**GP Specialty Approvals and Re-approvals – Some Explanatory Notes**

Visits overview

1. After the first part of the New Trainers Course, an “informal visit” by the locality programme director will be performed. The prospective trainer will be asked to discuss a self-assessment against the training criteria and the visit will assess the GPs readiness for progressing, and will provide formative advice on what needs to be done to reach the required standard, including what is expected for the self-assessment and what supporting information should be provided.
2. Should the outcome of the informal visit be satisfactory, the PD will complete the report on the criteria form reporting the developments still needed.
3. The formal visit management with the lead visitor will include a discussion about the circumstances of the visit. The situations presented to us by new trainers range from their being a new trainer in a new training practice to a new trainer in an existing training practice, with partners who will have been reapproved at a variety of times and with possible alterations to practice buildings and partnership and administrative or management changes. The lead visitor will need to make a judgement about the team required to perform the visit
4. The cycle of assessment is to remain at
   1. One year initial approval – always an actual and not virtual visit
   2. Two years first re-approval – always an actual and not virtual visit
   3. Thereafter a three cycle – an actual or virtual visit (see below)
5. A “standard” visiting team will include an APD (lead visitor), locality PD or senior trainer and a practice manager. Further development on this area may lead to the inclusion of a trainee.
6. The visit itself will assess the new trainer, and the educational environment of the practice using the current training criteria. The new trainer will have provided a self-assessment and will provide some supporting information for the visitors to view. When present, the practice manager will consider the areas highlighted for their purpose in the criteria and with the practice’s manager. The lead visitor will interview the new trainer. The PD/senior trainer may remain with the lead visitor for a joint discussion, but there may be other aspects of the practice that could be considered (e.g. perhaps there is a trainee already in the practice for whom the new trainer has provided some clinical supervision).
7. A report will follow the visit and either a recommendation for appointment as trainer or deferment with recommendations for further action needed to acquire this status.
8. After one year, (usually) there will be a first follow-up visit. The focus of this will be to discuss experience over the year, including successes and problems. The discussion again will be around the formal criteria, but a full self-assessment will not be required – only an updating of the original information. It would be useful to discuss the actual experience and supporting information (e.g. the trainee’s weekly timetable, any e-portfolio work) would be necessary.
9. Once again, a report following this will be required. This will be usually to recommend continuing training and a formal re-approval will be required in two further years.
10. When a re-approval date is approaching, eight months before this a lead visitor will be appointed.
11. If the trainer does not provide the information required or respond to the proposed date in a timely fashion, the admin team will in conjunction with the lead visitor point out to the trainer that any visit may be postponed and the placement of trainees in the interim may be suspended.
12. If a visit is not required, the re-approval will be recommended to the Academy Board for three years.
13. Visit timetables will be planned and submitted to the practice for them to negotiate if necessary to ensure that the visit is as efficiently and least disruptively planned as possible.

The Approval visit

1. The timetable of the visits will be decided by the lead. However, the “normal” format will involve interviews with the current trainee, the trainer and the practice manager. This will be to seek clarification of or discuss items in the self-assessment questionnaire. There will also be a tour of the practice premises.
2. The visitors will need a short meeting at the beginning to:

* Introduce themselves where necessary
* To ensure that each member is aware of their role in the visit (as directed by the lead visitor)
* Discuss any specific issues the visit will need to address

1. The meeting with the available doctors, nursing staff and management staff is intended to:

* Act as an introduction to the visitors
* Act as an introduction to the deanery
* Give the opportunity for the visitors to:
  + Congratulate the practice in their work towards training
  + Welcome them to faculty
  + Remind them that the deanery perceives training to be a team function and that the trainer will need the support of his colleagues in the enterprise and that the input of all individuals will be valuable.
  + Remind them that the trainee will be an employee of the practice with the resulting responsibilities for the practice
  + Assure them that the deanery will offer full support

1. The tour of the building is intended to:

* Gain an overview of the clinical and non clinical areas
* Assess the accommodation relevant to any forthcoming trainees
* Gain a feel for the atmosphere or culture of the organisation

1. The meeting with the prospective trainer is intended to:

* Be an opportunity for the lead and the new trainer to discuss the self-assessment questionnaire
  + It is not necessary to work through the questionnaire item by item as it is more useful to concentrate on items that are valuable to discuss
    - Induction timetables
    - Weekly timetables (including WTR)
    - Protected time for trainer and trainee
    - Knowledge of WPBA
    - Knowledge of the e-Portfolio
    - Previous training experience
    - CPD as a trainer
    - Quality control procedures
    - Aspirations
    - Knowledge of role of the deanery
    - Role of the locality programme
  + Ensure that the new trainer is aware of the role and schedule of re-approvals in the future
  + Review any other supporting information the new trainer wishes to submit

1. The meeting with the practice manager (usually by the visiting practice manager) is intended to:

* Cover the areas of the training criteria relevant to management
* Give the opportunity for the practice manager to demonstrate knowledge of the employment aspects of GP training status
* Give the opportunity for peer support and sharing of ideas for the practice managers
* Usually to look at practice material such as protocols, audits and audit timetables, physical educational resources and aspects of the practice accommodation

1. The meeting with the trainee is intended to:

* Triangulate feedback
* Give the opportunity for the trainee to be involved in the practice assessment
* Give an overview of the experience of being in the practice.
  + It is not necessary to cover all the areas in the BOS survey, but areas might include:
    - Experience of support in the practice
    - Satisfaction with support for WPBA
    - Experience of induction
    - Satisfaction with educational resources
    - Satisfaction with protected time
    - Satisfaction with educational and clinical supervision

1. Any meeting with other staff (such as nurses) is intended to:

* Offer recognition to others in the practice offering clinical supervision
* Assess attitude and capacity of others to be involved in the training process

1. When the visiting team members have obtained all the information they need to make their conclusions about the trainer and the practice, they should meet to summarise their findings and their recommendations. What is to go into the report is made clear and agreed at this stage.
2. The visitors meet the trainer and the practice manager to deliver their findings and discuss their recommendations.

Peer review of teaching

1. In order to be approved as a trainer there must have been recent peer review of teaching. This would not normally be done at the approval visit and therefore could have been at:
   1. The New Trainers Course
   2. At your local trainers group
   3. By your GP Training Programme Director
   4. By another experienced GP trainer
2. If there are no concerns at an approval or re-approval apart from the lack of this evidence, there will be a recommendation for provisional approval/re-approval with a mandatory recommendation that the evidence be supplied to the lead visitor within 4 months.
3. If this is the only omission, then provisional re-approval without a visit will still be possible.

The Re-approval visit

1. The steps here in a full re-approval visit are much the same. The meeting with the available doctors, nursing staff and management staff is usually omitted but sometimes other members of the team will be present initially and discussion can be around their experience and asking if they have any comments to make regarding training or regarding deanery support.

Visit report

1. This is the responsibility of the lead visitor and will be completed within 2 weeks of the visit. He/she will record the consensus of the visiting team in the report. The report will be submitted as a recommendation to the Academy Board. The visiting team itself cannot formally approve or re-approve, but will make such recommendations to the Board. The Board in turn technically makes a recommendation to the GMC, but the GMC will accept the view of Board.
   1. **NB, ONLY the GMC can remove trainer status. If problems at a re-approval visit are such that trainer status would seem questionable, recommendations can be made only. The management of the situation would be to offer support to improve the issues causing concern but not to send trainees to that practice until the situation has been rectified. Trainer status will not be awarded if there are serious concerns.**
2. Comments may or may not be written against the various criteria, *as long as* the self-assessment is accepted. Additional comments or changes can be made though if necessary.
3. The report is subdivided into headings:

* Highlights for the Practice offers the opportunity to record positive comments on the practice team and accommodation
* Highlights for the trainer offers the opportunity to record positive comments on the trainer herself
* Mandatory recommendations (trainer and practice) are those that **must be carried out** for training status or for re-approval to be awarded i.e. there are conditions around the recommendations. The report will
* Refer to the criterion number
* State what the problem is
* Prescribe an action that should be taken and any support that will be given
* Prescribe a time by which the action should be taken
* State who will return and when to reassess this particular point (following which a further report should be sent to Board).
* Developmental recommendations (trainer and practice) are those that may arise from aspirations identified in the visit discussions or from suggestions made by the visiting team. These are optional and approval and re-approval are not conditional upon them.
* The visiting team will be asked to recommend the number of trainees that the practice can support.

Practice feedback on the visit

1. This will be requested by questionnaire of the practice and trainer to provide some evaluation of the process.

Lead Visitor

1. The lead visitor is a key part of the approval and re-approval process. The duties are:

* As soon as the need for an approval is made:
  + Set a date
  + Define the team required for the visit
* Assess the self-assessment and supporting information in advance of the visit.
* Introduce and plan the visit as described above.
* Compile the report as above.
* To take responsibility for the visit’s recommendations to Board and to receive any feedback from Board – and to provide further information or actions as required by Board.
* A lead visitor will be a senior educationalist in the deanery or member of a quality team.
* The lead visitor will maintain responsibility for a practice’s approval until the next formal assessment (see triggered visits below).

Is a visit required?

1. A visit to new trainers will always be made
2. First re-approvals after a year will always be by visit to the trainer.
3. Subsequent re-approvals may be made without a visit if the submitted information is satisfactory and there are no other significant factors.
4. The assessment cycle will be three yearly.
5. If one assessment is successful without a visit, then the next assessment will include a visit.
6. If there is any uncertainty about whether a visit is required, the default will be to visit.

Triggered visits/assessments

1. These will fall outside the regular schedule.
2. Any number of things that might occur would suggest that training needs to be assessed in a practice. As such, it is impossible to specify them all. The lead visitor will normally assume that any re-approval cycle will be as decided at a previous assessment. Any concerns in between are to be raised by the locality programme, usually by programme directors.
3. Concerns would usually fall into the following categories with some examples. A judgement will usually be required as to the level of concern and once again, if there is any uncertainty as to the right approach, the default will be to visit. Any judgement will be supported by the directorate but will be open to scrutiny.

* Trainer issues:
  + Illness or other significant absence
  + Failure to engage in trainer CPD or locality programme support.
  + Poor trainee feedback
  + GMC matter
  + Soft concerns from the locality programme
* Practice issues:
  + Significant personnel changes
  + New practice manager
  + Building problems
  + Change of premises

1. The function of a triggered visit will usually be to address a specific issue and the lead visitor (having informed the locality GP Training Programme Director (PD), Associate Postgraduate Dean (APD) and Head of Academy (HoA) will ensure the visit will be conducted by the appropriate personnel. This will often be a PD, though an APD may be more appropriate. A report on the circumstances, the assessment findings, and recommendations with a timetable and a subsequent report will be made by the visitor, endorsed by the lead visitor for submission to Board. On occasions, a full assessment visit will be required.

“Routine assessments – visit or not?”

1. For many practices, there have been either no or no significant changes since the last approval. Where this is the case, the trainer’s self-assessment is satisfactory, and any supporting information is satisfactory, then no visit will be required. A lead visitor can re-approve the trainer based on the information given. A report should be made as usual, pointing out that no visit has been performed and giving the reasons for this. The lead may seek the advice of a peer to clarify any uncertainties, but if these remain, a visit should be performed.

Makeup of the visiting team

1. The visiting team required by the lead has a “standard” makeup as outlined above. However, a trainer’s approval or re-approval may come up when for one reason or another assessment of the practice has been made in the recent past. The most usual example of this is of a new trainer taking the New Trainer’s Course and wishing to be approved out-or-synchrony with the practice’s assessment cycle. In this instance, it would be entirely appropriate for the lead to visit on his/her own if there were no other significant changes.
2. Once again, the judgement of the lead on the makeup of the visiting team will be required, supported by the directorate but be subject to scrutiny.
3. The new trainer will supply a self-assessment and supporting information.

Assessments of more than one trainer in a practice

1. We require a separate form for each person to be approved. It is entirely acceptable however for information between application forms to be duplicated. This is particularly in the information, which pertains predominantly to the practice.

The first re-approval

1. This will be done one year after first approval and is intended mainly as an informal supportive event (unusually in our usual policy). It is intended as a “how-have-you-got-on” meeting to share experience, celebrate success and opportunity to discuss any problems that have arisen.
2. A fresh self-assessment against the criteria should be performed *but* this may be an updating of the information submitted a year earlier (e.g. CPD. information) rather than a complete re-write. A report as usual will be provided by the visitor.

Foundation trainees

1. Our assessment process includes an evaluation of the trainer and practice’s suitability for accepting foundation trainees. When a date is arranged with a lead visitor, the issue of foundation status will be raised by the admin team. Discussions are underway as what minimum data set would be acceptable by the foundation team for re-approval in this context to occur.

Extensions to training status

1. There are occasions when a trainer may ask for the reassessment (or assessment) to be postponed. The reasons will be assessed by the lead visitor. A normal extension will be for a period of six months, but will need to take into account several circumstances.
2. The usual reason for an extension is to coordinate the reassessment dates of multiple trainers.
3. Other circumstances may arise and have arisen that are too many to enumerate. They will require some judgement on the part of the lead visitor and confirmation of the reasons for allowing it to be part of a written report that should be available to the board, the HoA, the Dean, and the quality team.
4. To confirm an extension, the lead visitor will need data on the reason for the request, recent trainee feedback, a recommendation from the locality programme, a self-assessment questionnaire, and confirmation that there have been no significant changes in the practice.

**Further information about the approvals criteria document**

1. The approvals document is derived from the GMC publication, ‘The Trainee Doctor’ which can be found at <http://www.gmc-uk.org/Trainee_Doctor.pdf_39274940.pdf> - domains 4 and 9 of this document are not a practice responsibility and are therefore omitted from this criteria document
2. It is to be used for self/informal and formal assessment as well as the process of ‘virtual visiting’.
3. Self-assessment against standards must be recorded by the educational supervisor/potential educational supervisor.
4. Educational supervisors are required to complete a self-assessment of all criteria listed in this report and submit it by email to the Deanery at least 2 weeks prior to their visit date. The evidence to support each self-assessment must also be recorded.
5. It may not be necessary for visitors to record comments against each of the standards.
6. Where self-assessment or visitor comment is not applicable, please indicate with N/A.
7. In each section, there is a list of possible sources of evidence. It is intended as a guide only. Providing sufficient evidence where a virtual approval is possible will reduce the likelihood of an actual re-approval visit being needed. If unsure, please speak with the Lead Visitor.
8. For the first approval visit where questions may ask what IS in place please describe what you will be putting in to place.

**Notes on the trainee timetable**

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| **Trainee duties and activities suited to clinical sessions** |
| 1. Supervised or supported consultations within the practice, with a minimum appointments length of 10 (15 for Foundation trainees and most commonly a minimum 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. |
| **Trainee clinical activities that may be considered educational** |
| 1. Time spent in activities relating to work-placed based assessment and supervised learning events. |
| 2. Time spent analysing video recordings of consultations, such as Consultation Observation Tool (COT) (Mini-Cex for Foundation) 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. |
| **Trainee non-clinical activities suited to educational sessions** |
| 1. Locally organised educational events, e.g. specialty-specific educational programme run by the deanery or trust, including "half-day release" or "day-release" sessions. |
| 2. Structured and planned educational activities, such as tutorials delivered in the GP practice. |
| 3. Primary care team meetings. |
| 4. Educational supervisor meetings and other educational reviews. |
| 5. Audit and research in general practice. |
| 6. Independent study or revision. |
| 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 alternative and complementary therapists. |