**Regional Quality Management Groups**

**Quality Management of GP Specialty Training in Scotland**

**Terms of Reference and Standard Operating Procedures for**

**Educational Supervisor and Training Practice Approvals**

This document provides clarity on the role and operating procedures for General Practice Specialty Training (GPST) within the Quality Management of Medical Education in the Scotland Deanery.

**Principles:**

1. Quality Management-Quality Improvement (QM-QI) of GPST in Scotland forms a part of the QM-QI activity of the Medical Directorate and is managed through the annual quality cycle of the specialty grouping that includes GP, Public Health, Occupational Medicine and Broad-Based Training (BBT). This includes the annual Quality Review Panel (QRP) and the two-monthly specialty Quality Management Group (sQMG). Terms of reference for QRP and sQMG are described separately.
2. QM-QI of GPST programmes relate to GP trainees’ experience in hospital departments that host them, usually with other trainees (foundation, specialty). GP trainees’ experience will form part of the global quality assessment through the QRP process. GP Trainees are also hosted within general practices, which are in effect “Mini-Local Educational Providers” with individual Training Practice Service Level Agreements describing training arrangements. The nature of these arrangements requires a bespoke QM-QI approach, including the requirement for approval by the regulator of both the training environment (the training practice) and the educational supervisors (ES).
3. Approval and re-approval of ESs and Training Practices (TPs) therefore forms a significant part of the QM-QI of GPST and will be delivered regionally through Regional Quality Management Groups (RQMG) with oversight and approval through the sQMG.
4. QM-QI of training practices and ESs in General Practice is informed by triangulated data from a variety of sources detailed below.
5. The QM process and all decisions taken as part of it are guided by:
	1. GMC Document - Promoting Excellence: Standards for Medical Training and Education <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence> and the associated document Promoting Excellence for General Practice: Application of GMC Standards to GP Specialty Training <https://www.rcgp.org.uk/getmedia/a6772d50-7db0-4d51-bd4b-05038bc68892/Promoting-Excellence-for-General-Practice.pdf>
	2. The GMC policy relating to the recognition and approval of trainers
	3. RCGP guidance on the standards for training
	4. COGPED/ COPMED guidance on the principles of GP training and education [www.cogped.org.uk/archive/principles-of-gp-training.html](http://www.cogped.org.uk/archive/principles-of-gp-training.html)
	5. Any other relevant guidance that may arise from the GMC, COGPED/ COPMED or the RCGP

A single set of forms supports this process.

**Regional Quality Management Group**

RQMG Purpose

1. The GP Regional Quality Management Group (RQMG) is a pivotal component of the General Practice Quality Management structure.
2. The East/South-East and North regions of The Scotland Deanery will form one RQMG and the West region the other.
3. The role of RQMG is to review and make recommendations to the Specialty Quality Management Group (SQMG) as regards accreditation and re-accreditation of GP Educational supervisors (ES) and GP Training Practices, quality manage GP out of hours (OOH) training locations and Foundation training where co-located in an approved GP Training practice and GP Retainer practices. In doing so RQMG should consider applications considering other data, information and intelligence regarding the quality of training and of the training environment where such training takes place or will take place. It is also responsible for following up on requirements stipulated as part of the accreditation process.
4. Regions should arrange RQMG meetings numbering 4-6 per year (depending on regional workload). Dates of RQMG meetings should be set well in advance and planned to report into the 6 bi-monthly SQMG meetings.
5. The final decision for approvals rests with SQMG.

Composition

1. Each RQMG should be composed of the regional Assistant Directors for General Practice one of whom will act as chair, one or more Training Programme Directors (TPD), Associate Advisors (AA) with a QM remit, AA for the retainer scheme and the regional administrative lead for Quality Management. There should be external representation from the other RQMG or SQMG.

**The RQMG itself and workflow**

The RQMG will consider the following applications: -

Educational Supervisor in existing training practice first applications

1. RQMG will consider and make recommendations for Educational Supervisors from within existing approved training practices, who are making a first application to become an ES.
2. The TPD will meet with Scottish General Practice Trainer Entry Course (GPTEC) applicants initially and complete Form 6. These applicants must then successfully complete GPTEC.
3. On completion of GPTEC, the TPD will again meet with the applicant and update Form 6. RQMG will review the application and the summary meeting with TPD [Form 6]. These applications will be discussed at RQMG and a recommendation made. RQMG (not the TPD) will make a recommendation to accredit or not accredit and set an appropriate period of accreditation and any conditional requirements. If there are concerns about an initial ES approval this must be escalated to SQMG for discussion.
4. For a first approval, the maximum period of accreditation will be 2 years.
5. Details regarding the approval will be included in the SQMG summary sheet [Form 10] for presentation to the next SQMG where final approval rests. Completed Form 6 does **not** require to be presented to the next SQMG unless further discussion is required.

Educational Supervisor and Training Practice re-accreditation applications

1. Each regional quality administrative team has the responsibility to track ES and Training practices approaching the end of their current accreditation period and make appropriate arrangements for re-accreditation.
2. It is best practice to align ES and Training Practice accreditations.
3. ES’s and Training Practices will complete and submit self-assessment documentation [Forms 1 and 2] and the required accompanying evidence for consideration. Each individual ES must complete a Form 2.
4. Where a visit is required, this will include the Training Practice as an educational provider and all the Educational Supervisors at that site. Each training practice location and the ES’s therein should normally be visited every 6 years, with a desktop interim approval at 3 years, if there are no significant concerns identified at application.
5. For desktop accreditations a report (Form 4) should be drafted by a medical member of the RQMG team. RQMG will consider the submitted documentation along with other information including previous visit reports, TPD report, NTS and STS data including STS RAG aggregated data, ES use of e-portfolio and any other local intelligence. RQMG will decide to either recommend re-approval of the ES and practice for an appropriate duration and set any requirements or could arrange a site visit to the ES(s) and Training Practice if there were concerns. The RQMG outcome decision and details will be included in the SQMG summary sheet [Form 10].
6. Occasionally a practice or ES will change region within the Scotland Deanery. When considering a re-application, the accepting region will obtain the last approval report(s) from the region where the ES and /or practice were previously situated.
7. It is the responsibility of RQMG to manage the visit calendar.
8. When a decision has been made to visit the practice, appropriate arrangements should be made, and a visiting team appointed following the Practice Visit Standard Operating Procedures for General Practice. The visiting team will consist of a minimum of two people, be led by an experienced senior member of the Deanery GP team and accompanied by a trained second visitor who may be a TPD, AA or ES. A lay member will be included on a sample of visits. A trained Practice Manager could be included as an additional team member.
9. Re-approval of established ES’s and Training Practices will be for a maximum of 3 years but may be for a shorter duration dependant on the findings and recommendations made.
10. On completion of the visit, the lead visitor should complete a visit report and recommendations [Form 4] for consideration by RQMG. A decision on approval and any requirements set will be made and added to the SQMG summary (Form 10) for presentation to next SQMG.
11. Where there are significant concerns regarding a practice or ES re-approval this must be escalated for discussion to next SQMG.

Triggered Visits

1. From time-to-time, concerns about an individual ES or Training Practice may come to light from TPD feedback, expressed trainee concerns, NTS or STS data or due to substantial change within the practice. In these circumstances the RQMG should consider this intelligence and arrange a triggered visit where appropriate to all ES’s and the practice**.** Where a visit is triggered, it would be good practice that at least one visit member should be external to the region.

New Practice applications

1. Applications from new training practices will always require a practice visit. RQMG should be aware of these applications and a visiting team appointed.
2. For a first approval of a new training practice the maximum period of accreditation will be 2 years. When a new practice is approved the regional administrator must arrange for completion of the NES/BMA agreed Training Practice Service Level Agreement to be signed.
3. Following initial approval, a further re-accreditation will take place for re-approval at the set time period.

Practice and ES approvals to be discussed at SQMG

1. All approvals for new training locations (first approvals).
2. Reports from triggered visits.
3. If significant concerns have been identified about an ES or practice as part of the approval process.
4. If there is consideration that re-approval should be less than the normal 3 years or less than 2 years for a first approval.
5. If there has been or will be substantial change in the structure of a practice e.g. in medical staffing, independent contractor status to 2c or practice merger etc.
6. If there are concerns about the initial approval of an ES on completion of SPESC.
7. Quality Management Reports for Out of Hours settings.

Issues for discussion should be highlighted in advance and be noted on the agenda. In addition, a 5% sample of all routine approvals will be discussed at SQMG to ensure consistency in approach at RQMGs.

ES application from those undertaking ES training out with Scotland

1. When an application is received form a potential Educational Supervisor who undertook training as an ES out with Scotland, appendix 7 will be applied.

ES accreditation status when leaving a current approved Training Practice

1. If an approved ES leaves an approved training practice and joins another currently approved training practice, then the ES approval will continue and be aligned with the new practice and associated ES’s as soon as practical.
2. If an ES leaves an approved training practice and joins another non-training practice, and the ES wishes to continue training in the new location, a full new training practice application will be required, and a visit undertaken.
3. If an ES leaves an approved training practice and wishes to maintain their ES status with a view to resuming this later, they will need to demonstrate maintenance of skills and ongoing engagement with the GP training community. An interim re-approval may be considered for a maximum of 1 year’s duration but if the ES is not working in a substantive role in an approved training practice at the end of this approval period, then accreditation will lapse, and a re-application would be required at a later date.

Follow up of conditional requirements

1. Where conditional approval has been agreed by SQMG, local systems will be in place to ensure that requirements have been completed. Evidence regarding these will be considered by RQMG and a decision made as to whether these are satisfactory. If not, in most cases, further dialogue between RQMG and the ES/Training Practice should resolve the issue but if there is any uncertainty these should be escalated to the next SQMG.

Training Practices coming under Health Board Management or other providers

1. It may occur that an approved training practice changes from independent contractor status to being Health Board managed (2C status) or becomes managed by an external provider. If this occurs, then the existing NES/BMA Training Service Level Agreement will lapse. If the ES’s and Practice wish to maintain training status this would require a triggered visit. A visit to the practice must be organised as soon as practical. Applications should be made in the normal way.
2. There should be Health Board/provider representation at the visit who must confirm support for the practice and ES’s to continue training. There must be agreement with the Health Board that appropriate time for delivering training and the administration required will be accounted for. Time to deliver training, attendance at trainers’ meetings, trainer’s educational events and work placed based assessment calibration needs to be built into the ES’s job plan. A representative from the Health Board or provider will be required to sign the Training Practice Service Level Agreement and a covering letter sent [Appendix 8].

Administration following SQMG

1. It is the responsibility of the regional Assistant Director for General Practice to communicate to ES’s and Training Practices the outcome from SQMG by letter. Template letters for this purpose have been produced [Appendices 9a&b].
2. Summary reports approved by RQMG/SQMG for ES and training practice approval should accompany the letter. In particular circumstances it may be that the details of an ES approval would be best only sent to the individual ES. This will be approved by SQMG and acted upon by the AD with appropriate follow-up support instituted.
3. The regional administrative team should complete required TP4 forms and update TURAS and GMC Connect appropriately.

Out of Hours GPST Training locations

1. RQMG will oversee the quality management of the training experience in GP out of hours’ locations (where GPSTs work to gain experience required) as set out in the Scotland Deanery Operation Framework for GPST in the Out of Ours setting.
2. RQMG will consider the self-submission documentation along with other information including previous visit reports, TPD reports, trainee feedback and any other relevant local intelligence. RQMG will decide if the OOH location meets GMC requirements or arrange a meeting with the Medical Director or undertake a full visit if appropriate using the associated documentation. Following this an appropriate review time period (normally 5 years) will be set.
3. RQMG will complete an OOH summary report recommendation for submission to SQMG for consideration [Form 11].
4. A regional Assistant Director with responsibility for Quality will communicate the outcome in writing to the Medical Director of the appropriate organisation with a copy sent to the Health Board Director of Medical Education.

Foundation Training in General Practice

1. Where Foundation Training is co-located with GP Training, GP SQMG will include quality management of foundation training at re-accreditation on behalf of the Foundation QMG (FQMG). Where foundation training is stand alone in a GP Practice, monitoring will be the responsibility of FQMG but GP SQMG/RQMG will lead any necessary visits with Foundation representation as required and follow up any requirements set.
2. Foundation ES will complete and submit appropriate application form (Form 3a).
3. This will be considered by RQMG/SQMG as the same time as the Training practice and GP ES applications.
4. GP RQMG/SQMG will decide on whether GMC standards are being met for Foundation training and set any requirements. Action plans on requirements will be followed up through GP RQMG. An extract of the report relevant to Foundation and action plan updates will be shared with FQMG for information. There is no formal quality re-approval process for Foundation. Where a Foundation ES is not a GP ES, there will be a requirement for the individual to submit evidence for Recognition of Trainers at annual appraisal.
5. When an approved GP Training Practice wishes to commence Foundation training between approval cycles, initial approval is the responsibility of Foundation Training Management. The Practice and ES should submit a completed Form 3a to the regional Foundation Training management team who will arrange a visit to or discussion with the practice. Foundation TM team are responsible for updating TURAS when complete and the report should be shared with regional GP Quality Team and added to RQMG agenda for information (appendix 9).
6. When an approved GP Training Practice wishes to commence Foundation training and a re-approval is due, discussion should take place with the regional Foundation Training Management team on representation at the visit. Depending on the visiting team composition, a representative from Foundation may or may not be required. The Practice and ES should submit a completed Form 3a as part of their submission and Foundation Training discussed at the visit. The visit report requires to be shared with Foundation TM Team on completion and their view sought. Initial approval is still the responsibility of Foundation Training Management. Foundation TM team are responsible for updating TURAS. The report will be added to RQMG agenda as normal.

Retainer Practice applications and re-approvals

1. It is the role of RQMG to consider applications and re-applications from retainer practices. Arrangements for these are described separately.
2. New retainer application visit reports for non-training practices are submitted directly to RQMG and should appear on the summary sheet.
3. RQMG will consider new applications from an established Training Practice who wish to become a Retainer Practice or are seeking re-approval as a Retainer Practice.
4. RQMG should make a recommendation to SQMG and these should be included in the summary sheet.
5. Following SQMG approval, for accredited training practices, retainer approval notification will be included in the letter from the Assistant Director. When the practice is **not** a training practice, the approval letter should be completed by the local Associate Advisor for the Retainer scheme.

Foundation and Retainer Reports

1. It has been agreed that where Retaining and/or Foundation is co-located within a GP Training practice that the GP/OM/PH SQMG will undertake training site approval for these purposes. It is important that it is clearly reflected in the training practice report that standards for retaining and foundation have or have not been met.  Visitors completing reports must make mention of foundation and/or retaining under the relevant sections and in the executive summary.  These reports are shared with retaining and foundation colleagues and it must be clear that adequate assessment has taken place.

New Practice Application (Forms 1 &2)

Educational Supervisor and Training Practice re-accreditation applications (Forms 1 and 2 and Form 3a if a Foundation practice)

ES First Application in already approved Training Practice

RQMG reviews application along with TPD report, NTS, STS data including aggregated RAG data, ES use of e-portfolio, previous reports and other local intelligence. Visit arranged if appropriate. Form 4 completed for consideration by RQMG.

Application collated by local admin team with knowledge of RQMG

ES Completes Application (Form 6)

ES Meets with TPD, application and PDP discussed (Form 6 updated)

Visit arranged

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**No concerns** -Decision communicated to SQMG (on Form 10)

Triggered visits, emerging concerns, or less than 3 years approval considered -Form 4 to SQMG

Visit undertaken and report generated (Form 4)

RQMG considers application, decides recommendation/sets requirements (Form 6 updated).

Decision communicated to SQMG (on Form 10) **or** referred to SQMG if uncertainty/concerns

Letter created to ES/Training Practice re outcome with copy to TPD

TURAS, GMC Connect and TP4 updated by admin team

Training Practice SLA issued to new training locations

SQMG considers recommendations and determines outcome

**Form Summary:**

Form 1 Training Practice Application Form

Form 2 Educational Supervisor Application Form

Form 3a Foundation co-located with GP Training Form

Form 3b Stand alone Foundation Training

Form 4 Report Form

Form 5 New Practice/ES TPD Meeting

Form 6 TPD ES Post GPTEC Meeting

Form 7 GPST Timetable submission

Form 8 Practice workload analysis

Form 9 TPD Practice Report

Form 10 SQMG Summary

Form 11 OOH QM Report Form

**Quality Management of GPST**

**GP Educational Supervisor & Training Practice Approval**

**Appeals Procedure**

If there should be a dispute regarding the outcome of an Educational Supervisor approval or re-approval decision, or the approval of a practice as a training environment, the Educational Supervisor or prospective Educational Supervisor retains the right of appeal to the Deanery if he or she wishes. The procedure for appeal is set out below:

Criteria for an Appeal

1. An appeal can be made when the Educational Supervisor or prospective Educational Supervisor is dissatisfied with a decision that results in a recommendation for less than the maximum period of approval as described in the Scottish policy for approval and re-approval of GP Educational Supervisors and Training Practices, or where a practice has not been approved or re-approved as a training environment.
2. An appeal cannot be made where an approval for the maximum period has been made but with requirements.
3. Notification of appeal using the appeals pro-forma must be submitted within 21 days of receipt of the approval or re-approval decision.
4. An appeal will be considered if the appellant can provide a case that the process did not follow the Scottish policy for approval and re-approval of GP Educational Supervisors and Training Practices or that the decision made was not consistent with the evidence that was available.
5. The appellant should set out the reasons why they believe the way their application was processed may have disadvantaged them or their practice. Reasons should also be given to justify any allegation of unfairness or mal-administration which has negatively affected the appellant’s application.

Procedure

1. The appellant should notify the Director of Postgraduate General Practice Education in writing of his or her intention to invoke the appeal procedure using the appeal form.
2. The Director of Postgraduate General Practice Education will determine whether there are grounds for an appeal in relation to the criteria for appeal (above). In doing so the Director may wish to discuss the appeal on a less formal basis with the appellant.
3. If the appeal has merit, the Director of Postgraduate General Practice Education will inform the appellant that the request will be considered by a Deanery Appeal Panel.
4. The Director of Postgraduate General Practice Education will convene an appeal panel which will include a Postgraduate Dean from out with the specialty, who will chair the panel, a GP Training Programme Director who is ideally also an experienced Educational Supervisor, a trainee representative (both from other regions of the Deanery), a lay representative and if possible, a representative from the RCGP (RCGP External Advisor).
5. The Director of Postgraduate General Practice Education will arrange for the appeal to be heard by the panel as soon as practical after receipt of the appeal proforma.
6. The Deanery panel will be supplied with a copy of all documentation two weeks prior to the hearing.
7. The panel may wish to call the parties, including the lead visitor, to verify and clarify the evidence that they have considered. The Appeal Panel chair will request attendance of the relevant parties at the hearing.
8. If the appellant so desires, a personal representation may be made to the Deanery Appeal Panel. In doing so the appellant may be accompanied by but not represented by a friend or adviser.
9. After consideration of the written and heard evidence, the panel will deliberate and the chair will decide on the outcome of the appeal hearing.
10. The possible outcomes are that:

 (a) the appeal fails and the original decision not to approve/ re-approve is upheld.

 (b) the appeal is successful and the panel recommends approval/ re-approval of the applicant under such conditions as it decides.

 (c) the panel adjourns the appeal for further evidence to be brought. Depending on its previous decision the panel may /may not reconvene when the evidence is heard and dealt with by the Deanery Appeal Panel.

1. If the appeal succeeds the panel will recommend that the Deanery should make a recommendation to the GMC for recognition of the appellant as an Educational Supervisor, or the practice as a training environment for a length of time determined by the panel.
2. If the appeal fails in respect of re-approval of an existing Educational Supervisor, the panel will recommend that no further recommendation will be made to the GMC by the Deanery and the original duration of approval will remain. This may result in the Educational Supervisor’s recognition lapsing without renewal if it has not already expired.
3. If the appeal fails in respect of approval of a new Educational Supervisor or new training practice the panel will recommend that no further recommended action is taken.
4. The Chair will have the discretion to inform the appellant of the decision on the day of the hearing or at a later date. In any event the Chair will provide the appellant with the outcome of the appeal in writing within 7 working days, including any recommendation to the regulator.
5. It should be noted that the panel’s decision is final. An applicant who is not an existing GMC recognised Educational Supervisor who disagrees with the panel’s decision cannot appeal to the regulator and would need to pursue other legal routes to appeal the panel’s decision.
6. Appellants who fail in their appeal and are not approved or reapproved as Educational Supervisors, or whose practices are not approved or re-approved as learning environments may not re-apply for a period of at least twelve months of the final decision of the appeal unless otherwise advised by the Chair of the Panel.

The above appeals procedure does not cover the situation where serious concerns about an Educational Supervisor arise in the course of a training attachment. In these circumstances the Deanery should reserve the right to arrange transfer of any attached trainee and not to allocate any further trainees to the Educational Supervisor until any concerns have been investigated and resolved.

In the extreme situation where, for whatever reason, this procedure is not possible, the Deanery can recommend removal of training recognition to the GMC. The GMC can then consider invoking their own ‘withdrawals’ process.

**APPEALS PRO-FORMA**

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| --- | --- |
| Name and address of appellant |  |
| Date of Deanery approval/ re-approval decision (and visit if a visit took place) |  |
| Date of notification of appeal against Educational Supervisor or Training Practice approval/ re-approval decision |  |
| Reasons for appeal cross referenced against the Scottish policy for approval and re-approval of GP Educational Supervisors and Training Practices |  |
| Other reasons for appeal with supporting evidence |  |
| Available dates for possible hearing |  |

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