

**OXFORD DEANERY TRAINER APPLICATION**

**OXVT3 (April 2003)**

|                            |           |                     |
|----------------------------|-----------|---------------------|
| <b>Date of Application</b> | 4..4.2005 | <b>TYPE</b> RENEWAL |
|----------------------------|-----------|---------------------|

|                |                                    |
|----------------|------------------------------------|
| <b>NAME</b>    | Peter Daniel George von Eichstorff |
| Date of Birth  | *****                              |
| GMC Number     |                                    |
| Qualifications | MA (Hons) MB ChB MRCP DGM          |

|                         |  |
|-------------------------|--|
| <b>Practice Address</b> | East Oxford Health Centre<br>Raglan House<br>23 Between Towns Road<br>Oxford |
| Telephone               | 01865 722214   |
| Fax                     | 01865 200421   |
| Email                   | *****  |

|                           |             |
|---------------------------|-------------|
| <b>Primary Care Trust</b> | Oxford City |
|---------------------------|-------------|

| <b>Doctors Working in the Practice</b> |     |                |   |              |         |
|--|-----|----------------|---|--------------|---------|
| Name                                   | Age | Qualifications | Status<br><i>e.g. Partner /<br/>Non - Principal</i> | F/T<br>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       |         |

| <b>Names of Doctors in Training</b> | <b>Status</b><br>GPR, PRHO, Retainer |
|-------------------------------------|--------------------------------------|
| Ellie Holloway<br>Enas Al-Debagh    | Retainer<br>GPR                      |

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

| <b>List of Key Staff</b> | <b>Job Title</b>                      |
|--------------------------|---------------------------------------|
| Maggie Perrin FT         | Practice Manager                      |
| Marie Molloy FT          | Patient Services<br>Manager/Secretary |
| Jeannette Rose 0.82      | Practice Nurse                        |
| Ali Shlugman 0.53        | Practice Nurse                        |
| Amanda Stribling 0.58    | HCA                                   |
| Patrick Wilmore 0.54     | Data Quality/IT Admin                 |
| Christine Williams 0.54  | Reception/Admin                       |
| Alison Stubbs 0.62       | Summariser/Admin                      |
| Rita Foster 0.70         | Reception/Admin                       |
| Laura Maier 0.72         | Reception/Admin                       |
| Heather Paterson 0.83    | Reception/Phlebotomist                |
| Rosalie Simpson 0.40     | Clerical Assistant                    |
| Vacancy 1 0.54           | Receptionist                          |
| Vacancy 2 0.54           | Receptionist                          |

### **Practice Description**

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

8100

Inner City Oxford, normally co-located on Cowley Road with 2 other practices  
Currently undergoing redevelopment under LIFT scheme to provide 1 stop surgery  
In temporary accommodation from Feb 2005 to 2007  
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

We are planning to expand our premises with the new surgery. This will allow the possibility of more than one learner in practice. 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**

Nil

### **Trainers outside commitments**

Occasional lecturer at Brookes University for Nurse Prescribing course  
Local Improvement Finance Trust (LIFT) Champion for PCT  
CHD lead for PCT

### **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 to hit new contract standards
- 2) Improve protocols and appoint lead clinicians  
Action: Appointments made and protocols drafted
- 3) Start nurse triage. Appoint IT Manager  
Action: Nurse triage commenced but discontinued through staff turnover and sickness. IT 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**

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| <b>1. <u>Professional Values</u></b>   |
| <b>Evidence</b><br><i>E.g. Appraisal folder - Form 4, Personal Development Plan, Patient Feedback, Significant Event analysis, 360 degree feedback, Continuity of care provisions</i>  |
| <b>Self Assessment against Criteria</b><br><br>My first appraisal was not as constructive or helpful as it might have been. This was due to the use of the online system which I found constraining and an absence of elaboration/development/reflection in the submission. As a result I have been on an appraisal training course. Feed back from recent registrars has been good as has feedback from my nurse teaching. My 360 feedback was satisfactory, but needs to be repeated soon.   |
| <b>Visitors' Assessment</b><br>Sound professional values were demonstrated in the videoed consultation we reviewed. There was a demonstration of risk assessment & information sharing with the patient; the relationship was an adult-adult one<br><br>Peter gives the impression of still not being fully convinced by the need to base his personal development on identified educational needs despite attending the appraisal course. His current PDP is based on the roles he undertakes for the practice (and thus specify the need for a generalized update) rather than his personal educational needs arising from those roles. We recommend the Deanery Experienced Trainers Course 'Planning learning based on need' to help him develop this further. |

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| <b>2. <u>Revalidation</u></b>   |
| <b>Evidence</b><br><i>E.g. Revalidation certificate, Appraisal folder</i> |
| <b>Self Assessment against Criteria</b><br><br>Not applicable             |

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| <p>Visitors' Assessment</p> <p>We anticipate no problems. All partners have been appraised.</p> |
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| <p><b>3. <u>Continuing Education</u></b></p>  |
| <p><b>Evidence</b><br/> <i>E.g. List of CME undertaken in last 2 years, Personal Development Plan including Educational Developmental plan, 360 degree feedback forms, PUNS and DENS</i></p> <p>Journal Club<br/> LIFT meetings<br/> CHD meetings<br/> Appraisal training<br/> Trainers group<br/> In house sessions (CPN Physio)<br/> PEPCD<br/> Incidental / Internet<br/> Journals</p>   |
| <p><b>Self Assessment against Criteria</b></p> <p>Wide variety of resources appropriate to personal learning style. Could think about using Doctorsnet (concerns re commercial aspect), BMJ learning (not member) Wenesday lunch meetings (oncall and often not relevant). Also more reading from books-recent titles ordered. I practice what I have learned eg Physio referrals, DVT referrals, not injecting heels, COPD guidelines, video criteria, using a resource folder, mindmapping.</p> |
| <p><b>Visitors' Assessment</b></p> <p>Peter keeps a portfolio of articles and references on his computer (a resource much admired by his previous registrar); this has been in response to the patients expressed needs that Peter has needed to address.</p>   |

## 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

Practice development plan has been overshadowed by LIFT, building design, moving and nGMS. Time needs to be spent formalizing direction in particular with plans for training when relocated in 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.

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| <b>2. <u>Prevention And Chronic Disease Care</u></b>   |     |
| <p><b>Evidence</b><br/> <i>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</i></p>  |     |
| <p><b>Self Assessment against Criteria</b><br/> 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 and our low key approach 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.<br/> 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.<br/> Recall systems for clinics have been improved to avoid recalling patients who have been recently seen.<br/> 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. We have also used submissions from registrar (mental health support groups) and retainer (appointment making for under 16s)</p> |     |
| <p><b>Visitors' Assessment</b><br/> 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.</p>   |     |
| 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. I conduct many audits and these result in beneficial change.

#### **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**

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| <p><b>Evidence</b><br/> <i>E.g. Practice audit of records, Visitors' audit of records</i><br/> <i>Notes summarisation protocol, Registration procedures/protocol, Protocol for IOS claims</i><br/> <i>Medical Record system, Practice IT strategy</i></p>   |  |
| <p><b>Self Assessment against Criteria</b><br/> During last visit we were in process of going paperless and summaries were poorer than we would like. As a result of pump priming, using medical students and and nGMS summaries are timely and complete. Our retainer started in March 2005 supports this view. Registration is a constant battle with TVPCA who make frequent unwarranted deductions and even deaths-particularly galling for those whose first language is not English when they have to struggle to reregister. The IT strategy has improved and was identified as a strength and weakness in the last visit. We now have an IT manager. We hope he will train to further support the intranet and website (indeed booked a Frontpage course today). We have been most fortunate that even the most reluctant partners have braved the technology which has made managing the new contract so simple. It is hard to conceive how far the team has come since the last visit when all appointments were hand written into a book that had to be manually ruled with columns and headings. No longer are notes pulled for every surgery, every phone call, every report; nor are they all refiled. Clinical staff are generally excellent at using Read codes and electronic messaging is used over 95% of the time. We need to get away from circulating documents to all parties and photocopying large documents for people. Further planning is required. I keep good records and use appropriate Read codes and record details relevant to the contract. However, I could write more and in particular record negative examination findings. I could record fuller summaries of visits and do this quicker. I usually type while the patient is talking for speed and accuracy, but patients may consider this inattentive/rude/threatening.</p> |  |
| <p><b>Visitors' Assessment</b><br/> 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</p>  |  |
| Percentage Notes summarized   |  |

**C. The Teacher**

- [Previous Experience](#)

**Evidence**

*E.g. Years of experience in general practice, Years as trainer*

*Sessions in practice, Arrangements for cover*

Full time partner for 9 years

Trainer for 3 years

8 clinical sessions in practice

On call doctor covers registrar, reciprocal arrangement with TNL, and other partners supervise and conduct tutorials during annual leave

**Self Assessment against Criteria**

Satisfactory. Always things to learn. Time to consider advanced trainers course?

**Visitors' Assessment**

Well 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

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| 2. <b><u>Preparation for Teaching</u></b>  |
| <b>Evidence</b><br><i>E.g. Attendance at trainers course or Equivalent Experience, Higher qualification in Medical Education</i><br>Course attended locally. Certificate of Medical Education completed (not passed)   |
| <b>Self Assessment against Criteria</b><br>I feel that I have completed the equivalent experience to the certificate of medical education having attended all the classes and completed the essays which are available to view. These were not resubmitted for personal reasons. My previous honours degree in psychology is helpful in this regard. |
| <b>Visitors' Assessment</b><br><br><i>Agree with the above</i>   |

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| 3. <b><u>Continuing Commitment to Teaching</u></b>  |
| <b>Evidence</b><br><i>E.g. Attendance teachers courses last 3 years, PDP – development as teacher, Reading for teaching skills development, Course organisers report, Mentoring/Co-mentoring</i><br>Regular attendance at trainers group<br>MRCGP video course<br>Annual trainers' course 2004<br>Appraisal training<br>6 month assessment<br>2 * Training visits<br>Mentor to past retainer  |
| <b>Self Assessment against Criteria</b><br><br>Attended all the usual expected courses. Slightly missed out on new trainers' course. Have put into effect learning points Eg improved marking and coaching of videos. Also downloaded and used MindGenius mind mapping tool after course to aid registrar in expanding thinking beyond medical matters. Used MRCGP video skills to good effect.<br>In addition I have mentored our retainer.. I have supported our practice nurse in her minor illness course in the past and the development of COPD implementation in the practice. I continue to lecture at Brookes on nurse |

prescribing.

**Visitors' Assessment**

*Agree with the above, but see recommendation in 1:1 re attendance at Experienced Trainers Course*

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| 4. <b><u>Contribution to the Local Scheme and Deanery</u></b>   |
| <b>Evidence</b><br><i>E.g. Attendance trainers group, Contributions day release course, Assessment of SHOs + GPRs<br/> Training practice assessments, Involvement selection process, Course Organisers report</i>   |
| <b>Self Assessment against Criteria</b><br>I have attended all trainers groups except when on annual leave. I have offered to assist with the day release course especially in the area of prescribing. I have been on 2 mid term assessments and 2 practice visits. I could volunteer again to assist with day release |
| <b>Visitors' Assessment</b><br><br>Agree with the above   |

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| 5. <b><u>Relationships</u></b>  |
| <b>Evidence</b><br><i>E.g. OXVT7 report, Registrar interview, 360 degree feedback, Appraisal<br/> As above</i>  |
| <b>Self Assessment against Criteria</b><br>Generally good relationships with patients, staff, doctors. Non-confrontational, adult-adult style preferred. However, the wish to move things on quickly against the inertia to change may be wearing for some. |
| <b>Visitors' Assessment</b><br><br>Agree with the above   |

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| 6. <b><u>Assessment and Curriculum Planning</u></b>   |
| <p><b>Evidence</b><br/> E.g. <i>Methods and timetable and records of assessments, Curriculum plans, Induction programme, Registrars and Trainers Logs, Mid-term assessment arrangements, Trainer overall aims</i></p>   |
| <p><b>Self Assessment against Criteria</b><br/> Initially my records were very haphazard though all assessments were diligently done. After visiting on a mid-term assessment I 'saw the light' and copied an experienced trainer's format which works well and gives a more complete record. I find a reflective log very taxing. I am very comfortable with the idea of being learner centred and allowing the registrar to dictate the course of learning while still maintaining an overall perspective of the syllabus</p> |
| <p><b>Visitors' Assessment</b><br/> The trainers log showed a complete record of assessment and the planning of training based on these. Learning needs arising from the tutorial sessions were very sparsely recorded (we saw only 3 complete tutorial record sheets from the last years training) The value of keeping a fuller log might become more apparent from attending the experienced trainers course</p>   |

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| 7. <b><u>Teaching Record</u></b>   |
| <p><b>Evidence</b><br/> E.g. <i>Trainers and Registrars logs, Tutorial reviews, Reflection sheets, Practice feedback</i></p>   |
| <p><b>Self Assessment against Criteria</b><br/> My records for the first registrar are minimal as he left fairly early on and as my first registrar I was inexperienced in what was required. Records of my second 'registrar' are also scanty as he was a fully qualified GP with UK roots who simply needed NHS refresher training. My records for my most recent registrar are fuller. They could be neater and more reflective. I have not kept a daily log.</p> |
| <p><b>Visitors' Assessment</b></p>   |

The written record (although arguably adequate) is not one of Peter's strengths. He has insight into this, perhaps a computerized record rather than a written log would be more accessible to him.

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| 8. <b><u>Methods</u></b>   |
| <b>Evidence</b><br><i>E.g. (Training Behaviour Self Assessment - Ed Peile – not yet introduced), Video tutorial, Involvement of partners and practice team, Joint Surgeries, Use of Books and Journals and IT and EBM, Registrar PDP</i>   |
| <b>Self Assessment against Criteria</b><br>I am happy to assess the learners needs and use the modalities they prefer in teaching. I find joint surgeries and video analysis the most useful methods, but try to keep experience as varied as possible while reflecting learner preference.          |
| <b>Visitors' Assessment</b><br><i>Agree with the above, evidence from previous registrar of ability to adapt his methods to suit the registrar's needs. The last registrar often needed a very direct approach &amp; guidance on being an adult learner - Peter more than rose to the challenge.</i> |

## **D. The Practice in Teaching**

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| 1. <b><u>Partnership's Responsibilities</u></b>  |
| <b>Evidence</b><br><i>E.g. OXVT7 Registrar report, Partners' interview, Involvement of Registrar in practice activities, Induction process</i>   |
| <b>Self Assessment against Criteria</b><br>Everyone is signed up to the philosophy of the practice as a learning organization. Tarrant Stein was formerly a trainer and is sympathetic and understanding to what is required. Gina Robson maintains links with the university and arranges medical student attachments and takes responsibility for these. Kate Ward has been involved in teaching PRHOs in her last practice and has taken over mentoring the retainer. Ahsan Alvi works for OXEMS (OOH service) and is involved in registrar teaching on call as well as being a GP representative on the management board. In summary all partners demonstrate clear specific involvement in teaching. It is not surprising that they contribute in a |

more general way to registrar teaching by providing tutorials, debriefing sessions, on call cover and joint surgeries. The philosophy of the learning organization extends to a willingness to share all clinical and partnership meetings with the registrar as well as inviting him/her to their own homes in the evening for 6 weekly journal clubs.

#### 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

E.g. *Training timetable, protected time for trainer*

Self Assessment against Criteria

The registrar attends the training scheme all day every Tuesday and is treated as supernumerary in that there are never any problems getting time to attend recommended and other courses. The trainer is given a half day per week for training activities. This is adequate though underestimates the time put in for trainers' meetings, assessments, practice visits 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 nurses 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 is included in the induction period but do not feel it is necessary to have any other form 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, Accessibility audit*

**Self Assessment against Criteria**

There is no doubt that the registrar functions as a full member of the team by the end of their attachment seeing a variety of acute and chronic patients. We take steps to guard against the development of complex patients who become 'registrar patients'

**Visitors' Assessment**

*Agree with the above.*

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| 4. <b><u>Arrangements for Seeing Patients</u></b>  |
| <p><b>Evidence</b><br/> <i>E.g. Registrar workload, Registrar patient profile</i><br/> <i>Arrangements for consulting, Arrangements for specific experience</i></p>  |
| <p><b>Self Assessment against Criteria</b></p> <p>Steps are taken to ensure that the registrar sees a good mix of patients. This is controlled by enlisting the registrar to help with clinics eg CHD/hypertension, diabetes, child health when the responsible partner is absent. Joint surgeries are booked only 2 days in advance to ensure review and chronic patients do not dominate in these sessions. Visits are chosen for their educational value eg patient with new diagnosis of stroke or malignancy.</p> |
| <p><b>Visitors' Assessment</b></p> <p>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.</p>   |

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| 5. <b><u>Practice Premises, Equipment and Library facilities</u></b>   |
| <p><b>Evidence</b><br/> <i>E.g. Registrar's room and equipment, Video equipment, IT facilities, Library catalogue</i></p>  |
| <p><b>Self Assessment against Criteria</b></p> <p>Obviously temporary, but adequate if somewhat cramped. Some of our staff jokingly say that they are not moving back! New camera purchased last year. Recent IT upgrades including servers, flatscreens and printers. Fast broadband expected soon. Space currently limits the normal friendly intermingling of all staff</p> |

(though the new coffee room compensates to a degree). Space also limits the possibility of additional learners, which will not be a problem once we move again.

#### 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.

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| 6. <b><u>Involvement of the Partnership and Primary Health Care Team</u></b>   |
| <p><b>Evidence</b><br/> <i>E.g. Attendance registrar practice meetings, involvement registrar practice management, In house learning programme</i></p>   |
| <p><b>Self Assessment against Criteria</b><br/> The registrar is welcome and expected to attend and participate in all normal meetings.</p>  |
| <p><b>Visitors' Assessment</b><br/> 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<br/> Dr Kathryn Ward has extensive experience of teaching medical students and her support is much appreciated by the trainee, 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.</p> |

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| <b>E. Specific Regulations for GP Registrars</b> |
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| 2. <b><u>Night and Weekend Work</u></b>   |
| <p><b>Evidence</b><br/> <i>E.g. Practice arrangements for out of hours, Arrangements for Registrar out of hours experience, Calculation of annual patient hours of cover, Out of hours rota and Registrars contribution, Arrangements for cover for registrar</i></p> |

**Self Assessment against Criteria**

Arrangements were unclear last year. Despite a last minute ruling the registrar was able to satisfy the full number of sessions and I personally supervised 3 of these. Ahsan Alvi has undergone specific OOH training and has offered to do this for the practice.

**Visitors' Assessment**

*Agree with the above*

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| 3. <b><u>Summative Assessment</u></b>  |
| <p><b>Evidence</b><br/> <i>E.g. Record of previous summative assessments, Previous Registrar summative assessment audits</i></p> |
| <p><b>Self Assessment against Criteria</b></p> <p>All summative elements that have been sat/submitted have been passed.</p>      |
| <p><b>Visitors' Assessment</b><br/> <i>Agree with the above</i></p>  |

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| 4. <b><u>Contract or Letter of Employment</u></b>                               |
| <p><b>Evidence</b><br/> <i>E.g. GP registrar contract</i></p>                   |
| <p><b>Self Assessment against Criteria</b></p> <p>Standard contract is used</p> |
| <p><b>Visitors' Assessment</b><br/> <i>Agree with the above</i></p>             |

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**MANDATORY CRITERIA CHECK**

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

| <b>MANDATORY CRITERION</b>  | <b>Fully achieved</b> | <b>Needs Improvement</b> |
|---|-----------------------|--------------------------|
| <b>Teachers will be revalidated when required by the GMC.</b>   | Y                     |                          |
| <b>Teachers should have an educational development plan.</b>  | Y                     |                          |
| <b>The practice will need to demonstrate that it achieves the targets set out in the sustained quality payments</b>   | Y                     |                          |
| <b>The practice must demonstrate active audit cycles resulting in change in practice.</b>   | Y                     |                          |
| <b>Patient records should be 80% summarized and this should be demonstrated at the practice visit.</b>  | Y                     |                          |
| <b>From 2004 the Certificate of Medical Education (or equivalent) will be mandatory for all new trainers.</b>   | Y                     |                          |
| <b>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.</b> | Y                     |                          |
| <b>Trainers must belong and contribute to the local trainers group.</b>   | Y                     |                          |
| <b>Records and logs must be kept by each trainer and each registrar.</b>  | Y                     |                          |

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 <ul style="list-style-type: none"> <li>• Summary               <ul style="list-style-type: none"> <li>• Not updated</li> <li>• Significant omissions</li> </ul> </li> </ul> |                | Updated, but some diagnoses from letters not entered in the computer record |
| Regular medication <ul style="list-style-type: none"> <li>• Up to date authorisation</li> <li>• Drugs no longer used on screen</li> </ul>  |                | Yes<br>No   |
| PACT prescribing data <ul style="list-style-type: none"> <li>• Generic percentage</li> <li>• Cost relative to HA</li> </ul>  |                |   |
| Adults 18-80 (BHS guidelines) <ul style="list-style-type: none"> <li>• Number</li> <li>• BP recorded last 5 years</li> <li>• Smoking status (ever)</li> </ul>                          |                |   |
| Practice Cervical Cytology target over last year   |                |   |
| Practice Immunisation targets over last year <ul style="list-style-type: none"> <li>• 2 year olds</li> <li>• 5 year olds</li> </ul>  |                |   |

## 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*

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|-----------------------|
| <b>C. The Teacher</b> |
|-----------------------|

##### 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 as 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.

|                        |                      |         |
|------------------------|----------------------|---------|
| <b>NAME OF TRAINER</b> | Peter von Eichstorff | Renewal |
|------------------------|----------------------|---------|

|                      |   |
|----------------------|---|
| <b>Practice Name</b> | East Oxford Health Centre                               |
| <b>Address</b>       | Raglan House<br>23 Between Towns Road<br>Oxford OX4 3FQ |

|                      |         |
|----------------------|---------|
| <b>Date of Visit</b> | 26.5.05 |
|----------------------|---------|

|                      |   |
|----------------------|---|
| <b>Visiting Team</b> | Dr Nick Yates<br>Dr David Metson<br>Dr Viv Carter<br>Ms Pat Thurling<br>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.

#### **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

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|---------------------|
| <b>Observations</b> |
|---------------------|

For the Trainer

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|---|
| <p><b>Highlights</b><br/> Peter is an enthusiastic trainer, a driver for change. His previous registrar was ecstatic about his holistic approach to training and his ability to adapt his approach to support a 'non straight-forward' registrar.</p>       |
| <p><b>Recommendations against the Criteria</b><br/> The written record (although arguably adequate) is not one of Peter's strengths. He has insight into this, perhaps a computerized record rather than a written log would be more accessible to him.</p> |
| <p><b>Observations</b><br/> Having demonstrated his effectiveness with a tested set of skills, Peter is now in the position to expand his range of tools and options. The experienced trainers course could help him with this</p>                          |

| <b>MANDATORY CRITERION</b>  | <b>Fully achieved</b> |
|---|-----------------------|
| <b>Teachers will be revalidated when required by the GMC.</b>   | ✓                     |
| <b>Teachers should have an educational development plan.</b>  | ✓                     |
| <b>The practice will need to demonstrate that it achieves the targets set out in the sustained quality payments</b>   | ✓                     |
| <b>The practice must demonstrate active audit cycles resulting in change in practice.</b>   | ✓                     |
| <b>Patient records should be 80% summarized and this should be demonstrated at the practice visit.</b>  | ✓                     |
| <b>From 2004 the Certificate of Medical Education (or equivalent) will be mandatory for all new trainers.</b>   | ✓                     |
| <b>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.</b> | ✓                     |

|  |   |
|--|---|
| <b>Trainers must belong and contribute to the local trainers group.</b>  | ✓ |
| <b>Records and logs must be kept by each trainer and each registrar.</b> | ✓ |

**Recommendation for Appointments Committee**

|   |   |
|---|---|
| <b>Approval without reservation</b>                 | ✓ |
| <b>Approval with reservations</b><br><i>Reasons</i> |   |
| <b>Non-Approval</b><br><i>Reasons</i>               |   |

**Team Leader: Dr Jill Edwards**

**Date: 1.6.05**