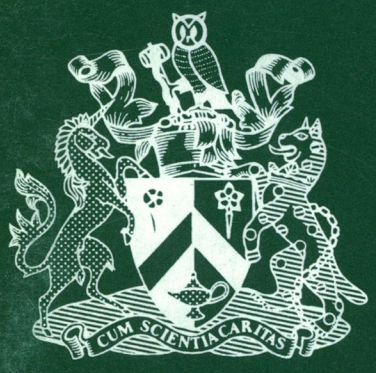

OCCASIONAL PAPER **81**

Primary Care Research Team Assessment (PCRTA): development and evaluation

Edited by **Yvonne H Carter, OBE, MD, FRCGP, FMedSci**
Sara Shaw, BA, MSc
Fraser Macfarlane, BSc, MBA, FCIPD

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Charter

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We also wish to thank Amanda Howe and Rodger Charlton for their helpful feedback and advice on earlier drafts of this document.

Preface

There are a number of drives behind increasing primary care-based research and development activity. Successive government documents continue to place primary care at the forefront of NHS development and primary care trusts will have responsibility for commissioning the majority of health expenditure by 2003 (Department of Health, 2001). Also, both NHS and major research charitable foundations increasingly recognise the importance of primary care research (Medical Research Council, 1997). In these times of evidence-based health care, and competing priorities for resources, much research remains to be done to establish the cost effectiveness of many interventions, particularly in primary care. One cannot assume that findings from specialist settings, where much of the published clinical research is conducted, are necessarily applicable to the majority of patient–professional contacts that occur in general practice. Thus, it is becoming commonplace for primary care teams to be involved in research activity.

Recent expansions in medical and other health professional training, shorter hospital inpatient stays, and changing educational goals and methods have resulted in primary care, and in particular general practices, being increasingly used as learning and teaching environments. This also drives interest and enthusiasm among practitioners. It is generally acknowledged that the culture within health care is shifting. Patients are increasingly partners, and expect high and consistent standards. An important development is the acceptance of clinical and research governance. Research must be ethically sound and observe strict regulations in accordance with the Data Protection Act, Caldicott and General Medical Council guidelines, among others. The RCGP has sought to establish a robust system of quality assessment, monitoring and accreditation for primary care-based research. The proposals were piloted and evaluated, and this scheme has now been formally launched across the UK.

This Occasional Paper reports both this research, and the monitoring system itself. It establishes the benchmark for research governance and quality in primary care. This scheme acknowledges varying levels of activity and development within research-active practices, as well as the importance of mentoring and support between practices and in partnership with academic centres. It is an important document, relevant to both providers and commissioners of research.

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Senior Lecturer in General Practice University of Liverpool, and Editor RCGP Occasional Paper series 2001

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SUMMARY

BACKGROUND

Since the early 1990s the United Kingdom (UK) Department of Health has explicitly promoted a research and development (R&D) strategy for the National Health Service (NHS). General practitioners (GPs) and other members of the primary care team are in a unique position to undertake research activity that will complement and inform the research undertaken by basic scientists and hospital-based colleagues and lead directly to a better evidence base for decision making by primary care professionals.

Opportunities to engage in R&D in primary care are growing and the scope for those wishing to become involved is finally widening. Infrastructure funding for research-active practices and the establishment of a range of support networks have helped to improve the research capacity and blur some of the boundaries between academic departments and clinical practice. This is leading to a supportive environment for primary care research. There is thus a need to develop and validate nationally accepted quality standards and accreditation of performance to ensure that funders, collaborators and primary care professionals can deliver high quality primary care research.

Several strategies have been described in national policy documents in order to achieve an improvement in teaching and clinical care, as well as enhancing research capacity in primary care. The development of both research practices and primary care research networks has been recognised as having an important contribution to make in enabling health professionals to devote more protected time to undertake research methods training and to undertake research in a service setting. The recognition and development of primary care research has also brought with it an emphasis on quality and standards, including an approach to the new research governance framework.

PRIMARY CARE RESEARCH TEAM ASSESSMENT

In 1998, the NHS Executive South and West, and later the London Research and Development Directorate, provided funding for a pilot project based at the Royal College of General Practitioners (RCGP) to develop a scheme to accredit UK general practices undertaking primary care R&D. The pilot began with initial consultation on the development of the process, as well as the standards and criteria for assessment. The resulting assessment schedule allowed for assessment at one of two levels:

- Collaborative Research Practice (Level I), with little direct experience of gaining project or infrastructure funding
- Established Research Practice (Level II), with more experience of research funding and activity and a sound infrastructure to allow for growth in capacity.

The process for assessment of practices involved the assessment of written documentation, followed by a half-day assessment visit by a multidisciplinary team of three assessors.

IMPLEMENTATION — THE PILOT PROJECT

Pilot practices were sampled in two regions. Firstly, in the NHS Executive South West Region, where over 150 practices expressed an interest in participating. From these a purposive sample of 21 practices was selected, providing a range of research and service activity. A further seven practices were identified and included within the project through the East London and Essex Network of Researchers (ELENoR). Many in this latter group received funding and administrative support and advice from ELENoR in order to prepare written submissions for assessment.

Some sample loss was encountered within the pilot project, which was attributable largely to conflicting demands on participants' time. Indeed, the preparation of written submissions within the South West coincided with the introduction of primary care groups (PCGs) in April 1999, which several practices cited as having a major impact on their participation in the pilot project. A final sample of 15 practices (nine in the South West and six through ELENoR) underwent assessment through the pilot project.

EVALUATION

A formal evaluation of the Primary Care Research Team Assessment (PCRTA) pilot was undertaken by an independent researcher (FM). This was supplemented with feedback from the assessment team members. The qualitative aspect of the evaluation, which included face-to-face and telephone interviews with assessors, lead researchers and other practice staff within the pilot research practices, as well as members of the project management group, demonstrated a positive view of the pilot scheme. Several key areas were identified in relation to particular strengths of research practices and areas for development including:

Strengths

- Level II practices were found to have a strong primary care team ethos in research.
- Level II practices tended to have a greater degree of strategic thinking in relation to research.

Development areas

- Level I practices were found to lack a clear and explicit research strategy.
- Practices at both levels had scope to develop their communication processes for dissemination of research and also for patient involvement.
- Practices at both levels needed mechanisms for supporting professional development in research methodology.

The evaluation demonstrated that practices felt that they had gained from their participation and assessors felt that the scheme had worked well. Some specific issues were raised by different respondents within the qualitative evaluation relating to consistency of interpretation of standards and also the possible overlap of the assessment scheme with other RCGP quality initiatives.

NATIONAL IMPLEMENTATION OF THE PRIMARY CARE RESEARCH TEAM ASSESSMENT

The pilot project has been very successful and recommendations have been made to progress to a UK scheme. Management and review of the scheme will remain largely the same, with a few changes focusing on the assessment process and support for practices entering the scheme. Specific changes include:

- development of the support and mentoring role of the primary care research networks
- increased peer and external support and mentoring for research practices undergoing assessment
- development of assessor training in line with other schemes within the RCGP Assessment Network
- work to ensure consistency across RCGP accreditation schemes in relation to key criteria, thereby facilitating comparable assessment processes
- refinement of the definition of the two groups, with Level I practices referred to as Collaborators and Level II practices as Investigator-Led.

The project has continued to generate much enthusiasm and support and continues to reflect current policy. Indeed, recent developments include the proposed new funding arrangements for primary care R&D, which refer to the RCGP assessment scheme and recognise it as a key component in the future R&D agenda. The assessment scheme will help primary care trusts (PCTs) and individual practices to prepare and demonstrate their approach to research governance in a systematic way. It will also provide a more explicit avenue for primary care trusts to explore local service and development priorities identified within health improvement programmes and the research priorities set nationally for the NHS.

BACKGROUND

GENERAL PRACTICE AND THE NHS

The recent renaissance of primary and community care, in both political and service terms, places new demands and new responsibilities on individual professionals, related health care organisations and the academic world that supports it.

Current opportunities and challenges facing general practice and primary care include: a focus on quality in the NHS with modernisation of the service; a commitment to addressing inequalities in health; the recent development of PCTs and the new workforce confederations; and a greater emphasis on clinical effectiveness with the application of evidence-based medicine. Undergraduate teaching now more closely reflects changing patterns of health care in the wider community, with a recognised need to train more doctors nationally and a new emphasis on integrated workforce planning and career development. New funding arrangements to support R&D in the NHS are also being implemented with an emphasis on priorities and needs and research governance.

These fundamental changes will have an additional impact on primary and community care services, where recruitment and retention of staff has been particularly difficult in recent times and where service needs and demands are often very high. Local health communities will need to respond to the challenges of this very considerable, additional and demanding workload whilst also adapting to the reconfiguration of clinical and support services and the evolving future role of health authorities, particularly around performance management and the devolution of public health functions to the primary care teams.

Against this background unique opportunities for research continue to be provided in general practice and primary care but much of this research is still done by those from other disciplines. Historically, family doctors and their teams have regarded research as a minority option. However, for those who decide to become actively involved in research there are numerous rewards. Besides enabling personal professional development it provides the opportunity to pursue an original line of enquiry, to acquire new skills, to collaborate with other like-minded people, and to have the satisfaction of completing a piece of research and seeing it published or disseminating its findings and ultimately observing the application of the findings in changes to recommended clinical practice. On the downside, research can be frustrating, severely test problem solving skills and can, unless care is taken to identify protected time for training and conducting research, start to impinge on family and personal time.

The development of research in primary care does not just benefit the individual researcher. Increasingly, patients expect their care to be informed by robust and relevant evidence. The development of evidence-based practice needs an appropriate research base to support it. We cannot simply continue to extrapolate the research findings from randomised controlled trials in acute settings to the community. Much of the evidence required by family doctors can only be obtained by conducting research involving primary care teams and their patients. This will necessitate a body of appropriately trained researchers in primary care and will require the existence of mechanisms to ensure the effective dissemination of research findings and their incorporation into every day clinical practice.

EVIDENCE-BASED MEDICINE MOVEMENT

General practice and primary care aim to provide the best possible clinical care for patients within their own environment. In order to achieve this, general practice needs a firm research base, not only to define and to teach the discipline but also to provide evidence upon which to practise high quality clinical care (Smith *et al*, 1998; Gray *et al*, 2000). Recent changes within the UK reflect the increasingly important role of R&D in primary care.

The concept of evidence-based health care is not new but its development has accelerated over the past decade. Much of the impetus comes from within medicine, and evidence-based medicine, or EBM as it has been commonly called, has also been an international phenomenon. In McMaster University in Canada, David Sackett and colleagues developed EBM as a method of promoting life-long learning. More recently, evidence-based health care has developed in a number of centres in the UK, including the development of the NHS Centre for Reviews and Dissemination at the University of York and the UK Cochrane Centre in Oxford.

Evidence-based health care has been described as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett *et al*, 1996). The practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research. All areas of the health service are being encouraged to develop a culture based on enquiry and the use of research evidence to inform practice. Evidence-based health care enables primary care teams to base decisions about diagnosis, treatment and management of patients on the best evidence available.

Using the best possible information to help in making clinical decisions is at the heart of evidence-based practice. Evidence-based health care and clinical governance aim to promote health care that is effective — and that does more good than harm. This can only be achieved if relevant research findings and valid guideline recommendations are incorporated into practice. The research literature, however, varies in its degree of accuracy and completeness. For family doctors to make properly informed decisions about care, it is essential that they have access to the best possible, most complete and up-to-date information they can find. Most people do not have the time to track down all the relevant research studies when trying to answer a clinical problem. Once the studies have been identified, it can also be both difficult and confusing to assess the quality and the sometimes conflicting results from different research studies.

Research findings can influence decisions at many levels — in planning care for individual patients, in the development of practice guidelines and in commissioning health care in developing strategies for health promotion and preventive health. It can also be used in the development of policy — at a local practice, PCT, hospital or national level. But research findings can only play this role if research knowledge is translated into action.

In order to practise evidence-based care we not only need to have the evidence, we also need to know how good the evidence is and whether it is appropriate for our patient populations. Traditionally, most medical research, particularly using a randomised controlled trial design, has been based in hospital settings. The importance of primary care as a setting for clinical research has been recognised. In putting the case for supporting R&D in primary care in the UK it has been accepted that over 90% of contact between the population and

the NHS takes place in a community setting. Most minor illness is treated entirely by family doctors and their teams and most serious disease presents first in primary care. In addition, chronic illness is increasingly managed within general practice.

General practitioners have responsibility in making decisions about diagnosis, referral to secondary care and prescribing medication. An evidence-based approach is important for all three. The need for a firm knowledge base is as important in primary as in secondary care. Much of the evidence required by family doctors can only be obtained through research that is conducted in community settings that involve primary health care teams and their patients.

NHS PLANNING AND RESEARCH DEVELOPMENT

The expansion in primary care research has occurred for several reasons. The infrastructure of primary care research has been changing over recent years with recent UK governments proposing to double the proportion of research money spent on primary care over a five-year period (Department of Health, 1996). These moves reflect the perceived increased importance of primary care as outlined by the Mant Report (1997) and the Medical Research Council's (MRC's) topic review on primary health care (1997). It also reflects the increasing involvement of GPs and the primary care team in commissioning and purchasing health care (Kernick *et al*, 1999) and the need for relevant evidence upon which to base decisions (Allen *et al*, 1993).

Although this has been a vital development on its own, the development of primary care research has been accompanied by a necessary cultural shift. For instance, the emphasis being placed on evidence-based prescribing and the increasing links between primary care research and education and training have meant that more and more primary care professionals are gaining an interest in research and how to do it. This cultural shift can now be realised as it is accompanied by the necessary planning and resources, which allows for the achievement of such goals.

The Culyer Report

The Culyer Report was instrumental in bringing about a change in culture within primary care research (Research and Development Task Force, 1994). The remit of the NHS Research and Development Task Force included examining funding of NHS research and determining whether mechanisms for this could be improved. This led to a new strategy being developed for funding R&D in the NHS and to raised expectations of new R&D support for NHS providers. Professor Culyer perceived that much research in the NHS, especially that done outside teaching hospitals, was unrecognised. The report recommended that all money spent by the NHS on R&D should be brought together into a single funding stream and that primary, secondary and acute sectors should have equal access to funding for R&D. The report also recommended that a compulsory levy be taken from the budgets of all health care purchasers to be put forward into the 'funding stream'. The funding stream became divided into Budget 1 (also known as Culyer Funding), which provided support for NHS R&D undertaken by providers, and Budget 2, which provided support for the NHS R&D programme, mainly research project grants and capacity development. Although these arrangements have now been superseded (Department of Health, 2000a; Department of Health, 2000b), they allowed for the development of primary care R&D on a much wider scale and, in particular, for research practices and other organisations to grow in terms of their infrastructure as well as their research activity, thereby encouraging research capacity.

Medical Research Council Topic Review and The Mant Report

The Culyer Report (Research and Development Task Force, 1994) was closely followed by the MRC's topic review on primary health care (1997) and The Mant Report (1997). Both of these important papers again emphasised the need to build research capacity and to increase the amount of high quality research within primary care. A number of strategic objectives were outlined as to how this might be achieved, including: the active support of an evaluative culture; the development and maintenance of an academic workforce; multidisciplinary and multiprofessional research training opportunities; the recruitment, development and retention of R&D leaders in primary care; the involvement of non-clinical disciplines; and the achievement of an evidence-based culture in primary care.

Clarke Review

Most recently, the long awaited Clarke Review (Department of Health, 2000a) has continued to build on policy relating to primary care R&D in recent years, highlighting the need to:

- ensure that there is a clearer focus on NHS needs and priorities within R&D
- improve quality assurance systems for research programmes
- encourage the systematic involvement of wider health communities and consumers in NHS R&D
- develop research capacity in terms of research training and career prospects
- organise the provision of R&D in terms of research units, programmes and projects
- provide R&D funding to total health communities rather than single health service providers
- ensure that clear paths for developing research capacity both long and short term should be part of all research portfolios.

New arrangements for NHS R&D funding

As described above, NHS R&D has been funded through two levies, established following the Culyer Report of 1994. From 2001/2 onwards, the two new NHS R&D funding streams will be 'Support for Science', largely equivalent to the Budget 1 levy, and 'Priorities and Needs' funding, somewhat analogous to the old Budget 2, but deriving funding from Budget 1 and also from NHS public health R&D.

NHS Priorities and Needs funding will support R&D required to underpin modernisation and quality of improvement in the NHS and will reflect the research needs of, for example, the National Service Frameworks. NHS Support for Science funding will meet NHS costs of supporting R&D under agreed standards of strategic direction and quality assurance with research councils and other eligible R&D funding partners. It will include, as appropriate, an element for the costs of developing R&D proposals and for building work around that supported by the external funder. The introduction of this new funding system has been slowed a little by the supervening priority of developing and disseminating a research governance framework in the NHS (Department of Health, 2001a).

At the time of going to print we are still awaiting a clear statement that a user-friendly mechanism for NHS R&D support for primary care research will be included in both Priorities and Needs and Support for Science funding streams. Any such plans will have to take into account the increasing importance of PCTs in the future and their potential role in the funding system.

In 2001, the intention to create a number of Teaching PCTs (tPCTs) was also announced. Their primary focus is to provide teaching and clinical opportunities for professionals in primary and community care in order to improve the delivery of services to the local population. These bodies may also have a key role to play in R&D, including the conduct of high quality research and evidence-based primary health care. The tPCTs will therefore need to demonstrate attainment of the core standards described in the national Research Governance Framework. It is likely that tPCTs will shortly be followed by a small number of demonstration sites developing as specific Research PCTs (PCTRs). This may then lead to the wider development of PCTRs in 2002/3. Both emerging organisations will need to establish strong relationships with the newly established Workforce Development Confederations (WDCs). Over the coming year as the R&D function in regional offices is reconfigured, the WDCs will become increasingly important in the distribution of funds for all aspects of education and training and integrated workforce planning, and will be frequently coterminous with the new strategic health authorities (Department of Health, 2001b).

Research governance

This is further reflected in a consultation document outlining proposals for a framework for research governance (Department of Health, 2001a). Just as the Department of Health has developed a framework for clinical governance, which sets out standards and systems for assuring the quality of clinical work within the NHS (Department of Health, 1998), so research governance aims to provide a framework to promote improvements in research quality:

As with clinical governance and "best value" in social care, research governance involves shifting the level of quality provided by the majority closer to the performance of those at the leading edge. The framework provides a context for the encouragement of creative and innovative research and for the effective transfer of learning, technology and best practice to improve care.

The framework also aims to prevent poor performance, adverse incidents and research fraud and to ensure that lessons are learned and shared when poor practice is identified. Achievement of these aims ... will promote good practice, enhance the ethical and scientific quality of research and safeguard the public. (Department of Health, 1998; page 3, para 1.5 and 1.6)

IMPACT OF POLICY ON PRIMARY CARE RESEARCH PROVISION AND FUNDING

Following the lead of the RCGP in 1994, several regions funded research general practices and more have been funded nationally through the Culyer awards (Research and Development Task Force, 1994). Alongside this there has been an exponential development of primary care research networks over the past five years, culminating in the recent establishment of the National Federation of Primary Care Research Networks (Pickering and Smith, 1999). Hence, one can begin to see the development of a sound infrastructure and culture of research within primary care, which has been espoused by all concerned over recent years. However, it appears that there is still much to be achieved to ensure greater research capacity, and research of a high and sustainable quality.

This is reflected within the new proposals for NHS R&D funding, with the recent consultation paper on priorities and needs funding setting out plans for funding within the context of a quality framework (Department of Health, 2000b). The paper outlines future collaboration and partnerships, as well as programmes of research. It also recognises the need to address NHS priority areas, of which primary care is identified as one, in order to build the evidence base on which high quality clinical care may be provided. The document outlines a number of guiding principles to achieve these ends, which reflect the overarching need to strengthen the knowledge base on which UK health care is based. It is acknowledged that NHS priorities and needs funding will build up and support research and development in primary care in order to deliver knowledge for health and ultimately improve patient care:

There has already been progress in building up R&D in primary care. The Department will develop further approaches to help secure and build R&D capacity in this setting. (Department of Health, 2000b; p11, para 4.7)

The proposals for NHS priorities and needs funding (Department of Health, 2000b) have emphasised the quality framework within which any such endeavour should operate. In discussing standards and monitoring in relation to all NHS R&D, the document refers to characteristics of work funded through priorities and needs as follows:

- independent review of proposals and outputs
- dialogue between decision-makers, other users and researchers to refine questions and methodologies and ensure relevant outputs
- high standards of research governance
- clear objectives, performance standards and milestones for delivery
- robust R&D management
- performance management and review
- annual reporting
- national reporting of work in progress and publication in peer-reviewed journals on completion
- accessible outputs
- resources and mechanisms for managing intellectual property (Department of Health, 2000b).

These standards are closely related to the criteria and indicators for PCRTA (Appendix E). The areas covered by the assessment scheme would ensure that those wishing to demonstrate high quality primary care research within a general practice setting would be enabled through successful completion of PCRTA.

Research practices

Several types of organisation are now more actively involved in UK-based primary care research. This includes academic departments of general practice and primary care and other university departments engaged in health services research or social science, as well as the RCGP Research Group. Along with the research potential of primary care groups and the growth in primary care research networks, Kernick *et al* (1999) identified research practices as key to development and to sustaining the changes outlined above. The first dedicated research practice was appointed by the RCGP in 1994 and provided limited financial support to cover infrastructure costs. Since this time the scheme has been evaluated (Sibbald *et al*, 1998) and there have been similar developments through regional research and development offices (Gray *et al*, 2000), nationally through the first round of Culyer awards (Research and Development Task Force, 1994) and also through primary care research networks (Thomas *et al*, 2001; Griffiths *et al*, 2000; Wright *et al*, 1999).

The development of research practices allows individual primary care teams to become more involved in research at a variety of levels. They may be involved in community-based pharmaceutical trials or be working in collaboration with local university departments or with acute or community hospitals. The largest number of research practices are those appointed by the MRC, which has now over 1000 General Practice Research Framework (GPRF) practices across the UK (Vickers *et al*, 1999).

Primary care research networks

The past 20 years has seen the further enhancement of the MRC GPRF in the UK (Thomas *et al*, 2001; Carter, Shaw and Sibbald, 2000; Vickers *et al*, 1999). More recently, 'networks' have developed rapidly across the country in order to accompany the changes in funding and research infrastructure outlined above. The creation and funding of primary care research networks has been supported by Regional R&D Directorates or their equivalent across the UK (NHS Executive North Thames, 1998; Carter, 1997). They are diverse in their aims, governance, size and organisational structure (Carter, Shaw and Sibbald, 2000; Griffiths *et al*, 2000; Vickers *et al*, 1999; Evans *et al*, 1997; Pickering *et al*, 1999). However, they generally reflect the proposals for networking arrangements set out in the Mant Report (1997), which indicates a need to strengthen and develop the research base of primary care. In the past five years, primary care research networks have come to be seen as a key route to achieving this end.

Primary care research networks have been characterised as either 'top down' or 'bottom up', according to whether their primary purpose is to meet commissioners' or members' needs respectively (Hungin, 1995; Hungin *et al*, 1999). There is no doubt that, whatever their approach, the emergence and success of networks in recent years has provided an important infrastructure for primary care research. The networks have made a great deal of progress in relation to research methods training and have begun to contribute important information to the primary care knowledge base (Nutting, 1996). However, the growth and facilitative role of networks in relation to primary care mean that they may have an important role to play in relation to the development, support and assessment of research practices. This will be discussed later in relation to the formative aspects of the assessment scheme.

Primary care groups/trusts

Other policy developments that deserve attention here include the development of PCGs and PCTs. Although currently unclear, such primary care organisations may have a vital role to play in the development of a research culture. Indeed, as a growing force across the UK, PCGs and their counterparts in Wales, Scotland and Northern Ireland have the potential not only to commission research but also to produce, disseminate and translate it into locally owned changes in practice, ensuring the further development of evidence-based practice within localities (Thomas *et al*, 2000; Kernick *et al*, 1999). The role of PCG/Ts in relation to primary care research is still open to debate. However, the emphasis placed on their role as commissioners and their ability to collaborate with researchers would indicate that they may have an increasingly important role to play. This may be in relation to primary care research and development and, more specifically, in relation to assessment. Primary care teaching trusts (PCT(tPCT)s) are already developing, and the idea of primary care research trusts (PCT(R)s) has also been considered, with the obvious possibility of PCT(T&R)s. It is possible, for example, that one of a cluster of PCTs would act as the PCT(R) and as the centre of a primary care network, with an explicit link to the appropriate academic department of general practice and primary care or research and development unit.

FUTURE DIRECTIONS

The development of the pilot assessment scheme and its subsequent evaluation highlighted a number of key issues; firstly, that no national system for the assessment of primary care research within a general practice service setting currently exists. Given the context of recent policy documents there is a need to ensure the continuing development of individual research practices, as well as the growth of research capacity within primary care on a wider scale. This will be particularly important as the new PCTs develop their organisational structure and set their priorities for research and development and education and training.

QUALITY ASSURANCE AND ASSESSMENT

The past five to ten years have seen an increasing emphasis on quality within health care. With this has come a widening of the systems of accreditation within the health service. Traditionally, this has focused on hospital services. However, the past ten to 15 years have seen a growth in accreditation within general practice and primary care. As with hospital services, this has been driven forward by the policy agenda and its emphasis on continuing development and issues around quality and improved patient care (Department of Health, 1998; General Medical Council, 2000).

There is now a range of schemes assessing different organisational and clinical aspects reflecting the quality of general practice and primary care. This may be in relation to clinical care, or perhaps education and training. Many of these are outlined below. However, there are none that focus on primary care research and development within service general practice. This is despite the possible benefits that may accrue at an individual practice, or possibly PCG/T, level. For instance, there is some evidence to suggest that it may promote multidisciplinary working (Gray *et al*, 2000). Accreditation may also provide a practice with a 'kite mark' of quality, which could be particularly useful for practices seeking funding opportunities. Furthermore, a formative scheme encouraging the continuing professional development of research practices will contribute towards the development of research capacity and culture, which has been so heavily emphasised within policy documents.

Scrivens refers to accreditation as "a system of external peer review for determining compliance with a set of standards" (1995). It is fair to say that all schemes described below have this in common, however, there is also immense variability, as quality can mean a number of things to different people. Hence, assessment may be purely about 'fitness for purpose'; or perhaps may develop to include more patient-orientated standards relating to expectations and satisfaction. Furthermore, quality could be about achieving either high standards of excellence or basic minimum requirements. Hence, each individual assessment or accreditation scheme will have its own context (Donlan, 1995). This will shape its aims and objectives and, therefore, how and to what extent quality is measured.

EXISTING QUALITY MARKERS

There has been an emphasis on developing assessment schemes in recent years. These vary in their focus, with a number of schemes developed through the RCGP concentrating on general practice and primary care and others with a wider focus depending on the organisational and policy objectives of each scheme.

In developing assessment for primary care R&D, the project team particularly looked at a number of schemes detailed below. This initial work was in relation to existing standards and criteria primarily

relating to practice organisation, but also to systems and structures for assessment. Indeed, given the focus of the assessment of primary care research on continuing development, the idea drew particularly from schemes such as Fellowship by Assessment (FBA), which are largely formative. It should, however, be emphasised that this provided a starting point for the scheme, rather than the basis for development.

- *What Sort of Doctor?* (Royal College of General Practitioners, 1981)
- Fellowship by Assessment (Royal College of General Practitioners, 2000)
- Membership by Assessment of Performance (Royal College of General Practitioners MAP Steering Group, 1999)
- Vocational Training (Joint Committee on Postgraduate Training for General Practice, 1998)
- Quality Team Development (formerly known as the RCGP Team-Based Practice Accreditation Programme) (Royal College of General Practitioners Practice Accreditation Working Party, 1997; Walshe and Walshe, 1998)
- Quality Practice Award (Royal College of General Practitioners, 1997)
- Criteria for the Medical Research Council's General Practice Research Framework (Medical Research Council, 1998)

The above list is by no means exhaustive, with others including Investors in People (Investors in People, 2000), the King's Fund Organisational Audit (King's Fund Organisational Audit, 1996) and other schemes outside of the UK, such as the Australian General Practice Accreditation Scheme (Royal Australian College of General Practitioners, 1996). The unit of assessment varies between schemes and depends on the aims and objectives of the scheme itself. For instance, this may be at an individual level, such as FBA, or at a practice level, such as the Quality Practice Award (QPA). However, whatever the focus, all schemes aim, at the very least, to ensure minimum standards and to recognise excellence where it is achieved. Other differences between schemes include the formative and summative aspects. Hence, whereas FBA is recognised as being extremely formative, other schemes do not have the same developmental aims.

A short summary of each of the assessment schemes mentioned above is provided in Appendix A.

ASSESSMENT OF PRIMARY CARE RESEARCH AND DEVELOPMENT

The present situation means that there are several types of organisation involved in primary care research. This includes university departments, commercial organisations and research networks. There is also an increasing number and variety of practices active in research. They may be research practices appointed and funded through one of the NHS Executive Regional R&D Offices, those who have been awarded Culyer funding to support their infrastructure costs, MRC GPRF practices or perhaps those appointed through other organisations such as primary care research networks.

Despite this growth in the number of research practices, the increasing commitment to both project and infrastructure funding within primary care, and the continued emphasis on quality assurance, there has been no formal assessment strategy for primary care research within general practice to date. A system of accreditation for primary care research and development would give those who are already 'research active' a 'gold standard' to achieve, as well as encourage those not yet active to participate (Carter *et al*, 1999). However, the policy agenda is also specific in its recommendations for ensuring quality standards (Department of Health, 2000a; 2000b; 2001a). In relation to the proposed framework for research governance, Research and Development for a First Class Service (Department of Health, 2000a) states the following:

R&D in the NHS must observe the principles of research governance ... Consistent quality standards, appropriate to the methodology, should be applied. This will involve appropriate external peer review of the adequacy of protocols and R&D teams. (p11, para 2.17)

The document expands further on this, stressing the importance of involving patients and ensuring high quality and ethical R&D and the importance of performance management in relation to such activities, as well as budgeting. These are all areas of concern that are included within the RCGP Assessment Schedule, reflecting the quality agenda.

Recognising this, *Research and Development for a First Class Service* refers explicitly to the RCGP Assessment Scheme in discussing R&D capacity:

The new funding system will be designed to be compatible with primary care structures and to minimise bureaucracy for those pursuing R&D in primary care. The Department will work with the Federation of Primary Care Networks and others during 2000 to agree core network and practice activities, and associated reference costs, that will be eligible for NHS Priority and Needs R&D Funding. It will also develop criteria along the lines of the Royal College of General Practitioners' research practices accreditation scheme to distinguish investigator and collaborating primary care sites for NHS Support for Science. (p21, para 3.29)

The recent consultation paper discussing the proposed new funding arrangements (Department of Health, 2000b) does not refer explicitly to the RCGP assessment scheme but does emphasise the need to work within a quality framework ensuring high quality and appropriate research within the NHS.

AIMS AND OBJECTIVES

AIMS

- To develop a mechanism to accredit general practices as competent participants in primary care research that can be adopted as a self-funding UK scheme.

OBJECTIVES

- To develop standards and criteria for assessment of research activity and quality of research within general practice, mirroring the existing assessment of competence in vocational training and clinical practice such as FBA and the QPA.
- To pilot the assessment process within the South and West Region and through ELENoR.
- To evaluate the pilot process.

METHODOLOGY

The research described in this Occasional Paper can be broadly divided into three areas:

1. The views of the project team on the advantages and disadvantages of the assessment scheme.
2. The design and implementation of the accreditation scheme, including a review of the assessment process.
3. The results of the formal qualitative evaluation of the accreditation process.

The methodology and approach to these, together with the stages of implementation, are described in this section. Quality assurance and assessment have previously been discussed, highlighting some of the differing approaches to accreditation. As expected, these approaches are further reflected in the organisation of assessment schemes and in the development of standards.

The first step in developing the PCRTA was to establish a project management group. Members are detailed in Appendix B. The group then met at key stages throughout the project. Aside from regular meetings, the group continued to input into the project, particularly through the use of electronic communication.

METHODOLOGY FOR DETERMINING THE ADVANTAGES AND DISADVANTAGES OF ACCREDITATION

As part of the process to develop an assessment scheme within primary care research and development, the team first identified the possible advantages and disadvantages. This was done through consultation with the project management and advisory groups, as well as the National Stakeholders, and also through key players identified within the South and West Region, including local medical committees, health authorities, primary care research networks, academic departments of general practice, and research and development support units. This was achieved through the use of several facilitated brainstorming sessions, telephone interviews and written questionnaires.

The interviews were transcribed and analysed using a framework developed by the researcher from the needs of the evaluation and the nature of the data generated.

METHODOLOGY FOR PROJECT DESIGN AND IMPLEMENTATION

Stage One: Collaboration and Consultation

Beyond the project management group, the first stages of the project involved extensive collaboration. Through continued networking and consensus, the core project team was able to communicate with key people across disciplines in order to assess their possible input into the assessment pilot.

Membership of the advisory group reflects the multidisciplinary nature of primary care research and development, as well as different geographical locations. Indeed, it was recognised from the outset of the project that the proposed implementation of the scheme on a national scale would require discussion of regional variations at the start of the pilot. Members of the group are detailed in Appendix C.

A National Stakeholders meeting was held in the early stages of the pilot. This was specifically aimed at addressing issues of fraud

RESULTS

There are a number of key result areas within the project, each of which are discussed below. These are divided into four sections:

1. The views of the project team on the advantages and disadvantages of the assessment scheme — this data was gathered by the RCGP accreditation team.
2. The level of participation in the scheme, including practice profiles — this data was gathered by the RCGP accreditation team.
3. A review of the assessment process — this data was gathered by the RCGP accreditation team.
4. The results of the formal qualitative evaluation of the accreditation process — this data was gathered by an external researcher.

VIEWS OF THE PROJECT TEAM ON THE ADVANTAGES AND DISADVANTAGES OF ASSESSMENT

Advantages and disadvantages of assessment

It was envisaged that accreditation will be a gateway to a range of benefits, including the following:

- Accreditation will represent a kite mark of quality and be a useful demonstration of a practice's capabilities and standards when seeking research funding.
- The proposed system of accreditation at two levels will offer practices the ability to develop as research practices — the assessment process being part of a process of continuing professional development.
- In view of the lack of a formal university-based research assessment exercise (RAE) for research general practices, it will offer an external peer review system of research activities/standards.
- Patients/consumers may be reassured by accredited research practices; for example, accreditation could be stated on practice stationery and leaflets, and patients may feel reassured when invited to participate in studies.
- Given that the ultimate beneficiaries of any system of accreditation should be the patients, they may benefit through investment in the practice gained from research grants or from pharmaceutical company payments, which are re-invested in practice facilities.
- It may be useful for practices wishing to participate in pharmaceutical trials indicating that they have achieved a particular standard in relation to both methodology and ethical standards. (Practices that may wish to then participate in pharmaceutical trials will need to ensure that they are compliant with the latest version of the *ICH Harmonised Tripartite Guidelines for Good Clinical Practice.*)
- A system of accreditation may be of benefit in submitting research for publication, in that the journal submitted to may see accreditation as a measure of quality assurance.
- It will be helpful in the process of co-location of research and educational activities. For instance, health authorities may see this as a useful way of identifying practices with whom they wish to work on the development and evaluation of new initiatives. This may be important in the development of primary care resource centres, particularly in the emerging PCG/Ts.

The scheme also wished to acknowledge that there may be some disadvantages to entering the assessment process:

- The scheme may be perceived as 'exclusive' by some as there will be practices that may not wish to be accredited in this way.
- The main disadvantage may come in the possible cost to practices in the form of time pressures. However, attempts were made to overcome these through minimising the amount of written documentation required for submission, providing electronic forms to enable the process of submission and also by limiting assessment visits to half a day.
- It may also be considered by some to be a scheme that focuses on GPs, rather than the primary care team, given the development of the project through the RCGP.

When this last issue, regarding the focus of the scheme, has been raised in consultation across disciplines and regions, it has not been found to be an issue of concern. In fact, the scheme has been designed to recognise the multidisciplinary nature of research and development in primary care. For instance, the lead researcher may be any member of the primary health care team and not necessarily a GP.

Levels of accreditation

All of those involved in the project, both within the core project team and more widely in relation to consultation, were very aware of the variety of practices that participate at all levels within research, and have taken this into account within the assessment process. There was overwhelming consensus that there should be two 'levels' of accreditation open to practices. A description of each of these is provided below.

Collaborative research practices

This is awarded when the ability to undertake research in a collaborative model is competently demonstrated. It is aimed at those who are relatively new to research with little or no direct experience of initiating their own project or of gaining project or infrastructure funding but who wish to move forward in relation to research activity, develop their infrastructure and undertake higher quality research. It is also aimed at practices whose main activity is to collaborate in research projects rather than initiate them.

Established research practices

This is awarded when there is a significant track record of sound research and evidence of its informing practice and improving the health of the relevant populations. It is therefore aimed at those who are experienced in research within a general practice setting. Practices will have received funding from one or more sources and have the resource and infrastructure to allow for a growth in research activity and dissemination.

In developing two levels of assessment it was envisaged that some practices accredited at Level I would wish to develop as Level II practices. This development was encouraged within the pilot scheme, although it was also recognised that research practices may develop in different ways. Indeed, some Level I practices may not regard external funding and leading research projects as a priority. Rather, they may wish to focus on collaborative research.

THE LEVEL OF PARTICIPATION IN THE PILOT SCHEME - INCLUDING PRACTICE PROFILES

Sample research practices

NHS Executive South and West Region

All practices in the new NHS Executive South and West Region were contacted at the start of the project to ask for expressions of interest to participate in the scheme as pilot practices. Practices were asked to reply to a short questionnaire, which provided information on their activities and interests in relation to research and development, as well as other activities, such as vocational training. Out of the 784 practices contacted in the first instance, 157 replied that they would be interested in participating; a response rate of 20%. Although this may seem relatively low, this represents the number of practices that are involved in research *per se* and who would be interested in participating in the pilot. Given this, the response was higher than expected. Discussions with stakeholders had indicated that, although the South West is a reasonably active region in relation to research and development, one may not necessarily expect to find one-fifth of practices active.

Of the 157 practices that expressed an interest in participating in the pilot project, 57 of these were not defined as research active (i.e. those who possibly have a research culture within the practice or who have an interest in research itself but are not currently undertaking any research work, either self-financed, collaborative or funded through external project grants). These were excluded from our sampling frame. All of these practices were contacted and sent an information pack with details on research funding, research training and avenues for support.

The remaining 100 practices were defined as research active. They were contacted and asked to confirm their expressions of interest. A purposive sample of 21 practices was then taken to provide maximum variety within the sample according to the level at which they wished to be assessed within the pilot scheme, their experience of research and other practice activity. This resulted in a sample of ten practices at Level I (Collaborative Research Practices) and 11 at Level II (Established Research Practices).

East London and Essex Network of Researchers

ELENoR receives funding to encourage local research capacity. Part of this funding allows for the support of seven research practices. As with the wider national policy agenda, there are moves to ensure evaluation of such schemes, in relation to both individual research practices and primary care networks themselves.

As discussions with ELENoR and research practices began, it was recognised by many that the assessment of research practices, either through the RCGP or any other organisation, was something that was on the agenda and would happen at some point in the future. This was accompanied by a feeling that primary care research networks may have an important role to play in relation to this. Involvement in the pilot project could therefore be beneficial in terms of entering and inputting to the scheme at a very early stage, providing feedback that may influence the process and allowing the role of the network in assessment to receive closer scrutiny.

Prior to the confirmation of funding for the inclusion of the research practices within the pilot project, there were a number of stages allowing for discussion within and between practices, the network itself and the project management group. This included discussion within the ELENoR management group as to the pilot project and the possible role of ELENoR within this, including the advantages and disadvantages of participation for the network, for individual research practices and for the pilot project itself. Informal discussions also took place between ELENoR and the project management group and led to a workshop for the research practices held at the RCGP to explain the project, to answer any queries and to address any concerns.

Other communication was largely between ELENoR and the NHS Executive London R&D Directorate in relation to possible funding. This was eventually secured with provision for the administration of the pilot project through the RCGP, administrative support for practices through the network and funding for research practices, where appropriate, to ensure protected time

Following the confirmation of funding, ELENoR emphasised to all seven research practices that, although the network considered this a valuable opportunity that would be beneficial to individual practices and the network itself, participation in the pilot project by the research practices was entirely voluntary.

Sample loss

On receiving the assessment schedule, several of the original sample of 21 practices within the South and West region contacted the RCGP Research Office regarding assessment. Some practices sought advice regarding submission of written documentation or wished to discuss submission dates. Others had particular concerns such as workload. Where this was the case, many practices continued to express an interest in the scheme itself but discussed deferring until such time as it may be a 'live' UK scheme, rather than a pilot.

The timing of the study meant that the issue of workload was particularly pertinent. Many of the practices referred to the introduction of PCGs in April 1999 as having a large impact on their workload and that they were unable to take on any extra work outside of this. Indeed, submissions for written documentation were requested at the end of July 1999 with the majority of preparation occurring during the introduction of PCGs. This was an issue raised by several practices that underwent assessment and in some cases the project management group was able to renegotiate deadlines for submission in order to encourage participation within the scheme. This was not regarded as problematic but rather it gave a more realistic idea of the time taken for research practices to prepare for submission and was regarded generally as a reflection of the number of activities open to primary care that need to be considered in developing such a scheme.

In relation to the ELENoR research practices, enthusiasm varied between practices, with some expressing reservations. One practice elected not to undergo assessment within the pilot project and a total of six research practices elected to participate in the pilot project only with administrative support and advice from the network itself. Discussions both directly with the practices and through the network had indicated some concerns. These had centred around workload and potential benefits, or 'value added', to practices through assessment. Concern was expressed in relation to the consequences of not achieving all of the standards and criteria and the implications for

research practices in relation to the network itself and to external bodies. Considering this, issues around confidentiality were raised, with concern over the publicity given to the pilot project and the identification of those practices that may not achieve pilot accreditation. Reassurances were given regarding the confidentiality of all data.

Out of the initial total sample (South and West, and London) of 28 practices that expressed an interest in assessment through the pilot project, 13 (46%) of these withdrew, providing a final sample of 15 practices (nine in the South and West and six in London).

Table 2. Reasons given for withdrawal from the pilot project.[a]

Reasons given for withdrawal (workload related to)	Number
General issue	5
Primary care groups	2
Single-handed practice	1
Research activity within the practice (e.g. submission of funding applications)	2
Lead researcher leaving the practice	1
Other changes within the practice	2
Practice does not meet criteria hence concern over implications that follow involvement	1
Involvement of all practice staff in relation to research (*... this is an important long-term aim, but one that very few practices will be able to achieve* [Feedback Report: ID136])	1
Research activity outside of practice e.g. setting up research network	1
Unknown	2

[a]In some cases, practices cited more than one reason for withdrawal.

A record was kept regarding main reasons for withdrawal from the scheme (Table 2). The decision to withdraw was not necessarily something that was driven forward by the lead researcher or the direct research team. Practices referred to team meetings, particularly with partners rather than the wider primary health care team, and discussion of assessment of primary care R&D in the wider context of other practice activities and priorities with regard to clinical work.

One issue raised in relation to withdrawal from the pilot has been the number of partners within a practice and the impact this has on participation. Table 2 shows that this was referred to as a specific reason for withdrawal for one single-handed practice. However, no other direct reference has been made, although workload has been a general issue for many of those participating. Despite this, in relation to the number of partners the two samples were not dissimilar, with a mean number of partners per practice of five for those who withdrew and six for those who were assessed within the pilot project. Looking more closely at the data in Table 3, there are some differences at the extremes. Of those who withdrew, two were single-handed practices, whereas those assessed tended to have a larger number of partners.

Table 3. Number of partners per practice (total sample $n = 28$).

Number of partners	Practices that withdrew from pilot project ($n = 13$)	Practices assessed within pilot project ($n = 15$)
1	2	-
2	-	-
3	-	-
4	1	3
5	6	5
6	1	1
7	1	2
8	3	1
9	-	3

Other reasons for sample loss worth noting here, particularly from a research point of view, include the occurrence of natural events, which led to some renegotiation of deadlines. Several practices within the South West region contacted the RCGP Research Office at the time of submission as they felt they might incur an increased clinical workload (with a knock-on effect on other work activities, including research and development) resulting from the total eclipse of the sun occurring in the South West region in the summer of 1999.

Practice activity

All 28 practices within the pilot project were asked to provide some basic information on their other activities. A summary is provided in Tables 4 and 5.

Table 4. Practice activity of those assessed within pilot project ($n = 15$).

	Level I ($n = 5$)	Level II ($n = 10$)	Total ($n = 15$)
Vocational training practices	4	10	14
Undergraduate teaching practices	3	9	12
Regional research practice	2	9	11
MRC general practice research framework	5	5	10
Active in pharmaceutical research	2	5	7
Fellowship by Assessment	1	3	4
RCGP research practice	0	1	1

Table 5. Practice activity of practices that withdrew from pilot project ($n = 13$).

	Level I ($n = 6$)	Level II ($n = 7$)	Total ($n = 13$)
Vocational training practices	4	3	7
Undergraduate teaching practices	5	4	9
Regional research practice	0	3	3
MRC general practice research framework	5	4	9
Active in pharmaceutical research	1	4	5
Fellowship by Assessment	1	0	1
RCGP research practice	0	0	0

Tables 4 and 5 provide a summary of data for all practices activity. Activity within those practices that withdrew from the pilot project is not dissimilar to that of practices that underwent assessment, although the data does highlight a greater level of educational activity amongst those who underwent assessment. Furthermore, fewer of those who withdrew from the pilot assessment at both levels had received funding as a research practice through their NHS Executive Regional Office.

Although not shown here, no difference was noted between regions. This would indicate that the activity reported is associated with research practices *per se* rather than a particular type of research practice.

As expected for both those who underwent assessment and those who withdrew, there were differences between Level I (Collaborative) and Level II (Established) Research Practices. This is particularly marked in relation to those who underwent assessment where there is a greater emphasis on educational activity within Level II practices and a higher percentage of Level I practices involved in the MRC GPRF (100% as compared to 33%).

Practice profile

Nearly all of the respondents were active in their local RCGP faculties and research networks. As demonstrated in Table 4, a number had FBA or were currently applying for this. Only one practice had a nurse as the lead researcher, although most had research nurses involved in the project. All practices visited were multi-partner. Many were teaching practices and had been through other accreditation processes including the RCGP QPA. One had just achieved the Investors in People award.

REVIEW OF THE ASSESSMENT PROCESS

Assessment of practices

Research practices in the South West varied considerably in the time taken to submit documentation. One practice was able to meet the original submission date with others renegotiating and submitting anything from two weeks to six months later. Along with support and advice, ELENoR research practices were provided with a clear deadline for written submissions to reach the ELENoR office before being forwarded to the RCGP. Despite this, not all submissions reached ELENoR by this deadline and two came directly to the RCGP.

ELENoR submissions varied from those in the South West. The ELENoR Research Manager had taken part in the pilot project in the South and West region as an assessor and therefore had a clear idea of the documentation required. Submissions to the RCGP Research Office and on to assessors therefore came with additional documentation, pre-empting requests from the assessment team. In many cases this was appropriate, however informal feedback from both assessment teams and pilot practices also indicated that in a minority of cases they felt overwhelmed by the extent of documentation. This was a reflection of the additional documentation within the submission, as well as the presentation of documentation, which was not always clearly marked in relation to individual criteria.

Additional documentation

Practices undergoing assessment were required to submit their written application on a limited number of sides of A4. This was sent to the assessment team, who may have then requested additional documentation prior to the assessment visit. Of the sample of 15 practices, assessors did not request additional documentation in three of these. Of the other 12 practices, the most common documentation requested are listed below:

- research strategy ($n = 6$)
- practice profile and description of PHCT roles ($n = 5$)
- information relating to complaints procedures ($n = 4$)
- practice development or business plan ($n = 3$)
- dissemination strategy ($n = 2$).

Other documentation provided by pilot practices or requested by assessors included surgery newsletters, minutes from meetings, information regarding research space within the practice and information relating to practice appraisal of PHCT members, as well as further detail on research protocols or external funded projects.

Contact with the RCGP Research Office and each research practice was generally undertaken by the lead assessor for each team. Lead assessors were sent additional documentation prior to each assessment visit, which they were required to complete. This included a feedback form and a confidentiality form. As the assessment visit involved looking at patient records or registers in particular, it was important that practices were assured of the confidential nature of the assessment itself. All rules for confidentiality were adhered to and, in addition, assessors were indemnified.

Feedback to pilot practices

Analysis of feedback reports has been undertaken to look more closely at the strengths and areas for development of pilot practices. For both Level I and Level II research practices, there was a strong primary health care team ethos that was highlighted as a key strength, however team working in relation to research tended to be raised as an area that needed to be developed. Hence, assessment teams talked about strengths of the primary health care team in relation to the supportive practice culture, good communication or enthusiasm across the team. In relation to research activity and team working, this was more specific, highlighting the need for practices to define roles and responsibilities in relation to research and to strengthen the commitment to research at a practice level. Indeed, it would seem that this relates to one of the main areas highlighted as an area for development: the research strategy. Recommendations were made to Level I research practices to develop or make more explicit their research strategy. At Level II, the emphasis appeared to be more on the need to clarify and discuss research strategies. As expected, this often related directly to other activities:

The team should consider establishing within their overall strategy plans for the pro-active involvement of all staff and plans for professional development in relation to research. (Feedback Report: ID205)

Indeed, several issues were raised in relation to education and training of all members of the primary health care team. Within several research practices assessed at Level I this was seen as a real strength. However, within the majority of pilot practices, particularly those assessed using criteria as established research practices (Level II), this was seen as an area for development in relation to the practice environment generally. More importantly, inadequacies were highlighted in the system for supporting individual and professional development in research:

There is a need to consider the research training needs in a more systematic fashion. [The lead researcher] should also develop his role as a research resource to the group. (Feedback Report: ID92)

From the feedback provided, there were clear areas where collaboration, both internal and external to the practice, was highly effective. In this respect, feedback tended to recommend strengthening links to particular organisations such as primary care research networks and academic departments.

In relation to undertaking research, several research practices were encouraged to develop procedures for involving patients in the research process and also to feed back research results to patients. Practices at both levels were also encouraged to disseminate their research activities on a greater scale and to plan for this within their dissemination strategy:

There is a need to develop a coherent dissemination strategy with a formalised action plan for publication. (Feedback Report: ID203)

Although no pilot practices have been formally accredited within the project, information has been recorded on those who achieved all criteria and indicators at the appropriate level (Table 6).

Table 6. Pilot practices achievement of essential criteria.

	Number achieving all essential criteria	Number not achieving all essential criteria
Level 1: Collaborative	3	2
Level II: Established	3	7

All of the pilot practices were provided with a Certificate of Assessment. This was presented at a conference held at the Institute of General Practice at the University of Exeter in April 2000 and aimed to involve all stakeholders within the pilot project, including research practices, assessors, project management and advisory group members, and local and national stakeholders. The day aimed to present and discuss the pilot project and preliminary results from the qualitative evaluation, as well as the way forward in relation to a national scheme. Certificates of Assessment were forwarded to those practices unable to attend the conference.

RESULTS OF THE FORMAL EVALUATION PROCESS

Broad/general overview

Broadly, every respondent interviewed was positive about the pilot accreditation scheme. Practices felt that they had gained from their participation, assessors felt that the scheme had worked well and the project management group stated that the pilot had been a success. There were specific issues that all respondents raised about the process of assessment and the criteria used by assessors; these are discussed in detail in this section. The detailed comments below must be taken in the context of the overall positive feedback gained during the interviews.

The majority of respondents stated that the current two-level accreditation process was about right. They felt that to have too many levels would be difficult to administer and that a clear distinction had to be made between collaborative practices and research-initiating practices. It was felt that gaining accreditation at the first level could be seen as a stepping stone to the second level. However, some respondents commented that some practices may wish to continue on a collaborative basis and it would therefore be unwise to insist (or expect) that they should all become Level II practices over time.

Practices and members of the project management group both highlighted that the scheme has a GP focus, which might deter practices where there is a strong nurse-led research programme. (One of the practices interviewed undertook mostly nurse-led research.) While it was recognised that the scheme was developed and led by the RCGP, and therefore would inevitably be perceived to be GP-led, it was felt that some explicit guidance could be offered to practices explaining that other models of research would be supported, valued and recognised.

Practice involvement

Practices could be grouped into three categories on the basis of their objectives for involvement in the accreditation process:

1. Supporting the RCGP.
2. Wanting recognition for their current research programme.
3. Wanting guidance on the best infrastructure and approach to establishing a research programme.

A number of practices also felt that their involvement in this scheme might act as a fast track method of gaining research funding from the National Health Service Executive, the RCGP or the MRC. In contrast, members of the project management group were adamant that this would not be the case. They felt that RCGP accreditation might act as evidence when awarding research funding but this would only be one of several criteria, with the overall decision being made on the strength of the application.

Assessors' reasons for involvement were very similar to the practices' motives in that they were supporters of the RCGP's local activities and were often active in local primary care research networks, members of local research ethics committees or had links with academic departments.

The researcher conducted interviews at two practices that had withdrawn from the accreditation scheme. Respondents in these practices stated that the reason for the withdrawal was the workload involved in preparing the initial submission and gathering the subsequent evidence for the assessors' visit. These informants also questioned the overall benefits to a busy practice of going through a pilot scheme such as this.

Practice views

Views on the preparation process

All the practices were very complimentary about the administration of the accreditation process. They stated that the documents were clear, the process was clear and explicit, and that the process generally ran to plan.

Many practices felt that the preparation stage was particularly useful as it allowed them to develop research documents, which they would not have otherwise produced. It was felt by many assessors that there was simply too much documentary evidence for them to assess in one day's visit and that there was a need for a smaller 'core' document set to be made available, but that assessment teams should be able to ask for further evidence if required.

The respondents were asked to estimate the time spent in preparing for the accreditation visit. Table 7 outlines the range of times stated.

Table 7. Time involvement in preparation of documentary evidence.

Activity	Lead GP time	Administrative support time
Level I practices		
Initial submission	1–3 days	2–6 days
Preparation of evidence for the visit	2–3 days	1–5 days
Level II practices		
Initial submission	1–2 days	2–4 days
Preparation of evidence for the visit	1–2 days	2–4 days

This time was usually spread over a period of three to four weeks and mostly undertaken during 'protected research time' or out-of-practice hours by the lead researcher. The data show that Level II practices found it took less time to prepare because they often had much of the material already available.

As mentioned, many practices felt that this stage was particularly useful as it allowed them to develop research documents, which they would not have otherwise produced. In particular, they felt that the following documents were useful:

- practice development plan
- research strategy
- research project planning protocols
- appraisal systems
- information (usually in newsletter or leaflet form) for research participants.

In a number of cases the practices did not have these documents and this process acted as a 'spur' to their development. Interestingly, a number of the practices without these documents were already accredited as training practices. It was noteworthy that some practices that had been involved in teaching registrars or FBA felt that it was unnecessary to 'repackage' many core documents and that there should be a system of exemption.

Views on the accreditation criteria

Where there was comment about the lack of suitability of particular criteria, this was generally because practices had found it hard to interpret what was wanted (for example, "What exactly is a research strategy?") or because they felt that the criteria did not reflect day-to-day general practice. The practices stressed that although it is important to have the correct framework for research this must be balanced with the main purpose of the practice, which is the delivery of health care.

It was also felt by many that there was a tension between the need to have a practice-based assessment process that involved all members of the primary health care team (and, in particular, had the support and understanding of all of the partners) and the reality of general practice where each member of the team has his/her interests (which may include teaching, local health care politics or management).

Many practices and assessors felt that there needed to be tighter definitions for many of the criteria supported by examples of what evidence would be acceptable to demonstrate compliance. In particular, there was concern about definitions of the following:

- primary health care team
- clear standards and guidelines
- practice development plan
- short- and long-term strategy for research and development
- appropriate space (within the practice).

There are a number of criteria supported by only 'desirable' indicators (with no explicit indicator of an 'essential' level of performance in this area). This caused confusion with practices (and some assessors). Does the lack of an essential benchmark mean that these criteria are desirable but not essential, or that some other indicators could be used to demonstrate essential performance?

Views on the assessment visit

In most cases the practices welcomed the assessors' visit and stated that it was extremely motivating and gratifying to have external visitors come to the practice and provide an objective overview of service and research delivery. It was felt by many that the assessors were fair, balanced and professional in their approach and had a good in-depth understanding of how general practice operates.

Several practices felt that the assessors had not really read the initial submissions prior to the visit. In these cases the assessors spent the initial two hours discussing the documentary evidence before meeting with practice staff. These practices felt that this was not a good use of their time and it meant that some of the primary health care team had made themselves available for the visit but were not actually interviewed by the assessors. This gave the impression of poor planning on the part of the assessment team.

One practice felt that the assessors were not in touch with the reality of general practice and were too academically based ("They expected us to co-ordinate the development of community staff employed by another organisation"). One practice knew their lead assessor, having worked closely with them on another project. The practice questioned if it were possible for the assessor to be impartial.

Practices felt that one of the most useful parts of the assessment visit was when the assessors spent time with the wider primary health care team — usually over lunch — and had a facilitated discussion about research activities.

The interviews with practices and assessors highlighted that there were certain inconsistencies in the assessment process. In particular, there was a variable approach to:

- interpretation of the criteria
- the stringency of application of the criteria
- selective application of the criteria
- the evidence sought
- the provision of written feedback (some practices had received only verbal feedback at the time of the interview)
- style of assessment — from adversarial to collaborative.

This variability caused some discontent with certain practices that were able to compare assessment experiences through their connections with their local primary care research networks.

Views on the feedback

The practices felt that the feedback provided at the end of the assessment was one of the most positive aspects of the whole process. Most practices felt that it was a pleasure to have external experts visiting their practice and giving objective feedback to the staff on the positive aspects of the service that was provided. The feedback on the developments that could improve the service was also welcomed.

The assessors were required by the RCGP protocol to follow a formal structured approach for giving verbal feedback by noting up to five positive aspects and five developmental aspects of the practices they visited. Without exception, practices stated that the feedback was delivered in a competent, constructive and structured manner.

The written feedback was apparently not handled so well. Some practices had not received any written feedback at the time of the interviews. Of the practices that did receive it, many stated that it took several weeks for it to be submitted, and there was one case where issues were raised in the written report that had not been raised at all in the verbal session. This aspect of the assessment caused the greatest discontent for the practices.

Views on facilitation of the process

The practices were asked about what support would have facilitated the assessment process and who would be best to provide it. The overwhelming response was a request for someone to act in a 'mentoring' role to help them prepare the evidence and interpret the criteria.

Practices felt that there was already enough support with the practical aspects of research with many stating that they got this through colleagues, research networks, the RCGP and local academic departments. Some did state that they would welcome help in preparing grant and funding applications. No practice wanted any organisational development or research infrastructure development support. It is interesting to note that a mentor/advisor might help them with organisational development, however it can be inferred from this study that many practices are not ready to take on this approach. This might be due to a misunderstanding of the role of organisational development in research practices. The interviews highlighted that practices were not keen to have external support in planning and developing research aims and objectives over the medium term. They were not against support that would help them disseminate and integrate research into the mainstream activities of the practice.

Assessors' views

The assessors attended a day's training, which introduced them to the RCGP's accreditation scheme, general practice and the skills needed for successful assessment. Broadly, assessors felt that the day was worthwhile. In particular, they felt that the following had been useful:

- discussion of the accreditation process
- discussion of the accreditation criteria
- a chance to meet fellow assessors (which subsequently helped when assessment teams visited research practices).

However, there were some concerns:

- insufficient opportunity to clarify the assessment criteria (more practical examples of how they could be applied were felt to be needed)
- insufficient opportunity to debate the validity of the criteria and introduce amendments
- not enough time spent on assessor skills — including team building, exploring evidence and giving feedback
- the introduction to general practice was felt to be appropriate and helpful for the lay assessors but not relevant to GPs and general practice academics.

These views may not be a true evaluation of the assessor training day, as many respondents noted that they found it hard to remember exactly what went on during the training day.

Assessors, however, felt that many practices did not 'sell' themselves particularly well through their written evidence and stated that they were always pleasantly surprised when they arrived at the practices and saw their achievements and approach to research. This indicates that the submission document may not be the best way of presenting a practice's research capacity.

Many of the assessors stated that it would be easier for them and more professional if they could reserve judgement on the practices until they had had a chance to reflect on all of the evidence away from the premises. It was stated that it is easy to give feedback when a practice has met the assessment criteria but it is much harder when it has not. It was felt that in the latter case the practice was less receptive to feedback and (in the pilot project) more likely to challenge the evidence base of the process and assessment criteria.

DISCUSSION

Reflecting current and planned legislation for primary care R&D, PCRTA provides a more detailed and rigorous approach to ensuring high quality standards, not least because it focuses specifically on one key area of the health care system: primary care. Those practices accredited within PCRTA will be able to clearly demonstrate their capabilities. The development of the RCGP scheme into a UK system allows research practices to have an achievable high standard to aim for. On a more strategic level, it provides a 'quality marker' that may be useful to a number of organisations, including funding bodies, who could identify practices with a high quality research capability (Royal College of General Practitioners, 1999). It also provides a formal statement of credibility to the practice and may be beneficial in reassuring patients of standards when involved in research with accredited practices.

In addition to the provision of a kite mark of quality and recognition of achievement, PCRTA has other benefits for practices. As well as developing a quality framework for individual and groups of research practices through the application and monitoring of standards and criteria, the scheme fosters a wider culture of research through encouraging practices to develop their research experience and infrastructure. Indeed, the scheme provides a framework for research practices to work towards. Furthermore, results from the pilot project indicated that, although preparation for assessment was hard work, it was a positive experience. It allowed teams to identify both good practice and areas for improvement and provided the motivation and encouragement to develop these areas.

As outlined in the sections above, assessment is at one of two levels. This provides an inclusive model for practices involved in collaborative research through to more experienced research practices. Although the scheme ultimately aims towards a gold standard in research, it primarily aims to support continuing professional development. Although not compulsory, the scheme encourages development from Level I to Level II and subsequent assessment and accreditation. Through the publication of clear standards and criteria, the scheme also encourages training, support and the sharing of ideas and experiences for all research practices, together with other organisations within primary care.

To look towards the future, although the role of PCG/Ts in England and their equivalent throughout the UK in relation to research is as yet unclear, one could envisage that they have an important role to play in the commissioning and undertaking of research within primary care. Indeed, as both their commissioning role and experience become stronger, this may go hand-in-hand with an increasing awareness of the need for locally appropriate research, as PCTs face a number of challenging questions relating to such developments as clinical governance or evidence-based prescribing (Thomas *et al*, 2000). It is suggested here that accredited research practices demonstrating a high level of quality and relevance would be an invaluable resource for primary care organisations such as PCTs. Little has been written or reported in relation to this aspect of PCTs, hence discussion here is largely anecdotal. However, given the importance placed on PCTs in relation to the wider role of primary care within specific localities, it would be surprising to find that research practices were not considered a resource in the way outlined above. Hence, one could envisage that, in much the same way as the MRC GPRF has a network of research practices throughout the UK, so PCTs may have a network of practices within their locality that are easily identified and capable of undertaking high quality research. With the appropriate structures in place, such research activity may then be more easily disseminated within the locality and enable growth of the knowledge base, together with EBM. In addition, PCRTA will be a key step towards achieving the elements of research governance (Department of Health, 2001a). PCG/Ts may ask their 'accredited' research practices to facilitate or take a lead in advising on governance arrangements for other practices/research practitioners across the group or trust.

So how many practices are involved in research and what are the implications for PCRTA? At this moment in time it is difficult to estimate the number of research practices that may undergo assessment. However, recent policy documents have indicated a total number of approximately 750 research practices, 598 at Level I and 133 at Level II (Workforce Capacity and Primary Care Implementation Group, 1999). Other figures supplement this information with an estimated number of over 1000 practices involved in the MRC GPRF (Vickers *et al*, 1999). The number of research practices that have been encouraged to develop through primary care research networks is also increasing (Gray *et al*, 2000), although UK-wide figures are currently unavailable. Anecdotally, it has been noted within this project, and through discussions with stakeholders, that research practices continue to be identified that have had no previous contact with organisations such as primary care research networks, regional research and development offices or academic units. It is envisaged that, although the number of practices in this situation is relatively small, more will continue to be identified in the years to come, increasing the estimated total number of UK research practices.

Of the ever-increasing number of UK research practices, there continues to be a small number of health professionals who undertake research as an individual within a general practice setting. However, as the research culture has developed, the availability of infrastructure funding has increased and there has been recognition of research as key to the development of EBM, leading to recognition of primary care research as a team-based activity within a general practice setting. This emphasis on team working was reflected in the original development of RCGP research practices in 1994 (Sibbald *et al*, 1998) and has continued to be encouraged and supported in subsequent initiatives (Wright *et al*, 2000; Gray *et al*, 2000). This includes PCRTA, which encourages a team-based approach to research, as well as leadership and individual learning, for both collaborative and investigator-led research practices. Hence, where a member of the primary health care team is undertaking research without the support of the primary health care team, they are unable to be accredited within PCRTA. Aside from team-based activity, other characteristics that are recognised as being of importance to the development of research practices within policy documents and other schemes are consistent with the main areas outlined within PCRTA: practice organisation; strategic planning; practice as a learning organisation; research resources and infrastructure; project funding and management; involvement of patients; and dissemination of research.

Characteristics associated with UK research practices have been reported both within the pilot project and elsewhere. In particular, the extent of educational activity within research practices has been noted. Nearly all of those assessed within the pilot project as Level II

research practices were also undergraduate teaching practices and involved in vocational training. This reflects other work, such as that undertaken by Smith (1997), who reported the characteristics of the first 14 funded research practices, 11 of which were GP training practices, 12 of which were teaching undergraduates and five of which were involved in the postgraduate education structure. This has been reported more recently in the South and West health region, where Gray *et al* (2000) reported that 15% of all general practices in the area were involved in both teaching and research. Such a network of practices involved in teaching and research has the potential to provide a vital resource to primary care organisations and the wider health care system in generating and disseminating knowledge relating to high quality clinical care. This is reflected in the practice activity of those research practices involved in the pilot assessment scheme. Level II practices were overwhelmingly involved in educational activity and Level I practices appeared to be developing in a similar fashion. Results appear to confirm Gray *et al*'s findings, which revealed that "enthusiastic individuals who lead research from a service general practice base are usually also involved in undergraduate and postgraduate teaching". Gray *et al* go on to discuss the appropriateness of generalising their results to the rest of the UK. They suggest that educational and research activity in the South and West has tended to have been higher than in other regions. However, they go on to say that any differences may diminish over time given the number of programmes adopted and implemented by different regions in recent years. The results from the pilot assessment scheme may elucidate this further, providing data for research practices outside of the South and West. Research practices within ELENoR were not dissimilar in their activity to those in the South and West and had a similar profile for both undergraduate and postgraduate education.

Other characteristics of research practices include formal or informal links with UK primary care research networks (Smith, 1997). PCRTA standards and criteria again reflect this and emphasise the need for practices to link with networks in order to develop at a practice level and also to encourage the development of research capacity on a local and national scale. Indeed, the development of PCRTA as a national system has included a much greater emphasis on the role of other primary care organisations, including primary care research networks. A number of benefits accrued to practices accredited through PCRTA have already been referred to above, not least of which is the formative nature of the scheme. Specific to PCRTA, the development of the scheme on a national basis has also stimulated discussion around mentoring for practices through primary care research networks. This was investigated within the pilot project through the involvement of ELENoR and its research practices. The model tested within the pilot project was well received, although evaluation has recognised that support needs to be extended to some practices to encourage not only a greater understanding of the assessment process but also more developmental work prior to an assessment visit. The qualitative evaluation therefore recommended the provision of mentoring for research practices, a role that would fit with primary care research networks' current aims and objectives and could possibly be seen as a core objective of UK networks in the future.

Research practices and primary care networks are varied according to their size, level of experience, expertise and level of funding (Evans *et al*, 1997; Pickering *et al*, 1999). Despite the different models in existence, aims and objectives are similar across the board. Hence, there are great advantages in investigating more fully greater interaction and opportunities for partnership between research practices and networks. Primary care research networks provide a vital role in the provision of peer support, collaboration and training. Those practices in the developmental stages of research will be able to draw on this process and learn from both networks and the more experienced research practices. Similarly, partnership between research practices and primary care research networks will encourage a two-way relationship, with those more experienced health professionals providing a valuable source of practical advice, support and guidance.

Mentoring is not a compulsory element of PCRTA. It is an option that the RCGP Research Office would be able to advise research practices on and would be able to direct them to; for instance, key contacts within their local primary care research networks. Mentoring could then take a number of different guises, depending on the needs and requirements of the practice, as well as the resources available through networks to provide support in this way. Hence, mentoring may involve discussion and advice in preparing written documentation or perhaps a 'pre-visit' by a mentor. This could help to identify a research practice's areas for development and assist in preparing for the PCRTA assessment visit.

Primary care research networks are highlighted here as a key resource for mentoring and a series of seminars and discussions are planned with the launch of the national scheme to facilitate this. However, PCRTA acknowledges that other individuals and organisations have the knowledge and facilities to fulfil such a role. Research and Development Support Units may have an increasing role to play, as would academic departments. The move towards a national scheme has also emphasised the capabilities of PCRTA accredited research practices to provide advice to others. Although not necessarily a formal source of guidance or support, PCRTA will encourage those accredited to share their experiences.

The formative nature of PCRTA and the recognition of a greater need for mentoring and support for some research practices addresses some of the concerns highlighted within the pilot project and qualitative evaluation. Several practices discussed their fear of failure within the pilot project and the implications that this may have for the practice itself. It is acknowledged here that assessment through the pilot project occurred within a relatively short timescale. Changes have been made to ensure that once research practices have confirmed their expression of interest to undergo assessment, they have sufficient time to discuss mentoring, identify areas where development may be needed and address these prior to assessment. Standards and criteria for assessment will be reviewed and updated on an annual basis, although versions of standards and criteria will be valid for a period of two to three years allowing practices the time needed.

Other specific concerns raised by pilot practices and assessors have related in particular to the possible cost to those involved in relation to both time and money. Indeed, feedback from those who were unable to undergo pilot assessment has highlighted the issue of workload as a major concern. This is particularly relevant given the different, and often competing, priorities that exist within general practice and primary care in relation to, first and foremost, clinical care, but also other activities such as education and training. Application to PCRTA will therefore need to be discussed openly within the primary health care team. Clear benefits have been identified for research practices, however both time and cost resources will need to be identified by the practice team before any commitment is made.

Discussion so far has concentrated on the implications of assessment for research practices and the wider context of UK primary care R&D. The other vital aspect of PCRTA relates to assessors themselves and consistency within the assessment process. PCRTA must be both valid and reliable. Training of assessors is therefore vital and needs to ensure that standards, criteria and

indicators are interpreted and applied in the same way across assessment teams. Further clarification and guidance relating to standards and criteria has been provided within the assessment schedule and standard electronic forms are being used for submission of written documentation. This provides a standardised format for submissions as well as a standardised training tool. The training of assessors will continue to develop to ensure all aspects of PCRTA are given full and proper consideration. Hence, it is envisaged that training across the UK will include in-depth discussion around standards and criteria. This ensures consensus, small group work relating to generic skills for assessment and workshops on key research topics (particularly important for lay assessors or those with limited experience of undertaking research within a primary care setting), as well as wider discussion and instruction relating to the management of the scheme and the processes involved in assessment.

The pilot project drew from on-going work within the RCGP Assessment Network, where a number of schemes have developed recruitment and training procedures for assessors. Recent work has included the identification of a set of core skills of assessors and the development of generic training in this area for RCGP assessors. PCRTA will continue to input into this work and undertake training in such a way as to be consistent with the standards of the RCGP Assessment Network. This also links with other work undertaken by the Assessment Network to map out standards and criteria across assessment schemes, with the long-term aim of allowing for exemption from specified areas within schemes where accreditation has been met. As with assessor training, PCRTA will continue to work with the Assessment Network in achieving these ends as soon as possible, thereby facilitating assessment for all those involved.

The results of both the pilot scheme and the evaluation have indicated that the continuation and development of the scheme into a UK-based assessment programme are not only realistic but also acceptable to those involved. Such a scheme would also address the national policy agenda relating to primary care R&D and the need for a mechanism to ensure quality standards. Recognising this, the Department of Health has provided 18 months' funding for the scheme to develop across the UK, after which the scheme will be self-funding.

RECOMMENDATIONS

Following the analysis of the interviews presented in the previous section the author has set out some recommendations. These are based on suggestions from the practices, assessors and project management group as well as the author's experience from other accreditation schemes.

It is therefore recommended that the RCGP is explicit about the two reasons for accreditation, namely:

1. As a kite mark, indicator, of the quality of the research infrastructure.
2. As a development process for practices.

The accreditation should be time limited and **it is recommended that practices should be re-assessed every three years,** as a maximum, which is in line with the Investors in People standard.

The accreditation process should be kept as simple as practically possible and **it is therefore recommended that the RCGP keeps the current two-level system and incorporates room for development within each category**. There should also be support mechanisms available for practices wanting to use the process as a development opportunity.

In the pilot scheme, there are 'desirable' and 'essential' indicators for the assessment criteria. **It is recommended that these should remain, but to avoid a perverse incentive for practices to provide only evidence for the essential indicators they should have to demonstrate that at reassessment they have achieved more of the desirable indicators.**

It is recommended that practices should demonstrate that all of the criteria (within the level) are met. Where these criteria are supported by desirable indicators, the practice should have a choice of which are used (including using indicators not documented in the assessment schedule).

It is recommended that the assessment criteria themselves should remain as published but the assessment schedule should include more examples of the documentary evidence that is required.

It is recommended that the assessor training is reviewed. The interviews indicated that three overall sets of competencies will be needed:

1. Assessment skills and team working.
2. Understanding the criteria and assessment process.
3. Understanding general practice (for lay assessors).

It is recommended that the training programme should also include an element of assessment of the assessors against a set of competencies. These competencies should include:

- understanding research in general practice
- knowledge and interpretation of the criteria and standards
- team working
- influencing skills
- 'client' handling skills
- feedback skills.

Once assessors have attended such a programme and have been accredited, they should be supervised in their initial assessment by an experienced assessor.

The assessment teams have three members, typically a nurse, a GP and usually a lay member. **It is recommended that this overall structure is retained, although they should, wherever possible, have a new assessor — to ensure that assessment capacity is built.**

The widespread feeling by the practices that the lead assessor should be a GP should be noted. **It is recommended that in terms of skills this may not be entirely necessary but in terms of credibility and acceptability with the practices the presence of a practising GP as lead assessor is probably appropriate.** All assessors should declare if they are known to the practices or have worked with them in the past to ensure impartiality. The RCGP should check this at the time teams are appointed.

If the accreditation scheme develops and is rolled out nationally, the RCGP will need to recruit more assessors. **It is recommended that lead researchers from accredited practices are recruited as assessors.** The College could explore recruiting nurse assessors from community trusts and PCTs, particularly those with a research or clinical audit/clinical effectiveness background. It is important that any assessor has a good understanding of research (in a primary care setting) and, therefore, the College may wish to stipulate that all assessors have a higher research-based degree or other evidence of relevant academic training and experience of conducting research.

One of the issues identified in the pilot project was the variability of the assessments, particularly in the way the criteria were interpreted and applied. **It is recommended that there is an assessor verification process established to ensure a robust approach to quality assurance.**

The assessment process, which currently consists of a written submission followed by a day's visit, seems to work well. There was concern that the initial submission did not always demonstrate the strengths of the practice with respect to research and, therefore, the initial documentary evidence could be presented in a slightly different way to counter this. **It is recommended that each practice should be invited to submit a 'storyboard' in which they demonstrate how they meet each criterion.** This would be supplemented with three documents:

1. A research review report.
2. The practice's business plan.
3. The practice's development plan.

The RCGP could provide a template for all four documents plus a sample that demonstrates best practice. The practices should be expected to write these documents themselves and not receive external support.

The assessment visit is currently an appropriate length and it is recommended that this should not be changed.

It is recommended that practices that have (or where the lead GP researcher has) achieved one of the College's other accreditation schemes, for example FBA or QPA, should be given exemption from overlapping criteria. Similarly, if the practice is an accredited training practice or has achieved the Investors in People standard it should also be given exemption on certain aspects of the assessment. It is understood that the RCGP's Assessment Network is undertaking work on mapping the various standards and identifying

the commonalities. This project should inform the process of exemption.

It is recommended that once a practice has been accredited this should last for a maximum of three years. After this time the practice should be reassessed and have to demonstrate developments by achieving more of the desirable criteria than for the previous assessment. It is important for practices not to have to go through a demanding assessment process too frequently. However, they must not be accredited indefinitely, as key staff may move on and priorities change, leading to unintended slipping of standards. Three years is the maximum time that Investors in People organisations can go before being reassessed and this approach seems to work quite well.

It is recommended that the RCGP should publish an explicit process for practices wishing to become accredited as research organisations. Some practices will be using the scheme as a development activity and time must therefore be allowed for these practices to achieve the standard.

The following approach is suggested:

- practice makes an initial commitment (this is supported with a 'gap analysis' and project plan detailing what will need to be done and when)
- 'gap filling' activities (practices could be supported by advisors or develop the systems themselves)
- 'pre-MOT check' (practices undergo a quick informal assessment check to determine if they are ready for a formal assessment — this audit could be carried out by a representative from the local primary care research network)
- formal assessment
- recognition
- reassessment in three years.

The development (gap filling) phase of research accreditation could be undertaken with the support of an advisor. As such, **it is recommended that the primary care research network co-ordinators could act in a mentoring role rather than directly preparing practice submissions for the practices and that some guidance as to what is considered appropriate/inappropriate could be given by the RCGP.**

Currently the scheme is focused on individual research practices, however with the establishment of PCG/Ts there is a real opportunity to become involved in research standard setting and development activity across the whole primary care setting. **It is recommended that the RCGP should explore enlarging the focus of the accreditation scheme to PCTs and accrediting the practices that are involved in research.**

DEVELOPMENT OF A NATIONAL SCHEME

The evaluation described above and the final report for the pilot project (Carter and Shaw, 2000) both outlined a number of recommendations as to the future of the scheme and its development on a national basis. These have been taken on board and a number of changes have been made. The main areas of change are detailed below in relation to specific areas relating to the scheme.

MANAGEMENT OF PRIMARY CARE RESEARCH TEAM ASSESSMENT

In moving to a national scheme, a decision was made to refer to the scheme as Primary Care Research Team Assessment, as opposed to Accreditation of Research and Development in UK General Practice. It was felt that this conveyed the more formative nature of the scheme and emphasised the possible role of different members of the primary care team within research in a general practice setting.

Management of the scheme will continue through project management and advisory groups. Membership of both groups will be reviewed and updated on a regular basis in order to ensure they reflect the focus of the scheme itself, together with wider developments in primary care. Other local and national stakeholders will continue to be consulted and, where appropriate, will collaborate in reviewing or updating the scheme.

The project management group will continue to work closely with the RCGP Assessment Network to ensure compatibility between schemes in relation to both standards and process. In the future it is envisaged that exemption will be provided to practices having undergone assessment through other schemes.

ASSESSMENT DOCUMENTATION

Criteria and indicators within the assessment schedule have been updated following feedback within the pilot scheme and the evaluation. Key areas for revision were raised through the results of the pilot project and through proposed policy for primary care R&D.

Standards, criteria and indicators will be reviewed on an annual basis within the national scheme. This will be done formally through the project management and advisory groups, as well as in consultation with national stakeholders, where appropriate.

Changes have also been made to align PCRTA with current policy. Hence, Level I practices are now referred to as Collaborators and Level II as Investigator-Led. This reflects terminology within the proposed new funding arrangements for primary care research and development (Department of Health, 2000a; 2000b).

In order to facilitate assessment, practices will be required to prepare their written documentation using a standard electronic form provided within the assessment folder on 3.5" floppy diskette. Following the pilot scheme and evaluation, several key documents were identified as being important for submission with written documentation. Space will therefore be provided within the electronic form for practices to provide the following: research strategy; practice development plan; practice profile; and dissemination strategy.

SUPPORT FOR PRACTICES

In order to ensure that research practices undergoing assessment are part of a wider process of continuing development, it is recommended that primary care research networks become more involved in PCRTA. A series of seminars will be held with UK primary care research networks to discuss PCRTA and the role of individual networks and their research practices.

To emphasise the formative aspects of the assessment process, it is recommended that a similar model be followed as that used by FBA. In liaison with the RCGP Research Office, each research practice will be encouraged to discuss assessment with a mentor who will be able to guide them through the process. It is recommended that those undertaking mentoring roles are independent of the assessment process itself. Primary care research networks are recognised as being in a key position to guide, support and advise research practices.

ASSESSORS

Lead assessors within PCRTA will be GPs, with a long-term view that this should expand to include assessors from other professional backgrounds.

Assessment teams will continue to be multidisciplinary with at least one GP. Each team of three will include at least one assessor within the team, who is external, and one who is internal to the region within which the research practice is based.

As recommended in the qualitative evaluation, assessors within the scheme will require a core set of skills. Furthermore, any minimum requirements (e.g. MRCGP for GPs) will need to be specified within the scheme.

All assessors will be required to attend the training day. Work will continue through the RCGP Assessment Network relating to generic assessors and training to ensure compatibility between schemes and rigorous preparatory training.

Where assessors within the pilot scheme qualify for and wish to assess within the PCRTA, a compulsory refresher training day will be organised in order for them to continue in that role.

ASSESSMENT VISIT

Feedback will continue to be provided to research practices at the end of each assessment visit and, where possible, a decision will be made at that time as to achievement of accreditation. Feedback following the assessment visit in the form of a written feedback report will also be provided within one month of the assessment visit.

APPEALS PROCEDURE

An appeals procedure will be made available to all practices entering the scheme, in line with the RCGP Assessment Network.

REACCREDITATION

Accreditation will last for a fixed period of three years. During this period practices will be required to inform the RCGP Research Office of any changes within or outside of the practice that would affect their accreditation status. Practices will also be required to complete a short questionnaire on an annual basis.

PILOT PRACTICES

Those practices that were assessed through the pilot project will be 'fast-tracked' through PCRTA. Hence, where practices have achieved all criteria within the pilot scheme, it is recommended that they be asked to submit written documentation relating to the revised or new criteria for PCRTA. Where practices did not achieve all criteria at the level applied for within the pilot scheme, they will be given the opportunity to submit written documentation relating to the revised or new criteria for the national scheme, as well as written documentation relating to those criteria previously not achieved.

Where practices are unable to achieve all PCRTA criteria through submission of written documentation, they will be required to undergo a full assessment through PCRTA, including an assessment visit if they wish to proceed with the formal scheme.

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Appendix A - Summary of Assessment Schemes

What Sort of Doctor?

This scheme was one of the first to be developed in relation to general practice and primary care. It is no longer in use, having been overtaken by the development of other schemes, such as Fellowship by Assessment (FBA) (Royal College of General Practitioners, 2000).

In developing criteria for assessment, *What Sort of Doctor?* identified four areas of performance including clinical competence, accessibility, communication and professional values (Royal College of General Practitioners, 1981). The method of assessment that was developed was based on a visit to the practice by at least two colleagues, supplemented by information including an inspection of a sample of patient records and video tape consultations.

Fellowship by Assessment

Fellowship by Assessment is the RCGP's highest level performance-based award aimed at College members of at least five years' standing. By undergoing assessment by peers, RCGP Members may become Fellows.

The assessment process involves detailed preparation by the doctor, which includes standards of records and clinical audits (Royal College of General Practitioners, 2000). This can typically last between one and three years. Inspection by a visiting team includes assessment of a videotape of the doctor's consultations. By the end of 1998, it was estimated that 150 doctors would have achieved FBA (Roland *et al*, 1998).

Membership by Assessment of Performance

Approximately half of the GPs in the UK have passed the examination to become members of the RCGP. Membership by Assessment of Performance (MAP) is a new route to membership aimed at experienced GPs that is based on performance in the surgery as opposed to the traditional RCGP examination (Royal College of General Practitioners MAP Steering Group, 1999).

Membership by Assessment of Performance assessment involves preparation of a portfolio of evidence and a practice visit. A videotaped surgery is used to assess consulting skills. The criteria for MAP include essential elements that must be passed by all candidates, and non-essential elements, a proportion of which must be passed (Roland *et al*, 1998).

Vocational training

The Joint Committee for Postgraduate Training for General Practice (JCPTGP) is the body responsible for the approval of training posts for general practice training.

Through assessment, training practices must demonstrate the achievement of quality standards of patient care (Joint Committee on Postgraduate Training for General Practice, 1998). This assessment would be in relation to such areas as performance review, records and registers, the practice team, practice management, workload, booking rates for surgery consultations, and out-of-hours training.

Quality Team Development

Formerly known as the RCGP Team-Based Accreditation Programme, Quality Team Development (QTD) is an RCGP initiative in collaboration with other professional bodies within primary care.

The scheme aims to help primary care groups (PCGs) and primary care trusts (PCTs) assess the performance of primary care teams against locally validated criteria in relation to both services for patients and primary care team philosophy and activity. This is assessed through both written documentation and an assessment visit by a multidisciplinary team (Royal College of General Practitioners Accreditation Working Party, 1997; Walsh *et al*, 1998).

Quality Team Development works easily within the structure of a PCG or PCT but can be undertaken by any group of primary health care teams. It is designed to be a supportive, educational and professionally led approach to quality improvement.

Quality Practice Award

Pitched somewhere between FBA and MAP, the Quality Practice Award (QPA) has been developed by the RCGP to provide a national accreditation scheme for practices (Roland *et al*, 1998). QPA is a process that allows every member of the practice team the opportunity to become involved in improving the quality of both practice systems and clinical care. QPA is awarded to practices that can produce written evidence documenting their ability to meet high quality criteria that is verified by a multidisciplinary team visit. QPA is awarded for a fixed period of five years (Royal College of General Practitioners, 1997).

Medical Research Council General Practice Research Framework

The Medical Research Council General Practice Research Framework (GPRF) is an organisation consisting of over 900 general practices across the UK (over 8% of the total) involved in epidemiological and health services research (Vickers *et al*, 1999). The GPRF provides a resource allowing a co-ordinated framework of selected practices to undertake studies. Initial membership of the GPRF involves a vetting process for practices interested in joining the framework and hence, as with other schemes, utilises a number of criteria for assessing practices (Medical Research Council, 1998).

Appendix B - Project Management Group

Name	Organisation/Role
Professor Yvonne Carter	Chairman of Research Royal College of General Practitioners Chair of Project Management Group
Dr Lindsay Smith	General practitioner Somerset
Dr Madge Vickers/Mrs Jeanett Martin	MRC Epidemiology and Medical Care Unit
Dr Selena Gray	Clinical Adviser South and West R&D Directorate
Professor Ann-Louise Kinmonth	General Practice & Primary Care Research Unit Cambridge University
Miss Sara Shaw	Research Facilitator Royal College of General Practitioners
Miss Fenny Green	Research Administrator Royal College of General Practitioners

Appendix C - Advisory Group

Name	Organisation/Role
Dr Tina Ambury	National Association of Non-Principals
Ms Pippa Bagnall	Consultant in Primary Care Nursing
Dr Scott Brown	General practitioner Northern Ireland Research Practice
Dr Jim Cox	General practitioner RCGP Research Practice (Rural)
Susan Gooding	Research active practice nurse
Mrs Beverley Hancock	Representative from the Federation of Primary Care Research Networks Trent Focus Local Co-ordinator
Professor Phil Hannaford	Dept of General Practice, University of Aberdeen RCGP Centre for Primary Care Research and Epidemiology
Professor Roger Jones	Dept of General Practice, UMDS Chair of the Advisory Group
Dr Alison Kay	General practitioner Chairman, Fellowship by Assessment
Caroline Lee	Practice Manager, Stoke Newington Inner City Research Practice
Aislinn O'Dwyer	Specialist in Public Health and Primary Care R&D NHS Executive North and West Directorate
Dr Adrian Roberts	General practitioner S&W Research Practice
Dr Roy Robertson	General practitioner Representative from Scotland
Professor Bonnie Sibbald	Deputy Director National Primary Care R&D Centre
Dr Simon Smail	UK Conference Director of Postgraduate GP Education
Dr Hywel Thomas	Part-time general practitioner (Wales) Director of Profiad
Mrs Patricia Wilkie	Chairman, RCGP Patient Liaison Group Chairman of LREC

Appendix D - National Stakeholders' Group

Name	Organisation/Role
Professor Yvonne Carter	Chairman of Research Royal College of General Practitioners
Dr Richard Tiner	Chair of the National Stakeholders' Group Medical Director, Association of British Pharmaceutical Industry
Dr John Chisholm	Chairman, GP Committee of the British Medical Association
Ms Ann Pickering	Federation of Primary Care Research Networks
Dr Madge Vickers	MRC Epidemiology and Medical Care Unit
Professor Cliff Bailey	Regional Director of R&D NHS Executive, Northern and Yorkshire
Professor Mike Pringle	Chairman, Royal College of General Practitioners
Dr Edward Dickinson	Director, Research Unit Royal College of Physicians
Professor Ann-Louise Kinmonth	General Practice & Primary Care Research Unit Cambridge University
Dr Brian Keighley	General Medical Council

Appendix E - Assessment Criteria: Levels I and II

THE PCRTA ASSESSMENT SCHEDULE
WRITTEN GUIDANCE FOR CANDIDATES

This first edition of the PCRTA Assessment Schedule takes effect on 1 April 2001. A new edition, which may contain changes to the criteria and regulations, will supersede this edition on 1 April 2002. However, it is expected that any changes will be kept to a minimum. Practices submitting their registration form for Assessment on or before 1 April 2002 will have until 31 March 2003 to submit their written evidence in accordance with this first edition. All registration forms received after 1 April 2002 must comply with the criteria contained in the second edition, which will be available on 1 April 2002.

STANDARDS CRITERIA & INDICATORS

Standards for both levels of assessment have been grouped into seven areas of activity that reflect the main areas of research and development. These areas are:

- Practice Organisation
- Strategic Planning
- Practice as a Learning Organisation
- Research Resources and Infrastructure
- Project Funding and Management
- Involvement of Patients
- Dissemination of Research

Standards quoted are the *minimum acceptable standards* for PCRTA, therefore practices must meet every standard in order to achieve assessment. The standards assume that practices comply with Government and professional regulations. Please note that the practice is required to declare any pending or upheld formal complaints, breaches of terms of service, litigation or similar.

In order to assess whether a standard has been met, each standard has been defined by a number of specific criteria, and each criterion is then defined by one or more indicators. Assessors will ascertain whether each indicator has or has not been met in order to ascertain whether a standard has or has not been achieved.

There are two types of indicator: essential indicators and indicators of good practice. Essential indicators must be met in order to meet the criterion and standard. Indicators are marked with letters of the alphabet: a), b), c) etc and may have subsections within them: a) i, b) ii etc.

Indicators of Good Practice are marked throughout the Schedule. These do not have to be met in order to achieve assessment. However they are designed to support practice development by providing a clear understanding of standards of excellence that should be aimed for. Indicators of Good Practice are especially helpful to Collaborator Research Practices and can provide a useful mechanism when working towards assessment as an Investigator Led Research Practice. Where appropriate, practices will be assessed according to indicators which are good practice and feedback will be provided accordingly. However, if practices achieve all essential indicators but none which are good practice, this will not affect their accreditation but we would hope that in future applications practices will aim to achieve these indicators of good practice.

Where all subsections of an individual indicator are either essential or good practice, this is clearly marked beside the indicator as follows: ●. Where subsections of an individual indicator are both essential and good practice, these are marked accordingly beside each subsection.

Other information provided on each page includes whether assessment is via submission of written evidence by the practice or through the assessment visit. These are clearly marked beside the indicators as follows: ● For selected criteria or indicators, practices are required to submit written evidence for review, as well as undergoing assessment during the visit.

The following pages list the standards, criteria and indicators for Collaborator Research Practices and Investigator Led Research Practices.

Italicised guidance notes are provided, where appropriate.

KEY

Essential indicators

Indicators of Good Practice

Written evidence required for document review

Assessment visit

PRACTICE ORGANISATION

PRACTICE PROFILE

Standard 1.1

The practice is organised in an effective and efficient way which allows for high quality clinical practice and research and development.

Criterion 1.1.1

The practice has a primary care team[1], including a practice manager, which provides a range of patient services.

Indicators

a) Practice profile including the following:
   i. Profile of all staff, including their roles and responsibilities, special interests and local/national representation.
   ii. Patient services which are provided by the practice.

Criterion 1.1.2

There are clear standards and guidelines for practice for all members of the primary health care team.

Indicators

a) Practice profile including the following:
   i Clear standards and guidelines for practice.
   ii Practice development plan.

Guidance

Please provide details of employment arrangements for those doing research, both patients and employed staff (if any).

Criterion 1.1.3

The practice has a clearly stated policy for encouraging suggestions and feedback from patients, and for dealing with complaints.

Indicators

a) Evidence of complaints procedure, as well as staff training and familiarity with procedures.

b) Incorporation of feedback from complaints into practice development and improvements.

Guidance

Please provide an outline of your practice complaints procedure and list the training undertaken by staff.

NB The practice is required to declare any pending or upheld formal complaints, breaches of terms of service, litigation or similar.

[1] For the purposes of assessment, the primary health care team is defined as 'professionals employed by or attached to the practice'. In reviewing the list of practice staff submitted by each practice, assessors will look to see if any of the main categories of staff are not listed. If this is the case they would enquire whether these staff exist and, if so, the rationale behind the practice omitting them.

PRACTICE ORGANISATION

PRACTICE PROFILE

Standard 1.1

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Criterion 1.1.1

The practice has a primary care team[1], including a practice manager, which provides a range of patient services.

Indicators

a) Practice profile including the following:
   i Profile of all staff, including their roles and responsibilities, special interests and local/national representation.
   ii Patient services which are provided by the practice.

Criterion 1.1.2

There are clear standards and guidelines for practice for all members of the primary health care team.

Indicators

a) Practice profile including the following:
   i Clear standards and guidelines for practice.
   ii Practice development plan.

Guidance

Please provide details of employment arrangements for those doing research, both patients and employed staff (if any).

Criterion 1.1.3

The practice has a clearly stated policy for encouraging suggestions and feedback from patients, and for dealing with complaints.

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PRACTICE ORGANISATION

RECORDS AND REGISTERS

Standard 1.2

The practice is able to demonstrate appropriate use and development of audit, disease registers and patient records for research.

Criterion 1.2.1

There are written audits available prepared within the last three years, each having completed the audit cycle.

Indicators

a) The practice has prepared 3 audits within the last 3 years, each having completed the quality improvement plan and prepared by more than one individual.

Guidance

Please ensure that audits are available during the assessment visit.

Criterion 1.2.2

An age/sex register is in use within the practice and regularly up-dated.

Indicators

a) The practice has an age/sex register and can give examples of any uses to which this information has been put within the last two years.

b) The practice can show that arrangements are in place to ensure that data is kept up-to-date.

Guidance

Please ensure that the age/sex register is available during the assessment visit.

Criterion 1.2.3

A diagnostic register is held on computer and is used in the practice and regularly up-dated.

Indicators

a) A diagnostic register is in use within the practice. The practice should be able to show what steps have been taken to assess the accuracy of this information, giving examples of uses to which this information has been put in the last two years.

b) The practice should be able to show what arrangements are in place to ensure data is up-to-date.

c) An ability to flag notes and/or identify groups of individuals with specific conditions or on specific therapy.

Guidance

Please ensure that the dignostic register is available during the assessment visit.

PRACTICE ORGANISATION

RECORDS AND REGISTERS

Standard 1.2

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Criterion 1.2.1

There are written audits available prepared within the last three years, each having completed the audit cycle.

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a) The practice has prepared 3 audits within the last 3 years, each having completed the quality improvement plan and prepared by more than one individual.

Guidance

Please ensure that audits are available during the assessment visit.

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An age/sex register is in use within the practice and regularly up-dated.

Indicators

a) The practice has an age/sex register and can give examples of any uses to which this information has been put within the last two years

b) The practice can show that arrangements are in place to ensure that data is kept up-to-date.

Guidance

Please ensure that the age/sex register is available during the assessment visit.

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Guidance

Please ensure that the dignostic register is available during the assessment visit.

STRATEGIC PLANNING

PRACTICE RESEARCH STRATEGY

Standard 2.1

The practice has a short and long-term strategy for research and development, both within and outside of the practice.

Criterion 2.1.1

The practice research team leader should normally be a member of the primary health care team.

Indicators

a) The practice research team leader (whether a general practitioner or not) is contracted to provide a minimum of 13 hours of service within the practice.

Criterion 2.1.2

There should be a practice research strategy that is clear and accessible to all members of the primary health care team.

Indicators

a) Practice research strategy including the following:
   - i Formal procedures for ensuring all partners approve of research being undertaken within the practice and will give their support as appropriate.
   - ii An outline research development plan detailing how the practice will build on its own strengths and link with external strengths (e.g. other practices, universities, trusts).
   - iii Milestones over the next five years.
   - iv Staff training.
   - v How research participants will be recruited.
   - vi How research should be disseminated to the team, colleagues and professionals.

Guidance

Please ensure that the practice research strategy is available during the assessment visit.

STRATEGIC PLANNING

PRACTICE RESEARCH STRATEGY

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   - iii Milestones over the next five years.
   - iv Staff training.
   - v How research participants will be recruited.
   - vi How research should be disseminated to the team, colleagues and professionals.

Guidance

Please ensure that the practice research strategy is available during the assessment visit.

STRATEGIC PLANNING

PRACTICE RESEARCH STRATEGY

Criterion 2.1.3

There should be a clear primary health care team philosophy about research being an integral part of the practice.

Indicators

a) Practice research strategy including the following:
   - i Details of the roles and responsibilities of all primary health care staff in relation to research.
   - ii Signatures of each GP partner demonstrating commitment to the research strategy.

b) Aside from the practice research team leader, at least one other member of the practice should have participated in research over the last 3 years.

Guidance

Please ensure that the practice research strategy is available during the assessment visit.

Criterion 2.1.4

There should be clear processes in place for financial management of the research budget.

Indicators

a) Arrangements within the practice for managing research budgets including:
   - i Separate account for research budget.
   - ii Named individual responsible for research budget.
   - iii Clear audit trail for dealing with research income.
   - iv Integration into the practice business plan.

Criterion 2.1.5

Demonstrate ability to fulfil the terms and ambitions of the research strategy.

Indicators

a) Written evidence of achievement of aims of research strategy to date by those members of the primary health care team directly involved in research.

Guidance

As a long term strategy, we appreciate that the practice may not have achieved all of the aims outlined in their research strategy. Please provide details of any achievements at the time of assessment.

STRATEGIC PLANNING

PRACTICE RESEARCH STRATEGY

Criterion 2.1.3

There should be a clear primary health care team philosophy about research being an integral part of the practice.

Indicators

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Guidance

As a long-term strategy, we appreciate that the practice may not have achieved all of the aims outlined in their research strategy. Please provide details of any achievements at the time of assessment.

PRACTICE AS A LEARNING ORGANISATION

INDIVIDUAL DEVELOPMENT

Standard 3.1

The practice demonstrates an effective strategy for the individual development of members of the primary health care team.

Criterion 3.1.1
Indicators

The practice structure and organisation allows for individual development.

a) Structures within the practice for individual development including a developed or developing appraisal scheme for all members of the primary health care team which occurs at regular intervals.

Guidance

Please ensure that a copy of your practice appraisal scheme is available for review at the assessment visit.

Criterion 3.1.2
Indicators

Development of individual research skills within the practice.

a) Strategic plans for developing individual research skills within the practice.

Criterion 3.1.3
Indicators

Encouragement to undertake research methods training.

a) Evidence of encouragement to members of the primary health care team directly involved in research to undertake research methods training, including information on anyone within the practice who is currently undertaking any training.

Guidance

During the assessment visit, members of the primary health care team directly involved in research may be asked about research methods training.

PRACTICE AS A LEARNING ORGANISATION

INDIVIDUAL DEVELOPMENT

Standard 3.1

The practice demonstrates an effective strategy for the individual development of members of the primary health care team.

Criterion 3.1.1

The practice structure and organisation allows for individual development.

Indicators

a) Structures within the practice for individual development including a developed or developing appraisal scheme for <u>all</u> members of the primary health care team which occurs at regular intervals.

Guidance

Please attach a copy of your practice appraisal scheme along with your written submission.

Criterion 3.1.2

Past, on-going and future training in research for all individuals involved in research within the practice.

Indicators

a) Written evidence of past, on-going and future training in research for all those involved in research within the practice.

b) Strategic plans for developing individual research skills within the practice.

Criterion 3.1.3

Planned programme for addressing the research training needs of members of the primary health care team directly involved in research.

Indicators

a) Evidence of encouragement to members of the primary health care team directly involved in research to undertake higher degrees and/or research methods training, including information on anyone within the practice who is registered for a higher degree and/or research methods training.

b) Evidence that the practice research team leader and at least one other member of the practice have attended at least one training course in research within the last three years (minimum course length three days).

(c) Evidence that at least one member of the practice research team has, or is registered for, an MD, PhD, MPhil or MSc from a research led programme.

Guidance

During the assessment visit, members of the primary health care team directly involved in research may be asked about research methods training.

PRACTICE AS A LEARNING ORGANISATION

TEAM DEVELOPMENT

Standard 3.2

The practice demonstrates an effective strategy for the team development within the primary health care team.

Criterion 3.2.1

Commitment to developing and maintaining teamwork within the practice.

Indicators

a) Arrangements for communication between primary care team members. This must include arrangements for the discussion of practice research, as well as wider research outside of the practice.

Guidance

Practices should provide details of regular research meetings and make minutes of these meetings available during the assessment visit.

Criterion 3.2.2

There are regular formal and informal meetings between members of the primary health care team which reflect the learning environment of the practice.

Indicators

a) Dates of team meetings, as well as their membership, attendance and minutes of these meetings.

Guidance

Evidence should reflect team development within the practice including discussions of a developmental nature involving the multidisciplinary clinical team and focusing on practice development, individual projects and cases and any other relevant activities (e.g. audit). Please ensure that minutes from relevant meetings are available during the assessment visit. Discussion with members of the primary health care team may also take place.

PRACTICE AS A LEARNING ORGANISATION

TEAM DEVELOPMENT

Standard 3.2

The practice demonstrates an effective strategy for the team development within the primary health care team.

Criterion 3.2.1

Commitment to developing and maintaining teamwork within the practice.

Indicators

a) Arrangements for communication between primary care team members. This must include arrangements for the discussion of practice research, as well as wider research outside of the practice.

Guidance

Practices should provide details of regular research meetings and make minutes of these meetings available during the assessment visit.

Criterion 3.2.2

There are regular formal and informal meetings between members of the primary health care team which reflect the learning environment of the practice.

Indicators

a) Dates of team meetings, as well as their membership, attendance and minutes of these meetings.

Guidance

Evidence should reflect team development within the practice including discussions of a developmental nature involving the multidisciplinary clinical team and focusing on practice development, individual projects and cases and any other relevant activities (e.g. audit). Please ensure that minutes from relevant meetings are available during the assessment visit. Discussion with members of the primary health care team may also take place.

PRACTICE AS A LEARNING ORGANISATION

EDUCATION OF OTHERS

Standard 3.3

The practice demonstrates an effective strategy for the education of others outside of the practice.

Criterion 3.3.1

Indicators

The practice is committed to primary health care education and training.

a) All members of the primary health care team are involved in multi-disciplinary team meetings.

b) Participation in Vocational Training Scheme and/or undergraduate teaching.

c) Participation in other education and training programmes for primary and community professionals.

Guidance

In relation to indicator a) practices should provide details of regular multi-disciplinary team meetings and make minutes of these meetings available during the assessment visit.

In relation to indicator b) please ensure that correspondence confirming either current Vocational Training and/or undergraduate teaching status are available during the assessment visit.

PRACTICE AS A LEARNING ORGANISATION

EDUCATION OF OTHERS

Standard 3.3

The practice demonstrates an effective strategy for the education of others outside of the practice.

Criterion 3.3.1

Indicators

The practice is committed to primary health care education and training.

a) All members of the primary health care team are involved in multi-disciplinary team meetings.

b) Participation in Vocational Training Scheme and/or undergraduate teaching.

c) Participation in other education and training programmes for primary and community professionals.

Guidance

In relation to indicator a) practices should provide details of regular multi-disciplinary team meetings and make minutes of these meetings available during the assessment visit.

In relation to indicator b) please ensure that correspondence confirming either current Vocational Training and/or undergraduate teaching status are available during the assessment visit.

RESEARCH RESOURCES AND INFRASTRUCTURE

RESEARCH RESOURCES

Standard 4.1

The practice has an appropriate infrastructure and sufficient resources to support research and development.

Criterion 4.1.1
Indicators

Access to a range of research resources.

a) A range of research resources within the practice including:
   - i Evidence of appropriate space within the practice dedicated to research activity including space to store confidential research records separate from clinical records and locked cabinets for confidential data and records etc.
   - ii Practice library with books and journals relative to research.
   - iii Access to the Internet and knowledge of available resources.

Guidance

It is appreciated that some practices may experience problems relating to dedicated space. This may be 'shared' space with, for instance, education or information resources. However, where this is the case, it must be clearly identified as research and issues concerning confidentiality must be given full and proper consideration.

Criterion 4.1.2
Indicators

Protected time.

a) A number of protected sessions dedicated to research available for use by all members of the practice team involved in research.

RESEARCH RESOURCES AND INFRASTRUCTURE

RESEARCH RESOURCES

Standard 4.1

The practice has an appropriate infrastructure and sufficient resources to support research and development.

Criterion 4.1.1
Indicators ● ● ●

Access to a range of research resources.

a) A range of research resources within the practice including:
   - i Evidence of appropriate space within the practice dedicated to research activity including space to store confidential research records separate from clinical records and locked cabinets for confidential data and records etc.
   - ii Practice library with books and journals relative to research.
   - iii Access to the Internet and knowledge of available resources.
   - iv Research secretary or assistant.

Guidance

It is appreciated that some practices may experience problems relating to dedicated space. This may be 'shared' space with, for instance, education or information resources. However, where this is the case, it must be clearly identified as research and issues concerning confidentiality must be given full and proper consideration.

Criterion 4.1.2
Indicators ● ●

Protected time.

a) A number of protected sessions dedicated to research available for use by all members of the practice team involved in research.

RESEARCH RESOURCES AND INFRASTRUCTURE

COMPUTERISATION AND DATA HANDLING

Standard 4.2

The practice has appropriate procedures for maintaining computerised records and for handling data relating to research.

Criterion 4.2.1

Indicators ● ● ●

The practice complies with the requirements of the Data Protection Act.

a) The practice data protection registration documents are current and comply with regulations.

Guidance

Indicate the last submission for Data Protection Act registration and indicate the type of approval you have. Please make all correspondence with Data Protection Register available at the practice assessment visit.

Criterion 4.2.2

Indicators ● ● ●

The practice acknowledges and adheres to guidelines on access to, and use of, patient records and procedures for informing patients.

a) Practice staff are aware of the guidelines laid out in *Duties of a Doctor* on access to and use of patient records and procedures for informing patients.

Guidance

At the time of submission of written evidence, please refer to the most recent version of 'Duties of a Doctor: Guidelines from the General Medical Council'. London: General Medical Council. The guidelines laid out in 'Duties of a Doctor' may be discussed with practice staff.

Criterion 4.2.3

Indicators ● ● ●

There is encouragement to develop data handling.

a) The practice should encourage all members of the primary health care team involved in research to develop data handling skills and approaches to searching for evidence.

RESEARCH RESOURCES AND INFRASTRUCTURE

COMPUTERISATION AND DATA HANDLING

Standard 4.2

The practice has appropriate procedures for maintaining computerised records and for handling data relating to research.

Criterion 4.2.1

Indicators ● ● ●

The practice complies with the requirements of the Data Protection Act.

a) The practice data protection registration documents are current and comply with regulations.

Guidance

Indicate the last submission for Data Protection Act registration and indicate the type of approval you have. Please make all correspondence with Data Protection Register available at the practice assessment visit.

Criterion 4.2.2

Indicators ● ● ●

The practice acknowledges and adheres to guidelines on access to, and use of, patient records and procedures for informing patients.

a) Practice staff are aware of the guidelines laid out in *Duties of a Doctor* on access to and use of patient records and procedures for informing patients.

Guidance

At the time of submission of written evidence, please refer to the most recent version of 'Duties of a Doctor: Guidelines from the General Medical Council'. London: General Medical Council. The guidelines laid out in 'Duties of a Doctor' may be discussed with practice staff.

Criterion 4.2.3

Indicators ● ● ●

There is encouragement to develop data handling.

a) The practice should encourage all members of the primary health care team involved in research to develop data handling skills and approaches to searching for evidence.

RESEARCH RESOURCES AND INFRASTRUCTURE

COMPUTERISATION AND DATA HANDLING

Criterion 4.2.4

Indicators

There is a security policy relating to practice computing.

a) Practice policy regarding:
   - i Levels of access to the computer system/s.
   - ii Backing up data, including frequency.
   - iii Keeping research records in confidential areas.
   - iv Secure arrangements for data analysis.

Guidance

Please ensure that the practice security policy for computing is available during the assessment visit.

Criterion 4.2.5

Indicators

The practice has a computer operator or staff member competent in computerised data handling.

a) Staff training in computerised data handling.

RESEARCH RESOURCES AND INFRASTRUCTURE

COMPUTERISATION AND DATA HANDLING

Criterion 4.2.4

Indicators ● ● ●

There is a security policy relating to practice computing.

a) Practice policy regarding:
   - i Levels of access to the computer system/s.
   - ii Backing up data, including frequency.
   - iii Keeping research records in confidential areas.
   - iv Secure arrangements for data analysis.

Guidance

Please ensure that the practice security policy for computing is available during the assessment visit.

Criterion 4.2.5

Indicators ● ●

The practice has a computer operator or staff member competent in computerised data handling.

a) Staff training in computerised data handling.

RESEARCH RESOURCES AND INFRASTRUCTURE

LINKS WITH OTHER ORGANISATIONS

Standard 4.3

The practice has links with other organisations which allow for encouragement of research and development, as well as increased awareness and ability.

Criterion 4.3.1
Indicators

Evidence of collaborative framework for research.

a) Collaborative framework for research within primary care.
b) Collaboration with purchasers and other providers.

Guidance

Discussion with the research team leader about the collaborative framework and collaboration with purchasers and providers may take place during the assessment visit.

Criterion 4.3.2
Indicators

Links into Primary Care Research Networks and/or Research Clubs.

a) Membership or involvement in Primary Care Research Networks and/or Research Clubs.

Criterion 4.3.3

Links with a range of academic units, including departments of general practice or departments of nurse education, including library and computing facilities.

Indicators

a) On-going and sustained links/collaboration with an academic establishment or R&D support unit.

Guidance

Discussion with the research team leader about the practices' links may take place during the assessment visit.

Criterion 4.3.4
Indicators

Contact with other organisations to heighten awareness of research activities.

a) Contact with other organisations to heighten awareness of research activities e.g. on-call co-operatives or deputising services and industry related professional bodies e.g. Association of British Pharmaceutical Industry.

Guidance

Discussion with the research team leader about the practices' contact with other organisations may take place during the assessment visit.

RESEARCH RESOURCES AND INFRASTRUCTURE

LINKS WITH OTHER ORGANISATIONS

Standard 4.3

The practice has links with other organisations which allow for encouragement of research and development, as well as increased awareness and ability.

Criterion 4.3.1

Planned strategy of linking with appropriate groups and organisations to take forward primary care or interface research.

Indicators

a) Evidence of collaborative framework for research.

b) Appropriate disciplinary mix within research projects including evidence of:

- i Multi-disciplinary working e.g. interface research with local NHS Trusts, social services, voluntary agencies, secondary and tertiary care sectors.
- ii Collaboration with other practices which are willing to host research.
- iii Membership or involvement in local Primary Care Research Networks and/or Research Clubs.
- iv On-going and sustained links/collaboration with an academic establishment (such as departments of general practice or departments of nursing education, including library and computing facilities) or R&D support unit.

Guidance

Discussion with the research team leader about the collaborative framework and disciplinary mix may take place during the assessment visit.

Criterion 4.3.2

Contact with other organisations to heighten awareness of research activities.

Indicators

a) Contact with other organisations to heighten awareness of research activities e.g. on-call co-operatives or deputising services and industry related professional bodies e.g. Association of British Pharmaceutical Industry

Guidance

Discussion with the research team leader about contact with other organisations may take place during the assessment visit.

Criterion 4.3.3

Helping to facilitate research locally.

Indicators

a) Provision of advice to other researchers.

Guidance

Discussion with the research team leader about facilitating research may take place during the assessment visit.

PROJECT FUNDING AND MANAGEMENT

PROJECT FUNDING

Standard 5.1

The practice has plans for future project funding.

Criterion 5.1.1

Indicators ● ● ●

Summary of research activity.

a) The practice should provide summary information relating to <u>all</u> current and planned research, including externally funded and self-financed research.

Guidance

The practice should use the proforma on the enclosed 3.5" diskette to provide a summary of each research project. Please ensure that all protocols are available during the assessment visit.

Criterion 5.1.2

Indicators ● ● ●

Research activity.

a) Participation in at least one collaborative research project within the past 3 years and details of who has funded project(s).

Guidance

Excluding those listed in 5.1.1, please list research projects undertaken within the last 3 years using the proforma on the enclosed 3.5" diskette. Please ensure that all protocols are available during the assessment visit.

Criterion 5.1.3

Indicators ● ● ●

Plans to obtain grants.

a) Plans to obtain project funding from either National or Regional Research and Development Directorates or the Department of Health, or equivalent, over the next three years.

● ● ●

b) Plans for research income from other sources.

Guidance

Discussion with the research team leader about plans to obtain research grants may take place during the assessment visit.

Criterion 5.1.4

Indicators ● ●

Self-financed research e.g. practice-based patient survey.

a) Details of any self-financed research within the practice over the last 3 years.

PROJECT FUNDING AND MANAGEMENT

PROJECT FUNDING

Standard 5.1

The practice has plans for future project funding.

Criterion 5.1.1

Indicators ● ● ●

Summary of research activity.

a) The practice should provide summary information relating to all current and planned research, including externally funded and self-financed research.

Guidance

The practice should use the proforma on the enclosed 3.5" diskette to provide a summary of each research project. Please ensure that all protocols are available during the assessment visit.

Criterion 5.1.2

Indicators ● ● ●

Research activity.

a) At least one project grant externally funded by non-commercial research and development sources, within the past 3 years.

● ● ● b) Information relating to any commercial research income.

Guidance

Excluding those listed in 5.1.1, please list research projects undertaken within the last 3 years using the proforma on the enclosed 3.5" diskette. Please ensure that all protocols are available during the assessment visit.

Criterion 5.1.3

Indicators ● ● ●

Plans to obtain grants.

a) Evidence of plans to obtain other grants (other than those outlined in criterion 5.1.1) over the next three years.

Guidance

Discussion with the research team leader about plans to obtain research grants may take place during the assessment visit.

Criterion 5.1.4

Indicators ● ●

Self-financed research e.g. practice-based patient survey.

a) Information relating to any self-financed research within the practice over the last 3 years.

PROJECT FUNDING AND MANAGEMENT

PROJECT MANAGEMENT

Standard 5.2

The practice has systems in place to ensure effective and efficient project management.

Criterion 5.2.1
Indicators

Quality assurance.

a) Internal processes assuring quality of research including accuracy of data collection.

b) External processes assuring quality of research including peer review.

Guidance

Discussion with the research team leader about quality assurance may take place during the assessment visit.

Criterion 5.2.2
Indicators

Project management (where appropriate).

a) Where the practice has secured external funding there should be a clear assessment of the record of research within the practice including the achievement of time and budget targets.

PROJECT FUNDING AND MANAGEMENT

PROJECT MANAGEMENT

Standard 5.2

The practice has systems in place to ensure effective and efficient project management.

Criterion 5.2.1

Indicators

Quality assurance.

a) Internal processes assuring quality of research including accuracy of data collection.

b) External processes assuring quality of research including peer review.

Guidance

Discussion with the research team leader about quality assurance may take place during the assessment visit.

Criterion 5.2.2

Indicators

Project management (where appropriate).

a) Assessment of the record of research within the practice including the achievement of time and budget targets.

b) Securement of infrastructure support funding.

INVOLVEMENT OF PATIENTS

CONSUMER PARTICIPATION

Standard 6.1

The practice has channels for ensuring that patients are informed of research within the practice and, where appropriate, that they are able to discuss and feed into specific research.

Criterion 6.1.1

Leaflets or other information must be available to patients on the practices' research activities.

Indicators

a) Leaflets or other information is made available to patients on the practices' research activities.

b) The practice has systems in place to:
   i Thank patients for taking part in research.
   ii Feedback any available results to patients involved in research.

Criterion 6.1.2

The practice should involve patients in research.

Indicators

a) Members of the primary health care team directly involved in research should have some knowledge of methods of consumer involvement in research.

Guidance

Discussion with members of the primary health care team directly involved in research may take place during the assessment visit.

Criterion 6.1.3

Research should be based on areas of need.

Indicators

a) Research is based on areas of need identified through health needs assessment, audit and community profiles. Core members of the practice research team should demonstrate knowledge of local Health Improvement Programmes.

Guidance

Discussion with members of the practice research team about local Health Improvement Plans may take place during the assessment visit.

Criterion 6.1.4

The practice has made arrangements for appropriate members of the primary health care team to see patients involved in clinical trials.

Indicators

a) Arrangements are in place for members of the primary health care team to see patients involved in clinical trials e.g. protected time, appointment diaries or out-of-hours cover.

INVOLVEMENT OF PATIENTS

CONSUMER PARTICIPATION

Standard 6.1

The practice has channels for ensuring that patients are informed of research within the practice and, where appropriate, that they are able to discuss and feed into specific research.

Criterion 6.1.1

Information must be available to patients on the practices' research activities.

Indicators

a) Leaflets or other information is made available to patients on the practices' research activities.

b) The practice has systems in place to:
   i Thank patients for taking part in research.
   ii Feedback any available results to patients involved in research.

Criterion 6.1.2

The practice should involve patients in research.

Indicators

a) Members of the primary health care team directly involved in research should have some knowledge of consumer involvement in research.

b) The practice must be able to demonstrate that they have taken steps to involve patients in the design, conduct and dissemination of research within the practice.

Guidance

Discussion with members of the primary health care team directly involved in research may take place during the assessment visit.

Criterion 6.1.3

Research should be based on areas of need.

Indicators

a) Research is based on areas of need identified through health needs assessment, audit and community profiles. Core members of the practice research team should demonstrate knowledge of local Health Improvement Programmes.

Guidance

Discussion with members of the practice research team about local Health Improvement Plans may take place during the assessment visit.

Criterion 6.1.4

The practice has made arrangements for appropriate members of the primary health care team to see patients involved in clinical trials.

Indicators

a) Arrangements are in place for members of the primary health care team to see patients involved in clinical trials e.g. protected time, appointment diaries or out-of-hours cover.

INVOLVEMENT OF PATIENTS

ETHICAL ISSUES

Standard 6.2

The practice team is aware of, and has systems in place to ensure, ethical approval of research and patient confidentiality.

Criterion 6.2.1

Systems are in place to ensure, where appropriate, the ethical approval of research.

Indicators

a) Knowledge of and, where appropriate, use of Local Research Ethics Committees (LREC) and Multi-centre Research Ethics Committees (MREC). All members of the primary health care team must demonstrate an understanding of ethical issues including the LREC and MREC process.

Guidance

Discussion with members of the primary health care team about ethical issues may take place during the assessment visit.

Criterion 6.2.2

Assurance of confidentiality for patients.

Indicators

a) Systems are in place to ensure patient confidentiality, including written assurance of adherence to the Data Protection Act in respect of data collected for research purposes.

Criterion 6.2.3

Systems are in place for seeking informed consent from patients.

Indicators

a) Systems are in place for seeking informed consent from patients including standard consent forms, patient information sheets etc.

b) All members of the primary care team must demonstrate an understanding of the term 'informed consent' and its application to research.

Guidance

Please ensure that example copies of consent forms and patient information sheets are available during the assessment visit. Discussion with members of the primary health care team about informed consent may take place during the assessment visit.

INVOLVEMENT OF PATIENTS

ETHICAL ISSUES

Standard 6.2

The practice team is aware of, and has systems in place to ensure, ethical approval of research and patient confidentiality.

Criterion 6.2.1

Systems are in place to ensure, where appropriate, the ethical approval of research.

Indicators

a) Knowledge of and, where appropriate, use of Local Research Ethics Committees (LREC) and Multi-centre Research Ethics Committees (MREC). All members of the primary health care team must demonstrate an understanding of ethical issues, including the LREC and MREC process.

Guidance

Discussion with members of the primary health care team about ethical issues may take place during the assessment visit.

Criterion 6.2.2

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Indicators

a) Systems are in place to ensure patient confidentiality, including written assurance of adherence to the Data Protection Act in respect of data collected for research purposes.

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Indicators

a) Systems are in place for seeking informed consent from patients including standard consent forms, patient information sheets etc.

b) All members of the primary care team must demonstrate an understanding of the term 'informed consent' and its application to research.

Guidance

Please ensure that example copies of consent forms and patient information sheets are available during the assessment visit. Discussion with members of the primary health care team about informed consent may take place during the assessment visit.

INVOLVEMENT OF PATIENTS

ETHICAL ISSUES

Criterion 6.2.4

Systems are in place for ensuring patient safety in research, where appropriate.

Indicators

a) Systems are in place to ensure patient safety through participation in any research relating to the practice.

Guidance

Systems to ensure patient safety should include ethical approval, standard operating procedures, management of adverse events and quality control systems.

INVOLVEMENT OF PATIENTS

ETHICAL ISSUES

Criterion 6.2.4

Indicators

Systems are in place for ensuring patient safety in research, where appropriate.

a) Systems are in place to ensure patient safety through participation in any research relating to the practice.

Guidance

Systems to ensure patient safety should include ethical approval, standard operating procedures, management of adverse events and quality control systems.

DISSEMINATION OF RESEARCH

DISSEMINATION STRATEGY

Standard 7.1

The practice has an effective strategy for disseminating their own and others research and for feeding this into practice.

Criterion 7.1.1
Indicators ● ●

Practice dissemination strategy.

a) Written dissemination strategy outlining the purpose(s) of dissemination and showing evidence of adherence to this strategy.

Guidance

This should be limited to one side of A4 and list key points.

Criterion 7.1.2
Indicators ● ● ●

Evidence of efforts to implement evidence based practice.

a) Journal club or practice team meeting to discuss policy and to feed research into practice, including the impact of research on service delivery and patient outcomes.

Guidance

The practice should provide dates of appropriate meetings, as well as membership and attendance. Minutes or a description of the aims and objectives of these meetings should be available during the assessment visit.

Criterion 7.1.3
Indicators ● ● ●

Plans to publish research in peer reviewed journals.

a) Plans to publish research by the practice research team leader over the next three years.

Guidance

Discussion with the research team leader about plans to publish may take place during the assessment visit. Where practices are involved in large scale multi-centre research, we will take into consideration the possibility of limited control over the publication of clinical research data and the impact this may have on achieving this criterion.

DISSEMINATION OF RESEARCH

DISSEMINATION STRATEGY

Standard 7.1

The practice has an effective strategy for disseminating their own and others research and for feeding this into practice.

Criterion 7.1.1

Indicators ● ●

Practice dissemination strategy.

a) Written dissemination strategy outlining the purpose(s) of dissemination and showing evidence of adherence to this strategy.

Guidance

This should be limited to one side of A4 and list key points.

Criterion 7.1.2

Indicators ● ● ●

Evidence of efforts to implement evidence based practice.

a) Journal club or practice team meeting to discuss policy and to feed research into practice, including the impact of research on service delivery and patient outcomes.

Guidance

The practice should provide dates of appropriate meetings, as well as membership and attendance. Minutes or a description of the aims and objectives of these meetings should be available during the assessment visit.

Criterion 7.1.3

Indicators ● ●

Published results in peer reviewed journals.

a) The practice research team leader has had at least 1 peer reviewed publication in the previous 3 years.

● ● b) One or more other members of the practice have had at least one peer reviewed publication in the previous 3 years.

Guidance

Discussion with the research team leader about plans to publish may take place during the assessment visit. Where practices are involved in large scale multi-centre research, we will take into consideration the possibility of limited control over the publication of clinical research data and the impact this may have on achieving this criterion.

DISSEMINATION OF RESEARCH

DISSEMINATION STRATEGY

Criterion 7.1.4
Indicators

Local dissemination.

a) Local dissemination including circulation of any available results to allied health professionals, Local Research Ethics Committees and other practices.

Criterion 7.1.5
Indicators

Attendance at any conference.

a) Attendance or presentations at any conference by the practice research team leader over the past year.

DISSEMINATION OF RESEARCH

DISSEMINATION STRATEGY

Criterion 7.1.4
Indicators ● ●

Local dissemination.

a) Local dissemination including circulation of any available results to allied health professionals, Local Research Ethics Committees and other practices.

Criterion 7.1.5
Indicators ● ●

Attendance at any conference.

a) Attendance or presentations at least one research focused conference by the practice research team leader over the past year.

Criterion 7.1.6
Indicators ● ●

Contributing to the National Research Register.

a) Evidence of projects that have been recorded on the National Research Register if funded by any of the following:
   i Health Technology Assessment programme.
   ii Other NHS national and regional programmes of R&D.
   iii Department of Health Policy Research Programme.
   iv Scottish and Welsh Office funded work.

Guidance

Where projects have been recorded on the National Research Register, please indicate as such on each pro forma completed for criteria 5.1.1 and 5.2.2.

Appendix F
Sample Timetable for Assessment Visit

10.30	Assessors meet at practice. Meet PHCT and look round practice premises. Sign confidentiality form. Assessors meeting and ensure clarification of tasks
11.30	Review documentation, infrastructure and records (assessors split up to complete tasks)
12.30	Light lunch with partners and members of PHCT involved in research
13.30	Meet and interview partners/practice manger and other key members of staff in relation to research
15.00	Assessors meet to review progress
15.30	Meet with lead researcher/s for clarification and discussion
16.00	Draft feedback report (all assessors)
16.30	Feedback to practice
17.00	End of Assessment Visit

Appendix G
Assessor Training Programme

9.30 – 10.00	Registration and coffee
10.00 – 10.15	Welcome and Introduction
10.15 – 10.30	The Assessment Process Professor Bonnie Sibbald
10.30 – 11.30	Discussion of Standards, Criteria and Indicators Small Group Work
11.30 – 11.50	Coffee
11.50 – 12.15	Feedback and Discussion
12.15 – 12.45	Structure and Management of Assessment Visits Miss Sara Shaw
12.45 – 13.00	Discussion
13.00 – 13.45	Lunch
13.45 – 15.00	Generic Skills Dr Val Wass (S&W) Alison Moore (ELENoR)
15.00 – 15.30	Research Workshop 1 Small Group Work
	Tea and coffee available outside workshop rooms
15.30 – 16.00	Research Workshop 2 Small Group Work
16.00 – 16.30	Research Workshop 3 Small Group Work
16.30 – 17.00	Discussion of points raised from workshops Professor Bonnie Sibbald
17.00 – 17.15	Evaluation of Accreditation Project and Assessment Process Miss Sara Shaw

Appendix H
Acronyms

EBM	Evidence-based medicine
ELENoR	East London and Essex Network of Researchers
FBA	Fellowship by Assessment
GPRF	General Practice Research Framework
JCPTGP	Joint Committee for Postgraduate Training in General Practice
MAP	Membership by Assessment of Performance
MRC	Medical Research Council
PCG	Primary Care Group
PCRN	Primary Care Research Network
PCT	Primary Care Trust
PCTR	Research Primary Care Trust
PCRTA	Primary Care Research Team Assessment
QPA	Quality Practice Award
QTD	Quality Team Development
RCGP	Royal College of General Practitioners
tPCT	Teaching Primary Care Trust
WDC	Workforce Development Confederation

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