement providers should empower students to feedback to them on poor supervision in confidence.

l. All supervisors should be engaged with teaching. They should make sure service delivery and competition from others receiving training doesn't deflect from the education of students.

m. Named educational and clinical supervisors should:

- be made aware of the details of the students they will be supervising before they arrive on placement. This information should be sent from the medical school to the person or team based at the placement provider responsible for organising the clinical placement
- show respect for diversity and difference in their interaction with medical students
- provide an inclusive and compassionate placement environment for the students
- be made aware of the learning objectives and skills expected for each of the students they are supervising in all settings. This information should be sent from the medical school to the to the person or team based at the placement provider responsible for organising the clinical placement
- make sure students are introduced to all members of the clinical team who they will be working with
- make sure all students receive an appropriate and fair breadth of experience
- receive the resources, time and support to allow them to fulfil their educational and training responsibilities as per standard 4.2 and requirement 4.3 from *Promoting excellence: standards for medical education and training*

- give students the chance to get the most out of their placement experience and not just meet service need. For example, allowing students personal study time if there aren't many learning opportunities at that time
- be understanding of personal and academic commitments which may fall within the duration of the placement, in line with medical school policy and student professionalism.

9. Remote consultations

a. Remote consultations are now embedded in routine NHS clinical practice in primary and secondary care practise. Medical students should expect to be part of remote consultations during their placements and placement providers should ensure to accommodate this experience if applicable. If undertaken in line with the good practice guidance outlined below, they are a valuable learning experience

b. Students should receive inductions specific to remote consultations which should include, but not be limited to:

- information governance and security, including the use of the placements' remote consultation software
- deciding when a remote consultation is appropriate
- getting consent in remote consultations
- confidentiality in remote consultations
- the principles of remote prescribing, referring to *Good practice in prescribing and managing medicines and devices*.

c. Medical schools and students should consider following MSC's guidance on students attending remote consultations.

10. Feedback and evaluation

a. Medical schools should evaluate how effective their clinical placements are, including the delivery of the set learning objectives. This may include:

- the quality and quantity of teaching, supervision and feedback on the placement

- the availability of resources, such as libraries and IT systems
- the personal support available to students on that placement, bearing in mind that some groups may need more support than others
- the ability of students with specific requirements, for example a disability, to access resources and learning opportunities
- the overall fairness of experiences on placement of different groups of students across a range of equality, diversity and inclusion indicators.

b. Medical schools should be aware that many placement providers will have internal quality assurance processes. They may be able to use these to evaluate the quality of their clinical placements. Additionally, schools should share appropriate data with the placement provider for use in the placement providers' quality management processes. This would be subject to legislation on the correct use of personal data.

c. Effective evaluation can take many forms. Two or more data sources could be used to triangulate the data and produce an accurate evaluation of the quality of the placement. Stability of the data can be assessed by longitudinal studies.

d. Some suggestions for how schools can collect data for evaluation include:
   - surveying students
   - analysing the portfolios or logbooks used by students on the placement
   - surveying clinical supervisors and those who have been involved in delivering the placement
   - getting the views of former students who are now F1s
   - getting the views of non-medical staff who have been involved in delivering the placement
   - getting the views of patients where appropriate, including those involved in teaching and assessing students
   - analysing the amount of time dedicated to teaching in the job plans of consultants and other doctors involved in teaching
   - use of focus groups.

e. There should be a feedback mechanism which includes input from students, both named and anonymised.

f. Feedback and evaluation of students' performance should be an active and continuous process throughout the clinical placement. Students and all members of the clinical team should proactively seek and give feedback.

g. The named educational and clinical supervisor should actively collect feedback from the team members to gain an insight of students' progress. Students should be signed off by a named educational supervisor who has an insight of students' progress.

Medical students should feel prepared, supported and safe

11. Preparing students

a. Medical schools should make sure students:

- are aware of the learning outcomes of each placement
- are aware of a placement timetable and learning activities
- are aware of conduct and behaviour policies of the placement provider
- know they are present in an employment environment and the need to behave as if they are employees
- are aware of how they can seek support to meet their needs and specifically how they make a case for reasonable adjustments
- are aware of how to raise concerns in the clinical environment and the steps involved
- are given information on social media policies before they start their first placement by their medical school. Students should be aware of our guidance on social media use
- have been offered the appropriate training (including training that covers IT systems they will need to use) and given appropriate resources to carry out their placement.

b. Medical schools and placement providers should make sure students have good access to accessible and flexible IT resources to meet the needs of virtual learning while on placement.

c. Medical schools should use simulation training and inter-professional learning to help prepare students for real life scenarios they'll encounter in their placement.

d. Processes should be in place to ensure confidentiality and allow a safe environment for students to learn from their mistakes.

e. Placement providers should be encouraged to identify a mentor or establish a 'buddy' system, pairing senior students to junior students. A 'buddy' can advise on learning opportunities and other related issues in clinical placement. Within this, placement providers should consider the diversity of the buddy system.

12. Induction into placements

a. Medical schools should make sure all students receive induction into placements. The requirement for induction should be part of their agreements with placement providers.

b. Medical schools should also consider the specific induction needs of individual students. They should make sure reasonable adjustments are made to address these.

c. Induction should be given by all placement providers and should include the following elements:

- the protocols, rules and procedures specific to that placement
- the context of practice in that locality, organisation and community. This includes an overview on the diversity of the patients they will see and the health inequalities in the surrounding area
- information about appropriate conduct and behaviour. For example, dress codes, good time keeping, reporting sickness absence, and treating patients and visitors with respect
- information about health and safety rules
- information about the importance of students looking after their own health. For example, recognising when their health could mean it's inappropriate for them to attend a placement
- roles and responsibilities in the team
- familiarisation with the physical setting and layout of the placement environment

- introduction of the student to relevant staff members, including levels of supervision and lines of accountability
- access to wellbeing, peer support and staff networks
- how to raise concerns, particularly around patient care and the level of support and supervision provided
- learning objectives
- schedule for learning activities
- access to clinical and learning resources including records and IT systems as appropriate
- how students will receive feedback on performance and how to respond

d. Medical schools should balance induction content to prevent repetition, information overload and student fatigue. A general element of induction should be offered centrally. Specific elements should be offered at the relevant placement providers.

13. Personal protective equipment (PPE)

a. Medical schools should make sure students receive training in all aspects of infection prevention and control (IPC), appropriate to the placement type.

b. Placement providers should make sure training includes putting on and taking off PPE for all students on placement.

c. Placement providers should be aware that some students are unable to use alcohol-based hand gels. These students will require additional access to handwashing facilities.

d. Placement providers should be aware that some students are unable to wear certain PPE. For example, religious head coverings mean a respirator can't be worn. They should provide alternative, but equally effective, protective equipment such as hoods appropriate to the placement requirements.

14. Wellbeing

a. Medical schools and placement providers should routinely monitor and support the wellbeing of their students.

b. Placement providers should make sure students have access to facilities that contribute to their wellbeing during a placement. For example, food, hydration, a private place for mothers to express milk, toilets and rest areas, especially for long or out of hours shifts.

c. Placement providers should make sure students have access to facilities to observe their faith. This should include appropriate breaks.

d. Placement providers should make sure students receive adequate breaks during long or out of hours shifts.

e. Medical school and placement providers should recognise that students will face challenging clinical and communication scenarios. For example, witnessing death or breaking bad news. This can affect students' mental health and wellbeing. Medical schools should provide tailored psychological support for students. Students should be supported to develop a set of mental health coping mechanisms. For example, reflection, debriefing, handing over to another colleague, peer support and asking for help.

f. Medical schools should make sure students completing a placement away from home get support in adapting to their environment. They should have access to all learning and wellbeing resources, including local support mechanism like peer support networks and diverse staff networks.

g. Medical schools should offer support for costs incurred for attending remote placements. For example, travel costs if a placement is an unreasonable distance from the student's residence.

h. Medical schools should make sure that, if there are a variety of placement locations, the method for allocating students is fair and transparent. No groups should be disadvantaged or unfairly treated.

i. Medical schools should offer specific support and reasonable adjustments to those with childcare or caring responsibilities.

15. Speaking up

a. Students should be empowered to speak up about any concerns. This can include safety and behavioural issues that affect themselves or others. Students should be able to do this openly, anonymously or confidentially. Their choice should be respected. In cases where

complete anonymity is not possible, medical schools and placement providers should take extra effort to safeguard these students.

b. Placement providers should make sure students are aware of the local speaking up policy. They should know the internal and external routes for raising issues or suggesting improvements. In England, students should be made aware of the role of the Freedom to Speak Up Guardian as an additional source of support. This can be used if they aren't able to escalate their concerns through the designated pathway locally.

c. Medical schools and placement providers should work together to make sure students know how to raise issues of bullying, harassment and undermining. They should effectively resolve any issues which are raised.

d. Medical schools and placement providers should make sure students who speak up are protected against any repercussion, victimisation or discrimination.

e. If concerns are raised about a supervisor or supervisors (or other relevant professionals at the placement provider), the individual/s should be informed of the concern and remediation allowed. If remediation is not successful, it may be possible to agree with the individual that he or she will no longer act as a named educational supervisor or named clinical supervisor. If agreement is not possible, the placement provider should speak to the student's medical school. It may be necessary to prevent the supervisor from acting in a specific role. Or to remove them from the database of recognised trainers. Further information can be found in the *Recognising and approving trainers: the implementation plan*.

f. Agreements between medical schools and placement providers should set out a process for raising concerns. For example, concerns about the quality of the placement or the engagement of individuals. The agreement should contain a clear series of steps through which concerns of the school or the placement provider can be raised. It should explain how these issues will be handled. When issues are raised that may impact on individuals, medical schools and placement providers should always consider appropriate support and protection that may be required.

16. Sexual misconduct

Power-imbalances can mean students don't feel able to speak up about sexual misconduct. It might also impact on the trust others have in the impartiality of the educator to deliver a fair and inclusive learning environment. Local cultures will also have a significant impact. If sexual banter

is tolerated in an environment, it can be even harder for an individual to speak up. This undermines trust and respect, which can gradually impact on patient safety.

a. Placement providers, as employers with responsible officers, have clear roles in identifying and managing sexual misconduct. This includes a doctor's alleged sexual harassment and abuse of colleagues, including students, within and outside medicine.

b. If students report sexual misconduct, the placement provider and medical school should be in contact. For example, inappropriate sexual remarks, persistence in asking for social engagement clearly directed to them as individuals, and unwelcome physical contact. Complaints must be taken seriously.

c. Medical schools should make sure procedures are clearly signposted on placements and inform students how to report misconduct. Information should be easily accessible, clear and give confidence that reporting misconduct won't impact their education.

d. Placement providers should make sure local policies addressing different aspects of sexual misconduct are up to date. They should be well publicised to raise awareness among employees and students. It should be known that all incidents are taken seriously.

e. Placement providers should make sure local polices don't create additional barriers to reporting, such as those highlighted in the 1752 group report *Silencing Students: Institutional Responses to Staff Sexual Misconduct in UK Higher Education*.

f. Alongside their own support services, medical schools should also signpost students to independent third-party services for support.

g. All members of a medical team have a professional responsibility to report all incidents they are aware of. Placement providers should remind supervisors of this responsibility.

17. Consensual relationships

a. Medical schools and placement providers should work together to develop robust consensual relationship guidelines or agreements. These should be in line with *Good medical practice*.

b. Students should follow the consensual relationship policy of their medical school while they are on placement.

c. Supervisors (or other professionals present on placement) and students should not be involved in a romantic or sexual relationship with each other during a clinical placement.

d. If a prior relationship exists between a student and supervisor (or other professionals present on placement), it's both the student and supervisor's responsibility to report to their line manager or medical school. The student should then be relocated to another team.

18. Return to medical school and mitigating circumstances

a. Students returning to medical school after extended time away should be offered additional support. For example, if they have been unwell or have been intercalating. This will help to make sure they're prepared for starting a clinical placement. Support could include simulation training of skills or resilience training. Where appropriate medical schools should refer to our guidance *Welcomed and valued*.

b. Medical schools should offer confidential services tailored to the needs of students. There should be a package of support for those seeking mitigating circumstances or needing to take time out from their course. This should include additional ways to complete attendance and curriculum requirements.

19. Information technology (IT)

a. Medical schools should make sure their students are aware that they're subject to the same obligations as other staff. This includes confidentiality and patients' consent to the use of their health records while on placement. Students may need access to their placement provider's IT systems to carry out their placement objectives effectively.

b. During an assistantship, students should be able to access IT systems to gain a realistic experience of patient care, including electronic record keeping and prescribing.

c. Medical schools should make sure their agreements with placement providers cover students' use of IT systems. The agreement should:

- include clear guidance on who is responsible for making sure the student understands and follows the rules and procedures for IT use in that placement
- enable safe student access, appropriate data protection and confidentiality.

Medical students should feel part of the team

20. During a placement

a. Staff and placement providers should make sure leadership teams are accessible to students and value their contributions. They should make sure engaged and positive leadership is the norm across all grades and specialities. This helps prevent cultures of blame or outsider dynamics forming.

b. Placement providers should give frequent, direct and honest feedback to students. They should adopt a learning focused culture when mistakes happen and implement strategies for inclusion that counter insider/outsider groupings and hierarchies.

c. Placement providers and clinical teams should recognise that students are valued members of the team. They play an important role in supporting patient care.

d. Placement providers should make sure students are protected to learn safely within clinical environments. They should receive the same level of protection as other members of the clinical team. This is particularly important during a pandemic or crisis. For example, when appropriate students should receive the same protective clothing (PPE), training for doffing and donning as the other members of the clinical team. Students should comply with the policies of placement providers during these times.

e. Members of the clinical team should act as role models for students. They should conduct themselves professionally at all times. The team should build a good culture and healthy learning environment for students. Students should have the opportunity to observe compassionate clinical leadership and empathetic, safe patient care.

f. Clinical teams should always involve students in all clinical activities and observations. This can range from participation, assisting or leading depending on the competencies of the student. There should be adequate supervision to make sure patients are safe. Students should have equal opportunities to be involved in clinical activities.

g. Clinical teams should give guidance for students on accessing, and working closely with, multidisciplinary clinical teams. Students should familiarise themselves with members of the clinical team and multidisciplinary teams attached to the department. Student should take

every opportunity to learn from all members of the multidisciplinary team. This helps to foster interprofessional learning and teamworking.

h. Students should be encouraged to use their experience on clinical placement to help develop time management and professional judgement skills. While it's important to learn theoretical knowledge, students should understand that experiential learning in clinical placements is fundamental. They should take every opportunity to be involved in day-to-day clinical activities. Equally students should be empowered to pursue learning through other means, such as self-study, lectures and webinars. This should happen when there are fewer clinical activities available for productive learning during the placement.

i. Placement providers should support the professional socialisation of students as it is key to professional development. For example, regular reflective practice and discussions with peers and teachers.

j. Clinical teachers should be involved in the assessment of the professionalism of students. This includes:

- observation
- case-based discussions
- the use of electronic/paper portfolios (which show an ongoing record of personal and professional development) that promote critical reflection in authentic clinical settings with face-to-face review (that can be virtual).

k. Placement providers should support the specialist lecture/teaching programme of medical schools.

l. This includes:

- the coordination of the schedules of the teaching programmes at both the medical school and placement provider
- quality assurance of teaching content at the placement provider to match school curriculum
- access of lectures for students on placements far from their medical school including IT services
- standardised assessments.

m. Clinical placement teams should engage students in all forms of clinical governance activities with educational value. They should encourage students to recognise the importance and benefits of these activities.

n. Placement providers should adequately support students by giving them the time and resources they need to be involved in activities such as:
    - performing full cycle quality improvement projects or audits
    - participating in clinical research
    - teaching activities including departmental teaching, peer teaching and interprofessional teaching
    - preparing and presenting in governance meetings. For example, morbidity and mortality meetings and multidisciplinary meetings
    - engaging with senior management team
    - learning about how the NHS functions.

o. Placement providers should work with medical schools to consider the diverse needs of students. For example, reasonable adjustments, allowing time to observe faith and supporting those with caring responsibilities.

21. Experience in a hospital setting

Hospital placement providers should:

a. give students a good exposure of a healthcare environment. Students should learn how secondary and tertiary care contribute to the patient experience

b. make sure students gain experience of a diverse group of patients

c. give students opportunities to build on compassionate leadership skills. Examples of activities under supervision are:

    - assigning patients to students who will coordinate care from admission until discharge
    - lead in aspects of ward round

- lead in departmental handover
- organise and participate in multidisciplinary team meetings
- attend departmental, division, directorate and network meetings.

d. provide students the opportunity to have hands-on experience of clinical activities. This should be under appropriate supervision and according to their level of competence. With appropriate supervision, and within the bounds of their competence, students should be encouraged to:
   - carry out procedures in accordance with *Practical skills and procedures.* The development of procedural skills may be best facilitated through scheduled sessions with other healthcare professionals. This includes (but is not limited to) phlebotomists, nurses and healthcare assistants
   - assist in surgical procedures or more advanced practical skills and procedures
   - carry out consultations with patients during face to face, telephone or video consultations
   - formulate management plans for patients including treatments and medications
   - make referrals and communicate with other medical specialties and members of the multidisciplinary team
   - keep accurate and concise patient records.

e. provide both scheduled and opportunistic bedside teaching to students. Clinical teachers should always consider students' level of understanding and learning objectives to make sure the teaching is relevant to them.

f. actively engage with the students when they're attending specialist clinics or observing complex clinical procedures. They should make sure the student understands the specialist area.

g. provide opportunities for students to meet different multidisciplinary team members. This helps the student understand different roles in the patient journey and fosters teamworking. This can be done by shadowing or participating in clinical activities such as:
   - shadowing nurses during drug rounds and observation rounds
   - shadowing pharmacists to learn good practice in prescribing

- shadow other members of the multidisciplinary team, for example healthcare assistants, physician associates, anaesthesia associates, physiotherapists, occupational therapists, advanced nurse practitioners, dieticians, speech and language therapists.

h. provide students with learning opportunities in other departments which students are not directly attached to. For example, radiology services or laboratory services.

i. encourage students to attend out of hours clinical activities to maximise their learning opportunities. For example, night shifts and weekends. Students should recognise the value of experiential learning by working out of hours. Clinical teams should facilitate students' learning during both working hours and out of hours. Students who can perform out of hours activities should be given enough notice of out of hours clinical activities. Out of hours activities should not exceed expectations of a doctor in training. Placement providers should offer adequate rest time and provide appropriate rest facilities, especially for those working out of hours.

22. Experience in a GP setting

GP placement providers should:

a. give students a:

- structured induction
- a clear timetable of activities
- opportunities for active participation, and
- review and feedback throughout their placements.

b. actively support the development of students' clinical and communication skills. This includes observation and feedback.

c. provide access to a diverse range of professional role models.

d. encourage understanding of medical generalism and the guiding principles of general practice (person-centred care, population centred care and organisational aspects of primary care within the NHS or HSC).

e. provide opportunities to follow patients with chronic illness or multimorbidity through their journey, including:

- the medical and social aspects of management
- the impact of illness on daily living and those close to them
- interaction with community services.

f. make sure students gain experience of a diverse group of patients.

g. promote understanding of primary and secondary care interactions. For example, for the referral and discharge processes, students can be encouraged to write referrals. This should include relevant supporting information and an understanding of red flag features.

h. support learning around service management and clinical leadership. For example, encourage attendance at practice meetings and local network meetings.

i. promote students' understanding of academic and scholarly aspects of general practice. For example, participating in:

- clinical audit and quality improvement projects
- primary care research
- medical education projects
- peer teaching.

j. promote skills in all aspects of consulting with patients. For example, face to face, telephone and video consultations. This should include the importance of concise and accurate record keeping.

k. provide opportunities for students to run clinics under supervision and in accordance with their competence.

l. encourage understanding of the population health role of primary care. For example, in relation to social determinants of health, health promotion and illness prevention.

23. Experience in a third sector/community setting

a. The curriculum should be inclusive and represent the values and needs of our diverse patient and student population. Medical schools should give all students a range of experience in third sector/social care/community settings that go beyond traditional hospital and GP placements.

b. Such placements should provide students with greater understanding of the social determinants of health and the importance of equality, diversity and inclusion in healthcare systems.

c. Active community engagement and outreach work should be encouraged. For example, visits to:

- public health departments
- community-based health services
- homeless shelters
- prisons
- charities
- disability centres
- care homes
- day centres
- hospices.

d. Students at all stages should be encouraged to take up opportunities to engage in local public health, third sector and community initiatives where this is possible.

e. Placement providers should get informed consent from patients and service users when speaking to students or being observed.

24. Interactions with patients and those close to them

a. Students should always respect patient dignity and confidentiality. Students should approach all communication with patients with sensitivity and empathy. They should maintain professionalism when dealing with patients and those close to them.

b. Students should feel comfortable communicating with patients of a variety of demographics. This includes different:

- ethnicity
- gender
- age

- socio-economic background
- disabilities
- non-native English speakers.

c. During interactions with patients and those close to them, students should learn about a patient's experience and journey, especially from patients who have a chronic disease. This is in addition to history taking, clinical examination and pathologies. This familiarises students with providing holistic medicine and understanding social determinants of health.

d. Students should be encouraged to familiarise themselves with the varying disease presentations in different groups, different modes of disease management for different groups and different experiences that may occur in certain groups, recognising that determinants of disease are intersectional.

e. Clinical teams should empower students to provide health promotion advice. They should make sure students consider how health promotion advice might help reduce health inequalities. This should include promoting lifestyle changes. For example, quitting smoking, avoiding substance misuse and maintaining a healthy weight through exercise and diet.

25. Medical electives

Medical electives play an important role in student experience in clinical years. Students may choose to have medical electives abroad or locally. They might choose a clinical setting or other health organisations. For example, in public health or global health.

a. Medical schools should make sure students who participate in medical electives are supported throughout. However, they should also acknowledge that the same levels of support or type of intervention may not be available on elective, especially when abroad.

b. Students should use this opportunity to pursue a special interest which they haven't much exposure to in clinical placements.

c. Medical electives planned by students should have educational value and be in line with the medical school's curriculum.

d. Students doing medical electives in a clinical setting should always show professionalism.

e. Students doing medical electives should always ensure their safety and that of the patient. They shouldn't work outside of their competence.

Student assistantships

26. Student assistantships

a. Medical schools should be confident that students are adequately prepared to take on the increased responsibility involved in an assistantship. This is shown by satisfactory coverage of *Outcomes for graduates*. Students shouldn't progress to an assistantship if there are concerns about this.

b. Where possible, schools should try to put students in an assistantship in the same location as their first F1 placement. For students where this isn't possible, a period of shadowing before they begin their F1 post is advised.

c. Medical schools and placement providers should prepare students for the reality of working in a clinical environment.

d. Medical schools and placement providers should give support and advice if students encounter difficult clinical and ethical issues.

e. Medical schools and placement providers should prepare students on the following before they start an assistantship:

- safe working practices: handwashing, infection control, occupational health information, health and safety in the workplace
- safe prescribing policy
- how to access IT support
- working hours and working patterns
- rotas and controls over hours worked (in light of the Working Time Regulations)
- contracts
- good time management skills and how to prioritise tasks
- how and when to take a break

- safe handover arrangements
- coping with working during winter pressures and crisis situations
- understanding learning outcomes
- portfolio preparation and completion
- development of clinical competences within curriculum progression
- career patterns and pathways
- local NHS or HSC structures
- hospital hierarchy and ward or clinic arrangements
- national NHS or HSC structures and commissioning arrangements
- careers advice and the importance of research and lifelong learning
- support structures available such as Doctors in Difficulty policies, the Guardian of safe working and the British Medical Association.

f. Students should have a designated doctor in training (preferably an F1 doctor) during assistantship to shadow and assist.

g. Students should maintain a good standard of professionalism which includes:
   - protecting patient confidentiality
   - working in a multidisciplinary team
   - treating colleagues, patients and visitors with courtesy and respect.

27. Tasks

a. A student assistantship isn't defined by its length or the specialty the student is working in. It's defined by what the student does and learns during their assistantship and how this period of time helps to prepare that student for practice.

b. Students should be fully integrated within a clinical team. They should be on the rota for that team and should have a defined role and responsibilities.

c. Students should participate in activities like those of a newly qualified doctor. This is subject to patient safety and consent, and legal requirements. Examples of tasks students should

carry out while on their student assistantship include:

- clerking patients in hospitals and consulting with patients in general practices under supervision
- managing acutely unwell patients under supervision
- carrying out practical procedures on patients under supervision. These could include procedures as set out in Outcomes for graduates – Practical skills and procedures
- helping F1s to make referrals to other specialties and order investigations whenever appropriate
- prioritising patients and completing tasks generated
- managing patients' paperwork such as medical notes and discharge summaries. Medical notes, checked by a doctor, can form the basis of the patient record
- making recommendations for the prescription of drugs to real patients. This could take the form of producing duplicate 'dummy' prescriptions. The student then gets feedback from a registered doctor or pharmacist.

d. Student assistantships should have clear learning outcomes relating to the tasks they are asked to perform. These outcomes should be communicated to those at the placement provider who organise and supervise assistantships. It's the responsibility of medical schools to set the outcomes for individual placements, but the areas they should consider for assistantships include:
   - complex communication skills, for example breaking bad news
   - prioritising a complex workload
   - understanding and applying legal and ethical considerations
   - understanding the operation of the NHS or HSC
   - knowledge of prescribing.

e. Medical schools should consider discussing with placement providers whether their governance procedures will allow students to write up actual prescriptions. This can be supervised by a registered doctor who checks and signs them. This key skill prepares students for practice after qualifying.

f. Students on assistantships should be prepared to give patient care to a level similar to that of an F1 doctor. This includes working on calls, out of hours and learning to manage workload due to winter pressures or crisis situations. However, this should not impact on their experience or learning during the assistantship. Students shouldn't be required to work extra shifts due to service pressure.

g. Students should be given the same protection as qualified doctors in terms of rest time and commute time after out of hours shifts. This should also include time needed in between changing placements in another location. Students should be given rest and commute time to prepare for next placement.

h. Placement providers and medical schools should consider the safety of students when arranging out of hours shifts. This includes providing an appropriate rest area or accommodation, and the availability of transport.

28. Feedback and evaluation

a. Feedback on a student's performance during an assistantship should follow the same principles as a clinical placement.

b. Feedback should mainly be given on a student's performance by the named educational and clinical supervisor. The rest of the clinical and non-clinical team should also provide feedback.

c. F1s should be empowered to give constructive feedback to reflect the true picture of a student's performance.

d. Student evaluation of their experience should form a significant part of the overall evaluation of an assistantship.

29. Indemnity

a. Medical schools should understand the issues around indemnity relating to students in clinical placements. They should make sure placement providers know how indemnity applies to student assistantships.

b. Statements from the relevant bodies in England, Northern Ireland, Scotland and Wales are available in the Annex to this document. They confirm that where students are working under the supervision of an NHS or HSC employee, they will be covered by NHS/HSC Indemnity.

Where a student is working under the supervision of an independent contractor GP (a GP who is not employed by the health service) the student will need to be included in the contractor's own indemnity cover. Or arrange their own full indemnity cover.

c. Accordingly, medical schools should make sure students in an assistantship with an independent contractor, are covered by their indemnity. This should be clearly signposted in the agreement with the independent placement provider.

d. Medical schools may also consider whether their students should be members of a medical defence organisation when they are doing assistantships. They can often provide advice on the type of cover required.

30. Shadowing

a. Shadowing should be provided to all graduates before they start Foundation Year 1, it is an important part of a medical student's preparedness for practice. Shadowing is organised by the UK Foundation Programme Office.

b. Graduates should be properly prepared for their first allocated F1 post. After their assistantship, they should have a period working with the F1 who is in the post they will take up when they start F1.

c. This shadowing period allows graduates to become familiar with the facilities available and working environment. They also learn their working patterns and get to know colleagues. It also provides them with an opportunity to develop working relationships with the clinical and educational supervisors they'll work with in the future.

d. It should be protected time with tasks that let graduates use their medical knowledge and expertise in a working environment. It should be different from the general induction sessions provided for new employees and Foundation Programme trainees.

e. The shadowing period should normally last at least one week. It should happen as close to the point of employment as possible.

Annex

Indemnity clauses

Scotland: NHS National Services Scotland – February 2021

NHS Indemnity will apply to students engaged by Health Boards in Scotland, or who are working under the supervision of NHS Health Board employees, or under the supervision of clinicians or teaching staff, holding honorary contracts with the relevant Health Board. NHS Indemnity also applies to GP Registrars and students working under the supervision of GPs whether in a GP practice run by the Health Board (in the community or a prison) or independent GP practice contracted to provide primary medical services for NHS Scotland patients. Work undertaken for Health Boards in connection with the Covid-19 pandemic, such as vaccinations, is also covered by NHS Indemnity. Where a student is working on a placement with a private healthcare provider, then the student is advised to confirm the position with the University.

England: NHS Resolution – December 2020

Where a medical student is providing care or treatment to an NHS patient in the course of a placement with an NHS Trust, the student will be covered under the NHS Trust's membership of our Clinical negligence scheme for trusts.

In regards to medical students undertaking a placement with a GP surgery, please refer to the FAQ page of our Clinical negligence scheme for general practice section of our website which confirms that students are covered under our CNSGP scheme where they are carrying our activities in connection with the delivery of primary medical services.

Unfortunately, we are unable to assist regarding non-NHS bodies delivering care or treatment, such as a charity, as our indemnity schemes are limited to care provided by the NHS. However, we can confirm that where a student is delivering NHS care "off site" eg in the community as part of a placement with an NHS Trust or GP practice, the relevant indemnity scheme referred to above would still apply.

Northern Ireland: Department of Health Northern Ireland - October 2021

Medical students on placement in Health and Social Care Trusts in Northern Ireland will be

indemnified by those Trusts where they are under the supervision of Trust employees, including clinicians; trust staff; teaching staff; or clinical academic staff holding an honorary HS contract. However, this indemnity does not extend to privately employed clinicians or independent contractors such as GPs or Independent Sector providers. This should be made clear in the agreement between the Health and Social Care Trust and the student's Educational Body.
For a clinician who is not a Health and Social Care Trust employee, the HSC Trust will allow only those whom the HSC Trust considers has suitable indemnity arrangements in place to supervise the medical students.

Supervising GPs should notify their Medical Defence Organisation (MDO) of their involvement in student placements and, in the event of a claim, GPs should seek advice and assistance from their MDO. All students are strongly recommended to have their own indemnity as whilst their supervising GP should notify their Medical Defence Organisation of their involvement in student placements this is to ensure they are appropriately covered for their supervisory role and does not extend to providing the medical student with full indemnity cover.

Wales: General Medical Practice Indemnity (GMPI) team - May 2021

The Welsh Risk Pool is able to confirm that NHS Indemnity will generally be applied to the placement activity of medical students involved in NHS Care. Indemnity is not extended when a student is supervised by a doctor undertaking private work. NHS Indemnity applies when the student is Health Body's management, supervision and control. It is essential that placement providers ensure that there is a clear agreement which outlines the activities that will be undertaken by the student and that there is an authorisation of the arrangements by the supervising doctor's employing health body. Indemnity of independent contractors is a separate process from NHS Indemnity and is known in Wales as the Scheme for General Medical Practice Indemnity. Placement providers should ensure that the independent contractor's activities are captured by the GMPI Scheme.

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Published August 2022

Code: GMC/GUCP/0822