NHS England Midlands

A clinical supervisor's guide to foundation year 2 training in general practice

May 2026



Introduction	3
Supervised learning events (SLE)	3
Foundation assessments	5
Practice supervision group	6
Portfolio	6
Curriculum	6
Induction	7
Working week	7
Rota	9
Clinical & educational activities/duties	10
Supervision & debrief	12
Tutorials	13
Community supervisor roles & responsibilities	14
APPENDICES	
Practice & supervisor approval	17
Induction template	18
Debriefing guidance	24
Educational contract example	25
Foundation doctors & home visits	29
Annual leave & sick leave record	31
Frequently asked questions	32
Modes of consulting	35
Contact details	37

Introduction

This Guide to Foundation Programme Training in community settings is intended to be exactly that. Every setting 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 Foundation doctors working in community settings. It may however be of use/interest to the wider team in Community/General Practice including the foundation doctors themselves.

It is important to remember:

- The rotation in your practice is part of a two-year programme and is to provide experience of a placement outside of the acute trust.
- Some capabilities may well be more readily met in community than in some other rotations e.g., Relationships with Patients and Communications.
- The foundation doctors will not cover all required capabilities during the community placement.
- Every setting is different and will offer different learning opportunities for their foundation doctor. Therefore, the foundation doctor is expected to be flexible to the working arrangements of individual settings and to discuss the timetable with the GP Clinical Supervisor (see pages 7 - 10 for further guidance).

Supervised Learning Events (SLE)

- These are designed to be supportive and formative.
- The foundation doctor can determine the timing of the SLE within each rotation and SLE must be completed by a trained foundation supervisor.
- It is important that all SLE are completed within the overall timetable for the assessment programme.
- Each foundation doctor is expected to record their SLE in their e-portfolio. These will then form part of the basis of the discussions during appraisals.
- The foundation doctor is an adult learner, and it will be made clear to them that they have responsibility for getting their SLE completed and for getting their capabilities evidenced.

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

SLE 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 foundation clinical supervisor should be used for each SLE wherever possible. GP Clinical Supervisor must have completed the supervisor training and approval process (See appendix 1) The foundation clinical supervisor for each post should perform at least one 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. Foundation supervisors 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.

SLEs

Supervised learning event	
Direct observation of doctor/patient interaction: Mini-CEX DOPS	F2 need to have enough SLE to cover the curriculum. There is no set minimum number for any of these.
Case-based discussion (CBD)	
Developing the clinical teacher	

Foundation assessments

Foundation assessments include a range of **core procedures** which are completed in F1.
Team Assessment Behaviour (TAB) is a tool for assessing the foundation doctors' attitude and/or behaviour, verbal communication, team working and accessibility.
Placement Supervision Group provides feedback from colleagues around the higher-level learning outcomes in the Foundation Curriculum.
The **Clinical Supervisor Report (CSR)** provides feedback and an assessment based on observed practice within the workplace during a particular placement.
The **Educational Supervisor Report (ESR)** provides a summary and review of all the evidence within the portfolio and gives an assessment of progress.

Frequency of assessments

Assessments	**Frequency**
E-portfolio	Contemporaneous
Team assessment of behaviour (TAB)	Completed in the first post of F1 – if unsatisfactory needs repeating. Can do more TAB but optional.
Placement Supervision Group	Recommended to complete in post 1 or 2 of F2
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

If you are acting in the role of assessor (for a DOPs as an example), you will not need an account for the e-portfolio to add the assessment. The foundation doctor will 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 NHS portfolios using the 10-digit code in order to record your assessment. NHS portfolio can be found at www.nhseportfolios.org

• The SLE /assessments do not have to be carried out by the doctor who is the nominated foundation clinical supervisor, but the assessor must have completed foundation clinical supervisor training in the context and use of the tools and have been approved.

• You can and should involve other doctors, nurses or other health professionals that are working with the foundation doctor. DOPs can be completed by any health care practitioner who has capability in the skill that they are completing a DOPs for.

• 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/clinic.

Placement Supervision Group (PSG)

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 foundation clinical supervisor (FCS) will seek information on the F2 for whom they are responsible from senior healthcare professionals who work alongside the F2 during the placement. These colleagues will make up the placement supervision group. It is expected that all healthcare professionals will be able to support and guide the F2, providing feedback on performance to the trainee and to the foundation clinical supervisor.

In compiling their report, the named foundation 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 & nurse practitioners (band 5 or above).
- Advanced Practitioners
- Practice Clinical Pharmacist.
- Allied health professionals – including first contact practitioners (FCPs)

In a community/general practice placement, the PSG may be limited to one or two members. The PSG is completed via a structured form to help guide feedback from other professionals who may not be as familiar with the F2 as educators directly involved in the training of learners. Those reviewing the outcome of the PSG must ensure the feedback is appropriate, fair, non- judgemental and is free from bias.

Further information about the placement supervion group can be found on the Horus portfolio website. You can find this at 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 an online learning portfolio (Horus). They will access their portfolio via the Horus log in. It will be how they will record their achievements, reflect on their learning experience, and develop their personal learning plans.

Foundation 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). The FAQs around Horus can be found on the Horus e-Portfolio support website.

The Foundation Curriculum

It is important to remember that community is just one of your F2s three placements where they can achieve their foundation doctor capabilities and cover the Foundation Curriculum.

More details about the foundation curriculum can be found on the UK Foundation Programme website.

The Induction

The induction programme should orientate the foundation doctor to the practice/community organisation to enable them to find their way around, understand a bit about the patient population, meets the multi-professional team, learn how to use the computer systems, and most importantly how to get a cup of coffee! As well as orientation it provides an excellent opportunity to get to shadow a range of staff (clinical & non-clinical) to better understand health care outside of the acute trust and the capabilities held by a range of staff.

This is very similar to the induction programme used for those in GP training, and should last a couple of weeks. It should be planned prior to them arriving with you. An introduction pack for the foundation doctor, which again can be like that which you might use for a locum, should be provided. An example induction timetable can be found in appendix 2 however 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

The induction should include opportunities for the foundation doctor to shadow their supervisor. 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 the foundation doctor would benefit from in this initial phase. Some may require a longer induction process, and this depends on their capability and experience. Their reflections about the various roles and responsibilities of the staff they meet should be recorded in their e-portfolio.

As covered in the supervisor training it is good practice to ensure that there are opportunities for the supervisor to shadow the foundation doctor before them commencing seeing patients to help in gauging capability.

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 – for a full-time equivalent (FTE) post.

- 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 (2 hours of the 'educational' hours) plus self-directed study time of 2 hours.
- The remaining hours of educational time could be demonstrated on the timetable as being tutorials, SLE, and sessions in the middle of the day and audit work.

Activities not intended to be carried out using 'self-development time' ie Private Study

'Self-development' time is not intended to replace time already available in work schedules for foundation doctors to carry out other non-clinical activities such as: Attending trust-delivered/regional teaching programmes.

- Attending practice/organisation meetings, such as audit, quality improvement, safeguarding, palliative care, morbidity and mortality or governance meetings.
- Taking study leave.
- Undertaking taster days / sessions to gain insights into potential career options.
- Attending induction programmes.
- Completing practice mandatory training, for example fire safety or information governance.
- Preparing for postgraduate examinations

Remember that your foundation doctor will be at work 40 hours spread across the week (FTE). This could be:

- 5 x 8-hour days – working 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 – if 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 foundation doctor and should allow the foundation doctor to get the most out of their community rotation.

There are also some Working Time Directive and new junior doctor's contract rules which are worth noting too:

- 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. Breaks come out of the 70% clinical experience time.

- For this basic banding trainees must not start their working day before 8am and must finish by 7pm.

The trainee timetable will be reviewed as part of the 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.

F2 ROTA EXAMPLES FOR GENERAL PRACTICE

This is an example template for the community post to base its own rota on. Please see the guidance re the junior doctors' contract below which needs to be abided by. Start times can be agreed with the foundation doctor as can the time for self-study. The day of trust teaching depends on which trust they are employed by.

	MON	TUES	WED	THURS	FRI
SURGERY 9AM - 12					
DEBRIEF 12- 12.30					
ADMIN 12.30 – 1.30					
LUNCH 1.30			**Trust teaching (2hrs)**		
SURGERY 2- 3.30			**Self-directed time (2hrs)**		
DEBRIEF 3.30 -4					
ADMIN 4-5					

- **<u>PLEASE NOTE</u>: Will need further educational time allocated (equivalent to a session) which is educational time – could include shared/joint surgeries, undertaking supervised learning events, tutorials, meetings with an educational component – doesn't have to be given in one block. <u>Most trust teaching</u> is 2hrs/wk, occasionally 4hrs/fortnight depending on the trust.**

For ease the junior doctor overview is below
40 hours week in GP maximum which consists of 70% Clinical, 30% Educational split
For every 3 hrs work – 1 hour admin (admin counts as clinical work)
Up to 5hrs work – no break
5-9 hrs work – 30 mins paid break (counts as clinical time)
Over 9 hrs – additional 30 mins paid break.
No split shifts. (Clock starts ticking when F2 arrives and stops when F2 leaves)
Debrief counts as clinical time.

Duties and activities suited to clinical sessions

1. Supervised or supported consultations within the community setting, with a **minimum** appointment length of 15 (telephone) and most commonly 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, familiarise them 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 F2 to debrief each patient with the supervising GP.
2. Supported online consulting. You may consider allocating the foundation doctor some of the low-risk 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”. It would be best practice to start with lower risk telephone consultations such as medication review/request, pathology results discussion etc rather than acute problems.
3. Supervised or supported home visits, nursing/care home visits, community hospital duties including time for debriefing, and travelling See appendix 5.
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, ARRS roles, clinical pharmacists, receptionists, triage nurses, GPwSIs.
6. Time spent with other healthcare professionals who are encountered in community & 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. Activities relating to supervised learning events & work-placed based assessment.
2. Reviewing/analysing video recordings of consultations, such as Mini-CEX exercises, where time is set aside for this purpose.
3. 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 clinicians – such as minor surgery lists, MSK, leaning disability review etc especially where direct supervision is required in the process to get formal verification of procedural competences for DOPs

Non-clinical activities suited to educational sessions

1. Locally organised educational events, e.g. foundation-specific educational programme run by NHSE 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/community care team meetings.
4. Educational supervisor meetings and other educational reviews.
5. Audit and research in community/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.

Indicative weekly timetable and further guidance

A maximum of 70% of the working week

- Patient contact time needs to be appropriate for the level of capability of the F2. For example in GP the F2 should initially start at 30-minute appointments for each patient and then reduce to 15- 20-minute appointments if and when the foundation doctor develops their skills, knowledge, capability and confidence.
- The foundation doctor must have access to another doctor within the building but not necessarily the F2 supervisor in the practice. If a long term locum doctor then the locum must understand their role and responsibilities in terms of debriefing/supervising the F2 surgery.
- The foundation doctor does not need to have their own dedicated 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.

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 foundation doctors 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 foundation doctors attend the local GP Speciality Training Programme with prior agreement.
- Audit work.

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 capability which is ideally associated with the trainee making a portfolio entry which reflects on that assessment.

1. Shadowed surgery - Supervisor sits in whilst foundation doctor consults – this can be a telephone consultation or a video consultation as well as Face to Face
2. Foundation doctor consults independently but all patients are reviewed by the supervising GP before they leave the consulting room.
3. Foundation doctor consults independently but all patients are reviewed by the supervising GP before they leave the practice.
4. Foundation doctor consults independently and each patient is presented to the supervising GP who may then review personally or give advice on management, at the end of each surgery.
5. Foundation doctor consults independently and patient is 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 doctors 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 capabilities. 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. (Please see appendix 3).

Foundation Doctors must NEVER be left alone unsupervised in a setting seeing/speaking to 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 foundation doctor 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 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 9 – Contact Details).

Tutorials

- Tutorials can be given either on a 1:1 basis or as part of a small group with other 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 roles and capabilities
- Clinical Governance and audit:
    - Who is responsible for what?
    - What is the role of audit/QIP?
    - What does a good audit/QIP look like?
- Primary, Community 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.
- Long term condition 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 foundation doctor will attend these sessions along with their colleagues in the hospital rotations and therefore must be released from the placement to do so.

- The classroom taught sessions cover some of the generic skills such as communication, teamwork, time management, evidence-based medicine.

The foundation doctor should contact the Foundation Programme to get a list of dates and venues at the start of their foundation doctor year 2 and it is the foundation doctor's responsibility to ensure that they book the time out of the practice.

Community Supervisor Roles and Responsibilities

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

More information regarding the course (how too book and course content) can be found by clicking Become a GP educator in the East Midlands | Health Education England East Midlands

Responsibilities

The community supervisor must:

- Make sure that foundation doctors are never put in a situation where they are asked to work beyond their capabilities without appropriate support and supervision. Patient safety must be always paramount.
- Make sure that there is a suitable induction to the practice.
- Meet with the foundation doctor at the beginning of each placement for an Induction Meeting 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 supervised learning events.
- Make sure that the supervisee can 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 and or Trust TPD. It may also be necessary to inform the Clinical Director (or Head of Service) or the Medical Director.
- Complete the clinical supervisor's report at the end of the placement.
- Relate to the F2 portfolio by looking at learning log entries and ensuring that the learner has demonstrated attainment of capability against the curriculum.

Performance Issues

Most foundation 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 Foundation TPD at their employing trust who will work with you to ensure that the appropriate level of support is given both to you and the foundation 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 foundation doctor regarding your concerns. The foundation doctor must be provided with copies and access to any information regarding concerns. This is bet done by sending summaries of conversations to the foundation doctor via email.

If you have any concerns regarding a foundation doctor whilst they are with you, please contact their educational supervisor in the first instance and then the Foundation Training Programme Director (FTPD) at the relevant hospital to discuss.

The Supervision Payment

The supervision payment, 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 foundation doctor at any one time.
- If you share the rotation with another practice, then payment will be split appropriately.
- The foundation doctor training grant will now be paid via NHS England. You will receive payment retrospectively, therefore please expect to see payment after the end of each rotation. All payments will be available to view on Open Exeter.
- NHSE will only pay for foundation doctor 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.

Further info can be found GP Practice Payments | Health Education England East Midlands

Foundation trainees as patients at the training practice

Foundation doctor placed in a practice where they are registered as a patient can pose potential difficulties which can affect both the trainee and the trainer/practice. Consequently, there can arise a tension/conflict between education, employment and being a patient in these circumstances.

It is the recommendation of the Foundation school that the foundation doctor either looks to swap GP practices with a colleague (ensuring that the programmes team are aware of this) or that the trainee registers as a temporary patient at a neighbouring practice.

Registering as a temporary patient is a simple process see the NHS temporary resident process which involves completing a form GMS3.pdf. Please be aware though is meant to be for a maximum of 3 months, but this should cover most of the placement requirements.

If a foundation doctor needs to remain under the care of their existing GP for health reasons this should be highlighted to the practice and Foundation School.

APPENDIX 1

Following on from educator training – next steps – Approval for Foundation

Many thanks for completing supervisor training including foundation. It was great to meet you. We hope that you found it useful and would like to outline the next steps.
As you will be aware from the training there is an expansion of the foundation programme underway which means more placements will be needed from August 2023 and again in August 2024, so we are keen to get foundation supervisors trained, approved and in place as quickly as possible. There are a few ways this happens.

- If you work in an already approved training practice then please contact Julia Taylor to arrange Foundation approval. Julia.taylor50@nhs.net
  This is a concise foundation approval form which supports the practice in understanding & preparing for the Foundation Doctors to be placed with them.

- If you work in a practice yet to be approved, then you will need to seek Learning Environment (LE) approval via your local training hub. Details of this can be found on the following link. Following the LE approval, each educator will need approval too.
  Become an approved learning environment in the East Midlands | Health Education England East Midlands

Once you have been successfully approved your GMC registration would be annotated to show you are an approved educator. It is at this point you can start being a clinical supervisor.

Approval Meeting

This maybe face to face or virtual.

The Foundation approval paperwork will be discussed including.

Induction, working rota, debriefing arrangements, educational opportunities, visits, supervised learning events, the educational environment, F2 nuances and capacity.

You will also need to submit a copy of your equality & diversity training certificate (Bluestream of ELfH is fine)

APPENDIX 2

INDUCTION TIMETABLE – Foundation doctor

WEEK 1	AM		PM
Wed	Meet with supervisor & practice manager. Shadow supervisor		Mandatory training & meet admin/secretarial teams
Thursday	Shadow GP	Practice meeting	Shadow Advanced practitioner
Friday	Shadow practice pharmacist	Shadow visits	Shadow practice counsellor

WEEK 2	AM		PM
Mon	Shadow call centre & reception		Shadow GP at branch surgery
Tues	Shadow acute home visiting team	Shadow visits	Palliative care and safe-guarding admin teams
Wed	Prescribing Team		HDR/trust teaching
Thurs	System 1 training 9-12.30	Practice meeting	Protected Learning Time
Fri	Shadow Senior Practice Nurse Minor illness		Shadow GP

WEEK 3	AM		PM
Mon	Shadow on call GP	Shadow visits	Shadow - GP/ARRS role if applicable
Tues	Shadow Senior PN Asthma/COPD		Shadow GP
Wed	Shadow Senior Practice Nurse Diabetes		HDR/trust teaching
Thurs	Shadow Care Home Team	Practice meeting	Safe practice Tutorial *
Fri	Shadowed surgery with supervisor observing ST1/F2		Protected Learning Time
	****Safe Practice Tutorial should cover essential knowledge required before the practitioner starts consulting such as;** • Emergency procedure/equipment – collapsed pt, violent pt • How to contact your CS mid-session/surgery • How to raise a safe-guarding concern • How to request bloods/investigations/refer • Managing blood results of different types, letters, tasks etc • Consulting methods which may include telephone, video e-consult if appropriate (this should form part of shadowed surgery if a part of role/scope)		

Sitting in Prompts

Questionnaire for sitting in with clinicians etc

1 What areas of special knowledge or interest do they have that you might find useful?

2 What is their clientele?

3 What do you like about their consultation style (what do the patients like?)

4 Of the consultations you observed which one seems to work best? What do you think happened?

5 Of the consultations you saw which had the most problems – what happened?

6 Three things that you learnt (or discovered that you don't know enough about) from this time sitting in.

Questionnaire for sitting in the Waiting Room/reception

1 How much stress do people show whilst waiting? How can you tell this? Why is this?

2 How do receptionists come across and the system for calling patients in?

3 Did you notice any breaches of confidentiality? How did these occur, could they have been prevented?

4 How much attention do people pay to the Health Education material around them? Could this be improved?

5 What has the practice done to try and reduce stress? Has this worked?

6 Three things you have learnt or been made to think about by doing this?

7 How might we improve this for a future learner?

Questionnaire for sitting in with call centre

1 Who knows most about how the practice runs day to day?

2 What is the hardest part of being a receptionist?

3 How well would you survive as a receptionist?

4 What skills does a receptionist need?

5 In what way will you depend on a receptionist?

6 What did the GP's do (or not do) that helped the Receptionists do their work more easily? Could they have done anything else?

7 What three things have you learnt from being in Reception?

8 What can we do to make this more successful and informative for a future learner?

Questionnaire for sitting in with other members of PHCT

1. What have you gained by spending time with the person (knowledge / attitudes / functions, etc.)?

1 What sort of problem will you feel happy referring to this person?

3What areas will this person be able to advise you about? How much will you use this?

4 How does the person consult? (Is this different from a GP how and why?)

5 Who are the clientele and how does this compare with the practice population?

6 What were the three most useful things you learnt from this person?

7 How could we make this time more useful for a future F2?

8 What training do other members of the PHCT have?

9 How do they develop their educational needs?

Appendix 3 – Debriefing

Please use a balance of support and challenges in a conversational format. The following may help you.

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.

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…

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…

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.

EXAMPLE EDUCATIONAL CONTRACT – APPENDIX 4

1. EDUCATION
   i. The foundation trainee should read regularly in a planned and programmed manner.
   ii. They should be able to identify and plan to correct their own weaknesses.
   iii. They should regularly examine their own work critically.

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

   b. Organisation
      v. The foundation trainee should be able to competently take part in practice management activities.
      vi. They should be able to extend their professional responsibilities beyond the remit of the practice.
      vii. They should be abreast of current and future developments in general practice and the Health and Social Services as a whole.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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 their 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.

8. 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.

9. FEEDBACK
    a. The foundation trainee should provide the supervisor with constructive feedback of theirgeneral practice attachment including their assessment of all educational content.

10. 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.

FY2 trainee name	
Signed	
Date	
Clinical supervisor name	
On behalf of	
Signed	
Date	

APPENDIX 5 - FOUNDATION DOCTORS AND HOME VISITS

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

All foundation doctors 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 a foundation doctor is not undertaking training for General Practice. Being able to undertake home visits does not form part of the curriculum. The foundation doctor must have sufficient knowledge and capability 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 and care home visits are a potentially rich educational experience for foundation doctors with the opportunity to see patients in their home environment. 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 foundation doctor 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 foundation doctor 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 foundation doctor 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 foundation doctor 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 foundation doctor 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 foundation doctor with regard to their experience and known capabilities, and safe for the patient; there must always be a post-visit debriefing immediately after the visit.

APPENDIX 6 - ANNUAL AND SICK LEAVE RECORD SHEET

Sickness/absence form for Foundation doctors in General Practice			
Name of Foundation 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)			

Leave returns are submitted via the electronic staff record (ESR) hosted by the relevant trust.

APPENDIX 7 - 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 doctor in GP training?	• 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 doctor in GP training • The aim of this rotation is to give the FY2 doctor a meaningful experience in Community/General Practice with exposure to the acutely ill patient outside of the acute trust, which will enable them to achieve the required capabilities. • 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. • NHSE approves suitable practices using an agreed set of approval criteria, via the Training Hubs. • FY2 doctors with community 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?	• NHSE 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	• In the event of a problem with a FY2 doctor in practice, the trainer must be able to demonstrate adequate supervision had been undertaken. • A Foundation Trainee undertaking a GP placement will be covered under Clinical Negligence Scheme for GP (CNSGP) for any activity that consists of, or is in connection with, the

Question	Answer
	provision of NHS services (primary medical services under a GMS, PMS or APMS contract or other NHS services that are within the definition of "ancillary health services"). • Where GP Registrars and Trainees undertake any clinical work during their training in organisations which are not part of NHS services, such work would likely fall outside the scope of CNSGP and CNST • Indemnity for activities that are out of scope of CNSGP and medico-legal support will continue to be provided via Health Education England (HEE)
Can an FY2 doctor sign prescriptions ?	• Yes. An FY2 doctor is post GMC registration and is therefore able to sign a prescription.
What about their Contract of Employment?	• 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 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 4
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.
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 polices on study leave for further information on how this is apportioned to foundation doctors. Foundation Schools | Health Education England East Midlands • It is essential that any applications for study leave are approved by the Foundation Trust 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 6.

Question	Answer
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 6. • 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 /extended hours during their community 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/home visits?	• If community visits are undertaken, then these should comply with the NHSE guidance regarding community visits (please see Appendix 5. There must be briefing before the visit to identify potential problems 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 FY2 cannot see patients without the supervisor being present in the building. This can be achieved by the foundation doctor: ○ taking leave at the same time as the supervisor ○ spending time with other members of the team as part of a planned educational experience and as an observer only ○ 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 acceptable providing the locum doctor fully understands their responsibilities re cover
Taking annual leave	• Should a F2 ask to take annual leave as individual days this should be discouraged. However, if single days are granted, they should be spread across all working days over the duration of the placement ie not just a Monday or Friday.
What if I want to become involved in Foundation training	• You should approach either your local GP training programme or Julia Taylor, Foundation Training Programme Lead for HEEM (julia.taylor50@nhs.net)

APPENDIX 8 – Modes of Consulting

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

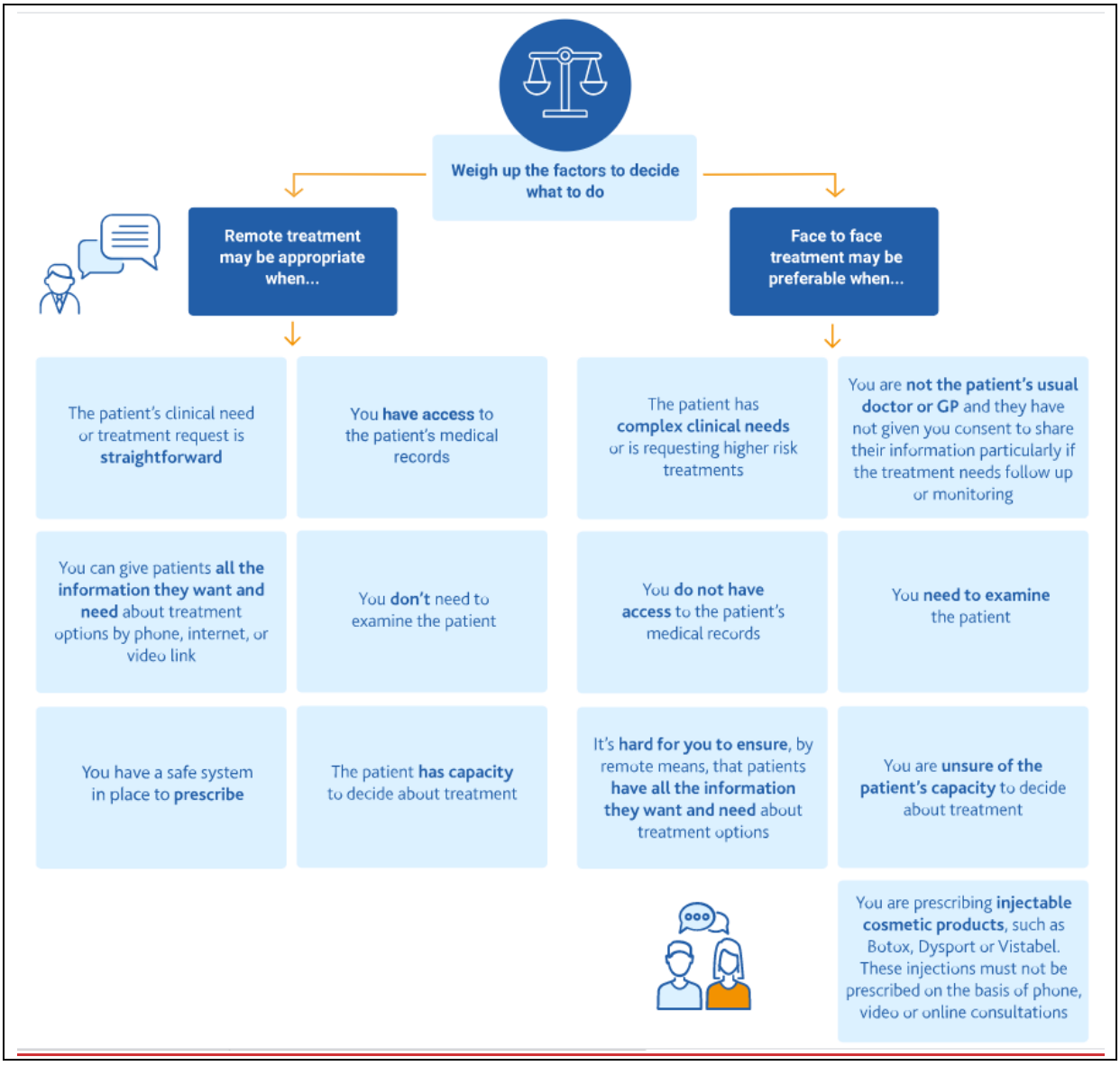
Many settings now have a balanced of F2F appointments and telephone, video and sometimes email consultations. FY2 should focus on F2F consultation and can with supervision undertake lower risk video and telephone consultations appropriate for their level of capability and confidence and stage of training. **All consultations regardless of mode must be debriefed.**

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:

- The General Medical Council's guide on remote consultations
- The Royal College of Practitioners' Principles for supporting high quality consultations by video in general practice during COVID-19
- E-Learning for Health


Weigh up the factors to decide what to do
Remote treatment may be appropriate when...
Face to face treatment may be preferable 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
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 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	Ed Villatoro, Foundation School Director eduardo.villatoro1@nhs.net Deputies Manjula Pammi manjula.pammi@nhs.net & Akin Falayajo akintayo.falayajo@nhs.net	School Administration england.foundationprogrammes.midlands@nhs.net
LNR	Rachel Parry, Foundation School Director rachel.parry18@nhs.net Deputy Kath Higgins kath.higgins3@nhs.net	
Website	Foundation Schools | Health Education England East Midlands	

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 relevant hospital to discuss. The foundation coordinators (listed below) will be able to direct you to the relevant TPD for your F2.

Chesterfield Royal Hospital	Abi Bosher abi.bosher@nhs.net 01246 512902
Kettering General Hospital	foundation.co-ordinators@kgh.nhs.uk 01536 491184
King's Mill Hospital mans.	sfh-tr.medical.educationp@nhs.net 01623 622515 ext 3647

Lincoln County Hospital	Tom Rennison Tom.Rennison@ULH.nhs.uk 01522 573867
Northampton General Hospital	Michelle Price michelle.price34@nhs.net 01664 545160
NUH	Tamara Coyne Tamara.Coyne@nuh.nhs.uk 0115 924 9924
Pilgrim Hospital	Wendy Mulraney wendy.mulraney@ulh.nhs.uk; 01205 446173
Royal Derby Hospital	Zoeie Spencer zoeie.spencer@nhs.net; 01332 789245
Burton Hospital	Ryan Moss Ryan.moss@nhs.net 01283 593066 ext 6488
University Hospitals of Leicester	Claire Bush claire.bush@uhl-tr.nhs.uk Jason Wilson jason.wilson@uhl-tr.nhs.uk 0116 2583603

GP Specific issues relating to the practice and <u>not</u> the F2	LNR and TRENT Julia Taylor – GP TPD Foundation Lead Julia.Taylor50@nhs.net