A SUPERVISORS SIMPLE GUIDE TO FY2 TRAINING IN GENERAL PRACTICE

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Introduction

This Simple 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 educational and 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 (Table 8) 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

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

*Based on a clinical placement of four months duration

### Frequency of assessments

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-portfolio</td>
<td>Contemporaneously</td>
</tr>
<tr>
<td>Core procedures</td>
<td>Throughout F1</td>
</tr>
<tr>
<td>Team assessment of behaviour (TAB)</td>
<td>Twice a year in both F1 and F2 (once in first and once in second placement).</td>
</tr>
<tr>
<td>Clinical supervisor end of placement report</td>
<td>Once per placement</td>
</tr>
<tr>
<td>Educational supervisor end of placement report</td>
<td>Once per placement</td>
</tr>
<tr>
<td>Educational Supervisor’s End of Year Report</td>
<td>Once per year</td>
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</tbody>
</table>

### The Learning Portfolio

Each foundation doctor will keep a learning portfolio. They will access their portfolio via the e-Portfolio website (https://www.nhseportfolios.org). 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 e-Portfolio. Access rights to the e-Portfolio system are granted by the foundation programme coordinator in the trainees employing acute trust (Appendix 6 – Contact Details).

### 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, meet doctors and staff, learn how to use the computer systems, and know how to get a cup of coffee! 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. If you don’t have one why not ask a neighbouring GP specialty training practice for theirs and adapt it? 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

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

Day 4
- Computer training 1-3
- Local Pharmacist 3-5
- 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. 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
- Of those 40 hours 70% (28 hours) should be defined as clinical experience and 30% (12 hours 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.
- One afternoon per week is usually taken up with Trust-based teaching (4 of the 12 ‘educational’ hours)
• The remaining 8 hours of educational time is best demonstrated on the timetable as being four 2-hour sessions in the middle of the day and labelled
  o Private study
  o Audit/project time
• The trainee should then be given one half-day off per week.

There are also some Working Time Directive rules which are worth noting too.
• 11 hours continuous rest in every 24 hours
• Minimum 20 minute break when working time exceeds six hours
• 24 hours off in seven days or 48 hours off in 14 days
• 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 and most commonly of 20 minutes for face to face consultations. 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. Supervised or supported home visits, nursing home visits, community hospital duties including time for debriefing, and travelling.
3. 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.
4. 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.
5. 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.
6. 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.
7. The patient safety component of the debrief.

**Clinical activities that may be considered educational**
1. Time spent in activities relating to work-place 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.

5. The educational component of the debrief.

**Non-clinical activities suited to educational sessions**

1. Locally organised educational events, e.g. foundation-specific educational programme run by the Deanery/Health education area (HETV) 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 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 supervisor protected time of four hours per week should be divided to cover the following:

1. The Supervised Learning Events
2. Tutorials
3. Meetings with the trainee to review progress
4. Time spent advising on research and audit
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
8. Debriefing time after consultations. This is an important issue as debriefing has 2 purposes. One is purely patient safety and the second is that in most cases debriefing has an element of education. Without making it too complicated the best way to look at this is that for every hour of debriefing in one week 30 minutes can be counted as educational time and 30 minutes as clinical time.

Remember that your FY2 will 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 and when agreed between the supervisor and the FY2 doctor;
- IF YOU HAVE AN ACADEMIC FY2 DOCTOR THEY WILL HAVE ONE DAY FREE FOR RESEARCH.
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 a learning log entry which reflects on that assessment.

‘Stages’ of debriefing
1. Supervisor sitting in whilst trainee consults.
2. Trainee consults independently but all patients are reviewed by the supervising GP before they leave the practice.
3. Trainee consults independently and patients are presented to the supervising GP who may then review personally or give advice on management.
4. 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. At the end of a busy day it may be best to have the emphasis of the debrief primarily on patient safety, consequently saving the slightly more educationally focussed debriefing for other times of the day.

In general terms, a debrief should take place as soon as possible after a clinical event, 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.

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
  o History taking and record keeping
  o Accessing information
  o Referrals and letter writing
  o Certification and completion of forms
• Primary Healthcare Team working
  o The doctor as part of the team
  o Who does what and why?
  o The wider team
• Clinical Governance and Audit
  o Who is responsible for what?
  o What is the role of audit?
  o What does a good audit look like?
• Primary and Secondary Care interface
  o Developing relationships
  o Understanding patient pathways
• Interagency working
  o Who else is involved in patient care?
  o What is the role of the voluntary sector?
• Personal Management
  o Coping with stress
  o Dealing with Uncertainty
  o 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 from practice to do so. They must attend a minimum of 70% over the year.
- 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.

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 6 – Contact Details).

Foundation ARCP process
Provided below is an overview of the foundation ARCP process. Items highlighted in bold indicate that a specific form is available within the e-portfolio to support the action/process.

Throughout the F1/F2 year:

- Foundation doctor records assessments, SLEs, reflections and other evidence within their e-portfolio.
- Clinical supervisor's end of placement report and an educational supervisor's end of placement report will be recorded for each placement.

Only if applicable:

- If a concern has been raised, a doctor leaves the FP/takes a break or to record progress of less than full time/out of phase trainees, an interim ARCP review of progress may be appropriate.

Towards the end of the year:

- Educational supervisor's end of year report will be completed. (An ES end of placement report is not required for the last placement if the ES end of year report is being completed at that time.)

ARCP Review:

In order to exit foundation year two training trainees will need the following in their eportfolio.
1. A self-declaration of absence. That is that the total absence, outside annual and study leave, must not exceed 4 weeks or 20 days.

2. A satisfactory educational supervisors end of year report
   a. The report should draw upon all required evidence listed below.

3. Satisfactory educational supervisor’s end of placement reports
   a. If the F2 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F2 doctor has met the requirements for satisfactory completion of F2. An educational supervisor’s end of placement report is not required for the last F2 placement; the educational supervisor’s end of year report replaces this.

4. A satisfactory clinical supervisor’s end of placement report for each placement
   a. If the F2 doctor has not satisfactorily completed one placement but has been making good progress in other respects, it may still be appropriate to confirm that the F2 doctor has met the requirements for completion of F2. The last end of placement review must be satisfactory.

5. Satisfactory completion of the required number of assessments
   a. Team assessment of behaviour (TAB) (Minimum of one per year)
   b. Evidence that the foundation doctor can carry out the procedures required by the GMC

6. A valid Advanced Life Support (or equivalent) certificate

7. Evidence of participation in systems of quality assurance and quality improvement projects.
   a. The Curriculum requires that F2 doctors manage, analyse and present at least one quality improvement project and use the results to improve patient care.

8. Completion of the GMC national trainee survey.

9. Completion of the required number of Supervised Learning Events
   a. Direct observation of doctor/patient interaction:
      i. Mini CEX
      ii. DOPS
         (Minimum of 9 observations per year; at least 6 must be mini-CEX)
   b. Case-based discussion (CBD) (minimum of 6 per year / 2 per placement)
   c. Developing the clinical teacher (minimum of 1 per year)

10. An acceptable attendance record at foundation teaching sessions (70%)

11. Signed probity and health declarations


ARCP Outcomes:

The following ARCP outcomes are available to ARCP panels for FP trainees:

- Outcome 1: Satisfactory progress - achieving progress and the development of competences at the expected rate
- Outcome 3: Inadequate progress – additional training time required
- Outcome 4: Released from training programme with or without specified competences
- Outcome 5: Incomplete evidence presented – additional training time may be required
- Outcome 6: Gained all required competences – will be recommended as having completed the Foundation training programme
Foundation trainees and Revalidation
Licensed doctors including doctors in foundation year two and specialty training will have to revalidate, usually every five years. In addition for doctors in postgraduate training the Health Education Thames Valley (HETV) is the designated body for Foundation doctors training in the area. Foundation doctors will revalidate in a similar way to other licensed doctors. When the time comes for them to be revalidated the Responsible Officer (Postgraduate Dean) will make a recommendation to the GMC that they are up to date, fit to practice and should be revalidated. As with all licensed doctors Foundation trainees will need to collect supporting information to show how they are meeting our professional standards in their daily practice based on the GMC’s core guidance for doctors Good Medical Practice.

Educational Supervisor Roles and Responsibilities

WE DO NOT REQUIRE THAT GP’S ARE EDUCATIONAL SUPERVISORS OF FOUNDATION TRAINEES. HOWEVER IF YOU DO WISH TO BE AN EDUCATIONAL SUPERVISOR PLEASE SPEAK WITH RICHARD MUMFORD.

Educational Supervisors
An educational supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified Foundation doctor’s educational progress during a training placement or series of placements. The educational supervisor is responsible for the Foundation doctor’s Educational Agreement. Only clinicians committed and engaged in teaching and training Foundation doctors should undertake the role. Educational supervisors must help Foundation doctors with their professional and personal development. They must enable Foundation doctors to learn by taking responsibility for patient management within the context of clinical governance and patient safety. Local education providers must ensure that educational supervisors have adequate support and resources to undertake their training role.

Training for educational supervisors
All educational supervisors should receive training and demonstrate their competence in promoting equality and valuing diversity. They must understand and demonstrate ability in the use of the approved in-work assessment tools and be clear as to what is deemed acceptable progress. In addition, they should understand and be able to monitor progress, provide appraisals, provide career advice and identify and contribute to the support of foundation doctors needing additional help.

Educational supervisors should complete training in equality and diversity, assessing Foundation doctors and the other aspects of educational supervision at least every three years.

Local education providers should maintain a register of educational supervisors including details and dates of training.

Responsibilities
The educational supervisor must:
- Meet with the supervisee at the beginning of each placement to agree how the learning objectives for this period of training will be met and confirm how formative feedback and summative judgements will be made.
• Make sure that the supervisee’s performance is appraised at appropriate intervals including providing the results of multi-source feedback. If concerns are identified, the educational supervisor should ensure that the Foundation doctor has access to the necessary support to address these issues and involves the foundation training programme director as appropriate.
• 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.
• Make sure that all doctors, other health, and social care workers who have worked with the supervisee have an opportunity to provide constructive feedback about their performance.
• Undertake and/or facilitate workplace-based assessments of the supervisee.
• Meet with the supervisee to assess whether they have met the necessary outcomes. The educational supervisor must complete an end of placement review form for each placement and only confirm satisfactory service if the foundation doctors have met the necessary outcomes.
• Tell the NHS employer and those responsible for training of serious weaknesses in their supervisee’s performance that have not been dealt with, and any problems with training programmes. The supervisor should tell the Foundation doctor the content of any information about them that is given to someone else. Where appropriate, and with the Foundation doctor’s knowledge, relevant information must be given to the educational supervisor for their next placement so that appropriate training and supervision can be arranged. Information that should always be passed on includes assessment results.

Clinical Supervisor Roles and Responsibilities

Clinical Supervisors
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.

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 HETV 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 6.

The Supervision Payment

The supervision payment, equivalent to the GPStR basic trainers 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.
- HETV will pay the FY2 placement grant directly to your practice.
- HETV 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.

The supervision payment is paid via bank transfer by HETV. If you are a new practice or an existing practice that 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.
This is included for information only – it must be completed online via the Foundation e-Portfolio. The table below is a good way of recording evidence contemporaneously. This makes the process of completing the CSR both easier and more valid.

**Foundation CSR – Live Recording of Evidence and Evaluation**

Describe this foundation doctor’s observed performance in the workplace against the outcomes specified in the syllabus of the Foundation Programme Curriculum in a range of situations of differing complexity using the following descriptors.

Please comment on this foundation doctor’s areas of excellence or areas of any concern under the following headings. Be as specific as possible.

This can be cut and pasted into the online CSR at a later date

<table>
<thead>
<tr>
<th>Section 1 The foundation doctor as a professional and a scholar</th>
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<tbody>
<tr>
<td><strong>Professionalism</strong></td>
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<tr>
<td>1. Behaviour in the workplace</td>
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<td>2. Time management</td>
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<td>3. Continuity of care</td>
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<td>4. Team-working</td>
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<tr>
<td>5. Leadership</td>
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<tr>
<td>Section 2 The foundation doctor as a safe and effective practitioner</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Good clinical care</td>
</tr>
<tr>
<td>Recognition and management of the acutely ill patient</td>
</tr>
<tr>
<td>Resuscitation and end of life care</td>
</tr>
<tr>
<td>Patients with long-term conditions</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Investigations</td>
</tr>
<tr>
<td>Procedures</td>
</tr>
<tr>
<td>Foundation doctor’s health</td>
</tr>
<tr>
<td>Do you have any concerns about the Foundation doctor’s health</td>
</tr>
<tr>
<td>Overall assessment</td>
</tr>
<tr>
<td>Does this Foundation doctor reach the level to satisfy the end of year requirements?</td>
</tr>
<tr>
<td>Any other comments:</td>
</tr>
</tbody>
</table>
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. The visit and consultation can safely be carried out by trainees with the same provisos.

- 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.**
- 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.
- 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.
- The trainee should be familiar with the local geography.
- 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.
- A stepwise approach which sees trainees observing on a home visit, being observed on a home visit, perhaps starting a visit and then being joined by the supervising GP and finally doing a home visit alone is what is required.

The key phrase here is that home visits carried out by foundation trainees should be valued for their unique educational experience and not in any way be part of service requirement.
**Approval**

A typical approval and reapproval visit for a supervisor and practice which has Foundation trainees only looks like this below.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00</td>
<td>Arrival and coffee (please)</td>
<td></td>
</tr>
<tr>
<td>9.10 to 9.30</td>
<td>Meeting with trainee</td>
<td>The purpose of this part of the visit is to obtain some feedback from the trainee about their experiences, level of support, curriculum exposure, and support in terms of the e-portfolio and supervised learning events and the timetable.</td>
</tr>
<tr>
<td>9.30 to 10.00</td>
<td>Joint meeting with clinical supervisor and practice manager</td>
<td>Here we can review the educational environment and processes relating to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Appointment systems relating to providing broad curriculum coverage</td>
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<tr>
<td></td>
<td></td>
<td>- Induction</td>
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<tr>
<td></td>
<td></td>
<td>- Obtaining and acting on trainee feedback</td>
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<tr>
<td></td>
<td></td>
<td>- Opportunities for trainees to learn from others</td>
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<tr>
<td></td>
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<td>- Patient safety</td>
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<tr>
<td></td>
<td></td>
<td>- Practice policies and procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Support available for trainees with additional needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The learning environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The trainee timetable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Trainee supervision</td>
</tr>
<tr>
<td>10.00 to 10.30</td>
<td>Meeting with clinical supervisor only</td>
<td>In this part of the visit we can look at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Approaches to supervision and debriefing</td>
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<td></td>
<td></td>
<td>- Discuss and assess your familiarity with the foundation curriculum, the eportfolio and the supervised learning events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How you encourage and facilitate trainees to direct their own learning</td>
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<tr>
<td></td>
<td></td>
<td>- The NEW clinical supervisors report</td>
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<td>- The teaching methods that you adopt</td>
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<td>- Your PDP</td>
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<td></td>
<td></td>
<td>- Your protected time for training</td>
</tr>
<tr>
<td>10.30</td>
<td>Expected finish time</td>
<td></td>
</tr>
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</table>
Preparation to become a GP Foundation Clinical Supervisor

This is a short course covering the following

- What is the Foundation Programme?
- Supervision arrangements and debriefing
- The trainee timetable
- Trainees requiring additional support
- A look at the trainee e-portfolio
- 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
  - 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

This is a requirement even if the prospective foundation clinical supervisor is an approved GP trainer. For those who are not approved GP trainers the following areas are also covered.

- An Introduction to how adults learn
- Principles of feedback

These sessions can be arranged by contacting Richard Mumford at richard.mumford@thamesvalley.hee.nhs.uk
<table>
<thead>
<tr>
<th>Sickness/absence form for Foundation Year 2 doctors in General Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Foundation Year 2 Doctor</strong></td>
</tr>
<tr>
<td><strong>GP Practice Address</strong></td>
</tr>
<tr>
<td><strong>Name of Practice Manager</strong></td>
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<tr>
<td><strong>First day in GP Placement</strong></td>
</tr>
<tr>
<td><strong>Total Annual Leave Entitlement for the Year August to August</strong></td>
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<tr>
<td><strong>From</strong></td>
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<tr>
<td><strong>Total During Placement</strong></td>
</tr>
<tr>
<td><strong>Sickness/Absence</strong></td>
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<tr>
<td><strong>Total During Placement</strong></td>
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<tr>
<td><strong>Other Absence (Please Specify)</strong></td>
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</table>

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’
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| 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 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  
• HETV 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?                  | • Deanery 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:  
| 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. |
<p>| Can an FY2 doctor sign prescriptions?                                   | • Yes. An FY2 doctor is post registration and is therefore able to sign a prescription. |
| What about their                                                       | • The Contract of Employment is held by the acute Trust where the FY2 |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract of Employment?</td>
<td>doctor is based. They are responsible for paying salaries and other HR related issues.</td>
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</tbody>
</table>
| 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 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 4. |
| 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 4.  
• 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.  
• Some FY2s have asked to experience out of hours or extended hours surgeries as a means of exposure to a different type of acute illness. This can be a useful learning opportunity but must be properly supervised and would be in lieu of other time spent in the practice during the same working week. There has to be adequate clinical supervision and a predetermined learning outcome if this is undertaken.  
• Thus every hour worked in out of hours settings must be ‘given back’ to the trainee 1:1  
• The FY2 working week must not exceed 40 hours and that includes time set aside for learning. It is up to each practice to decide what exactly |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>that working week will look like but some examples are given on pages 5-8.</td>
<td></td>
</tr>
<tr>
<td>Can an FY2 doctor do community/home visits?</td>
<td>• If community visits are undertaken then these should comply with the HETV guidance regarding community visits (please see Appendix 2). There has to be briefing before the visit to identify potential problems and learning outcomes and a debrief after the visit by the supervisor</td>
</tr>
</tbody>
</table>
| 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. Locum cover is not acceptable.                                                                                                                                                                                                                           |
| 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 Richard Mumford, Foundation GP Training Programme Lead for Heath Education Thames Valley (The Oxford Deanery)  
(richard.mumford@thamesvalley.hee.nhs.uk)                                                                                                                                                                                                                                                                                                                                                                                             |
## Contacts – Appendix 6

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Location</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Anne Edwards</td>
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<tr>
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<td><a href="mailto:Maura.stock@hwph-tr.nhs.uk">Maura.stock@hwph-tr.nhs.uk</a></td>
</tr>
</tbody>
</table>

**Key contacts**

- Practice payments – Ann Heath
- Trainee issues – the relevant Trust FTPD
- Practice issues and everything else – Richard Mumford