**Briefing notes for Care Assessment Tools for General Practice**

CbDs in General Practice are being replaced by CATs Care Assessment Tools, which allows a greater range of information and performance to be assessed and recorded against the capabilities. CbDs will remain in the none hospital setting but become one type of CAT in General Practice.

Below are suggested events that may be assessed, with details of the preparation required in advance, the content of the assessment, the type of capabilities that may be assessed using it and the recording required.

It will also be possible for any event that shows a trainee’s abilities with regard to the specific capabilities to be assessed and recorded and used as evidence towards periodic reviews and training progression.

A minimum of 4 CbDs will be required compared to 6 CbDs for each of ST1 and 2 and a minimum of 5 CATs compared to 12 CbDs by the end of ST3.

**Suggested types of CATs**

* Case based discussion
* Random case review
* Leadership activities
* Prescribing assessment follow up
* Consultation assessments- which are not COTs
* Referrals review
* Other e.g. debriefs, review of investigation or imaging use, follow up of QIP etc. (please describe)

**Case based discussion review**

Please see CbD document for full details the following is a brief summary of this type of CAT

Preparation in advance:

Trainee:

* Select cases for discussion
* State which capabilities they feel they can demonstrate with the case(s)
* Prepare a short summary of the case
* Prepare to discuss how they handled the case and how they met the capability descriptors

Trainer:

* Review the cases the trainee has suggested with the medical notes and chose the most appropriate one (taking into account the evidence needs that the trainee has for different capabilities)
* Check they are suitable for the capabilities suggested
* Prepare questions to test the capability areas and explore what the trainee actually did in that case
* Review the capability descriptors and suggested questions to become familiar with what the trainee needs to demonstrate for the various grades.

Content:

* Trainee briefly describes the case
* Supervisor asks which competency the trainee wishes to discuss first
* Clinical supervisor questions trainee stretching them to allow them to demonstrate the highest level they can, based on the competency descriptors
* Questioning continues with supervisor postponing any questions from the trainee until the feedback part
* Each capability of the 3-4 to be addressed is discussed with time for the trainee to add anything else they wish to add
* Refer to the capability descriptors throughout, it is good practice for both supervisor and trainee to see these during the discussion
* Once the case and capabilities have been fully discussed move to the feedback section
* It can be helpful to get the trainee to say which grade they feel they have demonstrated and to give their own feedback first
* Supervisor gives feedback on what was done well and demonstrated with grade decision followed by feedback for improvement, different cases, capabilities that need to be covered

Capability areas suggested:

* All

Recording in the ePortfolio :

* Pick which capabilities were covered and record the feedback given describing, using the case details, how the trainee met each of these individually relating to the capability descriptors such that the grading is clearly justified
* Against each capability make suggestions for development and detail any agreed plans

**Random case review**

Preparation in advance:

* None required

Content:

* Select a date and surgery at random from the computer and pull up the patients’ records
* There are many different ways to review random cases. Reviewing consecutive patients can be helpful and reviewing a whole surgery will give a picture of overall performance which is useful.
* It can also be useful to review a random surgery looking through one particular ‘lens’ e.g. the appropriateness of the diagnosis or decision making or understanding of the home circumstances of each patient/ their support systems etc. i.e. how well the trainee assessed them holistically. Or considering examinations carried out in detail, or recording (use of coding) or completion of all possible QOF/ CDM / pop up tasks. Some of the bullet points below will also suggest more options to look at here.
* Alternatively it can be appropriate to look at only 1-2 cases chosen by the assessor and review multiple capabilities and lots of detail in these cases.
* Review how long the consultation was as well as their recording of the consultation itself. These can be used to assess organisation management and leadership
* Review the trainee’s recording, using READ/ SNOMED codes as appropriate, observations recorded, history and other data gathering as well as clinical management, diagnosis and decisions and follow up.
* Involvement of other doctors or team members may also be reviewed which can give information for the capability working with colleagues and teams
* Were any pop ups missed or acted upon?
* How much health promotion was undertaken (Holistic care and managing medical complexity)
* Did the trainee see a range of patient types, conditions and mix of urgent and unscheduled care and routine appointments? Are there actions that need to be planned in response to the balance of their work across clinical experience groups and medical specialities?

Capability areas suggested:

* All areas may be possible depending on the detail of recording

Recording in the portfolio:

* Pick the capabilities demonstrated and giving specific case detail to justify the grading given, related to the capability descriptors.
* Give specific feedback for each capability with agreed plans for each

**Leadership activity**

The description of how to do a leadership activity is shared at

<http://www.rcgp.org.uk/-/media/Files/GP-training-and-exams/WPBA/Leadership_activity_trainers_and_trainees_manual.ashx?la=en>

**Prescribing assessment follow up**

*This should be a follow up to the full prescribing assessment and should focus on the areas for development detailed in the prescribing assessment and how the trainee has progressed with these. These may involve finding and analysing prescriptions done for specific clinical experience groups like children or end of life, controlled drugs use, advice re over the counter (OTC) medications or particular specialty drugs e.g. for COPD, contraception. See end of section for specific prescribing competencies*

Preparation in advance:

* Trainee to review prescribing assessment and their already agreed actions
* Trainee to upload any further results in the trainee report in the portfolio
* Trainee to reflect on their performance against the prescribing competences
* Clinical Supervisor to review trainee evidence in their portfolio

Content:

* Review and discuss the trainee further evidence in the portfolio and evidence from random case reviews and debriefs
* Review prescribing assessment action plan and PDP entry progress
* Discuss areas done well and areas for improvement
* Together agree plans for further improving the prescribing of the trainee or increasing their exposure to patient groups or to meet the prescribing competencies
* Discuss how this has provided evidence for the competencies for both feedback and recommendations
* Discuss hypotheticals where issues are not covered such as prescribing unlicensed drugs, drug interactions, over the counter (OTC) medication, allergies and monitoring requirements

Capability areas suggested:

* ***Clinical management***-has the trainee prescribed safely, are they aware of and applying local and national guidelines including drug and non-drug therapies, are they aware of legal frameworks for appropriate prescribing?
* ***Managing medical complexity***-has the trainee simultaneously managed the patients’ health problems, both acute and chronic (e.g. by taking into account comorbidities, existing medication and allergies), communicated risk effectively to patients (from documentation in the clinical records), recognised the inevitable conflicts that arise when managing patients with multiple problems and taken steps
* ***Organisation, management and leadership***-has the trainee produced records that are succinct, comprehensive, appropriately coded and understandable?
* ***Community orientation***-has the trainee demonstrated how they have adapted their own clinical practice to take into account their local resources, for example in cost-effective prescribing, colleagues with GPSPI experience and following local protocols?
* ***Maintaining performance Learning and teaching***-has the trainee shown a commitment to professional development through reflection on performance and the identification of personal learning needs
* ***Fitness to practice***- has the trainee reflected on and learnt from performance issues (drug errors) in order to improve patient care?
* to adjust care appropriately (taking into account comorbidities, investigations, existing medication and allergies)?

Recording in the portfolio:

* Complete a prescribing assessment CAT detailing the capabilities covered and record for each:
	+ Specific feedback on performance
	+ Recommendations for further development

GP Prescribing Proficiencies

All prescribing GPs are expected to demonstrate the following, across people of all ages which includes extremes of age, for example babies, children and older adults with frailty (based on the GMC GPCs 2017):

1. Assesses the risks and benefits including those posed by other medications and medical conditions, reducing polypharmacy where possible.
2. Identifies when prescribing unlicensed medicines and informs patients appropriately.
3. Adheres to national or local guidelines (including recommendations for over the counter prescribing (OTC) and evidence-based medicine.
4. Uses antimicrobials appropriately.
5. Counsels patients appropriately including giving instructions for taking medicines safety in line with up to date literature.
6. Reviews and monitors effects including blood testing at appropriate intervals.

**Referrals review**

Preparation in advance:

* Gather together either a list of all referrals made by the trainee or copies of the referrals letters to review
* Ensure sufficient time has elapsed to get letters back following appointments

Content:

* Look through the letters the trainee has written encouraging the trainee to critique their work
* Discuss the content and what is good and could be improved- see qualities of referrals letters
* Is there evidence in the letters written of appropriate data gathering, clinical examinations and procedural skills, clinical management and diagnosis and decisions?
* Look at correspondence back from the hospital and subsequent GP consultations
* Comment on the quality of the trainee’s records (organisation, management and leadership)
* Discuss the appropriateness and effectiveness of the referral, what other options were available? (community orientation, clinical management and teams)
* What does the trainee feel about each referral in retrospect?
* What feedback would you give the trainee in general about their referrals
* Were any 2 weeks wait referrals in line with current guidance?
* What percentage of 2 week wait referrals resulted in diagnosis of cancer?
* Review the appropriateness in particular of these referrals checking for any delays but also commenting on examples of good patient care.
* Has the referral review demonstrated that the trainee is being exposed to the full range of patients groups in general practice and a broad range of curriculum types?
* How might the trainee develop experience in populations or specialities in which there does not appear to have been sufficient exposure?

Capability areas suggested:

* Select the capability areas the trainee has demonstrated during this discussion
* Give feedback on what they did well and what they should work on to improve or demonstrate in future learning events

Recording in the portfolio:

* Describe for each capability assessed how the trainee did using the capability descriptors and specific aspects of the cases discussed
* Describe agreed actions discussed

**Characteristics of a good GP referral letter**

**Introduction**

Historically letters were a matter of taste but there are gradually emerging expectations relating to what is an appropriate letter and an evolving research base. Letters may be written for different reasons (to establish a diagnosis; to request a treatment, operation or test that the GP cannot do; for advice or for a second opinion; to reassure the patient.)

Referral rates vary enormously and for a variety of reasons.

It can be important to consider:

**How necessary the referral is**  (Though this is challenging as referrals for reassurance for the patient or the primary care team is appropriate as well as asking for a treatment / operation/ investigation which is not possible to provide in GP.)

If a letter is clear about **the reason for the referral** and what is requested, it is much easier for the secondary care provider to ensure that the most effective response is given; which may include feedback that the referral is not necessary because options should be provided in primary care.

**Timeliness** the assessment here will depend not only on whether the trainee responded within an appropriate timescale but also whether they ensured that **the patient’s details were accurate** and ensured that they were referred to the **appropriate department of the appropriate trust.**

So there is general agreement that the following would normally be expected in a referral letter, though keeping it short and clear is also very important and some of these could be less important in some letters.

* An assessment of urgency
* Explanation of the reason for referral
* Clarity about the expected outcome of the letter
* Clear description of the relevant history appropriate to the problems and questions
* Relevant psychosocial information including patient concerns or expectations
* Clear and complete summary of relevant past medical history (whilst not including irrelevant information)
* Clear summary of current and relevant past medication including doses
* Where relevant explanations for changes or choices to use or not to use certain drugs.
* Details of known allergies
* Description of relevant clinical signs and findings
* Details of relevant investigation or test results
* Current working diagnosis or diagnoses
* Patient choice has been respected in relation to place of referral and timing of appointments
* Sufficient information to allow the secondary care provider to assess pre-operative risk when this is relevant.
* Clarity about what information has been shared with the patient and or family
* A clear structure that helps the receiving clinician understand the situation

Letters should not contain irrelevant information