OXFORD DEANERY TRAINER APPLICATION   OXVT3 (April 2003)

Date of Application	April 2005	**TYPE** RENEWAL

NAME	Tom Nicholson-Lailey
Date of Birth	*******
GMC Number	*******
Qualifications	MA Cantab. MBBS MRCGP DRCOG

Practice Address	East Oxford Health Centre Raglan House 23 Between Towns Road Oxford OX4 3FQ
Telephone	01865 722214
Fax	01865 200421
Email	*******

Primary Care Trust	Oxford City

Doctors Working in the Practice					
Name	Age	Qualifications	Status *e.g. Partner / Non - Principal*	F/T equiv	Trainer
Tarrant Stein	*		P	4 / 10	In past
Gina Robson	*		P	3 / 10	
Tom Nicholson-Lailey	*		P	Full	Y
Kathryn Ward	*		P	Full	
Peter von Eichstorff	*		P	Full	Y
Ahsan Alvi	*		NP	4 / 10	

Names of Doctors in Training	Status GPR, PRHO, Retainer
Enas Al-Dabagh	GPR
Eleanor Holloway	GP Retainer

Do you need approval to have more than one learner in the practice at the same time? YES

List of Key Staff	Job Title	WTE
Maggie Perrin	Practice Manager	FT
Marie Molloy	Patient Services Manager/Secretary	FT
Jeannette Rose	Practice Nurse	0.82
Ali Shlugman	Practice Nurse	0.53
Amanda Stribling	Healthcare Assistant	0.58
Patrick Wilmore	Data Quality/IT Administrator	0.54
Alison Stubbs	Notes Summariser	0.62
Heather Paterson	Phlebotomist/Receptionist	0.83
Rosalie Simpson	Scanning Assistant	0.40
Christine Williams	Receptionist/Admin Assistant	0.54
Rita Foster	Receptionist/Admin Assistant	0.70
Laura Maier	Receptionist/Admin Assistant	0.72

Practice Description

Practice size, demography, location, and character of practice. Brief summary of recent practice history and strategic direction.

List size 8100. Mixed population including 30% ethnic minorities, 200 refugees and 300 students
We have the highest prevalence of diabetes in the City with 250 type 2 patients

Inner City Oxford, normally co-located on Cowley Road with 2 other practices

The past 2 years have been dominated by preparations for the redevelopment of our Health Centre as the first phase of Oxford's LIFT Partnership. An enormous amount of work –particularly by Peter von Eichstorff and Maggie Perrin - has gone into specifying our requirements for the new building and also planning and carrying out the move to temporary premises in February 2005.We should be moving back into a palatial new Medical Centre in September 2006 . We are planning to expand our premises with the new surgery. This will allow the possibility of more than one learner in practice.

On the patient care front nGMS and QOF have dominated the agenda, and we have strengthened our Practice Nursing team with the appointment of an Health Care Assistant to work

alongside our two registered nurses.

In our new premises we should be able to expand the use of our healthcare assistant and nurse triage and further improve on access. We intend to build on our use of IT to allow online registration, repeat prescription ordering and address changes.

Practice outside commitments

Maggie Perrin - PCT QOF Assessor , member of PCT Training and Development Committee
Takes Part in PMDGE Training Assessment visits, and short-listing and interviewing VTS candidates
Peter von Eichstorff - Local Improvement Finance Trust (LIFT) Champion for PCT
CHD lead for PCT

Trainers outside commitments

No formal work commitments outside the Practice.

My principal non-work commitment is to my wife (also a G.P. and trainer) and to my daughters (aged 14 and 12).

Other outside commitments include photography-learning to make the most creative use of my new digital SLR camera; and tennis - regular practices and matches for Oxford City LTC.

Recommendations from last Practice visit and Action taken

1) Improve summaries as practice was in process of going paperless

Action: Medical students employed and notes summarised (currently 90% updated computer summary)

2) Improve protocols and appoint lead clinicians

Action: Appointments made and protocols drafted

3) Start nurse triage. Appoint IT/Data Quality Manager

Action: Nurse triage commenced but discontinued through staff turnover and sickness. IT/Data Quality Manager appointed.

4) Premises to be improved and expanded

Action: LIFT development commenced with careful planning to avoid damaging good working environment - applies to temporary accommodation and final build.

Guidance for Completion of Remainder of Application form

The following sections have been designed to mirror NHS developments like appraisal, re-validation and clinical governance. There will be further modifications to match the new contract. The intention is to avoid duplication of systems for assessment of doctors.

The purpose of the application form is to move the responsibility away from the visiting team having to find the evidence, to the practice providing the evidence for good practice. This will enable the visit to concentrate where it matters, namely on the practice and trainer in their teaching role.

The application form sections exactly match the Training Practice Criteria, which should be used for guidance.

The application form contains Microsoft Word Hyperlinks, which will link headings to the corresponding criteria, which are contained in Appendix 1 to the document. Use the Web toolbar back button to navigate back to the application box (this should appear automatically but otherwise can be displayed by selecting View, Toolbars, Web)

*The Evidence box contains examples of evidence, which might be appropriate for the assessment. Application forms do **not** need to reproduce information, simply list the evidence and indicate where the information will be available for the visiting team. Unless requested otherwise practices do **not** need to send any other documents with the application form, but must have them immediately available for inspection on the day of the visit. (Practices might want to consider referencing the application form to the documents.)*

In the Self-assessment against criteria box, practices are expected to summarise the key information in the evidence, and identify their strengths and weaknesses, and the plans for development. For guidance, this section might range from 2 words for the Revalidation box "not applicable" to a maximum of 250 words for a box like Performance Review and Medical Audit.

We anticipate that for many of the Visitors' Assessment boxes there will be a straightforward endorsement of the practice's own assessment.

Finally, you will find at the end of the application form a check box containing the Mandatory Criteria. You should be confident that you have fully achieved the relevant criteria prior to the visit, if there are concerns you need to discuss them urgently with the team leader before confirming the practice visit.

This is an evolving document and process, and feedback will be helpful for the review to be undertaken in 2004.

WORKED EXAMPLE

A3 Continuing Education

Evidence

List of CME undertaken in last 2 years, Form 3 and Form 4 Appraisal, Personal Development Plan, 360 degree feedback form, PUNS and DENS

Self Assessment against Criteria

My Personal Development plan for last year was too ambitious, but I am pleased that I attended regular clinical meetings and the consultation course. I receive full PGEA payment. My appraisal has helped me create a "smart" PDP for next year, and also encouraged me to keep a record of PUNS and DENS, and possibly undertake some 360 degree feedback. As a practice we are measuring ourselves against the new contract Quality payments to improve our clinical care, and we plan to include practice needs in our individual development plans.

Visitors' Assessment

Impressive portfolio containing record of educational activities. The PDP is realistic and achievable, with a balance between clinical and educational development. There are already plans to include needs assessment. Interesting discussion about relative merits of regular clinical meetings and longer educational programmes.

Guidance for Visiting Team

We recommend that visiting teams should change the structure of the day. They will have received the trainer's application form with the self-assessment in advance of the visit, and will already have an idea of the practice's perception of its strengths and weaknesses. There will be a considerable amount of information which the practice will provide on the day as evidence of performance. The team should probably spend the first hour and a half of the day reading through the evidence.

Teams will have the option of undertaking a comprehensive verification of the practice's self-assessment, or adopting a more in-depth assessment of selected areas. Priorities for the remainder of the day should be agreed by the team, and the developmental focus of the day may well be negotiated with the practice.

Teams should play to the strengths of the team members, who will probably take individual responsibility for sections. For example, the practice manager may volunteer to take the lead on completion of Sections B and D, allowing the visiting educators to concentrate on the assessment and development of the Trainer as Doctor and as Teacher.

The Visitor's Assessment sections should identify specific highlights and celebrate achievements of the practice, and when necessary justify concerns with specific examples gathered from a number of sources. Recommendations for development should be supported by clear evidence for the need for development, and are most effective when they are multiple and practical and pitched at the practice's stage of transition. We anticipate that for many sections the visiting team will simply endorse the practice's self-assessment with comments like "Agree with practice assessment" or "Practice evidence accepted".

The practice report will use the original trainer's application form, and therefore the whole process needs to be electronically based. Team leaders should insert the Report Summary page at the beginning of the report, attached as Appendix 2. This includes the details of the visiting team, the date of the visit, and then the familiar sections of Highlights, Recommendations and Observations about the practice and the trainer respectively.

They should also include guidance for the Training Practice Approval Committee about whether they recommend approval without reservations, approval with reservations, or non-approval. Team leaders should specifically define and justify their reservations.
The final decision remains the responsibility of the committee.

A. The Trainer as Doctor

1. Professional Values

Evidence

Appraisal folder - Form 4, Personal Development Plan, Patient Feedback, Significant Event analysis, 360 degree feedback.

Self Assessment against Criteria

I am a conscientious and caring Doctor, and enjoy practicing Family Medicine. I am by nature a reflective practitioner, and my involvement in Training has helped to further develop my insights into key areas of my work.

Visitors' Assessment

All attest to Tom's high standards of professionalism (also demonstrated on the consultation video)

2. Revalidation

Evidence

Appraisal folder

Self Assessment against Criteria

My Appraisal folder and PDPs will contribute to my application for revalidation.

Visitors' Assessment

We anticipate no problems. All partners have been appraised.

3. Continuing Education

Evidence

Appraisal folder, Personal Development Plan

Self Assessment against Criteria

I have prepared and followed Personal Development Plans from April 2001.

My education programme includes in-house educational meetings / bimonthly Practice Journal Club / CME meetings /and reading prompted by day-to-day patient encounters.

Appraisal has provided an opportunity for discussing and re-framing my current PDP.

Visitors' Assessment

Tom was able to demonstrate a 'joined up' approach to how he integrated his personal development with the needs for the team. As lead for diabetes he had identified the need for an up-to-date protocol. This he developed with involvement from both the registrar & lead nurse & then refined with criticism from the team and comparison with national standards. His own educational needs were addressed with input from the local consultant. As a result the team decided to improve their recording of data & the updating of information from letters received.

B. The Practice as Provider of Health Care

1. Commitment to general principles of good practice

Evidence

E.g. Practice development plan, Patient Satisfaction Questionnaire, QTD / QPA Practice leaflet, Health and Safety report, Patient Representation Group, Appraisal process for staff, Uses Good Medical Practice for general practitioners in work and teaching, Confidentiality protocols, Risk Management protocol, Employment legislation

Self Assessment against Criteria

Our Practice Team is committed to high quality patient care, and to education. We are proud of the friendly supportive atmosphere in the practice, in which the input of all team members is valued.

The Practice Development Plan has been dominated by LIFT, building design, moving and nGMS. Time needs to be spent formalizing direction in particular with plans for training when relocated in our new building F2s (how many) registrars (how many) and PRHO.

Other issues for PDP include further work on access/nurse triage/reception philosophy.

Clinical areas on which to focus include Diabetes and COPD.

Developing the intranet and website will be beneficial

Visitors' Assessment

The practice is a very caring, supportive practice. The patient satisfaction questionnaire undertaken last year was generally good with the exception of access. The practice had audited its capacity and demand which resulted in the employment of an assistant, the introduction of a Health care Assistant and nurse triage. Unfortunately due to staff shortages the nurse triage had to be abandoned but having recently recruited a new practice nurse will hopefully introduce it again in July this year.
3 years ago the practice achieved the QTD Award however due to a shortage of assessors in the Oxford area have not been able to renew this.
The staff all have contracts with the exception of the very latest recruit who only started on Monday of the visit week.
The administrative staff have annual appraisals carried out by Maggie and one of the partners. The nurses have not yet been included in this process but Maggie hopes to rectify this in the near future. This has not restricted the development of the nurses, Jeanette,

the senior nurse, has completed the asthma diploma and Ali, the recently appointed nurse has been taking part in as much training as is available and will take the lead with the newly reintroduced triage system when she has completed the latest training course in June.
Including the registrar in the appraisal process will be considered however this may be at the expense of the partner as it may be too threatening for staff to be appraised by 3 people.

2. Prevention And Chronic Disease Care

Evidence

E.g. Chronic disease protocols with identified lead doctors/nurses. Details of Sustained Quality Payments targets, Recall systems for patients, Disease registers, NSF audits, new GP contract Quality Targets

Self Assessment against Criteria

We have done extremely well on the QOF achieving 960 points of our 990 aspiration. We were let down at the last minute by nurse appraisals, CPR training and holistic points. Considering the move we felt we did extraordinarily well with minimal exception reporting (46 patients out of population 8100).We know our weak spots and are confident we can continue to improve. Higher smear and immunization targets are reached but a major struggle every month and it has been hard to get robust systems in place, but members of staff are starting to take responsibility. The clinical work is often done but administrative systems let us down. We need to get clinicians to obtain informed dissent.
Audits are available on the intranet and in hard copy. We are particularly proud of our active plan to ensure those with CHD receive secondary prevention with statins especially as this is not rewarded in the contract, but an example of best practice.
Recall systems for clinics have been improved to avoid recalling patients who have been recently seen.
Many protocols have been recently redrafted and are available on the intranet. We are pleased that these have been specifically adapted for our practice and combine best and pragmatic practice from NICE, national societies and the new contract to give a workable and clear document.

Visitors' Assessment

Since the last visit protocols have been developed for the finding of raised BP, IHD, COPD,IIDM and criteria for addition to the Mental Health Register. Each of these protocols has an identified lead clinician and has been recently updated. Particularly in the areas of IIDM and COPD it is evident that the drive to meet quality markers has raised the standard of care delivered to patients. There are also many examples of protocols relating to administrative or procedural systems being developed (e.g. Notes summarisation, home visits, repeat prescribing etc) within the practice. Whilst some of the protocols are on the

intranet others are in EMIS or Word; hopefully locating these will become easier with the advent of additional IT input. The practice achieved 960 of their 990 aspiration points for QOF for 2004-2005.A remarkable achievement considering the disruption caused by the practice move.	
Sustained Quality Payment targets achieved	YES

3. Performance Review And Medical Audit

Evidence

E.g. Practice audits showing resulting changes, Significant Event meetings, Patient feedback audits
Complaints procedure and audit of complaints
PACT information, Practice prescribing audits

Self Assessment against Criteria

Many audits are undertaken on a regular and daily basis. A trail of these can be found in the EMIS search module. All MAAG audits are completed. A weakness of audit is completing the cycle though this is achieved more often than we realize. Auditing to a standard is less often achieved. Nevertheless change is very often achieved as result of audit. Eg Appointment waiting times audited-change to appointment times-re-audited-improved-practice questionnaire shows complaints re waiting time-re-audited-further change to schedules

Visitors' Assessment

QOF has driven numerous quantitative audits the results of which have been discussed at monthly focus meetings. Opportunities for additional data entry, alteration of templates, increased awareness of coding or diagnostic criteria have resulted with marked improvement in many disease performance markers particularly IHD. The patient survey revealed that patients believed appointment waiting times were too long- adjusting the length of appointments taking account of each doctor's personal preferences has significantly decreased waiting times and allowed the team to meet regularly for coffee. Although there are not many formal qualitative audits (Li monitoring-complete audit cycle 2003 and Cancer care review Dec 2004 and April 2005) there are many examples on ongoing audit cycles where change results (e.g. Use of statins in secondary prevention of IHD).Registrar use and access to audit cycles would be facilitated by better systematic recording. Development of the practice intranet and agreement as to where these changes will be logged could develop this.

Significant event meetings are held regularly and all members of the primary health care team are encouraged to contribute. These meetings are very productive and it has been suggested that their value might be further enhanced if a lead person was responsible for ensuring that recommendations resulting from the meetings were actioned and reviewed. The practice has a comprehensive complaints procedure and meets periodically to discuss learning points resulting from review of complaints or prescribing data

4. Medical Records

Evidence

E.g. Practice audit of records, Visitors' audit of records
Notes summarisation protocol, Registration procedures/protocol, Protocol for IOS claims
Medical Record system, Practice IT strategy

Self Assessment against Criteria

We transferred to EMIS in October 2001 and made a rapid transition to entering all consultations on to EMIS, and instituting paper-light Practice. We have scanned all documents since August 2002.

We instituted a programme to transfer our paper-based summaries to EMIS, following protocols. 90% of the notes now have an updated computer summary.

We have a system for continuously updating summaries from hospital letters, which works well.

Visitors' Assessment

We saw a very high quality of records and notes summarization. There were, however, one or two gaps due to failure to transfer important data from hospital letters. We suggest you revisit your system to develop a method that doesn't depend upon the doctors

Percentage Notes summarized	90%

C. The Teacher

1. Previous Experience

Evidence

Years of experience in general practice, Years as trainer
Sessions in practice, Arrangements for cover

Self Assessment against Criteria

I trained on the Oxford GPVTS from 1984-1987, then worked as a G.P. in New Zealand from 1987-1988, before joining a Training Practice in Suffolk in August 1989.

In 1990 I returned to Oxford, joining my current Practice.

I did the New Trainers Course in 1994, and have been a Trainer since 1995, mentoring successive registrars up to February 2003, when Peter von Eichstorff also started training.

I work 8 sessions a week in the Practice, of which one is devoted to my role as Trainer. Cover for the registrar in my absence is provided by all the Partners.

Visitors' Assessment

As above, extremely experienced, supported by a learning organization Out of hours experience for the registrar is currently provided by both trainers in the practice, an added resource is the salaried doctor (& previous enhanced registrar) Dr. Ahsan Alvi who works 3 sessions/week for OXEMS & has undertaken the OOHs teaching course

2. Preparation for Teaching

Evidence

See Appraisal folder/PDP

Self Assessment against Criteria

I have completed the New Trainers Course in 1994, and have since attended the 3-day Consultation Skills Teaching Course and the Experienced Trainers Course at Cumberland Lodge.

Visitors' Assessment

From reflection on his experiences with a previous registrar Tom has identified his educational needs to revisit assessment & feedback, particularly for learners at different stages of the registrar year. This could be addressed by attendance at the Oxford PGMDE experienced trainers course.

3. Continuing Commitment to Teaching

Evidence

See Appraisal folder/PDP/Course Organiser's Report

Self Assessment against Criteria

I regularly attend our bi-monthly Trainers' Group meetings. Recent topics for discussion have included the use of literature in training/ Registrar Appraisal/ and Video Tutorial Analysis.

I have attended 3 Trainers' Study Days in the past 2 years- the June 2003 Educators' Conference in Milton Keynes; MRCGP Video Training; and Senior Registrar Training/ GPWSI.

I applied to attend the 3-day Clinical Supervision Course in February/March this year, facilitated by John Launer from the Tavistock Clinic. Unfortunately the first day clashed with my holiday, but I am on top of Philippa Moreton's list for the next time this course is run.

I have also applied for 2 days Appraiser Training in September/October 2005.

Visitors' Assessment

Tom appreciated his 2 year break from training which has re-energized him for training again. We support his decision to train as an appraiser and would encourage him to consider having other types of learners in the practice

4. Contribution to the Local Scheme and Deanery

Evidence

Course Organisers report

Self Assessment against Criteria

I regularly attend our Trainers Groups and visit other Training Practices for mid-term assessment of Registrars.

I have participated in in Deanery Registrar Selection interviews.

My last Training Practice Assessment visit was with Simon Street a month ago.

Visitors' Assessment

Agree with evidence provided

5. Relationships

Evidence

Appraisal folder, 360 degree feedback.

Self Assessment against Criteria

I am proud of my good relationships with patients and colleagues.

I am pleased to have instigated our regular monthly Palliative Care meetings, which have further enhanced communication and joint-working within our team.

Visitors' Assessment

Excellent relationships are apparent across the partnership. There are no 'prima donnas' with everybody pitching in and supporting each other

6. Assessment and Curriculum Planning

Evidence

Training Log, Records of Assessments, Induction Programme

Self Assessment against Criteria

My initial assessment of a new Registrar is based on review of the C.V./ Structured Interview (Kiddy Ring)/PEPs/ and case-by-case review of early Registrar Surgeries.

The curriculum is planned jointly, reflecting the Registrar's needs and wants, while I provide an overview. We plan sessions 4-8 weeks ahead, with formal review and planning sessions every 3 months.

For the review after the first 3 months I seek written feedback from all members of the PHCT re. the registrar.

On going assessments are based on joint surgeries/ case discussions/ video consultation analysis and feedback from patients and colleagues.

Visitors' Assessment

We saw multiple examples as to how Tom was able to assess his registrar's needs and then plan learning opportunities based on them (the need for cardiology experience was addressed in the tutorial of a problem case with chest pain). He has changed his teaching style to adapt to the fact the Inaz learns best from real case discussions. This is interesting given that Tom has identified a need to improve his assessment of need and giving feedback as he quite clearly has the skills necessary.

7. Teaching Record

Evidence

Training Log

Self Assessment against Criteria

Weekly reflection-sheets, assessments and curriculum plans are kept in a Training Log, of which the Registrar and myself both have a copy.

Visitors' Assessment

A comprehensive log was demonstrated

8. Methods

Evidence

Tutorial Video, Training Log.

Self Assessment against Criteria

I am always looking for opportunities for learning from day-to-day patient encounters and

encourage the use of actual cases during tutorial sessions on specific topics.

I am aware of the importance of modeling in education, and strive to demonstrate in my Practice the principles which I am trying to teach.

Our Practice Library has a reasonable range of books and journals, and we are always open to suggestions re additional books to purchase.

The Registrar has full internet access in her consulting room, and is encouraged to use e-resources such as the nELH, bmj learning, and doctors.net.

The Registrar participates in our bi-monthly Journal Club.

Visitors' Assessment

Agree with the above. Ably demonstrated in videoed tutorial

D. The Practice in Teaching

1. Partnership's Responsibilities

Evidence

Induction Programme

Self Assessment against Criteria

We emphasise from the outset that all of the Practice team is involved in Training and the Induction Programme ensures a wide-ranging input in the first 2 weeks.

De-briefing of the Registrar's early consulting sessions is scheduled to involve all the doctors, encouraging continuing involvement of all doctors in problem-case discussions.

Visitors' Assessment

Agree with the above. This practice has signed up to the ethos of a learning organization with all developed to exploit their potential. These developments are successfully managed by the practice manager Mrs. Maggie Perrin who herself is a qualified teacher. The registrar is encouraged to be involved in all practice activities and meetings.

There is a full induction programme with all team members including the admin staff.

2. Time For Teaching and Other Educational Activity

Evidence

Weekly timetable

Self Assessment against Criteria

The Trainer does one less clinical session each week to allow time for preparation and teaching.

Extra study leave is allowed for courses/ interviewing etc.

Visitors' Assessment

Agree with the above
The trainer arranges the clinical teaching programme and there is a half day protected time for the trainer and the registrar.
Maggie undertakes management tutorials although there is no structured programme; the registrar generally agrees the topic although Maggie does ensure there are sessions on finance and HR. There are currently no tutorials on subjects which the registrar may find useful on leaving the practice such as on partnership agreements, joining practices, what to look for in the accounts.
The practice nusrses do not have formal tutorials neither do the community staff but all are available if the registrar should need to seek their advice. The admin team are included in the induction period but do not feel it is necessary to have any other for of educational sessions with the registrar.
The practice comes over as a very supportive learning organisation with excellent communication so that the registrar can approach any team member at any time should the need arise.

3. List Size and Workload

Evidence

E.g. *List size and patient profile, Annual consultation rates*

Self Assessment against Criteria

List size 8100. We have an interesting and varied Practice Population drawn from all social classes, and including a substantial representation of Ethnic Minority Groups- particularly South Asian (20%+) and African-Caribbean (12%).

Visitors' Assessment

Agree with the above.

4. Arrangements for Seeing Patients

Evidence

Registrar appointments schedule.

Self Assessment against Criteria

Registrar workload is organized to ensure sufficient time for developing consulting skills, and for reflection, balanced with the need to gain a sufficient breadth of experience- including experience of operating under the time pressure of NHS General Practice.

Thus Registrar surgeries are initially booked at 20-minute intervals, eventually progressing to 15, and finally 10-minute intervals.

Chronic disease management and experience is scheduled via shared sessions with PNs and "referrals" from PNs.

Visitors' Assessment

Agree with the above. The registrar is seeing a varied case load which she is confident to deal with. There is no selection of patients for the registrar they are included in the appointment system as any other partner. The difference is that they start with 20 minute appointments, reduce to 15 minutes after 3 or 4 months then 10 minutes towards the end of the year.

5. Practice Premises, Equipment and Library facilities

Evidence

Registrar's room, Video, I.T.

Self Assessment against Criteria

The Registrar has her own consulting room with computer with Internet access.

In our current, temporary, premises the library is split between the Registrar's room and the other Partners' rooms.

Visitors' Assessment

The premises are temporary having been converted from offices for use by the practice whilst their new surgery is being built. The conversion has been very cleverly done and provides good size consulting and treatment rooms. The office space is limited but good use has been made of what is available. It feels quite light and airy and everyone seems very appreciative of the room available. All the partners have their own reasonable well equipped rooms as does the registrar. The library is shared between the registrars consulting room and one of the partners.

6. Involvement of the Partnership and Primary Health Care Team

Evidence

Training Log, Timetable of Practice Meetings.

Self Assessment against Criteria

The Registrar participates in all Practice Educational and Management meetings, and is encouraged to express her ideas and discuss others' views.

A key part of the Registrar's Audit Project is the involvement of all relevant team members at each stage. See also D.1 (above).

Formal tutorial sessions are scheduled with other team members through the year, as appropriate, and we also look for opportunities to involve the registrar in management activities- e.g. recruiting and appointing new staff members.

Visitors' Assessment

Agree with the above - all participate in an 'open door' policy. The registrar is invited in to view interesting cases. Clinical problems and puzzling patients are discussed at coffee time that all attend. Marie, the patient services manager, provides a particularly good pastoral support and informal guide to registrars as to how the practice works. Educational opportunities are exploited – Enas sat in on the interviews for a new receptionist. Enas was encouraged to review COPD for her audit project to give her exposure to the wider expertise (particularly nursing) in the practice team

Dr Kathryn Ward has extensive experience of teaching medical students and her support is much appreciated by the retainee, Dr. Ellie Holloway, as is her expertise in dermatology by the registrar. This is a practice that could easily support 2 full time learners in the future when the accommodation is finished.

E. Specific Regulations for GP Registrars

2. Night and Weekend Work

Evidence

Practice arrangements for out of hours

Self Assessment against Criteria

We cover our own patients outside surgery hours, from 6.00-6.30pm, and from 8.00-8.30am, and the Registrar participates in the cover rota. The rest of OOH care is provided by OXEMS- a PCT-managed organisation. At present none of the Partners are doing OXEMS sessions, but we are liasing with other approved trainers to ensure that Enas can complete the necessary 12 mentored sessions.

Visitors' Assessment

Agree with the above

3. Summative Assessment

Evidence

All our previous registrars have passed summative assessment at the first attempt.

Self Assessment against Criteria

I am confident of guiding the Registrar through Summative Assessment.

We review the Trainers' Report together at the beginning of the year, and I keep notes from joint surgeries/ videos/ case-discussions etc. as evidence for completing the report.

Teaching on consulting skills and video consultation analysis is given a high priority.

I have discussed the opportunities for a range of different written submissions under the National Project Marking Schedule with recent registrars, but all so far have opted for the traditional audit

format.

Visitors' Assessment

Agree with the above

4. **Contract or Letter of Employment**

Evidence

Copy of contract

Self Assessment against Criteria

We use a standard Registrar Contract.

Visitors' Assessment

Agree with the above

MANDATORY CRITERIA CHECK
Are there any areas of these criteria about which you have concerns prior to the training practice assessment visit?

MANDATORY CRITERION	Fully achieved	Needs Improvement
Teachers will be revalidated when required by the GMC.	✓	
Teachers should have an educational development plan.	✓	
The practice will need to demonstrate that it achieves the targets set out in the sustained quality payments	✓	
The practice must demonstrate active audit cycles resulting in change in practice.	✓	
Patient records should be 80% summarized and this should be demonstrated at the practice visit.	✓	
From 2004 the Certificate of Medical Education (or equivalent) will be mandatory for all new trainers.	n/a	
Trainers must have attended a course for the general development of their teaching skills, which include communication and consultation skills, since their last inspection visit.	✓	
Trainers must belong and contribute to the local trainers group.	✓	
Records and logs must be kept by each trainer and each registrar.	✓	

Please detail any concerns you have:

Records Computer and/or Paper Notes

	Practice Audit	Visitor's Audit
Number of Sample	100	12
Notes in chronological order		12
Detailed consultation records with management plans		12

Summarised
 	
• Summary
  • Not updated
  • Significant omissions
		Updated, but some diagnoses from letters not entered in the computer record

Regular medication • Up to date authorisation • Drugs no longer used on screen		 Yes No
PACT prescribing data • Generic percentage • Cost relative to HA		
Adults 18-80 (BHS guidelines) • Number • BP recorded last 5 years • Smoking status (ever)		
Practice Cervical Cytology target over last year		
Practice Immunisation targets over last year • 2 year olds • 5 year olds		

APPENDIX 1 – TRAINING PRACTICE CRITERIA

A. The Trainer as Doctor

1. Professional Values

Teachers should be doctors committed to providing a high standard of care for their patients. They should believe in the importance of continuity of care, give a personal service and try to make it as comprehensive as possible. They should balance their own convenience against that of their patients and keep the interests of the wider community in mind. They should be of good repute and known for their integrity and have good relationships with their colleagues and staff. They should encourage patients' self help and keep in balance their need to be needed. Their clinical decisions should reflect the true long-term interests of their patients. They should see themselves as providing a service to their practice population, sharing with others the responsibility for promoting, preserving and restoring the health of the individual patients. Teachers should not display racial or sexual prejudice either in their practices or their teaching.

2. Revalidation

All teachers and teaching practices are expected to observe diligently and teach the professional guidance contained within the GMC publications *Good Medical Practice* and *Maintaining Good Medical Practice*. **Teachers will be revalidated when required by the GMC.** They will aspire to the excellent general practitioner as defined in *Good Medical Practice for GP's*. They should be able to display a high standard of clinical competence in their consultations, the long term care of patients, preventative medicine, prescribing, record keeping, auditing their own work and appropriate use of other members of the practice healthcare team and of colleagues in agencies outside.

3. Continuing Education

Teachers should subject their work to critical self-scrutiny and peer review and accept a commitment to keep up-to-date, to improve their skills and widen their range of services in response to needs identified. They must fulfill the annual requirements for the postgraduate educational allowance. **They should have and make available for inspection on the visit an educational personal development plan.**

B. The Practice as Provider of Health Care

1. General principles of good practice:

- The teaching practice should provide a high standard of care for its patients in order to provide an example for learners and to provide opportunities for learning. Services for patients should be accessible and include information for patients, the management of chronic illness, effective prescribing, appropriate investigations and referrals, preventive care and health promotion and the care of different groups within the practice population.

- The practice will need to demonstrate in its application a commitment to development over time. It should demonstrate how it involves patients in the delivery

and review of the services it provides. This can be done by means of a patient satisfaction questionnaire. The practice should also demonstrate a commitment to reviewing any complaints that are received and the actions taken.

- The primary care team is an essential part of general practice and working within it a vital part of the learning experience. The teaching practice must therefore be able to demonstrate an effective primary care team, including appropriate values, team working, continued professional development, patient involvement, quality improvement, records, registers, information technology, management, premises.

Specific areas of good practice:

2. Prevention And Chronic Disease Care

The practice must be committed to organised preventive medicine and effective chronic disease care. It therefore has to maintain an age, sex, disease and other registers, which are increasingly being held electronically. The partners should be able to state what their policies are in relation to health education, case finding, screening and protocols for chronic disease care.

Prevention data in individual patient records should be easily accessible. The practice must be able to produce prevention data in relation to its population. There should be appropriate child health and developmental surveillance arrangements and effective child immunisation levels.

Data relating to chronic disease surveillance should be easily identifiable in the medical records, and guidelines for nurses, where they are providing follow up care, should be available.

The practice will need to demonstrate that it actually achieves the targets set out in the sustained quality payments and this will be part of the evidence presented before the assessment visit.

3. Performance Review And Medical Audit

General practitioners are required to audit their work and it is important that registrars are fully prepared to undertake this.

The partners and other members of the health care team should be able to demonstrate how they identify strengths and weaknesses in the care of patients and how they take appropriate action to improve that care.

The practice must have in place an active programme of audit, which demonstrates the full audit cycle and the application of both standards and criteria. The practice will demonstrate the changes that have resulted from its audit programme and discuss the process of selection of areas for audit.

The training practice must be able to demonstrate that the audit process is being taught. The practice will have a practice professional development plan and be able to discuss the content and process of its development

4. Medical Records

The standard of medical records in a teaching practice should be sufficient to support a high standard of clinical care. Doctors and other members of the health team should be able to obtain necessary information rapidly and accurately.

Records are increasingly held electronically, and by 2004 the government expects all practices to be computerized. Training practices already use computers extensively, but practices will be expected to demonstrate a system to change from manual records to computer based records, and that the time frame for that change is appropriate.

Medical summarization has been a problem for many practices for some time. It is recognized that summarization for all practices is a matter of clinical governance and that practices may approach the Primary Care Trust to help fund notes summarization.

Patient records should be 80% summarized and this should be demonstrated at the practice visit. The summary can be in the notes or computer or a combination. The practice needs also to demonstrate how it will move from 80% to 100% summarization, and again the method and time frame for achieving this standard.

- Record cards, letters and results of investigation must be filed in chronological order after appropriate pruning.
- A full legible entry must be made at each doctor-patient consultation. The management and in particular, medication, should be clear. Management plans for the patient must be documented sufficiently that the registrar would have no problem following the plan from the records.
- The records of all patients on regular medication must contain easily discernible drug therapy lists.
- Each patient record should contain a medical summary or problem list. There must be a clear and effective system for the creation and updating of these summaries and a written agreement by the practice about the content.

Because medical records contain confidential information the GMC has advised that practices inform patients that their records may be inspected by other doctors for the purposes of education and training and that they have the right to object if they wish to do so. This information may be provided in the form of a notice in the waiting room and in statements in practice brochures.

The visiting assessment team will be pleased to accept the quality team development or quality practice award as evidence in many areas of the assessment process and practices are encouraged to undertake these initiatives

C. The Teacher

1. Previous Experience

A teacher must have at least two years experience in general practice. This can be either as a principal or salaried partner or assistant in a GMS or PMS practice. They should have a minimum four sessions per week regular commitment to the practice. They must be able to demonstrate (if not full time) that the teaching and arrangements

for the learner are not compromised by their absence, and that the registrar has access to the breadth of teaching from all members of the primary healthcare team.

2. Preparation for Teaching

A new teacher will be expected either to have attended an approved course for new trainers or be able to demonstrate that they have equivalent experience to be able to teach and train. It is expected that the vast majority of new teachers will attend a recognized course.

The demonstration of equivalent experience will be by the production of a portfolio outlining courses and experience that demonstrates the individual's ability to train. This could include attendance at consultation skills courses, having already gained a certificate or higher degree in medical education and experience of teaching other members of the primary healthcare team or undergraduates. Portfolios will be reviewed by the selection committee who will advise if a practice visit is applicable or what further evidence an individual needs to produce to fulfill the criteria.

All prospective trainers on the new trainers course are encouraged to undertake the Certificate of Medical Education. **From 2004 the Certificate of Medical Education (or equivalent) will be mandatory for all new trainers.**

All individuals are expected to be regular members of their local training group for at least 6 months prior to application.

New trainers must have the MRCGP (either by examination or by assessment of performance). New tutors must have passed the MRCGP or other equivalent higher professional examination. This demonstrates a willingness to be assessed and the attainment of an appropriate level of expertise. Preparation for an examination is also valuable preparation for teaching.

New trainers must be familiar with educational aims for vocational training and methods of teaching and assessment. A trainer should also be able to help the registrar prepare to sit the MRCGP Examination at the end of vocational training. Trainers will need to be able to demonstrate that they are able to teach and prepare the registrar for summative assessment and understands the criteria and components of both summative assessment and the MRCGP.

Teaching objectives (including those involving the primary health care team) must be clear and available in writing for inspection.

3. Continuing Commitment to Teaching

Teachers will regard teaching and meeting the educational needs of their registrar/student as a major commitment. This will be reflected in time, enthusiasm, and the desire to develop as a professional teacher. They should be aware of new ideas and developments in general practice and with the main literature of general practice. **By the end of their first two years approval they must have attended a course for the general development of their teaching skills which includes communication and consultation skills. Thereafter they must attend appropriate courses for teachers**

every three years. The teachers should demonstrate this commitment by ensuring that their personal development plan includes their own development as a teacher.

4. Contribution to the Local Scheme/Departmental teaching and Deanery/University

Trainers must belong and contribute to the local trainers group. They should be willing to work with, to support and be supported by colleagues in the development of teaching. Trainers should be prepared to assist and support the Course Organiser with the organisation of the scheme including help with the day release courses, and assessment of progress of SHOs and GPRs in training. After appointment, trainers will be required to become members of a visiting panel for re-approval of other trainers and their practices in the Deanery. They will be expected to have undertaken an assessment visit and will need to highlight that they have done so with their application. Such visits are a mandatory part of being a trainer and are a useful educational experience for all trainers.

The trainers may also be expected to take part in the recruitment and selection process for new GP registrars.

5. Relationships

Teachers should be able to develop and maintain an open, honest relationship with their registrar/student and generate enthusiasm and motivation in them. They should have the ability to understand their learner's problems and to communicate with them. They should demonstrate ability for logical and critical thought and a willingness and ability to encourage the registrar/student to direct their own learning.

6. Assessment and Curriculum Planning

The trainer must be familiar with the Oxford Deanery Priority Objectives of General Practice Vocational Training (RCGP Oct Paper 30). The trainer and registrar must jointly assess the registrar's needs at the start of the programme and these needs must be regularly reassessed during the course of the attachment. These assessments must be guided by the trainer's aims of what needs to be achieved by the end of the attachment and must cover appropriate aspects of knowledge, skills and attitudes. The trainer and registrar must negotiate appropriate educational goals and curriculum planning in the light of these regular assessments and the trainer will need to keep in mind both short and long term aims. These must reflect the increasing confidence and competence of the registrar we well as their personal growth.

7. Teaching Records

Records and logs must be kept by each trainer and each registrar so that it is possible to ensure that important aspects of training have been covered, that comprehensive assessments have been made and that curriculum plans are logically laid out.

8. Methods

The teaching must be planned and prepared on a logical basis in relation to the educational goals. The teacher should encourage the registrar/student to direct his or

her own learning and to develop self-awareness and critical thought. They should be able to use a variety of appropriate and effective teaching methods and be able to direct the learner to additional resources when required.

The teacher will be expected to demonstrate to the visiting team that they practise student centred teaching and patient centred consultations. It is expected that this will be demonstrated by video evidence and in discussion at the assessment visit.

Teachers should be able to direct learners to the use of additional resources especially those involving information technology. Other members of the partnership and the primary health care team will have important contributions to make.

D. The Practice in Teaching

1. Partnership's Responsibilities

The learner needs to be accepted and treated as a colleague in the practice and involved in the work of the practice by all its members. All partners should be willing to accept the educational purpose of the learner's attachment and their own responsibilities as members of the teaching practice. These responsibilities include welcoming the learner as a colleague and being willing to discuss and share the care of their patients. They should also recognize the financial contribution that teaching makes to the practice and be willing to participate in and support the development of the practice for teaching.

2. Time For Teaching and Other Educational Activity

The teacher and partners must make adequate time available for the provision of teaching and supervision within the practice and for other outside activities for the teacher. The trainer will require the equivalent of two half-day sessions per week.

The trainer and partners will need to be accessible to the registrar to discuss problems when required. Medical students must always be fully supervised when seeing patients and clinical responsibility must always remain with the supervising doctor.

The trainer must provide uninterrupted teaching time of at least two hours a week for teaching in normal working hours. The tutor must provide at least one hour of uninterrupted teaching time per week. This will normally be in one session and may be delegated usefully at times to partners and other members of the practice team. The learner will also require the opportunity for regular joint consultations and must be free to attend courses organized outside the practice.

The teacher will need time to attend the teachers' group, teachers' courses, take part in visits to other practices and scheme activities, and also time for his/her own educational activities.

3. List Size and Workload

The list size and workload of the teaching practice should be large enough to offer the learner adequate clinical experience but not too large to prevent time being available for teaching and for attending courses by both teacher and learner. The practice needs to

be able to offer a package of experience that would be regarded as normal everyday general practice not just specialist clinics.

4. Arrangements for Seeing Patients

The arrangements for the registrar/student to see patients should be planned to meet their educational needs. Learners need to have the opportunity both to have the time to study patients and their problems in depth and also, for registrars, to experience working at a similar rate to the partners in practice. These include seeing a representative cross-section of patients including those with long-term problems, and opportunities to establish continuity of care for patients. Learners must not be seeing patients at times when they do not have the opportunity to obtain advice from a partner present in the practice.

Where students are observing or conducting solo video recorded consultations, the practice must make appropriate arrangements for informing patients, offering them the option not to take part if they so wish and to consent if they are agreeable. The structure and length of appointments will require appropriate adjustment. Facilities must be available to allow the student to consult alone and make video recordings from time to time. Students should also have the opportunity to visit patients in their own home.

The tutor and practice must provide a framework whereby teaching within consulting sessions is practical and effective.

5. Practice Premises, Equipment and Library facilities

The learner should be able to consult in a well-equipped room and it is desirable that they should have a consulting room of their own. The practice should ensure that the registrar/student is provided with adequate equipment to carry out consultations and home visits. Access to video cameras must be provided.

Appropriate IT support should be available in the practice. This includes a computer with appropriate search facilities, internet and Medline access as well as facilities for private study (The University Department will provide the computer and software for students).

Equipment should be provided for presentations by the student/registrar.

The practice must have an organized library that is accessible to all members of the team and the registrar/student. The library should contain adequate up to date reference books, books relevant to general practice and recent copies of the major journals relevant to general practice.

6. Involvement of the Partnership and Primary Health Care Team

All partners should have a commitment to teaching. The learner should have the opportunity of participating in the work of the team and of attending special clinics. The learner should be encouraged to attend primary health care team meetings and educational meetings that should be held in the practice partnership. There should also be regular meetings for the purpose of planning and the learner should be encouraged to attend these.

Registrars should have access to all aspects of practice management, including business finance and employment.

E. Specific Regulations for GP Registrars

1. Appointment and Performance of Registrars

Appointment of registrars can only be made using the centralized Deanery selection process. Starting dates, which should be co-coordinated, should be agreed by the local trainer's group.

Whilst the registrar works in a teaching practice, he or she is also part of the local scheme. If problems arise in a registrar's performance the Course Organiser and local adviser should be involved at the earliest opportunity. Registrars who are appointed as an extension to the normal vocational training period because of actual or anticipated difficulties in certification must have their educational plan reviewed in consultation the local Course Organiser and Associate Adviser within the first month of appointment.

2. Night and Weekend Work

The provision of out of hours work is an important feature of NHS practice. Regardless of the system operating for each individual training practice, registrars must have sufficient exposure to all aspects of out of hours care to prepare them for independent practice, whatever type they subsequently choose.

The GMSC GP Registrars' Sub-committee in 1996 calculated that this involves between 5 and 10 million patient hours of cover for each registrar. This would mean that, for example, for a practice of 10,000 patients using the traditional system, the registrar would be on call for between 5 – 10 full weekends and 20-40 weekday nights approximately. If they were involved in Co-op sessions, the frequency would obviously be a lot lower. The GMSC Sub-committee has produced a useful list of administrative and clinical educational objectives. These include being familiar with NHS regulations regarding out of hours care, being able to demonstrate strategies for dealing with sudden emergencies and prioritising work.

Because of the changing situation in out of hours work, training practices differ in their own arrangements and some adaptation may be required. Whilst it is not feasible to lay down fixed arrangements, it should be possible for each trainers group to agree what is reasonable and equitable for their scheme. The following points should be noted:

- All registrars must participate in out of hours work in order to achieve the relevant objectives. Doing more emergency work whilst the practice is open as an alternative is not acceptable (The Joint Committee on Postgraduate Training for General Practice expects registrars to do weekend and night work).
- Ideally, registrars should do some out of hours work for their own practice in the traditional way and also have the experience of working in a co-operative. Co-operatives vary as to whether they allow registrars to work without the trainer or a partner being physically present. In any event, registrars should not work on their own in co-operatives until they are some way through their GP period, have worked

alongside their trainer or a partner and are considered experienced enough. There also need to be mechanisms to call in the trainer or a partner if the work becomes too intensive. Doing co-operative shifts with a partner is a useful educational exercise. Feedback and debriefing after a session on call is important, especially in the early part of a registrar's attachment.

- When the registrar is on duty, their trainer or a partner in the practice must always be available to help and advise.
- The training practice is responsible for making arrangements for telephone cover while the registrar is on call.

Registrars should receive appropriate teaching and support for dealing with violence. It is recommended that training practices should consider the use of mobile phones for registrars.

- Registrars should not take part in deputising services. However, it may be appropriate for them to visit deputising services and possibly to observe the work of deputies.

Trainers should document the requirements for out of hours work and Saturday morning work which is carried out by full-time registrars in their practices. This is so that the requirements for any part-time registrar can be easily calculated to ensure that they comply with EU legislation.

Registrars are not allowed to receive remuneration over and above their normal salary. However, money earned from working for a co-operative could be used, for example, for a fund for educational purposes within the practice.

The underlying principle is educational and the purpose of out of hours work is to prepare the registrar for work as an independent general practitioner.

3. Summative Assessment

As part of summative assessment, the registrar will submit an audit using the eight point criteria or a national project, and will be encouraged to present the findings to the practice.

Trainers are expected to use any appropriate information gained in a Summative Assessment process to inform their decision on signing a Certificate of Satisfactory Completion (VTR/1). They must be able to facilitate the technical and administrative aspects of the implementation of Summative Assessment.

4. Contract or Letter of Employment

The Registrar is an employee of the teaching practice and must be provided with a letter of employment or written contract. This contract must not contain conditions that restrict the registrar's rights under the Statement of Fees and Allowances, or that interfere with their training.

Appendix 2

Training Practice Visitors Report Summary **OXVT5 (2003)**

Oxford Deanery

NAME OF TRAINER	Tom Nicholson-Lailey	Renewal

Practice Name Address	East Oxford Health Centre Raglan House 23 Between Towns Road Oxford OX4 3FQ

Date of Visit	26.5.05

Visiting Team	Dr Nick Yates Dr David Metson Dr Viv Carter Ms Pat Thurling Dr Jill Edwards

For the Practice

Highlights

Enthusiastic, excellent team, supportive of themselves and the registrars with a strong ethos of a learning organization. All are empowered to develop themselves and to make changes to improve the practice. Fantastic practice management and organization; they were only closed to patients for two days whilst moving premises. All appears to be running smoothly yet they have been in their temporary accommodation for only 2½ months. Meanwhile they have achieved more than their aspiration through QUOF. This practice has the potential to support at least 2 fulltime learners when in its new premises; we encourage you to consider a F2 doctor who would develop the teaching ability of the wider team further.

Recommendations against the Criteria

Understandably most of the audits undertaken in the past year have been directed towards QUOF targets. Improvements have been made to patient care as a result of these; there is a culture of making things change in the practice. Unfortunately the changes made are not recorded systematically, thus it would be difficult for a registrar to appreciate that the audit cycle is actually being completed. Similarly for significant event meetings, the registrar is empowered to participate, but the changes made are not consistently recorded or revisited to ensure that they have happened. Development of the practice intranet and agreement as to where these changes will be logged could develop this.

We saw a very high quality of records and notes summarization. There were, however, one or two gaps due to failure to transfer important data from hospital letters. We suggest you

revisit your system to develop a method that doesn't depend upon the doctors
Observations

<u>For the Trainer</u>

Highlights Tom is a very experienced, mature trainer who demonstrated his skills in being able to competently assess his registrar and then tailor his training to address the needs identified. He skillfully demonstrated the ability to check out the registrar's clinical safety whilst building her confidence. He is very successful in promoting the team approach to training
Observations We recommend that the Deanery could exploit your expertise further and suggest you could now 'move on' as a trainer; perhaps by using your experience to facilitate others either as a team leader, appraiser or course organizer. Alternatively should the performance development unit be looking for future coaches, this is a role that could suit your particular skills.

MANDATORY CRITERION	Fully achieved
Teachers will be revalidated when required by the GMC.	✓
Teachers should have an educational development plan.	✓
The practice will need to demonstrate that it achieves the targets set out in the sustained quality payments	✓
The practice must demonstrate active audit cycles resulting in change in practice.	✓
Patient records should be 80% summarized and this should be demonstrated at the practice visit.	✓
From 2004 the Certificate of Medical Education (or equivalent) will be mandatory for all new trainers.	✓
Trainers must have attended a course for the general development of their teaching skills, which include communication and consultation skills, since their last inspection visit.	✓

Trainers must belong and contribute to the local trainers group.	✓
Records and logs must be kept by each trainer and each registrar.	✓

Recommendation for Appointments Committee

Approval without reservation	✓
Approval with reservations *Reasons*	
Non-Approval *Reasons*	

Team Leader: Dr Jill Edwards

Date: 1.6.05