Postgraduate School of Primary Care

GP Trainer Standards

Based on the GMC paper:
Promoting excellence:
Standards for medical education and training

2019.1.2

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GP Trainer Standards

These standards are based on the GMC standards *Promoting Excellence: Standards for medical education and training*. They do not replace the original document but are written to highlight certain areas and clarify how the Postgraduate School of Primary Care implements the standards. If the mandatory standards set by GMC, the Gold Guide or RCGP change, and exceed the standards below, the new mandatory standards will be adopted. The School has set guidance to help practical running of the standards and these are also included in red.

At the end of each standard, a note is made on how or who will quality manage that standard in purple.

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Theme 1: Learning environment and culture

Purpose
This theme is about making sure that the environment and culture for education and training meets learners’ and educators’ needs, is safe, open, and provides a good standard of care and experience for patients. Education and training should be a valued part of the organisational culture. Learners will have a good educational experience and educators will be valued where there is an organisational commitment to, and support for, learning. High quality organisations will promote excellence in education. The clinical learning environment is multi-professional, so an effective learning culture will value and support learners from all professional groups.

Responsibility
Local education providers (LEPs) – specifically the leadership at board level or equivalent – provide the learning environment and culture. They are accountable for how they use the resources they receive to support medical education and training. They are responsible for taking action when concerns are raised that impact on patient safety. They work with postgraduate deaneries, local education and training boards (LETBs) and medical schools in recognising and rewarding trainers.

Postgraduate deaneries, LETBs and medical schools make sure that medical education and training takes place in an environment and culture that meets these standards, within their own organisation and through effective quality management of contracts, agreements and local quality control mechanisms. They work together to respond when patient safety and training concerns are associated.

Standards
S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
   Trainer appraisal. Management of concerns. Trainee feedback

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.
   Trainer appraisal. Trainee feedback

Requirements
R1.1 Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.
   Trainee and trainer feedback.

R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.
   LET. Feedback. Program and central office processes.
R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities. SEA. SIRM's. CQC.

R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy. Where concerns with performance occur these must be dealt with quickly and in line with the LET and managing concerns document. See appendix 7 Appraisal. Revalidation and support systems.

R1.5 Organisations must demonstrate a culture that both seeks and responds to feedback from learners and educators on compliance with standards of patient safety and care, and on education and training. Each trainee must adhere to the European Working Time Directive (EWTD) standards and the new Junior Doctor’s Contract. Trainer reappointment process. Trainer appraisal. Trainee feedback and CQC.

R1.6 Organisations must make sure that learners know about the local processes for educational and clinical governance and local protocols for clinical activities. They must make sure learners know what to do if they have concerns about the quality of care, and they should encourage learners to engage with these processes. Trainee feedback and complaints.

R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.9 Learners’ responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner’s level of competence, confidence and experience and provide an appropriately graded level of clinical supervision. Trainer appraisal. Trainee feedback
R1.10 Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.

Trainees and medical students must have name tags and door labels identifying their status.

Trainee feedback. Appraisal.

R1.11 Doctors in training must take consent only for procedures appropriate for their level of competence. Learners must act in accordance with General Medical Council (GMC) guidance on consent. Supervisors must assure themselves that a learner understands any proposed intervention for which they will take consent, its risks and alternative treatment options.

Trainer appraisal. Trainee feedback.

R1.12 Organisations must design rotas to:
- make sure doctors in training have appropriate clinical supervision
- support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK.
- provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training program
- give doctors in training access to educational supervisors
- minimise the adverse effects of fatigue and workload. See NHS improvements 8 areas of high impact to improve the working environment of junior doctors.

Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.13 Organisations must make sure learners have an induction in preparation for each placement that clearly sets out;
- their duties and supervision arrangements
- their role in the team
- how to gain support from senior colleagues
- the clinical or medical guidelines and workplace policies they must follow
- how to access clinical and learning resources.
- as part of the process, learners must meet their team and other health and social care professionals they will be working with. Medical students on observational visits at early stages of their medical degree should have clear guidance about the placement and their role.
- health and safety should be discussed including use of panic buttons, flags for violent patients in records, lone working and safe home visiting.
- supervisors must make sure trainees meet the standard of safeguarding children. Facilitating access to training. Level 3 is necessary for completion of training.
- trainees must demonstrate the ability to undertake audit. see appendix 3 or a quality improvement project.
- trainees should have opportunity to discuss careers advice.
- trainees should have training in telephone triage, this can be provided by OOH services.
• trainers must ensure that trainees have had enough out of hours (OOH) experience and have evidence that the trainees are competent in OOH prior to signing them off. It is the trainee’s responsibility to arrange OOH and report concerns. The trainee should do usually 24 hours OOH in ST3 in a 6month pro rata.

New Junior Doctor’s Contract 2017

Key change:
Time back for reasonable travel to exams and for the duration of the exam should be provided.
Out of hours arrangements for the new contract see embedded document below.

Update about new OOH arrangements a

• it is important that all trainees understand the processes in place for the identification and management of patients with chronic diseases in their training practice. This should include computer data entry and other administrative processes.

Trainer appraisal. Trainee feedback. Trainer reappointment process

R1.14 Handover of care must be organised and scheduled to provide continuity of care for patients and maximise the learning opportunities for doctors in training in clinical practice.
Trainee feedback.

R1.15 Organisations must make sure that work undertaken by doctors in training provides learning opportunities and feedback on performance, and gives an appropriate breadth of clinical experience. Including training in family planning, safeguarding children, audit and immunisations schedules.
The school. Trainee feedback.

R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.
Trainees must have a named supervisor for each post. Trainees must have a minimum of 3 hours protected training each week, >50% one to one, a session of private study and mandatory release for Regional Teaching, pro rata.
Trainee appraisal. Trainee feedback. Trainer reappointment process
R1.17 Organisations must support every learner to be an effective member of the multi-professional team by promoting a culture of learning and collaboration between specialties and professions. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.18 Organisations must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum. Study leave policy. Trainee feedback.

R1.19 Organisations must have the capacity, resources and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.20 Learners must have access to technology enhanced and simulation based learning opportunities within their training programme as required by their curriculum. Clinical supervisors must be familiar and up to date with the MRCGP exam and provide training towards this. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.21 Organisations must make sure learners are able to meet with their educational supervisor or, in the case of medical students, their personal adviser as frequently as required by their curriculum or training programme. Clinical supervisors must meet on average weekly, educational supervisors once per 6 months. Trainer appraisal. Trainee feedback. Trainer reappointment process.

R1.22 Organisations must support learners and educators to undertake activity that drives improvement in education and training to the benefit of the wider health service. Appraisal preparation should take place in ST3 using local appraisal documentation. SEA and developmental learning should take place in each post. The school. Trainee feedback.

Theme 2: Educational governance and leadership

Standards
S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.
S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training. Practices must be registered with CQC and must inform the school of adverse CQC outcomes or GMC investigations.
The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity. Trainers must have E+D training once every 3 years. The school. Trainee feedback.

Requirements

**R2.1** Organisations* must have effective, transparent and clearly understood educational governance systems and processes to manage or control the quality of medical education and training. The service level agreement (SLA – appendix 6) for the LET agreement must be signed by practices prior to training. The school. The LET

**R2.2** Organisations must clearly demonstrate accountability for educational governance in the organisation at board level or equivalent. The governing body must be able to show they are meeting the standards for the quality of medical education and training within their organisation and responding appropriately to concerns. The school. Trainee feedback.

**R2.3** Organisations must consider the impact on learners of policies, systems or processes. They must take account of the views of learners, educators and, where appropriate, patients, the public, and employers. This is particularly important when services are being redesigned. The school. Trainee feedback.

**R2.4** Organisations must regularly evaluate and review the curricula and assessment frameworks, education and training programmes and placements they are responsible for to make sure standards are being met and to improve the quality of education and training. The school. Trainee feedback.

**R2.5** Organisations must evaluate information about learners’ performance, progression and outcomes – such as the results of exams and assessments – by collecting, analysing and using data on quality and on equality and diversity. The school quality teams and programmes. Trainee feedback.

**R2.6** Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities and learning opportunities on placements, and must respond when standards are not being met. The school.

**R2.7** Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns. See managing concerns appendix 7 The school quality teams

**R2.8** Organisations must share and report information about quality management and quality control of education and training with other bodies that have educational
governance responsibilities. This is to identify risk, improve quality locally and more widely, and to identify good practice.

The school quality teams

R2.9 Organisations must collect, manage and share all necessary data and reports to meet GMC approval requirements.

The school quality teams. Programmes.

R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers’ job plans. See R1.10

The school quality teams. Trainer reappointment. Programmes.

R2.11 Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture. See R1.13

Trainer appraisal. Trainee feedback. Trainer reappointment process. Programmes.

R2.12 Organisations must have systems to manage learners’ progression, with input from a range of people, to inform decisions about their progression.

The school ARCP process and programmes.

R2.13 Medical schools must have one or more doctors at the school who oversee medical students’ educational progression. They must have one or more doctors at each LEP who coordinate training of medical students, supervise their activities, and make sure these activities are of educational value.

The school.

R2.14 Organisations must make sure that each doctor in training has access to a named clinical supervisor who oversees the doctor’s clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor’s clinical or medical practice throughout a placement, and contributes to the educational supervisor’s report on whether the doctor should progress to the next stage of their training.

Programmes. Trainee feedback.

R2.15 Organisations must make sure that each doctor in training has access to a named educational supervisor who is responsible for the overall supervision and management of a doctor’s educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Programmes. Trainee feedback.

R2.16 Organisations must have systems and processes to identify, support and manage learners when there are concerns about a learner’s professionalism, progress, performance, health or conduct that may affect a learner’s wellbeing or patient safety.
R2.17 Organisations must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practise concerns about a learner, particularly when a learner is progressing to the next stage of training.

R2.18 Medical schools (and the universities of which they are a part) must have a process to make sure that only those medical students who are fit to practise as doctors are permitted to graduate with a primary medical qualification. Medical students who do not meet the outcomes for graduates or who are not fit to practise must not be allowed to graduate with a medical degree or continue on a medical programme. Universities must make sure that their regulations allow compliance by medical schools with GMC requirements with respect to primary medical qualifications. Medical schools must investigate and take action when there are concerns about the fitness to practise of medical students, in line with GMC guidance. Doctors in training who do not satisfactorily complete a programme for provisionally registered doctors must not be signed off to apply for full registration with the GMC.

R2.19 Organisations must have systems to make sure that education and training comply with all relevant legislation.

R2.20 Organisations must make sure that recruitment, selection and appointment of learners and educators are open, fair and transparent.

Theme 3: Supporting Learners

Standard

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Requirements

R3.1 Learners must be supported to meet professional standards, as set out in Good medical practice and other standards and guidance that uphold the medical profession. Learners must have a clear way to raise ethical concerns.

R3.2 Learners must have access to resources to support their health and wellbeing and to educational and pastoral support, including:

a confidential counselling services
b careers advice and support
Learners must be encouraged to take responsibility for looking after their own health and wellbeing.

**R3.3** Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.

**R3.4** Organisations must make reasonable adjustments for disabled learners, in line with the *Equality Act 2010.* Organisations must make sure learners have access to information about reasonable adjustments, with named contacts.

Training in equality, diversity and human rights must be undertaken once every 3 years. In accordance with the requirements of the Gold Guide. See appendix 1.

**R3.5** Learners must receive information and support to help them move between different stages of education and training. The needs of disabled learners must be considered, especially when they are moving from medical school to postgraduate training, and on clinical placements.

**R3.6** When learners progress from medical school to foundation training they must be supported by a period of shadowing that is separate from, and follows, the student assistantship. This should take place as close to the point of employment as possible, ideally in the same placement that the medical student will start work as a doctor. Shadowing should allow the learner to become familiar with their new working environment and involve tasks in which the learner can use their knowledge, skills and capabilities in the working environment they will join, including out of hours.

**R3.7** Learners must receive timely and accurate information about their curriculum, assessment and clinical placements. The e-portfolio should be read weekly by clinical supervisors and monthly by educational supervisors.

**R3.8** Doctors in training must have information about academic opportunities in their programme or specialty and be supported to pursue an academic career if they have the appropriate skills and aptitudes and are inclined to do so.

**R3.9** Medical students must have appropriate support while studying outside medical school, including on electives, and on return to the medical programme.

**R3.10** Doctors in training must have access to systems and information to support less than full-time training.
**R3.11** Doctors in training must have appropriate support on returning to a programme following a career break.

The school. The LET.

**R3.12** Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service. See study leave policy.

Trainer appraisal. Trainee feedback. Trainer reappointment process.

**R3.13** Learners must receive regular, constructive and meaningful feedback on their performance, development and progress at appropriate points in their medical course or training programme, and be encouraged to act on it. Feedback should come from educators, other doctors, health and social care professionals and, where possible, patients, families and carers.

Trainer appraisal. Trainee feedback. The ARCP process

**R3.14** Learners whose progress, performance, health or conduct gives rise to concerns must be supported where reasonable to overcome these concerns and, if needed, given advice on alternative career options.

The ARCP process. Quality team.

**R3.15** Learners must not progress if they fail to meet the required learning outcomes for graduates or approved postgraduate curricula.

The ARCP process.

**R3.16** Medical students who are not able to complete a medical qualification or to achieve the learning outcomes required for graduates must be given advice on alternative career options, including pathways to gain a qualification if this is appropriate. Doctors in training who are not able to complete their training pathway should be given career advice.

**R3.17** Where there are multiple learners being supervised there must be adequate capacity for both supervision and the learner's individual needs.

The LET. Trainer appraisal. Trainee feedback. The ARCP process

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**Theme 4: Supporting Educators**

**Standards**

**S4.1** Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.

**S4.2** Educators receive the support, resources and time to meet their education and training responsibilities.

The school.

**Requirements**

**R4.1** Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities.
Applicants to be a trainer must;
• work in a GP practice, approved for training trainees.
• have satisfactorily completed an approved trainers course
• have been trained in equality, diversity and human rights best practice. See Appendix 1
• demonstrate that they are involved in educational activities
• be familiar with the regulatory framework surrounding GP specialty training
• have been awarded MRCGP or the equivalent for the country of training. Others doctors without the MRCGP can be considered on an individual basis.
• be familiar with the GP curriculum
• be familiar with the technical and administrative aspects of the MRCGP

Trainer appraisal. Trainee feedback. Trainer reappointment process

R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience. Trainers should have 2 sessions of trainer time allocated each week one of which is notional the other for training. At least one hour of preparation time should be timetabled and protected for educational supervision, teaching preparation and training duties.

Trainer appraisal. Trainer reappointment process

R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.

Trainer appraisal. Trainer reappointment process

R4.4 Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities. Debriefing of surgeries should initially be during and after each session; this may reduce as the trainee gains experience.

The school. The LET.

R4.5 Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.

The school. The LET. The quality team.

R4.6 Trainers in the four specific roles must be developed and supported, as set out in GMC requirements for recognising and approving trainers.

The school. The LET. The quality team.

R4.7 Trainers will be formally selected and re-appointed. The process of selection and re-appointment will comply with the following standards: see appendix 8

Theme 5: Developing and implementing curricula and assessments.

Standards
S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Requirements

Undergraduate curricula

R5.1 Medical school curricula must be planned and show how students can meet the outcomes for graduates across the whole program.

The medical school.

R5.2 The development of medical school curricula must be informed by medical students, doctors in training, educators, employers, other health and social care professionals and patients, families and carers.

The medical school.

R5.3 Medical school curricula must give medical students:

- a early contact with patients that increases in duration and responsibility as students’ progress through the programme
- b experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor
- c the opportunity to support and follow patients through their care pathway
- d the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics
- e learning opportunities that integrate basic and clinical science, enabling them to link theory and practice
- f the opportunity to choose areas they are interested in studying while demonstrating the learning outcomes required for graduates
- g learning opportunities enabling them to develop generic professional capabilities
- h at least one student assistantship during which they assist a doctor in training with defined duties under appropriate supervision, and lasting long enough to enable the medical student to become part of the team. The student assistantship must help prepare the student to start working as a foundation doctor and must include exposure to out-of-hours on-call work.

The medical school.

Undergraduate programmes and clinical placements

R5.4 Medical school programmes must give medical students:

- a sufficient practical experience to achieve the learning outcomes required for graduates
- b an educational induction to make sure they understand the curriculum and how their placement fits within the programme
- c the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of teachers, before using skills in a clinical situation
d experiential learning in clinical settings, both real and simulated, that increases in complexity in line with the curriculum
e the opportunity to work and learn with other health and social care professionals and students to support inter-professional multidisciplinary working
f placements that enable them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress.

The medical school.

Undergraduate assessment

R5.5 Medical schools must assess medical students against the learning outcomes required for graduates at appropriate points. Medical schools must be sure that medical students can meet all the outcomes before graduation. Medical schools must not grant dispensation to students from meeting the standards of competence required for graduates.

R5.6 Medical schools must set fair, reliable and valid assessments that allow them to decide whether medical students have achieved the learning outcomes required for graduates.

R5.7 Assessments must be mapped to the curriculum and appropriately sequenced to match progression through the education and training pathway.

R5.8 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the medical student’s performance and being able to justify their decision.

The medical school.

Postgraduate curricula

The development of postgraduate curricula is addressed in the standards for curricula and assessment.

The school.

Postgraduate training programmes and clinical placements

R5.9 Postgraduate training programmes must give doctors in training:
a training posts that deliver the curriculum and assessment requirements set out in the approved curriculum
b sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum
c an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme
d the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation
e the opportunity to work and learn with other members on the team to support inter-professional multidisciplinary working f regular, useful meetings with their clinical and educational supervisors
g placements that are long enough to allow them to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress
h a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by
doctors in training should support learning opportunities wherever possible. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.
The school. The quality team.

Postgraduate assessment
R5.10 Assessments must be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors’ progression through their education and training.

R5.11 Assessments must be carried out by someone with appropriate expertise in the area being assessed, and who has been appropriately selected, supported and appraised. They are responsible for honestly and effectively assessing the doctor in training’s performance and being able to justify their decision. Educators must be trained and calibrated in the assessments they are required to conduct.
The school ARCP process. The quality team.

Reasonable adjustments
R5.12 Organisations must make reasonable adjustments to help disabled learners meet the standards of competence in line with the Equality Act 2010, although the standards of competence themselves cannot be changed. Reasonable adjustments may be made to the way that the standards are assessed or performed (except where the method of performance is part of the competence to be attained), and to how curricula and clinical placements are delivered.
The school. The LET.
Guidance documentation

GP training practices

6.1 GP training practices must be formally selected and regularly re-accredited by the GP School via the trainer appointment process. A practice cannot be accredited in the absence of an approved GP trainer.

6.2 All premises used for training trainees must have been approved by the School of Primary Care. Major structural or organisational changes must be notified to the Training programme and the School of Primary Care. The details of all training premises must be notified and approved by GMC.

Medical records/information technology

6.3 Practices must normally have at least 90% of notes adequately summarised.

An adequate summary is defined as a list, in a single view, of all relevant past and current significant medical problems. The practice should have a policy for what information goes into the summary. It should not be cluttered with non-significant information. New training practices will audit their record standards prior to accreditation.

6.4 The practice should use a local formulary and have agreement on the preferred drugs to be used in common conditions.

6.5 The practice must have warning message system to alert trainees to particular potential risk in a consultation e.g. patients who are potentially violent, vulnerable adults and children at risk. ( system1 go to ‘patient >patient maintenance > patient plan.’ Then allow viewing of the plan at; User>user preference > patient record> patient plan allow.)

The School does expect that trainees, especially in ST3, would consult with potentially violent patients so that they are prepared for independent practice.
It is a CQC requirement to have a lone worker policy. Practices should also have a system to ensure that they are aware that a trainee has safely completed all of their visits before they go home.

*Trainer appointment, trainer appraisal*

**Premises**

6.6 Ideally the trainees should have their own, well equipped, consulting room. If they do not, they will not be expected to use more than 3 different rooms (including any in branch surgeries). These rooms should be set up and stocked identically.

6.7 The trainees’ consulting room will be of such a size that the trainer may easily observe their consultations. There will be facilities to record consultations. It should be close to the consulting room of the trainer. It must contain a paper or electronic copy of the BNF and Children's BNF.

6.8 Trainees should have their own space and facilities in the practice to secure their personal items safely.

6.9 The practice must provide an up to date library/learning resource, including electronic resources. The trainer should be able to demonstrate how they facilitate the learner to know where, and how to look for information, and how they use evidence in their day to day work.

**Equipment**

6.10 There will be a camera for recording consultations; the equipment should work and be available to the trainee all or most of the time.

6.11 The trainee will have access to the drugs and equipment needed to provide effective routine, emergency and out-of-hours care. If controlled drugs are required and these are provided by the practice, the practice must provide a lockable bag, personal controlled drugs register and ensure that the trainee is familiar with, and complies with, the regulations for this.

*Trainer approval, trainer appraisal, trainer re-appointment*

**Training capacity**

6.12 The involvement of the educational supervisor or other GPs in the practice in local and national professional organisations must not compromise clinical contact with patients, time for training and quality of training.

6.13 The list size and workload of the practice must be large enough to offer trainees a wide variety of clinical experience representing normal, everyday general practice. If this is not available, the practice must make alternative arrangements to ensure this.

6.14 The practice must normally be able to cope with its patient load effectively with or without a trainee.

*Trainer approval, trainer appraisal, trainer re-appointment*
Patient Involvement

6.15 The practice must inform patients that it is a training practice, particularly with reference to the recording of consultations and the inspection of medical records for the purpose of educational supervisor selection and accreditation; school and GMC quality assurance activities.

Trainer appraisal

6.16 The practice must be able to show evidence that patients are satisfied with its services and physical environment.

Trainer appraisal

6.17 The training practice must be able to demonstrate how they involve patients in the running of the practice.

Trainer reaccreditation

6.18 The practice will have a well thought through and well publicised patient complaints procedure.

Trainer appraisal

Practice Management and clinical governance

6.19 The practice team should be reflective and show evidence of improvements in clinical care. They must undertake regular, documented significant event analysis. They must undertake regular clinical audit in areas other than QOF.

6.20 The practice should ensure doctors or other staff providing regular supervision and teaching should have received some documented training for this role. Their teaching sessions must be documented and feedback obtained.

6.21 The trainer should be able to describe how they ensure that trainees know how to attain the skills necessary to successfully manage a business. The trainees should understand business management, leadership and commissioning of services, along with the other areas in this area of the curriculum.

Good practice in this area would include involving trainees in a full range of practice meetings, and debriefing after these.

6.22 The training practice will ensure that the practice and registrar’s weekly timetable is sufficiently flexible to allow experience of all the relevant activities of the practice (including special clinics, meetings and working alongside different members of the PHCT, including doctors).

6.23 The RCGP recommends that CBDs and COTs should only be done by clinical supervisors, trainers or intending trainers under supervision. Mini-CEX and CEPS can be done by suitably trained ST4s and above, staff grades and consultants. CEPs may also be done by an appropriately trained nurse.

Trainer appointment, trainer appraisal, trainer reappointment
References

GMC Generic standards for training
GMC standards for trainers
A Guide to specialty training in the UK: the Gold Guide (published by the Department of Health and updated annually
COGPED/RCGP standards for GP trainers

Definitions in General Practice

A practice is the unit which has a contract with the PCT to provide services. If an organisation holds more than one contract to provide medical services, each contract will be deemed to be a separate practice and accredited separately.

An Educational Supervisor is the trainer providing overarching supervision of a trainee. They will ideally be the same person for the entire training programme of an individual. They will be the trainer who is named on the trainee’s e-portfolio as the Educational Supervisor.

The Clinical Supervisor in General Practice will normally be the same trainer as the Educational Supervisor. However, if they are not the same person, such as during an Integrated Training Post, the Clinical Supervisor is responsible for the day to day education of that trainee. This will include the delivery of teaching and appropriate assessments. The Clinical Supervisor will be named as such on the e-portfolio.

Clinical supervision refers to the clinician supervising a trainee at any particular time. They may be any suitably trained clinician. The Clinical Supervisor is responsible for ensuring that they delegate this task appropriately.

The Lead Training Programme Director (LTPD) is responsible for running the GP Training programme.

Robin Douglas
Appendix 1
Equality and diversity training requirements for the Postgraduate School

All GP Educationalists, including trainers, must have up to date equality and diversity training. This must be renewed at least once every three years using an appropriate course/module with different content to that done previously.

A level three course must be done at least every 9 years.

Teaching a course will count towards the appropriate level.

Level 1
Any e module

Level 2
Presentation about equal opportunities legislation and its implication for training – e.g. that given to new Recruitment and Selection assessors or at ARCP training

Level 3
Presentation about equal opportunities legislation and its implication for training, with opportunities to discuss real examples and experiences – e.g. that given at Intending trainers course or the Educationalist conference course
-Or-
One day cultural competence course

Other courses may be accepted as equivalent. A level 3 course must be of at least ½ day duration and be interactive.

Appendix 2
European Working Time Directive

Implications of the European Working Time Directive (EWTD) for GP Registrars

Background
The European Working Time Directive (EWTD) has been fully implemented and applicable to doctors in training since 1 August 2009.

1 Maximum working week of 48 hours
The deadline for the 48-hour maximum working week is from 1 August 2009. On an exceptional basis Trusts were permitted to apply for derogation up to the maximum of 52 hours per week. According to DoH website, no Trusts in our patch has done so.

It is important to note that these working week requirements are based on the average number of working hours over a reference period of up to 6 months (26 weeks). These requirements must be considered when planning the registrar’s timetable.

2 A minimum daily consecutive rest period of 11 hours
3 A minimum rest break of 20 minutes when the working day exceeds 6 hours. This must be taken in the middle of the day, i.e. not at the beginning or the end. Any break from work where you are not permitted to leave your workplace is
not counted as a rest period. Working lunch is not counted as rest.

4 A minimum rest period of consecutive 24 hours in each 7 day period (or 48 hours in 14 days).
5 A minimum of 4 weeks’ paid annual leave.

GP and OOH (Out of Hours)

It is likely that particularly Out of Hours in General Practice will breach the EWTD without careful attention. It is essential that registrars have an unbroken 11-hour rest away from work in any one 24-hour period. Being on call where you are required to be at a place other than home is counted as continuous work even if you are asleep. Practices should ensure that their registrars keep them informed as to their OOH shifts and suitable adjustment of their practice workload is implemented.

What is ‘working time’?
The definition of working time includes:
1 any period during which you are working at your employer’s disposal and carrying out your activity or duties (including travelling where it is part of the job and working lunches)
2 any period during which you are receiving relevant training
3 any additional period which is to be treated as working time for the purpose of the Directive under a relevant agreement
4 ‘on-call’ time or out-of-hours training when you are required to be at your place of work. [If you are permitted to be away from the workplace and are accordingly free to pursue leisure activities, on-call time is not defined as working time.]
5 Requirement to travel as part of job, for example between sites.

What is ‘not working time’?
1 travelling to work
2 voluntarily staying to help finish a task off
3 Self organised study groups

The opt-out clause
It is possible for an employee to opt-out of elements of the Working Time Regulations, providing this is entirely voluntary. The opt-out, however, only applies to total hours of work. It is not possible to opt-out of rest requirements. If you wish to opt-out you need to sign an opt-out agreement with your employer. You are free to cancel any opt-out agreements within the agreed period of notice, which cannot be longer than three months long. The BMA would not advise any doctors in training posts to opt-out of the Working Time Regulations.

Compensatory rest
In a number of specific circumstances, including those relating to patient care, the European Working Time Directive allows employers to exclude the provisions in relation to length of night work, daily rest, weekly rest and rest breaks (without employee opt out) if compensatory rest is provided. There has been prolonged discussion about the implementation of this element of the legislation and the BMA is still awaiting clarification. Updates can be found at www.bma.org.uk/ewtd
Liability

Liability in the case of a breach of the Working Time Requirements lies solely with the employer (training practice). Each breach risks a fine of £5,000 from the Health and Safety Executive. As yet, no fines have been imposed with respect to doctors in training, despite breaches still being relatively common in some hospital environments. As long as the registrar has suitable membership of a medical defence organisation, and considers themselves “fit” to work, there is not currently thought to be any excess liability associated with a breach of the Working Time Regulations with regards to medico legal complaints.

Appendix 3
Basic guidance on what is expected of a standard 8 point audit

Structure
1. Reason for choice of audit - Potential for change. Relevant to the practice.
2. Criterion or criteria chosen - Relevant to audit subject and justifiable e.g. current literature.
3. Standards set - Target towards a standard with suitable timescale.
4. Preparation and planning - Evidence of teamwork and adequate discussion where appropriate.
5. Data collection (1) - Results compared against standard
6. Change(s) to be evaluated - Actual examples described
7. Data collection (2) - Comparison with data collection 1 and standard
8. Conclusions - Summary of main issues learned.

1. Reason for the choice of Audit

Pick a topic where there is the potential for improvement that is relevant to the practice, and also to you as a practitioner

2. Criterion

Criteria and standards are often cited as the most confusing terms associated with audit. Both cause doctors and others the greatest difficulty in understanding and putting into practice. If you can understand and differentiate between an audit ‘criterion’ and a ‘standard’ then you are well on your way to grasping basic audit method.

Criteria are simple, logical statements used to describe a definable and measurable item of health care, which describes quality and can be used to assess it.

Examples of audit criteria:

1. Patients with a previous myocardial infarction should be prescribed aspirin, unless contraindicated.
2. Patients with chronic asthma should be assessed at least every 12 months.
3. Patients should wait no longer than 20 minutes in the surgery before consultation.
4. The GP’s medicine bag should contain a supply of in-date adrenaline.
5. Surgeries should start within 5 minutes of their allotted time.
6. The blood pressure of known hypertensive patients should be <140/85
Examples of non-criteria statements
1. All hypertensives should have a BP of $< 140/85$ and a urine ACR
2. GPs should be smartly dressed
3. All patients on the pill should be given an information leaflet

It is best to restrict the number of criteria to be measured for any given audit. Unless otherwise specified auditing a single criterion is acceptable for both Appraisal and e-portfolio purposes. Focusing on one or two criteria makes data collection much more manageable and the introduction of small changes to practice much less challenging. Overall it offers a better chance of the audit being completed successfully within a reasonable time span.

It is important that any criteria chosen should be backed up with quoted evidence (e.g. from a clinical guideline or a review of the relevant literature). Occasionally because of the type of topic chosen, suitable evidence is not always readily available and therefore cannot be cited. If this is the case then simply explain that there is a lack of suitable evidence on the subject, but also stress that there is consensual agreement amongst your colleagues on the importance to the practice of the particular topic and criteria that have been chosen.

If criteria need further explanation, this should be documented e.g. what the contraindications for aspirin are, and if they have been documented in the records

3. Standards

An audit standard quite simply describes the level of care to be achieved for any particular criterion. It is unlikely that you will find actual percentage standards quoted in the literature or in clinical guidelines. You should arrive at the desired level of care (standard) by discussing and agreeing the appropriate figures with colleagues. There is no hard rule about standard setting – the agreed level is based on both you and your colleagues’ professional judgment, and this will obviously vary between practices for a variety of medical and social reasons. A standard is not normally 100%.

Examples of audit standards:

1. 90% of patients with a previous myocardial infarction should be prescribed aspirin, unless contraindicated.
2. 80% of patients with chronic asthma should be assessed at least every 12 months.
3. 75% of patients should wait no longer than 20 minutes after their allotted appointment time.
4. 100% of GPs’ medicine bags should contain a supply of in-date adrenaline.
5. 95% of surgeries should start within their allotted times.
6. 70% of blood pressure measurements of known hypertensive patients should be $< 140/85$

Agree on a standard, which you all believe to be an ideal or desired level of care and briefly explain why each standard was chosen (remember that different standards can be applied to each criterion). The standard(s) set should be outlined together with a time-scale as to when you expect it to be achieved (for example within 3 months if that is how long you envisage to complete the audit project). In some cases you might require to set realistic targets and a time scale towards the desired standard over a longer period of time.
4. Preparation and Planning

This is where you explain how you went about deciding on the topic and who was involved. There needs to be emphasis on all the team members involved and also how a consensus was reached. Describe methods of data collection and who was involved.

5. Data collection (1)

The initial data collected should be presented using simple descriptive statistics in table format or using graphs (bar charts, pie charts etc.) Remember to quote actual numbers as well as the percentage. Make sure all the numbers add up properly. Always remember to comment on how the data compares to the original standard.

6. Change implemented

An accurate and clear description of what changes to practice will be made needs to be included here. Where possible include an example of the changes made, e.g., questionnaire, forms, template, protocols etc.

7. Data collection (2)

After a reasonable amount of time a second data collection should be completed (3-6 months later) with results demonstrated as before. Compare the first data set to the second, and then compare all against the standards set. Discuss why the standards are not met if this is the case. The data collection should not normally be exactly the same group of patients e.g. sending for all the patients on methylphenidate to have their growth measured and then repeating the data collection 2 weeks later does not demonstrate that you have put long lasting changes in place.

8. Conclusions

The final section of the audit report should conclude by briefly and simply summarising what the audit achieved, and what are the main learning points gained from this exercise. In doing this, the benefits achieved through the audit should be discussed along with any problems encountered with the process or findings. Some thought should also be given as to whether the audit will be repeated in future and if so when.
Appendix 4
Single Handed Trainers and cover for absence

Background

Trainees must have adequate clinical cover. This is explicit in the trainer standards. Cover may be by suitable locums or it may be possible for a trainee to move to another training practice whilst their trainer is absent. This document is to explore the requirements for approval of such an arrangement. There needs to be a range of options as different things work for individual practices.

Practices need to tell us what they are doing and then approval sought before training commences.

Options include:

1. Job share
   Two trainees share 2 GP posts. The arrangement would be similar to those in integrated training posts. Trainees would be inducted into one post first (full time) and then the second post later as a part time induction.
   The single trainer would be unable to have planned holiday until induction was completed.
   The trainee would work full time within the job share practice when their other trainer was absent. The practices would therefore need to have capacity to have two trainees at once.
   New trainers cannot normally supervise two trainees at once and the school would need to consider whether both trainers had both capacity and capability to manage this arrangement.
   There would need to be a formal written agreement and timetable between both practices and approved by the School.

2. Temporary cover arrangements with another training practice
   The single handed trainer’s trainee would be attached to the cover practice when their own trainer was absent. The cover practice should have the same computer system and be in the same CCG as the trainee’s usual practice. There must be an approved proposal for cover which includes:
   - Name of the practices and trainers
   - Type of computer system for each practice
   - The CCG name for each practice
   - A statement that both trainers will not be absent at the same time
   - The duration of holiday and sickness cover within this arrangement
   - The induction programme and timing for both practices
   - Teaching arrangements whilst the trainee is in the cover practice
   - The process for covering unexpected absence of the trainer

3. The trainee does paid self-directive learning whilst the trainer is absent.

Please note that any financial arrangements between the practices do not form part of the School approval process.
Appendix 5
Guidelines for assessing whether trainers can be personally responsible for more than one (WTE) trainee

There is currently no guidance on how to judge whether a trainer has the personal and practice resources to be the named clinical supervisor for more than one trainee at a time. Below is a list of suggested areas that the training programme will explore with a trainer who wishes to have, or already has, more than one trainee. If the training programme has concerns about the capacity of the trainer/practice that cannot be resolved with the trainer, a decision will be made with senior educators at the central office.

If a trainer expresses an interest in having more than one trainee, their training programme held records should be reviewed prior to a visit, including trainer appraisal records. This exploration below is only for 6 month posts, not for temporary cover.

Areas to consider

Acting as a personal supervisor for an F2 - Trainers should not normally be named clinical supervisor for more than one trainee at a time until they have been a trainer for 2 years or had 4 trainees, whichever is the longer. Doctors wanting to supervise more than one trainee should not have outstanding actions from their last trainer reappointment. Attendance at trainer groups/workshops should be at least the minimum in the trainer standards. Trainee feedback forms show no significant outstanding issues. How many educational supervisees do they have and how are ES reviews managed? Doctors supervising more than one trainee at a time in a single surgery should have blocked out appointments and debrief time at the end of surgery. A trainer with more than one trainee should have at least 2 hours per week protected for training related administration. A trainer with more than one trainee should be able to demonstrate how the practice is offering the equivalent of at least 3 sessions per week to GP training. Trainers wishing to be responsible for more than one trainee should have their capacity to do so assessed and documented at a practice visit (other than for short term overlaps/emergencies etc.). There should be a note added saying 2 trainee status, to the LTPD reappointment report. What support is to be given to the trainer from the rest of the practice in respect to the educational activities?

After the practice visit/trainer meeting

The programme documents the discussion and sends a copy to the trainer. This may be asked for at reappointment as these trainers will have a higher degree of scrutiny. Confirmation that the practice has agreed to the plan from practice manager (deputy) of intended plan is required.
Appendix 6
Service Level Agreement

A GP Trainer who hosts a GP trainee is thereby explicitly agreeing to undertake all of the obligations of being a host employer, as defined by the GP Lead Employer Trust (LET) and defined in the Service Level Agreement (SLA).

- Each host practice must sign and return the SLA to allow trainees to be sent to the practice.

- Exit reports for the purpose of revalidating trainees must be returned every six months. See below

The GMC processes insist that we cannot assume that no return = your trainee has not had a complaint / been named in a Serious Incident. Please note the definition of an SI – there will in fact be very few of them to report, but we must have the forms back please. The info below is the detailed guidance on the matter, but note that for most trainees the system will be extremely simple and involve just replying “no”!

...The host practice is required to provide information relating to any trainee’s involvement in a Serious Incident / significant event or complaint which requires investigation. This should be done via:

- Completion of the collective and individual exception reports which are required on a six-monthly basis which are sent directly to the practice for their completion and return to HENE by the Practice. Confirmation must be sent to HENE for each trainee. HENE is unable to accept a nil response as confirmation the trainee has no involvement in any incidents.

- ‘Live’ incident reporting through use of HENE’s ‘Live Flow’ reporting processes.

The underlying principle for reporting issues is that the HENE Revalidation Team should be notified about anything which causes concern that the junior doctor may not be meeting the requirements of “Good Medical Practice”.

The GMC define a significant event as ‘A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.’

The HENE Revalidation Team are only interested in junior doctors for whom the Supervisor has significant concerns about the junior doctor in question’s clinical performance or conduct.
Appendix 7
Managing concerns

Click [here](#) for full guidance.

Appendix 8
R8.1 Trainers’ re-appointment and clinical supervision.
The process of selection and re-appointment will comply with the following standards:

- Doctors may not start the intending trainer’s course until they have the equivalent of eighteen months experience in GP.
- They should have been in a substantive post, for at least 6 months
- New trainers will be appointed for no more than two years on first appointment. Re-appointment thereafter will normally take place at least every three years. New Trainers should be allocated at least 2 trainees in their first 18 months of training where possible. These trainees should not have known problems so that trainers have more chance of a positive experience. Multi trainer practices may redistribute trainees between them but they should be encouraged to prioritise the new trainer for 18 months.
- Re-appointment will take into account the views of past and present trainees and the training programme director.
- Evidence of observation of a trainer’s teaching. This may either be done as part of the trainer’s appraisal by the training programme or as part of a peer appraisal process.
- When the trainer is acting as the Clinical Supervisor for the trainee they must be working alongside that trainee for at least 2 clinical sessions per week. They will ensure that there is always adequate, named, clinical supervision for the trainee.
- If the named trainer is absent for more than 3 weeks the lead training programme director must be contacted by the practice.
- The trainer will have time to prepare reports, undertake continuing professional development (trainer group, educationalists conference etc.).
- Consultations should normally 10 minutes in duration
- The trainer will record personal evidence for audit and significant events. This must be of a standard to demonstrate their grasp of the principles of these tools and to provide examples to trainees.

R8.2 Trainers will be committed to continuing professional development as an educator. They must:

- Have an up to date personal educational development plan derived through annual appraisal for their work as an educator. They will present their educational PDPs, if requested, with their re-appointment documentation.
They will have a documented annual appraisal for their work as an educator. If this is not through their Training programme, they will undertake this with another suitable educator.

- be willing to undergo performance review
- be familiar with current medical literature and its implications for both general practice and general practice teaching

R8.3 If a clinical supervisor is unexpectedly unavailable:
- There must be a documented assessment by the named trainer as to whether the trainee may work on site alone. If the named trainer is not available, this assessment may be made, and documented, by another competent person.
- It is likely that only an experienced, and good, ST3 trainee would be deemed competent to work alone in these circumstances.
- If it is not possible to have a clinical supervisor on site, there must be a named supervisor on another site who is available to assist the trainee, and visit the trainee’s site, if needed.
- There should be a debriefing session by telephone or in person at the end of the session.
- If there is more than a single session, within a standard 6 month training attachment, without onsite supervision, the lead training programme director must be informed promptly.

R8.4 Trainers will maintain independent trainer records. These should include record of protected teaching sessions, significant educational events, the teaching timetable and all assessments.

This independent trainer record should be shared with the trainees

R8.5 Trainers who are not selected or re-selected will have the right of appeal through the appeals procedure.

R8.6 Trainers must be skilled and committed teachers, able to demonstrate through their personal development plan that they have attended courses and engaged in other activities relevant to their role as educators.

Educationalists are expected to make brief reflective notes on all courses attended which may be requested as part of the trainer reappointment process.

**Clinical supervisor**

Clinical supervisors are clinicians responsible for overseeing the day-to-day clinical work of the trainees in individual placements and for providing regular feedback on progress to the trainees and Educational supervisor.

8.7 Applicants to be an OOH clinical supervisor must have satisfactorily completed the intending trainer’s course unless they are doing OOH supervision only. In the latter
case, they must have satisfactorily completed the one day School of Primary Care OOH supervisors course or possess equivalent skills from other educational activities. School of Primary Care to hold list of trained supervisors, training programme to manage QA internally and QM visits to monitor

8.8 Locums do not usually supervise trainees however there may be occasions when this is unavoidable.

The school has some written guidance for practices and locums when this situation arises which can be found on the website here.

Supervising Locums will require time allocated within the working day to provide support for the trainee.

**Educational supervision**

R8.9 The educational supervision must be the clinical supervisor for one post in training. The educational supervisor must use the E-portfolio and be available for discussion of progress and problems with the trainee and program.

R8.10 Trainees must have an Educational Supervisor from general practice throughout their program. Where that supervisor changes during the program, the supervisor will ensure that there is a managed and recorded handover of responsibilities. When a trainer’s status changes, and there are no performance concerns, their temporary continued role as Educational supervisor is at the discretion of the LTPD.

Educational supervision is usually undertaken by a trainer and monitored via trainer appraisal and reappointment. It may be necessary for the head of school/AD/ LTPD/ TPD to act as an educational supervisor. This is acceptable as they will be reading and assessing ESRs in these posts. This role should be monitored in the annual appraisal of their primary role.

Supervisory trainers also get priority; this may not need to happen as the teaching could take place with the GP trainee in the practice.

**Trainee feedback, ARCP feedback, educationalist appraisals**

5.4.19
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