POSTGRADUATE INSTITUTE FOR
MEDICINE & DENTISTRY

NORTHERN DEANERY
GP TRAINER HANDBOOK

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SECTION ONE
THE APPOINTMENT AND RE-APPOINTMENT OF TRAINERS AND TRAINING PRACTICES IN THE NORTHERN DEANERY

INTRODUCTION

Doctors intending to practice in general practice are required to complete satisfactorily a recognised programme of vocational training. This includes a period in a teaching practice where they are expected to learn about the diagnosis and management of acute and chronic illness, the provision of anticipatory care and health promotion. There should be opportunities to learn about practice management, teamwork, standard setting and how practices relate to the hospital, social and voluntary services.

At the end of training they will be required to satisfy national Summative Assessment and expected to pass the MRCGP examination. They should be able to produce a personal development plan (PDP) in readiness for their next role and to take advantage of the HPE programme. They should be ready for the world of appraisal and revalidation.

Trainers and their teaching practices will be judged against the following criteria when applying to the Education Committee for approval or re-approval.

This is a handbook of deanery policy affecting the appointment and reappointment of trainers and teaching practices, together with policies, appendices and references that amount to a handbook of advice for trainers, their GPRs and others involved in the education of tomorrow's GPs. The handbook is updated annually by electronic consultation with all GP trainers and taking account of the latest pronouncements and relevant deanery decisions.

TRAINING PRACTICES

Training practices are carefully chosen by the University of Newcastle Standing Conference for GP Education (Trainer Appointment sub-committee) which acts on behalf of the Joint Committee for Postgraduate Training for General Practice (JCPTGP). The JCPTGP publishes a number of relevant documents – most are available on their website – www.jcptgp.org.uk. The JCPTGP is due to be abolished and its functions taken over by the Postgraduate Medical and Education and Training Board (PMETB). At the time of writing, it is not expected that this will occur before spring 2005. Furthermore, there is likely to be initial continuity in processes when PMETB takes over the responsibilities of the JCPTGP.

They provide services for patients that reflect the latest clinical, technological, organisational, social and economic advances in primary health care. Consequently such practices furnish registrars with a period of practical experience under the supervision of trainers who are skilled clinicians and teachers. They also provide the facilities and atmosphere to encourage registrars to read critically and widely, and establish their professional values. They provide a "tailor made" educational programme based on each Registrar's specific needs.

Training is a practice commitment. Therefore partners, and other members of practice teams, are expected to contribute to the education of their practice registrar. In this way teaching practices can provide learning experiences that are as rich and varied as possible.

In appointing training practices, the sub-committee takes account of the guidelines published by the JCPTGP, the requirements of the Royal College of General Practitioners (RCGP) for its Membership examination, and 'Duties of a Doctor' published by the General Medical Council (GMC, 1995).

The training practice:

1. Will provide a consulting room dedicated for registrars; if this room is to be shared, the registrar's use will be prioritised.

2. Will ensure the designated consulting room(s) be well equipped, well maintained and of suitable size for a training doctor.

3. Will enable the registrar to consult near to and normally at the same time as the trainer or other supervising doctor.

4. Will normally book no more than 6 patients per hour (i.e. a ten minute booking interval) in the surgeries of the trainer or other doctor whilst supervising a GPR.

5. Will provide room for informal discussion and small group teaching,

6. Will have facilities for video-taping and reviewing consultations.

7. Will develop an educational contract with the registrar, based on a joint assessment of needs. The curriculum and educational goals will be based on this assessment.

8. Will ensure that formative assessment forms a regular and continuing part of the attachment and keep a contemporaneous written record of training and assessments to ensure that all important aspects of the training programme have been covered.
   The minimum standard is
   - a record of the teaching timetable
   - a record of all teaching sessions, contributed to by both learner and teacher
   - a record of all significant assessments used in the attachment

   (see also Deanery Standard below).

9. Will provide an appropriate induction to working in the practice, incorporating written information, an introduction to the members and methods of working of the members of the Primary Healthcare Team (PHCT) and an appropriately paced introduction to clinical responsibility.

10. Will keep a record of sickness and unauthorised absence to inform a longitudinal personnel record for each GPR. The JCPTGP permits no more than 2 weeks of sickness or unauthorised absence per annum without the need to lengthen a training period – this is only ONE WEEK PER 6 MONTHS. If their registrar exceeds this, the trainer should inform the Scheme Organiser/Director.

11. Will assign the equivalent of two notional half days per week for teaching, one of which will be in 'protected time', i.e. timetabled, dedicated, uninterrupted time with no other commitments. In practice this means a minimum of 3 hours of 'protected time' in formal teaching sessions and 3 hours further for teaching support e.g. for preparing an audit or other private study (and pro-rata for a part time registrar).

12. Will provide an up-to-date library of books and journals of relevance to general practice on the practice premises, and appropriate bench books in the registrar's consulting room.

13. Will provide local access to the internet and to electronic information systems and be able to demonstrate the skills to use them to support the registrar's teaching.

14. Will accept that registrars are selected by the deanery mechanisms on their behalf.

15. Will accept that registrars so appointed maybe either full time or part time and will undertake to accommodate them appropriately. There is no right of veto over part time placements.

16. Will ensure that a partner is nominated and prepared to supervise the registrar in the trainer's absence or if the registrar is working at another site.

17. Will ensure that, in practices with two or more trainers, one trainer per GPR is clearly responsible for supervision, assessment and co-ordination of training,

18. Will accept that normally there should be only one registrar appointed to any trainer at any one time. Whilst appropriately experienced trainers may supervise two registrars by negotiation with the Scheme Organiser, only one trainer grant will normally be payable from deanery funds under these circumstances.

19. Will provide a contract of employment for registrars.

20. Will ensure safe working arrangements for the registrar, both within and outside the practice.

21. Will ensure that the workload of the practice is such that the registrar sees an adequate range of clinical cases. This means seeing enough patients in total, with a wide enough range of clinical problems.

22. SATISFACTORY COMPLETION OF PHASE ONE (the first GPR posts). It is not possible to cover all eventualities, however a consensus exists that a registrar who isn't ready for Phase 3 (final GPR placement) has not satisfactorily completed Phase 1 and will need a further period of training as a GPR (AND WILL NOT HAVE A VTR1 ISSUED, IN LINE WITH JCPTGP INSTRUCTIONS). In practice, **a registrar who is unable to survive 2 hour surgeries booked at 10 minute intervals in the last fortnight of their Phase 1 attachment at an adequate standard of performance** might be considered not to have satisfactorily completed.

    In addition, GPRs are expected to have achieved independence in the management of urgent situations in and out of hours, by the end of a Phase 1 (first six-month) attachment.

Finally, a GPR in whom for whom it has not been possible to complete a significant portion (consensus = 40%) of the Structured Trainers Report might be regarded as not having reached the necessary standard.

23. Trainers who have any doubts about their registrar's progress to this standard should seek a second opinion, normally from outside the practice. A local Course or Scheme Organiser would usually be appropriate. In practice, most trainers report having some doubts within the first month of an attachment. The more time available to manage the situation the better.

24. Will ensure that the practice is able to function without the services of registrars i.e. the practice should not be dependant upon the presence of a registrar to deliver its clinical services.

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

26. Will respond reasonably to specific needs of a registrar (e.g. part time registrars or those with a disability) and in any event ensure that their employment practices conform to relevant legislation (e.g. regarding disability, racial discrimination etc.).

27. Will provide consistent support for Summative Assessment and the MRCGP exam, including providing appropriate facilities for videotaping consultations and time and practical support for preparation.

28. Will conduct formal appraisals of their registrars, in line with the precise procedures of their vocational training scheme. In any event, ensuring that their registrars have an appraisal at least annually.

29. Will keep clinical records that fulfil the current JCPTGP and regional requirements (see below and www.jcptgp.org.uk).

30. Will release the trainer to provide centrally co-ordinated teaching at least four half days each year.

31. Will inform patients that the practice is a training practice and what this means. In practices intending to be newly appointed, will inform patients of the proposal and allow responses. There is conflicting evidence about the value of training practice status to patients. Training practices have consistently been shown to be "more developed" than non-training practices, but patients in one study preferred non-training practices, which were more likely to offer personal continuity of care (Baker R, Thompson J. Is the gap between training and non-training practices getting wider? Br J Gen Pract 1995;45:297-300)(Baker R, Streatfield J. What type of general practice do patients prefer? Br J Gen Pract 1995;45:654-9).

THE TRAINER

Trainers are role models of crucial importance for the development of their registrars. The deanery and the JCPTGP take this very seriously and as a result, the following attributes are required of trainers at first and subsequent appointments.

1. Trainers in general practice are expected to be caring, competent and enthusiastic general practitioners i.e. model the attitudes that society expects to see in its doctors. Certain attitudes are unacceptable (e.g. racism). If displayed, these would be expected to lead to withdrawing of training approval.

2. Trainers' practices must be well organised, be delivering a high standard of care and of teaching about it.

3. Trainers should be good communicators and clinically skilful.

4. Trainers should be available and accessible to their patients. Care must be taken by trainers who are absent from the practice when their registrar is present. Clear arrangements must be made for immediate care of the GPR and subsequent follow up of less urgent learning needs that the GPR may develop.

5. New trainers are required to have passed the MRCGP exam or obtained Membership by Assessment of the RCGP. At reappointment, trainers must provide evidence of their personal clinical and educational development.

6. Trainers will be familiar with the GMC's publication "Doctors as Teachers" (summarised in appendix 4).

7. They are expected to understand the theoretical principles of education.

8. They will have practical skills in curriculum formation, teaching, and assessment.

9. Trainers will be strongly committed to their own professional development both within and outside the practice. Dr Brian McKinstry's questionnaire is offered as a formative tool to inform the visits of Associate Directors to established trainers (see Appendix 6). See also Rutt G, Dodd M. Occasional Paper 85: A Toolkit for Trainer Appraisal and Development (2003) RCGP, London.

10. They will be willing and able to critically evaluate their own and their colleagues performance as teachers.

11. Trainers will be familiar with the 'Attributes of the General Practitioner' as described by the JCPTGP (appendix 1) and Good Medical Practice for GPs published by the RCGP (summarised in appendix 3).

12. Trainers are responsible for the general arrangements for training, and the supervision of registrars in the practice. The educational programme will fulfil both the wants and assessed needs of the registrar and it will contain specific reference to the appropriate study leave identified.

13. If the practice is not involved with the management of significant patient groups (e.g. drug misusers) then the trainer will ensure that the registrar obtains the relevant experience in some other way.

SKILLS THE REGISTRAR MUST ACQUIRE

Trainers and their practices will provide registrars with sufficient experience for them to develop the following essential skills:-

1. *Professional values*
   The training practice should provide an exemplary model for registrars. Trainers and registrars should practice ethically and professionally as outlined in the GMC document 'Duties of a Doctor' (appendix 2).

2. *The Consultation*
   Registrars must master consultation skills. Trainers will regularly teach and assess their registrars' consultation skills. Video analysis is the method of choice and a skills based approach is recommended (e.g. Calgary Cambridge framework). Other teaching methods should include random case analysis and problem case analysis.

3. *Clinical Record Keeping*
   Registrars will learn how to keep good clinical records. Those practices relying heavily on information technology (IT) will ensure that registrars are provided with training in traditional methods of recording. Written and/or electronic records must be available to all registrars and comply with the following criteria:-

   - They should allow the process of care easily to be followed.
   - They should contain current summaries, drug therapy, referral letters, out-of-hours contacts and health promotional data.
   - They should contain, in date order, legible clinical notes, copy letters and results of investigations.
   - All records should be capable of yielding data for clinical audit.

   All practices will soon be fully electronic. Appropriate training (including in keyboard skills) should be available to the registrar.

   The records will be maintained, at a minimum, to the deanery standards (see below).

4. *Prescribing*
   Registrars will learn the basic skills required for responsible, effective and economic prescribing. They should also be able to interpret prescribing data, justify decisions about prescribing with reference to published literature and be able to develop and modify a practice formulary.

5. *Management*
   Trainers will ensure that their practices have systems of management that provide an appropriate model for experiential learning. Registrars will be introduced to the principles and skills of personal and practice management. Registrars will develop their interpersonal, team working and leadership skills. They should become skilled in time, personal and change management. They must understand and respect other team members' professional status and roles.

   Most practices are run as businesses. It is important that registrars be offered education in the business side of the practice.

Registrars will learn the application of planned care in the management of acute and chronic illness, anticipatory care and health promotion.

6. *Quality*
   Trainers will ensure that registrars learn the skills required for effective clinical audit and see it as a tool for quality management. Clinical audit should be a routine activity in training practices. Decision-making and guideline formation should be evidence based.

   Registrars will learn the skills of guideline development. They will be able to organise, carry out and lucidly write up an audit to a standard acceptable to external review.

7. *Specific Skills*
   The training practice should ensure that the GPR can gain experience in Minor Surgery/Child Health Surveillance/Family Planning.

   At the end of training those registrars who so wish will have achieved current National Standards and be eligible for PCT accreditation.

   It seems likely that the list of certifiable competencies will grow in future. The training practice will ensure that registrars are supported in gaining the training relevant to their own career goals.

8. *Out of Hours Care*
   All GP registrars must gain adequate experience in out of hours care during their general practice attachments. Ideally they should gain practical experience in the different models by which out of hours care is provided.

   The degree of supervision needed by registrars will depend on their confidence and competence and these attributes must be assessed by trainers. **During their first 3 months as a GP registrar, they should not be left alone in any out-of-hours setting** unless thoroughly assessed by the trainer as having sufficient competence. Eventually GP registrars must be able to undertake unsupervised out of hours care – see above re Satisfactory Completion of the first 6 months.

   Adequate Experience. Several factors will influence trainers in certifying GP registrar competence in out of hours care including their previous experience and the amount of out of hours patient contact which the practice normally experiences. Sufficient teaching, experience and assessment must take place for the trainer to be sure that the GPR can perform effectively as an independent practitioner – this will normally be at least 6 sessions per 6 month attachment (may be more depending upon the needs of the individual GPR).

   The new world of most practices opting out of direct OOH provision presents challenges – trainers will need to cooperate with local OOH services in this regard. The latest COGPED thinking is appended (Appendix 7).

   It remains the responsibility of the trainer, when signing a VTR1 form, to assess the competence of the GPR to deliver safe and effective care outside normal hours. COGPED has produced a GPR OOH workbook (www.yorkshiredeanery.com and follow links GP → GP VTS Trainee → OOH Training for GPRs).

CONDITIONS OF APPOINTMENT OF G.P. TRAINERS

Whilst applicants will usually have been principals for a minimum of three years there is no bar to doctors with other general practice backgrounds, for example those working in salaried or assistant posts, from applying. 'Career Start' type schemes vary considerably in their experience – doctors wishing to count such experience will need a specific assessment of their experience to be made. Similarly with doctors who wish to count a substantial period of part time experience. The responsible Associate Director of Postgraduate GP Education will advise on the suitability of their experience.

Initial discussion

A doctor who wishes to become a trainer should initially contact their local Associate Director who will advise about any necessary personal and practice developments. The Associate Director will visit the intending trainer and the practice to ensure that the appointment criteria can be met and to negotiate a contract for further development (telephone GP at the Postgraduate Institute on 0191 222 6766).

Course for Intending Trainers

If the initial visit from an Associate Director results in a positive report, he or she will attend a training course for intending trainers and will satisfactorily complete six months supervised teaching experience in an appropriate practice in the Northern Deanery.
If the initial visit reveals significant development work to be necessary, then attendance at the training course for intending trainers will be deferred until a second visit confirms satisfactory progress.

Application to become a trainer in the Northern Deanery

Upon completion of the four modules of the Intending Trainers Course, the doctor will make a formal application to the Trainer Appointment sub-committee of the Standing Conference for GP Education. He or she will be visited formally by the relevant Associate Director of Postgraduate GP Education, who will prepare a formal report to the sub-committee.

The sub-committee will consider

- The doctor's written application and evidence
- A full 8-point Summative Assessment Audit produced by the new trainer to a Summative Assessment "pass" standard
- The report of the supervisory trainer
- The formal report of the Associate Director

And will interview the doctor.

The conditions of appointment in the form of a contract will be agreed with the Standing Conference for GP Education through its trainer appointments' sub-committee. This contract will form a basis for subsequent periodical review and for re-appointment. Trainers must be willing to have their teaching skills evaluated formatively by peers and summatively by the Deanery.

First appointments are normally for two years. Subsequent appointments are normally for three years. These are the maximum periods permitted by the JCPTGP.

The appointments sub-committee reserves the right to shorten the period of appointment if necessary. The Director of Postgraduate General Practice Education and the Associate Directors may withdraw a registrar from a practice should it not provide a training experience of the required nature and standard.

At first appointment, intending trainers are required to show that they and their practice meet the requirements specified above and that they have successfully completed a recognised training for trainers course (not necessarily in the Northern Deanery). They must also have successfully completed a period of supervised training WITHIN the Northern Deanery.

At re-appointments, trainers will be required to furnish proof about their practice of teaching and assessment and of their continuing development as a teacher. Information from registrars supervised during the period under review will be sought in corroboration. The visit of the Associate Director will be preceded by the opportunity to complete Dr Brian McKinstry's validated trainer self-assessment questionnaire (Appendix 6) for discussion at the visit.

Trainers are appointed by the Standing Conference for General Practice Education. A practitioner whose application is rejected has the right to appeal. Details may be obtained from the Deanery office.

These regulations will be updated annually and will be amended periodically in the light of relevant announcements, especially those by the JCPTGP (until spring 2005) and the Postgraduate Medical Education and Training Board (PMETB – after spring 2005).

POLICY FOR TRAINERS RETURNING TO TRAINING

1. Trainers in the Northern Deanery, who have had a break from actual training, should arrange an interview with the appropriate Associate Director.

2. If the break in their trainer activity has been for less than 2 years there should be no reason why the trainer cannot return to training straight away. Any major change in training, introduced during the break from training (e.g. the introduction of Summative Assessment, changes in MRCGP teaching) should be addressed at the interview with the Associate Director. Appropriate arrangements should be made to update the trainer (e.g. by meetings with the trainer group, MRCGP examiner, deanery advisor on Summative Assessment etc.).

3. If a returning trainer has had a break from training for more than 2 years, the same rules should apply as to an intending trainer who does not begin training within 2 years of completing the Intending Trainers Course i.e. the returning trainer should undertake a period of supervised training prior to beginning training again.

4. The Associate Director should ensure that the returning trainer develops an educational programme which identifies and addresses their educational needs. The plan should include the number of supervised sessions which the trainer feels are necessary to address perceived weaknesses in competence and confidence. This should normally never be more than six sessions. The educational plan should be agreed by the Associate Director and will form the basis for preliminary discussion with the supervisory trainer.

5. The PIMD will assign a supervisory trainer to the returning trainer. Because of the pressure on supervisory trainers it may not be possible to assign a supervisory trainer to a returner for up to 6 months.

6. The relation between supervisory and returning trainers will be exactly the same as for intending trainers i.e. returners will have to make all the running with the GPR and supervisory trainer, but can expect written feedback and a report at the end of the supervised training.

7. Returning trainers will have priority over intending trainers with regard to allocation.

8. The Associate Director will have to ensure appropriate funding for the returning trainer. Supervisory trainers are currently paid £1000 for supervising intending trainers for six sessions i.e. £150/session.

9. There is no need for the returning trainer to appear for an interview if the Associate Director feels it is unnecessary. The appropriate database record plus director's report, plus the supervisory trainer's report will be considered by the 'established trainers' committee', on behalf of the Educational Committee for General Practice.

POLICY FOR TRAINERS TRANSFERRING TO THE NORTHERN DEANERY

1. Trainers who have been appointed in another deanery and who come to work in the Northern Deanery need not undertake the Intending Trainers Course. Reciprocal arrangements now exist which mirror those that apply to GPRs who transfer between deaneries.

2. Transferring trainers should provide the names of referees from their previous deanery. These would normally be the appropriate 'patch' Associate Director, and local Course Organiser. One or both of these referees will be contacted by the Associate Director responsible in the Northern Deanery.

3. If the break in their trainer activity has been for less than 2 years there should be no reason why the trainer cannot start training straight away. Any major change in training, introduced during the break from training (e.g. the introduction of Summative Assessment, changes in MRCGP teaching) should be addressed at the interview with the Associate Director. Appropriate arrangements should be made to update the trainer (e.g. by meetings with the trainer group, MRCGP examiner, deanery advisor on Summative Assessment etc.).

4. If a transferring trainer has had a break from training for more than 2 years, the same rules should apply as to an intending trainer who does not begin training within 2 years of completing the Intending Trainers Course i.e. the transferring trainer should undertake a period of supervised training prior to beginning training again.

5. The Associate Director should ensure that the transferring trainer develops an educational programme which identifies and addresses their educational needs. The plan should include the number of supervised sessions which the trainer feels are necessary to address perceived weaknesses in competence and confidence. This should normally never be more than six sessions. The educational plan should be agreed by the Associate Director and will form the basis for preliminary discussion with the supervisory trainer.

6. The PIMD will assign a supervisory trainer to the transferring trainer. Because of the pressure on supervisory trainers it may not be possible to assign a supervisory trainer to a transferring trainer for up to 6 months.

7. The relation between supervisory and transferring trainers will be exactly the same as for intending trainers i.e. transferring trainers will have to make all the running with the GPR and supervisory trainer, but can expect written feedback and a report at the end of the supervised training.

8. Transferring trainers will have priority over intending trainers with regard to allocation.

9. The Associate Director will have to ensure appropriate funding for the transferring trainer. Supervisory trainers are currently paid £1000 for supervising intending trainers for six sessions i.e. £150/session.

10. There is no need for the transferring trainer to appear for an interview if the Associate Director feels it is unnecessary. The appropriate database record plus director's report, plus the supervisory trainer's report will be considered by the 'established trainers' committee', on behalf of the Educational Committee for General Practice.

SECTION TWO
STANDARDS AND POLICIES

STUDY LEAVE FOR GPRS

The following statements represent Northern Deanery policy for GPRs during general practice placements in the light of regulation and local decisions.

1. The prime educational opportunity for GPRs is seeing patients in the practice – with appropriately facilitated reflection and feedback on performance. The time available to do this is gradually being squeezed by other demands.
2. The half-day release course COUNTS as study leave and accounts for around 10 days per 6 months.
3. Therefore, most registrars have a further 5 days (maximum) of their "entitlement" to study leave left.
4. Any further study leave should be given by the GP trainer only if carefully targeted and in line with the GPRs educational development plan. And normally ONLY for a mandatory deanery course.
5. In particular, time off for study for exams is NOT normally considered appropriate use of study leave entitlement (in other disciplines as well as GP).
6. Most innovative placements contain a half-day study period in the weekly timetable, which for these purposes would be treated as equivalent to the 10 days of half-day release.

These principles should be taken to apply pro-rata to GPRs training part time.

QUALITY STANDARDS FOR MEDICAL RECORDS: NORTHERN DEANERY

The following standards apply to manual and computerised records.

1. All medical records, hospital correspondence and results of investigations must be filed in practice notes, in date order.

2. They should be readily available for the registrar's consultations and teaching and should allow the process of care to be easily followed.

3. Appropriate medical records must contain easily discernible drug therapy lists for patients on long term therapy.

4. 100% of records should contain medical summaries.
   80% or more should be complete (ALL major and most minor diagnoses present).
   90% or more should be adequate (no more than ONE major diagnosis missing and/or more than half of minor diagnoses present).

Practices should be seen to reach these targets prior to appointment and also have mechanisms in place to maintain these standards after appointment.

5. Copies of referrals and out-of-hours contacts should be kept on record.

6. Entries should be legible, and where suitable a structured format should be followed.

7. Up-to-date preventive medicine and health promotion data should be available during the consultation.

8. The training practice must decide whether paper or electronic records are their primary record system. It must then demonstrate that the primary system conforms to the above principles and that robust systems are in place to maintain (and preferably improve on) this level of compliance.

QUALITY STANDARDS FOR THE LIBRARY: NORTHERN DEANERY

The Northern Deanery has never produced a rigid library list for the use of training practices. We have adopted the approach that trainers, as individual indicators, have their own preferences for library texts.

The Postgraduate Institute spends a considerable amount of money updating Postgraduate Centre libraries and all trainers and GPRs have access to these facilitates (including librarians, who are an underused and expert resource).

The following is a minimum standard for practice libraries.

- BMJ and the British Journal of General Practice
- A good **up-to-date** general medical textbook,
- Core general practice texts i.e. covering topics not suitable for electronic enquirey e.g. texts on
- Teaching the consultation
- Communication with patients
- Preparing for Summative Assessment and the MRCGP examination
- Minor surgery in general practice.

It is also expected that practices have a strategy for access to relevant texts in

- ENT,
- Dermatology
- Ophthalmology
- Child health surveillance
- Paediatrics
- Obstetrics & gynaecology
- Emergencies in general practice
- Psychiatry

IT is increasingly important. In this respect trainers will

- Provide a computer and internet access in the consulting room
- Demonstrate skills in asking good questions, designing appropriate search strategies and then executing them.
- Therefore be able to help registrars with this task
- If not skilled in any significant respect, they will show that they make routine use of adequately skilled colleagues (e.g. a partner, a Postgraduate Centre or other librarian etc.)

The following is a list of texts recommended after a consultation with GP trainers in 2002

- The Inner Consultation – Neighbour
- The Trainers Handbook – Middleton & Field
- The Consultation – Pendleton et al
- The Doctors Communication Handbook- Tate
- Contraception – Guillebaud
- Practical General Practice – Polmear & Khot
- The Inner Apprentice – Neighbour
- Women's Health in General Practice
- Skills for Communicating with Patients & companion volume – Kurtz, Silverman & Draper
- Making Audit Simple – Irvine
- Symptom sorter – Hopcroft
- Clinical Method – Fraser
- Oxford Handbooks (GP/Clinical Specialties/Medicine)
- Emergencies in General Practice – Morrell
- Tutorials in General Practice – Mead
- ABC of Dermatology - BMJ

The following is a short list of websites of relevance and recommended in the same exercise (2002)

- http:///www.wellclosesquare.co.uk – run by Brad Cheek – a trainer and Course Organiser on the Northumbria Scheme. Lots of resources and links. Updated regularly.
- http://www.emedicine.com/, this is a general medical textbook. It is hugely referenced.
- http:///www.nelh.nhs.uk/, national electronic library for health
- www.campus.ncl.ac.uk/pimd PIMD website - links to the vocational training schemes and summative assessment
- www.google.com the best search engine (usually)
- www.bmj.com
- www.doctors.org.uk
- www.nosa.org.uk

Practices will have a protocol for keeping their libraries up to date.

QUALITY STANDARDS FOR FORMATIVE (EDUCATIONAL) ASSESSMENT: NORTHERN DEANERY

As a minimum, the following formative assessments should be documented in each GP registrar's file. The file should also demonstrate that the educational programme is based upon the results of the assessments.

1. **Initial Assessment**
   During the first month of each period of training in general practice GP registrars should complete a confidence rating and an MCQ.

2. **Regular Assessment**
   Videotape assessment or joint consulting using a recognised assessment instrument should be completed at least monthly throughout the general practice component of training.

3. **Rating Scales**
   A rating scale should be completed at least once during each period of training in general practice.

Examples of assessment instruments (not exclusive):

Rating Scales:
- New Manchester Rating Scale
- Northumbria Rating Scale

MCQ:
- "PEP" programme (which includes both an MCQ and a confidence rating scale).

Video Assessment:
- Northern Regional Video Assessment Instrument
- Pendleton et al.
- Leicester Assessment Package (LAP)

Reference
- Appendix 10 below

SECTION 3
USEFUL APPENDICES

APPENDIX 1

The Attributes of the General Practitioner

I Values and Attitudes

Fully trained general practitioners are expected to be:

(a) caring and understanding of patients and their families;

(b) committed to providing high quality care;

(c) aware of the need to be readily accessible and available to patients;

(d) aware of their own limitations and willing to seek help from others when appropriate;

(e) committed to keeping up to date with developments in practice - both clinical and organisational;

(f) committed to improving the quality of their professional performance through active participation in audit and quality assurance;

(g) aware of the ethical principles which govern the medical profession and committed to observing them;

(h) appreciative of the value of teamwork to patient care in general practice;

(i) willing to teach others, including colleagues and practice staff, and willing to acquire the teaching skills necessary for this;

(j) willing to contribute, when possible, to the advancement of medical knowledge.

(k) able to care for themselves and to balance the demands of a busy professional life with the need for personal time.

II Clinical Competence

General practitioners are expected to be:

(a) knowledgeable about clinical general practice. This will require an appropriate level of understanding of the physical, behavioural, epidemiological and clinical sciences of medicine, the aetiology and natural history of diseases, the impact of psychological factors upon illness, and of illness upon patients and their families, and of the social, cultural and environmental factors that contribute to health and illness;

(b) skilled in recognising and making appropriate decisions about all problems presented by their patients.

(c) able to examine a patient's physical and mental state and to investigate further as appropriate;

(d) able to assess symptoms and physical signs, to establish a diagnosis when possible, and to exercise sound clinical judgement in further management;

(e) skilled in communication and in the process of the consultation. This will include the ability to listen carefully and to explain effectively to patients, families, colleagues and others, and the ability to involve patients in decisions about their health care;

(f) able to contribute to the prevention of illness and the promotion of health, and to understand a doctor's role and that of others in these;

(g) able and willing to deal with common medical emergencies appropriately;

(h) able to prescribe effectively and with due thought to economy;

(i) able to keep clear, coherent and up-to-date medical records for each patient using a format that enables information to be easily identified for clinical and auditing purposes.

III Organisational Ability

General practitioners are expected to be:

(a) able to assess the health status, needs and expectations of the practice population;

(b) able to plan, organise and manage a practice to provide a broad range of accessible services including the management of acute and chronic illness, medical emergencies, health promotion and preventive activities;

(c) able to function as a member of a multidisciplinary, practice based team and, when appropriate, able to assume the responsibilities of a team leader. This will involve an understanding and appreciation of the roles, responsibilities and skills of other health care workers such as community nurses, practice nurses, health visitors and midwives;

(d) able to make effective use of resources including, for example, money, time, skills, both within and out with the practice setting;

(e) able to organise and carry out effective clinical audit; and have the skills necessary to bring about change in the practice where audit shows this to be necessary;

(f) conversant with and willing to participate in the work of organisations that advise, plan and assist in the development and administration of health services, such as NHS authorities, medical Royal Colleges, professional associations, local medical committees and regional medical committees.

Joint Committee on Postgraduate Training for General Practice 1992

APPENDIX 2

Duties of a Doctor

- make the care of your patient your first concern;
- treat every patient politely and considerably;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor; and
- work with colleagues in the ways that best serve patients' interests.

In all these matters you will never discriminate unfairly against your patients or colleagues. And you will always be prepared to justify your actions to them. For further information on how to apply these principles, please read our booklet 'Good medical practice'.

'Duties of a Doctor', General Medical Council 1995

APPENDIX 3

‘Good Medical Practice for GPs’ (RCGP/GPC) – chapter headings

Cross-referencing to the GMC’s *Good Medical Practice* (2001)

		Paragraph in GMC’s *Good Medical Practice*
Section 1. Good clinical care		
	Introduction	1
1.	Clinical care	2, 3 (a-c), 3 (f-h), 4
2.	Keeping records, writing reports and keeping your colleagues informed	3 (d), 3 (e), 51
3.	Access, availability and providing care out of hours	19 (e), 39, 40
4.	Treatment in emergencies	9
5.	Making effective use of resources	3 (i), 7
Maintaining good medical practice		
6.	Keeping up to date, and maintaining your performance	10 - 12
Relationships with patients		
7.	Providing information about your services	48 - 50
8.	Professional relationships with patients – maintaining trust	17, 18, 19 (a-d), 20, 21
9.	Avoiding discrimination and prejudice towards patients	5, 6, 8
10.	If things go wrong	22 – 25, 29 - 33
Working with colleagues		
11.	Working with colleagues and working in teams	34 – 38, 43, 46
12.	Referring patients	42, 44, 45, 47
13.	Accepting posts	41
Teaching and training, assessment and appraisal		
14.	Teaching and training, assessment and appraisal	13, 15, 16
Probity		
15.	Research	52
16.	Financial and commercial dealings	53-58
17.	Providing references	14
Health and the performance of other doctors		
18	Protecting patients when your own health or the health, conduct, or performance of other doctors puts patients at risk	26 – 28, 59, 60

APPENDIX 4

The Doctor as Teacher

Introduction

1. In our *Recommendations on the Training of Specialists,* we acknowledge that the example of the teacher is the most powerful influence upon the standards of conduct and practice of every trainee, whether medical student or junior doctor.

2. Our recommendations about the pre-registration year, *The New Doctor,* and about training at senior house officer grade, *The Early Years,* discuss in some detail the arrangements that should be made for the supervision of new medical graduates and those in the early stages of training for specialist practice.

3. The guidance in this pamphlet supplements that in our recommendations about general clinical and general professional/basic specialist training. It sets out our expectations of those who provide a role model by acting as clinical or educational supervisors to junior colleagues, and of the bodies under whose auspices this task is undertaken. The guidance applies equally to those who supervise medical students, as they begin to acquire the professional attitudes, skills and knowledge they will need as doctors.

The educational obligations of all doctors

4. All doctors have a professional obligation to contribute to the education and training of other doctors, medical students and non-medical healthcare professionals on the team

5. Every doctor should be prepared to oversee the work of less experienced colleagues, and must make sure that students and junior doctors are properly supervised.

6. Teaching skills are not necessarily innate, but can be learned. Those who accept special responsibilities for teaching should take steps to ensure that they develop and maintain the skills of a competent teacher.

7. We expect doctors to be honest and objective when assessing those they have supervised or trained. Patients may otherwise be put at risk.

The professional attributes of the doctor with responsibilities for clinical training/educational supervision

8. Every doctor who is appointed to provide clinical or educational supervision for a doctor in training, or who undertakes to provide clinical training and supervision for medical students, should demonstrate commitment to our professional guidance in *Good Medical Practice*. This will involve:

    - maintaining a high standard of professional and personal values in relation to patients and their care

    - being available and accessible to patients

    - maintaining a high standard of clinical competence

- an ability to communicate effectively
- a commitment to personal, and professional, development as a doctor
- a commitment to professional audit and peer review
- a commitment to team working in a multi-professional environment
- an understanding of the multi-cultural society in which medicine is practised.

The personal attributes of the doctor with responsibilities for clinical training/educational supervision

9. The attributes of the doctor with teaching responsibilities will include:

    - an enthusiasm for his/her specialty
    - a personal commitment to teaching and learning
    - sensitivity and responsiveness to the educational needs of students and junior doctors
    - the capacity to promote development of the required professional attitudes and values
    - an understanding of the principles of education as applied to medicine
    - an understanding of research method
    - practical teaching skills
    - a willingness to develop both as a doctor and as a teacher
    - a commitment to audit and peer review of his/her teaching
    - the ability to use formative assessment for the benefit of the student/trainee
    - the ability to carry out formal appraisal of medical student progress/the performance of the trainee as a practising doctor.

The roles and responsibilities of the undergraduate and postgraduate training bodies

10. The universities, Royal Colleges and Faculties, the Specialist Training Authority and the Joint Committee for Postgraduate Training in General Practice should publish clear statements of the outcomes of training provided under their auspices for junior doctors. These will include not only the attitudes, skills and knowledge to be acquired but also an indication of the kind of doctor they expect their training programmes to develop. They should ensure that their philosophy is understood by teachers and trainers within both academic medicine and the health service.

11. Criteria for the selection of clinical and educational supervisors (including those with responsibility for the clinical training of medical students) should also be drawn up and published. These should make explicit the professional and personal qualities needed by the training bodies' role models. There should be formal arrangements both for reviewing the performance of supervisors and clinical teachers and providing feedback, and for addressing any problems identified.

12. The universities should ensure that formal training in teaching skills, and in the facilitation of student learning, is provided for all new appointees. Satisfactory completion of such training, and evidence of competence in teaching, should be required before probationary appointments are confirmed. The training needs of staff already in post should also be addressed.

13. Changes in undergraduate education have emphasised learner-centred education, problem solving and the acquisition of clinical and communication skills within hospital and community settings. For this reason, more hospital doctors and general practitioners are likely to be involved in teaching and the facilitation of learning, including the provision of feedback about performance, than hitherto.

14. Training should therefore be offered to NHS employees with honorary university appointments and to others with substantial commitments to the clinical training of medical students. The postgraduate training bodies should ensure that the training needs of those providing clinical and educational supervision for junior doctors only, who may not have the opportunity to benefit from university-organised courses, are met.

15. Large group teaching within the formal environment of a lecture theatre is a particular skill which needs to be taught and practised. Different demands are made of those with responsibilities for tutoring or facilitating the learning of small groups of students or trainees, whether in a clinical or a problem-solving environment. Staff development programmes should be designed to meet the on-going needs of doctors with a range of different teaching responsibilities. Within the universities, particular expertise can usually be provided by Medical Education Units, staffed by professional educators.

16. Small group teaching in general practice is well established, and has been extensively reported in the literature. As general practice has found, the time and resources to provide training for the trainers are critical to the successful outcome of programmes of teaching and learning.

The responsibilities of National Health Service employers

17. Teaching has traditionally formed a large part of the workload of full-time medical academic staff but increasingly, those working in the NHS are undertaking teaching and supervision of students and junior doctors as part of their job plans. While consultants have a contractual requirement to teach, clinicians in all grades may now have to combine service to patients with teaching duties.

18. NHS Trusts should recognise that employees with responsibilities for teaching and training our future doctors need time to learn how to carry out their duties effectively, and time to discharge these functions.

19. Uniquely in the NHS, the contribution of general practitioners selected to train others is nominally acknowledged in financial terms, presently through a ‘one session’ grant. However the conscientious trainer will often devote considerably more than one session per week to the trainee. Increasingly, the entire practice, with its extended primary health care team, is being viewed as the training environment and the commitment of all members to high professional standards taken into account for accreditation purposes.

20. APPENDIX 5

GP TRAINER VISIT REPORT TO EDUCATION COMMITTEE FOR GP, NORTHERN DEANERY

INTRODUCTION
This document guides all the headings needed to make a report to the Trainer Appointment Sub-committee of the GP Education Committee. The same document supports initial and re-appointments. Some modification is necessary in the case of initial appointments – there will be no GPR feedback and the visitors will be testing understanding of the trainers educational principles in a more theoretical way – "what will you do?" rather than "what have you been doing?"

BASIC INFORMATION

DATE AND TIME OF VISIT:	

NAME OF TRAINER: **Date of first appointment as GP Trainer:** **Date of most recent appointment As GP Trainer (if relevant)**	

PRACTICE NAME & ADDRESS:	

Date practice first appointed as a training practice:	

INFORMAL VISIT / INITIAL TRAINER APPOINTMENT VISIT / RE-APPOINTMENT VISIT	**Please delete as appropriate**

VISITORS NAMES & ROLES – Specifying lead visitor & roles	

GENERAL COMMENTS **e.g. recent changes in personnel (especially medical personnel), building or demography. Other developments in hand. Any external factors we should know about? Support for the practice in its training role?**

INFRASTRUCTURE

1. PREMISES **Do they meet Deanery standards? Yes/No** **Comment especially on GPR consulting room, seminar room, video Facilities.**

2. RECORDS **Do they meet Deanery standards?   Yes/No** **Primary record – paper / electronic?** **Comments?**

3. LIBRARY	
Does the physical library meet Deanery standards?	**Yes/No**
Is there a protocol for maintaining the library?	**Yes/No**
Does the trainer have adequate skills (or timely access to someone who does) in asking good questions and answering them effectively via electronic media (including critical appraisal)?	**Yes/No**
Comments?	

GPR PROGRAMME

1. Is there a PRE-EMPLOYMENT meeting?	
2. Is the INDUCTION satisfactory	
3. Is there a CONTRACT OF EMPLOYMENT?	
4. Is there an EDUCATIONAL CONTRACT?	
5. Is the GPR TIMETABLE jointly constructed	
6. Does the PROTECTED TIME conform to Deanery standards?	
7. Are the ASSESSMENTS of GPR performance of sufficient quality and standard? Do they meet Deanery minimum standards?	
8. Is FEEDBACK to the GPR timely, frequent, appropriate and helpful to learning?	
9. Is the DOCUMENTATION at or above Deanery standard levels, including • The programme • Assessments by both parties of individual teaching encounters • Formal assessments and Recommended actions	
10. Does the GPR WORKLOAD guarantee sufficient breadth and depth of clinical experience? Is it fair to the GPR	
11. Is it flexible so as to allow the GPR to experience all the Activities of the practice?	
12. Does the OUT-OF-HOURS EXPERIENCE meet current Deanery standards?	
13. Is the SUPERVISION of the GPR satisfactory? Are suitable arrangements made for supervision in the absence of the trainer?	

TEACHING SPECIFICS

What is the evidence for the teaching in the following specific areas?
Does it happen and is it good enough?

1. Consultation	
2. Prescription	
3. Referrals	
4. Record Keeping	
5. Audit and Quality Improvement	
6. Practice management	
7. Team working	

GPR FEEDBACK

1. Has the current GPR given feedback? In writing / In person / both	
2. Summary of Feedback	
3. Is there feedback from previous GPRs (up to the last 5 years may be relevant)? What message does the feedback give?	

TRAINER DEVELOPMENT

1. How is the trainer ASSESSING THEIR NEEDS as a trainer and meeting them?	
2. Is there an approved personal development plan, which includes training? Comments:	
3. What evidence is there that the trainer is INCREASING THEIR TEACHING SKILLS? e.g. information finding skills? communications skills teaching?	

4. What support has the trainer had in this respect? • Courses • Qualifications taken • Other means of support	

CONTRACT AGREED AT THE PREVIOUS VISIT **Re-iterate date of that visit and note the headline contractual elements agreed then. Report progress against those elements.**

CONTRACT AGREED AT THIS VISIT **Typically 3 or 4 elements with clarity of outcome and timescales.**

FINAL RECOMMENDATION AND SUMMARY	
Signed:	**Date:**

APPENDIX 6

Trainer needs assessment questionnaire – by permission of Dr Brian McKinstry

Methods of teaching and learning

How would you rate your competence in carrying out the following educational tasks or skills?	**Very good**	**Quite good**	**Not so good**	**Poor**	**Importance : High, Medium or Low**
Assessing the registrar learning style and recognising your own teaching style(s)					
Using different methods of learning and knowing when they are best used. e.g. random and problem cases analysis, video, referral and prescribing analysis					
Able to discuss theories of adult learning, learning-centredness, experiential learning, learning cycles					
Able to use learning plans portfolios					
Able to describe methods for continued self-appraisal and professional development					
Run a small group of registrars					
Use role-play					

Communication skills

How would you rate your competence in carrying out the following educational tasks or skills?	**Very good**	**Quite good**	**Not so good**	**Poor**	**Importance : High, Medium or Low**
Able to discuss common models of the consultation, with particular knowledge of Pendelton, Tate and Neighbour					
Able to use Cambridge-Calgary model or other system for analysing videos					
Knows marking scheme for summative assessment					
Knows marking scheme for MRCGP					
Able to advise a registrar on the technical aspects of recording					
Able to discuss the special challenges of telephone consulting and out-of-hours work					

Tutorial skills

How would you rate your competence in carrying out the following educational tasks or skills?	Very good	Quite good	Not so good	Poor	Importance: High, Medium or Low
Able to make use of different types of educational method in tutorials Able to set a learner-centred curriculum					
Able to integrate teaching from other members of the PHCT, and advise colleagues on registrar's needs and what is required of them when teaching					
Able to adapt quickly to make use of opportunistic educational needs					
Able to challenge the registrar, confident use of silence and awareness raising questions					
Assessing your own tutorial skills on video					

Critical reading / thinking and EBM

How would you rate your competence in carrying out the following educational tasks or skills?	Very good	Quite good	Not so good	Poor	Importance: High, Medium or Low
Explaining simple statistical concepts, e.g. P value, confidence interval, odds-ratio					
Explaining the merits of different types of study design, e.g. case control, cohort, RCT					
Explaining how to interpret meta-analyses					
Explaining how to assess the quality of an editorial or review articles in terms of bias, assumptions, conclusions drawn					
Able to demonstrate the use of evidence in the trainer's own practice					
Able to discuss the merits and drawbacks of guidelines					
Able to demonstrate a simple search on Medline, BMJ and a search engine on the internet					
Able to describe to the registrar useful sources of information concerning EBM					

Audit

How would you rate your competence in carrying out the following educational tasks or skills?	**Very good**	**Quite good**	**Not so good**	**Poor**	**Importance : High, Medium or Low**
Able to explain the principles of audit and describe the audit cycle					
Able to explain the difference between criteria and standards					
Able to advise, supervise or identify skilled help for the registrar so they can complete an audit cycle during the training year					
Able to demonstrate the value of audit in practice					

Appraisal

How would you rate your competence in carrying out the following educational tasks or skills?	**Very good**	**Quite good**	**Not so good**	**Poor**	**Importance : High, Medium or Low**
Be able to explain the principles of appraisal					
Be able to give specific non descriptive feedback					
Able to assess the needs of a registrar and set earning goals					
Be able to document progress by an educational log					
Be able to let a failing registrar know your concerns and devise a plan of remedial action					
Be able to advise a registrar on the standards required for summative assessment trainer’s report					
Be able to advise on the different parts of the MRCGP					

Literature of general practice

How would you rate your competence in carrying out the following educational tasks or skills?	Very goo d	Quite good	Not so good	Poor	Importance : High, Medium or Low
Be able to recommend appropriate texts for the MRCGP					
Be able to recommend medical texts or articles or fictional works on common problems, ethical and clinical, which the registrar may confront					
Be able to discuss important papers in the general medical journals and general practice					

The trainer as employer

How would you rate your competence in carrying out the following educational tasks or skills?	Very goo d	Quite good	Not so good	Poor	Importance : High, Medium or Low
Know the standards required of training practices for premises, records, audit and management					
Know the principles of interviewing registrars for employment (equal opportunity policy)					
Be able to advise on the different parts of the eligibility of employment in the UK as a registrar					
Know Scottish Council regulations governing sick leave, study leave, flexible training, hours of work, on and contracts					
Know regulations governing Health and Safety and employment law					
Know who to contact if are having problems with a registrar that you can't resolve yourself					
Able to discuss the financial and administrative aspects of a general practice partnership					
Able to negotiate protected teaching time with partners					
Able to discuss political aspects of general practice such as GMC, LMC, LHCC, BMA, GMSC, LIP, HIP					

- Which areas do you feel you need to develop most?

- What would be the best way for you to develop these?e.g. general reading, workshop attendance, special course, distance learning package

- Please make any comments about the form or content of the questionnaire that will enable you to improve it in future.

APPENDIX 7

C O G P E D

CHAIRMAN: DR PAT LANE *FRCGP*
20 GUILFORD STREET LONDON WC1N 1DZ

Out of Hours (OOH) Training for GP Registrars
COGPED - Position Paper – Spring 2004

Introduction

This paper sets out COGPED's position on the way in which GP registrars are to continue to obtain experience in out of hour's care where their GP trainers' practices have opted-out of providing OOH services

The Committee of General Practice Education Directors (COGPED) has consulted with the main stakeholders in this process, including the General Practitioners Committee (GPC), Royal College of General Practitioners (RCGP), The Joint Committee on Postgraduate Training for General Practice (JCPTGP), National Association of GP Cooperatives and the Department of Health (DH), to seek their views throughout the development of this paper. The preliminary response has been very positive and we have received extensive constructive comments from the GPC and RCGP, GP Postgraduate Deaneries and others, which are reflected in this draft with the intention of modifying it further in the light of experience and development of the OOH services in the months and years ahead.

The JCPTGP (the Joint Committee) as the Competent Authority has approved the content of the revised paper for training of GP Registrars in OOH care and stated that the content of this position paper should be implemented.

COGPED will continue to liaise with representatives from the GPC, GPR's subcommittee of GPC, RCGP, providers of OOH Organisations, JCPTGP, DH and PCOs to review and consider all issues of importance in the future for OOH training of GPRs.

Background

The delivery of OOH services, and the nature of the work, has changed over the past few years. As the nGMS contract comes into place, many GP trainers will choose not to take on the responsibility for OOH work, and thus put their GPRs at a disadvantage. The strong view of COGPED is that the generalist role of the GP should be maintained, and newly accredited GPs will be expected to have demonstrated their ability to perform competently in OOH primary care. It is still the GP Postgraduate Deaneries' responsibility to ensure that OOH experience occurs in training and for the JCPTGP/PMETB to be satisfied that all generalist competencies have been successfully assessed in order for a certificate of completion to be issued.

There is general agreement that the OOH changes in the new GMS contract are the first in a line of probable radical changes for general practice services. The OOH position itself is likely to alter rapidly over the next five years, and with the development of emergency care pathways in the NHS, this will have a significant impact on the primary care OOH services.

The new GP contract defines core services, and when implemented will allow practices to opt out of OOH. Between 1 April 2004 and 31 December 2004, practices can opt out of OOH where this is part of the PCO strategy. From 31 December 2004, PCOs will take full responsibility for making sure there is effective OOH provision. Some PCOs are organising this to take place from April 1st 2004, which is the earliest possible date. The UK Health Departments are currently working with the Strategic Health Authorities (SHAs) and PCOs **[NB: "PCO" is the generic term that covers English and Scottish Health Boards, Welsh LHBs and the NI equivalent]** to scope alternative arrangements for OOH provision, with an expectation that most practices will be able to opt out of the responsibility from January 1st 2005. It is important to clarify that whilst most GPs wish to give up the responsibility for OOH work, they are not giving up the option of being able to do it. It is likely that for a period of time, there will be significant variability in the arrangements for providing OOH in the UK.

Early indications are that at least 90% of practices will opt out initially and that the responsibility will pass to the PCOs who may contract for the delivery of this care from a range of agencies including reconstituted co-operatives and commercial services, or provide this directly themselves.

It is anticipated that with the progressive development of various patient care pathways, including emergency care in the NHS over the next five years, we will need to review the provision of the OOH training delivery for GPRs regularly. In addition, we are mindful of the implication of the European Working Times Directive that will be in place from August 2004, for GPRs' working times, though it is unlikely initially that this will impact significantly on the training for GPRs

The ideas and competencies presented in this paper are based upon the recently published article, which is fully endorsed by COGPED. We support the position of the generalist role and define the competencies that should be in place. In order to develop the OOH training programme, COGPED has facilitated the involvement and agreement of all the appropriate organisations and stakeholders in the provision of OOH primary care.

DEFINITIONS

Out of Hours service: The new contract (nGMS) has defined the normal working day for general practice to be between 08.00 and 18.30. Thus, OOH is defined as that work undertaken between 18.30-08.00 and all day at weekends and on public holidays. However, for the purpose of this paper, OOH is also taken to mean the type and style of working that takes place in this time. This recognises that the processes for providing general practice and primary care, both during the normal working day, and outside that, have changed over the last decade, and these processes provide different models of working, with the need for possession of different knowledge and competencies by GPs. It is important to make clear that these do not just refer to the management of emergencies, but also to the experience of dealing with patient contacts in a different quantity and context to the general normal working day.

Educational supervision of the GPR is usually undertaken by the GP Trainer. They undertake overall supervision of the individual's learning experiences, manage the process, commission learning opportunities, and are responsible for the delivery of the formative and summative assessment processes. Others may provide the educational supervisor with data to inform formative assessments, appraisal, and the completion of the Structured Trainers Report.

Clinical supervision may vary according to the learning situation. At its most basic, clinical supervision is a clinical governance issue, ensuring the quality of care and patients' safety. In this context it is taken to mean this, as well as the supervision of a GP Registrar's learning and experience. In some areas the clinical supervisor is called an associate or assistant trainer (and in secondary care, a consultant trainer). It is likely that Postgraduate GP Deaneries will need to develop and monitor the competencies of the clinical supervisors for this role, as well as clarifying the requirements of the job for the OOH provider organisation.
It is desirable for the clinical supervisor to have additional skills to that of being a proficient professional, and these will include the ability to teach observation and feedback to learners. The clinical supervisor could be a clinician who is beginning the process of becoming a trainer. Clinical supervisors need not be GPs.
Those doctors already approved as GP Trainers by their Postgraduate GP Deaneries will be automatically deemed qualified to supervise GPRs.

The Assessment Systems must be fit for a range of purposes. The methods used within the programme will be selected in the light of the purpose and content of that component of the assessment framework. Methods will be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning. For example, work-based assessment must be subject to reliability and validity measures. Evidence must be collected and documented systematically. This paper indicates that the assessment of the GPR will remain the responsibility of the Trainer, supported by evidence supplied by the GPR, which will include their own self-assessments.

JCPTGP View

The Joint Committee has debated this issue and has noted that their certificate licenses the holder to work in any capacity unsupervised in UK general practice. They therefore concluded that GP training should continue to be designed to equip GP Registrars to deal with all work that currently forms part of UK general practice. The opinion of the Joint Committee is that GP Registrars should continue to be trained in OOH work, as this remains a core part of the GP's role. Moreover, completion of the Structured Trainer's Report and the signing of the VTR1, and thus the overall educational supervision, would still be the responsibility of the GP Trainer, even if their service responsibility changes. In effect, the GP Registrar would be trained in OOH competencies, but under the supervision of a trained clinical supervisor in the local OOH organisation. The GP trainer would be in receipt of written evidence and formative feedback from clinical supervisors in the OOH Organisation that would allow the trainer to monitor and assess the GPR's competencies in this aspect of the training, and eventually sign off the registrar as appropriately competent. In some instances, the demonstration of some of the skills and competencies needed for OOH care could also take place during the normal working day, and could be signed off by the GP trainer from personal assessment. The quality assurance of this aspect of training would remain the responsibility of the JCPTGP via the GP Postgraduate Deaneries.

Expectation of GP Postgraduate Deaneries

The Postgraduate GP Deaneries would expect all GP registrars to obtain the necessary OOH experience and training. Where the practice has not opted out of responsibility for OOH services the responsibility for providing the experience and supervision of OOH training for the GPR would remain with that practice, but where training practices have opted-out of responsibility for OOH services delegated arrangements for supervision would be made with the OOH service providers, who would develop locally agreed criteria with the Directors of Postgraduate GP Education for training and the appointment of clinical supervisors. In some circumstances, this could be the GP Registrar's usual GP trainer. A formal feedback of each GP Registrar in their OOH competencies would be made on a regular basis (at least three times during the year) and this evidence would inform the GP Trainer's decision-making in signing off the trainer's report. The aim of the training is to enable GPRs to learn, develop, practice and maintain their competencies in OOH working. It is likely that one session, at a certain clinical intensity, per month will be necessary or the equivalent in another appropriate and negotiated combination of sessions. In some instances, the GP Trainer, in agreement with the GP Registrar, may indicate that additional time in this experience is required so that the competencies can be signed off. GP Registrars will be responsible to keep completed records of experience and feedback on all sessions that they attend in a workbook as evidence of their competencies in OOH training.

Assessment of out of hour's competencies

GP Registrars would have to demonstrate competency in the provision of OOH care. The overall responsibility for assessment of competency is with the GP Trainer but GPRs have duty to keep the record of their self-assessment, feedback and their experience in the competency domains. The five generic competencies are defined:

1. Ability to manage common medical, surgical and psychiatric emergencies in the out of hours setting.

2. Understanding of the organisational aspects of NHS out of hours care.

3. Ability to make appropriate referrals to hospitals and other professionals in the out of hours setting.

4. Demonstration of communication skills required for out of hours care.

5. Individual personal time and stress management.

Provision of Out of Hours Services

There are a number of organisations involved in the delivery of OOH services, including NHS Direct, GP Co-ops, Commercial Deputising Services, Nurse Triage, minor injury centres, Primary Care walk-in centres, and A&E departments. The model of service provided will be of necessity varied, but there will be a need for partnership and collaboration between all agencies at the local level. This will be driven and shaped by a national quality standards process. It is expected that the service will follow care pathways and patient journey/s, delivered in multi-professional settings, which will include GPs, nurses, paramedics, and A&E staff etc.

There will be a strong likelihood of consortia forming to serve this need. We need to encourage collaboration, and co-operation to ensure the success of the service.

Every model of service will have a place and thus should be able to offer training for GPRs.

The attached pictorial images demonstrate possible routes for the provision of services for patients out of hours, drawing on models of likely patient pathways (appendices 1, and 2).

The role of Primary Care Organisations

The PCOs will be required to secure the OOH services, either from appropriate organisations or consortia of organisations, or by direct provision. The PCOs will also have responsibility for the recruitment of competent GPs (as generalists who have adequate experience in the provision of OOH services) to serve in this area. Although the consensus opinion at present is that OOH services provided by GPs is that they are there as generalists, it is inevitable that changes and developments will occur, and PCOs might consider the development of Practitioners with Special Interest including GPwSI in the area of OOH provision, not only to enhance the quality of the service, but also as part of the overlying strategy for the retention of GPs. PCOs will need to ensure that the OOH service includes the provision of appropriate training for GPs in training. The PCOs are encouraged to work closely with the GP Postgraduate Deaneries in assuring the quality of training in the OOH organisations.

The role of GP Postgraduate Deaneries

When commissioning services, PCTs will need to reassure themselves that the provider will not only deliver high quality OOH care, but also has the capacity and capability to deliver the required training for GPRs. They will also need to ensure that the provider complies with the quality assurance processes of the GP training programme delivered by each Deanery.

The quality assurance of the GP training programme in OOH will include the assessment of:

- The post holder's educational plan, progress report, and monitoring processes, and the process for assessment of competencies (all to be documented).
- The post's level of workload, educational facilities and the overall quality of the learning environment.
- The clinical supervisor's ability (which must include skills in observation and the ability to give feedback).
- The capability and capacity of the OOH organisation in delivery of the clinical supervisory process.

It is essential that GPRs keep documented evidence of achieved competencies and experience, which will include their own self-assessment, the clinical supervisor's feedback, and any formal or informal comments made by others appropriately involved in the process. In order to support the skills of the OOH clinical supervisors, the GP Postgraduate Deaneries will provide programmes of training and skills development for them. The GP Postgraduate Deanery, in consultation with PCOs, may provide on going development programme as part of professional development of clinical supervisors.

Educational Materials

The workbook and record of sessions are suggested as a model, and will not be compulsory. However, a nationally agreed model could be available electronically which could operate similarly to that for GP appraisal, and allow both GPRs and GP Trainers to access records easily.

The role of GP Trainers

The GP Trainers would be expected to sign off the Trainer's report using the written evidence provided by the workbook and to provide the assessment of their GPRs in the competencies that have been recorded with the help of OOH clinical supervisors. It may be useful for trainers to use other assessment methods from a variety of sources, as they feel appropriate.

GP Trainers should make arrangements, as part of their initial educational planning with the GPR, for their sessions with the OOH service. This should take place at a time agreed by the trainer and GPR, following a clear evaluation of the GPR's level of skill and competency and their learning needs. The Trainer should also ensure that the GPR gets exposure to community based emergency and OOH care, as part of their negotiated sessions.

THE RESPONSIBILITY OF GP REGISTRARS

GPRs would work in the OOH services, under supervision, in order to gain competence and confidence in delivery of these services, as required as a necessary part of becoming registered as GPs. Therefore, GPRs would work in OOH services as part of their normal contract of employment.

The Role of the OOH Service

The OOH service would gain a contribution to service work from the GPR and would have the opportunity to promote OOH working to the future workforce. OOH providers will need to continue to have service input from doctors trained in, and certified for general practice work, and thus have a vital interest in maintaining their capacity. In addition, as the service will gain a contribution to service work in return, the OOH organisation would provide the clinical supervision and written and oral feedback to both GPR and GP Trainer. In order to support this, the OOH clinical supervisors will receive appropriate training commissioned or provided by the GP Postgraduate Deaneries. It will also be important to ensure that clinical supervisors have adequate time after a session in order to debrief the GPR.

The role of the PCO

The PCO would need to ensure that each OOH provider is able to provide the necessary training opportunities, has a sufficient number of trained clinical supervisors in their organisation, and that these supervisors are appropriately trained and supported. The PCOs are encouraged to consult with their GP Postgraduate Deaneries in advance of commissioning the OOH services.

Sessions in Out of Hours

The number of sessions worked by a GP Registrar will vary according to the number of patients covered but, in an urban setting, normally a six hour session every four weeks would seem appropriate, and in other settings on a pro rata basis. It is likely that organisations will form to provide cover for similar numbers of the population, but as variations will occur, each GP Trainer and each GP Postgraduate Deanery will need to assess the provision of experience for each individual GPR. The purpose of having a minimum number of sessions worked by GPRs, even if they can demonstrate the competencies, is that these sessions would increase the experience and exposure to different aspects of OOH work, particularly if they are undertaken in a wide variety of OOH settings. The negotiation of this is an issue for all involved organisations and GP Trainers.

With the inclusion of a necessary period of induction into general practice and primary care for GPRs, a minimum of twelve sessions would be expected over the (normal) GPR year. The number of hours worked in any week, would also have to comply with the appropriate European Working Time Directive. Furthermore, OOH work should not be undertaken the night before any organised educational activity, and Trainers will need to be aware of this. It is desirable that GPRs have experience of different models and shift times of the OOH service, but a GPR who works an overnight session should have the following day off. Although this would more commonly be worked as a session per month, it would also be possible for the GPR to have two separate weeks, for example, one week in the first six month period and one week in the last part of their GP training year.

Exposure to a variety of community based emergency and OOH cover should be provided for GPRs as part of their training programme. This should be acknowledged and negotiated with the GP Trainer, as part of the GPR's PDP.

Medico-Legal

The GPRs will be subject to the normal processes of clinical governance, GMC regulations and civil law. Their contract is likely, in the near future, to remain with the training practice or their GP Trainer, but they will be supervised by a clinician who may not be from that practice, or, on occasion, a professional who may not be a doctor (but who will be an approved clinical supervisor in OOH care). When working directly for a PCT, GPRs are likely to be covered by NHS indemnity arrangements. Other OOH providers will need to ensure that their insurance is adequate to cover liabilities in connection with the work done for them by GPRs.

Review

COGPED recognise that the process and structures for delivering OOH care are going through rapid and fragmentary change; thus the processes for delivering the training for OOH care for GPRs will require to be formally reviewed regularly and further consultation after the first year. To this end, the steering group of appropriate stakeholders should continue to exist and meet regularly.

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APPENDIX 8

NORTHERN DEANERY POLICY @ SPRING 2004

Towards identifying, preventing and tackling GP registrar problems[1]

- Early and thorough assessment is critical, including sitting-in, joint surgeries and/or video of consultations, and the views of other members of the team.
- Regular assessment and feedback to the registrar, coupled with documented development planning and scheduled review.
- Explicit expectations - practices should be explicit about the behaviour expected of the registrar e.g. working hours, participation in practice meetings etc, and what the registrar can expect from the practice.
- Understand that registrars may be going through an important transitional phase of their lives. Their background and culture e.g. a longish spell hospital medicine, may be relevant.
- If there are problems ***focus on behaviour and expected behaviour change.***
- Document and share all documentation with the registrar. In case of disagreement the registrar can register their view in writing to be kept with the documentation.
- Seek help early from colleagues in the practice, trainer group, course organiser and/or scheme organiser.
- Identify any need for an extra six months early. It should not be seen as "failure", but as an opportunity to hone the skills of being a really good GP.
- Consider need for an occupational health assessment (the schemes have the details).
- Trainer groups and schemes need to consider how best to provide structured and early support for new trainers.

Resources

1. see www.bmjlearning.com for useful advice on dealing with difficult doctors, ill doctors etc
2. action plan for future registrars – outcome of a practice's critical event discussion

Anne Holmes & Tim van Zwanenberg
March 2004

APPENDIX 9

[1] Based on a workshop at the GP Trainers' Faculty Conference in Durham in 2004

EXAMPLE OF EDUCATION CONTRACT FROM CRUDDAS PARK HC
(with permission Dr Philip Antoun)

1) Introduction:-

- this usually lasts one week
- shadowing the trainer for surgeries and visits
- introductory pack (useful phone numbers; referral waiting times; arranging admissions and investigations)
- all partners work at both surgeries, slight variations depending on holidays
- a weekly timetable is prepared

2) Timetable/workload

- traditional AM + PM surgeries with home visits between (9 am and 3.30 pm start - 10 minute appointments). please start on time
- booking lighter at first and building up to 14 appointments at 10 minute intervals
- extras generally fitted in before and after surgeries and seen equally by doctors (except AM at Cruddas Park)
- doors close at 6.00pm we all wait to cover any late calls
- Thursday PM - off (half day)
- Wednesday PM - VTS
- Monday AM - 9-11 protected time for teaching
- daily debriefing (? any problems)
- Monday 1-2 - Primary Care Team meeting (with practice nurse, district nurse, health visitors)
- every 6th Friday in house meeting (critical event analysis IHD etc).
- On call - 1 in 6 with one of the partners; days arranged at monthly business meetings (welcome to attend)

- <u>Cruddas Park</u> - baby clinic Wednesday 1.30-2.30pm

- Ante Natal clinic - Monday 2.00-3.00pm

- Kenton Clinic - ante natal clinic Tuesday 2.00pm-3.00pm

- Baby clinic Thursday 1.30-2.30pm

- Registrar free to select night/weekend to be with one of the partners (registrar to stop at 11pm)

3) Supervision/teaching

- tutorial agenda - agreed in 4-6 weekly blocks by mutual consent.

- preparation (reading, gathering case notes, preparing videos) - will make these more profitable

- in each tutorial - house keeping
  - summary of further learning needs

- review of tutorials (preparation, value, enjoyment) reviewed 6 weekly

- review of progress - every 2 months

- methods of assessment to include (PEP, referral letters, prescribing, random cases, videos,, Manchester rating, STAR, feedback from staff and partners)

- MRCGP/summatative assessment - support to complete within defined time periods.

4) Miscellaneous:-

- Drs Pilkington and Dr Brougham do minor surgery

- monthly business meeting - start 6.15pm registrar welcome to attend

APPENDIX 10

Assessing the performance of GP registrars: a toolkit for GP trainers

Mike Dodd and Julie Eccles

INTRODUCTION

A commonly expressed concern of trainers is ‘How can I tell my registrar how he/she is performing?” [2] ‘Performance’ is defined as ‘achievement under test’ [3] and GPRs undergo a number of end point assessments involving performance criteria as part of their training. These procedures are externally imposed, required by statute and involve adherence to predefined criteria. Studies have shown there are differences between what doctors can do in controlled high stakes situations (exams) and what they actually do in practice[4,5]. Trainers have a dual role in assessment of registrars: the formative assessment of performance and summative or endpoint assessment. Trainers are concerned with the ‘functioning’ of the GPR in the practice and sometimes struggle with the assessment of performance. Robust assessment is important to inform both feedback to the registrar and summative assessment to satisfy the regulatory authorities.

Educational theory suggests that feedback on performance can help the learner along the road from novice to expert [6]. Learners need to know, (and often ask) how they are doing. Feedback on performance has different purposes, ranging from helping with professional development to identifying the poorly performing registrar and validating achievement of externally imposed standards. There is literature concerning the assessment and revalidation of experienced doctors and the end point assessment of registrars (GPRs) but little about performance based assessment of GP registrars.

Performance assessments require learners to use prior knowledge and recent learning to accomplish tasks that demonstrate what they know and can do. Teachers and learners like this type of assessment because they can see the direct link between instruction and assessment. There is a dissonance as there is a difference between what ‘can be done’ (competency) and what ‘is done’ (activity). Many tools that measure performance will identify competencies but identifying activity is more difficult.

Miller [7] describes a conceptual model (*Miller’s Triangle* that identifies competence as progressing through a number of stages: ‘Know>Know How>Shows How>Does’. The

important step is assessment of ‘does’, because good practice depends upon what is done. *Good Medical Practice for General Practitioners* [10] categorises aspects of care against which performance can be assessed under seven broad headings; based on the GMC’s standards and principles®.

We have produced a toolkit to assist trainers with the assessment of the performance of their GPR. We have derived a number of domains based on the categories in *Good Medical Practice*. These domains are broken down into components, and take into account the needs of the learner. We suggest tools that are readily available and can be used to measure aspects of performance in each domain. Most trainers will already be using some of the tools but should consider extending their repertoire in order to ensure a robust assessment of their GPR’s performance. We are not suggesting that all tools are used with each GPR but trainers decide on the most appropriate depending on the circumstances. Some of the tools rely on observation, but there is evidence to suggest that regular observational assessment of performance is reliable [11]. Some have been robustly tested for reliability and validity but others are more subjective and trainers need to bear this in mind when using them.

Gathering the evidence is an iterative process. Some will be gathered by day-to-day contact with the GPR, others will need to be done more proactively. A log of activity will assist trainers to maintain a record of performance. The exact timing of the assessments and formal feedback to the GPR are a matter for the individual trainer to decide depending on the abilities and progress of the GPR. Training schemes may have their own recommendations for assessment but these may be focussed upon the needs of the summative assessment timetable. However we would suggest that formal feedback on performance should happen early in the training, at the midpoint stage and towards the end. This will give the GPR a clear idea as to how they are progressing and what their developmental needs are. It will also inform summative assessment by providing robust evidence for completing the trainer’s report.

We hope that trainers will find this toolkit useful, with its stress on formative assessment and the development of GPRs.

THE TOOLKIT

We present the toolkit in several sections:

1. Domains for assessing performance as derived from the GMC

2. A list of possible assessment tools for each domain with accompanying notes to help users understand their application
3. References that include the evidence for many of the assessment methods
4. Appendix 1 which describes assessments using video consultation analysis
5. Appendix 2 which is a list of websites from which more detail of the assessment methods can be obtained

DOMAINS FOR ASSESSING PERFORMANCE

1. **Clinical care**.
2. **Communication skills.**
3. **Maintaining good medical practice.**
4. **Relationships with patients**.
5. **Working with colleagues**.
6. **Personal attributes.**

1. Clinical Care

Component	Tools
Knowledge	MCQ PEP (Phased evaluation programme) Tutorials Audit e.g. of prescribing, referrals/complaints Mini-CEX
Skills Problem solving Practical skills	 Random Case Analysis Problem Case Analysis Video Tutorials Direct observation/sitting in Complaints Mini-CEX

Notes:

1. MCQ/PEP is a test of knowledge, which can be used to give a global overview and may be useful for initial screening when the GPR arrives in the practice.

2. Tutorials/Random Case Analysis/Problem Case Analysis may be used to explore specific educational needs e.g. a tutorial about ischaemic heart disease can expose deficiencies about secondary prevention and drug issues. They may also help identify the ability of the GPR to use a problem solving approach. Analysis of clinical scenarios will help the trainer assess the GPR's problem solving skills by encouraging the GPR's to explain their reasoning and thus allowing the trainer to explore their thought processes. It may identify specific issues with knowledge, hypothesis generation, pattern recognition and deductive reasoning.

3. Although the main use of video analysis is to look at communication skills, it can provide valuable evidence for clinical care. Video review has similar reliability to direct observation and has the advantage that it is less intrusive and onerous for the assessor, as practice may be observed at a more convenient time. However it is resource intensive and knowledge that performance is being observed may influence behaviour [12]. There are many video analysis tools available; appendix 1 suggests a framework for using them.

4. Specific clinical skills are best assessed by direct observation. A reliable and valid measure of the clinical encounter can be obtained by the Mini-CEX (Clinical Evaluation Exercise). This short (15-20 minute) assessment, initially piloted in the USA for residency programmes and now used in this country, looks at a variety of skills such as history taking, clinical examination and diagnosis, communication and professionalism and organisational skills giving an overall score for clinical competence. The assessment is designed to be repeated with different patients.

2. Communication skills

Component	Tools
Oral	Video consultation Skills Questionnaires (e.g. DISQ) Mini-CEX
Written Records/letters	SAIL – (Sheffield Assessment Instrument for Letters)

Notes:

1. The ability to communicate effectively is considered by the regulatory authorities as a measure of excellence. [9,10]
2. Video analysis is the tool par excellence for observing communication within the consultation.
3. Consultation skills questionnaires [13,14] are methods for obtaining patients' feedback on doctors' abilities to communicate effectively. DISQ is a validated questionnaire consisting of 12 items that obtain specific feedback on interpersonal competencies. Others are listed in the references.
4. The GPR needs to communicate effectively with other members of the primary care team and professional colleagues. We have not come across any specific tools that measure performance in this area other than requesting feedback from those concerned.
5. The Sheffield Assessment Instrument for Letters [15] assesses communication by letter using a consensus framework developed to look at routine letters between primary and secondary care.

3. Maintaining good medical practice

Component

Tools

Component	Tools
Commitment to Life long learning	**Punctuality/preparation for teaching sessions** **Evidence of Self Directed Learning** **Attendance at/feedback from ½ day release groups** **Use of log diary** **Reading**
Commitment to reviewing personal performance – audit/peer review	**Willingness to take part in audit** **Response to feedback** **Log or learning diary**
Reflective practice	**Ability to reflect, evidenced from case analysis/tutorial /video** **Discomfort log**

Notes:

Keeping knowledge and skills up to date is a major aspect of the GMC's standards for revalidation [16]. The maintenance of 'currency' of practice requires a capacity and motivation to change and requires the learner to possess insight into his/her performance.

1. Attendance and punctuality are measures of commitment to the learning process.
2. Willingness to take part in and respond to audit and feedback activities demonstrate evidence of motivation to change.
3. Keeping log diaries/discomfort logs [17] fosters critical thinking and reflection about professional practice and can demonstrate that the learner is prepared to analyse their own performance.
4. Reading educational material may not change doctors' performance but evidence that the GPR is reading and accessing information appropriately can demonstrate the doctor's ability to keep up to date and address gaps in their knowledge.

4. Relationships with patients.

Component	Tools
Polite and considerate	Consultation Skills Questionnaires
Patients best interests	Video
Non discriminatory	Joint visits and surgeries
Honesty	Complaints/compliments
Integrity	Case discussion
Confidentiality	Knowledge of ethics
Maintaining trust	Mini-CEX

1. Evidence suggests that good interpersonal skills result in more favourable health outcomes for patients [14], so feedback on doctors' interpersonal skills is important. Regular review of video consultations, sitting in and joint visiting will give the trainer an opportunity to assess interpersonal skills. Reference has already been made to DISQ.

5. **Working with colleagues**

Component	**Tools**
Working with colleagues Team working With secondary care Other agencies	Feedback from colleagues STAR Complaints/compliments

All GPs work in teams and good team working enhances patient care. Feedback from team members will be required to assess how the GPR functions within the team. This can be anecdotal or based on questionnaires.

1. The STAR rating scale (Staff Trainee Assessment Rating Scale) seeks the views of primary care team staff about the GPR. It is returned anonymously. 'Scores' can be collated and compared to other registrars in a qualitative way. The feedback may require considerable skill on the part of the trainer, particularly if the results are poor.

2. Compliments from colleagues can be a useful performance indicator and help to build trust. Complaints need careful exploration and handling but if consistent could point to major problems with the doctor concerned.

6. Personal Attributes

Component	Tools
Maintaining own health	Substance misuse policy Sickness/unauthorised absences Life outside medicine Discomfort Log
Commitment & Punctuality	Accessibility: to patients/on call Timekeeping Time management
Coping with Pressure	Observation of registrar behaviour

Maintenance of mental, emotional and physical health is a responsibility that, if neglected, can put patients at risk. Absences, whether authorised or not may provide evidence of a problem, e.g. the GPR who is consistently absent on Monday with minor illness might have a major underlying problem. A discomfort log [17] can provide an opportunity to discuss worries and concerns about managing self.

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APPENDIX (I)

Using Video as a tool for giving feedback on performance

There are number of methods to analyse consultation performance. All the methods concentrate on the doctor's performance in the consultation, but a stepwise approach can be used to move from assessment of minimal competencies [1] to the development of excellence [4]. The Cambridge Calgary approach [20] can be used throughout to develop and assess communication skills.

1. Summative Assessment Video marking Schedule [21]

This tool is the most basic of assessment measures and concentrates on 'minimum' competencies. It can be used with the inexperienced GPR to look at basic competencies that are:

- defining the reason for the patients attendance.
- taking a history.
- organising and agreeing a management plan.
- demonstrating an understanding of what is happening in the consultation.
  www.nosa.org.uk/downloads/htm/cogped/1stmarking.htm

2. Pendleton [18]

This method introduces seven consultation tasks and a focus on the patient's agenda and developing a shared understanding of the presenting problem.

The method requires 'that the learner develops the ability to assess his present level of performance and to take corrective action'. Commitment to reviewing personal performance is one important aspect of maintaining life long learning.
www.wellclosesquare.co.uk/nntg/docs/consmap.doc
www.trainer.org.uk/members/tools/pendleton_rules.htm

3. Cox [19]

This tool develops the theme of patient centredness but builds on a number of additional competencies and introduces areas to assess such as attitudes, specific clinical skills, efficiency and patient satisfaction.
www.wellclosesquare.co.uk/training/pgi/coxvid.htm

4. MRCGP Video Assessment Marking Schedule [22]

No new areas are introduced but it breaks the consultation down into more specific criteria (cf Cox). Each area elicits specific competencies known as 'performance criteria', e.g. ' the doctor takes the patient's health beliefs into consideration'. Some criteria are 'pass' criteria and a few are 'merit' ones, thus introducing the idea of excellence. Reviewing 'merit' criteria can add an aspect of challenge for the competent registrar. This encourages them to build on already acceptable performance.
www.wellclosesquare.co.uk/nntg/docsmrcgpvid.doc

5. Cambridge-Calgary [20]

This is different as it concentrates on communication within the consultation. By drawing on the available body of evidence about effective communication it develops specific skills, e.g. agenda setting and signposting. The registrar has the opportunity to practice new skills through rehearsal. As it encourages the registrar to identify problems and to propose strategies for change, we feel that this method can help trainers assess GPRs' problem solving skills.

www.wellclosesquare.co.uk/training/theory/calgary/
www.trainer.org.uk/members/tools/calgary_cambridge.htm

APPENDIX (II)

RESOURCES

1. STAR Rating Scale ("*Staff Trainee Assessment Rating)*
   [http://*www.wellclosesquare.co.uk/training/tools/star.htm*](http://www.wellclosesquare.co.uk/training/tools/star.htm)

2. Consultation Satisfaction Questionnaires.

   i) DISQ. The Doctors' Interpersonal Skills Questionnaire
   http://latis.ex.ac/cfep/disq.htm

   ii) Consultation Satisfaction Questionnaire
   http://www.wellclosesquare.co.uk/training/tools/csq.htm

3. SAIL. Sheffield Assessment Instrument for Letters

4. PEP
   www.rcgp-scotland.org.uk/products/pep.asp

5. Mini-CEX
   http://www.medicine.ufl.edu/3rdyearclerkship/documents/MiniCEXform.pdf

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