NHS
Health Education England

A SUPERVISORS GUIDE TO FY2 TRAINING IN GENERAL PRACTICE

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Introduction

This Guide to Foundation Programme Training in General Practice is intended to be exactly that. Every practice is different and will offer different learning opportunities for their foundation doctors. This guide is not intended to be either definitive or prescriptive but a framework that you can build on and adapt to suit your circumstances.

It is written specifically for clinical supervisors of FY2 doctors working in General Practice. It may however be of use/interest to the wider team in General Practice including the FY2 doctors themselves.

It is important to remember:

- The rotation in your practice is part of a two-year programme.
- Some competences may well be more readily met in general practice than in some other rotations e.g. Relationships with Patients and Communications
- The foundation doctor will not cover all competences during the GP placement.
- Every practice is different and will offer different learning opportunities for their foundation doctor. Therefore, the FY2 doctor is expected to be flexible to the working arrangements of individual practices and to discuss the timetable with the GP Clinical Supervisor (see pages 5-7 for further guidance).

Supervised Learning Events and Workplace-based Assessments

- The assessments are designed to be supportive and formative.
- The foundation doctor can determine the timing of the assessments within each rotation and to some degree can select who does the assessment.
- It is important that all assessments are completed within the overall timetable for the assessment programme.
- Each FY2 doctor is expected to record their assessments in their e-portfolio. These will then form part of the basis of the discussions during appraisals.
- The FY2 doctor is an adult learner and it will be made clear to them that they have responsibility for getting their assessments done and for getting their competences signed off.

The Foundation Programme requires that all foundation doctors complete supervised learning events (SLEs) and formal assessments as evidence of their professional development. Different tools are used for SLEs and assessments

Supervised learning events represent an important opportunity for learning and improvement in practice, and are a crucial component of the Curriculum. It is the duty of the foundation doctor to demonstrate engagement with this process. This means undertaking an appropriate range and number of SLEs and documenting them in the e-portfolio. The clinical supervisor's end of placement report will draw on the evidence of the foundation doctor's engagement in the SLE process. Participation in this process, coupled with reflective practice, is a way for the foundation doctor to evaluate how they are progressing towards the outcomes expected of the programme, which are specified in the Curriculum.

The purpose of the SLE is to:

- highlight achievements and areas of excellence
- provide immediate feedback and suggest areas for further development
- Demonstrate engagement in the educational process.

SLEs are designed to help foundation doctors improve their clinical and professional practice. They do not need to be planned or scheduled in advance and should occur whenever a teaching opportunity presents itself. The SLE should be used to stimulate immediate feedback and to provide a basis for discussion with the clinical and/or educational supervisor. Foundation doctors are expected to demonstrate improvement and progression during each placement and this will be helped by undertaking frequent SLEs. Therefore, foundation doctors should ensure that SLEs are evenly spread throughout each placement. Improvement in clinical practice will only happen if regular SLEs lead to constructive feedback and subsequent review of and reflection on progression. For this to occur some targeted SLEs should specifically be related to previous feedback and developmental targets. This may be facilitated if the foundation doctors agree the timing and the clinical case/problem with the trainers in advance. However, unscheduled SLEs can also be focused on specific needs.

SLEs use the following tools:

- Mini-clinical evaluation exercise (mini-CEX)
- Direct observation of procedural skills (DOPS)
- Case based discussion (CBD)
- Developing the clinical teacher.

A different teacher/trainer should be used for each SLE wherever possible, including at least one at consultant or GP principal level per placement. The educational or clinical supervisor should perform an SLE. The SLE must cover a spread of different acute and long-term clinical problems and discussion should include the management of long-term aspects of patients' conditions. Teachers/trainers should have sufficient experience of the area under consideration, typically at least higher specialty training (with variations between specialties); this is particularly important with case based discussion.

The foundation doctor, with the support of the supervisor(s), is responsible for arranging SLEs and ensuring a contemporaneous record in the e-portfolio.

If you are acting in the role of assessor, you will not need an account for e-portfolio in order to assess a foundation doctor. The foundation doctor will however need to nominate you as an assessor. This process will generate a message to your email account, which contains a unique 10-digit code. You login via

https://www.nhseportfolios.org using the 10-digit code in order to record your assessment.

- The assessments do not have to be carried out by the doctor who is the nominated trainer but the assessor must have completed training in the context and use of the assessment tools.
- You can and should involve other doctors, nurses or other health professionals that are working with the FY2 doctor.
- It is important that whoever undertakes the assessment understands the assessment tool they are using.

The assessments are not intended to be tutorials and although they will need to have protected time this could be done at the beginning, end or even during a surgery.

Recommended minimum number of SLEs per placement

Supervised learning event	Recommended minimum number per placement*
Direct observation of doctor/patient interaction: Mini-CEX DOPS	3 or more Optional to supplement mini-CEX
Case-based discussion (CBD)	2 or more
Developing the clinical teacher	1 or more

**based on a clinical placement of four months duration*

Frequency of assessments

Assessments	Frequency
E-portfolio	Contemporaneous
Core procedures	Throughout F1
Team assessment of behaviour (TAB)	Twice a year in both F1 and F2 (once in first and once in second placement).
Placement Supervision Group	Recommended with each placement (minimum one per year)
Clinical supervisor end of placement report	Once per placement
Educational supervisor end of placement report	Once per placement
Educational Supervisor's End of Year Report	Once per year

Placement Supervision Group

Within any placement, an individual healthcare professional is unlikely to build up a coherent picture of the overall performance of an individual foundation doctor. Whenever possible, the named clinical supervisor (CS) will seek information on the FD for whom they are responsible from senior healthcare professionals who work alongside the FD during the placement. These colleagues will make up the **placement supervision group.**

It is expected that all healthcare professionals will be in a position to support and guide the FD, providing feedback on performance to the FD and to the CS.

In compiling his or her report, the named clinical supervisor nominates the members of the PSG who will contribute to the CSR and should identify them to the foundation doctor.

The makeup of the PSG will vary depending on the placement but is likely to include:

- Doctors more senior than F2, including at least one GP principal
- Senior nurses including practice nurses or nurse practitioners (band 5 or above)
- Practice Pharmacist
- Allied health professionals

In a general practice placement, the PSG may be limited to one or two GPs.

The PSG is completed via a structured form to help guide feedback from other professionals who may not be as familiar with the FP as educators directly involved in the training of FDs. Those reviewing the outcome of the PSG must ensure the feedback is appropriate, fair, non- judgemental and is free from bias.

Please see further information:
https://supporthorus.hee.nhs.uk/faqs/placement-supervision-group-psg-feedback/what-is-the-placement-supervision-group-psg/

The Learning Portfolio

Each foundation doctor will keep a learning portfolio (HORUS). They will access their portfolio via the HORUS log in. It will be the means by which they will record their achievements, reflect on their learning experience, and develop their personal learning plans.

Clinical and educational supervisors are granted access to a trainee's HORUS e-Portfolio. Access rights to the e-Portfolio system are granted by the foundation programme coordinator in the trainees employing acute trust (Appendix 7 – Contact Details). FAQs arounf HORUS are here.

The Foundation Curriculum

It is important to remember that GP is just one of your FY2s three placements where they can achieve their FY2 competencies and cover the Foundation Curriculum

More details can be found here:

http://www.foundationprogramme.nhs.uk/curriculum/

The Induction

This is really an orientation process so that the foundation doctor can find their way around the practice, understand a bit about the practice area, meets doctors and staff, learns how to use the computer systems, and knows how to get a cup of coffee! Particularly in the current climate where things have very much changed in clinical practice take this opportunity to clearly explain to the FY2 about the practice COVID policy/standard opperating policy.

This needs to cover (but not exhaustive):

- PPE and how to access this
- How you as CS want them to debrief – remote/f2f?
- Where to see patients – if you have a hot and cold area/room
- How to access help both clinically and pastorally
- What to do if covid suspected during a consultation
- Remote consulting (see appendix 8 for useful on line resources via e-lfh)

This is very similar to the induction programme used for registrars but will probably last about a week. It should be planned for the first week of their 4-month rotation with you. An introduction pack for the foundation doctor, which again can be similar to that which you might use for a locum or GP registrar, should be provided. An induction week might look something like the timetable below but this is only a guideline and should be adapted to suit the learner and your practice.

Some things that might be included in a typical induction timetable (Please note these will need to be adapted to virtual meetings often and consider social distancing).

Day 1

- Meeting doctors/ staff 9-10
- Sitting in the waiting room 10-11
- Surgery & Home visits with Trainer 11-1
- Working on Reception desk 2-3
- Surgery with Trainer 3-5

Day 2

- Treatment Room 10-12
- Chronic Disease Nurse clinic 12-1
- Computer training 2-3
- Surgery with another doctor 3-6

Day 3

- District Nurses 9-12
- Computer training 1-3
- Local Pharmacist 3-5

Day 4

- Health Visitors 10-12
- Admin staff 12-1
- Shadowing on-call doctor 2-6

Day 5

- Surgery and home visits with another doctor 9-12
- Practice meeting 12-1
- Computer training 2-3
- Surgery with trainer 3-5

Sitting in with other members of the team exposes the learner to different styles of communication and consultation. Of course, this will not necessarily fit into neat hourly blocks of time and you may have several other opportunities that you feel your foundation doctor would benefit from in this initial phase. Some doctors may require a longer induction process. Their reflections about the roles and responsibilities should be recorded in their e-portfolio.

The working and learning week

Every experience that your Foundation doctor has should be an opportunity for learning. It is sometimes difficult to get the balance right between learning by seeing patients in a formal surgery setting and learning through other opportunities. The table below is an indicator as to how you might plan the learning programme over a typical week with a doctor who is in your surgery on the standard 4-month rotation. We have set out below the principles which must be followed when defining the timetable for your foundation trainees.

- The maximum hours worked must not exceed 40 per week, including paid lunch break
- Of those 40 hours (less lunch) 70% should be defined as clinical experience and 30% as educational experience. What should be classed as each is summarised below.

The commonest area of confusion seems to arise around the issue of what to class the gap between the morning and afternoon/evening surgeries. The second is that junior doctors must have their lunchtime counted towards their working hours. This gap must be counted as something and the most logical way of looking at this is to use the following points as a guide.

- The total working day should not exceed 8.5 to 9 hours. That is from the point they walk in the door in the morning to the point they walk out again at the end of the day ie no split shifts
- One afternoon per week is usually taken up with Trust-based teaching (4 of the 'educational' hours)
- The remaining hours of educational time could be demonstrated on the timetable as being debriefs, tutorials and sessions in the middle of the day and labelled
    - Ensure 3 hours of Self development Time SDT per week (Private Study)
    - Audit/Quality Improvement Project (QIP) time
- The trainee should then be given one half-day off per week

There are also some Working Time Directive and new junior doctor's contract rules which are worth noting too – see: http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff/doctors-and-dentists-in-training/terms-and-conditions-contracts

- 11 hours continuous rest in every 24 hours
- Minimum 30 minute break when working time exceeds five hours, plus an additional 30 minute break if working over 9 hours
- For this basic banding trainees must not start their working day before 8am and must finish by 7pm.

We will be looking at the trainee timetable as part of our quality assurance procedures (approval visits) and it is useful to have a clearly defined timetable for that purpose. This should delineate very clearly between clinical and educational time as well as being very clear about the maximum 40-hour working week.

Duties and activities suited to clinical sessions

1. Supervised or supported consultations within the practice, with a **minimum** appointment length of 15 (telephone) and most commonly of 20 minutes for face to face consultations or video consultations. Initially it is advisable to start F2 doctors at 30 minute appointments to allow plenty of time to read clinical notes adequately, familliarise with the computer and debrief with the supervising doctor. There should be adequate time provided for at the end of any consulting period to allow a trainee to debrief with the supervising GP.
2. Supported online consulting. You may consider allocating the F2 doctor some of the online consultations that come through, but vet these first like with all contacts to ensure they are appropriate to their level of experience. Remember to timetable these as they are still "consultations"
3. Supervised or supported home visits, nursing home visits, community hospital duties including time for debriefing, and travelling (This might be wise to limit F2 exposure to these in the current climate of Covid).
4. Administrative work that directly and indirectly supports clinical care, which includes: reviewing investigations and results, writing referral letters, acting upon clinical letters, preparing reports, general administration. One hour of admin time should be allowed per 3 hours of clinical contact time.
5. Time spent with other members of the practice and healthcare team for the purposes of care and learning e.g. practice nurses, community nurses, nurses with a role in chronic disease management, receptionists, triage nurses, GPwSIs.
6. Time spent with other healthcare professionals who are encountered in primary care e.g. ambulance crews, school nurses, midwives, occupational therapists, physiotherapists, counsellors, to gain a necessary understanding of working relationships within primary care.
7. Time spent with dispensing and pharmacy professionals gaining experience in these areas, especially where a trainee might have duties that require training to be able to assist with dispensing duties, for example.

Clinical activities that may be considered educational

1. Time spent in activities relating to work-placed based assessment and supervised learning events.
2. Time spent analysing video recordings of consultations, such as Mini-CEX exercises, where time is set aside for this purpose.
3. Time spent in specialist clinics; especially where these are arranged to gain exposure to patient groups and illnesses not covered elsewhere in a trainee's programme, e.g. family planning clinics, joint injection clinics.
4. Participation in clinics run by other GPs – such as minor surgery lists, especially where direct supervision is required in the process to get formal verification of procedural competences.

Non-clinical activities suited to educational sessions

1. Locally organised educational events, e.g. foundation-specific educational programme run by the deanery or trust, including "half-day release" or "day-release" sessions.
2. Structured and planned educational activities, such as tutorials delivered in the GP practice.
3. Primary care team meetings.
4. Educational supervisor meetings and other educational reviews.

5. Audit/QIP and research in general practice.
6. Independent study.
7. Case Based Discussions (CBDs) selected from outside the debrief time.
8. Commissioning services.
9. Time spent with other professionals who deliver services that are not considered part of general medical services, such as alternative and complementary therapists.
10. Time spent with other professionals who have expertise in other matters that relate to aspect of healthcare and death administration, social workers and undertakers. Getting to know local healthcare professionals and helping the practice maintain links with the local community.

It follows then that the <u>supervisor protected time</u> of four hours per week should be divided to cover

1. The Supervised Learning Events
2. Tutorials
3. Meetings with the trainee to review progress
4. Time spent advising on research and audit/QIP
5. Advising on action plans for further learning
6. Time spent relating to the eportfolio as well as writing Clinical Supervisor Reports
7. Preparation time for the above

It does not cover: Debriefing time after consultations

Indicative weekly timetable and further guidance

7 x Surgeries OR A MAXIMUM OF 70% OF THE WORKING WEEK	• These will usually start at 30-minute appointments for each patient and then reduce to 15- 20-minute appointments as the foundation doctor develops their skills, knowledge, and confidence. • The FY2 doctor must have access to another doctor (not a locum doctor) but not necessarily the trainer in the practice. • The FY2 doctor does not need to have their own consulting room and can use different rooms so long as patient and doctor safety and privacy are not compromised. • Some equipment e.g. diagnostic sets should be available.
2-3 x sessions in other learning opportunities OR A MAXIMUM OF 30% OF THE WORKING WEEK	This could be: • 1:1 session with the trainer or other members of the practice team. • Small group work with other learners in the practice. • Small group work with FY2s from other practices. • Shadowing or observing other health professionals or service providers e.g. outpatient clinics pertinent to primary care, palliative care teams, voluntary sector workers. • Some FY2 doctors attend the local GP Speciality Training Programme with prior agreement.
1-2 x sessions on project work or directed study OR A MAXIMUM OF 20% OF THE WORKING WEEK	• Your FY2 will be undertaking a quality improvement project or audit during their time with you. They should have protected time to do some research, collect the data, write up the project, and present their work to the practice team.

Remember that your FY2 will be at work 40 hours spread across the week. This could be:

- 5 x 8 hour days – working exactly the same time each day;
- 5 x 8 hour days – but with staggered start times to the beginning and end of the day;
- 4 days with a half day – as long as the total does not exceed 40 hours per week;
- Other combinations compliant with the Working Time Regulations, new Junior Doctors Contract and when agreed between the supervisor and the FY2 doctor;
- IF YOU HAVE AN ACADEMIC FY2 DOCTOR THEY WILL HAVE AT LEAST ONE DAY FREE FOR RESEARCH.

There are several combinations but no working day should extend beyond 7am-7pm. The times must be convenient to the practice as well as the FY2 doctor and should allow the FY2 doctor to get the most out of their general practice rotation.

The debrief and supervision arrangements

The case review by the supervising GP should be a staged process. The transition to the next phase should be based on an assessment of competence which is ideally associated with the trainee making an ePortfolio entry which reflects on that assessment.

1. Supervisor sitting in whilst trainee consults – this can be a telephone consultation or a video consultation as well as Face to Face (considering social distancing difficulties with too many in a room)
2. Trainee consults independently but all patients are reviewed by the supervising GP before they leave the consulting room
3. Trainee consults independently but all patients are reviewed by the supervising GP before they leave the practice.
4. Trainee consults independently and patients are presented to the supervising GP who may then review personally or give advice on management, at the end of each surgery. This consultation could be remote – video or telephone.
5. Trainee consults independently and patient may be allowed to leave the surgery. The debrief after each patient or group of patients does then provide an opportunity to call the patient back or otherwise contact the patient if the supervisor considers that the trainee has not provided optimal care or if the management plan is inappropriate.

Foundation trainees should never progress to the point of entirely managing their case load without the supervisor having input during either direct supervision or indirect supervision via the process of debriefing.

In general terms, a debrief should take place as soon as possible after a clinical event (whether this be a telephone consultation/face to face or video consultation), and focus on progress/achievement as evidenced by, for example, mini-CEX assessment. Reference should be made to the syllabus and competences. An action plan should be made for learning in terms of knowledge and behaviours.

Whatever the style of feedback/debriefing, the aim is to have a conversation that is genuine, mutual, clear, and trusting. The conversation must also set out to understand personal and situational factors.

This can be done in various ways:

a. Ask foundation doctors to talk through the procedure, and discuss their ‘story' with them:
   - How did you make your decisions?
   - What different decisions might you have made, and on what basis?
   - Let us discuss similar and variant cases.

b. Tell the foundation doctors their strengths and points for improvement:
   - … was good/excellent
   - Maybe you need to improve or to consider…
   - So, to sum up…

c. Ask the foundation doctors about their strengths and points for improvement (What were you happy with?)
    - I liked…
    - What would you do differently next time?
    - What about… (Suggested alternatives)?
    - So, in summary…

d. Ask for a reflective account of what happened (usually chronological) and of the thinking behind it from all perspectives, including the patient's, if appropriate. Then have a conversation about strengths, points for improvement and clarification:
    - I see from your personal learning plan that you wanted to focus on… Can you tell me what triggered that?
    - I see that you… What was your intention then?
    - How was that compared to last time?
    - What was different?
    - I am concerned that… How does that sound to you?
    - How did it go with the team?
    - I am interested to know how you are getting on with…
    - I am getting worried that you may be… Is that a possibility do you think?
    - I think… How do you see it?
    - So, how will you proceed now to increase your flexibility/speed of response/team communication?
    - What other questions does this raise for you/the team?
    - So, what have we discussed?
    - Appropriate education and support of supervisors will be a precondition for undertaking these roles.

Foundation trainees must NEVER be left alone unsupervised in a practice seeing patients. This would contravene the guidelines for a Foundation trainee's exemption from the Performers List.

Complaints from patients

Despite the best efforts of all involved complaints from patients may still happen. In this circumstance the practice complaints policy and procedures must be followed. Important principles are:-

- The trainee must be given an opportunity to respond and the complaint details must be shared with them – even if they have since left the practice. This will enable the Practice to have all of the information available to enable them to respond to the patient appropriately.
- It is also important to let the relevant Foundation Training Programme Director know about the nature of the complaint if not the detail (Appendix 7 – Contact Details).

Tutorials

- Tutorials can be given either on a 1:1 basis or as part of a small group with their learners.
- Any member of the practice team can and should be involved in giving a tutorial.
- Preparation for the tutorial can be by the teacher, the learner, or a combination of both.

The list below is a suggestion for tutorial topics. It is by no means prescriptive or definitive.

- Managing the practice patient record systems – electronic or paper
    - History taking and record keeping
    - Accessing information
    - Referrals and letter writing
    - Certification and completion of forms
- Primary Healthcare Team working
    - The doctor as part of the team
    - Who does what and why?
    - The wider team
- Clinical Governance and audit?QIP
    - Who is responsible for what?
    - What is the role of audit/QIP?
    - What does a good audit/QIP look like?
- Primary and Secondary Care interface
    - Developing relationships
    - Understanding patient pathways
- Interagency working
    - Who else is involved in patient care?
    - What is the role of the voluntary sector?
- Personal Management
    - Coping with stress
    - Dealing with Uncertainty
    - Time Management
- Chronic Disease Management
- The sick child in General Practice
- Palliative Care
- Social issues specific to your area which have an impact on health

Classroom taught sessions

In addition to the weekly timetable organised by the practice, the trainee will attend regular Trust-based education which may include mandatory training. These Trust-based sessions usually take place on a weekly or fortnightly basis.

- It is expected that the FY2 doctor will attend these sessions along with their colleagues in the hospital rotations and therefore must be released form practice to do so.
- The classroom taught sessions cover some of the generic skills such as communication, teamwork, time management, evidence based medicine.

The FY2 doctor should contact the (FTPD) to get a list of dates and venues at the start of their FY2 year and it is the FY2 doctor’s responsibility to ensure that they book the time out of the practice.

Clinical Supervisor Roles and Responsibilities

A clinical supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified foundation doctor's clinical work and providing constructive feedback during a training placement.

Training is provided to new clinical supervisors in a one and a half day course covering

- The roles and functions
    - Clinical supervisor (CS)
    - Placement Supervision Group (PSG)
    - Educational supervisor (ES)
    - Annual Review of Competence Progression (ARCP) panel
- Assessments – an overview of the main changes
    - New forms and guidance - see www.foundationprogramme.nhs.uk
    - Assessment Methods
    - TAB and self-TAB
    - ES end of placement report
    - ES end of year report
    - CS end of placement report
- Supervised Learning Events (SLE)
    - DOPS
    - mini-CEX
    - CBD
    - developing the clinical teacher
- The principles of feedback
- Supervision arrangements
- Approaches to debriefing
- Helping trainees with additional learning needs

New supervisors can book onto this course via the website:
https://www.eastmidlandsdeanery.nhs.uk/page.php?id=792

Responsibilities
The clinical supervisor must:

- **Make sure that foundation doctors are never put in a situation where they are asked to work beyond their competence without appropriate support and supervision. Patient safety must be paramount at all times.**
- **Make sure that there is a suitable induction to the practice.**
- **Meet with the supervisee at the beginning of each placement to discuss what is expected in the placement, learning opportunities available and the foundation doctors learning needs.**
- **Provide a level of supervision appropriately tailored for the individual foundation doctor. This includes making sure that no foundation doctor is expected to take responsibility for, or perform, any clinical, surgical, or other technique if they do not have the appropriate experience and expertise.**
- **Provide regular feedback on the foundation doctor's performance.**

- **Undertake and facilitate workplace-based assessments.**
- **Make sure that the supervisee has the opportunity to discuss issues or problems, and to comment on the quality of the training and supervision provided.**
- **Investigate and take appropriate steps to protect patients where there are serious concerns about a foundation doctor's performance, health, or conduct. The clinical supervisor should discuss these concerns at an early stage with the foundation doctor and inform the educational supervisor. It may also be necessary to inform the Clinical Director (or Head of Service) or the Medical Director and the GMC.**
- **Complete the clinical supervisor's report at the end of the placement.**
- **Relate to the trainee eportfolio by looking at learning log entries and ensuring that the trainee has demonstrated attainment of competence against the curriculum.**

Performance Issues

The vast majority of FY2 doctors will complete the programme without any major problems. However, some doctors may need more support than others because of; for example ill health, personal issues, learning needs or attitude. If you feel at any time that the doctor under your educational or clinical supervision has performance, issues you should contact the FTPD at their employing trust who will work with you to ensure that the appropriate level of support is given both to you and the FY2 doctor in accordance with deanery process.

It is very important that you keep written records of the issues as they arise and that you document any discussions that you have with the FY2 doctor regarding your concerns. The FY2 doctor must be provided with copies and access to any information regarding concerns.

If you have any concerns regarding a Foundation Doctor whilst they are with you, please contact the Foundation Training Programme Director (FTPD) at the relevant hospital to discuss. You should not contact the GP FTPD. Each FTPD is supported by an administrator (Foundation Programme Coordinator); their details are included in Appendix 7.

The Supervision Payment

The supervision payment, equivalent to the GPR basic training grant (pro rata) is paid for each foundation doctor.

- You can if you have sufficient capacity in terms of space and resources have more than one FY2 at any one time.
- If you share the rotation with another practice then payment will be split appropriately.
- The HEE will pay the FY2 placement grant directly to your practice.
- HEE will only pay for FY2 doctors recruited to an approved foundation training programme. Please note that locums appointed to cover service (LAS appointments) will not attract a supervision payment from the deanery.

The supervision payment is paid via bank transfer by the HEE. If you are a new practice or an existing practice who has changed their banking details you will need to send confirmation of the account name and number along with the bank sort code you would want the supervision payment to be paid in to, this must be on practice headed paper.

Please contact the Foundation School for further details: foundationprogrammes.em@hee.nhs.uk

APPENDIX 1 - EXAMPLE EDUCATIONAL CONTRACT

1. INTRODUCTION

   a. This document is an agreed educational contract between:

      i. Foundation Trainee

         Dr ………………………………………………………………

   and

      ii. GP Clinical Supervisor (CS)

         Dr ………………………………………………………………

   b. This document is intended to make explicit what a foundation trainee can expect from the foundation training practice and what is expected of the foundation trainee in return.
   c. The CS (or their named deputy) should be an immediately available source of advice, constructive criticism, and guidance. The CS should keep themself up-to-date with medical developments and provide a structured framework and environment for learning general practice.
   d. The foundation trainee is involved in caring for the practice's patients. The partners have a contract for the provision of medical services to these patients with the CCG and as the foundation trainee is working in the practice he/she acts as a practice representative/deputy at all times. The foundation trainee therefore has a service commitment to the practice and patient. The nature of the medical services to be rendered is laid out in the National Health Service (General Medical Services Regulation) 1992. The foundation trainee should be familiar with and abide by these regulations.
   e. The foundation trainee should be punctual, appropriately dressed and courteous to patients at all times. He/she should never decline an explicit or implicit request by a patient to be seen without first discussing this with the supervisor or his deputy.

2. TRAINING OBJECTIVES
   a. The Consultation
      i. This is the basic tool for patient care. The foundation trainee should: -
         - Regularly extend his enquiry beyond the presenting complaint, for example, to "at risk" factors and continuing problems;
         - Regularly recognise and respond to emotional cues from the patient.
         - Become familiar with all the tasks of the consultation and the various consultation models.

   b. Medical Records
      i. These are the keys to delivering systematic patient care.
      ii. The foundation trainee should keep comprehensive, yet concise records in such a way as to facilitate continuing care. These should include relevant past medical history, up to date medication lists, management plans where appropriate, details of lifestyle e.g. smoking status, alcohol intake, and allergies/hypersensitivities.

a. Education
   iii. The foundation trainee should read regularly in a planned and programmed manner.
   iv. He/she should be able to identify and plan to correct their own weaknesses.
   v. He/she should regularly examine their own work critically.

b. Teamwork
   vi. The foundation trainee should aim to regularly and appropriately use members of the primary healthcare team to assist in patient care.

c. Organisation
   vii. The foundation trainee should be able to competently take part in practice management activities.
   viii. He/she should be able to extend his professional responsibilities beyond the remit of the practice.
   ix. He/she should be abreast of current and future developments in general practice and the Health and Social Services as a whole.

3. CURRICULUM
   a. This is the key to ensuring a productive attachment. Initially learning priorities are established by means of:
      i. Personal reflection.
      ii. Review of clinical experience.
      iii. An initial confidence rating.
      iv. An initial learning plan is set following these combined assessments. Subsequent modifications are made, considering the following:
         1. Feedback from staff and patients.
         2. Foundation trainee assessments completed.

4. TEACHING/LEARNING PROCESS
   a. The foundation trainee is expected to take responsibility for his/her own education and expected to facilitate the learning process.
   b. The following assessment methods may be used: -

      i. Joint consultations and home visits
      ii. Problem and random case discussion 5 - 10 (variable) minutes at the end of surgeries and sometimes during surgery.
      iii. Analysis of video consultations using consultation maps and rating scales
      iv. Tutorials - weekly time has been set aside for learning/teaching. This is 'protected time' during which there will not be any interruptions unless they are deemed to be absolutely necessary by practice staff. Other partners will also take tutorials (times to be mutually agreed). Tutorials may be joint with other foundation and/or GP trainees.
      v. Topics for tutorials are agreed in advance by the foundation trainee and supervisor/partner. Preparation for tutorials must be shared by the foundation trainee and the supervisor/partner. Ideally, a programme of tutorials shall be arranged 4-6 weeks in advance.

vi. It is expected that there will be other informal additional teaching sessions/opportunities offered during normal working hours.

c. Attendance at practice and team meetings the foundation trainee is expected to attend and contribute to these on a regular basis.
d. Audit/QIP the foundation trainee should regularly examine his/her own work critically, for example, by suggesting and performing audits on referral, prescribing and investigations or QIPs on areas they have identified as suitable.
e. Reading supervisor and foundation trainee should regularly read relevant medical literature.
f. Core HEEM Educational events should be notified to the practice and the trainee should attend these.

5. ASSESSMENT
   a. The foundation trainee is expected to studiously complete the e-portfolio and submit to the appropriate WPBA diligently.
   b. It is the foundation trainee's responsibility to ensure that these assessments are undertaken.
   c. Should there be disagreements in interpretation of feedback from foundation trainee assessments, including staff or patient feedback, these disagreements will be discussed immediately.

6. WORKLOAD
   a. The foundation trainee, during his/her attachment, should be able to cope with an increasing workload, dependant on the trainee and in discussion with their GP clinical supervisor. By the end of the GP placement it would be expected that an F2 to be on no shorter than 15-20 minute appointments, with a debrief at the end of each surgery.

7. INDUCTION
   a. The first two weeks will normally involve minimal independent clinical activity. The time is spent rotating through attachments to the various PHCT members, together with learning administrative systems in the practice, including how to use the computer. The foundation trainee will be helped to learn the geography of the surgery building and practice area.
   b. In the third and fourth weeks, the foundation trainee will begin closely supervised, independent clinical work.

8. EQUIPMENT
   a. The training practice will provide the foundation trainee with basic medical equipment (doctor's bag and instruments) although the foundation trainee is encouraged to acquire his or her own equipment.
   b. Drugs for emergency use are provided. Used (injectable) drugs should be accounted for, by completing a prescription and making an entry in the patient records. All unused drugs must be returned to the practice at the end of the attachment.

9. SURGERIES

a. The GP foundation trainee is usually provided with their own consulting room, which will contain the usual, expected equipment to conduct a modern GP surgery

and service. The GP foundation trainee is expected to take reasonable care of the provided instruments and facilities etc. and to maintain an adequate level of security, particularly in relation to the video camera.

b. The normal minimum consultation time is 20 minutes, although expected initial consultation time will be 20-30 minutes.
c. During or after any surgery, non-planned/extra/emergency patients may require to be seen and these ‘extra’s’ are shared between the available consulting doctors.
d. The foundation trainee should not be left to consult without the supervisor or their named deputy available in the practice premises. That named deputy can be a locum doctor providing they fully understand their duties and only undertake clinical cover & debriefs.
e. Supervisor and foundation trainee should collaborate to ensure the foundation trainee sees a representative case mix.

10. FEEDBACK

a. The foundation trainee should provide the supervisor with constructive feedback of his general practice attachment including his/her assessment of all educational content.

11. SICK LEAVE AND NON-ATTENDENCES

a. All non-attendance including sick leave will be summated and the employing Trust will be informed of total number of days absence.

GP foundation trainee name	
Signed	
Date	
GP supervisor name	
On behalf of	
Signed	
Date	

APPENDIX 2 - FOUNDATION DOCTORS AND HOME VISITS

The guidance for FY2 trainees and their clinical supervisors, about what sort of consultations they carry out in their GP placements is as follows.

All trainees must be supervised and supported in a way which does not jeopardise patient or trainee safety (both physical and emotional). The experience and clinical exposure they receive must be appropriate for their Foundation Curriculum and the Supervisor must be familiar with this document. Please remember an FY2 trainee is not undertaking training for General Practice. The trainee must have sufficient knowledge and competence to consult alone with patients, and familiarity with the support mechanisms such as IT systems, practice policies, and protocols. To that effect, trainees must consult in a way, which allows immediate access to either the designated supervisor or an approved deputy. This would always be a doctor, usually a partner, but it could be a salaried doctor or regular locum. Any deputy should be aware of the responsibilities of a supervisor. This access to a supervisor is necessary at the time of the consultation to clarify any clinical need of the patient, and educational access should also be available after the consultation as "debrief" time

Home visits are a potentially rich educational experience for trainees. They also offer opportunity to take an adequate and appropriate history from the patient and family or carer. An examination can be carried out **with consent**, in the same way as for surgery consultations The visit and consultation can safely be carried out by trainees with the same provisos as above. The trainees and supervisors should confirm that the appropriate indemnity cover from the host trust (secondary care) is in place, but historically this has always been the case. If using their own car, the trainee should have business usage cover. The trainee must be competent clinically, and the supervisor must be able to satisfy themselves that this is so. This would normally be in the second half of a 4-month placement and follow several shadowed visits, but is open to negotiation.

The trainee must be safe to do the visit; this applies to personal safety as well as familiarity with what resources may be needed away from the surgery. The trainee should be familiar with the local geography and encouraged to check this and ring the patient before leaving the surgery. The practice should undertake a risk assessment of the environment they are asking the trainee to go into and be particularly wary of: tower blocks; lone female doctors visiting lone male patients; patients with known alcohol or drug history; patients with a history, or suspicion of risk of violence. They should have essential clinical equipment and access to the same protocols and data, which they might have in the surgery, including adequate patient medical records. It is recommended that the trainee rehearses the likely clinical issues with the supervisor in advance of the visit. It should NOT be a visit requested as an emergency call under any circumstances, although it would be good experience for a trainee to accompany a supervisor on an urgent visit if possible.

There should be instant access to the supervisor via a practice supported mobile phone and direct phone number for the supervisor. The trainee should be able to request attendance by the supervisor rather than only ask for advice. There should be pre-visit briefing to be clear that the visit is appropriate for the trainee with regard to their experience and known competencies, and safe for the patient; there must always be a post-visit debriefing immediately after the visit.

APPENDIX 3 - BECOMING APPROVED AS A FOUNDATION SUPERVISOR/FOUNDATION TRAINING PRACTICE

Approval

A typical first approval visit for a supervisor and practice which has foundation trainees only looks something like this.

Time	Activity	Comments
9.15	Arrival and coffee (please)	
9.30 to 10.00	Joint meeting with clinical supervisor and practice manager	Here we can review the educational environment and processes relating to • Appointment systems relating to providing broad curriculum coverage • Induction • Obtaining and acting on trainee feedback • Opportunities for trainees to learn from others • Patient safety • Practice policies and procedures • Support available for trainees with additional needs • The learning environment • The trainee timetable • Trainee supervision
10.00 to 10.30	Meeting with clinical supervisor only	In this part of the visit we can look at • Approaches to supervision and debriefing • Discuss and assess your familiarity with the foundation curriculum, the eportfolio and the supervised learning events • How you encourage and facilitate trainees to direct their own learning • The clinical supervisors report • The teaching methods that you adopt • Your PDP • Your protected time for training
10.30	Expected finish time	

You will be contacted by Sinead Cobb (Sinead.Cobb@hee.nhs.uk) from HEE who will liaise with you about the approval/reapproval visit. In addition to providing the application/self-assessment form she will agree a date with you when the visit can be carried out. She will also advise of the various other ‘visit permutations’ of being a practice already approved for GP speciality training and/or being an already approved GP trainer.

APPENDIX 4 - ANNUAL AND SICK LEAVE RECORD SHEET

Sickness/absence form for Foundation Year 2 doctors in General Practice			
Name of Foundation Year 2 Doctor		**Name of Educational Supervisor**	
GP Practice Address			
Name of Practice Manager		**Name of Person Completing Form**	
First day in GP Placement		**Last Day in GP Placement**	
Total Annual Leave Entitlement for the Year August to August	**27 days. It would be expected that approximately one third of this amount is taken during the 4-month placement in GP**		
	From	**To**	**Total**
Annual Leave Dates			
Total During Placement			
Sickness/Absence			
Total During Placement			
Other Absence (Please Specify)			

Please email or fax to the relevant Foundation Programme Coordinator at the FY2 doctor's host trust monthly and at the end of the FY2 doctor's rotation in your practice EVEN IF IT IS A 'NIL RETURN'

LNR FS & Trent FS General Practice - End of Rotation Survey

Demographic Information

2. Which practice have you been attached to for your current rotation? (please answer the survey questions in relation to one site only)	
3 Have you been subject to bullying or undermining while in the post? (Please note your responses to this question will not be used to instigate a specific investigation. If you require support as a result of being subject to bullying and/or harassment please contact your FTPD or the Foundation School.)	
3.a If 'Yes', who was the source of the bullying?	
3.a.i If you selected Other, please specify:	

Induction (Practice and Trust)

5 From your PRACTICE induction, did you get all of the information you needed about working in the practice?	
5.a If 'No', what information about the practice did you need but did not get?	
6 How long did your PRACTICE induction programme last?	
6.a If you selected Other, please specify:	

Supervision

10. Did you meet with your GP Clinical Supervisor to discuss your duties and expectations of your progress within the first 2 weeks of starting in the post?	
11. Has your GP Clinical Supervisor informed you who is in your Placement Supervision Group?	
12. In the post, have you received regular constructive feedback from your GP Clinical Supervisor on your clinical performance?	
13. In the post, how would you rate your GP Clinical Supervisor's familiarity with the Foundation Curriculum, including the assessment tools?	
13.a If you selected Other, please specify:	

Learning Environment

15 Do you feel that your current post has afforded you sufficient opportunities to demonstrate a range of foundation competences?	
15.a If no, in which areas are you lacking?	
18 How would you rate the on-the-job training you have been acquiring in this GP post?	
19 Overall how would you rate your learning experience in this GP post?	
19.a If you stated poor please explain why?	
20 Would you recommend your GP post to a colleague and/or medical student?	
20.a If no; please state why not?	
21 How often did you have the opportunity to have joint consultations with either your GP clinical supervisor or another GP from the Practice?	
22 Have you had the opportunity to participate in significant event analysis in this placement?	
23 Have you performed an audit during this placement?	
24 Has your GP Clinical Supervisor asked you to feedback on educational experience in the practice?	

Patient Safety

25 Have you ever been asked to do anything which you felt was beyond your competence and/or had to cope alone beyond your knowledge and experience? Please note your response should relate to your level of competence and not level of confidence.	
25.a If yes; please provide an example of when you have worked beyond your competence.	
26 What level of supervision were you given when you first started seeing patients on your own?	
26.a If you selected Other, please specify:	
27 Do you do home visits?	
27.a If you do home visits, are they?	
28 Have you ever obtained consent for a procedure with which you were unfamiliar?	
28.a If yes please provide examples.	

Assessments and e-Portfolio

29 In general, how familiar do you think the assessors in your post are with the SLEs & foundation assessment tools?	
30 Does your GP Clinical Supervisor have access to your e-portfolio?	
31 Have you experienced difficulties finding assessors for your SLEs in your post?	
31.1 CBD	
31.2 DOPS	
31.3 Mini-CEX	
31.4 Clinical Teacher	

APPENDIX 6 - FREQUENTLY ASKED QUESTIONS

Question	Answer
What is a Foundation Programme Year 2 Doctor (FY2)?	• The second year of the Foundation Programme builds on the first year of training. The programme focus is on training in the assessment and management of the acutely ill patient. Training also encompasses the generic professional skills applicable to all areas of medicine – teamwork, time management, communication and IT skills. • As an FY2 doctor they will have full GMC registration • In 'old money' a 1st year foundation doctor is equivalent to a PRHO and the second year of foundation is equivalent to the old first year SHO
How is an FY2 doctor different from a GP registrar?	• The FY2 doctor is fundamentally different from a GP Registrar. • The FY2 doctor is not learning to be a GP. • You are not trying to teach an FY2 doctor the same things as a GP Registrar but in a shorter time. • The aim of this rotation is to give the FY2 doctor a meaningful experience in General Practice with exposure to the acutely ill patient in the community, which will enable them to achieve the required competencies. • The FY2 doctor requires a greater level of supervision.
Who decides which doctor will come to my practice?	• Each FY2 programme usually consists of three four-month rotations. There are numerous combinations and all programmes are designed to ensure that trainees achieve acute competencies and generic skills. • Medical students usually rank their rotations for the entire two years of foundation and the Foundation School then allocates based on these preferences and the score obtained during national recruitment • The LETB approves suitable practices using an agreed set of approval criteria. • FY2 doctors with GP in their placements are allocated to those placements by the Foundation School and the local GP training programme team.
Does the FY2 doctor have to be on the performers list?	• LETB Guidance on Foundation Placements in General Practice (received in June 2006) stated that from 2nd July 2006 Foundation doctors are exempt from the PCO Performers List. Full details are available at: http://www.legislation.gov.uk/uksi/2006/1385/pdfs/uksiem_20061385_en.pdf
What about indemnity cover	• Deanery Guidance on Foundation Placements in General Practice (received in June 2006) has stated that Trust indemnity through the employing trust will cover the GP period. • In the event of a problem with a FY2 doctor in practice, the trainer has to be able to demonstrate adequate supervision had been undertaken.
Can an FY2 doctor sign prescriptions?	• Yes. An FY2 doctor is post registration and is therefore able to sign a prescription.
What about their Contract of	• The Contract of Employment is held by the acute trust where the FY2 doctor is based. They are responsible for paying salaries and other HR

Question	Answer
Employment?	related issues. • However in addition to this legal contract we also require that each practice has an educational contract with each of its Foundation Doctors. • A specimen copy is attached at Appendix 1 p15.
Are travel costs reimbursed?	• The FY2 doctor will be able to claim for travel to the practice from the base hospital • They can also claim for any travel associated with work • Travel claims are made through the host trust
Who keeps cremation form fees?	• The FY2s contract of employment sits with their host trust. It is normal for junior doctors to keep category 2 fees, which crem form payments fall under. However in GP it is normal for crem form fees to go into the practice pot. • Please clarify the practice policy on crem form payment at induction
What about Study Leave?	• The FY2 doctor is eligible for up to 30 days study leave during the year. Formal FOUNDATION teaching sessions count towards this • Please consult the Foundation School policies on study leave for further information on how this is apportioned to foundation doctors. • It is essential that any applications for study leave are approved by the Foundation Programme Training Director (FTPD) and the postgrad centre • The FY2 doctor must be released by the practice to attend their host trusts FY2 teaching programme.
What about annual leave entitlement?	• The FY2 doctor is entitled to 27 days per annum; where possible no more than 9-10 should be taken in each 4-month rotation and 15 in every 6-month rotation • If an FY2 doctor, wishes to take either significantly more or less than those suggested amounts in general practice please contact the FTPD at the employing trust. • A record of annual leave taken during the general practice placement should be submitted to the host Trust's medical staffing department at the end of each month; using the pro forma attached in Appendix 5.
What about sickness and other absence?	• Any absence due to ill health or for any other reason should be recorded and sent to the host trust medical staffing department on a monthly basis using the pro forma attached as Appendix 5. • If sick leave exceeds 1 week during the GP placement, you must inform the FTPD and Foundation Coordinator at the host Trust as this may have implications on a FY2 doctor's ability to complete the year on time. • If sickness leave exceeds 4 weeks in a year then trainees will not be signed off and will have to repeat all or part of the year.
Should an FY2 doctor do out of hours shifts?	• They are not expected to work out of hours shifts during their general practice rotation, as they receive no 'banding' payment for out of hours work nor are they on the performers list.
Can an FY2 doctor do community/hom	• If community visits are undertaken then these should comply with the LETB guidance regarding community visits (please see Appendix 3, p23). There has to be briefing before the visit to identify potential problems

Question	Answer
e visits?	and learning outcomes and a debrief after the visit by the supervisor
What about supervision if I am a “single-handed” GP and take leave?	• The most important thing is that the Foundation doctor cannot see patients without the supervisor being present in the building. This can be achieved by the foundation doctor: o taking leave at the same time as the supervisor o spending time with other members of the team as part of a planned educational experience and as an observer only o spending time in another suitable local practice • Thus, the Foundation doctor is at no time left seeing patients without the supervisor being on-site. Regular Locum cover is t acceptable providing the locum doctor fully understands their responsibilities re cover
What if I want to become involved in Foundation training as a new practice/new supervisor	• You should approach either your local GP training programme or Pete Wells, Foundation GP Training Programme Lead for HEEM (peter.wells@hee.nhs.uk)

APPENDIX 7 – COVID-19

As with all of General Practice, working life has changed dramatically since the onset of the COVID-19 pandemic. Some of which has forced us to work far more efficiently and utilising technology in different ways.

Training and supervising F2 doctors may now seem a little daunting. I am sure you will be asking if you can do this safely and what do you get them to do?

Most GP practices if not all have moved to a triage led service. This should hopefully provide a layer of safety to your patients ensuring as much as possible that the F2 doctors are supported and seeing appropriate patients to their level of training and experience.

Think about the calls that come in and where possible to minimise the COVID risk to the patients and staff offer telephone consultations or video constulations if you have the facilities to do this.

Examples:

Telephone	Video
Pain relief request	Skin rashes
Skin lesion (supported with photo)	Depression
Hypertension (with home readings)	Joint pains – may need F2F
Follow up to treatment initated by F2 doctor	TATT
Simple medication reviews	Patient needs reassurance
Test results	Child with parent
Sick note requests	Limited examination necessary

Please see:
https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf

https://portal.e-lfh.org.uk/myElearning/Index?HierarchyId=0_45016_45125_47372&programmeId=45016

Weigh up the factors to decide what to do

Remote treatment may be appropriate when...

- The patient's clinical need or treatment request is **straightforward**
- You **have access** to the patient's medical records
- You can give patients **all the information they want and need** about treatment options by phone, internet, or video link
- You **don't** need to examine the patient
- You have a safe system in place to **prescribe**
- The patient **has capacity** to decide about treatment

Face to face treatment may be preferable when...

- The patient has **complex clinical needs** or is requesting higher risk treatments
- You are **not the patient's usual doctor or GP** and they have not given you consent to share their information particularly if the treatment needs follow up or monitoring
- You **do not have access** to the patient's medical records
- You **need to examine** the patient
- It's **hard for you to ensure**, by remote means, that patients **have all the information they want and need** about treatment options
- You are **unsure of the patient's capacity** to decide about treatment
- You are prescribing **injectable cosmetic products**, such as Botox, Dysport or Vistabel. These injections must not be prescribed on the basis of phone, video or online consultations

APPENDIX 8 – HOW TO SUPERVISE FY2 TRAINEES REMOTELY

Supervision can continue to happen, it is just about changing our mindset to the way we communicate with people and interact obeying social distancing rules. It is possible to continue to supervise foundation doctors quite safely in primary care by just thinking through a few issues. Below are a few pointers:

- Triage all F2 patient contact and decide on the appropriate modality for patient consultation: online, telephone, video and utilise the F2 to help in those contacts which are likely to be more lengthy and not necessarily suitable for a busy triage list – schedule in a longer telephone or video consultation
- Provide "pre brief" for the F2 via the patient notes especially if red flag's a possibility
- There are NHS approved apps for video consulting which could be used to debrief F2 doctors after patient contact: EMIS, Accurx, TPP, Vision
- It is possible to still debrief F2F after each patient, remembering to continue to wear face masks and socially distance as per government recommendations.
- Encourage the F2's to attend and participate in the reestablishment of practice meetings (remotely where possible)
- QiP opportunities. Following on from COVID there are lots of opportunites for primary care improvements/developments which could be harnessed as great learning opportunities and practice development
- Contacting shielding patients regularly to establish rapport and offer support
- Help support in proactive contact of vulnerable/safeguarding patients
- Work with practice pharmacist on helping conduct annual medication reviews

APPENDIX 9 - CONTACT DETAILS

East Midlands Foundation Schools

The East Midlands Deanery has two foundation schools; LNR covering the Leicestershire, Northamptonshire and Rutland region and Trent covering the Derbyshire, Lincolnshire and Nottinghamshire region. Contact details for each of the foundation schools are detailed below:

East Midlands Foundation Schools		
Trent	Charlie Mackaness, Foundation School Director charlie.mackaness@hee.nhs.uk	School Administration foundationprogrammes.em@hee.nhs.uk
LNR	Rachel Parry, Foundation School Director Rachel.parry@hee.nhs.uk	
Website	http://www.eastmidlandsdeanery.nhs.uk/page.php?area_id=15	

Foundation Training Programme Directors and Coordinators

The Foundation Training Programme Director (FTPD) is responsible for managing and leading a foundation programme within a specific acute NHS Trust.

If you have any concerns regarding a Foundation Doctor whilst they are with you; please contact the FTPD at the relevant hospital to discuss. Each FTPD is supported by an administrator (Foundation Programme Coordinator); their details are also included in the table below:

Chesterfield Royal Hospital	Dr Kiran Kumar; Kiran.kumar@nhs.net	Deborah Couzens; deborah.couzens@nhs.net; 01246 512902
Kettering General Hospital	Dr Syed Jafri; syed-zulqarnain.jafri@nhs.net	Caitlin Mulligan; foundation.co-ordinators@kgh.nhs.uk 01536 491184
King's Mill Hospital mans.	Mr Ed Villatoro; e.villatoro@nhs.net	Tracey Clarke; tracey.clarke2@sfh-tr.nhs.uk 01623 622515 ext 3647
Lincoln County Hospital	Dr Akila De Silva; akila.desilva@ULH.nhs.uk	Mandy Deane; mandy.deane@ulh.nhs.uk; 01522 573867

Northampton General Hospital	Dr Brian Richardson; brian.richardson@ngh.nhs.uk	Lyn Holmes; lyn.holmes@ngh.nhs.uk 01664 545160
NUH	Dr Gabby Chow: Gabby.Chow@nuh.nhs.uk Dr Manjula Pammi: Manjula.Pammi@nuh.nhs.uk Dr Raza Darraza.dar@nuh.nhs.uk Dr Senthil Raghunathan: Senthil.Raghunathan@nuh.nhs.uk	Caroline Bosworth Caroline.bosworth@nuh.nhs.uk 0115 924 9924 ext 66081
Pilgrim Hospital	Dr Tauseef Ashraf; tauseef.ashraf@ulh.nhs.uk	Wendy Mulraney; wendy.mulraney@ulh.nhs.uk; 01205 446173
Royal Derby Hospital	Dr Gill McCulloch: gill.mcculloch1@nhs.net	Zoeie Spencer; zoeie.spencer@nhs.net; 01332 789245
University Hospitals of Leicester	**F2s based at United Hospitals of Leicester** Dr Nahin Hussain: Nahin.hussain@uhl-tr.nhs.uk Dr Tanu Singhal: Tanu.singhal@uhl-tr.nhs.uk Dr Biju Simon: biju.c.simon@uhl-tr.nhs.uk Dr Cho Phyu: cho.phyu@uhl-tr.nhs.uk Dr Kath Higgins: Kath.Higgins@uhl-tr.nhs.uk Dr Winston Rennie: Winston.rennie@uhl-tr.nhs.uk **F2s based at Leicestershire Partnership Trust** Dr Steve Dyer: steve.dyer@leicspart.nhs.uk	Claire Bush; claire.bush@uhl-tr.nhs.uk 0116 2588094

GP Specific issues relating to the practice and not the trainee	LNR and TRENT Pete Wells – GP Foundation Lead peter.wells@hee.nhs.uk	