General Practice
Specialty Training School

Clinical Supervisors

Guidance on Out of Hours Training & Competences

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Foreword

The purpose of this document is to provide updated guidance for clinical supervisors (CS). It is accompanied by a new GP Specialty Training Registrar (GPStR) workbook for Out of Hours (OOH) General Practice Training.

Many of the ideas for the updated guidance and workbook came from a clinical supervisor workshop held in May 2010. I would like to thank all of those who took part in the day. Suggestions from the workshop were further developed by Dr Janet Watters, an OOH clinical supervisor in the North and West Belfast Out of Hours Centre, into the new guidance and GPStR workbook that follows.

The documents should provide clear information to clinical supervisors (CS) about the competence of the GPStR on starting OOH training and their subsequent learning needs. Prior to attending the first OOH session, it is expected that the trainer (if they are not the CS in OOH) will discuss the GPStR level of competence with the CS. They should further discuss GPStR progress on at least 3 other occasions over the 18 months of GPStR training (pro rata if the training is split between a number of clinical supervisors).

A copy of the workbook can also be found on the website, together with a copy of the latest advice to trainers who do not work in OOH. It is intended that the guidance will evolve and improve over time. We will run a series of CS updates later in the academic year. In the meanwhile, we welcome your feedback and will incorporate constructive suggestions into the next edition.

Yours etc.

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1.0 INTRODUCTION

Given the small number of hours (108) that General Practice Specialty Registrars (GPStRs) spend doing OOH work, the recording of experience in care of acutely ill patients also includes cases and situations encountered in day time practice.
This GPStR workbook is based on OOH care in Belfast. There are variations between OOH providers in Northern Ireland in how care is organized. GPStRs should add the different contact numbers and other details relating to their locality at the end of each relevant section.

1.11 WHO CAN ACT AS A CLINICAL SUPERVISOR?

Where possible OOH experience and training will be supervised and conducted by the trainee's usual daytime trainer. If this in not possible then clinical supervision in OOH training may be carried out by another trainer in the practice, another trainer in the locality of the training practice or an accredited clinical supervisor (CS). The usual trainer will arrange OOH supervision with another trainer or help the trainee to contact an alternative clinical supervisor. A list of approved clinical supervisors and their contact details is available via the NIMDTA website. (http:www.nimdta.gov.uk/generalpractice/gp-vocational-training/gptrainees/out-of-hours-sessions/).

1.12 WHEN SHOULD TRAINING BE DELIVERED?

GPStRs should undertake a variety of weeknight, weekend, bank holiday and red eye sessions. If they wish to undertake independent employment in OOH on completion of training they must undertake at least one red eye session. To comply with the requirement to cover a number of different types of session it may be necessary to work with more than one clinical supervisor. The maximum number of clinical supervisors per trainee is 3.
For ST2 and ST3 doctors there is an expectation that sessions will be roughly one per month, but most ST2s do 6 sessions over 5 months, and most ST3s do 12 sessions over 10 months or less due to time pressures regarding examinations, and the time needed to obtain certification of completion of training. During ST training day time experience would be expected to be 70 cases per week for ST2s and 80 cases per week for ST3s, so that the OOH case load is relatively small.

1.13 BOOKING OF OOH SESSIONS

Specific dates for sessions should be arranged between the trainee and the alternative trainer/CS directly. It is then the GPStR's responsibility to inform the OOH service provider of the date and times of the training sessions. At weekends there may not be enough work stations in the OOH base to allow for more than one trainee to attend during a session. In the event of a clash with another trainee's booking the proposed session may need to be re-arranged.

1.14 GPStR INDUCTION

Prior to undertaking OOH sessions each GPStR will take part in an induction day fulfilling a regional core programme, and have an induction session at the OOH base, where the OOH training is to be undertaken. The induction to the OOH base will be provided by OOH staff at a time agreed in consultation with the local GP Training Programme.

1.15 LIAISON BETWEEN CS AND TRAINER

If at any time the CS has concerns about the performance of the trainee, these should be immediately discussed with the trainer. Possible areas of concern would be attitude, telephone manner, over confidence, under confidence, poor attendance, late arrivals, and poor time management.

(In day time practice ST2s start with 20 minute appointments, moving to 15 minute slots by the end of 6 months. ST3s start with 15 minute appointments and move to 10 minutes. In OOH base consultations may be longer than day time equivalents due to the need to gain additional information not held on computer, and the need to dispense medication).

It is proposed that trainees have 4 formal assessments of competence during their training.

1. Baseline assessment of the GPStR
OOH sessions should only take place following an assessment of each GPStRs level of competence and identification of their learning needs. Normally the trainer will undertake this review during the first month in practice.

The baseline assessment has 3 sections;

- Statement of previous experience, description of current GP practice (if CS is not the trainer) (St2 appendix 2.0 page 42, St3 appendix 2.1 page 43)
- Baseline Needs Assessment Tool (appendix 3, page 44)
- Identification of learning needs (PDP) (appendix 4, page 48)

A copy of the assessment should be kept in the GPStR's OOH Workbook. If the clinical supervisor is not the trainer this provides valuable information to make a judgement regarding the level of clinical supervision required and to better understand the GPStR's learning needs.

2. Second Assessment
This should be carried out by the CS at the end of the GPST2 placement in OOH and should include;

- A review of the PDP and gaps in the record of training
- The CS will make a formal assessment of knowledge using a modified Canbury Structural Assessment Questionnaire
- Preparation of a new PDP for ST3 OOH training
- Record of Progression (initial review) (appendix 6, page 53 - 60)

3. Third assessment
This should be carried out by the CS at round about the 8-9 month stage of the GPST3 year, corresponding to session 14 or 15 in OOH. As most GPStRs do examinations in February, this will probably take place in March or April to allow time for completion of certification of competence by the end of July.

- This review will assess progress towards completion of the previous PDP, identify any gaps in training and agree a short final PDP for completion by the end of OOH training.
- Record of progression (mid-point review), (appendix 6, page 53 - 60)

4. Completion of training – signing off
At the last session in OOH the GPStR and clinical supervisor should be able to sign off the final section of the Record of Progression (Appendix 6, page 53 – 60, GPStR Guidance on Out of Hours Training).

GPStRs will be invited to give feedback on their experience of OOH training via the electronic deanery survey and suggestions for improvement will be acted upon.

It is expected that the CS and the trainer (if not the same person) will discuss each assessment and agree full competence for the final assessment.

1.16 SUPERVISION NEEDS: PROGRESS FROM RED> AMBER > GREEN

During training doctors' skills may be graded as novice, competent or proficient. This equates to the colour coding of supervision needs red, amber and green as follows:

Novice (Red): Requires direct supervision by the CS, with the GPST taking no clinical responsibility
Competent (Amber): Requires close supervision by the CS, with the GP ST consulting independently, but feeding back to the CS, who is in the same building.
Proficient (Green): The GP ST consults independently, and can practice remotely from the CS for example doing home visits while the CS is in the base, or vice versa. Telephone contact is readily available if needed.

During the first two sessions of OOH training for ST2s it is expected that the CS will directly supervise trainee consultations on the phone, at base and at home to ensure competence. During periods of high workload it is suitable to swap some consultations so that the trainee directly observes the CS performing telephone triage, base visits and home visits, and is invited to comment.

It is expected that GPStRs will rapidly progress from direct (red) to close supervision (amber) by sessions 3 and 4, allowing for increasing experience via day time practice. The CS will check details and outcomes of consultations to confirm that management has been appropriate.
For ST2s it is hoped that by the end of the 6 months in most areas of care they will be practicing at a green level. For some areas of care such as obstetrics and gynecology, where there has been no experience of hospital care, a trainee may remain at an amber level depending on the amount of experience achieved during day time practice.

At the end of the ST2 placement a second assessment of competence will be made, by specifically looking at how earlier learning needs have been met, performing a modified Canbury SAQ test Appendix 2 (page 15), and producing a new learning plan (PDP) Appendix 4 (page 48 of GPStR Guidance on Out of Hours Training) for the ST3 stage.

For ST3s, given the prior and current level of day time experience, it is expected that they should be functioning at a green level from the outset of their time in out of hours. Some specific areas of practice may be identified as needing more supervision, via the assessment of learning needs, for example acute psychiatric emergencies, or management of red eye.
Grading of practice at the independent level does not preclude the need to ask for support or

advice for difficult consultations. The recognition of when it is appropriate to seek advice is part of the knowledge base of the proficient doctor.

In practice all trainees will have some supervision at all points in their training due to the employment obligations of clinical supervisors to be present and ensure that patient management has been appropriate. When STs are at the green level of performance it would be expected that CS clinical activity should be such as to keep overall workload under control, while allowing trainees to have maximum appropriate clinical exposure. Discussion between the CS and ST regarding consultations dealt with by the CS is a useful source of additional educational activity. When trainees are practicing independently it is still useful for them to accompany the CS or one of the non training OOH doctors to interesting consultations, and to record their experience of this activity. Examples of this would be unusual clinical presentations, rashes, and unusual visits, for example to a wet hostel, or children's home, or care home for dependent adults. The CS will facilitate this trainee activity.

1.17 RECORDING WORK

The OOH workbook should contain copies of all of the forms recording OOH sessions, detailing types of session, type of cases seen and significant events, competencies demonstrated, learning needs identified and debriefing notes.

When entering details of competencies on the OOH record form it is suggested that cases be mapped to the relevant clinical competence of the OOH curriculum, and given a colour grading of red, amber, or green depending on level of competence. This allows evaluation of the level of supervision required on a regular basis and shows progression of experience and knowledge. Mapping OOH activity to each curriculum area facilitates the trainee in recording their experience on their e portfolios.

It is desirable that the in hours trainer should add comments to the OOH record copy regarding follow up action re learning needs identified. At the next OOH session these follow up actions can be discussed.

1.18 COMPLETION OF TRAINING

At the end of the training time the ST2 should have a certificate of competence regarding their OOH work, with clear identification of any needs for further training. At the end of their time in OOH each ST3 should complete a sign off form with their trainer/clinical supervisor as a fully competent OOH doctor. In anticipation of this any learning needs should be actively targeted and met during the final 3 sessions of OOH training.

1.19 FEEDBACK

At the end of each trainee course the trainer and trainee should provide feedback regarding the training received. A format for this will be developed during 2011-12.

1.20 FURTHER TRAINING

An update training session for Clinical Supervisors will be arranged at least annually.

1.21 PAYMENT

For the 2010 – 2011 educational year the payment system has reverted to the previous method in that payment to clinical supervisors will be prompted by the submission of the completed ROS form/section 3 form to NIMDTA by trainees, thus trainers will need to encourage trainees to do this promptly.

2.0 THE CURRICULUM FOR OOH TRAINING

The six generic competences, embedded within RCGP Curriculum statement on 'Care of the acutely ill patient' are listed below.

By the end of the GPST programme, a GPStR must be competent to provide out of hours care by demonstrating:

- Ability to manage common medical, surgical and psychiatric emergencies in the out-of hours setting
- Understanding of the organizational aspects of NHS out-of –hours care
- Ability to make appropriate referrals to hospitals and other professionals in the out-of hours setting
- Appropriate communication skills required for out-of-hours care
- Individual personal time and stress management
- Maintenance of personal security and awareness and management of the security risks to others

The new workbook gives short advice notes to trainees about clinical and organizational issues in OOH practice and specifically maps areas of competence in a curriculum map, to be marked off with date of achievement and grading of competence.

A number of blanks have been left to allow for the recording of significant clinical/organizational experiences. Items completed in these blanks will be considered for addition to future editions of the workbook.

The following sections detail some suggestions as to how to assess trainee competence.

2.10 MANAGEMENT OF EMERGENCIES

Curriculum Requirement 1 (CR1)

Assessment of competence;

- By observation of action in emergency/urgent situations.
- By recording of clinical experience.
- Using discussion of possible presentations of emergencies/urgent cases.
- By asking Trainees to make a list of cases for whom they would call 999.
- Test trainee's knowledge of the importance of key words/phrases in the diagnosis of serious conditions.
- Clinical exercises – for example - what questions and answers would give you a diagnosis of limb ischaemia? – what questions do you ask in assessing a feverish child?

- Use the modified Canbury SAQ, (see appendix 2) as a way of testing trainees. This will be part of the formal assessment at the end of the ST2 stage.

COGPED defines proficiency as;
- Knowledge of clinical conditions
- The doctor is easily able to recognize the manifestations of acute serious disease and can act appropriately, effectively and with speed to manage these.
- The doctor has a comprehensive working knowledge of these conditions and has demonstrated management of at least one important condition in each area.
- Knowledge of symptoms
- The doctor is aware of the significance of symptoms of emergencies, and can demonstrate this through actions and decision making.
- The doctor can demonstrate how to appropriately assess patients with these symptoms.
- Ability to carry out basic life support
- The doctor has had recent training in BLS and has planned refresher training, and has been able to demonstrate these skills.

2.20 ORGANISATION OF OOH CARE

Curriculum requirement 2 (CR2)

This should be largely covered under the Induction to the OOH base, mostly by OOH staff prior to the first session, but should be checked by the CS at the first session

Assessment of competence;
- Observation of trainee performance in making use of this information
- By asking trainees about specific case or situational scenarios.
- Understanding of and respect for staff roles (especially urgency grading), knowledge of their experience and training.
- Are they able to lead a response to a clinical/situational crisis
- Are they aware of how to manage emergencies occurring in the base – eg collapsed patient, limitations of environment
- Ask the trainee what they would do if someone else is wrong – eg overheard triage.
- Assessment of their ability to transfer care from ooh to in hours and vice versa, communication, handover – base and home visits at end of shift. Alerting patients own GP to problem diagnoses, giving patients copy of ooh notes

COGPED defines proficiency as;
- The doctor is aware of the processes that are in place both locally and nationally, and can understand the context of the provision of OOH care in Primary Care.
- The relationship of all those other organizations that provide care in the community OOH is well understood, along with the relationship of these organizations to the PCT and the role and responsibilities of the PCT in supporting and monitoring these services.
- There is appropriate awareness of the complaint and Clinical Governance processes for the organization.

2.30 REFERRALS

Curriculum Requirement 3 (CR3)

Assessment of competence;

- Direct observation of referrals and letters
- Discussion of trigger factors for admission.
- Who is safe to leave at home?
- What to do if a patient refuses admission when mentally competent to do so?
- Observation of mental health referrals.

COGPED defines proficiency as;

- The doctor is able to communicate effectively and courteously with all other professionals who are involved with, or need to be involved with, the care of the patient.
- The doctor respects the roles and skills of others, and can effectively engage and refer to other sources of care, such as ambulance and paramedic services, and those in secondary care.

2.40 COMMUNICATION SKILLS

Curriculum requirement 4 (CR4)

Assessment of competence;

- Direct observation of trainee performance - personal behavior and knowledge
- Discussion of the triggers for base/home visits and any difficulty in decisions
- Assess trainee's ability to take a systematic approach to diagnostic possibilities, correctly pick up on significant words, eg floppy, grunting, and ability to diagnose from history alone.
- Discussion of difficult cases, observation of the trainee's ability to reflect upon and understand the origin of perceived difficulties and learn from these.

COGPED defines proficiency as;

- Communication skills with patients
- The doctor is able to elicit the appropriate information effectively from patient whatever the mode of contact, and is able to check all relevant areas when there is no prior information available.
- The doctor is able to make an appropriate management decision within an appropriate timescale.
- The doctor shares with the patient their thinking and allows the patient to be involved in the decision making where appropriate.
- Communication skills with other colleagues (teamwork)
- The doctor respects others in the team in which he is working and deals with them professionally and courteously.
- The doctor can effectively record and transmit necessary information about the patient to others who will be involved in their care.
- The doctor is willing to learn and be involved in the work at all times during the session and is prepared to support colleagues who ma be having difficulties during their shift.
- The doctor understands the duties of a medical practitioner in relation to working with their colleagues.

2.50 TIME AND STRESS MANAGEMENT

Curriculum requirement 5 (CR5)

Assessment of competence;

- Direct observation of performance.
- Debriefing after cases.
- Discussion of items on check list prior to signing off on them.
- Discussion regarding reflection and ongoing learning and attitude to the future in practice.

COGPED defines proficiency as;

- Problem solving and triage skills, prioritizing the management of presentations
- The doctor makes effective use of time during the period of work and can quickly assess the severity of presentations appropriately.
- The doctor has a robust and effective structure for prioritising patient presentations and demonstrates well-developed problem solving and triage skills.
- He/she knows when to ask for more information if not enough is provided and demonstrates effective methods for dealing with the uncertainty that arises from dealing with large numbers of case presentations in a short period of time.
- The doctor understands the management of uncertainty related to triage processes and is able to deal with this effectively and with safety for patients.
- Managing the medical record
- The doctor provides a clear, legible and concise record of the patient interaction that includes all the salient points relating to the diagnosis and management of the situation.
- The doctor ensures that this record will be transmitted to any other professional who will need to see it.
- The doctor can share his or her decision making with other members of the organization and will make arrangements to do so for appropriate further management of the patient.
- Time management, awareness of personal limitations and self-care.
- The doctor arrives for work on the majority of occasions with both the physical and mental energy to perform effectively.
- The doctor can recognize when personal stress during a session will diminish their effectiveness as a doctor and a learner, and will obtain support for themselves when appropriate.
- The doctor is prepared to come early, or stay late, for OOH sessions if necessary to support colleagues and avoid reduction in patient care.

2.60 LOOKING AFTER YOURSELF AND OTHERS (SECURITY)

Curriculum requirement 6 (CR6)

Assessment of competence;

- Direct observation of performance
- Debriefing after cases
- Discussion of organisational scenarios.

APPENDIX 1 – SUGGESTED LEARNING SCHEDULE FOR USE WITH GPSTs

OOH Training

The intention is that these outline tutorials are used with the OOH workbook and introductory section on the individual curriculum requirements. A lot of the material should be familiar. Some of the exercises are designed for the GPR to "find a quiet spot" and work through, freeing you during the course of the shifts!

OOH Competencies	Resources
Managing Emergencies	Canbury SAQ "And don't miss this" (Appendix 1)
Organisation of OOH Care	Who is involved in OOH Care? (Page 12 – Workbook)
Making Referrals	Using other OOH service providers (Page 19 – Workbook)
Communication & Consultation Skills Telephone vs face-to-face consulting Consultation model for telephone work.	Telephone consultations article BMJ (available on NIMDTA website)
Managing Personal Time	Personal skills and duties as a doctor (Page 23 – Workbook)
Personal Security, Security of Others	Reducing risk of harm to self and others (Page 23 – Workbook)

Session 1

Orientation and introduction

- Show around OOH base and introduce to staff
- Brief history of evolution of OOH care

- **C 4 Communication Skills**
- Exercise 1 Compare phone and face-to-face consultations, then discuss.
- Exercise 2 Consultation model for telephone work, based on Neighbour. The GPR could complete this in session 1 and session 2 whilst watching the Trainer conducting phone consultations
- C 1 Managing Emergencies
- GPR's experience to date and confidence - BLS / ALS (CPR) training
- Self-Assessment Exercises
- Give GPR the 2 self-assessment exercises to read through before session 2

Session 2

C 4 Communication Skills

- GPR observes trainer during telephone consultations, develops the Neighbour model
- C 1 Managing Emergencies

- Work through one or both of the self-assessment exercises
- Discuss issues arising from GPR's answers
- **Session 3**

C 2 Organisation of OOH care

- Discussion topics from sheet C 2 - who are the providers of OOH services?
- Communication processes within OOH providers

Session 4

C 3 Making Referrals

- How to refer to, and how to contact the other OOH services

Session 5

C5 Managing personal time

- Personal skills, duties as a doctor

Session 6-12

- General OOH experience

APPENDIX 2 – MODIFIED CANBURY SAQ – IDENTIFYING EMERGENCIES

Emergencies in practice

The diagnosis and management of acute conditions that could result in death, disability or severe pain if not properly treated within 24 hours, is a vital part of general practice. This is a test of your current skills at suspecting emergencies from clues in the history. List the emergency that might be presenting with the information given.

	DIAGNOSIS	SCORE
Cardiovascular system		
Elderly patient SOB at night (in winter)		
Middle-aged man, chest pain central and refer to left arm		
Sudden onset of pleuritic pain and haemoptysis		
Sudden onset painful, cold pale leg		
Faintness, abdominal and back pain in elderly man		
Sudden onset of occipital headache		
Unilaterally painful swollen lower leg		
Sudden onset unilateral headache		
Increasingly severe chest pain SOB over a few days		
Gastrointestinal system		
Haematemesis after stag night		
Worsening abdominal pain in a dyspeptic		
Vomiting in a 6 week baby boy		
Blood stained diarrhoea in 70 year old		
Severe bleeding PR		
Abdominal pain after minor RTA		
Orthopaedics		
18 month old refusing to walk		
14 year old with painful hip		
75 year old lady unable to move one leg		
Back pain with urinary retention		
Ophthalmology		

Metal worker with sore eye

Severe painful eye with vomiting

Respiratory

Pyrexial, ill, breath sounds chesty, quiet

Chest pain in man, sudden onset of breathlessness

Hot, sweaty child, sore throat, dribbling, unable to swallow

Acute shortness of breathe in pt with COPD

Cough and chest pain with haemoptysis

Obstetrics and Gynaecology

28 week pregnancy with slight pv bleed

36 week pregnant with headache & oedema

15 year old with heavy and painful blood loss

28 week pregnant with chest pain

IUD fined today Now has abdominal pains

Neurological

Sudden onset of severe occipital headache

Unexpectedly confused old lady, 2 weeks after a fall

A pyrexial twitching child

Pyrexial child with mottled rash

Urological

Man with agonising loin pain

Cyclist with pain in left testicle for past hour

Elderly man has not passed urine for 12 hours

Child with vomiting and rigors

Swollen penis for 6 hours

Psychological

Agitated, excited young man talking nonsense

Withdrawn morose nurse with access to insulin

And Also Don't Miss This One ……

Read the cancer referral guidelines

Do and record your "obs" – temperature, pulse, BP

	Don't Miss	**Contrast With**
Cardiology	MI	Non-cardiac chest pain
Chest	PE	Panic attacks
	Acute asthma	Acute asthma
ENT	Epiglottitis	Croup
	Acoustic neuroma	Labyrinthitis
Eyes	Retinal detachment	Floaters
	Acute glaucoma	Red eye
Gen Surgery	Aneurysm	Back ache
		Renal colic
	Severe GI bleed	Stomach ache
	Appendicitis	Stomach ache
Gynae	Ectopic	Stomach ache
Neurology	Brain tumour	Headaches
Obstetrics	APH	Irrelevant bleed
	PET	?uti
Orthopaedics	Septic joint	Frozen shoulder
	SUFE	Irritable hip
	Central disc prolapse	Other PID
Paediatrics	Kawasaki	Sore throat
	Meningitis	URTI
	Torsion	Abdominal pain
Renal	Obstructed & infected	Renal colic

APPENDIX 3, EXAMPLE ROS FORM – SUMMARY OF OOH SESSION

(Photocopy blank form for each session attended)

Name of GP Registrar:
Trainee NTN Number
Please tick ST2 or ST3 Session number 1-18
Type of session (e.g. base doctor (including walk-in centre), visiting doctor, telephone triage, minor injuries centre):
Date of session:
Out of Hours Centre:
Time of session and length (hours):
Type of cases seen and significant events:
Examples – A = advice, B = base consultation, V = home visit A F8y temp and sore throat -6min B M 58y painful swollen leg 12min V F 85 fever and confusion 18min A M 28y head pressure – 8 min B F 26y 24/40 pregnant, vomiting 15 min V M 77 copd, breathless 12min A F 54y chest pain – 999- 5 min B F 45y suicidal 40min, ref psych V F 69 hyperkalaemia, hosp result 10 min, ref RVH A&E
Competencies Demonstrated (please relate to OOH curriculum areas 1-6), and grade R A G
C1 management of emergencies – independent / green C2 appropriate referral to hospital – independent/green , activation of 999 and referral to A&E and psychiatric services C3 organisational aspects of OOH care – close supervision/amber – notification of abnormal lab result C4 appropriate communication skills for OOH care – independent/green

Learning areas and needs identified (to be discussed with trainer)
First experience of process for abnormal lab results, process taught and learnt effectively Clarity of action re trigger diagnostic words – 'burning pain on breathing in', NICE re recent chest pain
Follow up action taken re learning needs (to be added to copy prior to next session in OOH) NICE guidelines read, recommended these to learning partners
Debriefing Notes from Clinical Supervisor
Very satisfactory performance. From learning needs ST identified lack of confidence re management of red eye and we have discussed this tonight.

Please complete in BLOCK CAPITALS FOR PAYMENT PURPOSES

Name & Address of OOFH Clinical Supervisor:

____

____

Signature of OOFH Clinical Supervisor: _________________________________
Please select category (circle): Normal Trainer, NIMDTA Trainer, OOFH Registered Trainer

Countersignature by GP Trainer: ______________________

(If the GP Trainer is not the supervisor)

Date: ___________________
OOFH SUPERVISOR – TO RECEIVE PAYMENT YOU MUST COMPLETE THE NIMDTA EXPENSES FORM
http://www.nimdta.gov.uk/downloads/nimdta expense form aug 09.pdf