RCGP WPBA Handbook
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Version Control:

- Previous version updated 1.9.20. Updates to QIA and to worked examples for Learning Logs
- Previous version updated 3.8.20. Updates to learning log examples and the addition of a summary sheet to the “WPBA Requirements for every training year” section.
- Previous version updated 20.10.20. Updated COT section, Audio Cot section and added Audio COT FAQs.
- This version updated 7.1.20 – CPR/AED and Safeguarding details added to the requirements table on page 20.
Introduction

This manual has been written to help you understand the Work Place Based Assessment (WPBA) requirements, which contribute towards your MRCGP. If you have already started GP training, it will introduce you to the changes and provide clear guidance on each aspect to make transition to the new assessments as smooth and straightforward as possible.

WPBA has recently undergone a review. The current assessments have been updated along with the introduction of new assessments. This was needed to reflect and respond to the changes in General Practice, the new RCGP curriculum, and the mandatory requirements of the GMC. Some assessments have changed completely, others have undergone minor modifications.

For those of you who are familiar with WPBA, the Competency descriptors have not changed, and the basis on which you are judged and the level you are required to attain by the end of your training is also unchanged. Competences have been renamed and are now called Capabilities to fit with the new curriculum. These are described later in this manual.

These changes will be introduced in August 2020 along with the release of the new Portfolio platform.

The Purpose of WPBA

WPBA comprises one third of your MRCGP qualification and provides a framework for evaluating your progress in areas of professional practice best tested in the workplace. In addition, its purpose is to:

- Look at your performance in your day to day practice to provide evidence for learning and reflection based on real experiences.
- Support and drive your learning in important areas of Capability with an underlying theme of patient safety.
- Provide constructive feedback on areas of strength and developmental needs, identifying those of you who may need more help.
- Evaluate aspects of professional behaviour that are difficult to assess in the other assessments.
- Determine your fitness to progress towards completion of training.

Evidence of WPBA, as approved by the GMC, includes the completion of specific assessments and reports, the documentation of naturally occurring evidence, as well
as certain mandatory requirements such as child and adult safeguarding and cardio pulmonary resuscitation. More information on the requirements for WPBA can be found below.

The RCGP Capabilities

Throughout GP training, you will collect evidence relating to 13 areas of professional Capability. These will be evidenced in your assessments and in your personal reflections in your Portfolio. This information is used to support your progress in training during your Educational Supervisor Reviews. These, in turn, provide information for the Annual Review of Competency Progression (ARCP) panels. Satisfactory progression at the ARCP panel is required for you to progress to your next year of training and, at the end of training, for a judgment to be made on your readiness for independent practice.

Capability means having the abilities, knowledge and skills necessary for professional practise.

The 13 Capabilities are as follows:

1. Fitness to practise – your awareness of when your performance, conduct or health, or that of others, might put patients at risk, and taking action to protect patients.
2. Maintaining an ethical approach – practising ethically, with integrity and a respect for diversity.
3. Communication and consultation skills – communication with patients, and the use of recognised consultation techniques.
4. Data gathering and interpretation – the gathering, interpretation, and use of data for clinical judgement, including information gathered from the history, clinical records, examination and investigations.
5. Clinical examination and procedural skills – competent physical examination of the patient with accurate interpretation of physical signs and the safe practice of procedural skills.
6. Making a diagnosis / decision – a conscious, structured approach to making a diagnosis and decisions.
9. Working with colleagues and in teams – working effectively with other professionals to ensure good patient care, including sharing information with colleagues.
10. Maintaining performance, learning and teaching – maintaining performance and effective CPD for oneself and others.
11. Organisation, management and leadership - understanding how primary care is organised within the NHS, how teams are managed and the development of clinical leadership skills.
12. Practising holistically promoting health and safeguarding – operating in physical, psychological, socioeconomic and cultural dimensions, taking into account feelings as well as thoughts.

Evidence of the Capabilities should reflect your understanding of the breadth of the curriculum and can be evidenced from several sources:

**Capability progression through completing the assessments**

Capabilities are assessed by the full range of WPBA tools and this information is documented by your assessors in your Portfolio. It is best practice for each Capability to be assessed at different times using different tools and ideally with multiple assessors.

**Capability assessment through naturally occurring evidence**

You will need to record and validate informal or ‘naturally occurring’ evidence against the Capability framework in your learning log.

For example, you might perform an audit on a specific topic and present it at a practice meeting. This could provide evidence of several Capabilities, including maintaining performance, learning and teaching and communication skills.

**Capability progression over time**

Evidence of your progress in the WBPA Capability areas is gathered throughout your training programme. You are unlikely to be able to show evidence of being competent within each Capability at the start of training and this will gradually build up as time goes on.
Indicators of potential underperformance

You will see in the word descriptors 'indicators of potential underperformance'. The Capabilities framework was developed for the MRCGP from the GP curriculum and it is a series of word pictures that describe positive behaviours that doctors display in practice.

The framework has now been augmented by selectively adding a number of negative behaviours and placing these alongside the themes in the Capabilities framework to which they are particularly (but not exclusively) related.

These behavioural descriptors are intended as an additional interpretative tool to make it easier to recognise underperformance and for your supervisor to be able to give you useful and helpful constructive feedback. Please do not view this negatively as it is there as an aid to help you improve and progress through training.

The word descriptors for each Capability are described in depth in Appendix A and these need to be viewed to help you understand what you need to do in order to be signed off as competent by the end of training.

GP Curriculum and Clinical Experience Groups

The core GP Curriculum is entitled 'Being a General Practitioner'. It is broken down into topic guides relating to professional issues, life stages and clinical areas. Further information relating to the curriculum can be found on the RCGP website and it is recommended that this is viewed to increase your understanding of these domains.

For the purpose of WPBA, the topic guides have been grouped into a shorter list of Clinical Experience Groups and these will need to be linked to your learning logs and assessments.

Clinical Experience Groups

1. Infants, children and young people (under the age of 19 years).
2. Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast).
3. People with long-term conditions including cancer, multi-morbidity and disability.
4. Older adults including frailty and/or people at the end of life.
5. Mental health (including addiction, alcohol and substance misuse).
6. Urgent and unscheduled care.
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability).
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems).
9. Clinical problems not linked to a specific clinical experience group.
## Linking the curriculum areas to the Clinical Experience Groups

<table>
<thead>
<tr>
<th><strong>Topic guides on Professional Issues</strong></th>
<th><strong>Clinical Experience Group - possible linkages</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulting in General Practice</td>
<td>1 - 9</td>
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<tr>
<td>Equality, Diversity and Inclusion</td>
<td>2, 7</td>
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<tr>
<td>Evidence Based Practice, Research and Sharing Knowledge</td>
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<td>Improving Quality, Safety and Prescribing</td>
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<tr>
<td>Leadership and Management</td>
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<tr>
<td>Urgent and Unscheduled Care</td>
<td>1, 2, 3, 4, 5, 6, 7, 9</td>
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<thead>
<tr>
<th><strong>Topic Guides about Life Stages</strong></th>
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<tbody>
<tr>
<td>Children and Young People</td>
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<tr>
<td>People with Long-term Conditions including Cancer</td>
<td>3</td>
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<tr>
<td>Maternity and Reproductive Health</td>
<td>2</td>
</tr>
<tr>
<td>Older adults</td>
<td>4</td>
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<tr>
<td>People at the End of Life</td>
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<tr>
<th><strong>Topic Guides about Clinical Topics</strong></th>
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<td>Allergy and Immunology</td>
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<td>Cardiovascular Health</td>
<td>1, 3, 4, 6, 7, 8, 9</td>
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<tr>
<td>Dermatology</td>
<td>1, 4, 6, 7, 8, 9</td>
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<tr>
<td>Ear, Nose and Throat, Speech and Hearing</td>
<td>1, 3, 4, 6, 7, 9</td>
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<tr>
<td>Eyes and Vision</td>
<td>1, 4, 6, 7, 8, 9</td>
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<td>Gastroenterology</td>
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<td>Gynaecology and Breast</td>
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<tr>
<td>Infectious Disease and Travel Health</td>
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<tr>
<td>Kidney and Urology</td>
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<td>Mental Health</td>
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<td>Neurology</td>
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<td>Sexual Health</td>
<td>2, 6, 8</td>
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<tr>
<td>Smoking, Alcohol and Substance Misuse</td>
<td>5, 6, 7, 8</td>
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Descriptions of Assessments, Learning Logs, Reports and Reviews

**Workplace Based Assessment (WPBA) tools**

- Case Based Discussion (CbD)
- Care Assessment Tool (CAT) – which includes CbDs for use in ST3
- Mini Clinical Evaluation Exercise (MiniCEX)
- Consultation Observation Tool - replaces MiniCEX in primary care placements
- Audio-Consultation Observation Tool (Audio-COT)
- Clinical Examination and Procedural Skills (CEPS)

- Multi-Source Feedback (MSF)
- Patient Satisfaction Questionnaire (PSQ)

- Quality Improvement Project (QIP)
- Leadership Activity
- Prescribing Assessment

- Clinical Supervisors Report (CSR)
- Educational Supervisors Review (ESR)
- Interim Educational Supervisors Review

- Learning Logs
- Personal Development Plan (PDP)

**Mandatory requirements**

- Safeguarding - Adults and Children
- Cardio Pulmonary Resuscitation and Automated external defibrillator
Summary of the assessments

Case Based Discussion (CbD)

The CbD is a structured oral interview designed to assess your professional judgment in a clinical case. The assessment assesses your performance against the Capabilities and looks at how you make holistic, balanced and justifiable decisions in relation to patient care. It assesses your understanding and application of medical knowledge, ethical frameworks, ability to prioritise and how you recognised and approached the complexity and uncertainty of the consultation.

Care Assessment Tool (CAT)

This tool includes CbDs and it has been introduced for trainees in ST3. It allows you to demonstrate your performance and be assessed in other activities during your GP placement. The CAT, like CbDs, assesses your abilities against the Capabilities and feedback is given immediately. Examples of CATs include a case review, a review of referrals and a review of prescribing as a follow up the prescribing assessment.

Mini Clinical Evaluation Exercise (MiniCEX)

The MiniCEX assesses your clinical skills, attitudes and behaviours while consulting with patients. These assessments need to cover a range of different clinical problems. Your supervisor will observe your interaction with a patient and provide immediate feedback on your performance. This assessment is completed during your non-primary care placements and is replaced by the Consultation Observation Tool while in the primary care component of your rotation.

Consultation Observation Tool (COT) which includes The Audio-COT (Audio-COT)

The COT which includes the Audio-COT assesses your consultations within the primary care setting. As with the MiniCEX, it gives you an opportunity to demonstrate your performance and competence in consulting and it assesses the clinical skills and professionalism necessary for good clinical care. In addition, it includes your performance of the more holistic judgements needed to consult in general practice. Immediate feedback is provided on your performance.

The COT assesses face to face consulting be that with patients in your consulting room or via video links, whilst the Audio-COT assesses your ability to consult on the telephone. Different assessment forms are used to reflect the different skills needed to carry out a consultation safely within these settings. It is recommended that your assessments cover both settings.
Clinical Examination and Procedural Skills (CEPs)

CEPS are assessments of your ability to perform examinations and procedures with patients and should cover the full range of examinations required in general practice. There are 5 specific GMC mandated intimate examinations, which include breast, rectal, prostate, male genital and female genital (which includes speculum and bimanual).

Multi-Source Feedback (MSF)

The MSF is used to obtain your colleagues’ opinions of your clinical performance and professional behaviour. The responses are amalgamated and allow you to reflect, evaluate and develop learning plans based on this feedback.

Patient Satisfaction Questionnaire (PSQ)

The PSQ is used to ask your patients to assess your performance within the consultation. It provides feedback on your empathy and relationship building skills. As with the MSF, you are required to reflect on the assessment and develop appropriate action plans.

Leadership activity

You are required to complete a leadership activity while in GP training. This activity needs to demonstrate your organisational skills, willingness to take responsibility for your own decisions, team management, and your understanding of health service management. Your activity needs to be presented to your team. A leadership MSF will need to be completed by your peers after this activity.

Quality Improvement Project (QIP)

This tool is designed to assess your competence in your understanding and completion of a quality improvement project. You are assessed on your choice of project, how you effectively collected and measured the data, your use of QI methods, your suggestions for change, how you involved the team, and your evaluation of any proposed changes and their impact.

Prescribing Assessment

This assessment involves you initially self-assessing your prescribing against specific proficiencies which are believed to be essential for any trainee to achieve before
completing their training. You will review your prescriptions against 6 prescribing headings. Prior to the assessment your supervisor will have reviewed your self-evaluation. Reflecting on errors identified in your prescribing both during your self-assessment and through discussion with your supervisor will allow appropriate learning plans to be put in place in order to improve future prescribing.

Clinical Supervisors Report (CSR)

The CSR is a structured report of your clinical ability and gives you observational information on your performance. The GP Capabilities are assessed and commented upon by your supervisor. This is a report completed by Clinical Supervisors in both non-primary care placements as well as Clinical Supervisors in General Practice.

Educational Supervisors Review (ESR) and Interim Educational Supervisors Review

The ESR is a structured review and judgment on your progress. You will need to prepare for the review by completing a self-assessment of your progress against each of the Capabilities before meeting your Educational Supervisor (ES). Your ES also rates these Capabilities and considers all of the available information within your Portfolio, including assessments, naturally occurring evidence and reports, before making a global judgment on your progress. This feeds into the Annual Review of Competence Progression (ARCP) panel process which all trainees are required to have on an annual basis.

Guidance for satisfactory progression at ARCP panels has been written by COGPED and is supported by the RCGP. For further information this is available on the RCGP website.

The Interim ESR is a ‘light touch’ ESR which can be completed instead of a full ESR at the midpoint of each training year, providing there have been no concerns raised about your progress.
Who can complete the assessments?

Trainees in non-primary care placements – CSRs, CbDs and MiniCEXs

- The Clinical Supervisors Report should be completed by the named Clinical Supervisor, who needs to have met the educator requirements of the GMC.
- It is to be expected that at least one assessment and ideally one CbD and one MiniCEX be completed by the doctor completing your CSR.
- Other assessments can be completed by a doctor who is at a level of ST4 or above, or SAS equivalent.
- Assessors should not be a peer, or anyone at the same or a lower level of training.

Exceptionally, and only with the express permission of the Head of School, other assessors may be considered appropriate.

Trainees in GP (primary care) placements – CATs, COTs/Audio-COTs and CSRs

- A GP Educational Supervisor or an approved Clinical Supervisor who needs to have met the educator requirements of the GMC should complete all assessments.
- Assessments should be conducted by more than one such person in each post and MUST be conducted by more than one such person over your time in training. This allows for triangulation of evidence and is recommended by the GMC.
- If all other avenues have been exhausted and the Postgraduate School is aware of a lack of Educational Supervisors / named Clinical Supervisors, then your triangulation of evidence can be achieved by Training Programme Directors or other GPs who have been trained and remain updated in the use of WPBA.
- Where assessments are conducted in settings outside the practice (e.g. Unscheduled Care / OOH), the format can be used by the relevant supervising clinician but if they have not met the educator requirements of the GMC, then the assessment will not contribute to the minimum mandatory evidence.

You must make every effort to work with your supervisors in a timely fashion to ensure that assessments and reports are completed. However, if there is persistent lack of engagement by the supervisor, you should inform your Training Programme Director at the time and record this in your Portfolio.

Clinical Examination and Procedural Skills – throughout GP training

You need to be observed performing these examinations by a suitably trained professional. If this is another doctor they must be at ST4 level or above, or SAS equivalent. If the colleague is another health professional, such as a specialist nurse,
they must confirm their role and training so that your Educational Supervisor can be satisfied that they have been appropriately trained.

**Calibrating the standard required in assessments**

When in a non-primary care / hospital setting you are rated in comparison to other trainees at the same stage of training or to comparable specialty trainees.

When you are in primary care placements you are rated against the expected standard required at the end of GP training.

The only exception to this is the assessment of competence in CEPS (Clinical Examination and Procedural Skills) where the standard is that of an independent practitioner carrying out this examination or procedure whether you are in a primary care or non-primary care post.

All assessors, whether in a primary care or non-primary care setting, will be asked to define the level of complexity of the case as low, medium, or high and to link the case to the relevant Clinical Experience Groups.

Below, are the ‘assessment of performance levels’ and grades for all of your assessments. In addition, as part of the CSR, your Clinical Supervisor will also be asked an entrustable question relating to the level of supervision you have required during that post. This is also documented below.

Word pictures for the grades within each Capability have been written to support you and your supervisor. These should be used alongside the assessment until you become familiar with their content. The word pictures in primary care can be found in Appendix A, the CSR word pictures for use in non-primary care placements can be found in Appendix B.

**Assessment of performance levels for the CbD, CAT, MiniCEX and COT**

**Based on this observation, please rate the trainees overall performance:**

- Below the level expected prior to starting on a GP Training programme [ ]
- Below the level expected of a GP trainee working in the current clinical post [ ]
- At the level expected of a GP trainee working in the current clinical post [ ]
- Above the level expected of a GP trainee working in the current clinical post [ ]
Assessment of Performance for Clinical Examination and Procedural Skills

Based on this observation, please rate the trainees overall performance:

Unable to perform the procedure appropriately □
Able to perform the procedure but needs direct supervision and/or assistance □
Able to perform the procedure with minimal supervision or assistance □
Competent to perform the procedure unsupervised □

Non-primary care/hospital assessment grades:

CbD / MiniCEX / QIP / CSR (non-primary care) grades

• Significantly below expectations
• Below expectation
• Meets expectations
• Above expectations

MiniCEX also has a grade of ‘not applicable’.

Primary care assessment grades:

CbD / CAT / COT / Audio-COT grades

• Needing Further Development - Below Expectations
• Needing Further Development - Meeting Expectations
• Competent
• Excellent

CSR grades in primary care in ST1/2

• Needing Further Development - Below Expectations
• Needing Further Development - Meeting Expectations
• Competent
• Excellent
CSR grades in primary care in ST3

- Needing Further Development - Below Expectations
- Needing further Development
- Competent
- Excellent

CSR levels of supervision for use in non-primary care and primary care placements

<table>
<thead>
<tr>
<th>Level</th>
<th>Supervision definition</th>
</tr>
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</table>
| 1*    | Cannot be left without direct supervision  
Limited to observing care and/or  
Seeing patients alone but not allowed to let patients leave the building or complete an episode of care before review by the supervisor. |
| 2*    | Requires more supervision than expected in their clinical role  
Requires direct supervision by named supervisor:  
The trainee may provide clinical care, but the supervisor (or in their absence a delegated supervisor) is physically within the building and is immediately available if required to provide direct supervision on specific cases and non-immediate review of all cases. |
| 3     | Requires expected levels of supervision in their clinical role  
Requires indirect supervision by the named supervisor:  
The trainee may provide clinical care when the supervisor is at a distance (urgent /unscheduled care, home visits) but is available by means of telephone to provide advice, and available to attend jointly if required to provide direct supervision.  
The trainee does not need to have every case reviewed but a regular review of random or selected cases takes place at routine intervals. |
| 4 (ST3 only) | Requires no supervision in their clinical role  
*If levels 1 or 2 are selected the Clinical Supervisor will be required to clarify their reasons for this choice and it is expected that they would then also contact their local GP Associate Dean/Training Programme Director and/or Educational Supervisor to inform them of their concerns.*  
*It is proposed that GP trainees will only reach Level 4 at the end of their training.* |
Progression Points in the ESR

The Educational Supervisor Review rates trainees against the 13 Capabilities and uses the ratings of Needing Further Development, Competent for Licensing, and Excellent.

Needing Further Development (NFD) is subdivided into 3 sections

- Below expectation
- Meets expectation
- Above expectation

Trainees are not rated as competent until they are finishing training, so ‘needing further development’ should not be considered in terms of a trainee who is failing but rather as someone who hasn’t yet completed their GP training programme. Trainees who are rated as ‘NFD – meets expectation’ or ‘NFD – above expectation’ will not lead to any concerns being raised at the subsequent ARCP panel. However, a trainee who has been rated as ‘NFD – below expectation’ will raise concerns and further information and explanation will be required for the ARCP panel.

The progression points use the same terminology to support continuity. The ST2 progression point is entitled ‘Needing Further Development (NFD)’ to recognise trainees who are still within the training programme. Trainees need to be rated as ‘NFD – meets expectation’ or ‘NFD – above expectation’ in their ESR to progress.

The progression point for ST3 is entitled ‘Competent’ as this relates to trainees finishing training and who have been assessed as competent for licensing and independent practice.
Where the Capabilities are assessed in WPBA

Capability assessments through WPBA

The table below shows where you are most likely to find evidence for each Capability.

<table>
<thead>
<tr>
<th>Capability area</th>
<th>MSF</th>
<th>PSQ</th>
<th>COT</th>
<th>CAT/CbD</th>
<th>MiniCEX</th>
<th>CEPS</th>
<th>CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Fitness to practise</td>
<td>Yes</td>
<td></td>
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<td></td>
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<td>Yes</td>
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<tr>
<td>2 Maintaining an ethical approach</td>
<td>Yes</td>
<td></td>
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<td></td>
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<td>Yes</td>
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<tr>
<td>3 Communication and consultation skills</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<td>4 Data gathering and interpretation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>5 Clinical examination and procedural skills</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>6 Making a diagnosis / decisions</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>7 Clinical management</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
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<tr>
<td>8 Managing medical complexity</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Working with colleagues and in teams</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Maintaining performance, learning and teaching</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>11 Organisation, management and leadership</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Practising holistically, promoting health and safeguarding</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Community orientation</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Numbers of Assessments

The following table summarises the number of assessments required per training year. It should be emphasised that this is a minimum number and to achieve the Capabilities to the required standard, further assessments may be required.

Less than full time (LTFT) placements

If you who are on a less than full time rotation you need to complete the same number of assessments overall and these need to be distributed throughout your training time.

For example, if you are in ST1 and on a 50% LTFT rotation and will therefore take 2
years to complete ST1, you will need to have completed 4 MiniCEXs and 4 COTs by the end of ST1 and for these to be spread over the 2 years.

WPBA numbers for each year of training

<table>
<thead>
<tr>
<th></th>
<th>ST1</th>
<th>ST2</th>
<th>ST3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mini-CEX/COT</strong></td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Any setting (face to face, telephone, or video)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CBD / CAT</strong></td>
<td>4 CbD</td>
<td>4 CbD</td>
<td>5 CAT</td>
</tr>
<tr>
<td><strong>MSF</strong></td>
<td>1 (with 10 responses)</td>
<td>1 (with 10 responses)</td>
<td>2 (1 MSF, 1 Leadership MSF)</td>
</tr>
<tr>
<td><strong>CSR</strong></td>
<td>1 per post*</td>
<td>1 per post*</td>
<td>1 per post*</td>
</tr>
<tr>
<td><strong>PSQ</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>CEPS</strong></td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Across 3 years 5 intimate plus a range of others</td>
</tr>
<tr>
<td><strong>Learning Logs</strong></td>
<td>36 Case Reviews</td>
<td>36 Case Reviews</td>
<td>36 Case Reviews</td>
</tr>
<tr>
<td><strong>Placement Planning Meeting</strong></td>
<td>1 per post</td>
<td>1 per post</td>
<td>1 per post</td>
</tr>
<tr>
<td><strong>QIP</strong></td>
<td>1 (in GP)</td>
<td>1 (in GP) – if not done in ST1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Quality Improvement Activity</strong></td>
<td>All trainees must demonstrate involvement in Quality Improvement at least once a year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Significant Event</strong></td>
<td>Only completed if reaches GMC threshold of potential or actual serious harm to patients</td>
<td>Only completed if reaches GMC threshold of potential or actual serious harm to patients</td>
<td>Only completed if reaches GMC threshold of potential or actual serious harm to patients</td>
</tr>
<tr>
<td><strong>Learning Event Analysis (LEA)</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Prescribing Review</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Interim ESR</strong></td>
<td>1**</td>
<td>1**</td>
<td>1**</td>
</tr>
<tr>
<td><strong>ESR</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>CPR &amp; AED Use (BLS)</strong></td>
<td>Competence in CPR and AED use for all placements</td>
<td>Competence in CPR and AED use for all placements</td>
<td>Competence in CPR and AED use for all placements</td>
</tr>
<tr>
<td><strong>Child &amp; Adult Safeguarding</strong></td>
<td>Knowledge and Reflection***</td>
<td>Knowledge and Reflection***</td>
<td>Knowledge and Reflection***</td>
</tr>
</tbody>
</table>

*CSR to be done in a primary are post if any of the following apply: The Clinical Supervisor in practice is a different person to the Educational Supervisor, the evidence in the Portfolio does not give a full enough picture of the trainee and information in a CSR would provide this missing information, or either the trainee or supervisor feel it is appropriate
** The Interim ESR can only be completed if the trainee is progressing satisfactorily - see interim ESR guidance. Otherwise a full ESR is required at the midpoint of each calendar year.

***If a trainee does not have a placement within a specific training year that includes children, then it is not mandatory (but still recommended) to record and document their learning on Child safeguarding.
WPBA Requirements for every training year

Summary Sheet

<table>
<thead>
<tr>
<th>Portfolio – check posts and dates correct and any declarations completed</th>
</tr>
</thead>
</table>

**Beginning of each Placement**

<table>
<thead>
<tr>
<th>Meeting with supervisor for placement planning meeting – complete placement planning learning log</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add PDP for each placement</td>
</tr>
</tbody>
</table>

**During Placement**

| 3 clinical case reviews per month* |
| 1 other learning log entry per month* |
| Complete assessments regularly throughout placement |

<table>
<thead>
<tr>
<th>MiniCEX, COT, Audio-COT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cbd / CAT</td>
</tr>
<tr>
<td>MSF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CEPS – complete throughout training programme</th>
<th>5 observed mandatory CEPS and range of others</th>
<th>latter to be added to learning log</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIP in ST1/2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing assessment / leadership activity / PSQ in ST3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Towards end of Placement**

<table>
<thead>
<tr>
<th>Meet with clinical supervisor to complete CSR **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete PDP for placement</td>
</tr>
</tbody>
</table>

**During each calendar year** – you need to ensure you have completed:

<table>
<thead>
<tr>
<th>BLS or equivalent and AED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child safeguarding level 3</td>
</tr>
<tr>
<td>Adult safeguarding level 3</td>
</tr>
<tr>
<td>Learning event analysis and (Significant event analysis if applicable)</td>
</tr>
<tr>
<td>Reflection on involvement in quality improvement activities</td>
</tr>
</tbody>
</table>

**Mid Year - approximately 6 months into each calendar year**

<table>
<thead>
<tr>
<th>Arrange meeting with ES for interim ES review*** - complete review paperwork prior to meeting</th>
</tr>
</thead>
</table>

**End of year prior to Annual Review of Competency Progression Panel (ARCP)**

<table>
<thead>
<tr>
<th>Arrange meeting with ES for ES review – complete review paperwork prior to meeting and any outstanding PDPS and action plans prior to review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attach Urgent Unscheduled Care log if contractually required</td>
</tr>
<tr>
<td>Add Form R / SOAR or equivalent to learning log</td>
</tr>
</tbody>
</table>

* Full time equivalent

** CSR in Primary Care post if CS different from ES, insufficient evidence in portfolio to give a full enough picture or either trainee or supervisor feel it is necessary

***Interim ESR if trainee progressing satisfactorily – otherwise full ESR needed
Learning Logs

All trainees are expected to document their learning through their learning log. The summary below describes the changes taking place in the learning log with the introduction of the change to assessments, the GP Curriculum and the Portfolio.

Overview of new formats

- Clinical Case Reviews replace Clinical Encounters and Professional Conversations, and these will make up the majority of your entries. For a full time GP trainee there is a requirement for a minimum of 3 in each calendar month.
- Supporting Documentation (CPD) replaces reading, eLearning, lecture/seminar, course/certificate, OOH attendance sheets.
- CEPS - these are unchanged from the current format apart from the grade of the observer.
- The Placement Planning Meeting template remains unchanged but this is now a requirement to complete an entry for all of your placements. Please arrange to meet with your supervisor so you can complete this entry.
- The Significant Event Analysis template has been rewritten to enable you to reflect on the event and to make it clear whether the event relates to revalidation. There is now an explicit difference between a Learning Event Analysis and a Significant Event (GMC level). A Learning Event Analysis is required in each year of training.
- A Quality Improvement Activity reflection log has been introduced. This is separate to the required Quality Improvement Project in ST1/2 and meets the GMC guidance that all doctors should reflect annually on Quality Improvement Activities.
- A new entry for Leadership, Management and Professionalism. The GMC is clear that all trainees in all specialties should engage in and reflect on their
developments in these areas. You will be involved in a range of organisational roles and a learning log format enables reflections on these areas to be captured.

- Academic Activities (for academic trainees only).
- A Feedback template which allows and encourages you to feedback on your PSQ, MSF, CSR, patient interactions, etc. This has also been introduced to allow you to respond and reflect on your assessments / reviews, if required.
- Prescribing Review. This is a new assessment and it takes place in the ST3 year. A learning log template linked to prescribing competences can also be found in the learning log section.

The learning logs are grouped in a manner that mirrors your post-CCT GMC requirements:

I. Reflection on reviewing what you do, and learning from cases, data and events.
II. Seeking and reflecting on feedback about what you do.
III. Evidence of keeping up to date (for trainees, becoming up to date across the curriculum) – Continuous Professional Development (CPD).

For most log entries you will suggest linkage to the relevant Clinical Experience Groups and Capabilities, providing justification of the Capabilities chosen in certain logs. The GMC requires you to demonstrate reflective practice, which is core to your professionalism and learning and this will be done through your learning logs.

The RCGP website has further guidance on reflection in WPBA.

How many log entries are required?

You are required to write THREE Clinical Case Reviews per month on average (pro rata for those who are Less Than Full Time (LTFT)).

You are also required to arrange and write up a placement-planning meeting at the start of each new post.

You are expected to have more than one log entry which addresses each Capability in each 6-month review period. You will therefore need to complete learning log entries in addition to Clinical Case Reviews, which reflect on your experiences in such a way that they are appropriately linked to Capabilities such as Organisation, management and leadership, Ethics, and Fitness to Practice. Learning logs looking at leadership, quality improvement and prescribing activities, for example, will be very important in achieving these links.
Clinical Experience Groups

Clinical Experience Groups map to the RCGP curriculum. Instead of linking individual learning logs to individual sub headings of the curriculum, these curriculum headings have been grouped into Clinical Experience Groups. Up to two Clinical Experience Groups can be linked to each learning log. Your supervisor is encouraged to review the links and amend/remove any inappropriate links.

The Clinical Experience Groups are:

1. Infants, children and young people (under the age of 19 years).
2. Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast).
3. People with long-term conditions including cancer, multi-morbidity and disability.
4. Older adults including frailty and/or people at end of life.
5. Mental health (including addiction, alcohol and substance misuse).
6. Urgent and unscheduled care.
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability).
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems).
9. Clinical problems not linked to a specific clinical experience group.

GP trainees are reminded to regularly review the topic guides in the curriculum for further understanding of these areas.

Capability linkage

The majority of the reflective learning log entries require you to suggest links to the 13 GP Capabilities (the basis of ‘Being a General Practitioner’). Most of which also require justification, describing how your actions and approach link to the capability suggested. This should help focus your thinking when writing entries and helps alignment with the Educational Supervisors Review, where you are required to demonstrate how you are meeting the Capabilities.

The revised format for learning logs is intended to reduce the time you spend time summarising the case in detail, commenting on what you have done or learnt and possibly identifying some learning needs, without any clear connection to the Capabilities that you are trying to demonstrate. Your supervisor will be able to
confirm each of your suggested links and add further comments about the capabilities chosen. The text inputted when justifying the capabilities chosen will be auto-populated and available to you as part of your Educational Supervisors Review, in addition to those entries purely linked. You and your supervisor should be aware that the links to be made to Clinical Experience Groups is to enable you to demonstrate that you are competent in each of the Capabilities across the range of Clinical Experience Groups with whom GPs work.

It is expected that by the end of training there should be sufficient coverage of the Clinical Experience Groups to demonstrate your ability to work as a General Practitioner in the UK in a range of settings. The coverage of the Clinical Experience Groups in each Capability should be reviewed at your placement planning meeting and periodic Educational Supervisor meetings. You therefore need to be aware at each stage of training whether you are accumulating sufficient evidence. Minimum expected numbers have deliberately not been set and should not be set locally as the demonstration of Capability depends on your educational needs, the quality of evidence, and the reflections on learning rather than on numbers alone.

Outline of revised log entries (11)

I. Reflection on reviewing what you do, and learning from cases, data and events

1. Clinical Case Reviews

These should account for more entries than other learning logs and provide the best opportunities for linkage to the Capabilities and Clinical Experience Groups. Entries previously described as Clinical Encounters and Professional Conversations will be mapped to this new entry. The clinical learning from acute, chronic, emergency or unscheduled care experiences is recorded here. There is now the option within the Clinical Case Review to document learning in a variety of settings (both in and out of standard GP hours) in addition to the type of consultation. You are expected, after a brief description of the case, to reflect on what you need to maintain, improve, or stop doing. Before considering this, it is recommended that you reflect on what went well and why, so that you can maintain these behaviours. This reflection should include actions required in response to your emotional needs as well as clinical and educational actions i.e. ‘how did it make you feel?’

The option for the supervisor to comment on the entry is retained. The supervisor is encouraged to comment on each capability linked. Whenever the supervisor disagrees with a suggested Capability or Clinical Experience Group link their explanation should appear in the comments section.
When new learning or experiences present themselves, these should be documented in your log. It is particularly important to document learning in Unscheduled Urgent Care/ OOH care within your Clinical Case Reviews, as this will provide evidence of your understanding of working in this setting. It is not mandatory that you complete a Clinical Case Review for each Unscheduled / OOH care session undertaken but documentation of any attendance in this setting should be entered in the 'supporting documentation' section of the log.

2. Clinical Examination and Procedural Skills - CEPS

The CEPS entry format is unchanged. Evidence of your ability to perform a variety of examination and procedural skills in order to demonstrate this Capability (including the mandatory skills) remains essential.

3. Placement Planning Meetings

This allows for a record of placement planning meetings which are now mandatory. It links in particular to Working with colleagues and in teams, Fitness to practice, and Organisation, management and learning.

4. Quality Improvement Project (to be completed in ST1/2)

This is separate to the learning log entry for Quality Improvement Activity. The form assesses the mandatory project undertaken in ST1/2 (ideally in a GP setting). The actual project should also be uploaded to provide proof of undertaking the activity. There are a range of resources to help you and you educators with the marking and assessment of this project and these are available on the RCGP WPBA website. These include training resources for individuals or schemes, mock examples which have been marked, as well as a list of projects which have already been completed at this stage in GP training.

5. Quality Improvement Activity - QIA

This reflective learning log entry enables QIA to be captured across the full training programme. At present, the GMC and RCGP are promoting quality improvement activity projects, which use a different methodology to audit. (Previous Audit/Project entries will be mapped to this area). The quality improvement activity should be robust, systematic and relevant to your work. The QIA reflection should include an element of evaluation and action, and where possible, demonstrate an outcome or change.
The GMC recommend that all doctors demonstrate involvement in Quality Improvement at least once a year. The definition of QIA covers a wide range of activities including Quality Improvement Projects, Audits, Significant Event and Learning Event Analysis. This mirrors the broad definition for post-CCT doctors and ensures that you are equipped with appropriate quality improvement methods for lifelong competence.

6. Prescribing

This assessment has been created because of the importance attached to prescribing by the GMC. You will complete this assessment and reflective entry in ST3. It follows a formal process where you will reflect on your prescribing of 50 consecutive prescriptions in relation to safety and appropriateness. See the section on prescribing assessment for more information.

7. Learning Event Analysis (LEA) and Significant Events

The analysis of events which do not reach the GMC threshold for harm but present an opportunity for learning are referred to as Learning Events Analysis and need to be documented annually on this form. This might include events which may not have a serious outcome but highlight issues which could have been handled with greater clinical effectiveness and from which lessons can be learnt.

An entry under Learning Event Analysis would normally involve sharing information within the team and demonstrating learning. Areas for further learning and development should be reflected in your Personal Development Plan (PDP).

Significant Events must be reflected on, and the new format allows clarification of which events have been identified as being in this category through having an additional drop-down box.

8. Leadership, Management and Professionalism

A new reflective log entry in relation to leadership, management and service delivery changes, has been created to ensure you have the opportunity to reflect on your experiences of the identified leadership qualities within a non-clinical log entry. Learning about leadership skills is an important area of GP training. The non-clinical work a GP is required to do is complex within an increasingly diverse clinical workforce. This new log entry enables appropriate documentation of experiences and reflection. You are encouraged to record activities such as chairing a meeting, giving a
presentation, or a ‘Fresh Pair of Eyes’ exercise. The NHS Leadership Academy suggests leadership in the health and care services is about delivering high quality services to patients by: demonstrating personal qualities, working with others, managing services, improving services, setting direction, creating the vision, and delivering the strategy. ‘Delivering the Service’ is at the core of this leadership model.

9. Academic Activities

The Academic Activity log remains unchanged and is designed to be used by trainees in an academic post.

II. Seeking and reflecting on feedback about what you do

10. Reflection on Feedback

A new reflective log entry enables you to reflect on the following feedback: colleagues (MSF), patients (PSQ) and leadership (leadership MSF), in addition to reflections on the ESR, CSR, Educator notes, examination results for example.

III. Evidence of keeping up to date – Continuous Professional Development (CPD)

11. Supporting Documentation (Continuous Professional Development (CPD) evidence)

This new area allows you to record and reflect on relevant pieces of evidence that you may have highlighted from your clinical reviews or PDP. It also allows you to provide evidence and share brief summative reflections of your CPD evidence of reading / reflections on learning events. By separating this from the reflections on clinical work we are supporting a degree of separation between WPBA and the appraisal functions of the GP trainee Portfolio. Basic life support, safeguarding certification, Unscheduled / Out of Hours attendance should be appropriately recorded here.

Other learning such as eLearning, tutorials, courses/certificates, lectures and reading can appropriately be recorded in the CPD area. Trainees may want to note that entries which are purely documentation of reading or of doing an online course are not Workplace Based Learning Activities

Unscheduled urgent care (UUC) / Out of Hours (OOH)

All trainees need to get experience in UUC/ OOH and evidence of your attendance at these sessions needs to be included in your supporting documentation section.
Some areas of the UK expect the number of hours/sessions undertaken in the UUC / OOH setting to be documented as part of your GP trainee contract. In this case a summary table should be completed and uploaded as a separate ‘supporting documentation’ entry before your final ARCP.

Examples of different types of learning logs

**Clinical case review**

**Title:**

**Date:** xx yy zz

**Setting:** [GP Surgery, Telephone triage, Electronic (video consult etc), Home visit, Out of hours GP setting, Hospital, Other _______________]

**Brief description:**

**Clinical experience groups (max 2):**

**Capabilities that this entry provides evidence for (you can only add 3 capabilities)**

**Capability:**

**Justification** *[describe how your actions and approach link to the capability]:*

**Supervisor: add/change capabilities chosen**

**Reflection and learning needs**

**Reflection:** what will I maintain, improve or stop?

**Learning needs identified from this event**

**Supervisor comment**

**Supporting Documentation (CPD Evidence):**

**Title:**

**Date:**

**Clinical Experience Groups (max 2):**

**Capabilities that this entry provides evidence for (you can only add 3 capabilities)**

**Capability:**

**Justification** *[describe how your actions and approach link to the capability]:*

**Supervisor: add/change capabilities chosen**
Briefly describe your key learning from this event [this could include helping you to maintain existing knowledge and skills]

Reflection: what will I maintain, improve or stop?

What learning needs have you identified from this event?

Supervisor comments:

Learning Event Analysis (Significant Event):

Title:

Date:

Setting: GP Surgery, Telephone triage, Electronic (video consult etc), Home visit, Out of hours GP setting, Hospital, Other ________________

Clinical Experience Groups (max 2)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
Justification [describe how your actions and approach link to the capability]:

Supervisor: add/change capabilities chosen

What happened, including your role?

Why did it happen?

What was done well? [describe your personal involvement]

What could be done differently?

Who was involved in the discussion of the event?

What have you and the team learnt?

What changes have you or the organisation made in response to this review?

Does this significant event meet the threshold for reporting as a Significant Untoward Incident (SUI) for revalidation purposes on Form R in England (and SOAR in Scotland). : Yes / No

If yes, additional boxes appear:
Have you discussed this event with your ES/CS?
How was the SUI identified?
How did identification and progress of this SUI make you feel?

**Supervisor comments**

**Reflection on Feedback:**

Title [e.g. *feedback was received*]:

Date: xx yy zz

Clinical Experience Groups:

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
Justification [*describe how your actions and approach link to the capability]*:

**Supervisor:**

Brief description

How does this feedback make you feel?

What are your key learning points?

Reflection: what will I maintain, improve or stop?

What support have you had or require?

Have you taken your plans to your PDP? No

How will you re-assess/monitor improvements?

**Supervisor comments:**

**Leadership, management and professionalism:**

Title of event :
Date: xx yy zz

Clinical Experience Groups (max 2):

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
State your role in relation to the activity:

How did you approach this activity? [what planning you undertook for the activity]

How did you demonstrate your ability to work with colleagues, patients, learners and/or users (individually or in teams)?

How effective were you within this role? [Reflect on your achievements and feedback received]

Reflection: what will I maintain, improve or stop?

What have you learnt about yourself? [Consider what motivates you, your core beliefs and areas to develop]

Supervisor comments:

QIA Reflective Log:

Title:

Date: xx yy zz

Clinical Experience Groups (max 2):

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:

Brief description of QIA [Be explicit about your role and the extent of your contribution]

What were you trying to accomplish? [This could include a statement of the problem, a brief summary of relevant literature or guidelines, relevant context, and the priority areas for improvement]

How will we know that a change is an improvement? [What information/data did you gather – baseline and subsequent data?]

How have you engaged the team, patients and other stakeholders?

What changes have taken place as a result of your work? How will these be maintained? [If improvement was not achieved, explain why]

Reflection: what will I maintain, improve or stop in QIA?

Supervisor comment:

Prescribing trainee assessment reflection
Clinical Experience Groups (max 2):

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
Justification [describe how your actions and approach link to the capability]:

Supervisor:

I confirm that I have completed a review of 50 of my prescriptions in line with the RCGP WPBA prescribing assessment guidelines and have attached my spreadsheet of results to this log: Yes / No

Reflect with reference to the 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 people with frailty (based on the GMC GPCs 2017):

Assesses the risks and benefits including those posed by other medications and medical conditions, reducing polypharmacy where possible.

Identifies when prescribing unlicensed medicines and informs patients appropriately. Adheres to national or local guidelines (including recommendations for over the counter prescribing (OTC) and evidence-based medicine.

Uses antimicrobials appropriately.

Counsels patients appropriately including giving instructions for taking medicines safety in line with up to date literature.

Reviews and monitors effects including blood testing at appropriate intervals.

What do you plan to maintain with regard to your prescribing? [Reflect on what you are doing well]

What do you plan to improve with regard to your prescribing? [Consider how to improve your suboptimal prescribing]

What do you plan to stop with regard to your prescribing? [Comment on any significant errors]

Which of the GP prescribing skills listed above have you not covered (if any) in this assessment? How will you address these?
Supervisor comment:

Using your reflections above complete the following PDP(s): [creates a mandatory
draft PDP entry which trainer will review]
Learning Objectives:
Target Date: xx yy zz
Action plan:
How will I know when it is achieved?
[Request generation of second PDP as required]

CEPS reflection
Title:
Date: xx yy zz
CEPS performed: [Please be specific, for example prostate examination not just rectal
examination or cranial nerve examination not just neurological examination] :
Reason: [State reason for examination or procedural skill performed. Describe physical
signs elicited (to include if this was the expected finding):
Communication: [reflect on any communication and cultural factors]:
Ethics: [reflect on any ethical factors (to include consent)]:
Self assessment: [Self assessment of performance (to include overall ability and
confidence in this type of examination or procedure)]:
Learning needs identified: How and when will these learning needs be addressed?

Supervisor comment:

Placement Planning Meeting entry

Title:
Date xx yy zz
What were the main areas discussed?
What learning opportunities were highlighted in this placement?
What objectives did you agree on?
What plans have you agreed to achieve these objectives?

Supervisor comment:

Academic Activity entry:
Title:

Date: xx yy zz

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
Justification [describe how your actions and approach link to the capability]:

Supervisor:

How did you approach this task?

How did you gather, appraise and interpret available information?

What problems did you encounter and how did you solve them?

Describe any other strengths highlighted by this work?

What developmental needs are highlighted by this work?

Supervisor comment:

See Appendix C – for learning log examples with educator comments

Clinical Experience Groups - FAQs

Why was the curriculum linkage removed from learning logs?
The RCGP curriculum has been updated and the new approach to linking with clinical experience groups has been approved by the GMC. You are now expected to link learning log entries to nine clinical experience groups rather than the previous 25 curriculum statements. Historically trainees felt compelled to complete log entries in order to demonstrate adequate curriculum coverage. However such entries often had minimal content and so little educational benefit. The focus has shifted away from specific topics and now looks at the GP population setting.

How does the clinical experience groups link into the curriculum?
The GP training curriculum is constantly evolving to meet the changes in general practice – and the changing needs of the trainees. The move to using clinical experience groups within the WPBA ensures that you gain adequate breadth of exposure to the general practice population. A mapping document demonstrating the association has already been documented in this manual.

How many clinical experience groups can I link to in one log entry?
You can link up to two different clinical experience groups. It is not expected that every case review will be linked to one of these groups, and in some, two groups might be applicable. There is no benefit to linking to more than one group as we are not counting up numbers of linked groups.

**Is there a minimum number of clinical experience groups that I need to link to each year?**
No. It is expected that by the end of training there should be sufficient coverage of the clinical experience groups to demonstrate your capabilities to work as a GP in the UK within a range of populations with differing health needs. You should therefore be aware at each stage of training whether you are accumulating sufficient evidence. Minimum expected numbers have deliberately not been set and should not be set locally as the demonstration depends on the educational needs of the trainee, the quality of evidence and the reflections on learning rather than on numbers alone.

**Does the requirement change for the number of clinical experience groups linked depending on which training year I am in?**
No. Please see above answer.

**What happens if I can’t link to specific curriculum experience groups?**
Where there is no linkage between one clinical experience group and a capability for example no Fitness to Practise evidence relating to young people, consideration should be made of the quality of evidence relating to the Fitness to Practise capability in other clinical experience groups, and in other WPBA tools.

**How do I record non-clinical entries within the clinical experience groups?**
Evidence of professional learning such as attending conferences, external courses for leadership etc. should only be linked to the relevant GP capabilities of ‘Being a General Practitioner’, the basis for all reflective log entries. For log entries that don't have a clinical component, it is appropriate, and acceptable to not tick any clinical experience group headings. These log entries are equally as valuable as you need to cover the capabilities too.

**How do I decide how I link to which clinical experience groups?**
Depending on the focus of the log entry, you can choose whichever clinical experience group(s) you feel is most appropriate to what you have written about. The linking relates to the context of the reflections and the capability linking. Should a clinical case not sit appropriately in the main clinical experience groups, there is an option to link to the group ‘Clinical problems not linked to a specific clinical experience group’, however this should only need to be used infrequently. There are
examples at the end of the section as to how the clinical experience groups can be linked.

**Why does the adult population not appear as a group?**
A group specific to the adult population (between young people and older adults) is not included as it is implied that this group is seen when all other groups relating to population groups are covered. Should it be felt the case does not fit into any other category then the category 'Clinical problems not linked to a specific clinical experience group' should be used, although as much as possible linking to this group should be discouraged unless absolutely necessary.

**Examples of how Clinical Experience Groups can be linked to a case**

**Patient with vertigo**
Examples of how could link depending on which aspect of the patient contact is reflected on:

1. **Infants, children and young people [under the age of 19yrs]:** uncommon but could be present in young people
2. **Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)**
3. **People with long term conditions including cancer, multi-morbidity and disability:** patient might have a background history breast cancer raising suspicion of brain metastasis causing the vertigo
4. **Older adults including frailty and/or people at end of life:** patient could be in the older adult category
5. **Mental health (including addiction, alcohol and substance misuse)**
6. **Urgent and unscheduled care:** If seen in the urgent/unscheduled care setting or acute onset and unwell with symptoms
7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability):** might have difficulty explaining the condition to patient due to mental capacity difficulties if elderly/frail
8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems):** could be picked if the focus was more on health promotion – empowering the patient to self manage their symptoms, depending on the cause of the vertigo or discussing not driving etc.
9. **Clinical problems not linked to a specific clinical experience group:** this might be appropriate if no other relevant groups are covered as part of the history/presentation.

**Patient with diabetes**
Examples of how could link depending on which aspect of the patient contact is reflected on:

1. **Infants, children and young people [under the age of 19yrs]**: could be picked if seeing a new diagnosis diabetic
2. **Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)**: could be picked if a patient presents with recurrent thrush/erectile dysfunction/complications when pregnant
3. **People with long term conditions including cancer, multi-morbidity and disability**: could be an option if seen in diabetic clinic
4. **Older adults including frailty and/or people at end of life**: could be picked if for example a medication review is being undertaken and rationalizing medication /realization overmedicated
5. **Mental health (including addiction, alcohol and substance misuse)**: could be picked if the mental health problem means they don't understand they need to take diabetic medication, or the medication to manage the mental health problem has caused diabetes
6. **Acute, urgent and unscheduled care**: could be an option if seen in the urgent/unscheduled care setting or acute onset and unwell with diabetic symptoms
7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)**: could have a learning disability which limits their understanding of diabetes and their compliance with medication
8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems)**: could be picked if the focus was more on health promotion
9. **Clinical problems not linked to a specific clinical experience group**: this might be appropriate if no other relevant groups are covered as part of the history/presentation.

**Heroin addict**
Examples of how could link depending on which aspect of the patient contact is reflected on:

1. **Infants, children and young people [under the age of 19yrs]**: Could be the parent of a drug addict, could be a young person who has become addicted
2. **Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast)**: could have contracted bloodborne illnesses through drug seeking behaviour which have an implication with a sexual relationship
3. **People with long term conditions including cancer, multi-morbidity and disability**: might have other long term medical conditions
4. **Older adults including frailty and/or people at end of life**: could misuse heroin which would affect medication used in end of life

5. **Mental health (including addiction, alcohol and substance misuse)**: drug misuse

6. **Acute, urgent and unscheduled care**: could be admitted septic and seen in same day access GP appointment

7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)**: patients children need safeguarding due to the presentation on this occasion

8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems)**: encourage patient to engage with drug misuse services locally

9. **Clinical problems not linked to a specific clinical experience group**: this might be appropriate if no other relevant groups are covered as part of the history/presentation.

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**Rash on arm that patient thinks might be due to a tick bite and is worried about Lyme disease**

Examples of how could link depending on which aspect of the patient contact is reflected on:

1. **Infants, children and young people [under the age of 19yrs]**: could be a young person and need to consider treatment if high level of suspicion

2. **Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)**: not likely linked

3. **People with long term conditions including cancer, multi-morbidity and disability**: a relative might have had a disability from chronic Lymes disease

4. **Older adults including frailty and/or people at end of life**: could be an older adult with the rash

5. **Mental health (including addiction, alcohol and substance misuse)**: suffers with significant health anxiety

6. **Acute, urgent and unscheduled care**: presented on GP triage list /phones 111 and is given an appointment at a hub

7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)**: patient could have a learning disability and attend with their carer and may not have capacity to make decisions or alternately has communication difficulties.

8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems)**: discussion around what Lymes disease is and the typical rash and how to protect self against getting Lymes disease and
manage a tick bite. If the patient was of an adult age, this is likely to be the category picked.

9. **Clinical problems not linked to a specific clinical experience group**: this might be appropriate if no other relevant groups are covered as part of the history/presentation.

Patient with a 2 month history of altered bowel habit which has worsened in the last 3 weeks. **The patient has been on the Internet and thinks they have irritable bowel syndrome.**

Examples of how could link depending on which aspect of the patient contact is reflected on:

1. **Infants, children and young people**[under the age of 19yrs]: could be a young person (18 years old), with a family history of inflammatory bowel disease/irritable bowel syndrome
2. **Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)**: it might be a consideration to check a CA125 with symptoms that might mimic irritable bowel syndrome in an older woman
3. **People with long term conditions including cancer, multi-morbidity and disability**: the patient might be presenting with symptoms as a side effect of multiple medications or have a background history of cancer
4. **Older adults including frailty and/or people at end of life**: could be an older adult with symptoms, although this would be rare to present with new symptoms of IBS
5. **Mental health (including addiction, alcohol and substance misuse)**: suffers with anxiety and/or depression which makes the symptoms worse
6. **Acute, urgent and unscheduled care**: could have presented in the acute/urgent/unscheduled care setting which is likely to be inappropriate
7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)**: patient could be deaf and use sign language/relying on an interpreter and/or write on paper to have a conversation.
8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems)**: likely to fit most appropriately here. History/examination and exploring ideas/concerns/expectations and discussion around what IBS is and how to best manage, empowering the patient
9. **Clinical problems not linked to a specific clinical experience group**: this might be appropriate if no other relevant groups are covered as part of the history/presentation.
Patient presents with second episode of tonsillitis this year and wants referral for tonsillectomy
Examples of how could link depending on which aspect of the patient contact is reflected on:
1. **Infants, children and young people [under the age of 19yrs]:** could be a young person in their first year of university or at school and parents are requesting the referral to avoid missing school
2. **Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast):** not likely linked
3. **People with long term conditions including cancer, multi-morbidity and disability:** patient may have chronic fatigue syndrome/ME which is worsened by the tonsillitis
4. **Older adults including frailty and/or people at end of life:** not likely linked
5. **Mental health (including addiction, alcohol and substance misuse):** suffers with anxiety/depression and has had lots of episodes of time out of work which is affecting employment, therefore wants to prevent further tonsillitis
6. **Acute, urgent and unscheduled care:** presented on GP triage list /phones 111 and is given an appointment at a hub to treat tonsillitis and during consultation requests referral
7. **People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability):** patient could have presented to A&E with tonsillitis inappropriately and then to GP and could be on a child protection plan
8. **Population Health and health promotion (including people with non-acute and/or non-chronic health problems):** if presented in a routine appointment to discuss onward referral, the patient could be educated on the process for individual finding requests and the need to have further episodes before onward referral.
9. **Clinical problems not linked to a specific clinical experience group:** this might be appropriate if no other relevant groups are covered as part of the history/presentation.
Multisource Feedback (MSF)

The Multi-Source Feedback (MSF) tool is used to collect your colleagues’ opinions on your clinical performance and professional behaviour. It provides data for reflection on your performance and self-evaluation.

*The Multisource feedback takes place in every year of training and you need a minimum of 10 respondents each time. In ST3 you will also need to do a leadership MSF in addition to this MSF and this is described later in this manual.*

Preparing for the MSF

You need to agree a date to conduct the MSF with your Educational or Clinical Supervisor, and set aside time after the closing date so you can discuss the feedback generated.

Complete the self-assessment and then select the respondents.

- In non-primary care placements, you will need to select 5 clinicians and 5 non-clinicians who know your work well. It is recognised that identifying 5 non-clinicians might be more challenging in some placements, in which case more clinicians may be asked. Your respondents should come from a variety of roles and include people with a range of seniority.
- In primary care, 5 clinicians (usually established GPs) and 5 non-clinicians are required and again it is advised you choose people who know your work through working alongside you.
  - It is recommended you ask more than 10 people, i.e. 15 people to ensure you get 10 responses.
- From your Portfolio you will need to generate a ticket code which you then email to your respondents for them to be able to answer the questions. Their answers are anonymous.

Using MSF feedback

Your Educational Supervisor will have access to the anonymised results once the MSF closes. Once authorised by the Educational Supervisor, the results will be available to you through your Portfolio.

You will then have a feedback discussion with your Clinical or Educational Supervisor and an opportunity to reflect on the results. You can record this discussion and the resulting action plan in your Learning Log / PDP.

The MSF form is available on the RCGP website.
Multisource Feedback (MSF) - FAQs

How many MSFs do I need to complete during training?
You will need to complete one MSF in ST1, one in ST2 and one in ST3. During ST3, you will also be required to complete a leadership MSF.

Why do we have to complete a self-assessment?
This is so you can compare how you think you score in the areas concerned to the scores given to you by your colleagues. This requirement has been set by the GMC.

How many colleagues do I need to get to complete the survey?
10 respondents are needed for each MSF. This should normally be 5 clinicians and 5 non-clinicians. It is recognised that to find 5 non-clinicians in a non-primary care post might be difficult and in this situation, it would be acceptable to ask more clinicians. 10 replies are the minimum number and the assessment will not count without this number.
For each MSF we would recommend asking more than 10 people to ensure you do reach the minimum number.

Why won't my Portfolio let me send out the invitations?
You need to submit details of the minimum number of colleagues AND complete your self-assessment before the system will let you send out the survey invitations.

Can I see who has responded?
If you log into your Portfolio and visit the survey setup page you will see how many of your colleagues have responded but not which individual.

How do I remind colleagues who have not responded?
The Portfolio automatically sends out reminders if colleagues have not responded within 10 days of the initial invitation.

I have had an email saying the survey can be closed. What does this mean?
This means that you have had enough recipients to be able to complete the survey. You don't have to close the survey and can wait longer to give more colleagues the chance to respond. Once the survey is closed, if any of your colleagues try and complete the survey they will be notified that it is has been completed. Your Educational Supervisor (ES) will be notified when you have closed the survey and they will be able to review this before releasing it to you.

I think I can identify who has made an upsetting comment. What should I do?
Whilst we want MSFs to be anonymous, you may be able to identify individuals who have written certain comments. We would suggest discussing this with your ES should this occur.

I am completing the survey for a colleague. Will they be able to identify me? Your colleague will not see any names in the completed summary report.

How is my data held?
It is held securely and in accordance with the General Data Protection Regulations.
Clinical Examination and Procedural Skills (CEPS)

It is essential you learn how to examine patients within the general practice setting.

To be awarded your CCT, evidence for both of the following must be included:

- The five mandatory intimate examinations. A suitably trained professional will need to observe and document your performance on a CEPS evidence form.
- A range of additional Clinical Examination and Procedural Skills relevant to General Practice.

Introduction

Proficient Clinical Examination and Procedural Skills are fundamental to effective general practice. Relevant evidence for this Capability needs to be gathered regularly throughout each review period and recorded in your Portfolio. As with the other Capabilities there are sets of word descriptors to help you reflect on your progression as you acquire these skills. See Appendix A.

Which skills need to be assessed?

There are 5 intimate examinations which need to be specifically included, as these are mandated by the GMC. These include breast, rectal, prostate, male genital examination and female genital examination (which includes a speculum and bimanual pelvic examination).

You need to be observed performing the intimate examinations by a suitably trained professional. The assessor records their observation on the CEPS evidence form. If this is another doctor they must be at ST4 level or above, or an SAS equivalent. If the colleague is another health professional, such as a specialist nurse, they must confirm their role and training so that your Educational Supervisor can be satisfied that they have been appropriately trained. You may also decide to write a separate log entry on any of these specific skills.

It is also important to note that this is not an exhaustive list of intimate examinations and indeed any examination can be considered intimate by some patients (for example, a competent examination of the eye with an ophthalmoscope), but the examinations listed are those that, due to their particularly intrusive nature, need to be specifically observed, and commented on, during your training.

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The 5 mandatory examinations are not a 'minimum requirement' and cannot by themselves demonstrate overall competence in CEPS. A range of CEPS which are relevant to general practice are also required. This again is not an exhaustive list, nor is there a set minimum number as everyone has different needs. You are expected to document your performance in CEPS in your learning log and/or discuss your learning needs during placement planning meetings with your supervisors. The range of examinations, procedures and the number of observations will depend on your particular requirements and the professional judgement of your Clinical and Educational Supervisors.

For example, you may recognise that your learning needs include more experience of joint examinations, the examination of the eye, or doing a newborn baby check. You may wish to discuss with your supervisor how these can be addressed. Your supervisor may also recognise areas that need to be addressed such as completing a neurology examination within a GP-length consultation, or examining a diabetic patient’s feet correctly.
You may already be aware of specific CEPS you want to address but these can equally become apparent during your consultations with patients.

In addition, it is important to recognise the procedures you may need during emergency presentations in General Practice. For example, can you explain to a patient who is having an asthma attack what you are going to do in setting up a nebuliser?

Completion of CEPS

These can be completed in a variety of ways:

1. CEPS evidence form (in the evidence section of the Portfolio)
2. Learning logs (there is a filter for CEPS entries)
3. MiniCEX
4. COT

You will not be able to be signed off as competent in CEPS by your Educational Supervisor during your final review unless there is observed evidence of the 5 mandatory intimate skills and a range of CEPS relevant to General Practice. This will also be reviewed at your ARCP panel and an unsatisfactory outcome given if these are not present.
Clinical Examination and Procedural Skills (CEPS) - FAQs

What is the range of evidence I need for CEPS?
Apart from the five mandatory examinations as required by the GMC it will be up to you to discuss your learning needs with your Educational Supervisor. The CEPS to be considered and the range of evidence required will depend on various factors such as your prior experience and the nature of your current placement. Remember that you are training to be a GP and so procedures that are unlikely to be performed in a GP setting, whilst interesting to reflect on, are not so relevant. Nevertheless, all examinations and procedures have some common features such as the need to gain consent and the need to consider the comfort of the patient.

What are intimate examinations is there a definition?
There is no agreed definition of what constitutes an intimate examination. The five examinations for which evidence of competence is required by the GMC are generally accepted examples of intimate examinations but there are many others. For instance, the competent examination of the eye with an ophthalmoscope is considered by many, if not most, patients to be an intimate examination, especially as it requires the examination room to be darkened. Ultimately it is the individual patient who determines what is intimate or invasive for them and this will be determined by a number of possible factors including their prior experiences, their religion and their cultural background.

Is it sufficient to just do each mandatory CEPS once in training?
Yes, if the observer states you are competent to perform that specific CEPS unsupervised, if not it will need repeating.

How many CEPS do I need?
There is no set number. There needs to be enough to demonstrate, to your Educational Supervisor’s satisfaction that you are competent in the CEPS capability by the end of training.

What is the standard of the clinical examination expected?
The standard is that of an independent fully qualified General Practitioner. As well as the technical aspects of examination and the ability to recognise abnormal physical signs, it includes the choice of examination best suited to the clinical context. For instance, a competent GP very rarely performs an extensive neurological examination but will perform a limited neurological examination as determined by the history taken from the patient.
Can CEPS be assessed in a skills laboratory?
Training in a skills lab and the use of manikins can be a very helpful adjunct to training in the workplace. In general, and certainly in the case of the five intimate examinations as required by the GMC this will not be sufficient evidence of competence without the demonstration that your skills can be applied in a clinical context.

Would an observed full insurance medical examination be enough evidence
Although being observed performing such an examination might be helpful it would be unlikely to provide sufficient evidence of clinical competence. For instance, the extent of the examination in such a situation is determined by the insurance company and not by the clinician.

If I have demonstrated competence in an examination does this need repeating?
No, if your Educational Supervisor is satisfied that the evidence you have provided for one of the five intimate examinations as required by the GMC is sufficient this does not need to be repeated. However, it is important that this evidence is recorded in such a way that you can remember where it is. The easiest ways to do this is to use the CEPS forms. At the final review before a Certificate of Completion of Training (CCT) your Educational Supervisor will need to answer a specific question in relation to these examinations.

What if I am unable to complete a CEPS due to a disability?
All GP trainees regardless of whether they have a disability need to meet the required competences to ensure patient safety is maintained. This though includes having the insight to recognise when your disability prevents an examination from being completed, understanding which examination is needed and that it is a necessary part of the consultation, being able to facilitate your patient having the examination in a timely fashion and demonstrating that you know what to do with the findings.
Educational Supervisors Review

The GMC have mandated that all trainees are required to have an annual Educational Supervisor Review (ESR). This is irrespective of whether you are full time or in a less than full time rotation.

Workplace Based Assessment (WPBA) builds up a qualitative picture of your performance in training. You are responsible for monitoring the evidence you collect in your Portfolio to ensure you are completing your assessments in a timely fashion, covering the Capabilities and Clinical Experience Groups, and keeping up to date with your mandatory training requirements.

Frequency of ESR

In GP training an ESR is conducted every six calendar months, whether you are training full-time or in a less than full time rotation.

An interim ESR will be completed at the midpoint of your training year if you are progressing satisfactorily. If you are not progressing at the expected rate you will need to have a full ESR at the midpoint of each training year.

ESRs are carried out even if they do not coincide exactly with the end of placements. This ensures regular feedback and engagement with the evidence in the Portfolio. It also ensures the ARCP panel has a recent ESR to inform their decision making.

ESR meetings usually take between one and two hours, followed by a write-up in the Portfolio.

How does the ESR work?

For a full ESR, you will first complete a self-assessment of your progress using the 13 Capabilities. Using the evidence you have recorded in your Portfolio you will rate your level of performance and write descriptive statements supporting your decisions. You will have already linked evidence to the Capabilities, which in turn can be linked to the review.

Your ES will then also rate each Capability area. They may add further supporting information and state whether or not they agree with your self-assessment. Your self-assessment must be completed before you meet with your supervisor. It is your responsibility to arrange the meeting with your supervisor for your review to be completed.
In addition, during the meeting several other areas will be discussed. These include the completed assessments, the quality of evidence that you are documenting in your learning log, how reflective your entries are, your progress with your Personal Development Plan and your performance in Clinical Examinations and Procedural Skills.

The quality of evidence is more important than quantity and in the early stages of training it is unlikely that you will be able to provide evidence of readiness to practise. The review will form the basis of a learning plan, highlighting where you are doing well and where more support is needed.

**Completing your self-rating:**

For each Capability the list of linked evidence should be reviewed. These can be opened and reviewed by clicking on them in your Portfolio. You are required to pick three pieces of evidence from the range available for each Capability. The evidence chosen needs to demonstrate your current performance within that Capability area. It is preferable that a range of types of evidence from logs and assessments (CbDs, CSR etc) are selected, though often logs alone may be used if these demonstrate a range of the descriptors.

Using the Capability descriptors, you need to state what these pieces of evidence demonstrate and how they support the rating you have selected. You should only comment on evidence within your Portfolio not your opinion of anything that is not recorded.

As an ST1/2 it would be expected that you would be mostly meeting the Needing Further Development (NFD) descriptors.

**NFD- Below Expectations** should be selected if the evidence you have used demonstrates poor performance, elements of the Indicators of Potential Underperformance (IPUs) or if the quality or quantity of evidence is of a standard that it is not possible for you to rate this any higher.

**NFD- Meets Expectations** should be selected if you have demonstrated the NFD Capability descriptors within that specific Capability and you have several pieces of evidence supporting this.

**NFD- Above Expectations** this can be used if the evidence cited demonstrates some of the competent Capability descriptors and your linked evidence supports this rating.

For an ESR prior to your Annual Review of Competency Progression (ARCP) panels evidence from any time in that year even if it does not appear in this review can be cited. For example, in a learning log entry which you completed 8 months earlier titled
DVT – this entry showed me using “a stepwise approach, basing further enquiries, examinations and tests on what is already known and what is later discovered” as having calculated a Wells score I did an inhouse D dimer and then referred the patient for an US scan of the leg. This would be evidence of NFD-AE for a ST1/2 ESR trainee or competent or excellent for a ST3 trainee completing their final ESR.

In order to have a good range of evidence to use it is important that all of the capabilities have at least one log linked to it in the review period. More logs allow for more of the capability descriptors to be evidenced and a higher grade awarded.

It is important to demonstrate the capabilities across the range of Clinical experience groups but not all have to be demonstrated in each one. How many is possible will depend of the post under review.

Examples: (These are taken from the old ePortolio but give an example of the information which needs to be documented)

**ST3 final ESR**

<table>
<thead>
<tr>
<th>Capability Area</th>
<th>Rating</th>
<th>Dated</th>
<th>View</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness to practise</td>
<td>Competent for Licensing</td>
<td>17/12/2019 15:21</td>
<td>View</td>
<td></td>
</tr>
</tbody>
</table>

**Evidence**

The first evidence (4/10) showed how I anticipated an effect on my work life balance (by the case being on my mind outside of work), and talked about it with colleagues and other GP friends in order to work out the complex emotions provoked. I did this carefully to maintain confidentiality as some specifics about the case would be identifiable to local people who might know the family etc. I also recognised the impact of bringing up feelings about other people who have died by suicide and took steps to mitigate any adverse effect of this, by setting aside time to think about them and also talking to friends. The second log (3/11) is about how I talked to another registrar who was struggling a bit, demonstrating other aspects of Fitness to Practice - reaching promptly and discreetly when there are concerns about others, providing positive support. This log also showed how I achieved a balance by deciding to walk to the Nursing Home on occasion - building some exercise and fresh air into the day, and providing a relaxed atmosphere to talk about things; whilst also being aware of the professional duty to get there and see patients and get back in time to write the notes and get on with the day. The final evidence (6/11) discusses a discussion I had in OOH about the different ways of working and how this impacts on the balance between personal and professional demands (including the mental and physical effects of working nights and how to minimise these).
Action Plans in the ESR
As part of the review, and prior to the meeting with your ES, you are required to provide three action plans. These are linked to the Capabilities and relate to an area that you would like to improve on before your next review. At your review your ES can edit these and add two further action plans, if required. All the action plans will be summarised in a single table against the Capability headings and will be accessible in your Portfolio as a succinct list.
Your Educational supervisor should read your self-rating, review the evidence you have linked and decide if this supports the rating you have given. They also need to decide if this is a true representation of your current performance level as demonstrated within the Portfolio. To do this they need to be aware of, or review all the linked evidence. If you have clearly stated what the evidence shows, used the capability descriptors and the linked evidence supports this, the ES can simply agree, stating that they have confirmed this to be correct.

The ES can give a different rating to your self-rating if they feel this is incorrect. If there is evidence that they feel supports a lower rating they need to link this evidence and state the reasons why. Similarly, if they feel that your performance level is higher than you have rated, they can justify this different grade using linked evidence and stating how this supports their rating. They are also able to link up to an additional 3 pieces of evidence.

**PDP review in the ESR:**
Reviewing your PDP is an important part of the ESR meeting and review. Your ES will read your PDP entries and support you in making these SMART.
Before each placement, as well as during it, you should be thinking about your learning needs relevant to that post and how you can address these. In ST1s this can be done before or at your initial meeting with your ES and/or when completing your self-assessment review for your ESR. You need to propose at least one PDP entry that covers a learning need and make a SMART plan for achieving this. At the ESR your trainer will review and edit your PDPs if required and also help you create other relevant ones if needed.
PDPs focus on specific topic, skills or learning needs that the next post will require. They may well be about specific parts of the GP curriculum and are separate to the actions plans which focus on demonstrating progression in the capabilities.

Your ES, after reviewing all the evidence in your Portfolio, will provide feedback on your overall progress and, if needed, identify areas where you need more focused training. The outcome of your review will be recorded in your Portfolio. If your ES has concerns regarding your progress, they may refer the outcome to the Deanery / Local Education Training Board.

By the end of ST3, your ES will be looking for evidence to establish your fitness to practise independently, through submissions in each Capability area, collected from a range of settings and using different tools. Every Portfolio will look slightly different, but all should provide a rich picture built up over the training years. Your Educational Supervisor in your final review makes a recommendation to the ARCP panel on your overall competence. The ARCP panel in turn makes a final judgement on whether you are competent for licensing. If there are no concerns then you will be able to apply for your Certificate of Completion of Training.

**Interim Educational Supervisors Review (ESR)**

For trainees where there are no concerns regarding progress in training, you will now have a ‘light touch’ interim review instead of a full ESR at the midway point of each year.

You will meet with your ES at the 6 month point of the training year and together review your progress since your most recent ESR and the training requirements which will need to be completed before your next annual ESR. As with the full ESR you need to rate your competence against the 13 capabilities, add evidence to support your rating and generate 3 action plans prior to the meeting. The ES can then decide at the meeting whether they need to complete a full ESR or continue with the light touch interim review.

**The interim ESR is only appropriate to use** between annual ESRs and when there is no ARCP scheduled within the next two months. The interim ESR meeting should review progress and ensure that you are well supported. The ES should ensure that there is evidence of appropriate progression in each of the Capabilities across the Clinical Experience Groups appropriate to your placements and stage of training.
The Interim ESR is a formative process to ensure you are on track to achieve 'satisfactory progress' at your next ARCP.

You cannot have an interim ESR if:

- Your most recent ARCP was an outcome 2 or 3,
- The panel asked for a full ESR at your most recent ARCP,
- You have a newly identified or previously declared Significant Event (GMC threshold of potential or actual serious harm to patients, not a Learning Event Analysis), complaint or other investigation which have not been resolved since your most recent ARCP i.e. any declaration made on the last Form R (or SOAR in Scotland) which is outstanding.

The interim ESR form is also not suitable if the ES has any concerns about your progress. This should include any of the following concerns:

- If concerns raised at a previous ESR have not been resolved.
- Not all of the expected Workplace Based Assessments (WPBA) have been completed.
- There are concerns over the 'Level of Supervision' needed, or your performance in WPBA tools.
- There have been concerns identified about a lack of engagement in the Portfolio or additional concerns have been highlighted by the local education team or supervisors in the 'Educator Notes' section.
- An initial review of the Portfolio suggests that there are insufficient high-quality links made to demonstrate progress in all of the 13 Capability areas.
- An initial review of the Portfolio suggests a lack of exposure to the curriculum, or (after considering the jobs undertaken) a lack of exposure across the breadth of the Clinical Experience Groups.

If any of these conditions apply, then a full ESR should be completed.

Interim Educational Supervisors Review (ESR) – FAQs

When is it appropriate to complete an interim Educational Supervisor Review (ESR)?
You need to have a review with your Educational Supervisor (ES) annually and at the midpoint of each year.
If you are progressing satisfactorily you can have an interim review at the midpoint of the year rather than a full ESR.

What will be assessed at an Interim ESR?
It is important to assess whether you are producing satisfactory evidence across all of the 13 capabilities as well as reviewing the overall quality of your Portfolio. It will be important to check that the required numbers of assessments have been completed.

**What should an Educational Supervisor do if a trainee has not completed all their mandatory assessments?**
If you do not complete your mandatory assessments then a full ESR will be needed with the potential of a referral to panel if they remain incomplete.

**Does it make any difference to the review needed if I am less than full time?**
You need to have a full ESR each calendar year you are in training whether you are full or less than full time. All reviews in between these ESRs can be Interim ESRs as long as the stipulations detailed above are followed.

**Who can complete my interim ESR?**
Only your ES can complete an interim ESR.
Personal Development Plan (PDP)

On-going assessment of learning needs and plans to address these are an essential part of development, preparing for your ESRs and for your on-going annual appraisal process following completion of training. As such, it is an essential part of GP training and it is both demonstrated and assessed within WPBA.

The Personal Development Plan (PDP) area in the Portfolio is designed to ensure that you are able to demonstrate that you can:

- Assess your learning needs.
- Plan actions to meet these needs.
- Review your achievement of these needs, with supporting evidence and, as a result, demonstrate the completion of learning cycles.

The PDP template

Within the Portfolio there are initially four strands to the PDP:

1. Learning objective
2. Target Date
3. Action plan
4. How will I know when it is achieved?

A date is added when a PDP entry is created and subsequently every time you update or amend it a 'last updated' date is recorded. An 'is achieved' box and an 'Outcome (after PDP achieved)' box also appear.

How should a PDP be written?

PDPs should be:

- Specific - this means clear and possible to demonstrate. For example, 'learning all about women’s health’ is not specific, but ‘improving knowledge of contraception options’ is. It should be about you and your needs as a GP and the practice where you work.
- Measurable - this means you can demonstrate that your objective has been achieved. For example, by a reflection in your learning log or CbD in that area.
- Achievable – this means that it is possible to cover your learning need as part of your GP training. For example, doing an eLearning module on joint injections,
attending a minor surgery course or clinic, and documenting your learning from these in your learning log.

- **Realistic / Relevant** - this means with respect to time and ability, and appropriate for your role as GP trainee and GP in the future as well as relating to personal goals. For example, it may be relevant to you to complete a rural practitioner emergency course if you plan to work in a rural or remote setting, but not if you intend to work in an urban based practice.

- **Time-bound** - setting a ‘target date’ that is realistic, reviewed and changed as needed is key to setting a time-frame for achievement.

**Learning objective**

- The more specific your learning objective, the easier it is to construct a learning plan, set a focused date by which to achieve this and to evaluate how it has been achieved.

- Confidence on its own is very hard to measure and, therefore, we would recommend avoiding this term in setting your learning objective.

- Suggested words for learning objectives include - provide, learn, develop, deliver, manage, summarise, demonstrate, document and evaluate.

- Appropriate examples:
  - Learn about acute eye conditions and demonstrate in log entries use of this knowledge and skills in assessing and managing them.
  - Demonstrate the ability to recognise and safely manage the acutely unwell child.
  - Summarise learning about management options for menorrhagia, and demonstrate applying these in clinical cases.
  - Learn about and identify resources for supporting patients and their relatives suffering from dementia.

- Several short specific PDPs are better than an extensive single entry.

- Inappropriate examples would be: Pass my exams or add more log entries.

**Target Date**

This can be:

- **Short term**, in the next few weeks. For example, entries that involve eLearning or looking up information.
- **Medium term**, in the next six months. For example, to attend courses, or gain experience from others.
- **Longer term**, by end of ST3 year. For example, in becoming competent in managing specific conditions.
Action plans

- These need to be specific and relevant to the objective and the time-frame set.
- They can have a variety of elements. For example:
  - eLearning modules
  - sitting in
  - attending clinics
  - attending courses
  - looking up on the internet / in a book
  - visiting social services
  - writing a practice protocol
  - writing patient information leaflets

How will I know when I have achieved my PDP?

- This is easier the more specific the learning objective.
- By reflecting on your action plans in your learning log and recording the learning from these.
- By reflecting on clinical encounters and how your learning was applied.

Examples of PDPs: (Taken from the old ePortfolio)

These are real examples taken with permission

This PDP might be improved by changing ‘to get good feedback and ...reflecting on my practice...’ to a statement such as ‘shown by my COT assessments and reflective log entries....’ as this would provide evidence of completion within the Portfolio.
This is long and detailed and may have been better separated into two learning objectives. It clearly shows how it has been met within the Portfolio.

Although these are simple, they are effective PDP entries.
This is another good example of an identified learning need, which was addressed using a variety of sources.

These entries addressed a learning need but also how to demonstrate Capability
areas. The first ethics, the second holistic care, and the third community orientation. In addition, the first was demonstrated with three separate log entries.

This is a straightforward entry, met in a variety of ways, which has attached evidence to demonstrate completion. It would have been improved further by describing a log reflection on demonstrating breaking bad news effectively.
Adult and Child Safeguarding

The GP curriculum states that all GPs should be competent in dealing with safeguarding. This includes recognising abuse, knowing about local arrangements for safeguarding, referring effectively and playing a part in assessment and continuing management, including prevention of further abuse. You need to satisfy the GMC and the public that you have the appropriate knowledge, clinical skills, and understanding of safeguarding to be able to apply these skills when they arise. Safeguarding training is an integral and on-going part of your GP training and professional development as a qualified GP.

You need to have a knowledge update, which includes adult and child safeguarding, at the start or early part of each training year, i.e. in ST1, ST2 and ST3. This includes key safeguarding information and appropriate action to take if there are any concerns. This evidence must be documented in your Portfolio. In addition, you require a minimum of one participatory piece of learning and reflection for both adult and child safeguarding in each training year. *

It is recommended that demonstration of on-going learning come from participatory and non-participatory training activities.

Participatory training activities

- Attending face-to-face training.
- Group case discussion.
- Reflection on the learning from a case you have been involved in and how this applied to your practice.
- Webinars.
- Attendance at safeguarding practice meetings.
- Demonstrating how learning gained from reading the RCGP Child Safeguarding and Adult Safeguarding toolkits has been applied to your clinical practice.

Non-participatory training activities

- eLearning.
- Reading the RCGP Child Safeguarding and Adult Safeguarding toolkits.
- Relevant safeguarding guidelines in journal articles.

Both participatory and non-participatory learning which supports safeguarding needs to be linked in the Portfolio to the clinical experience group, ‘People with health disadvantages and vulnerabilities’. This learning then needs to be applied throughout
training. The information on both child and adult safeguarding needs to be documented in your Portfolio for each training year and made available to the ARCP panel.

*It is recognised that if a trainee does not have any placements within a specific training year which include children then although it would be still recommended for the trainees to understand and document their learning about child safeguarding, this would not be mandatory.

Adult and Child Safeguarding - FAQs

**Why has the safeguarding requirements changed?**
Intercollegiate documents and the RCGP supplementary guidance, which has had four-nation approval, have recently been updated and published. In addition several GP practices have been criticised during CQC inspections for their GP trainees not being up to date with both level 3 adult and children safeguarding. The previous guidance on safeguarding for GP trainees was vague as to when this needed to be done and many trainees were not completing this until the end of training. There was also no requirement for adult safeguarding during GP training.

**Do I have to complete the requirements as detailed in the Intercollegiate documents?**
You need to be aware of these documents but they are based on a certain number of hours, which need to be completed. The RCGP curriculum and its assessment requirements will need you to document your understanding and experiences in adult and child safeguarding but not the amount of time it has taken you do this.

**What are the minimum requirements?**
You need to have demonstrated some form of knowledge update in your Portfolio annually and a reflective log entry on both adult and child safeguarding.

**How do I demonstrate my knowledge?**
This can be done through eLearning, attending local workshops, looking at the RCGP toolkits. There is a list of activities on the RCGP website as to how this can be done. For example, attending a single workshop if it covered both adult and child safeguarding would be sufficient to cover both areas. The knowledge update needs to be done early in each training year and not left until the end.

**Do adult safeguarding modules at level 3 exist as I haven't been able to find one?**
Trainees need to be compliant in adult safeguarding at level 3, but as this is a new recommendation it is recognised that these are not yet widely available. The
knowledge of adult safeguarding can still be done through reading and any encounters with patients where safeguarding has been a concern. It is not expected for you to pay personally for a commercial level 3 adult safeguarding course.

If I haven't been directly involved in a safeguarding case, how do I write a reflective entry?
It is recognised that not every trainee will be directly involved in clinical cases on safeguarding, but this can be achieved through attending local safeguarding meetings, group discussions, webinars, reading about cases for example.

I am in ST1 but I don't have a GP placement during this time, do I have to complete the child safeguarding requirements?
If you have placements, which involve children for example Paediatrics, Accident and Emergency, Primary care, Child Psychiatry etc. then you will need to have completed the child safeguarding requirements and demonstrated these in your Portfolio. If your placements for that year do not involve children then you would not be expected to include this in your Portfolio although it is felt to be good practice to have an understanding about child safeguarding irrespective of your placements.

I am in ST1 but I don't do Primary Care until my last post in ST1. The requirements state that I need to demonstrate my knowledge in child safeguarding early in the training year but does this apply to me?
Ideally you should learn about safeguarding requirements as soon as possible but as above you would not need to demonstrate your understanding in safeguarding until you started a post which involved children, so although you wouldn't be doing this at the beginning of your ST1 time, it would need to be done at the start of your Primary care post and not left until it was nearly over.

I completed adult and child safeguarding in my foundation post, do I need to do it again?
Yes the requirements are for a knowledge update in each year of training ST1/2/3 and a reflective entry for both adult and child safeguarding.
Cardio Pulmonary Resuscitation and Automated External Defibrillator

You must demonstrate competence in CPR and AED use for all of your placements. This needs to have been done through a practical workshop or training session. An eLearning module by itself is not sufficient. CPR and AED training may be completed through Advance Life Support (ALS) or Basic Life Support workshops (BLS).

Once complete you must scan, upload and attach a valid certificate of competence into a learning log entry in the 'supporting documentation' section of your Portfolio. Your Educational Supervisor can then validate it. This will be checked to ensure it is in date at each ARCP panel.

It is your responsibility to maintain your CPR and AED skills by regular attendance at training run by an approved Resuscitation Council trainer/assessor.

Certificate of competence in CPR and AED

The certificate must be issued by a Resuscitation Council (UK) instructor or equivalent, and conform to the Resuscitation Council (UK) guidelines in place at that time.

Most CPR / Basic Life Support certificates have an annual expiry but if you have completed practical courses which have a longer expiry, then this needs to be clearly visible on the certificate.

It is essential that the certificate is valid at the time of CCT and extends beyond the end date of training.

Trainees with physical disabilities

If you are unable to undertake CPR as a result of physical disability, you will be able to satisfy the RCGP WPBA requirements if you can demonstrate successfully your ability to direct others to undertake CPR. This includes the use of an Automatic External Defibrillator.
Unscheduled Urgent Care/ Out of Hours

One of the requirements during GP training is to demonstrate your Capabilities in Urgent and Unscheduled Care (UUC). This includes delivering safe patient care, demonstrating effective communication skills, maintaining continuity for patients and colleagues, coordinating across services and enabling patient self-efficacy.

The requirements for urgent and unscheduled care, which includes out of hours have recently changed.

You will need to provide evidence of your engagement with UUC / OOH. Similarly you will need to provide evidence of your learning in this setting.

Documentation of UUC / OOH can be done in 2 ways:

1. Recording learning and your reflections within the Clinical Case Review learning log.
2. Completing the UUC/OOH session feedback forms with the supervisor for that session. These should be uploaded to the ‘supporting documentation’ section of your learning log.

If you have a contractual requirement to complete UUC/OOH, the number of sessions and the hours spent in these sessions will also need to be documented. A spreadsheet will need to be completed and uploaded to your Portfolio under the ‘supporting documentation’ heading so that it can be reviewed before the completion of training.

Please refer to the RCGP website for the

- Urgent and Unscheduled care session feedback form
- Urgent and Unscheduled / OOH log sheet for countries with a contractual requirement to complete a certain number of hours / sessions
- Capability areas you can cover in Urgent and Unscheduled Care
- COGPED position paper for Urgent and Unscheduled Care
ST1 and ST2 - Assessments and Reports

- CbD
- MiniCEX
- COT when in Primary Care in ST1/2
- QIP when in Primary Care in ST1/2
- CSR
- The requirements listed for all years

Case Based Discussion (CbD)

The CbD is a structured oral interview designed to assess your professional judgment in a clinical case. The assessment assesses your performance against the Capabilities and looks at how you made holistic, balanced and justifiable decisions in relation to patient care. It assesses your understanding and application of medical knowledge, ethical frameworks, ability to prioritise and how you recognised and approached the complexity and uncertainty of the consultation.

How to complete a CbD

CbDs can be carried out in hospital by Clinical Supervisors (which is best practice), by doctors who are ST4 or above, or Specialist and Associate Specialist (SAS) doctors with equivalent experience who have met the GMC assessor requirements. You choose who undertakes your CbDs. You are encouraged to complete assessments with a range of assessors. Your named Clinical Supervisor should complete at least one CbD during each rotation. Within primary care placements in ST1/2, your assessors will be approved GP Clinical/Educational Supervisors who have met the GMC standards.

Protected time is needed for the assessment.

The case should be one that you have managed independently. It is NOT appropriate to have received advice from another doctor for the consultation and then to be assessed on actions taken by that other doctor.

You need to share the clinical entry with your supervisor before the assessment so they can familiarise themselves with the case.

Before the assessment you will need to map the case to up to three Capability areas as you will be discussing these areas during the assessment. It is these Capabilities your supervisor will grade. The Capabilities should not necessarily be those that you covered well, as more useful learning can be achieved by choosing areas that you found challenging. You also need to be aware of the Capabilities you have chosen in
previous assessments to ensure you cover the range of Capabilities during your training.

Your supervisor can support you in case and Capability selection if you are unsure how to do this.

The RCGP has produced questions to support assessors in assessing the Capabilities and it would be useful for you have a look at these prior to your assessment. These can be found in Appendix D for non-primary care supervisors and Appendix E for primary care supervisors.

The CbD discussion should normally take no longer than 30 minutes for your discussion and your supervisor’s feedback. During the discussion, if your supervisor feels any other Capabilities have been covered, these can be added to the assessment form.

Your supervisor will then complete the assessment form within your Portfolio. Each of the discussed Capability areas will be graded. Your supervisor will document their feedback on your performance and their justification for their grades as well as their recommendations for further development.

Some assessors will have full access to your Portfolio but in non-primary care settings you may need to send them a ticket code to enable the assessment form to be completed.
In this situation, having ideally agreed a mutually appropriate time to complete an assessment, it is preferable to send the ticket code in advance to your assessor.

To use the ticketed feedback system you need to click on ‘generate a new ticket’ within the Portfolio after which the ‘generate a new ticket’ page will appear. You select the ‘CbD assessment form’ and complete your assessor’s details. An email will then be sent providing a login code for the assessor to use to complete the ticketed CbD assessment form.

When you are in primary care placements in ST1/2 you will use the CAT form which includes CbDs. This form is available in Appendix I.
Case Based Discussions (CbDs) - FAQs

How many CbDs am I required to do?
As an ST1/2 it is expected that you would only do CbDs. Trainees are expected to complete four CbDs in each training year (2 in each 6-month period for a full time trainee).

Do all the capabilities have to be graded in at least one CbD?
Ideally the CbDs will cover the full range of the capabilities providing triangulation of grades for each capability across a range of different assessment methods. It is expected that all the capabilities will have been assessed using a formal assessment tool at least once in the three-year training period but not all need to be done within a CbD. You will have, prior to the CbD, prepared up to 3 capability areas you wish to discuss with your supervisor.

Do I need to do a CbD for each of the Clinical Experience Groups?
It is expected that the CbDs will cover the range of Clinical Experience Groups. While it is not mandatory to have a CbD for each Clinical Experience Group, a range of types of assessment and information will need to be provided in the Portfolio to show exposure to, learning from, and competence in caring for, the range of Clinical Experience Groups across each training year.

Is the number of CbDs required reduced for less than full time trainees?
The numbers required are prorata for less than full time trainees.

How many capabilities and Clinical Experience Groups can be linked to each CbD?
It is expected that a maximum of 4 capabilities, (3 of the trainees and up to one additional added by the assessor) and 2 Clinical Experience Groups be linked to each CbD so that in-depth reflection and meaningful feedback is given for each. Separate assessments can be used if the assessment covers a larger number of either.

Can all the CbDs in ST1 and ST2 be done in one tutorial?
No. It is expected that the assessments will be spread over time to demonstrate that you are progressing. The number of assessments stated are a minimum and if you are not demonstrating the grade expected for your level of training, additional assessments should be completed.

How long will it take to complete a CbD?
This will depend on the complexity of the case. A CbD usually takes between 20-30 minutes. The time for each assessment will depend on the content and the discussion you have with your supervisor.
Do I have to give my assessor details of the case in advance?
Yes. You can only be assessed on the case if you have prepared the case and stated which of the capabilities you feel you have demonstrated in advance of the discussion.

Can I be asked about theoretical situations rather than just the case I managed?
The assessment is about what you actually did so that your performance in the capability being reviewed can be assessed. However, for some more difficult capabilities it may be necessary to add hypothetical challenge to assess your knowledge, for example with regard to ethics or fitness to practice. The assessment is most robust when based on what you actually did in that case.

Do I need to provide cases of varying complexity?
Yes. It is expected that you will be assessed in a range of cases that cover varying complexities. You will be asked to bring more complex cases if all those you bring are of low challenge.
Mini Consultation Evaluation Exercise (MiniCEX)

A MiniCEX is an observed, real-life, interaction between you and a patient. The MiniCEX assesses your clinical skills, attitudes and behaviours. The MiniCEX is completed in the non-primary care setting.

It is your responsibility to identify and approach an appropriate clinician to be an assessor. You are advised to arrange a time and date for the assessment in advance. It is recognised that on occasion, real time opportunities present themselves that are suitable for MiniCEXs. However, this should not be seen as the norm. The assessments need to be spread out across the duration of the post rather than just at the end and the assessment should not last more than fifteen minutes.

Each MiniCEX should represent a different clinical problem. It is helpful to vary the types of cases that are assessed using MiniCEXs so that your competence is reviewed with different challenges.

MiniCEXs can be carried out in hospital by your Clinical Supervisor (which is best practice), by doctors who are ST4 or above, or Speciality and Associate Specialist (SAS) doctors with equivalent experience and who have met the GMC assessor requirements. You choose who undertakes your MiniCEX. You are encouraged to complete assessments with a range of assessors. Your named Clinical Supervisor should complete at least one MiniCEX during each rotation.

Your assessor will give you immediate specific constructive feedback on this interaction, focussing on your:

- Professionalism
- Communication and consultation skills
- Clinical assessment and judgement
- Clinical management
- Organisation/efficiency

The assessor will also rate your performance and document their verbal feedback on the assessment form. This feedback will subsequently be used as evidence of your progress within the Educational Supervisor Review (ESR).

Some assessors will have full access to your Portfolio but in non-primary care settings you may need to send them a ticket code to enable the assessment form to be completed.

In this situation, having ideally agreed a mutually appropriate time to complete an assessment, it is preferable to send the ticket code in advance to the assessor.
To use the ticketed feedback system you need to click on 'generate a new ticket' within the Portfolio after which the 'generate a new ticket' page will appear. You select the 'MiniCEX assessment form' and complete your assessor's details. An email will then be sent providing a login code for the assessor to use to complete the ticketed MiniCEX assessment form.

**Mini Consultation exercise (MiniCEX) - FAQs**

**Why use the MiniCEX?**
It allows you to get feedback on your performance from an experienced clinician about a real patient, in real time.

**Why does my clinical supervisor have to complete one WPBA (MiniCEX/CbD)?**
The MiniCEX /CbD are best overseen by your clinical supervisor. This helps the clinical supervisor gain an understanding of you in terms of your clinical ability and the level of supervision required. This is valuable to help you gain the most from the rotation, but it also enables your clinical supervisor to have first-hand experience when completing their clinical supervisor report.

**Can I do a MiniCEX and Case based Discussion on the same patient?**
This would be discouraged. Different cases at different times should be used. The focus and set up of each assessment is different and should not be transferred.

**What standard am I assessed against?**
The trainee should be graded in relation to those at the same stage of training. When grading the trainee, there is the option to put 'Not applicable' which means that the trainee did not cover the identified area as it was not within the context of the case. This is different to 'Significantly below expectation and/or below expectation', which means that either the trainee did not cover the identified area to a competent level or it was not demonstrated at all, and should have been.

**How many MiniCEX should I complete?**
4 MiniCEXs/ COTs are required in both ST1 and ST2.

**Do half of the annual number have to be done before each six-month review?**
Yes.

**Do I need to cover all the clinical experience groups?**
Over the GP training programme, it is expected that you will submit a breadth of WPBAs relating to all the clinical experience groups.
Does it matter what level of complexity the cases I have observed are rated?
No, however it contextualises the subsequent grades. You would be expected to complete the breadth of complexities and bear in mind low complexity consultations will be unlikely to give adequate opportunity to demonstrate your ability.

Is the MiniCEX mapped to the 13 Capabilities?
Yes. The MiniCEX has been mapped to the RCGP capability statements and these are detailed below

1. Consultation and communication skills
   Capability: Communication and consultation skills, practising holistically

2. Clinical assessment & judgement
   Capabilities: Data Gathering and interpretation, CEPS, Making a diagnosis / decisions,

3. Clinical management
   Capability: Clinical management,

4. Organisation/Efficiency
   Capabilities: Working with colleagues and in teams, Organisation, Management and Leadership

5. Professionalism
   Capabilities: Ethics, Fitness to practice

Capabilities not included:
- Community orientation
- Maintaining performance, learning and teaching
- Managing medical complexity

Can I be awarded a satisfactory Educational Supervisor's Report outcome if the overall rating for the last MiniCEX is ‘below expectations’?
Yes. The Educational Supervisor makes a recommendation to the ARCP panel based on all work place based assessment and the content of the Portfolio.

Do I have to have had a minimum number of scores of 'meets expectations' for each of the five identified areas?
No. The Educational Supervisor makes a recommendation to the ARCP panel based on all of the work place based assessment and content of the Portfolio. Progress varies from trainee to trainee. You will need to demonstrate competence by the point of CCT.
Consultation Observation Tool (COT)

The COT is an expanded version of the MiniCEX and considers your consultations with real patients in real time during your primary care placements. It assesses the clinical skills and professionalism necessary for good clinical care within your consultations and this includes your performance of the more holistic judgments needed to consult in General Practice.

How the Consultation Observation Tool (COT) works

During training you are encouraged to video record and then review your consultations as these are an essential way of improving your consultations. The COT assessment can then be carried out using a recorded consultation; or you can arrange for your supervisor to observe you consulting directly.

The assessment can be completed using face to face, video or telephone (audio) consultations. If a telephone consultation is being assessed then please use the Audio-COT assessment form and not the standard COT form.

Selecting consultations

Any consultations you video record will require the patient’s consent. A sample consent form is available on the RCGP website.

The choice of consultations should cover the full breadth of Clinical Experience Groups and be in different settings, such as surgery consultations, home visits and Unscheduled urgent care / Out of Hours.

When you are selecting a recorded consultation, it is natural to choose one where you feel you have performed well. Complex consultations or consultations that you found challenging are more likely to generate learning.

Please note that WPBA and RCA are independent components of the MRCGP Tripos and therefore evidence submitted for one assessment cannot also be used for the other. All recordings submitted for the RCA should not be utilised for evidence for WPBA. Similarly, a consultation that has previously been assessed e.g. as a COT or Audio-COT may not be submitted for the RCA as it has already been used as evidence for WPBA.

Collecting evidence from the consultation
You will review the consultation with your supervisor, who will relate their observations to the WPBA Capability framework and COT or Audio-COT criteria. The performance criteria for the COT can be found in Appendix F. Your supervisor will grade each section of your consultation, make an overall judgement on your performance and provide formal feedback with recommendations for further development.

When to use the COT

COTs are only completed in primary care placements. MiniCEXs are completed during non-primary care placements. The total number of COTs required in ST1 and ST2 will therefore very much depend on your placements. A total of 4 MiniCEXs/COTs/Audio-COTs are required in both ST1 and ST2. The COT/Audio-COT is used solely in ST3.

Consultation Observation Tools (COT) - FAQs

When are COTs done?
COTs are done in all primary care placements.

How many are needed?
In ST1 and ST2 when you are in a primary care post you will need to complete 2 COTs for each 6-month placement. Some areas of the UK have 4 month primary care placements in ST1 and ST2. It is recommended that 2 COTs are also completed in these posts. A total of 4 COTS/mini-CEXs are required in each training level in ST1 and ST2.

7 COTs are required in your ST3 year. For trainees working less than full time these requirements will be pro-rata.

Do I have to have a certain number of COTs which are face to face and a certain number of AudioCOTs?

No, there is no set requirement of the different types of consultations you experience in Primary Care. Ideally these should not just be solely face to face or audio consultations and a mixture of the different types of consultations would be recommended.

Am I required to complete half of the annual number before each six-month review in ST3?
Yes.

Who can assess a COT?
COTs can be assessed by either an approved GP Educational Supervisor (ES) or an approved, appropriately trained, and updated GP Clinical Supervisor.
Do COTs need to cover all the Clinical Experience Groups?
Over the three-year training programme, it is expected that you will submit COTs related to most of the Patient Experience Groups. However, your Educational Supervisor will be able give relevant advice to you in the context of the rest of your Portfolio.

Can COTs only be completed on patients who attend the surgery as I mostly consult over the telephone?
No, COTs can be completed through face to face consulting with patients in your GP surgery, over video links or on the telephone.

Is there a minimum or maximum length of consultation to be submitted for a COT?
No. However, brief, low challenge consultations will be unlikely to give adequate opportunity to demonstrate your ability; and overly long consultations may lack structure. It would be expected that COTs are generally 8-15 minutes long.

Can I be awarded a satisfactory Educational Supervisor’s Report outcome if the overall rating for my last COT is ‘needs further development’?
Yes. The Educational Supervisor makes a recommendation to the ARCP panel based on all workplace-based assessment and the overall content of your Portfolio.

Do I need to have a minimum number of ‘competent’ ratings for each of the 12 capabilities?
No. Your Educational Supervisor makes a recommendation to the ARCP panel based on all of your workplace based assessments and the additional evidence you have submitted in your Portfolio. Progress varies from trainee to trainee but you will need to demonstrate competence by the end of training.
Quality Improvement Project (QIP)

As a trainee you are in good position to identify areas of practice that frustrate you and that possibly have an impact on patient safety. During your primary care placements in ST1 /2 you are required to complete a quality improvement project with the aim of improving patient care. Audit is a type of QIP as both look at the quality of care provided with the aim of improving it and both require measurements to demonstrate change. More generally, QIPs can be about making small incremental changes and measurements which may be done weekly to test the impact of the changes. In contrast an audit has set criteria, each with their own defined standards, and has two sets of measurements over a longer time period, to demonstrate a baseline and then improvement. Completing a QIP allows change to be tested both quickly and successfully and is easier to do in a short time frame, for example in a 4 - 6 month trainee post. The QIP should be written up in the relevant section on the Portfolio and your supervisor will both assess and discuss this with you.

How to undertake a QIP

There is a lot of information on the RCGP website with ideas for QIPs, if you are unsure what to do. Guidance on the tools used and completed templates which have been marked by supervisors are there to guide you. It is suggested you look at this section before starting your QIP.

The Model for Improvement is a recognised tool for undertaking a Quality Improvement Project in a health care setting and can be used as a framework to help you. It asks three questions:

1. Aim – What are we trying to accomplish?
2. Measure - How will we know if a change is an improvement?
3. Change - What changes can we make that will result in improvement?

First of all you need to decide what the aim of your project is going to be.

Projects can be chosen following a significant event, a patient complaint; or an area of care you feel passionate about.

Do not make your project too complicated; it needs to be completed within your primary care placement in ST1/2.

The project should aim to improve patient safety or care and be ‘SMART’.
• Specific - do not make it too broad and choose something you are interested in. Words such as increase / reduce help to set a clear goal.
• Measurable – ensure that there is something you can easily measure to demonstrate any change. It can be qualitative data (descriptive) as well as quantitative data (numerical data).
• Achievable - ensure the data is easily collectable and keep the aims simple.
• Relevant - project should be focused on patient safety.
• Time defined – choose something that can be done in your time frame. You need to be able to complete your project in your primary care placement.

For example a 'SMART' aim looking at doing 6 week baby checks in a timely manner could be ‘To improve the percentage of 6 week baby checks performed between the start of week 6 and by end of week 8’.

The QIP template requires you to describe your QIP in logical steps. This is then reviewed and graded by your ES. Appendix G provides you and your supervisor with word pictures to describe the grading for each section.

Quality Improvement Project (QIP) - FAQs

Why do a QIP project?
The GMC is clear that all doctors in training will have to participate in Quality Improvement work throughout their training. The RCGP has designed a tool and process, which enables participation early in training.

When do I need to do the QIP?
The QIP project should ideally be completed in the your ST1 year whilst in primary care. It is encouraged that you complete the QIP in the primary care setting, therefore the assessment might be undertaken in your ST2 year (assuming you have a GP post in their first two years of training, otherwise the assessment is required to be completed during the trainees ST3 year). You do not have to do 2 QIPs if you have a primary care placement in both ST1 and ST2.

Is it a mandatory assessment?
Yes.

What do I have to do?
You are required to undertake a QIP and then complete the QIP template demonstrating your learning and reflection. The project should be uploaded to provide proof of undertaking the activity in addition to completing the QIP template. Your GP supervisor assesses the QIP project and Portfolio entry and feedback is
given to you by them, which should encourage further discussion. Guidance should be given by the local GP education team and/or utilising the wide range of resources available on the RCGP website to support this.

Can I fail the assessment?
The assessment is not a pass/fail exercise, however if you are consistently below expectations when assessed by your supervisor, it might be recommended to repeat the exercise, or a component of it and write a follow up learning log entry. It is though mandatory to complete the assessment and this would result in an unsatisfactory outcome if not completed by the end of training.

What are the feedback levels?
You are given the following feedback levels: below expectation, meeting expectation or above expectation for each domain. The supervisor also rates the trainee on their overall competence at which the trainee has shown that they have performed, in relation to the expected level of a GP trainee working in the clinical post.

What would an unsatisfactory QIP look like?
Indicators of an unsatisfactory QIP would include:

- No team engagement,
- No engagement of stakeholders (people affected by change including patients)
- Minimal measurement
- No real attempt at implementing change, just a discussion that change should happen.

Please refer back to the RCGP WPBA QIP Word Descriptors to gain a further understanding of what is required within the project and write up Appendix G.

Do I need to do any other QIP activity during my training?
Yes. The GMC recommend that all doctors demonstrate involvement in Quality Improvement at least once a year. You are required to demonstrate that you regularly participate in activities that evaluate the quality and improvement of your work for the purposes of revalidation. When qualified, it is a requirement each year at your appraisal to demonstrate that you doctor have been involved in quality improvement activities (QIA). The definition of QIA includes a wide range of activities including Significant Events and Learning Event Analysis; this mirrors the broad definition for post-CCT doctors and ensures that you are equipped with appropriate quality improvement methods for lifelong competence. At present, the GMC and RCGP are promoting quality improvement activity projects, which use a different methodology to audits (Old Audit/Project entries will be mapped to this area) however audits are
still considered in the wider environment to be a quality improvement activity. A new Quality Improvement Activity reflective learning log entry has been created to enables QIA to be captured across the full training programme (which is separate from the required QIP in ST1/2) to enable trainees to annually reflect on QIA, as required by the GMC. The quality improvement activity should be robust, systematic and relevant your work. The QIA reflection should include an element of evaluation and action, and where possible, demonstrate an outcome or change.

**What is the difference between an audit and a QIP?**
Both aim to improve patient care. Audits are more formal and tend to be done over longer time frame; an audit cycle includes setting a standard, collecting data, analysing the data, implementing change(s) and then repeating the cycle. Model for improvement is often used as framework to do QIPs. This has been shown to test changes successfully and quickly. The PDSA cycle is iterative (repetitive with the aim of approaching a desired goal and the results of each repetition used as starting point for next iteration). PDSA cycles can be done often e.g. weekly. They generally tend to generate enthusiasm and be less tiring.

**Can I just do an audit?**
No. The methodology is different (see above question). It is expected that specific quality improvement tools are used e.g. the model for improvement, Plan Do study Act (PDSA), process mapping, run carts, fishbone diagrams, driver diagrams and Gantt charts. See the RCGP website for further information on these tools.

**I don't know what to do my QIP on?**
Ideally the QIP needs to be an identified need in the trainees local practice however there are lots of ideas on the RCGP WPBA website to help get trainees started.

**What resources are available to help me?**
There are a range of resources to help trainees and educators with marking and assessment of this project available on the RCGP WPBA website. These include training resources for individuals or schemes, mock examples and completed marking of these as well as a list of projects of this size which have already been completed at this stage in GP training.

**Which capabilities does the QIP map to?**
The QIP contributes to evidence in the relevant capabilities: Fitness to practice; maintaining performance learning and teaching; data gathering and interpretation; working with colleagues and in teams; organisation management and leadership.
Clinical Supervisors Report (CSR)

The Clinical Supervisors Report (CSR) is a short, structured report completed by your Clinical Supervisor in each post. It is essential this is done towards the end of your non-primary care placements and also in primary care placements if any of the following apply:

- The Clinical Supervisor in practice is a different person to the Educational Supervisor.
- The evidence in the Portfolio does not give a full enough picture of your progress in training and information in a CSR would provide this missing information.
- Either you or your supervisor feels it is appropriate.

The CSR is an opportunity for you to receive feedback about your performance and the conversation with the CS that accompanies it can be particularly useful. A well completed CSR is also a valuable source of evidence for each Capability in the Educational Supervisor Review and for ARCP panels.

The new CSR has been rewritten to:

- Make a clear link between each section and the relevant GP Capabilities.
- Ensure that all the GP Capabilities are covered in the report.
- Introduce an overall assessment by the Clinical Supervisor (CS) of the level of supervision that you have required.
- Make the report shorter and easier for busy clinicians to complete.

Who carries out the CSR?

The Clinical Supervisor is responsible for writing the report although it is appropriate and usual for the CS to discuss the CSR with colleagues to inform the final report. In addition to this gathering of information from colleagues it is expected that the CS will have carried out at least one of the mandatory Work Place Based Assessments personally (CBD/MiniCEX/COT) prior to each CSR. Where there are particular concerns about your progress and there is more than one experienced CS working in the department or practice, it is appropriate, and good practice, for there to be more than one CSR written for a single period of training.

It is your responsibility to arrange a meeting with your CS to ensure the report is completed before the end of your placement and in time for your ESR meeting.
**What is the reference point?**

Because the CSR is used in both primary care and non-primary care, it is important that the reference point is one that will be recognised in both settings. Two versions of the CSR have been written - one for non-primary care placements and a second version for primary care placements.

The Clinical Supervisor in a non-primary care CSR is asked to make a comparison of your performance with the expected performance of a GP trainee at that level of experience in that post. The assessment form, therefore, asks the CS to make a judgement (after recording their comments) of whether you are:

- Significantly Below Expectations
- Below Expectations
- Meets Expectations
- Above Expectations

The Clinical Supervisor in a primary care post is asked to make a comparison of your performance with the standard expected of a trainee at the end of ST3 (a newly qualified independent GP). The grades match those in the ESR and the form asks the CS to make a judgement of whether you are:

- Needing Further Development - Below Expectations
- Needing Further Development - Meeting Expectations
- Competent
- Excellent

**What does the form review?**

Each of the seven questions covers a particular area of practice, for example Professionalism. There follows a description of how this is likely to be observed in the working environment. Professionalism, for example, includes being respectful, diligent and self-directed in your approach to patients and others and to your own learning needs, developing resilience and making appropriate ethical decisions. Each question will automatically be linked to specific Capabilities in the Portfolio (e.g. Maintaining Performance Learning and Teaching, Ethics, Fitness to practice).

Word descriptors have been written to support the grading and feedback for each question. See [Appendix A (primary care)](primary-care) and [B (non-primary care)](non-primary-care)
The CS is also asked to make an assessment of the level of supervision required compared to the expected level of performance for a GP trainee at this stage. There are 4 levels of supervision and if more supervision than would be expected is required, or you cannot be left without supervision, then an additional comment box will appear asking for further details.

Finally, in line with all other specialties there is a question about whether you have been involved in conduct, capability or Significant Events and what the outcome has been.

**Short Placements (for example 3 months or less)**

It is particularly important that a CSR is completed if you have been in a short post so that there is an assessment of engagement and learning in the post. (It would also be expected that there should be pro rata assessments (CBD/ MiniCEX/ COT) for these placements).

**Being both ES and CS**

There are occasions when the same person will be your Clinical Supervisor and Educational Supervisor. The CSR is a summary of the observations of the supervisor (whether or not they are also an ES) on your performance under the various Capability headings. It is an opinion based on observation, debriefing, tutorials, etc. The ESR, in contrast, is a summary of the information from different sources of your performance, recorded in your Portfolio. It is appropriate for the ES to quote as evidence along with other evidence the assessment made by the CS (even if the ES also completed the CSR).

If the CS is also your ES in a primary care post then the CSR does not need to be completed unless the evidence within the Portfolio does not give a full enough picture and information in a CSR would provide this missing information, or you and your supervisor feel it is appropriate. In these situations, the CSR should be completed irrespective of whether the CS and ES are the same person.

**Communication between the CS and ES**

The CSR is one of several sources of evidence used by the ES to reach a judgement about your progress. While it has been designed to provide useful structured information, it is no substitute for dialogue between the Clinical and Educational Supervisor. If there are known concerns about your performance prior to the start of a post it is appropriate for your ES and/or the Training Programme Director to ensure that the CS is aware of the concerns and for the ES to remain available for advice. It is
good practice for you also to be aware of these conversations and their overall content.

**Clinical Supervisors Report (CSR) – FAQs**

**When do I need a CSR completed?**
You will need to have a CSR completed at the end of each non-primary care placement.
You will also need a CSR completed in your primary care placement if:

- Your named Clinical Supervisor is different to your Educational Supervisor (ES)
- The evidence in your Portfolio does not give a full enough picture of your progress and information from a CSR could provide this missing information, or
- Either you or your Supervisor feels it is appropriate.

The CSR provides important evidence about you to your ES and must be completed prior to your Educational Supervisor Report (ESR).

**What happens if I didn't complete my post due to absence or if I had to move post unexpectedly?**
In this case, a CSR is especially important as it will help the ARCP panel determine whether a short post (less than 3 months) can count towards your overall training time. However, if you were only in a post for less than a month then you should contact your programme director as this post may not count and if this is the case, a CSR will not be necessary.

**Who should complete my CSR?**
Your named Clinical Supervisor in both non-primary and primary care placements should complete your CSR. If your Clinical Supervisor is also your ES in your primary care post then ideally another Clinical Supervisor in the practice should complete the CSR if it is required. If this this is not possible then your ES should also complete the CSR if it is needed in this scenario.

**If I work less than full time in a one-year hospital placement, will I need a CSR after 6 months to use in my ESR?**
Yes.

**I have only spent a small amount of time with my Clinical Supervisor. Can I ask another Clinical Supervisor to complete my CSR?**
No. Your named Clinical Supervisor must complete the assessment. However, your Clinical Supervisor is expected to seek the views of colleagues prior to completing the report.

**Why are there three different versions of the CSR?**
One is for use by hospital based Clinical Supervisors for trainees in non-primary care placements. The second is for use by GP Clinical Supervisors in primary care placements during ST1 and ST2. The third is for use by GP Clinical Supervisors in ST3 GP placements. The key difference is that in hospital placements you are assessed against the expected level for a GP trainee at the same stage in training, but in primary care placements you are assessed against a trainee at the point of Certificate of Completion of Training (CCT). The only difference between the two GP primary care forms is that the one for use in ST3 includes a fourth ‘Level of Supervision’ grade of ‘requires no supervision in their clinical role’ and one of the grades are worded slightly differently.

**Does every section of the CSR need to be completed?**
Yes.

I disagree with comments on my CSR. How can I get it changed?
It cannot be changed. If you wish to clarify a matter it is suggested you discuss it with your Clinical Supervisor and ES. If you wish for your comments to be recorded, you should write them as a reflective log entry and add to ‘Supporting Documentation’ and ask your ES to reference them in Educator Notes or in your ESR.

If level 1 or 2 of ‘Level of Supervision’ is ticked, why is referral to the Training Programme Director or Associate Dean required?
In this scenario the local Training Programme Director or Associate Dean would be expected to assess your training needs and, if necessary, arrange appropriate support and write an educational plan. An ARCP panel may need to be triggered.

**What is the difference between “significantly below expectations” and “below expectations”?**
Please refer to ‘CSR with word descriptors for non-primary care placements’ where there are descriptors for a trainee performing significantly below or below expectations for each section.

I am a Clinical Supervisor and I have significant concerns about my trainee’s performance. Do I need to wait until the end of the post before completing the CSR and highlighting my concerns?
You should not wait until the end of the post to highlight if your trainee is performing significantly below expectations. You should contact your local GP Training Programme Director or Associate Dean and share your concerns. They may ask you to summarise your concerns in writing and may also ask you to do an early CSR.

I am a Clinical Supervisor and I have highlighted significant concerns about a trainee’s performance in the CSR. How can I be certain these will be acted upon? An Educational Supervisor’s report should be written every six months. This will involve reviewing that trainee’s CSR. However, if you have significant concerns you should contact your local GP Training Programme Director or Associate Dean.

**ST3 - Assessments and Reports**

- CAT (which includes CbD)
- COT and Audio-COT
- PSQ
- Leadership activity and leadership MSF
- CSR for ST3
- Prescribing Assessment
- The requirements listed for all years

**Care Assessment Tool (CAT which includes CbD)**

CbDs in General Practice / primary care placements are being replaced by Care Assessment Tools (CATs), which allows a greater range of information and performance to be recorded and assessed against the Capabilities. CbDs will remain in the non-primary care setting and become one type of CAT in in the primary care setting.

Below are suggested events that may be assessed as CATs, with details of the preparation required in advance, the content of the assessment, the Capabilities that may be assessed and the recording required.

A minimum of 4 CbDs will be required for both ST1 and 2, and a minimum of 5 CATs (which can include CbDs) by the end of ST3.

**Suggested CAT formats**

- Case based discussion (CbD)
- 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. (Please describe)
Case based Discussion (CbD)

Please refer back to the earlier section on CbDs for further details.

The following is a brief summary of this type of CAT:

Preparation in advance:

Trainee:
- Select a case for discussion.
- State which Capabilities you feel you can demonstrate with the case.
- Prepare a short summary of the case.
- Prepare to discuss how you handled the case and how you met the Capability descriptors.

Supervisor /Trainer:
- Review the case the trainee has suggested along with the medical notes.
- Check it is suitable for the Capabilities suggested and of a sufficient complexity.
- Prepare questions to test the Capability areas and explore what the trainee actually did in that case. See Appendix E for suggested questions.
- Review the Capability descriptors and suggested questions to become familiar with what the trainee needs to demonstrate for the various grades.

Content:

Supervisor guidance:
- The trainee briefly describes the case.
- The supervisor asks which Capabilities the trainee wishes to discuss first.
- The supervisor questions the trainee in a way that allows them to demonstrate the highest level they can, based on the Capability descriptors.
- Questioning continues with the supervisor postponing any questions from the trainee until the feedback section.
- Each Capability of the 3-4 to be addressed is discussed with time for the trainee to add anything else they wish.
- Both refer to the Capability descriptors. It is good practice for both the supervisor and trainee to consider these during the discussion.
- Once the case and Capabilities have been fully discussed the supervisor moves 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.
• The supervisor gives feedback on what was done well and demonstrated with grade decision followed by feedback for improvement, future different cases, and Capabilities that still need to be covered.

Capability areas suggested: All

Random case review

Preparation in advance:
None required

Content:
Supervisor guidance
• Select a date and surgery at random from the trainee’s appointment list and access the patient 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.
• 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 pop up tasks.
• Alternatively, it can be appropriate to look at only 1-2 cases chosen by the supervisor and review multiple Capabilities in more detail in these cases.
• Review how long the consultation took, 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 of working with colleagues and teams.
• 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:
Supervisor guidance:
- Pick the Capabilities demonstrated and give specific case detail to justify the grading given, relating this 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 in this document.

Prescribing assessment follow up
This is a follow up to the full prescribing assessment and should focus on the areas for development detailed in the prescribing assessment and how you (the trainee) have progressed with these. This may involve finding and analysing prescriptions done for specific Clinical Experience Groups, for example, children, end of life, controlled drugs use, advice re over the counter (OTC) medications, particular specialty drugs e.g. for COPD, or contraception. The Prescribing Assessment is covered later in this document.

Preparation in advance:
Trainee:
- You review your prescribing assessment and agreed actions. In particular you need to ensure that any of the prescribing proficiencies which you did not cover in your assessment have now been met
- You will need to upload any further results in the Portfolio learning log.
- You will need to reflect on your performance against the prescribing competences.
- Your supervisor will review your evidence and discuss this with you.

Supervisor guidance:
- Review and discuss the trainee’s further evidence in the Portfolio and evidence from random case reviews and debriefs.
- Review the prescribing assessment action plan and PDP entry progress.
- Discuss areas done well and areas for improvement.
- Together agree plans for further improving the trainee’s prescribing or increasing their exposure to patient groups to meet the prescribing competences.
- Discuss how this has provided evidence for the prescribing competences as described in the feedback and recommendations.
• Discuss hypothetical situations where issues have not been 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 are they 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 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 to address these.
• **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 colleagues with GPSPI experience; or in cost-effective prescribing by 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 (e.g. drug errors) in order to improve patient care?

Recording in the Portfolio:
Supervisor guidance:
• the supervisor completes a prescribing assessment CAT detailing the Capabilities covered and record for each:
  o Specific feedback on performance
  o Recommendations for further development

Referrals review
Preparation in advance:

Trainee:
• Gather together either a list of all your referrals or copies of the referral letters to review.
• Ensure sufficient time has elapsed to get letters back from the clinic visit following the patient appointment.
Supervisor guidance:

- Look through the letters the trainee has written encouraging the trainee to critique their work.
- Discuss the content commenting on what is good and what could be improved.
- Is there evidence in the referral letters of appropriate data gathering, clinical examinations and procedural skills, clinical management and diagnosis and decisions?
- Look at the correspondence received following the referral and subsequent GP consultations.
- Comment on the quality of the trainee’s records.
- Discuss the appropriateness and effectiveness of the referral. What other options were available?
- What does the trainee feel, in retrospect, about each referral?
- What feedback would you give the trainee in general about their referrals?
- Were any 2 week wait referrals in line with current guidance?
- What percentage of 2 week wait referrals resulted in a 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 specialties 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:
Supervisor guidance:

- Describe for each Capability how the trainee performed using the Capability descriptors and specific aspects of the cases discussed.
- Describe the agreed actions discussed.

Care Assessment Tools (CATs) – FAQs

What is a CAT?
A CAT is a Care Assessment Tool. It is a workplace-based assessment that is used to record a trainee’s ability in any of the capabilities, and can be any one of a variety of different types of assessment tools including the Case Based Discussion (CbD).

How many CATS do I have to do?
In ST1/2 you will only need to do CbDs and not any of the other types of CAT. You are expected to complete four CbDs in each training year (a minimum of two for each 6 monthly Educational Supervisor Report (ESR)). In ST3 five CATs are required.

How is a CAT different from a CbD?
A CAT is an overarching work place assessment term which includes CbDs. Other types of assessment can also be used to assess and record your performance in all the capabilities and are also considered to be CATs. These include problem patient discussions, random case reviews, debriefs, referral analysis and other consultation assessment tools.

Are a range of CATS needed or are single assessments sufficient e.g. all random case reviews?
In ST1 and ST2 you will only do CbDs as this is a tool that is already familiar in both primary and secondary care settings and it will ensure consistency. In ST3, however, you can complete a range of different types of CAT depending on the clinical / educational setting. There are no set numbers for each different type of CAT.

Do all the capabilities have to be graded in at least one CAT?
Ideally the CATS will cover the full range of the capabilities. This will provide a triangulation of grades for each capability across of range of different assessment methods.
It is expected that you will have been assessed in all of the capabilities using a formal assessment tool at least once in your training.

Do I have to do a CAT for each of the Clinical Experience Groups?
While it is not mandatory for you to have a CAT for each Clinical Experience Group, a range of types of assessment and information will need to be provided in the Portfolio to show exposure to, learning from, and competence in caring, for the range of Clinical Experience Groups across each training year.

I am a less than full time trainee. How many CATs do I need to complete?
You will complete the same number of assessments in total as a full time trainee but these will be spread throughout your training and a prorata number of assessments will be needed for each calendar year.
When I am in Primary care as an ST1 or 2, in addition to the required number of CbDs can I also complete other types of CAT?

You will need to complete the minimum number of CbDs for that post but you can also complete additional CATs. However, it should be noted that these will not replace other mandatory assessments.

How many capabilities and Clinical Experience Groups can be linked to each CAT?

It is expected that a maximum of 3 capabilities and 2 Clinical Experience Groups be linked to each CAT so that in-depth reflection and meaningful feedback is given for each.

Separate assessments can be used if the assessment covers a larger number of either.

Can I do all the required number of CATs in one or two tutorials?

No. It is expected that the assessments will be spread out over time to demonstrate that you are progressing. The number stated are a minimum and if you are not demonstrating the grade expected for your level of training, additional assessments should be completed.

How long will it take me to complete a CAT?

This will depend on the type of assessment being completed. A referrals review may take a couple or hours. A debrief may take 15 minutes and a CbD usually takes between 20-30 minutes. A random case review may take an hour but will depend on the number of consultations reviewed. The time for each assessment will depend on the content and the discussion that takes place.
COT and Audio-COT

The COT has been explained earlier in this document. In ST3, in total 7 COTs / Audio-COTs must be completed. This is a minimum requirement. Although it is recommended that the assessment is completed on different types of consultations, for example patients attending the surgery, telephone consultation or consultations over a video link there is no requirement for how many should be completed in each setting. Additional assessments may be required to demonstrate satisfactory progress.

Audio-COT

General Practice has evolved, and more consultations are being carried out by phone. Different skills are needed to carry out a consultation safely and appropriately on the phone from those needed for face-to-face consultation.

The Audio-COT provides an additional tool to enable the assessment of your telephone consultation skills, which complements the existing components of the WPBA. The Audio-COT uses the same methodology and process of completing the assessment as the COT, but is used in a different setting. The Audio-COT counts towards the total number of COTs you need to do in each training year.

How the Audio-COT works

Your supervisor will review a number of your telephone consultations during your placement in primary care, either via direct observation of a telephone consultation or via an audio recording. Your supervisor will discuss the case with you and give you feedback. An Audio-COT assessment is then completed as evidence and documented in your Portfolio.

Selecting consultations for an Audio-COT

You can either be observed directly undertaking a telephone consultation (using a dual headset, for example) or via a recording of the discussion (both patient and doctor).

Complex consultations are likely to generate more evidence. The telephone consultation used for an Audio-COT should typically last between 10-15 minutes. Telephone consultations should be drawn from your entire period of GP training, reflecting a range of patient contexts.
Telephone consultations can be complex. It is therefore recommended that Audio-COTs are completed during the ST3 year of GP training. During your primary care placements in ST1 and/or ST2 we would recommend you are assessed following face to face consultations. However due to the increase in telephone consulting this may not be possible and the COT requirement for that placement can include the assessment of your telephone consulting.

In ST3 it would be expected for trainees to demonstrate their competence in consulting both in face to face consultations and on the telephone. There is no set number for how many of each are needed.

Telephone consultations are undertaken in both the Unscheduled care / OOH setting as well as in the GP setting and you are encouraged to undertake assessments in both clinical environments.

Telephone consultations can either take the form a telephone triage call or a full telephone consultation. For this reason, not all areas of assessment may be covered in all telephone calls. Supervisors are encouraged to mark ‘not observed’ for those descriptors that are not assessed.

It is natural for you to select telephone consultations in which you feel you have performed well; the ability to discriminate between good and poor consultations indicates professional development. However, you are reminded that the Audio-COT is not a pass/fail exercise. The assessment is part of a wider picture of your overall practice and presenting recordings that you feel perhaps did not go as well as you had hoped may result in greater learning.

**Patient consent**

The patient must give consent to the telephone consultation either being listened to by a second doctor or being recorded, in accordance with the guidelines for consenting patients. Please see the separate patient consent document for further information on gaining informed consent for audio recording the consultation on the RCGP website.

**Collecting evidence from the consultation**

Your supervisor will review the consultation with you, relating their observations to the WPBA Capability framework and Audio-COT performance criteria - see Appendix H. Your supervisor will then make an overall judgement and provide structured feedback, with recommendations for further development. You are encouraged to reflect on the telephone consultation through a separate learning log entry.
Capabilities

The Audio-COT has been mapped to the RCGP Capability statements, which in turn will link to work place-based assessment evidence in the Educational Supervisor Review.

Trainee rating and overall assessment

Trainees are rated for each area within the Audio-COT as ‘not observed’, ‘needing further development’, ‘competent’ or ‘excellent’. Your supervisor is rating you against detailed performance criteria. ‘Competent’ refers to the standard that would be expected of a GP trainee on completion of their training. A global judgement is made at the end of the assessment tool regarding the safety of the telephone call.
What is an Audio-COT?
General Practice has evolved, and it is likely that you will carry out more and more consultations by phone. Different skills are needed to carry out a consultation safely and appropriately on the phone from those needed for face-to-face consultation.

The Audio-COT provides an additional tool to enable an assessment of your telephone consultation skills, which complements the existing components of the Workplace Based Assessment (WPBA). The Audio-COT uses the same methodology and process of completing the assessment as the COT, but is used in a different setting.

When should I complete an Audio-COT?
Audio-COTs are undertaken in primary care placements. They contribute to the total COT requirement for each training year.

During your non-primary care posts the mini-Clinical Examination Exercise (miniCEX) tool is used rather than the COT to record consultation observations.

Do I have to have a certain number of COTs which are face to face and a certain number of Audio-COTs?
No, ideally these should not just be solely face to face or audio consultations and a mixture of the different types of consultations would be recommended.

It is recommended that in ST1/2 you are assessed on face to face consultations, but if this is not possible then a telephone consultation can be used.

Why use the Audio-COT?
The Audio-COT is a time efficient way of assessing your telephone consulting in a real practice setting and so it is a complete and realistic challenge. It allows you to get feedback on your performance from an experienced clinician about a real patient/scenario, in real time.

Who can assess an Audio-COT?
Either your approved GP Educational Supervisor, or approved, appropriately trained and updated GP Clinical Supervisors can assess Audio-COTs.

What is the process to complete an Audio-COT?
The process is similar to completing a face-to-face Consultation Observation Tool (COT) in the GP setting. GP Supervisors will naturally review a number of your telephone consultations throughout your training in a GP setting, either via direct observation of a telephone consultation or via an audio-recording. To complete an Audio-COT, your GP Supervisor will review the consultation with you, relating their observations to the WPBA capability framework and Audio-COT performance criteria. Your GP Supervisor then makes an overall judgement and provides structured feedback, with recommendations for further
development. An Audio-COT assessment is then completed as evidence in your Portfolio (see below for further information about how the form is completed).

**How do I select consultations for an Audio-COT?**

You can either be observed directly undertaking a telephone consultation (using a dual head-set for example) or via a recording of both sides of the discussion (patient and doctor).

Telephone consultations should be drawn from your entire period of GP training, reflecting a range of patient contexts. Telephone consultations can be complex, therefore completion of Audio-COTs is recommended during your ST3 year of GP training.

Telephone consultations are undertaken in both the out of hours (OOH) and the GP surgery setting. You are encouraged to undertake assessments in both clinical environments. Telephone consultations can either take the form of a telephone triage call or a full telephone consultation. For this reason, not all areas of assessment will be covered in all telephone consultations. GP Supervisors are encouraged to mark ‘not observed’ for those descriptors that are not assessed. It is advised that you complete at least one telephone consultation in the OOH setting and one in the setting of the GP surgery.

It is natural for you to want to choose telephone consultations where you feel you have performed well. This is not a problem - the ability to discriminate between good and poor consultations indicates professional development. You are reminded that the Audio-COT isn’t a pass/fail exercise; it is part of a wider picture of your overall capability.

Each Audio-COT should represent a different clinical problem. It is helpful to vary the types of cases that are assessed as an Audio-COT so that your capability is reviewed throughout the cases.

**Is there a minimum or maximum length of consultation for an Audio-COT?**

No. However, brief, low challenge consultations will be unlikely to give adequate opportunity to demonstrate your ability, and overly long consultations may lack structure. Complex consultations are likely to generate more evidence. The telephone consultation used for an Audio-COT should typically last between 5-10 minutes.

**How long should the assessment last?**

The assessor should give you immediate feedback after the telephone call (which would typically last 5-10 minutes) and then provide a contemporaneous report, rating you and capturing the feedback within the Audio-COT form on the Portfolio. When assessors have provided more detailed written feedback on the Audio-COT this has been very helpful evidence for the Educational Supervisor Report (ESR).

**How do I gain patient consent?**

The patient must give consent to the telephone consultation either being recorded or having a second doctor listening into the consultation, in accordance with the guidelines for consenting patients. Please see the separate patient consent document for further information on gaining informed consent for Audio-recording the consultation.
How is the Audio-COT assessment captured?
Educational Supervisors and some Clinical Supervisors have access to your Portfolio. If this is the case, the supervisor can log on and complete the assessment. For those who do not have access to your Portfolio, you should send a ‘ticket’ in advance to the assessor, which will allow a direct link to the online assessment form.

To use the ticketed feedback system you need to generate a new ticket after which the ‘Generate a New Ticket’ page will appear. You should select the ‘Audio-COT assessment form’ and fill in the assessor’s details. An email will then be sent to the assessor providing the login code for the assessor to complete the ticketed Audio-COT assessment form.

What standard am I assessed against?
You will be graded in relation to the standard expected at certificate of completion of training (CCT). Competent refers to the standard that would be expected of a GP trainee on completion of their training. The GP Supervisor is rating you against set performance criteria. The grading scale includes the option of ‘not applicable’ which means that you did not cover the identified area, as it was not within the context of the case. This is different to ‘significantly below expectation and/or below expectation’, which means that either you did not cover the identified area to a competent level, or it was not demonstrated at all, and should have been. An overall assessment of performance is made at the end of the assessment.

What feedback should I expect?
Your assessor should provide specific, constructive feedback both verbally and documented on the Audio-COT form, which aims to enhance your performance. The feedback will be used as evidence of your progress within ESR. The comments about each assessment area are important. Areas of strength and suggestions for development are both encouraged.

Is the Audio-COT mapped to the 13 Capabilities?
Yes. The Audio-COT has been mapped to the RCGP capability (competency) statements, to allow the linking of workplace-based assessment evidence in the ESR.

Do I need to cover all the clinical experience groups?
Over the GP training programme, it is expected that trainees will submit a breadth of WPBAs relating to all the clinical experience groups. However, the Educational Supervisor will be able give relevant advice to individual trainees in the context of the rest of their Portfolio.

Does it matter what level of complexity is recorded for Audio-COT cases?
No, however it contextualises the subsequent grades. You would be expected to complete the breadth of complexities and bear in mind low complexity consultations will be unlikely to give adequate opportunity to demonstrate your ability.

Can I be awarded a satisfactory Educational Supervisor’s Report outcome if the overall rating for an individual Audio-COT is ‘needs further development’?
Yes. The Educational Supervisor makes a recommendation to the ARCP panel based on all your overall workplace-based assessments and the content of the Portfolio.

**Can the Audio-COT be used for online/skype style consultations?**
The Audio-COT form could be used in other types of remote consulting where you are not consulting face to face in the same room as your patient in a GP setting (virtual consultations). Examples include the evolving digital audio/video consultations via mobile applications e.g. ‘Skype’ which are being introduced into the primary care setting. Please await further information on the extended use of the Audio-COT.

**How do I access the Audio-COT form?**
The Audio-COT form can be found in the trainee Portfolio or downloaded via the RCGP WPBA website.

**How is the Audio-COT assessment captured?**
If you have any queries about using the Portfolio, please contact FourteenFish via www.fourteenfish.com/support where you can find a “Submit a request” form.
Patient Satisfaction Questionnaire (PSQ)

The Patient Satisfaction Questionnaire (PSQ) provides patient feedback on your empathy and relationship-building skills during consultations. It is completed once in ST3 and it recommended you do this after the mid-way point of your time in ST3.

Patients are requested to complete the questionnaire after their consultation and are asked 9 questions. Each question has 5 options for them to choose from. It is worth familiarising yourself with the questions before starting the PSQ process. You may have to remind patients to complete the questionnaire after their consultation and hand in the completed form before they leave the surgery as it can sometimes be a challenge to get sufficient responses.

How to complete the Patient Satisfaction Questionnaire

1. Log into your Portfolio and click on ‘Patient Feedback’.
2. Complete the self-assessment (this is the score that you would give yourself for each question).
3. Print out the survey questionnaire. We suggest 50 copies as 34 are required for analysis.
4. Give the questionnaires to your receptionist to hand out to patients before they come to see you. If you do not have a receptionist to do this then please look at alternative options. You should not be handing questionnaires to patients.
5. The completed questionnaires should be handed back at reception or left in a sealed box in reception. The forms should not be handed to you.
6. Once you have more than 34 responses, the data will need to be entered into the Portfolio. This should not be done by you. Please discuss this with your practice manager as usually an administrative member of staff will complete this on your behalf.
7. Once more than 34 responses have been entered into your Portfolio, you will be able to close the PSQ.
8. Your Educational Supervisor will receive a notification that the PSQ has been completed. They will review the results and comments and will add their own comments and feedback in the Portfolio.
9. You should arrange a meeting to discuss the PSQ with your ES.
10. If your scores are significantly below the average of your peers, then it would be appropriate to repeat the PSQ at a later date to demonstrate progress.
Patient Satisfaction Questionnaire (PSQ) – FAQs

How many PSQs do I need to complete?
You will need to complete one PSQ during ST3.

How do I collect the data?
There are several ways to do this. From your Portfolio you can send the patient a link to complete the questionnaire online or you can download a paper copy and ask your reception staff to hand out the questionnaire to patients.

How many responses do I need?
You need at least 34 responses.

How are the paper forms uploaded?
The paper forms should be collected by an administrator (not yourself). You will need to invite an administrator to enter the data to the Portfolio. To invite an administrator, go to your survey and scroll to the bottom of the page, where you will see the section for printed forms. There are instructions explaining how the paper forms can be uploaded to the system. You can email the instructions to an administrator who will be able to add the PSQ forms for you using the provided ID and password.

How will I know when I have had the electronic forms completed?
A number count is displayed on the survey page in the Portfolio so you know how many have been returned.

Can I add paper forms to the electronic questionnaires?
Yes, your administrator will be able to add these for you. Please see "How are the paper forms uploaded?" for information about how your administrator can upload the paper forms. Any forms uploaded by an administrator will be added to the questionnaires completed electronically.

How do I close the PSQ once there are 34 electronic responses?
You will receive an email notification when you have obtained the minimum of 34 responses, this is when you can close the survey. To close the PSQ, go to your survey and click "close survey" in the "your progress" section. This will send the PSQ results to your Supervisor for analysis.

How can I see the results?
Once you have closed your PSQ, the results will be released to your Supervisor. They will then be able to review the results, comment on these and release them to you.
Leadership Activity and MSF

Leadership skills are an essential component to the everyday work of a GP. This is reflected in the RGCP Curriculum and Topic Guides and GMC Generic Professional Capabilities. Good leadership skills enable improvement of health outcomes, high quality patient care and fulfilling work environments for staff, by inspiring and empowering all who journey towards a shared vision. Leadership is a skill that everybody can learn and requires continuous development and refinement. Whilst there are aspects of theory to learn, the most important learning in leadership is from practicing the skill set. The Leadership Work Placed Based Assessment (WPBA) gives all trainees the opportunity to gain practical experience in developing these skills in primary care.

The leadership Capabilities as listed by the GMC require doctors in training to demonstrate that they can lead and work effectively in teams by:

- Demonstrating an understanding of why leadership and team working is important in their role as a clinician.
- Showing awareness of their leadership responsibilities as a clinician and why effective clinical leadership is central to safe and effective care.
- Demonstrating an understanding of a range of leadership principles, approaches and techniques.
- Demonstrating an ability to moderate their leadership behaviour to improve engagement and outcomes.
- Appreciating their leadership style and its impact on others.
- Thinking critically about decision making, reflecting on decision making processes and explaining those decisions to others in an honest and transparent way.
- Supervising, challenging, influencing, appraising and mentoring colleagues and peers to enhance performance and to support development.
- Challenging and critically appraising performance of colleagues, peers and systems.
- Promoting and effectively participating in multidisciplinary, inter-professional team working.
- Understanding and appreciating the roles of all members of the multidisciplinary team.
- Promoting a just and fair, open and transparent culture.
- Promoting a learning culture.
During your training you are required to link evidence from a range of sources to the Capability for Organisation, Management and Leadership. For example, this could be a log entry about a course or an event that you helped run.

In addition, there is now a specific mandatory requirement for trainees to undertake a leadership activity and provide a completed log entry relating to this, as a way of demonstrating the requirements expected by the RCGP and GMC.

Completing a leadership activity provides an opportunity for you to submit evidence linking to leadership and teamwork. The likely benefits will include a deeper level of integration for you within the organisation, benefits for the practice by system development, and improvements in patient safety.

GP trainees usually start GP training with a range of experience in leadership and it is important for you to consider, in conjunction with your supervisors, how to develop these skills during your training.

Like all Capabilities, you should aim to develop your skills in this area incrementally during your training programme, in line with the Capability descriptors for organisation, management and leadership.

Mandatory requirements for WPBA

1. A **Leadership Activity** will be undertaken in ST3. You can propose your own activity or select from the examples below. In all cases the proposed activity should be discussed and agreed with your Educational or Clinical supervisor to ensure its suitability. The activity will be recorded in your Portfolio by writing a reflective entry using the specific leadership log entry template.

2. The second MSF in ST3 will be a **Leadership MSF** with questions specifically focused on obtaining feedback around your leadership skills. Ten respondents are required (ideally 5 clinicians and 5 non-clinicians), these should be people who you involved or included in your Leadership Activity.

In addition trainees are encouraged to develop their leadership skills incrementally over their training programme and record any other leadership activities undertaken. There are a variety of ways to record evidence of leadership activity within your Portfolio:

- Log Entries: Leadership activity experience and reflections, along with any learning points should be recorded in the Portfolio. There is a specific leadership log entry
template that should be used to record leadership activity. This could provide
evidence for the capability ‘Organisation, management and leadership’, and may
also provide evidence for other Capabilities, for example ‘Working with colleagues
and in teams’, and activities such as ‘audit and quality improvement’.
• PDPs: The PDP could be used to record areas around leadership activity that you
may wish to develop during your training.
• CATs: A Case based discussion can be a good opportunity to discuss feedback on
and develop areas around leadership.

Approaching the Leadership WPBAs
When creating or selecting a proposed leadership activity it is useful to first consider
which particular leadership skills you wish to focus on developing, so that the
proposed activity is one that allows for this.
There are many models of leadership within health care and a variety of resources
describing the skill set. Trainees may find it helpful to look at these to appreciate the
different skills within Leadership. A simple way to consider your leadership
development, and structure some of the skills described in the referenced models, is
by breaking it down into leadership of self, teams and systems.

Leadership of Self
This is the foundation of your leadership journey - in order to effectively lead others
you must first develop an understanding of yourself. This includes, but is not limited to:
• Understanding your own values and vision for the future and how these affect
your behaviour
• Managing your own emotions
• Knowing your preferred leadership and communication styles and how to adapt
these to have the maximal positive impact
• Knowing the limits of your own abilities and when to seek support from others
• Skills to ensure your wellbeing is preserved
• Commitment to continuous development including seeking out and acting upon
feedback

Leadership of Teams
This involves leading groups of people e.g. the practice team. At different times
various members of the team can take on this role, for example a Practice Nurse
trying to improve the quality of annual reviews of asthma will need to lead the team
to ensure success. Some of the relevant skills include but are not limited to:
• Promoting a shared vision
• Managing change including explaining why the change is needed and role modeling the change
• Understanding and appreciating the roles and skills of all members of the team and ensuring these are utilised to achieve the best outcomes
• Recognise the importance of distributed leadership within health organisations, which places responsibility on every team member and values the contribution of the whole team
• Delegating effectively, setting clear objectives, providing feedback, and holding people to account if required
• Recognise that at times some team members may require more support or guidance and to provide this in a supportive and non-judgemental way
• Empowering and motivating others to deliver, improve and innovate
• Supporting a diverse workforce and understanding the value diversity brings to patient care
• Contribute to a clinical and working environment where everyone is encouraged to participate and alternative views are considered seriously
• Promoting an organisation culture in which the health and resilience of staff is valued and supported

Leadership of Systems
As a GP at the frontline of health services, you will need to understand how to work within systems of healthcare for the benefit of your patients. This will require an understanding of the context, structures and processes in and by which care is delivered.
There are also a growing number of roles for GPs which involve leading across systems e.g. Clinical Directors of Primary Care Networks, CCG roles, lead of GP federations etc. Some of the relevant skills include but are not limited to:
• Recognise that your duty to your patients extends beyond your immediate team and spans across organisations and services (e.g. when safeguarding children, caring for vulnerable adults or addressing unsafe services)
• Identifying opportunities for collaboration and partnership, connecting people with diverse perspectives and interests
• Seeks out beyond the immediate team and professional area for new perspectives, ideas and experiences and shares best practice, incorporating this to enhance quality and delivery of services
• Openly shares own networks with colleagues and partners to improve information, influencing
• Connects individuals, teams and organisations for mutual benefit

GPs and GP trainees have a wide variety of experiences in leadership and it is not always necessary to progress in a stepwise progression through leadership of self,
teams and then systems. Indeed, some GPs leadership roles focus on system level leadership rather than practice level. However, for the purposes of this WPBA it is expected that all trainees will demonstrate a clear understanding in leadership of self, by reflecting upon what they have learnt about themselves. All trainees will also be able to demonstrate some experience in leading teams through their written reflections. It is hoped most trainees will have an awareness of system leadership and some may be able to demonstrate this in their reflections.

Prior to starting delivery of your leadership activity it is recommended to spend some time in a tutorial with your Educational supervisor discussing your proposed leadership activity, the learning you hope to gain from it and your planned approach.

You may also wish to dedicate some further tutorial time during and after completing the leadership activity to discuss progress and your learning goals. It is important to remember throughout this WPBA that leadership is a set of skills which requires constant development and so approach any set backs as important learning opportunities.

Suggestions for trainees

Examples of potential leadership activities are given below. This is not an exhaustive list and you should feel able to develop your own ideas and activities.

**Menu of activities (not exclusive)**

- Trainees own idea
- Fresh pair of eyes
- Chairing a meeting
- Quality Improvement Project
- Wellbeing Project
- Clinical protocol (review/creation)
- Practice leaflet review
- Website design

Guidance on these activities is provided on [the RCGP website](https://www.rcgp.org.uk). For each activity some background information is given to explain the rationale for including it as a leadership activity, followed by a short description of the process and some intended learning outcomes.

**Leadership log entry**

Suggested Capability links
Date
Title of event

1. State your role in relation to the activity *
2. How did you approach this activity? * [what planning you undertook for the activity]
3. How did you demonstrate your ability to work with colleagues, patients, learners and/or users (individually or in teams)? *
4. How effective were you within this role? * [Reflect on your achievements and feedback received]
5. Reflection: what will I maintain, improve or stop?
6. What have you learnt about yourself? *[consider what motivates you, your core beliefs and areas to develop]

Leadership Activity - FAQs

Is participation in a leadership activity mandatory?
It is mandatory to do a leadership activity in ST3 and write this up using the specific log entry for leadership activities.

How is it assessed?
It will be assessed using the descriptors for the organisation, management and leadership capability. This is done by the supervisor using evidence directly observed, logs for leadership activity, Multisource feedback and CbDs, which link to leadership activity.

Are trainees expected to have protected time to do their leadership activity?
There is educational time included in the your and all trainees are expected to have protected personal study time as part of their working week as well as time in groups for shared learning.

Does the leadership activity have to be done in the practice?
The leadership activity is done as part of the training to become a GP. It is therefore necessary that the activity is done within the normal work that a GP would be expected to be involved in. This might therefore include work with commissioning organisations, networks of primary care teams or with District Nurses, palliative care teams or others with whom GPs regularly work.

When can the leadership activity be started?
It is expected that the ST3 leadership MSF will be linked to the leadership activity, so that the people who provide feedback on leadership through the MSF have seen your
leadership activity. Although some elements of the leadership activity could have started before ST3 it is required that the ST3 leadership activity is completed during ST3.

Leadership Multi Source Feedback (Leadership MSF)
Once you have completed the leadership activity, the Leadership focused MSF then gives the opportunity for you to receive some feedback from colleagues on the leadership skills you have demonstrated. The exercise has been designed to evaluate your strengths in the area of leadership and to reflect on where you need to concentrate your efforts before becoming an independent practitioner.

Guidance for the use of the MSF
Your leadership activity needs to have been completed before you start the MSF. Prior to requesting your colleagues to complete this form you need to complete a self-assessment. This will enable a comparison to be made between the two sets of results. The more respondents who complete the MSF the more useful the results. It is therefore suggested that you consider a wide range of colleagues, both within the organisation in which you work day to day and also colleagues with whom you have contact outside the organisation. Your respondents are asked to answer 5 questions, each with a rating scale, and to comment on any highlights of your leadership, and suggest areas for improvement. As with all MSFs, the results will be made available to your Educational Supervisor to access first and then released to you. You should arrange to meet with your Educational Supervisor to allow discussion and feedback with the creation of a personal development plan if required.

Notes for Clinical and Educational Supervisors
A significant part of the value that comes from a leadership activity is being observed and having formative feedback from the Educational supervisor, or an appropriate deputy, within the practice. This will support your trainee in reflecting upon their strengths and how they can improve in other areas as they continue their leadership journey, which requires career-long learning. This can be done both verbally, e.g. during a tutorial and also in a written format, e.g. through comments relating to a log entry, a CAT, the leadership MSF or an educator’s note. If your trainee is performing below the level expected for their stage of training it is important to be specific about why this conclusion has been reached and develop a plan the trainee can follow to try and alter the situation.
For many leadership activities it is important that an appropriate environment is created. The environment should be one that expects the trainee to undertake this work, facilitates this process and allows the trainee to feel comfortable in their role, for example when giving feedback to their practice as part of a fresh pair of eyes activity.

Leadership Multi-Source Feedback (Leadership MSF) – FAQs

When do I have to do the leadership Multi-Source Feedback?
This is completed once in ST3 and ideally after your leadership activity. This will, therefore, normally take place in the second half of ST3. You will have already completed the MSF rating your clinical and professional behaviour in the first half of ST3.

Does a written reflection on the leadership MSF need to be made?
Yes. Reflections on the feedback need to be recorded in a ‘Reflection on Feedback’ log entry. A PDP item can be developed if appropriate.

How many respondents are required?
As with any MSF, 10 replies are needed. These can be either clinical or non-clinical respondents. There is no defined number of clinical or non-clinical respondents.

What if insufficient responses are submitted?
If you are working in a very small practice it may not be possible to achieve sufficient responses. In this circumstance, the Educational Supervisor should make an Educator’s Note stating that there are insufficient members of staff to complete your leadership MSF.

If I receive negative feedback, or areas for improvement are identified, does the leadership MSF need to be repeated?
No. You should record your reflections in the “Reflection on Feedback” section of the learning log and develop a personal development plan to address any identified needs. Your ES can comment on these reflections and PDP.
Clinical Supervisors Report (CSR)

The Clinical Supervisors Report (CSR) has been described in detail in the ST1/2 section earlier in this document. It is a short, structured report and required in your ST3 post if:

- You have a Clinical Supervisor in ST3 in addition to your ST3 Educational Supervisor
- The evidence in your Portfolio does not give a full enough picture of your progress in training and information from a CSR would provide this missing information, or
- Either you or your Supervisor feels it is appropriate.

The CSR is an opportunity for you to receive feedback about your performance. A well completed CSR is also a valuable source of evidence for each Capability in the Educational Supervisor Review and for ARCP panels.

The CSR for ST3 is almost identical to the ST1/2 primary care CSR form with the exception of a change in one of the marking grades. ‘Needing further development - meeting expectations’ has been replaced with ‘Needing further development’.
Prescribing assessment

Prescribing is an integral part of any GP's work and several high profile cases have been published where qualified doctors have made prescribing errors. In 2017 the GMC published a document which included competences related to prescribing. These competences are thought to be essential for every specialty trainee to attain before the completion of training.

GP Prescribing Proficiencies

All prescribing GPs are expected by the GMC (GPC 2017) to demonstrate the following prescribing proficiencies across a range of ages and different clinical areas:

- Assess the risks and benefits including that posed by other medications and medical conditions.
- Identify when prescribing unlicensed medicines and informs patients appropriately.
- Adhere to local guidelines and evidence-based medicine.
- Use antimicrobials appropriately.
- Counsel patients appropriately including instructions for taking medicines safety in line with up to date literature.
- Review and monitor effects including blood testing at appropriate intervals.

The WPBA prescribing assessment comprises a self-assessment prescribing review based on the PRACtICE and REVISIT studies. These were GMC led reviews looking at the number of errors found in prescriptions issued by GPs and GP trainees.

The assessment is a formative exercise to aid reflection on your prescribing practice. It will highlight trends and learning needs within your prescribing. By reflecting on the errors identified it will enable learning plans to be put in place in order to improve your prescribing. There is no set standard as it is designed as a learning exercise. However, if no errors are highlighted, and if no learning is identified, this in itself would raise concerns as previous studies have all demonstrated an error rate for participants.

It is recommended you familiarise yourself with the details of the prescribing assessment on the RCGP website before you start the process.

In order to capture normal prescribing habits, the review is retrospective with a start date set by the Educational Supervisor that you will not be aware of in advance.
You then either:

a) Reviews consultations on the start date before working backwards in time until at least 50 prescription items have been identified for review (these are referred to as *prescribed prescription items*), or

b) Run a computer search to identify your last 50 prescriptions and add them to a standard spreadsheet (see the RCGP website for more information). A computer search is available for some clinical systems.

The prescribed prescription items should have been issued during a consultation (either a telephone or face to face consultation). The prescribed prescription item could be a:

- New Acute (NA) – acute item never prescribed before
- Repeat Acute (RA) – acute item that has been prescribed from the medication history screen.
- New Repeat (NR) – new item added to repeat medication list and prescribed
- Repeat Repeat (RR) – item prescribed from the current repeat medication list

The clinical system searches provided as part of this assessment vary slightly depending on the clinical system in use and may not collect data from all of these categories.

More than one item may be issued during a single consultation and these may be different prescription types e.g. a 'new acute' and a 'repeat repeat'.

Prescribing that is included in the review:

- Any prescribing where there has been a patient consultation in a clinic setting either face to face or by telephone. You must also have issued and signed (by hand or electronically) the prescription yourself.

Prescribing that is not included in the consultation review but may occasional arise in the computer search review are:

- Prescriptions issued during paperwork review without consultation with the patient e.g. processing of letters from secondary care.
- Items that are for administration in the practice e.g. vaccinations, IUD.
- Signed prescriptions issued by other members of the practice team e.g. nursing staff.
- Prescriptions issued in response to requests made by patients via the repeat prescription service or via reception.
When a prescribed prescription item is identified, each item should be considered in detail by considering the following questions:

1. Was the **RIGHT DRUG (s)** selected for the indication and the patient?
2. Was the drug prescribed at the **RIGHT DOSE** for the indication and the patient?
3. Were the **RIGHT DOSAGE INSTRUCTIONS** written on the prescription in a way the patient can understand?
4. Was the **RIGHT FOLLOW UP** planned, enacted or acted upon with regards to the medication?
5. Have you provided the **RIGHT DOCUMENTATION** to support prescribing?
6. Has the medication been subject to the **RIGHT REVIEW** before prescribing (including checking adherence to therapy)?
7. Are there any examples of **GOOD PRESCRIBING** practice?

When a prescribing event has been identified you should consider:

- The possible reasons why the event occurred.
- Possible methods to avoid the event happening in the future.
- How they will check that the methods they have tried are working.

**What might the review identify?**

The 100-prescription study (REVISIT) identified areas where prescribing could be improved in all participants and therefore this review is likely to highlight areas for improvement. Making small changes to prescribing habits may help protect a prescriber from recurrent prescribing errors in the future. This prescribing review is intended to be educational and supportive to the prescriber. How these strategies can be incorporated into everyday practice and become long term prescribing habits should be identified.

The review will also highlight areas of good prescribing practice that you will want to make a conscious decision to continue as you will be contributing to safe prescribing. This aspect is just as important as highlighting areas for improvement.

When the results are reviewed it is important to look for themes and patterns either in the type of error or the BNF category of medication. It may also be useful to review the breadth of prescribing across the categories and consider whether your current prescribing reflects the variation that would be expected of a qualified GP.
If a prescribing error is identified as part of the review, the possibility of actual patient harm should be considered. If appropriate, you should highlight the incident to your supervisor immediately and follow the practice procedure for managing prescribing errors.

Preparing for the review

When undertaking self-review, it is useful to have all the reference sources that you will need either in paper form or in your computer browser. Examples include:

- BNF and BNF for children
- Local formulary guidance
- Local clinical guidelines e.g. antimicrobial guidelines
- This handbook (especially appendices 1 and 2)

Try not to presume that your knowledge of a medicine is correct even though you may prescribe it frequently. To ensure that you have complete and current knowledge consider reading around the monograph to refresh your knowledge.

When checking antimicrobial dosages with the local antimicrobial guidelines you should also check indication, allergy status, place of therapy and course length. When reviewing documentation, try and imagine that you are looking at the notes for the first time and do not have prior knowledge about the patient. You may remember why you prescribed an item and be able to explain the rationale but if this reason is not clear in the notes then the issue should be highlighted in the review.

Using the Excel spreadsheet

An Excel spreadsheet is provided to help you undertake the review and reflect on the results. If a search has been run on the clinical system, it may be possible to copy and paste the relevant information into the review spreadsheet. You may choose to create your own method of collecting and reviewing your data. However, the review must cover and document the same areas.

The Excel spreadsheet provided can be divided into three sections.

The first section contains columns to enter the prescribing that has occurred. If you have used a clinical system search provided with this assessment, the report created should match the spreadsheet below:
The second section helps to review prescribing by considering each of the prescribing categories. If an issue is identified, place a number 1 in the column on the spreadsheet (otherwise enter a 0). Ensure that the last column of this section is completed describing what should have been done and why e.g. ‘dose should have been 500mg as per local antimicrobial guideline’. Make sure you identify good prescribing that is occurring as well.

The third section asks you, the reviewer, to reflect on the possible reasons as to why the issue occurred (or in the case of good prescribing whether it was it a considered action and if so, what that reason was). It also asks you to look at possible strategies that could be used in the future to prevent the issue occurring again (or in the case of good prescribing, how the good practice can be embedded). This section is essential. A review that only looks at the number of issues found is not acceptable.

This spreadsheet will help when analysing the results and can be used to complete the table in the prescribing assessment form.

Once you have analysed your results you need to pass your spreadsheet to your supervisor who will review 20 of your prescriptions and document this information on
your spreadsheet. The completed spreadsheet then gets handed back to you so this can be attached, in an anonymised way, to your learning log, within the prescribing section.

Analysing the results of the prescribing review

It will be possible to analyse the results in various ways and the spreadsheet provided can be manipulated to help you achieve this. While the individual prescribing events will have been reviewed, the data should also be viewed as a whole. It is important to look for trends or themes in prescribing that you can highlight as good prescribing or areas that could be improved. Each review will highlight different aspects of prescribing. The following questions are suggested to help with overall evaluation:

- How many prescribing events you have highlighted?
- Are there any themes that can be identified with these prescribing events?
- Which areas of good prescribing did your review identify?
- How many prescribing events are there in each of the prescription categories (New Repeat, Repeat Repeat, etc.)?
- How many prescribing events are there in each of the prescribing event categories (right drug, right dose, etc.)?
- Are there any prescribing events that have occurred more than once (e.g. incorrect dose of an antibiotic)?
- Are there examples of good prescribing that have occurred more than once?
- When the possible reasons and possible strategies for the future are considered, are there recurring themes (e.g. need to refer to guidelines, need to document indication)? How can this then link to your personal development plan?
- Which areas of the BNF cover the majority of your prescribing (e.g. antimicrobial and analgesia)? Would your supervisor consider this typical of current prescribing and that of a post CCT GP?

You should record this reflection in the prescribing learning log.

The Assessment

When you have completed the prescribing learning log, you should arrange a time to complete the prescribing assessment with your supervisor. The prescribing assessment will add to the evidence of progress in your Portfolio.

At the end of the assessment your supervisor is asked to make a judgment on your overall proficiency by choosing one of the following statements:

- A safe, reflective GP prescriber at this point in time.
  [It is still expected that they have PDPs to further improve their prescribing]
• Need to develop specific prescribing skills to fulfil the prescribing proficiencies.
• Need support and educational input prior to repeating all of this assessment.

If you do need to develop specific skills in prescribing then these will be documented as an educational plan with a time arranged for when these will be reviewed.

In summary

1. You search on your last 50 retrospective prescriptions.
2. Using the prescribing manual, you review the prescriptions and map them against potential prescribing errors.
3. Your supervisor reviews 20 of these prescriptions, maps these against potential errors and adds these to the spreadsheet.
4. You complete the trainee reflection form in the Portfolio and in particular reflect on your prescribing using the GP prescribing proficiencies.
5. You and your supervisor complete the assessment using the prescribing assessment form found in the Portfolio.
6. You upload the anonymised spreadsheet to your learning log.
Appendix A - Word descriptors with Indictors of underperformance

**Fitness to practise**

This is about professionalism and the actions expected to protect people from harm. This includes the awareness of when an individual's performance, conduct or health, or that of others, might put patients, themselves or their colleagues at risk.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fails to respect the requirements of the organisation e.g. meeting deadlines, producing documentation, observing contractual obligations</td>
<td>Understands the GMC document, &quot;Duties of a Doctor&quot;.</td>
<td>Demonstrates the accepted codes of practice in order to promote patient safety and effective team working.</td>
<td>Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change.</td>
</tr>
<tr>
<td>Has repeated unexplained or unplanned absences from professional commitments</td>
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</tr>
<tr>
<td>Prioritises his/her own interests above those of the patient</td>
<td></td>
<td>Achieves a balance between their professional and personal demands that meets their work commitments and maintains their health.</td>
<td></td>
</tr>
<tr>
<td>Fails to cope adequately with pressure e.g. dealing with stress or managing time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the subject of multiple complaints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fails to respect the requirements of the organisation e.g. meeting deadlines, producing documentation, observing contractual obligations</td>
<td>Attends to their professional duties.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has repeated unexplained or unplanned absences from professional commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritises his/her own interests above those of the patient</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Awareness that physical or mental illness, or personal habits, might interfere with the competent delivery of patient care.</td>
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<tr>
<td>Takes effective steps to address any personal health issue or habit that is impacting on their performance as a doctor.</td>
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<tr>
<td>Demonstrates insight into any personal health issues.</td>
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<tr>
<td>Takes a proactive approach to promote personal health.</td>
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<tr>
<td>Encourages an organisational culture in which the health of its members is valued and supported.</td>
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</tr>
<tr>
<td>Fails to cope adequately with pressure e.g. dealing with stress or managing time</td>
<td>Identifies and notifies an appropriate person when their own or a colleague's performance, conduct or health might be putting others at risk.</td>
<td>Reacts promptly, discreetly and impartially when there are concerns about self or colleagues. Takes advice from appropriate people and, if necessary, engages in a referral procedure.</td>
<td>Provides positive support to colleagues who have made mistakes or whose performance gives cause for concern.</td>
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</tr>
<tr>
<td>Is the subject of multiple complaints</td>
<td>Responds to complaints or performance issues appropriately.</td>
<td>Uses mechanisms to reflect on and learn from complaints or performance issues in order to improve patient care.</td>
<td>Actively seeks to anticipate and rectify where systems and practice may require improvement in order to improve patient care.</td>
</tr>
</tbody>
</table>
Maintaining an ethical approach

This is about practising ethically with integrity and a respect for equality and diversity

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
</tr>
<tr>
<td>Does not consider ethical principles,</td>
</tr>
<tr>
<td>such as good versus harm, and use</td>
</tr>
<tr>
<td>this to make balanced decisions</td>
</tr>
<tr>
<td>Fails to show willingness to reflect on</td>
</tr>
<tr>
<td>own attitudes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of the professional codes of practice as described in the GMC document &quot;Good Medical Practice&quot;.</td>
<td>Demonstrates the application of &quot;Good Medical Practice&quot; in their own clinical practice.</td>
<td>Anticipates the potential for conflicts of interest and takes appropriate action to avoid these.</td>
</tr>
<tr>
<td>Understands the need to treat everyone with respect for their beliefs, preferences, dignity and rights.</td>
<td>Demonstrates equality, fairness and respect in their day-to-day practice.</td>
<td>Anticipates situations where indirect discrimination might occur.</td>
</tr>
<tr>
<td>Recognises that people are different and does not discriminate against them because of those differences.</td>
<td>Values and appreciates different cultures and personal attributes, both in patients and colleagues.</td>
<td>Awareness of current legislation as it applies to clinical work and practice management.</td>
</tr>
<tr>
<td>Understands that “Good Medical Practice” requires reference to ethical principles.</td>
<td>Reflects on and discusses moral dilemmas encountered in the course of their work.</td>
<td>Actively supports diversity and harnesses differences between people for the benefit of the organisation and patients alike.</td>
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</tbody>
</table>
Communication and consultation skills

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consultations and the use of interpreters.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td>Develops a relationship with the patient.</td>
<td>Explores and responds to the patient’s agenda, health beliefs and preferences.</td>
<td>Incorporates the patient's perspective and context when negotiating the management plan.</td>
</tr>
<tr>
<td>Does not establish rapport with the patient</td>
<td>The use of language is technically correct.</td>
<td>Elicits psychological and social information to place the patient’s problem in context.</td>
<td>Employs a full range of fluent communication skills, both verbal and non-verbal, including active listening skills.</td>
</tr>
<tr>
<td>Makes inappropriate assumptions about the patient's agenda</td>
<td>Provides explanations that are medically correct.</td>
<td>The use of language is fluent and takes into consideration the needs and characteristics of the patient, for instance when talking to children or patients with learning disabilities.</td>
<td>Uses a variety of communication techniques and materials (e.g. written or electronic) to adapt explanations to the needs of the patient.</td>
</tr>
<tr>
<td>Misses / ignores significant cues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not give space and time to the patient when this is needed</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Has a blinkered approach and is unable to adapt the consultation despite cues or new information</td>
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<td></td>
</tr>
<tr>
<td>Is unable to consult within time scales that are appropriate to the stage of training</td>
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</tr>
<tr>
<td>Uses stock phrases / inappropriate medical jargon rather than tailoring the language to the patients' needs and context</td>
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<td></td>
</tr>
<tr>
<td>The approach is inappropriately doctor-centred</td>
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</tr>
<tr>
<td>Communicates management plans and is starting to involve the patient in decision-making.</td>
<td>Works in partnership with the patient, negotiating a mutually acceptable plan that respects the patient's agenda and preference for involvement.</td>
<td>Whenever possible, adopts plans that respect the patient's autonomy. When there is a difference of opinion the patient's autonomy is respected and a positive relationship is maintained.</td>
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<tr>
<td>Consults to an acceptable standard and is starting to focus the priorities of the consultation.</td>
<td>Consults in an organised and structured way, achieving the main tasks of the consultation in a timely manner.</td>
<td>Consults effectively in a focussed manner moving beyond the essential to take a holistic view of the patient's needs within the time frame of a normal consultation.</td>
<td></td>
</tr>
<tr>
<td>Aware of when there is a language barrier and can access interpreters either in person or by telephone.</td>
<td>Manages consultations effectively with patients who have different languages, cultures, beliefs and educational backgrounds.</td>
<td>Uses a variety of communication and consultation techniques that demonstrates respect for, and values, diversity.</td>
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</tr>
</tbody>
</table>
## Data gathering and interpretation

This is about the gathering, interpretation, and use of data for clinical judgement, including information gathered from the history, clinical records, examination and investigations.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Has an approach which is disorganised, chaotic, inflexible or inefficient</td>
<td>Accumulates information from the patient that is relevant to their problem.</td>
<td>Systematically gathers information, using questions appropriately targeted to the problem without affecting patient safety.</td>
<td>Expertly identifies the nature and scope of enquiry needed to investigate the problem, or multiple problems, within a short time frame.</td>
</tr>
<tr>
<td>Does not use significant data as a prompt to gather further information</td>
<td>Uses existing information in the patient records.</td>
<td>Understands the importance of, and makes appropriate use of, existing information about the problem and the patient’s context.</td>
<td>Prioritises problems in a way that enhances patient satisfaction.</td>
</tr>
<tr>
<td>Does not look for red flags appropriately</td>
<td>Employs examinations and investigations that are in line with the patient’s problems.</td>
<td>Chooses examinations and targets investigations appropriately and efficiently.</td>
<td>Uses a stepwise approach, basing further enquiries, examinations and tests on what is already known and what is later discovered.</td>
</tr>
<tr>
<td>Fails to identify normality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination technique is poor</td>
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<td></td>
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</tr>
<tr>
<td>Fails to identify significant physical or psychological signs</td>
<td>Identifies abnormal findings and results.</td>
<td>Understands the significance and implications of findings and results, and takes appropriate action.</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Examination and Procedural Skills

This is about clinical examination and procedural skills. By the end of training, the trainee must have demonstrated competence in 5 mandatory skills and a range of other examination and skills relevant to General Practice.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td>Chooses examinations in line with the patient’s problem(s).</td>
<td>Chooses examinations appropriately targeted to the patient’s problem(s)</td>
<td>Proficiently identifies and performs the scope of examination necessary to investigate the patient’s problem(s).</td>
</tr>
<tr>
<td>Patient shows no understanding as to the purpose of examination</td>
<td>Identifies abnormal signs</td>
<td>Has a systematic approach to clinical examination and able to interpret physical signs accurately</td>
<td>Uses a step-wise approach to examination, basing further examinations on what is known already and is later discovered.</td>
</tr>
<tr>
<td>Fails to examine when the history suggests conditions that might be confirmed or excluded by examination</td>
<td>Suggests appropriate procedures related to the patient’s problem(s).</td>
<td>Varies options of procedures according to circumstances and the preferences of the patient.</td>
<td>Demonstrates a wide range of procedural skills to a high standard.</td>
</tr>
<tr>
<td>Inappropriate over examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fails to obtain informed consent for the procedure</td>
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<td></td>
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</tr>
<tr>
<td>Patient appears unnecessarily upset by the examination</td>
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</tr>
<tr>
<td><strong>Observes the professional codes of practice including the use of chaperones.</strong></td>
<td><strong>Identifies and reflects on ethical issues with regard to examination and procedural skills.</strong></td>
<td><strong>Engages with quality improvement initiatives with regard to examination and procedural skills.</strong></td>
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</tr>
<tr>
<td>Arranges the place of the examination to give the patient privacy and to respect their dignity. Examination is carried out sensitively and without causing the patient harm.</td>
<td>Recognises and acknowledges the patients concerns before and during the examination and puts them at ease.</td>
<td>Recognises the verbal and non-verbal clues that the patient is not comfortable with an intrusion into their personal space especially the prospect or conduct of intimate examinations. Is able to help the patient to accept and feel safe during the examination.</td>
<td></td>
</tr>
<tr>
<td>Performs procedures and examinations with the patient’s consent and with a clinically justifiable reason to do so.</td>
<td>Shows awareness of the medico-legal background, informed consent, mental capacity and the best interests of the patient.</td>
<td>Helps to develop systems that reduce risk in clinical examination and procedural skills.</td>
<td></td>
</tr>
</tbody>
</table>
**Making a diagnosis / decisions**

This is about a conscious, structured approach to making diagnoses and decision-making

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
</tr>
<tr>
<td>Is indecisive, illogical or incorrect in decision-making</td>
</tr>
<tr>
<td>Fails to consider the serious possibilities</td>
</tr>
<tr>
<td>Is dogmatic/closed to other ideas</td>
</tr>
<tr>
<td>Too frequently has late or missed diagnoses</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs Further Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generates an adequate differential diagnosis based on the information available.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes diagnoses in a structured way using a problem-solving method.</td>
</tr>
<tr>
<td>Uses an understanding of probability based on prevalence, incidence and natural history of illness to aid decision-making.</td>
</tr>
<tr>
<td>Addresses problems that present early and/or in an undifferentiated way by integrating all the available information to help generate a differential diagnosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses pattern recognition to identify diagnoses quickly, safely and reliably.</td>
</tr>
<tr>
<td>Remains aware of the limitations of pattern recognition and when to revert to an analytical approach.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generates and tests appropriate hypotheses.</th>
</tr>
</thead>
</table>

| Revises hypotheses in the light of additional information. |

<p>| No longer relies on rules or protocols but is able to use and justify discretionary judgement in situations of uncertainty or complexity, for example in patients with multiple problems. |</p>
<table>
<thead>
<tr>
<th>Makes decisions by applying rules, plans or protocols.</th>
<th>Thinks flexibly around problems generating functional solutions.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is starting to develop independent skills in decision making and uses the support of others to confirm these are correct.</td>
<td>Has confidence in, and takes ownership of own decisions whilst being aware of their own limitations. Keeps an open mind and is able to adjust and revise decisions in the light of relevant new information.</td>
<td>Continues to reflect appropriately on difficult decisions. Develops mechanisms to be comfortable with these choices</td>
</tr>
</tbody>
</table>
**Clinical management**

This is about the recognition and management of patients' problems

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
</tr>
<tr>
<td>Asks for help inappropriately: either too much or too little</td>
</tr>
<tr>
<td>Does not think ahead, safety net appropriately or follow-through adequately</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses appropriate management options</td>
<td>Varies management options responsively according to the circumstances, priorities and preferences of those involved.</td>
<td>Provides patient-centred management plans whilst taking account of local and national guidelines in a timely manner.</td>
</tr>
<tr>
<td>Suggests possible interventions in all cases.</td>
<td>Considers a &quot;wait and see&quot; approach where appropriate.</td>
<td>Empowers the patient with confidence to manage problems independently together with knowledge of when to seek further help.</td>
</tr>
<tr>
<td>Arranges follow up for patients</td>
<td>Suggests a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing patient autonomy.</td>
<td>Able to challenge unrealistic patient expectations and consulting patterns with regard to follow up of current and future problems.</td>
</tr>
<tr>
<td>Makes safe prescribing decisions, routinely checking on drug interactions and side effects.</td>
<td>In addition to prescribing safely is aware of and applies local and national guidelines including drug and non-drug therapies.</td>
<td>Regularly reviews all of the patient’s medication in terms of evidence-based prescribing, cost-effectiveness and patient understanding.</td>
</tr>
<tr>
<td>Refers safely, acting within the limits of their competence.</td>
<td>Maintains awareness of the legal framework for appropriate prescribing.</td>
<td>Has confidence in stopping or stepping down medication where this is appropriate.</td>
</tr>
<tr>
<td>Recognises medical emergencies and responds to them safely.</td>
<td>Refers appropriately, taking into account all available resources.</td>
<td>Identifies areas for improvement in referral processes and pathways and contributes to quality improvement.</td>
</tr>
<tr>
<td>Ensures that continuity of care can be provided for the patient’s problem, e.g. through adequate record keeping.</td>
<td>Responds rapidly and skilfully to emergencies, with appropriate follow-up for the patient and their family. Ensures that care is coordinated both within the practice team and with other services.</td>
<td>Contributes to reflection on emergencies as significant events and how these can be used to improve patient care in the future.</td>
</tr>
<tr>
<td>Provides comprehensive continuity of care, taking into account all of the patient’s problems and their social situation.</td>
<td>Takes active steps within the organisation to improve continuity of care for the patients.</td>
<td></td>
</tr>
</tbody>
</table>
### Managing medical complexity

This is about aspects of care beyond the acute problem, including the management of co-morbidity, uncertainty, risk and health promotion.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td>Manages health problems separately, without necessarily considering the implications of co-morbidity.</td>
<td>Simultaneously manages the patient's health problems, both acute and chronic.</td>
<td>Accepts responsibility for coordinating the management of the patient's acute and chronic problems over time.</td>
</tr>
<tr>
<td>Inappropriately burdens the patient with uncertainty</td>
<td>Identifies and tolerates uncertainties in the consultation</td>
<td>Is able to manage uncertainty including that experienced by the patient.</td>
<td>Anticipates and employs a variety of strategies for managing uncertainty.</td>
</tr>
<tr>
<td>Finds it difficult to suggest a way forward in unfamiliar circumstances</td>
<td>Attempts to prioritise management options based on an assessment of patient risk.</td>
<td>Communicates risk effectively to patients and involves them in its management to the appropriate degree.</td>
<td>Uses the patient's perception of risk to enhance the management plan.</td>
</tr>
<tr>
<td>Often gives up in complex or uncertain situations</td>
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<tr>
<td>Is easily discouraged or frustrated, for example by slow progress or lack of patient engagement</td>
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<tr>
<td>Manages patients with multiple problems with reference to appropriate guidelines for the individual conditions.</td>
<td>Recognises the inevitable conflicts that arise when managing patients with multiple problems and takes steps to adjust care appropriately.</td>
<td>Comfortable moving beyond single condition guidelines and protocols in situations of multi-morbidity and polypharmacy, whilst maintaining the patient’s trust</td>
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<tr>
<td>Considers the impact of the patient’s lifestyle on their health.</td>
<td>Consistently encourages improvement and rehabilitation and, where appropriate, recovery. Encourages the patient to participate in appropriate health promotion and disease prevention strategies.</td>
<td>Coordinates a team based approach to health promotion in its widest sense. Maintains a positive attitude to the patient’s health even when the situation is very challenging.</td>
<td></td>
</tr>
</tbody>
</table>
**Working with colleagues and in teams**

This is about working effectively with other professionals to ensure good patient care and includes the sharing of information with colleagues.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td>Shows awareness of working within a team rather than in isolation.</td>
<td>Is an effective team member, working flexibly with the various teams involved in day to day primary care.</td>
<td>Helps to coordinate a team-based approach to enhance patient care, with a positive and creative approach to team development.</td>
</tr>
<tr>
<td>Works in isolation</td>
<td>Understands the different roles, skills and responsibilities that each member brings to a primary health care team.</td>
<td>Understands the context within which different team members are working, e.g. Health Visitors and their role in safeguarding.</td>
<td>Shows awareness of the strengths and weaknesses of each team member and considers how this can be used to improve the effectiveness of a team.</td>
</tr>
<tr>
<td>Gives little support to team members</td>
<td></td>
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</tr>
<tr>
<td>Doesn't appreciate the value of the team</td>
<td></td>
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</tr>
<tr>
<td>Inappropriately leaves their work for others to pick up</td>
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<td></td>
</tr>
<tr>
<td>Feedback (formal or informal) from colleagues raises concerns</td>
<td></td>
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</tr>
<tr>
<td>Responds to the communications from other team members in a timely and constructive manner.</td>
<td>Communicates proactively with team members so that patient care is enhanced using an appropriate mode of communication for the circumstances.</td>
<td>Encourages the contribution of others employing a range of skills including active listening. Assertive but doesn't insist on own views.</td>
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<tr>
<td>Understands the importance of integrating themselves into the various teams in which they participate.</td>
<td>Contributes positively to their various teams and reflects on how the teams work and members interact.</td>
<td>Shows some understanding of how group dynamics work and the theoretical work underpinning this. Has demonstrated this in a practical way, for example in chairing a meeting.</td>
<td></td>
</tr>
</tbody>
</table>
**Maintaining performance, learning and teaching**

This is about maintaining the performance and effective continuing professional development (CPD) of oneself and others. The evidence for these activities should be shared in a timely manner within the appropriate electronic Portfolio.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not a level below NFD</td>
<td>Knows how to access the available evidence, including the medical literature, clinical performance standards and guidelines for patient care.</td>
<td>Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision-making.</td>
<td>Uses professional judgement to decide when to initiate and develop protocols and when to challenge their use. Moves beyond the use of existing evidence toward initiating and collaborating in research that addresses unanswered questions.</td>
</tr>
<tr>
<td>Fails to engage adequately with the Portfolio e.g. the entries are scant, reflection is poor, plans are made but not acted on or the PDP is not used effectively</td>
<td>Engages in some study reacting to immediate clinical learning needs.</td>
<td>Shows a commitment to professional development through reflection on performance and the identification of personal learning needs. Addresses learning needs and demonstrates the application of these in future practice.</td>
<td>Systematically evaluates performance against external standards. Demonstrates how elements of personal development impact upon career planning and the needs of the organisation.</td>
</tr>
<tr>
<td>Reacts with resistance to feedback that is perceived as critical</td>
<td>Changes behaviour appropriately in response to the clinical governance activities of the practice, in particular to the agreed outcomes of the practice's audits, quality improvement activities and significant event analyses.</td>
<td>Personally, participates in audits and quality improvement activities and uses these to evaluate and suggest improvements in personal and practice performance.</td>
<td>Encourages and facilitates participation and application of clinical governance activities, by involving the practice, the wider primary care team and other organisations.</td>
</tr>
<tr>
<td>Fails to make adequate educational progress</td>
<td>Engages in learning event reviews, in a timely and effective manner, and</td>
<td></td>
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</tr>
<tr>
<td>Recognises situations, e.g. through risk assessment, where patient safety could be compromised.</td>
<td>Learns from them as a team-based exercise.</td>
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</tr>
<tr>
<td>Contributes to the education of others.</td>
<td>Identifies learning objectives and uses teaching methods appropriate to these.</td>
<td>Evaluates outcomes of teaching, seeking feedback on performance, and reflects on this.</td>
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<tr>
<td></td>
<td>Assists in making assessments of learners where appropriate.</td>
<td>Actively facilitates the development of others.</td>
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<td></td>
<td>Ensures students and junior colleagues are appropriately supervised.</td>
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</tbody>
</table>
### Organisation, management and leadership

This is about understanding how primary care is organised within the NHS, how teams are managed and the development of clinical leadership skills.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
</table>
| Not a level below NFD                   | Demonstrates a basic understanding of the organisation of primary care and the use of clinical computer systems. | Uses the primary care organisational systems routinely and appropriately in patient care for acute problems, chronic disease and health promotion. This includes the use of computerised information management and technology (IM&T). | Uses and modifies organisational and IM&T systems to facilitate:  
• Clinical care to individuals and communities  
• Clinical governance Practice administration |
| Consults with the computer rather than the patient | Uses the patient record and on-line information during patient contacts, routinely recording each clinical contact in a timely manner following the record-keeping standards of the organisation. | Uses the computer during consultations whilst maintaining rapport with the patient to produce records that are succinct, comprehensive, appropriately coded and understandable. | Uses IM&T systems to improve patient care in the consultation, in supportive care planning and communication across all the health care professionals involved with the patient. |
| Records show poor entries e.g. too short, too long, unfocused, failing to code properly or respond to prompts | Personal organisational and time-management skills are sufficient that patients and colleagues are not inconvenienced or come to any harm. | Is consistently well organised with due consideration for colleagues as well as patients. Demonstrates effective:  
• Time management  
• Hand-over skills  
• Prioritisation  
• Delegation | Manages own work effectively whilst maintaining awareness of other people's workload. Offers help sensitively but recognises own limitations. |
<table>
<thead>
<tr>
<th>Responds positively to change in the organisation.</th>
<th>Helps to support change in the organisation. This may include making constructive suggestions.</th>
<th>Actively facilitates change in the organisation. This will include the evaluation of the effectiveness of any changes implemented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manages own workload responsibly.</td>
<td>Responds positively when services are under pressure in a responsible and considered way.</td>
<td>Willing to take a lead role in helping the organisation to respond to exceptional demand.</td>
</tr>
</tbody>
</table>
This is about the ability of the doctor to operate in physical, psychological, socio-economic and cultural dimensions. The doctor is able to take into account patient’s feelings and opinions. The doctor encourages health improvement, self-management, preventative medicine and shared care planning with patients and their carers.

<table>
<thead>
<tr>
<th>Indicators of Potential Underperformance.</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treats the disease, not the patient</td>
<td>Enquires into physical, psychological and social aspects of the patient’s problem.</td>
<td>Demonstrates understanding of the patient in relation to their socio-economic and cultural background. The doctor uses this understanding to inform discussion and to generate practical suggestions for the management of the patient.</td>
<td>Accesses information about the patient’s psychosocial history in a fluent and non-judgemental manner that puts the patient at ease.</td>
</tr>
<tr>
<td></td>
<td>Recognises the impact of the problem on the patient.</td>
<td>Recognises the impact of the problem on the patient, their family and/or carers.</td>
<td>Recognises and shows understanding of the limits of the doctor’s ability to intervene in the holistic care of the patient.</td>
</tr>
<tr>
<td></td>
<td>Offers treatment and support for the physical, psychological and social aspects of the patient’s problem.</td>
<td>Utilises appropriate support agencies (including primary health care team members) targeted to the needs of the patient and/or their family and carers.</td>
<td>Facilitates appropriate long-term support for patients, their families and carers that is realistic and avoids doctor dependence.</td>
</tr>
<tr>
<td>Recognises the role of the GP in health promotion.</td>
<td>Demonstrates the skills and assertiveness to challenge unhelpful health beliefs or behaviours, whilst maintaining a continuing and productive relationship.</td>
<td>Makes effective use of tools in health promotion, such as decision aids, to improve health understanding.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B - Trainee assessment grade word descriptors for CSR (non-primary care)

When in a hospital setting trainees are rated in comparison to other trainees at the same stage of training or comparable specialist trainees. (Please note this is different to rating GP trainees when in primary care who are rated compared to the expected standard required at the end of training).
### Trainee performance descriptor

**Professionalism**

Includes being respectful, diligent and self-directed in their approach to patients and others and to their own learning needs, developing resilience, making appropriate ethical decisions.

**Capabilities:** Maintaining Performance Learning and Teaching (MPLT), Ethics, Fitness to practice (FTP)

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MPLT</strong> Is not aware of the limitations of their knowledge or skills and practices outside their ability, level of experience or confidence without seeking necessary support.</td>
<td>Is often inconsistent in their awareness of their own knowledge and skills and/or does not always seek help appropriately.</td>
<td>Demonstrates the same level of knowledge and skills as other trainees at this stage of training.</td>
<td>Demonstrates a level of knowledge above other trainees at this stage of training.</td>
</tr>
<tr>
<td><strong>MPLT</strong> Does not identify, address or attend to own learning needs. Does not participate in the education of others.</td>
<td>Struggles to identify and/or consistently address own learning needs in a timely way. Peripherally involved in the education of others.</td>
<td>Keeps up to date with immediate clinical learning needs. Contributes to the education of others.</td>
<td>Shows a commitment to professional development through reflection on performance and identification of personal immediate and long term learning needs. Actively seeks out training experiences and opportunities and regularly uses opportunities to teach others.</td>
</tr>
<tr>
<td>MPLT</td>
<td>Unaware and unresponsive to the need to respond to local or national governance changes or new guidelines</td>
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<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td>Approach to other people's beliefs, dignity, preferences and rights adversely affects patient care and/or teamwork.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td>Fails to show willingness to reflect on own attitudes or behaviours and does not demonstrate an ethical dimension in their work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTP</td>
<td>Does not appropriately balance personal and professional demands resulting e.g. in failure to achieve deadlines, or observe contractual obligations. This may include unplanned absences from professional commitments.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| | Demonstrates a limited response to local or national governance or new guidelines |
| | May make comments that are inappropriate or seem to be discriminatory but this does not appear to affect the team or patients. |
| | Demonstration of an ethical dimension to their work is inconsistent. Limited willingness or demonstration of reflection on own attitudes and behaviours. |
| | Needs support to manage the balance between personal, physical or mental illness demands and patient or teamwork especially when under pressure. Attendance at meetings and achievement of deadlines is largely achieved. |

| | Changes behaviour in response to the organisation's clinical governance activities but may have limited involvement |
| | Understands the need to treat everyone with respect for their differences, beliefs, dignity preferences, and rights and does not discriminate. |
| | Demonstrates an understanding of ethical principles and reflects on own attitudes and behaviours. |
| | Aware that personal physical or mental illness, or habits may interfere with the competent delivery of patient care even when under pressure. Manages to attend meetings and deadlines consistently. |
| | Responds to complaints or performance issue appropriately. |

| | Personally participates in quality improvement activities or audits and suggests appropriate responses |
| | Demonstrates equality, fairness and respect in their day to day practice. Values and appreciates different cultures and personal attributes in patients and colleagues. |
| | Gives due consideration and reflects on and discusses moral dilemmas encountered in the course of their work. |
| | Addresses personal health issues or habits that impact on their performance as a doctor even when under significant pressure. |
| | Reflects and learns from complaints |
| FTP | Involved in more than one complaint and either fails to respond appropriately or to learn from the experience. Is resistant to feedback that is perceived as critical. | Provides a limited response to complaints though able to improve this with help. | to improve patient care. |
**Trainee performance descriptor**  
**Communication and consulting skills**

Includes communication with patients, establishing patient rapport, managing challenging consultations, third-party consulting, the use of interpreters  

*Capability: Communication and consultation skills*

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not establish rapport with patients.</td>
<td>Rapport is only intermittently established.</td>
<td>Rapport is established with almost all patients.</td>
<td>Achieves excellent rapport with patients.</td>
</tr>
<tr>
<td>Consultations are disorganised/long &amp; lack structure.</td>
<td>Consultations take longer than peers and may lack focus.</td>
<td>Consults in an organised and structured way.</td>
<td>Responds to the preferences of the patient achieving an effective consultation.</td>
</tr>
<tr>
<td>Explanations are confusing or unclear and / or medically inaccurate.</td>
<td>Explanations are inappropriately doctor-centred but generally medically correct.</td>
<td>Provides explanations that are medically correct but may be doctor-centred.</td>
<td>Offers patient centred explanations.</td>
</tr>
<tr>
<td>Consultations may be chaotic or very formulaic</td>
<td>Consultations are commonly rigid or formulaic.</td>
<td>Consultations are sometimes rigid or formulaic.</td>
<td>Language and consultation are fluent, adapted to the needs and characteristics of the patient.</td>
</tr>
<tr>
<td>Does not treat patients with adequate attention, sensitivity or respect for</td>
<td>Treats patients with some sensitivity and respect but the trainee regularly does not</td>
<td>Shows sensitivity and tries to involve the patient.</td>
<td>Shows sensitivity, actively shares ideas and may empower the patient.</td>
</tr>
<tr>
<td>their contribution.</td>
<td>sufficiently facilitate or respond to the patients' contribution.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainee performance descriptor</td>
<td>Working with colleagues and in teams</td>
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</tr>
<tr>
<td>Includes working effectively with others, sharing information with colleagues, leadership, management and team-working skills</td>
<td>Capabilities: Working with colleagues and in team, Organisation Management and Leadership (OML)</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Working with colleagues</strong></td>
<td>Routinely works in isolation giving little support to team members.</td>
<td>May sometimes work on own without appropriate involvement of the team.</td>
<td>Works effectively in a team rather than in isolation.</td>
</tr>
<tr>
<td><strong>Working with Colleagues</strong></td>
<td>Doesn't appreciate the value of the team. Inappropriately leaves their work for others to pick up</td>
<td>Respects other team members and their contribution but has yet to grasp the advantages of harnessing the potential within the team. Completes work identified as their own adequately.</td>
<td>Respects and understands other team members, their roles and contributions.</td>
</tr>
<tr>
<td><strong>Working with Colleagues</strong></td>
<td>Communication with others in the team is incomplete or late (or haphazard) impacting on patients and colleagues.</td>
<td>May fail to communicate constructively or in a timely fashion with others in the team though generally this does not affect patient care.</td>
<td>Responds to communications from other team members in a timely and constructive manner.</td>
</tr>
</tbody>
</table>
| **OML** Lack of Organisation of self and others, time-management and hand over skills has clear negative effects and / or create problems for colleagues or patients. e.g. regularly or consistently being late for shifts, not advising of lateness or sickness, failing to complete tasks required or failing to respond to emails. | Organisation of self and others, time-management and hand over skills may be limited and impact on colleagues and patients. | Organisation of self and others, time-management and hand over skills are sufficient that patients and colleagues are not unreasonably inconvenienced or come to any harm. | Is consistently well organised with due consideration for colleagues as well as patients. Demonstrates effective:

- Time-management
- Hand-over skills
- Prioritisation
- Delegation. |
Trainee performance descriptor
Clinical assessment

Includes patient history, Clinical Examination and Procedural Skills choosing investigations, and making an appropriate diagnosis or decision. Please also comment on clinical skills that have been observed Capabilities: Data Gathering (DG), Clinical Examination and Procedural Skills (CEPS), Making a diagnosis / decisions (Diagnosis)

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DG</strong> Has an approach to information gathering which is disorganised, chaotic, inflexible or inefficient.</td>
<td><strong>DG</strong> Accumulates a mixture of relevant and irrelevant information from the patient.</td>
<td><strong>DG</strong> Accumulates information from the patient that is mainly relevant to their problem.</td>
<td><strong>DG</strong> Systematically gathers information, using questions appropriately targeted to the problem.</td>
</tr>
<tr>
<td><strong>DG/CEPS</strong> Examination and/or investigation is not planned with a clear relevance to the history or situation.</td>
<td><strong>DG/CEPS</strong> Examines and/or investigates patient but with inconsistent relevance to the patient’s problem.</td>
<td><strong>DG/CEPS</strong> Chooses examinations and investigations broadly appropriate for the patient’s problem.</td>
<td><strong>DG/CEPS</strong> Chooses examinations and investigations targeted to the patient’s problem.</td>
</tr>
<tr>
<td><strong>CEPS</strong> Fails to identify or examine for significant physical or psychological signs and examination technique is technically incompetent.</td>
<td><strong>CEPS</strong> Misses some abnormal signs or fails to recognise the significance of signs they identify. Examination technique is some of the time technically proficient.</td>
<td><strong>CEPS</strong> Identifies common abnormal signs and recognises their significance. Examination technique may not be fluent but is technically proficient.</td>
<td><strong>CEPS</strong> Has a flexible &amp; organised approach to examination and interprets physical signs accurately.</td>
</tr>
<tr>
<td><strong>CEPS</strong> Fails to obtain informed consent for examinations or procedures.</td>
<td><strong>CEPS</strong> May fail to explain the need or process of the examination.</td>
<td><strong>CEPS</strong> Performs procedures/examinations with the patient’s consent.</td>
<td><strong>CEPS</strong> Fluently incorporates consent for examination, assessment of mental capacity and other</td>
</tr>
<tr>
<td><strong>Diagnosis</strong> Struggles to provide an</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

152
<table>
<thead>
<tr>
<th>Appropriate differential diagnosis. Fails to consider serious possibilities and fails to review in the light of new information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generates a limited differential diagnosis or one that is poorly focused around the problem (but covers serious possibilities). At times may not ask for help when should or asks too often. May struggle to work independently</td>
</tr>
<tr>
<td>Generates and tests out an adequate differential diagnosis. Asks for help appropriately but may not progress to making independent decisions.</td>
</tr>
<tr>
<td>Medico-legal issues into consultations. Generates a differential diagnosis clearly and flexibly, integrating available information. Owns their own decisions whilst being aware of their limitations</td>
</tr>
</tbody>
</table>
**Trainee performance descriptor**

**Management of Patients**

Includes recognition and appropriate management of medical conditions encountered in the role, prescribing safely, and taking account of co-morbidity, poly-pharmacy. Managing uncertainty & risk

**Capabilities: Clinical management, (Clinical Mx), Medical complexity**

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Mx</strong> Struggles to think of management options.</td>
<td>Uses appropriate but limited management options. Makes suggestions for prescribing but without considering interactions or side effects. May make some prescribing errors. Referral pathways are followed inconsistently. Tentatively or hesitantly identifies or responds to medical emergencies and may struggle to</td>
<td>Uses appropriate management options but may not include all options. Makes safe prescribing decisions, routinely checking on drug interactions and side effects.</td>
<td>Varies a good range of management options responsively. Prescribes safely including applying local and national guidelines and uses drug and non-drug therapies appropriately. Refers safely and appropriately considering all available resources. Responds rapidly and skilfully to emergencies with appropriate follow up. Ensures care is coordinated with other services.</td>
</tr>
<tr>
<td><strong>Clinical Mx</strong> Prescribing decisions are commonly not safe; or not based on guidelines. Side effects and interactions are commonly neglected. <strong>Clinical Mx</strong> Ignores or are unaware of appropriate referral pathways. <strong>Clinical Mx</strong> Fails to identify or respond to emergencies safely or may fail to work collaboratively in this setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Mx</td>
<td>Does not safety net appropriately</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Complexity</strong></td>
<td>Unable to contribute in complex or uncertain situations. Finds it difficult to suggest a way forward in unfamiliar circumstances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Complexity</strong></td>
<td>Does not consider the impact of the patient's lifestyle on their health or the problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Complexity</strong></td>
<td>Does not prioritise management options based on patient risk, and or inappropriately burdens the patient with uncertainty.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| | engage the rest of the team. |
| | Uses safety netting intermittently. |
| | Manages problems in isolation and does not take into account the impact or effect of other conditions. |
| | Limited consideration on the impact of patient's lifestyle on their health or the problem. |
| | Management options are restricted due to poor prioritisation of patient risk. |

| | services. |
| | Safety nets appropriately. |
| | Manages acute and chronic health problems with some consideration of the implications of co-morbidity. |
| | Considers the impact of patient’s lifestyle on their health. |
| | Makes adequate attempts to prioritise management options based on their assessment of patient risk. |

<p>| | Excellent use of safety netting |
| | Simultaneously manages the patient's health problems, both acute and chronic. |
| | Integrates patient's lifestyle into suggested approaches. |
| | Communicates risk effectively to patients and involves them appropriately in its management. |</p>
<table>
<thead>
<tr>
<th>Trainee performance descriptor</th>
<th>Clinical record-keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes showing an appropriate use of administration systems, effective and appropriate record-keeping and use of IT for the benefit of patient care.</td>
<td>Capability: Organisation Management and Leadership (OML)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation, management and leadership. Records may miss important information for safe patient care or be long and/or poorly organised making retrieval of key information hard. Recording may contain inaccuracies or is not contemporaneous.</td>
<td>Records do not consistently meet the normal standards for the organisation.</td>
<td>Routinely records each patient contact, in a timely manner following the record-keeping standards of their organisation.</td>
<td>Produces records that are timely, succinct, comprehensive, appropriately coded and in line with good practice.</td>
</tr>
</tbody>
</table>
Trainee performance descriptor

Context of care

Includes seeking to understand and support patients through an appreciation of the interplay between their disease and their lives and considering local pathways, formularies and resources.

*Capabilities: Holistic care (HC), Community orientation (CO)*

<table>
<thead>
<tr>
<th>Significantly Below expectations</th>
<th>Below expectations</th>
<th>Meets expectations</th>
<th>Above expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Holistic Care</strong> Does not adequately recognise the impact of the problem on the patient nor enquire into the physical, psychological and social aspects of the patient's problem.</td>
<td>Recognises the impact of the problem on the patient and enquires into physical, psychological and social aspects of the patient's problem.</td>
<td>Recognises the impact of the problem on the patient, their family and/or carers and demonstrates understanding of the patient in relation to their socio-economic and cultural background. The doctor uses this understanding to inform discussion and to generate practical suggestions for the management of the patient.</td>
<td>Recognises and shows understanding of the limits of the doctor's ability to intervene in the holistic care of the patient and accesses information about the patient's psycho-social history in a fluent and non-judgemental manner that puts the patient at ease.</td>
</tr>
<tr>
<td><strong>Community Orientation</strong> Limited understanding of the importance of the local population and available services locally.</td>
<td>Understands the important characteristics of the local population, with some understanding of the services available locally.</td>
<td>Understands how the characteristics of the local population shapes the provision of care in the setting in which the doctor is working.</td>
<td>Takes an active part in helping to develop services in their workplace or locality that are relevant to the local population.</td>
</tr>
</tbody>
</table>
Appendix C - Worked examples for new log entries/evidence tools

Clinical case review

Example 1:

Title: Tele-text Telephone Consultation

Date: xx yy zz

Setting: General Practice

Brief description:
During a duty day I noticed VH, an elderly gentleman was on the list requesting a call back. The telephone number had a code in front of it. I was aware VH was very hard of hearing. The telephone number took me through a text telephone service. I witnessed the use of the text telephone system and conveyed my questions via an operator. VH in turn answered the questions. VH was concerned he may have had a recurrence of his piles and was keen for something to help. We had a brief conversation on the telephone. I became acutely aware that I needed to ask short and simple questions that could be conveyed via a text. Having never seen VH with a similar problem, nor could I see a recent documentation of treatment for haemorrhoids and that it was harder to communicate over the telephone I arranged to see him to further assess face to face.

Clinical Experience Groups (max 2):
- People with vulnerabilities (for example veterans, addictions, mental capacity difficulties, safeguarding issues, and those with communication difficulties)
- People with long-term conditions and disability

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Communication and consultation skills
Justification [describe how your actions and approach link to the capability]: It was interesting to experience the text telephone system. I have now had experience of using a different communication modality. I was able to adapt the language that I used to take into consideration his individual needs. I was able to manage the consultation effectively with the patient through using the text telephone interpreter, which required me to be organized and structured.

Supervisor:
You adapted the language you used to take into consideration the communication difficulties. Your questioning style was adapted to allow for the tele-text service, using an 'interpreter'. Additional consideration to what you asked and explained to the patient was needed due to the way the information was conveyed to the patient.

Reflection and learning needs
Reflection: what will I maintain, improve or stop? [Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]
When asking questions via an operator it is important to be precise with the questions to. It made me consider the importance of each question I asked to discriminate what the underlying problem was. I felt it was clinically appropriate to ask VH to come to the surgery for a further assessment. For some patients it is appropriate to take a full history over the telephone however for others, it is more appropriate and easier to take full history face to face such as this patient. I will continue to build up my experience of using the text telephone system as well as improving communication with patients using different modalities. Overall I felt this telephone consultation and the process of the consultation was successful.

Learning needs identified from this event
I would like to gain experience of using a translation telephone line (something we don't use regularly in my current practice). I would also like to develop further strategies to communicate effectively with patients who have a loss of hearing – should they present alone, or with a signer.

Supervisor comment
I'm really glad that you have used this service and found ways to adapt to make it useful for you and the patient. Your capability link here look very appropriate and I’ve confirmed this. In this situation the offer to use a text telephone service came from the patient who had given this number to the practice. Have you considered how you as a team might encourage use of this service? The newer texting service which allows patients to respond with text/pictures may also be of benefit to patients who have communication difficulties (you could reflect on the Organisation, Management and Leadership capability!)

Example 2:

**Title:** Reflection on on-call shift

**Date:** xx yy zz

**Setting:** Other: out of hours psychiatry hospital setting

**Brief description:**
I worked a busy weekend on call covering general psychiatry over several hospital sites.

**Clinical Experience Groups (max 2):**
- Mental health (including addition, alcohol and substance misuse)
- Urgent and unscheduled care

**Capabilities that this entry provides evidence for** (you can only add 3 capabilities)

**Capability:** Working with colleagues and in teams
**Justification (describe how your actions and approach link to the capability):** I find that during on calls you have to use a very particular type of team working skills, as you have to create a mini, instant team for the on calls without knowing who is going to be in the team in advance. The same doctors do nights and days for the weekend, so you hand over to them at the start and end of the shifts, and this continuity is really helpful for patient care. Since the pandemic, there has been a meeting every night at 21.30 via skype, which includes the SHOs, registrar, consultant and matron or nurse in charge. It is really helpful to have the nursing
staff represented at the meeting. In one meeting, I discussed a patient who had just become unwell and the meeting meant that the consultant was able to share an experience of Covid19 presenting in a manner like my patient, and the nursing staff being present meant they could immediately go and put the plan we came up with into place, as well as me phoning the nurse directly after the meeting. It facilitated improved patient care.

Supervisor:
The pattern of work during COVID has evolved. You highlight a really positive step of having a remote handover with the whole team present, to deliver efficient, safe patient care. I wonder if this will remain moving forwards.

Capability: Clinical examination and procedural skills
Justification [describe how your actions and approach link to the capability]: I was attended one of the psychiatric hospitals to review a male patient with abdominal pain. In order to assess him I examined him. At the moment, in a psychiatric hospital, this involves reviewing them in a locked treatment room with a nurse present. I also wear PPE with gloves, a mask and apron. I tried to be sensitive to the fact that I knew he was in a lot of pain and very anxious, and that examining his abdomen was likely to be very uncomfortable, but very important as it meant I could elicit signs such as guarding, which added to my concerns about him needing to go to hospital to rule out serious pathology.

Supervisor:
You recognised that the patient was anxious and carried out the examination without causing any harm. Wearing PPE causes additional anxiety for patients, given they can’t always hear what we are saying, and we lose some of our communication by wearing a mask covering a lot of our face.

Capability: Organisation, management and leadership
Justification [describe how your actions and approach link to the capability]: During this busy weekend, I attended Ravenswood Hospital, which is geographically remote and therefore I needed to manage my time well to ensure I did tasks at hospitals which were on my way to Ravenswood. When I arrived, there was a major incident occurring and therefore I could not immediately do the seclusion reviews which I had attended to do. Once I established that there was nothing I could do to help, I asked if there was somewhere I could work, so that whilst I was waiting I could continue to work remotely on my laptop. This allowed me to ensure that the delay did not effect patients which still needed my attention, for example medications prescribing remotely, as I could access their records online and prescribe remotely.

Supervisor:
COVID has enabled much more remote working, with IT being provided, and system in place to enable this, which has benefits to providing safe and timely reviews and care whilst on call. You utilised your time efficiently and prioritised tasks to help manage your time during your on-call shift.

Reflection and learning needs

Reflection: What will I maintain, improve or stop? [Look at the word descriptors. Think what
you would need to change to demonstrate competence or excellence]
I will continue to improve my time management skills during busy working periods. I feel that every job I have done have been busy in different ways and have required me to juggle tasks and prioritise tasks differently. I am now imminently going to be moving to GP and am excited to see how my skills transfer and what new ones I need to learn. The experience of covering multiple different sites has been unique with this job and is extremely challenging at times, when you cannot be everywhere at once. There will also be a different type of team in GP, which I am looking forward to, especially after having quite minimal contact with a team for much of this rotation.

**Learning needs identified from this event**
I am aware that I need to continue to improve my skills in seeing patients in remote of non-clinical environments, for example on home visits. There are parallels with seeing patients with medical problems OOH in a psychiatric hospital with doing home visits, as psychiatric hospitals are not set up for medical emergencies, and is it very limited in terms of what medical problems can be dealt with.

**Supervisor comment:**
COVID has led to us working more closely as a team, working from the same list at times, rather than having our own clinics. We have introduced video consultations which has helped some remote consultations, in addition to using a text service to submit pictures. It is now possible to have an additional clinician/relative join a video call; this will help during the 'shadowing' induction period.
Supporting Documentation (CPD Evidence):

Example 1

Title: CPR update

Date: xx yy zz

Briefly describe your key learning from this event [this could include helping you to maintain existing knowledge and skills]

- Annual CPR update within the practice. Adults 30:2 breaths at a rate of 120 compressions a minute pressing approx. 6cm down. Use of automated defibrillator and bag and mask for giving breaths. Practice administering shocks
- Paediatric – child and baby 15:2
- Anaphylaxis – using auto filled pens with adrenaline
- Choking child and adult recap

Reflection: what will I maintain, improve or stop? [Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]
It is important to practice regularly so that when I need to use the skills I feel confident to do so until further support arrives. I have already experienced the need to use the skills outside the GP practice when someone arrested outside the practice- it feels quite different performing CPR outside the hospital environment. I am aware as I near the end of my GP training that I must ensure when I move to a new practice once qualified that I find out where the emergency bag/equipment is before starting my clinical work. Should I need to double-check any protocols – I am aware all emergency protocols are easily accessible in the BNF as a resource.

What learning needs have you identified?
I am aware as I near the end of my GP training that I must ensure when I move to a new practice once qualified that I find out where the emergency bag/equipment is before starting my clinical work.

Clinical Experience Groups (max 2):
- Urgent and unscheduled care

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Maintaining performance, learning and teaching
Justification: [describe how your actions and approach link to the capability] It is a requirement to complete annual BLS training when qualified. Having recently worked in the acute hospital setting, I have used my resuscitation skills so this was a refresher. I will ensure I remain in date with the mandatory training requirements and seek opportunities to attend appropriate courses.

Supervisor:
You allude to the session being a refresher and that it can feel quite different in real life – especially when outside the hospital setting. I have wanted to set up a few emergency situations in the surgery – as a role play – possibly without too many staff having awareness of this, so we can practice our theoretical knowledge in a more real life setting. Maybe we could set this up as a mini QIP?
**Supervisor comments:**
I'm aware that the bits that I find easy to forget are checking for safety (as you don't practice this with the mannequins) and the paediatric rescue breaths.

You have suggested links to working with colleagues and in teams. Whilst I'd agree that this is necessary for effective life support when I look at your entry I can't see evidence that you have reflected on your practice against the word descriptors for this capability. Similarly, this is the case too I'd suggest in relation to clinical management, you have not written about the learning in such a way that a connection has been clearly made I'm afraid so I've not linked to these. (Linking to capabilities is much less commonly appropriate when looking at CPD events rather than at clinical practice as it is hard to demonstrate what you do in a CPD setting.)

**Example 2:**

**Title:** Supporting Documentation entry: Certificate in the Management of Drug Misuse Part 1 RCGP

**Date:** xx yy zz

**Briefly describe your key learning from this event** *[this could include helping you to maintain existing knowledge and skills]*

This course took place online during the pandemic, and was very well run online. It was really useful to hear from others who work or would like to work within substance misuse all over the country. It helped me see the wealth of experience I've gained already doing this post.

**Reflection: what will I maintain, improve or stop?** *[Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]*

I will continue to learn from this placement in substance misuse and ask questions. The course made me more confident in the skills in prescribing methadone and buprenorphine which I've developed already and gave me additional knowledge, for example, I learned that methadone can be up titrated slightly more rapidly than I thought, and that this can actually be desirable - both for the patient's withdrawal symptoms and in terms of getting on top of drug seeking behaviour and drug taking rapidly. Taking about clinical experiences with other attendees on the course made me realise that I am confident prescribing in patients with very chaotic lives and medical histories, and that this type of patient is actually the norm we see here.

**What learning needs have you identified?**
I need to continue to learn about specific times when prescribing is more complex - for example, I have had a few patients recently where the drug taking is actually the secondary issue compared to their alcohol dependence (here methadone prescribing has to be kept to minimal doses) or in pregnancy.

**Clinical Experience Groups (max 2):**
-Mental health (including addition, alcohol and substance misuse)
- People with vulnerabilities (for example veterans, addictions, mental capacity difficulties, safeguarding issues, and those with communication difficulties)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

**Capability:** Clinical Management  
**Justification** [describe how your actions and approach link to the capability]: This course expanded my clinical management skills. I am confident prescribing methadone and buprenorphine within the legal parameters, and in initiating, uptitrating and reducing doses. I am learning more about more complex prescribing situations, such as in pregnancy and in alcohol dependence.

**Supervisor:**
You have gained increased knowledge and confidence in the management of patients on methadone, in particular safe prescribing, particularly amongst specific patient groups, which you can now put into clinical practice.

**Capability:** Organisation, Management and Leadership  
**Justification** [describe how your actions and approach link to the capability]: This course originally should have been a face to face day of teaching in London, however it was moved to online learning because of the pandemic. It ran very smoothly, and I made sure I could access the live teaching via zoom before the start time. There are different considerations to make with teaching moving to online, such as working equipment, speakers and being familiar with the technology. It was a useful experience as it likely that more teaching and courses will be delivered in this manner in the future, which I would welcome.

**Supervisor:**
You have used your time-management skills to complete this certificate, whilst insuring patients and colleagues are not affected during this time out. You have reflected on the adaptations made with remote education/teaching. Within the GP setting, we are using Microsoft teams often for meetings we would previously have attended face to face. I’m aware the GP Half Day release course is currently running a remote teaching programme too, and will be for some time due to COVID. Moving forwards, I think some meetings will remain remote log ons, as this reduces travelling time.

**Capability:** Maintaining performance, learning and teaching  
**Justification** [describe how your actions and approach link to the capability]: Attending this course, which ran online because of the COVID19 pandemic, contributed to my professional development and consolidated learning and experienced gained during this placement in substance misuse. I also recognise that there is more experience I need to gain in the field and will continue to attend supervision and ask questions of my consultant during this placement.

**Supervisor:**
You have accomplished additional learning during your rotation. You have addressed a learning need, and have been able to implement your learning during the remainder of your rotation.

**Supervisor comment:**
You have clearly gained quite a lot of knowledge and experience from this rotation, which is further enhanced by your additional learning. Have you thought if you would want to consider developing a specialist interest, for example exploring options to become a GPwSI?
Learning Event Analysis/Significant Event:

Title: Late diagnosis of pancreatic cancer

Date: xx yy zz

Setting: GP Surgery

What happened, including your role?
An 80-year-old woman with known IBS following full investigation in 2009 presented to the surgery in February with feeling of nausea and gas following bowel movements. She had previously been investigated in 1990s with similar results. She was under the colorectal team and had a planned dilatation of anal stenosis; she had postponed her procedure as she didn't feel up to it following a recent fall. The patient saw a colleague a couple of weeks before I met her for the first time due to her abdominal pain; they ordered bloods and an abdominal USS, which she had had, and was reported as being normal. At the time she reported that she was passing flatus, burping and didn't get any relief from buscopan. She described being off food but not having any weight loss. She admitted to being under stress recently, she thought nortriptyline was working. Examination revealed some epigastric tenderness but no guarding/rebound tenderness, and normal bowel sounds. I suggested that she trialed omeprazole, continued paracetamol, considered amitriptyline which had worked before, and to contact the colorectal surgeons. I safety netted advising to return depending on response to medication and symptoms. The patient had a subsequent fall, and was seen by the falls service, who assessed her, and didn't find anything untoward on abdominal examination. A subsequent CT scan (arranged by the Gastroenterology team) showed a pancreatic cancer with liver mets the same day, despite a normal reported USS within the last month, and normal bloods 5 weeks before the scan. Unfortunately, the patient deteriorated quickly and passed away in the local hospice 2 weeks after initial cancer diagnosis. The family reported the hospice were very caring, and that the patient had a peaceful death.

Why did it happen?
There was a quick deterioration in patients' condition. The patient had normal blood tests and ultrasound scan the day I saw her in clinic. The patient had been seen by a geriatrician, and the emergency department team and a colleague in the surgery when she had a fall in the interim between my review of her abdomen and the diagnosis. No abnormality was detected on USS; I wonder if the USS was reviewed again if it may show early signs of abdominal pathology.

What was done well? [describe your personal involvement]
I felt I made an appropriate assessment of the patient the one time I saw her. I took a thorough history, checking for red flags. I examined her, and made an appropriate management plan given the information that I had at the time. I also safety netted appropriately. I had also encouraged involvement of secondary care colleagues who were already involved in the patients care, to provide an additional level of assessment. My colleagues promptly referred to oncology/the palliative care team, as well as involving the community nursing team. Good communication with the patient's husband and family took place throughout the diagnosis and subsequent management, including proactive home visits being arranged.

What could be done differently? [describe your personal involvement]
I feel given the information I had at the time when I reviewed the patient that I would not
have changed my management plan and advice. I am unsure if the pancreatic cancer was very aggressive and that it was undetectable at the time of the ultrasound scan.

Who was involved in the discussion of the event?
The registered GP and one of my colleagues were closely involved in the care of the patient after the diagnosis. The registered GP wrote to inform both the ultrasonographer and the geriatrician the outcome of the CT scan to enable them to reflect on their assessments.

What have you and the team learnt?
This case highlights that pancreatic cancer can often present late. It often has non-specific symptoms. At times an USS can be unreliable, and falsely reassuring. I will consider pancreatic pathology within my differential when seeing a patient with abdominal pain.

What changes have you or the organisation made? [As a consequence of this learning event]
We have discussed the patient's care within the surgery and reviewed the notes to see if we could have done anything different to improve the quality and safety of care of patient's in my practice, which we concluded we couldn't.

Does this learning event meet the threshold for reporting as a Significant Event for revalidation purposes on the Form R in England, Wales & Northern Ireland (and on the SOAR declaration in Scotland)?: No

Clinical Experience Groups (max 2):
- People with long-term conditions including cancer, multi-morbidity and disability
- Older adults including frailty and/or people at end of life

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Data gathering and interpretation
Justification [describe how your actions and approach link to the capability]: I systematically gathered information, targeting my examination. I utilised the investigations and imaging that was available to me at the time, taking a stepwise approach, however this in the end was misleading, as the blood test and ultrasound were normal however the patient ended up having the diagnosis of pancreatic cancer with liver metastasis.

Supervisor: You tried to take a stepwise approach to this patients' care. The blood test and USS were falsely reassuring, as was the additional reviews away from the surgery.

Capability: Making a diagnosis and making decisions
Justification [describe how your actions and approach link to the capability]: I had reviewed previous letters/secondary care reviews and built on my examination findings to suggest that the patient might benefit from trying a PPI, however with a CT scan eventually, a diagnosis of pancreatic cancer as made, which sadly is often a late diagnosis as it presents with non-specific symptoms initially. Unfortunately, blood tests can sometimes be falsely reassuring.
Supervisor: The pancreatic cancer presented in quite an undifferentiated way, which unfortunately it often does. You correctly highlight tests can sometimes be falsely reassuring – a limitation of pattern recognition. Both yourself and the practice reflected on this case and the patients’ journey.

**Capability:** Clinical management

**Justification** *(describe how your actions and approach link to the capability)*: I had attempted to take an incremental approach to the management and tried to remain patient centred throughout. I safety netted when seeing the patient, and she had clearly followed colleague’s safety netting advice as she had re-presented. We discussed this patients’ care within the practice as a significant event, given the normal investigations that were reported just a short time before the cancer diagnosis.

Supervisor: You took a step-wise approach to this case. The patient had been referred to secondary care already and was actively under their follow up. We have discussed this case and reflected on it both formally and informally.

**Supervisor comments**
This was really difficult for all concerned. It is stressful being involved in the care of people when you might feel you did thing badly... you might like to reflect in the ePortfolio about the emotional challenges of this case, ( F to P elements here). Though we have talked about it and you assure me that you feel fine.
Reflection on Feedback:

Title A verbal compliment

Date: xx yy zz

Brief description
A patient, JS booked to seem me about her allergic rhinitis. Previously she had told me about her negative experiences of our local hospital. JS had recently been referred by a colleague via a 2-week wait proforma for a breast lump she had detected. JS managed to go to the appointment however she was fairly sure she was going to be told bad news at her follow up appointment and was unsure whether she could go back to the hospital. She knew she was unable to have surgery at the local hospital following the experiences she had witnessed through the care of her late mother, sister and brother in law. JS approached me to ask what she should do. She had private health insurance that would cover her to have her operation privately. I respected her views and explained there was no specific reason why she needed to be treated in the local hospital. I agreed to speak to the team at the hospital to ascertain what the results were and find out how best to change the route of care to private care. I was unable to be told over the telephone what JS was going to be told at her clinic appointment however I clarified with the secretary the process to transfer between NHS and private care and conveyed this information to the patient.

I phoned JS following her appointment to find out what was happening. JS was diagnosed with breast cancer. She was pleased with how she was able to transfer her care to a private team. She was pleased she had managed to go into the local hospital. JS described feeling ‘numb’ and was fairly stunned with the diagnosis of breast cancer. I offered for me to make an appointment for JS to be reviewed in the surgery to talk face to face about the diagnosis. I explained that there would be lots of hospital appointments but wanted to make sure that she felt she could come to the surgery and talk at any stage. JS was grateful for the telephone call and we made an appointment. We talked further at the follow up appointment. I encouraged JS to return to discuss any concerns whenever she wished.

How does this feedback make you feel?
JS was very grateful for the support that I had given her. She was touched that I had bothered telephoning to check how she had got on at the hospital appointment (we had received a fax highlighting the breast cancer diagnosis). For some patients it is helpful to know that we are aware of the diagnosis however they feel they don’t need our support at present as they have other appointments at the hospital. For others it is important to maintain the contact with the GP practice. One telephone call and a possible appointment can go a long way in patient satisfaction.

What are your key learning points?
I felt this was a good example of patient care. The positive response I have received has reiterated the importance of the call to check a patient is OK.

Reflection: what will I maintain, improve or stop? [Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]

Should I meet a similar situation of a new diagnosis I will place importance on contacting the patient. Depending on how well I know the patient I will either telephone the patient, or write to them to highlight that we are aware of the diagnosis and to invite them to come to
the surgery as they feel is appropriate. I will continue to develop communications and links with patients following diagnosis of cancer. I will continue to reflect on my consultations and learn from colleague's experiences in the context of breaking bad news/checking understanding following breaking bad news and providing appropriate support.

**What support have you had or require?**
Within my practice all partners try to contact patients once they have received notification of a cancer diagnosis. Should I not be able to make telephone contact with a patient, I will explore the options for sending a carefully worded letter to the patient to let them know they can contact the surgery as required.

**Have you taken your plans to your PDP? No**

**How will you re-assess/monitor improvements?**
I will reflect on formal patient feedback via my PSQ which I will undertake in the next 2 months.

**Clinical Experience Groups (max 2):**
- People with long-term conditions including cancer, multi-morbidity and disability
- Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast)

**Capabilities that this entry provides evidence for** (you can only add 3 capabilities)

**Capability:** Practising holistically and promoting health  
**Justification** [describe how your actions and approach link to the capability]: I understood the patients problem, with patients reported concerns about the local hospital, following the death of her late mother. I worked with the patient to find a agreeable and practical solution to her concerns and aimed to support her through a difficult time of her breast cancer diagnosis.

**Supervisor:** You clearly put the patient at ease during your consultations. You remained non-judgemental when the patient told you about her previous experiences of the hospital. We of course can't comment on previous care provided by colleagues as we don't have all the facts.

**Capability:** Communication and consultation skills  
**Justification** [describe how your actions and approach link to the capability]: I was able to explore and respond to this patients’ preferences and agenda and work with her to negotiate a mutually acceptable plan, creating a positive, supportive relationship with the patient.

**Supervisor:** We have previously talked about how taking the time to contact a patient is often greatly appreciated. When seeing the patient face to face you were able to use both verbal and non-verbal communication including active listening to elicit the patients concerns, build rapport and help her feel comfortable during the consultations.

**Supervisor comments:**
It’s great when you get positive feedback like this; well done. You have described what you did to achieve this and clearly demonstrate communication skills and holistic care here. Do try and keep the brief description brief – using this box to contextualise the entry, and channel your energy into the reflective boxes.
If you had wanted to take this further there are some interesting Community Orientation elements here (effective MDTs in a private setting, why not use another local hospital through choose and book) follow up implications of being out of NHS system) and some ethical and Fitness to practice ones too as you juggle the patient's needs and beliefs and your own ones... possibly for another time though!
Leadership, management and professionalism:

Title: Chairing a Meeting

Date: xx yy zz

State your role in relation to the activity:
I chaired the palliative care Gold Standards Framework (GSF) Meeting

People present at meeting: Secretary (taking minutes), community nurse representative, palliative care nurse attached to practice, assistant practice manager, all doctors present on day of meeting (GP partners and Foundation doctor in GP)

How did you approach this activity? [what planning you undertook for the activity]
Prior to the meeting the assistant practice manager had put together an agenda, we have a process in the practice to update a spreadsheet before the meeting with all patients on the GSF – outlining when they were last seen, any current problems and whether we have proactively involved the relevant health care professionals and had advanced planning discussions. This forms the list of patients that are discussed. From this information – which is shared with the external visitors, the chair can then look at patient notes to complement the discussion taking place. I made sure I familiarised myself with the list prior to the meeting.

How did you demonstrate your ability to work with others? [For example, how did you demonstrate your ability to work with colleagues, patients, learners and/or users (individually or in teams)?]
I have looked after a couple of the patients on the list but I did not know all the patients well. During the meeting, whilst acting as the chair, it was important to allow all health care professionals to share their involvement with the patients (including the GP partners), to ensure everyone was aware of the patient’s current situation and allow a management plan to be constructed as appropriate. I was conscious of the need to keep to time – as we had a predefined time for the meeting, and needed to ensure all patients had adequate discussion. If we went off topic, I was able to guide the team back to the aim of the meeting. I was able to communicate with all the team members in the room, rather than getting bogged down looking at the computer too much. All team members knew what they needed to do for each patient following the meeting.

How effective were you within this role? [Reflect on your achievements and feedback received]
I think I was effective in this role. I accomplished the task of chairing the meeting, keeping within the time frame we had without any major problems. My trainer fed back afterwards that she was impressed with how I managed to keep to time, allowing all the different health care providers to share their information. As a GP trainee, it was helpful to be given the opportunity to chair the meeting in a safe environment – something I was slightly anxious about doing before, as historically this has been undertaken by the senior partner.

Reflection: what will I maintain, improve or stop? [Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]
This experience has given me confidence in my ability to chair a meeting and take on more leadership roles, even as a trainee. It was important that I was prepared for the meeting – ensuring I had all the information to hand, whilst working with the secretary/assistant practice manager to ensure all team members had been invited and knew when and where to
meet in addition to having the correct paperwork to hand. I believe in proactive care for patients who have a terminal diagnosis. This meeting reinforced the importance of good clinical care and good communication.

I will continue to take opportunities to chair meetings within the practice to develop these important leadership skills, which I will need once qualified. This meeting has given me confidence in my abilities; I will have more courage in my conviction when I am given the opportunity to chair a meeting. I will try to stop worrying about the meeting in anticipation of it taking place!

What have you learnt about yourself? [Consider what motivates you, your core beliefs and areas to develop]
I need to have faith in my abilities a little more when chairing a meeting, gaining confidence in my skills as a chair. I have also learnt that I have a keen interest in palliative care – striving for proactive care, tailored to patients’ needs and wishes. This is an area I would like to specialise in (within a practice) once I qualify.

Clinical Experience Groups (max 2):
- People with long-term conditions including cancer, multi-morbidity and disability

Capabilities that this entry provides evidence for (you can only add 3 capabilities)
Capability: Organisation, management and leadership
Capability: Working with colleagues and in teams

Supervisor comments:
Clearly a very effective meeting, I wish I could have been there. Did you have any or the senior members of the team trying to take over and run things... or dominating the meeting (hopefully not!)? Did you have plans on how to manage these behaviours?
QIA Reflective Log:

Title: Visual acuity charts in the surgery

Date: xx yy zz

Brief description of QIA [Be explicit about your role and the extent of your contribution]
I conducted a small quality improvement project in the surgery looking at how the GPs use their visual acuity chart. I undertook the QIA with my supervisor overseeing me. I proposed the idea to the GP partners at their clinical meeting and shared my findings with the team.

What were you trying to accomplish? [This could include a statement of the problem, a brief summary of relevant literature or guidelines, relevant context, and the priority areas for improvement]
As a trainee I often move between consulting rooms. I recently saw a patient who had described an acute deterioration in vision. I realised the room I was in didn't have an easy set up for recording visual acuity. On making my referral to hospital I was asked what the visual acuity was for the patient. I wasn't able to give an accurate reading. I wanted to ensure all rooms had an appropriate and accurate visual acuity chart in the clinical consulting rooms. I was keen to put the theory of the PDSA cycle that I have read about into practice – plan - do - study – act.

How will we know that a change is an improvement? [What information/data did you gather – baseline and subsequent data?]
I collected data before I made any changes to aim to demonstrate an improvement. I asked each clinician how they measured visual acuity in their consulting room. I measured the distance from the point they measured from and the chart. I subsequently asked the clinicians once I had measured the accurate distance from the visual acuity chart and put a mark on the floor to signify the distance (having got support and agreement from the partners that they were happy with this suggestion). No clinicians measured visual acuity correctly at the correct distance initially, following my intervention all clinicians correctly measured visual acuity.

How have you engaged with others? [For example, the team, patients and other stakeholders?]
All the clinical team were on board to have an accurate way to measure visual acuity to aid assessment and referrals. On raising the problem at the clinical meeting, the clinical team were keen to make a change. This in turn allows better patient care with an accurate clinical assessment. Marking the floors did not require input from anyone else and minimally disrupts how the room looks, and does not affect the cleaning of the rooms.

What changes have taken place? [What changes have taken place as a result of your work? How will these be maintained? If improvement was not achieved, explain why]
A marker is in place marking out an appropriate distance to measure visual acuity in each clinical room. The marker is fairly permanent. Should it wear off, it is easy to re-apply.

Reflection: what will I maintain, improve or stop? [Look at the word descriptors. Think what you would need to change to demonstrate competence or excellence]
This QIA demonstrated it is easy to make improvements within the practice. I have also shared some of the QI methodology with colleagues in the practice. I will continue to undertake QIA in the GP setting. I am keen to develop my understanding of other QI tools and approaches. I would like to integrate a different approach with the next QIA I undertake.
I will stop worrying that QIA means a big project, and embrace the methodology to make more improvements within not only my training practice, but also in the practices I work in once qualifying.

Clinical Experience Groups (max 2):
- Clinical problems not linked to a specific clinical experience group

Capabilities that this entry provides evidence for (you can only add 3 capabilities)
Capability: Working with colleagues and in teams
Capability: Maintaining performance, learning and teaching
Capability: Organisation, management and leadership

Supervisor comment:
This was simple, but a small step in the right direction for the practice. Did you also check that there was enough light on the chart when testing the acuity?
Prescribing trainee assessment reflection

Title: Prescribing assessment reflection

Date: xx yy zz

I confirm that I have completed a review of 50 of my prescriptions in line with the RCGP WPBA prescribing assessment guidelines and have attached my anonymised spreadsheet of results to this log: Yes

Reflect with reference to the 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 people 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.

What do you plan to maintain with regard to your prescribing? [Reflect on what you are doing well]
I hope to maintain a high quality of safe, appropriate and accurate prescribing going forwards. I feel that I am a safe prescriber and that this is reflected in my assessment. In future, I will continue prescribing in an evidence-based manner using guidelines and best practice. I feel this is demonstrated by appropriate antibiotic and other prescribing (e.g. for acne) in my assessment attached. I did prescribe some medication in my assessment which diverged from guidelines or local policy but it was clear from my documentation (and noted in my Excel document) that this was a conscious decision informed by clinical and individual need - something I am keen to continue ongoing forwards.

What do you plan to improve with regard to your prescribing? [Consider how to improve your suboptimal prescribing]
There are a few key areas in the assessment that were highlighted for improvement. The main area is being mindful when using EMIS pre-populated dosage instructions and editing these where appropriate. I used these in multiple instances but, for instance, often didn't qualify the 'Twice Daily' Naproxen as 'When Required.' Although not a frank error, this isn't best practice and isn't a clear and appropriate instruction. More generally, ensuring clarity with regards to how to take a medication and for how long could be improved going forward.

As an aside, my antibiotic prescribing which was audited was generally good. Despite this, there were some instances where I could have employed delayed prescribing or altered the length of course of antibiotic so it was in line with national guidelines. This is something that I will be more mindful of in the future.

With regards to using unlicensed medications, only one such medication was highlighted (Nifedipine for Oesophageal Spasm). Although I remember discussing it being off license with
the patient, I didn't document this appropriately. This is something I must improve on in the future.

**What do you plan to stop with regard to your prescribing? [Comment on any significant errors]**
From the assessment there wasn't any specific things that I needed to stop outright but, as discussed above, I need to not use the EMIS generated dosage instructions and instead tailor these where appropriate.

**Which of the GP prescribing skills listed above have you not covered (if any) in this assessment? How will you address these?**
Due to the assessment being conducted at the start of the COVID pandemic, there were fewer chronic disease management medications included as part of the assessment. This is due to the nature of the work being carried out during this time in GP. This meant that very few if any of the medications in the assessment required follow up blood tests or similar. This is something, however, that has formed a large part of my practice before COVID and will after COVID and which I will be more aware of as a result of this exercise.

**After saving and submitting this log please go and create a PDP entry using your reflections above.**

**Clinical Experience Groups:**
- Clinical problems not linked to a specific clinical experience group

**Capabilities that this entry provides evidence for** (you can only add 3 capabilities)

**Capability:** Clinical management
**Justification** [describe how your actions and approach link to the capability]: The audit demonstrated my ability to prescribe safely as well as my awareness of local and national prescribing guidelines. In addition, it demonstrated where I actively chose to deviate from these guidelines and why. I feel I was also able to demonstrate elements of empowering patients to manage their own medical problems - giving them leeway to titrate dosages for instance - where appropriate.

**Supervisor**
I agree this review demonstrates that you are a safe prescriber. You are very aware of guidelines and know where to look them up if needed. You have the ability to choose to make decisions outside of these, and can justify when you choose to do so.

**Capability:** Maintaining performance, learning and teaching
**Justification** [describe how your actions and approach link to the capability]: This assessment demonstrates good critical appraisal of my practice and a willingness to grow and improve. Engaging in this process demonstrates good clinical governance and an active approach to seeking feedback. I found it a useful exercise with tangible learning points to take away.

**Supervisor**
You continue to have a great approach to learning and development and are willing to receive feedback which is important for all of us.

**Capability:** Fitness to practice
Justification: This assessment was an exercise in scrutinising my individual prescribing behaviour with a view to improving my prescribing. I feel I have demonstrated a good critical approach and a willingness to improve and change as a result of measures resulting from the assessment.

Supervisor
You have a very thorough approach, and if anything, are more critical of yourself than you need to be. You have high standards which is good and are open to comment and any suggestion of improvement (not that there were many!)

Supervisor comment:
This was an interesting exercise for both of us. It didn't bring up any worrying trends and its affirming to see that you are a safe effective prescriber.
CEPS reflection

Title: Fundoscopy examination

Date: xx yy zz

CEPS performed: [Please be specific, for example prostate examination not just rectal examination or cranial nerve examination not just neurological examination] : Fundoscopy

Reason for CEPS: [State reason for examination or procedural skill performed. Describe physical signs elicited (to include if this was the expected finding): I reviewed a 30 year old woman who presented with headache and was found to have new significantly elevated blood pressure (200/125). I needed to perform fundoscopy to look for signs of retinal haemorrhage or papilloedema (accelerated hypertension). I thought I could see papilloedema so I referred the patient into hospital for further review.

Communication and cultural factors: [reflect on any communication and cultural factors]:
I made sure I clearly explained to the patient what the examination entailed. It was important to assess whether there were any changes in the back of the eye as this might influence the management strategy I took and whether the patient required a hospital admission.

Reflect on any ethical factors: [to include consent]:
As a male doctor, I am aware this is actually quite an intimate examination, as I am required to come very close to the face of a patient in a darkened room. This patient presented alone. I did consider whether I should get a chaperone for this examination.

Self assessment of performance: [to include overall ability and confidence in this type of examination or procedure]:
I find fundoscopy sometimes quite difficult depending on how dilated the pupils are, and how dark I can get my room. I am aware I can dilate the pupils when assessing, however consideration needs to be given as to how the patient arrived at the surgery (I don’t want to prevent them from driving home if they would otherwise be able to!)

Learning needs identified: [How and when will these learning needs be addressed?] Fundoscopy is not as routinely conducted as examining chests, therefore I must ensure that I take each opportunity to practice the skill to help ensure a reliable assessment is made.

Clinical Experience Groups:
- Clinical problems not linked to a specific clinical experience group

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability: Clinical Examination and Procedural skills
Justification [describe how your actions and approach link to the capability]:

Supervisor comment:
You correctly identify that actually fundoscopy could be considered an intimate examination. Appropriate informed consent, and clear documentation of your examination and findings is important. If there was a language barrier, have you thought how you would gain appropriate consent and explain what and how you plan to undertake the examination?
Placement Planning Meeting entry

Title: Clinical supervisor meeting Palliative Care  
Date xx yy zz

What were the main areas discussed?
- My goals for the rotation  
- My background and previous experience of palliative care  
- Educational opportunities including protected study time  
- Pastoral care needs

What learning opportunities were highlighted?
- Regular teaching  
- Opportunity to give teaching  
- Regular small group teaching discussions with clinical supervisor  
- MDTs  
- Ward rounds  
- Opportunity to go into the community

What objectives did you agree on?
- Develop understanding of how the hospice fits into the wider community of services available to patients  
- Develop knowledge and confidence in prescribing palliative drugs  
- Develop communication skills further in discussing end of life to patients and families through observing other clinicians and 'useful phrases'  
- Go on community visits as possible

How do you plan to achieve these objectives?
- Attend teaching and ward rounds  
- Ask questions  
- Complete CBDs and mini CEXes

Clinical Experience Groups: (max 2)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)

Capability:
Justification [describe how your actions and approach link to the capability]:

Supervisor comment:
Sounds like it was a helpful meeting focusing your learning over the next 6 months. We have regular gold standard framework meetings, where we discuss our palliative patients. We have a link palliative care nurse. Maybe you could organise to come with our link nurse to the practice to see how this works from both sides?
How did you approach this task?
I volunteered in 2017 to run the Foundation Investigation Group (FIG) at the local hospital, which was set up by a Geriatrician with the aim of collating and disseminating learning points of Foundation doctor's quality improvement and serious incident (SIRI) investigations. I organise meetings for interested heads of department, clinicians and junior doctors approximately quarterly, and chair these meetings.

As the main task of the group is to try to spread learning points, we have tried to develop systems such as a How To Guide for juniors doing QI/SIRI projects which includes creating a poster. This can then be used in the live learning screens which are being used in the hospital - they were initially used it ITU to good effect.

How did you gather, appraise and interpret available information?
I chair meetings, which I set up and consider the agenda of beforehand. We get given new QI/SIRI projects and have developed an area of the local intranet to 'advertise' these projects to people who may want to complete one. These meetings are a useful way to develop my leadership skills and work on important patient safety issues. Often these QI/SIRI projects are done in isolation and the learning points which are gleaned from them not shared widely enough. The Foundation Investigation Group was developed as a way of overcoming this problem.

What problems did you encounter and how did you solve them?
The meetings are an opportunity to practise my leadership and organisational skills, as I help organise each meeting and chair them. I also answer emails in between meetings and have been invited to sit on other patient safety panels. Chairing meetings involves organisation to decide on an agenda beforehand and good communication skills to listen to ideas and make sure everyone is heard. It’s a good opportunity to utilise a different type of communication skill to that which I use daily on wards; here I'm communicating with doctors of all levels and ages and may other members of the wider multi-disciplinary team including pharmacists, nursing leads and non-clinicians.

Describe any other strengths highlighted by this work?
This group helps share learning points, with the aim to help prevent similar potential patient safety concerns in the future. By a junior doctor chairing the meeting, it might be perceived as less ‘threatening’ than attending the meeting presented by a senior colleague. I hope I have shown others they can take part in similar and make a difference.

What developmental needs are highlighted by this work?
It is important to ensure that the group continues as doctors move through the hospital with different speciality placements. Having reviewed the projects, it might be helpful to re-review them some time after, to check the changes have been properly embedded into the wards.

Clinical Experience Groups: (max 2)

Capabilities that this entry provides evidence for (you can only add 3 capabilities)
**Capability:** Organisation, management and leadership  
**Justification** *describe how your actions and approach link to the capability*: I helped run a group with aimed to support change in my local hospital, by disseminating learning points of QI projects and SIRI investigations. In order to run the meetings effectively, it relied on good time management skills.

**Supervisor:** This is a fantastic opportunity to actively facilitate change in the local organisation. It is good practice to share the learning points from SIRI/QIPs. You were able to integrate IT into this work, developing part of the intranet for sharing this information having discussed it.

**Capability:** Communication and consultation skills  
**Justification** *describe how your actions and approach link to the capability*: I communicated with colleagues from a multidisciplinary team and with doctors both more junior and senior than myself. I used my communication skills to communicate with colleagues rather than with patients.

**Supervisor:** Although not communicating with patients, you needed to communicate with the whole team involved in an organised and structured and timely way, bringing together everyone’s thoughts.

**Capability:** Maintaining performance, learning and teaching  
**Justification** *describe how your actions and approach link to the capability*: I have helped to coordinate disseminating information about quality improvement activities that have taken place in the local hospital, which itself is a quality improvement activity! I chaired the meeting, and sought feedback from my senior colleagues on this experience.

**Supervisor:** You have actively facilitated the development of a multi disciplinary team by chairing this meeting. You were inclusive of the wider team. You continue to go above what we would expect in terms of teaching and learning during your training.

**Supervisor comment:**
What a fantastic learning experience, not only have you gained experience of chairing a meeting, but you have also worked with a multi disciplinary team, and also seen how the reporting systems work in hospital. In the GP setting, we hold regular significant event meetings, reviewing cases. We revisit the outcomes at a later date to check the changes have been imbedded into our working practice. When in GP, you will have other opportunities to chair meetings and get involved in other projects.
Appendix D Case Based Discussion (CbD) Question Generator for Clinical Supervisors when not in General Practice

The trainee should have shared information in advance of the CbD meeting including details of the cases to enable you to prepare well. You should not aim to cover every capability area, concentrating instead on those most relevant to the case you choose. It should be unusual to cover more than four capability areas during a CbD. You should bear in mind the trainee’s request to have evidence for certain capabilities to help them show evidence in all areas from a range of sources for each capability in this review period. The prompts below should generate information related to each capability you choose to address. You don't have to ask every question in each category, but keep exploring until you feel you have enough info to make a decision in relation to the description of the capability in the hyperlink.

Case based discussions should be about what was actually done rather than what the trainee might have done. The cases should be ones which they managed independently. (It is NOT appropriate to have got advice from another colleague for the consultation and then to be assessed on actions which were not independent.)

When in a hospital setting you are rating trainees in comparison to other trainees at the same stage of training or comparable specialist trainees. (Please note this is different to rating GP trainees when in primary care who are rated compared to the expected standard required at the end of training).

Communication and consultation skills - communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consultations and the use of interpreters.

- What questions did you ask to establish what the patient expected to achieve when coming to the hospital. How did you separate these from what the patient thought about his or her health problems?
- Describe what you did or asked to balance the need to be focussed and see enough patients in the department with the need to allow patients to explain things in their way and feel heard.
- How did you adapt your language or communication to suit this patient? [for example the patient might have communication difficulties, have learning difficulties, be working in a second language, or be a child] Please give me examples of things that you said.
- Describe how you used the patient’s health understanding to adapt your language and explanations.
• Describe how you adjusted your medically safe plans to suit the patient’s agenda and desire for inclusion in decision making.
• How did you adjust your consultation to suit this patient given their background and beliefs?
• Describe how you used communication techniques or materials to improve patient understanding.

Practising Holistically - physical, psychological, socio-economic and cultural dimensions; patient’s feelings and thoughts

• What was the patient’s agenda (ideas, concerns and expectations)? How did you elicit their agenda? Why did they present now? What feelings did you explore?
• Did you identify any on-going problems which might have affected this particular complaint?
• What effect did the symptoms have on the patient’s work, family or carers and other parts of their life? (i.e. consider the difference between illness and disease)
• How did the symptoms affect him/her psychosocially? What phrases did you use to elicit these?
• What did you discover about the patient’s culture and background? How did you use this to help advise the patient and their family about the next steps in their care?
• Did you explore the impact it had on other family members, carers or close friends? What did you find? How did you support them?
• What other teams or organisations have become involved in this person’s care? How does this involvement link to the patient’s needs?
• How have you involved the patient (and their carers or family?) in planning their own care?
• How did the patient feel about your choice of treatment? Did this influence your final decision?

Data gathering and interpretation - gathering and using data for clinical judgement, the choice of examination and investigations and their interpretation.

• Tell me about the key findings in this case including duration of symptoms, pattern etc.
• How did you focus on getting this information in the limited time available to you?
• How did you make sure that you gathered enough information to make sure the patient was safe?
• Describe how you kept a balance between keeping focussed and excluding worrying things? (for you and for the patient?)
• How did you use pre-existing information (consultations, summary, letters, investigations) to help formulate your diagnosis/decision?
• Had you gathered any further information about this case from others?
• What bits of information from the history, examination and investigations) did you find helpful in this case? Why? How did you elicit those?
• What examinations and/or investigations did you do? Explain why you did all of these? Were there any abnormalities?
• How did you interpret your findings from your examinations and/or investigations? How did you act on any abnormal or unexpected findings/results?
• I see from the notes that there is no reference to examining... their “chest” for example. Why is it not there?
• What prior knowledge of the patient did you have which affected the outcome of your consultation(s)?
• Tell me about the abnormalities that you have found examining this person and that you found on investigation. Tell me about which bit of the examination were most useful. Can you explain why this was?
• You have described how you gathered your data, how was this adapted for this particular patient?

**Making diagnoses & decisions - conscious, structured approach to decision-making**

• Tell me about the commonest causes locally of these symptoms? How does knowing this help you to care for this patient?
• What is the natural history/pattern of this condition? How does that fit with your findings and your plans for the next steps?
• What differential diagnoses did you consider? What features made each one more or less likely?
• You have suggested that the diagnosis might be x. Which bits of the history and examination made or make you wonder about other diagnoses?
• How did you come to your final working diagnosis? Remind me which bits of the history and examination were instrumental in this?
• When you got the result of the (names particular test) can you explain how it changed the diagnoses that you were considering?
• Did you use any tools, guidelines or frameworks to help you with making the diagnosis? (Which ones?)
• Tell me about how you used time to help you when making decisions here.
• Hospitals have clear guidelines which are easily applied in clear situations. How did you use these when approaching this rather more confusing situation?
• What were your treatment options? Which did you choose? Why this one? Convince me that you made the right choice.
• Did you consider any evidence in your final choice? Tell me about it.
• Did you use any tools, guidelines or frameworks to help you with treatment decisions?

Clinical Management - recognition and management of common medical conditions

• You have described a patient with several different problems. How did you choose which of these to prioritise?
• In what ways could this patient have been followed up. What were the advantages of using the way you have suggested? (What form of follow up did the patient suggest/ want, how did you incorporate this and keep the follow up plan safe?)
• What management options did you consider at the time? Tell me about some of the pros and cons of these options. Did the patient’s preferences or situation affect the management plan? How?
• What made you prescribe x? How did you come to choosing that? What does the evidence say about it? Do you know how much that costs? Why not y which is cheaper and effective? What else is the patient on: did you check for interactions?
• You have described various medications that you have used. What non-drug interventions did you suggest to manage this patient?
• Did you involve or make a referral to anyone else? What was the added value of involving this other team or person? (Considerations here might include use of resources, (including time) but also patient safety, and/or recognition of limits to personal recognition of medical conditions)
• Describe how you monitored the patient’s progress. How did you ensure continuity of care?
• Did you put in place any follow up/review? Why do you want to see them again?

Managing medical complexity - beyond managing straightforward problems, e.g. managing comorbidity, uncertainty & risk, approach to health rather than just illness

• What made this case medically complex? How did you resolve that?
• Were there any areas of uncertainty? What strategies did you use to manage that uncertainty? (e.g. using time)
• There was a lot to coordinate in this consultation – from the acute to the chronic comorbidities. What strategies did you use to coordinate it all?
• The advantages and disadvantages of different options were complex here. How did you explain these to the patient? How do you know that this worked for them?
• In the course of your work with this family (carer or patient network) can you describe the areas where your “medical” training found it hard to adjust to their “patient” perceptions of what should be done? How did you manage these differences? What did you do to address this area?
• Was there a difference of agendas? How did you tackle this? Tell me exactly how you managed to merge agendas.
• Tell me about how you managed the on-going problems that added to the complexity of this case whilst also dealing with the immediate acute problems?
• How did you explain ‘risk’ to the patient? Did you involve them in the risk management? To what extent and how? How did that risk affect your management plan?
• Did you use any health promotion strategies? How did you encourage the patient to e.g. stop smoking/lose weight/go back to work/other rehabilitation and recovery? Can you describe how this fitted into the rest of the discussions you had with this patient?

**Organisation Management and Leadership** - *This is about understanding primary care’s role in the NHS; how teams are managed and the development of clinical leadership skills.*

• Is the trainee’s computer or paper record entry satisfactory? Have any important negatives been left out? Have they captured the patient’s narrative? Is it concise yet thorough?
• Did they use appropriate coding for diagnosis and treatment in line with local expectations or guidance?
• How effective and helpful is the future management plan they have written for their colleagues? What is the trainee’s suggestion on how to improve this?
• Did you use any online information or resources to help you? What? Why? How did this help?
• Describe the ways in which delegation and good time management improved your care of this patient.
• Do you have any suggestions about how your management of this case would have been better if the guidance or organisation in the hospital was different? What suggestions for change can you make based on this experience?
• How did the overall workload of the department affect how you managed this patient?
Working with colleagues and in teams - working effectively for good patient care; sharing information with colleagues

- Did you involve anyone else in this case? Who? Why? How did they help? What skills did they bring that you don't have? (This may be especially relevant when involving Allied Health Professionals.)
- Did you involve any other organisations/agencies in this case? For what purpose?
- Some of the teams that you worked with have been working with this patient before your involvement. How did this affect your role in the wider team caring for this patient?
- What information did you provide with your referral? How did you make sure that this was as useful as possible to the team you referred to?
- How did you ensure you had effective communication with others involved in this particular case?
- If many people/organisations are involved in the case, What do you see as your role considering so many others are already involved in this case? Do so many people need to be involved? Did you do anything to ensure coordination of the overall care to promote more effective team working?
- What steps did you take to ensure continuity of care?

Community orientation - management of health and social care of local community

- You have described the care you and this hospital have given this patient; how would it be different at x Hospital (either more specialist or less specialist than current setting) Can you explain this difference by thinking of the two local populations and the roles of the hospitals?
- Can you tell me about the cost of investigation, treatment and/or referral/care here? How did you consider these when making your decisions?
- How have you have adjusted the care to fit the resources we have here?
- Can you tell me now about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more about these conflicting pressures.
- How did you balance the needs of this patient against the needs of the whole local population?
- What characteristics of the local community impact on this patient's care (epidemiological/social/economic/ethnic)?
- What local health resources are available that you encouraged the patient to access? (e.g. particular clinics that the hospital offers or weight loss/exercise classes)
• You have prescribed a range of different medications. Please tell me more about them concentrating on their costs and the evidence base for their use in this setting?
• Are there any limitations of local healthcare resources that impact on this patient’s care?
• Did this case make you think of any greater social/health care changes/provision we need to consider for our local population? What would we need to do to make this happen?

**Maintaining an ethical approach to practice - ethical practice, integrity, respect for diversity**

Given there is an ethical dimension to all cases (e.g. did you overload or starve the patient of information, involve them too much/little, spend too much time with them (to the loss of other patients) or spend too little):

• Tell me about the ethical aspects of his case? What were they? How did you manage them?
• Did any of your own values attitudes or ethics influence your behaviour this case?
• What particular professional codes of practice did you have to make sure you adhered to in this case? (e.g.in relation to Equality and Diversity issues or those who might perceive themselves as marginalised.)
• Do you think you might have directly/indirectly discriminated and therefore judged this patient because of their x? If not – how did you anticipate it – making sure the patient didn’t feel discriminated against??
• What ethical principles did you use to inform your choice of treatment? How did you ensure the patient had an informed choice in terms of management?
• Was there a need to address confidentiality issues with the patient (e.g. in cases where the patient is a teenager)

**Fitness to practise - awareness own performance, conduct or health, or of others; action taken to protect patients**

• Was there any point in the consultation where you felt out of your depth? How did you define your limits? What did you then do?
• It sounds like this was quite an emotionally charged case. It may have caused some internal feelings. How did you manage or neutralise those to ensure they did not impact on the next patient you had to see?
• Our home or family life can change our behaviour and performance at work. Can you tell me about how your non work life might have affected you, when you were caring for this patient?
• Safety Netting: did you advise on when to come back? Why did you choose this time/ approach? (How did you ensure patient safety?)
• Chaperones: Did you use a chaperone? Tell me more about your decision on this. Was it for your benefit or theirs? (protecting patients, protecting doctors)
• How did you feel after you looked after this patient? How did you care for yourself?
• After the consultation, did you have any thoughts on your performance (include knowledge, skills and your approach to the patient)? Did you have any thoughts on how your performance could have been improved? What were these? Have you made any plans to tackle them? (PUNs and DENs)
• Were there any significant learning issues raised by this consultation (including complaints)? What were they? How did you proceed?
• Did you have any concerns over what any of the previous health care professionals had done? What did you do about it?
• Have you considered ringing your defence organisation for advice? (If relevant to the case) Why did you call them? What did you ask? What did they say?

CEPS - clinical examination and procedural skills

• Which examinations did you do in this case and why each one carried out?
• When you examined this patient, how did you assess his or her x e.g. knee/abdomen etc. What were you intending to gain from assessing x in this level of detail?
• Do you think that your assessment (examination) allowed you to make a definitive assessment; what further assessment might you have done?
• You have explained that you found x when you examined the (part of body). Tell me what this implies to you. What further examination did you do? What was the order of your examination (and your reason for this)?
• You have described doing x examination and then going on to do y. Was it your preference or the patient’s?
• How did you manage the medico-legal aspects of your examination here? (considering informed consent, mental capacity, best interests etc.)
• You have described doing an intimate examination. Tell me how you managed the patient’s needs and care whilst also gaining the clinical information you needed.
• Patients do not always want to have the examinations that a doctor might want to carry out. (How did you manage this difference?)
• Describe how you managed any cultural and ethical issues that arose in this case.
Appendix E Care Assessment Tool which includes Case Based Discussion (CbD) Question Generator for General Practice Supervisors

The trainee should have shared information in advance of the CbD meeting including details of the cases to enable you to prepare well. You should not aim to cover every capability area, concentrating instead on those most relevant to the case you choose. It should be unusual to cover more than four capability areas during a CbD. You should bear in mind the trainee’s request to have evidence for certain capabilities to help them show evidence in all areas from a range of sources for each capability in this review period. The prompts below should generate information related to each capability you choose to address. You don’t have to ask every question in each category, but keep exploring until you feel you have enough info to make a decision in relation to the description of the capability in the hyperlink.

Case based discussions should be about what was actually done rather than what the trainee might have done. Please do not take the trainee down a line of hypothetical exploration or teach during the CbD (please save this for the end of the CbD if appropriate). The cases should be ones which they managed independently. (It is NOT appropriate to have got advice from another colleague for the GP consultation and then to be assessed on actions which were not independent.) For further information on how to conduct a CbD please see the RCGP WPBA website (hyperlink).

When in primary care you are rating trainees compared to the expected standard required at the end of training. (Please note this is different to rating GP trainees in the hospital setting where they are being rated in comparison to other trainees at the same stage of training or comparable specialist trainees).

The grade ‘needs further development’ (NFD) means the trainee has more to learn and does not signify failure overall. A NFD grade is expected for many ST1s and ST2s especially in more complex cases.

Communication and consultation skills - communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consultations and the use of interpreters.

- What questions did you ask to establish what the patient expected to achieve when coming to the GP practice. How did you separate these from what the patient thought about his or her health problems?
• Describe what you did or asked to balance the need to be focussed and keep to your appointment times with the need to allow patients to explain things in their way and feel heard.

• How did you adapt your language or communication to suit this patient? [for example the patient might have communication difficulties, have learning difficulties, be working in a second language, or be a child] Give examples of things that you said.

• Describe how you used the patient's health understanding to adapt your language and explanations.

• Describe how you adjusted your medically safe plans to suit the patient’s agenda and desire for inclusion in decision making.

• How did you adjust your consultation to suit this patient given their background (educational and cultural) and beliefs (health and religious)?

• Describe how you used communication techniques or materials to improve patient understanding.

Practising Holistically - physical, psychological, socio-economic and cultural dimensions; patient’s feelings and thoughts

• What was the patient’s agenda (ideas, concerns and expectations)? How did you elicit their agenda? Why did they present now? What feelings did you explore?

• Did you identify any on-going problems which might have affected this particular complaint?

• What effect did the symptoms have on the patient’s work, family or carers and other parts of their life? (i.e. consider the difference between illness and disease)

• How did the symptoms affect him/her psychosocially? What phrases did you use to elicit these?

• What did you discover about the patient’s culture and background? How did you use this to help advise the patient and their family about the next steps in their care?

• Did you explore the impact it had on other family members, carers or close friends? What did you find? How did you support them?

• What other teams or organisations have become involved in this person’s care? How does this involvement link to the patient’s needs?

• How have you involved the patient (and their carers or family?) in planning their own care?

• How did the patient feel about your choice of treatment? Did this influence your final decision?
• You have described a difference in health beliefs between you and the patient (or their carers / family). How did you address this difference whilst not losing the patient’s trust?

**Data gathering and interpretation** - gathering and using data for clinical judgement, the choice of examination and investigations and their interpretation.

• Tell me about the key findings in this case including duration of symptoms, their pattern or variability etc.
• How did you focus on getting this information in the limited time available to you?
• How did you make sure that you gathered enough information to make sure the patient was safe? How did you exclude red flags? (E.g. How did you carry out a suicidal risk assessment? How did you exclude a brain tumour?)
• Describe how you kept a balance between keeping focussed and excluding worrying things? (for you and for the patient?)
• How did you use pre-existing information (consultations, summary, letters, investigations) to help formulate your diagnosis/decision?
• Had you gathered any further information about this case from others?
• What bits of information from the history, examination and investigations did you find helpful in this case? Why? How did you elicit those?
• What examinations and/or investigations did you do? Explain why did you do all of these.
• How did you interpret your findings from your examinations and/or investigations? How did you act on any abnormal or unexpected findings/results?
• I see from the notes that there is no reference to examining... their "chest" for example. Why is it not there?
• What prior knowledge of the patient did you have which affected the outcome of your consultation(s)?
• Tell me about the abnormalities that you have found examining this person and that you found on investigation. Tell me about which bit of the examination were most useful. Can you explain why this was?
• You have described how you gathered your data, how was this adapted for this particular patient?

**Making diagnoses & decisions** - conscious, structured approach to decision-making

• Tell me about the commonest causes locally of these symptoms? How does knowing this help you to care for this patient?
• What is the natural history/pattern of this condition? How does that fit with your findings and your plans for the next steps?
• What differential diagnoses did you consider? What features made each one more or less likely?
• You have suggested that the diagnosis might be x. Which bits of the history and examination made or make you wonder about other diagnoses?
• How did you come to your final working diagnosis? Remind me which bits of the history and examination were instrumental in this?
• When you got the result of the (names particular test) can you explain how it changed the diagnoses that you were considering?
• Did you use any tools, guidelines or frameworks to help you with making the diagnosis? (Which ones?)
• Your description of the diagnosis was not very clear; describe how you approached defining your next steps.
• Tell me about how you used time to help you when making decisions here.
• What were your treatment options? Which did you choose? Why this one? Convince me that you made the right choice.
• Did you consider any evidence in your final choice? Tell me about it.
• How did you balance your treatment plan with the treatments requested or expected by the patient, their carers or family?
• Did you use any tools, guidelines or frameworks to help you with treatment decisions?
• You have described starting off on one treatment plan. What led to a change in your plan
• How close to the limits of your competence were you in managing this case?
• Primary care has clear national and local guidelines which are easily applied in clear situations. How did you use these when approaching this rather more confusing situation?

Clinical Management - recognition and management of common medical conditions

• You have described a patient with several different problems. How did you choose which of these to prioritise? How did this affect your final management plan?
• In what ways could this patient have been followed up. What were the advantages of using the way you have suggested? (What form of follow up did the patient suggest/ want, how did you incorporate this and keep the follow up plan safe?)
• What management options did you consider at the time? Tell me about some of the pros and cons of these options. Did the patient’s preferences or situation affect the management plan? How?
• What made you prescribe x? How did you come to choosing that? What does the evidence say about it? Do you know how much that costs? Why not y which is cheaper and effective? What else is the patient on: did you check for interactions?
• You have described various medications that you have used. What non-drug interventions did you suggest to manage this patient?
• Did you involve or make a referral to anyone else? What was the added value of involving this other team or person? (Considerations here might include use of resources, (including time) but also patient safety, and/or recognition of limits to personal recognition of medical conditions) What did you put in the referral letter?
• How did you use the practice computer system to communicate with others? (e.g. electronic referrals, messaging, email)
• Describe how you monitored the patient’s progress. How did you ensure continuity of care?
• In what ways could this patient have been followed up? What were the advantages of using the way you have suggested? (What form of follow up did the patient suggest/ want, how did you incorporate this and keep the follow up plan safe?)
• Did you put in place any follow up/review? Why do you want to see them again? How did you decide if you or another doctor should review the patient?

Managing medical complexity - beyond managing straight-forward problems, e.g. managing co-morbidity, uncertainty & risk, approach to health rather than just illness

• What made this case medically complex? How did you resolve that?
• Were there any areas of uncertainty? What strategies did you use to manage that uncertainty? (e.g. using time)
• There was a lot to coordinate in this consultation – from the acute to the chronic comorbidities. What strategies did you use to coordinate it all?
• The advantages and disadvantages of different options were complex here. How did you explain these to the patient? How do you know that this worked for them?
• In the course of your work with this family (carer or patient network) can you describe the areas where your “medical” training found it hard to adjust to their “patient” perceptions of what should be done? How did you manage these differences? What did you do to address this area?
• Was there a difference of agendas? How did you tackle this? Tell me exactly how you managed to merge agendas.
Tell me about how you managed the on-going problems that added to the complexity of this case whilst also dealing with the immediate acute problems?

How did you explain 'risk' to the patient? Did you involve them in the risk management? To what extent and how? How did that risk affect your management plan?

Did you use any health promotion strategies? How did you encourage the patient to e.g. stop smoking/lose weight/go back to work/other rehabilitation and recovery? Can you describe how this fitted into the rest of the discussions you had with this patient?

Organisation Management and Leadership - This is about understanding primary care’s role in the NHS; how teams are managed and the development of clinical leadership skills.

Is the computer record entry satisfactory? Have any important negatives been left out? Have they captured the patient’s narrative? Is it concise yet thorough?

Did you use appropriate Read or SNOMED coding for diagnosis and treatment in line with local expectations or guidance?

Was the consultation entry added in a timely manner?

Describe how you balanced your need to record the consultation on the computer with the need to maintaining rapport with the patient.

How did you use the computer in the consultation (including previous consultations results, letters and on-line resources)?

What steps did you take to keep this consultation to time, whilst ensuring appropriate record keeping. Was the consultation entry added in a timely manner?

How did you balance your need to record the consultation on the computer with the need to maintaining rapport with the patient?

How did you use the computer in the consultation (including previous consultations results, letters and on-line resources)?

How effective and helpful is the future management plan they have written for their colleagues? What is the your suggestion on how to improve this?

Did you use any online information or resources to help you? What? Why? How did this help?

Describe the ways in which delegation and good time management improved your care of this patient.

Do you have any suggestions about how your management of this case would have been better if the guidance or organisation in the GP practice was different? What suggestions for change can you make based on this experience?
• How did the overall workload of the practice affect how you managed this patient?

**Working with colleagues and in teams - working effectively for good patient care; sharing information with colleagues**

• Did you involve anyone else in this case? Who? Why? How did they help? What skills did they bring that you don't have? (This may be especially relevant when involving Allied Health Professionals.)
• Did you involve any other organisations/agencies in this case? For what purpose?
• Some of your colleagues will have been working with this patient before your involvement. How did this affect your role in the wider team caring for this patient?
• What information did you provide with your referral? How did you make sure that this was as useful as possible to the team you referred to?
• How did you ensure you had effective communication with others involved in this particular case?
• *If many people/organisations are involved in the case,* What do you see as your role considering so many others are already involved in this case? Do so many people need to be involved? Did you do anything to ensure coordination of the overall care to promote more effective team working?
• What steps did you take to ensure continuity of care?
• Can you describe what this case tells you about how our team works and the members interact?

**Community orientation - management of health and social care of local community**

• You have described the care you and this GP practice have given this patient; how would it be different in a neighbouring CCG area which has a different population?
• Can you tell me about the cost of investigation, treatment and/or referral/care here? How did you consider these when making your decisions?
• How have you have adjusted the care to fit the resources we have here?
• Tell me now about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more about these conflicting pressures.
• How did you balance the needs of this patient against the needs of the whole local/patient population?
• What characteristics of our local community impact on this patient's care (epidemiological/social/economic/ethnic)?
• What local health resources are available that you encouraged the patient to access? (e.g. particular clinics that the hospital offers or weight loss/exercise classes)
• You have prescribed a range of different medications. Please tell me more about them concentrating on their costs and the evidence base for their use in this setting?
• Are there any limitations of local healthcare resources that impact on this patient’s care?
• Did this case make you think of any greater social/health care changes/provision we need to consider for our local population? What would we need to do to make this happen?

Maintaining an ethical approach to practice - ethical practice, integrity, respect for diversity

Given there is an ethical dimension to all cases (e.g. did you overload or starve the patient of information, involve them too much/little, spend too much time with them (to the loss of other patients) or spend too little):
• Tell me about the ethical aspects of his case? What were they? How did you manage them?
• Did any of your own values attitudes or ethics influence your behaviour this case?
• What particular professional codes of practice did you have to make sure you adhered to in this case? (e.g.in relation to Equality and Diversity issues or those who might perceive themselves as marginalised.)
• Do you think you might have directly/indirectly discriminated and therefore judged this patient because of their x? If not – how did you anticipate it – making sure the patient didn’t feel discriminated against??
• What ethical principles did you use to inform your choice of treatment? How did you ensure the patient had an informed choice in terms of management?
• Was there a need to address confidentiality issues with the patient (e.g. in cases where the patient is a teenager)

Fitness to practise - awareness own performance, conduct or health, or of others; action taken to protect patients

• Was there any point in the consultation where you felt out of your depth? How did you define your limits? What did you then do?
• It sounds like this was quite an emotionally charged case. It may have caused some internal feelings. How did you manage or neutralise those to ensure they did not impact on the next patient you had to see?
• Our home or family life can change our behaviour and performance at work. Can you tell me about how your non-work life might have affected you, when you were caring for this patient?
• Safety Netting: did you advise on when to come back? Why did you choose this time/approach? (How did you ensure patient safety?) Did you use any tools to help with your safety netting e.g. online resources?
• Chaperones: Did you use a chaperone? Tell me more about your decision on this. Was it for your benefit or theirs? (protecting patients, protecting doctors)
• How did you feel after you looked after this patient? How did you care for yourself?
• After the consultation, did you have any thoughts on your performance (include knowledge, skills and your approach to the patient)? Did you have any thoughts on how your performance could have been improved? What were these? Have you made any plans to tackle them? (PUNs and DENs)
• Were there any significant learning issues raised by this consultation? (including complaints). What were they? How did you proceed?
• Did you have any concerns over what one of the previous health care professionals had done? What did you do about it?
• Had you considered ringing your defence organisation for advice? (If relevant to the case) Why did you call them? What did you ask? What did they say?

CEPS - clinical examination and procedural skills

• Which examinations did you do in this case and why each one carried out?
• When you examined this patient, how did you assess his or her x e.g. knee/abdomen etc. What were you intending to gain from assessing x in this level of detail?
• Do you think that your assessment (examination) allowed you to make a definitive assessment; what further assessment might you have done?
• You have explained that you found x when you examined the (part of body). Tell me what this implies to you. What further examination did you do? What was the order of your examination (and your reason for this)?
• You have described doing x examination and then going on to do y. Was it your preference or the patient’s?
• How did you manage the medico-legal aspects of your examination here? (considering informed consent, mental capacity, best interests etc.)
• You have described doing an intimate examination. Tell me how you managed the patient’s needs and care whilst also gaining the clinical information you needed.
• Patients do not always want to have the examinations that a doctor might want to carry out. (How did you manage this difference?)
- Describe how you managed any cultural and ethical issues that arose in this case.

Developed in Dec 2006 by Dr. Ramesh Mehay, Programme Director Bradford VTS (updated April 2010) for the Bradford VTS website www.bradfordvts.co.uk an independent GP site. Further adapted and updated with permission by RCGP WPBA group October 2018)
Appendix F COT: Detailed Guide to the Performance Criteria (PC)

PC1: The doctor is seen to encourage the patient’s contribution at appropriate points in the consultation.

This Performance Criterion is particularly looking for evidence of a doctor’s active listening skills, the ability to use open questions, to avoid unnecessary interruptions, and the use of non-verbal skills, in exploring and clarifying the patient’s agenda.

Remember to think of the competences as active ones. In many consultations there is little need to encourage; the patient comes in and states what the matter is, and the doctor may not necessarily be given credit for that. You should seek for evidence that the doctor can encourage a contribution from a patient when encouragement is needed.

PC2: The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem.

The competence is to respond appropriately to important, significant (in terms of what emerges afterwards) cues.

Take account of non-verbal cues, if these are evident. However, the doctor’s response to a non-verbal cue may either be verbal (commenting that a patient seems upset, worried etc), non-verbal (use of silence) or active (a change in body posture, a touch to the patient, offering the patient a tissue). It is important that you are alert for these responses.

This PC certainly incorporates “rapport” and/or “showing empathy”, and if you notice an empathic response, consider whether it represents a response to a cue (i.e. the “cue” may be explicit, but the emotional significance that is being responded to may be quite subtle).

PC3: The doctor uses appropriate psychological and social information to place the complaint(s) in context.

We expect candidates to consider relevant psychological, social (including occupational) aspects of the problem. These may be known beforehand, or offered spontaneously by the patient, or elicited. The competence is to use the information in exploring the impact of the problem e.g. “how does your backache affect your life as
a builder”. It may also be appropriate to consider how the patient’s lifestyle impacts on the problem.

PC4: The doctor explores the patient’s health understanding.

This PC incorporates exploring the patient’s perspective of the problem (including health beliefs and “ideas, concerns and expectations”). Has (s)he read something on the Internet, been told something…? The competence is the curiosity to find out what the patient really thinks - a cursory “what do you think?” without any response to the answer will not do. But questions like “what did you think was going on..........what would be your worst fear with these symptoms..........were you concerned this was serious...what were you hoping I would do for this condition?” are much more likely to get a valuable response.

PC5: The doctor obtains sufficient information to include or exclude likely relevant significant conditions.

Registrars demonstrate this competence by asking questions around relevant hypotheses. It is important to remember the context of general practice, and especially that registrars are not (usually) specialist-generalists in any field.

This is the medical safety PC, which addresses the focused enquiry that commonly occurs during the consultation, not necessarily at a particular stage: it may happen during an examination, or later, during the explanation, or even as an afterthought.

This is an occasion when closed questions may be the most efficient method of obtaining the information, for example to determine whether or not a patient with headaches might have a serious illness such as raised intracranial pressure. It does not mean that the doctor has to go into every conceivable detail or chase rare diagnoses. Remember that it is part of the element obtain sufficient information about symptoms and details of medical history which in turn is part of defining the clinical problem(s). It is about taking a history in the degree of detail which is compatible with safety but which takes account of the epidemiological realities of general practice.

PC6: The physical/mental examination chosen is likely to confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient’s concern.

The competence will usually be the choice of examination, not the way it is done. Video may not be the best place for that to be assessed - however it may generate discussion. It is still usually possible to hear what examination is being undertaken
and what explanations are being given. A mental state examination would be appropriate in a number of cases. Intimate examination should not be recorded!

**PC7: The doctor appears to make a clinically appropriate working diagnosis.**

Whilst this is included in the consultation summary form there should be evidence on the video of a clinically appropriate diagnosis or hypothesis having been made. On occasions, however, it may not be possible to make a diagnosis, but discussion of what has been ruled out will be important.

**PC8: The doctor explains the problem or diagnosis in appropriate language.**

There must be evidence of an explanation of the patient’s problem. The element states that the findings should be shared with the patient. As educational supervisors we need to judge the quality of the explanation. A short explanation may be enough but it must be relevant, understandable and appropriate. Using diagrams or language aids for non-English-speaking patients may be appropriate.

Excellent registrars will incorporate some or all of the patients' health beliefs - in other words, one that responds to the health beliefs considered in PC4. It is unlikely that this PC could be demonstrated in the absence of PC4. However, on occasion, the patient will volunteer their health belief without prompting.

Essentially it requires a reference back to patient-held ideas during the explanation of the problem/diagnosis.

**PC9: The management plan (including any prescription) is appropriate for the working diagnosis, reflecting a good understanding of modern accepted medical practice.**

It is important that the management plan relates directly to the working diagnosis and must represent good current medical practice. Management must be a safe plan even though it may not be what you would do. Investigations and referral should be reasonable. The prescribed medication (if any) should be safe and reasonable, even if not your preferred choice!

**PC10: The patient is given the opportunity to be involved in significant management decisions.**

This was formerly "sharing management options" - the new version seeks to reward the underlying competence of doctor and patient engaging in shared decision
making. Included in this competence is establishing the conditions for shared decision-making, such as the patient's willingness to be involved (at least a third are unwilling), their ability to take decisions (some are not able), and the evidence-base on which any decisions are being made. The registrar should be rewarded for addressing any of these aspects of the competence: they do not need to take the patient right through to a decision.

PC11: The doctor checks that there is a shared understanding of the diagnosis, management plan, treatment, safety-netting and follow-up arrangements.

Surprisingly high proportions of patients do not understand or remember what their doctors tell them about diagnosis or treatment. Cultural differences may exacerbate this. Uncertainty and lack of information or clear explanation can lead to patient anxiety and dissatisfaction. Feedback from patients suggests that information should not just be ‘given’ but shared and made accessible so that they can enter into a discussion with the GP.

This competence is about ensuring, as appropriate to the individual patient, the accuracy of the patient’s understanding of the diagnosis and management plan. It may be necessary overtly to check the patient’s understanding of red flags and safety netting, or of the follow-up arrangements and attention to medication compliance. A cursory “Is that OK?” or the patient simply nodding is not enough. It must be an active seeking out of the patient’s understanding, agreement and an encouragement to accept appropriate responsibility.

It is essential that this should not be formulaic, but, if it is appropriate with the patient involved, phrases such as “We've covered a lot today, would you mind just running through our plan, so I can be sure we are in agreement?” or “Can I just check how you will take the medication and when?” may be valuable.

PC12: Makes effective use of resources

Time management is important here. Was the consultation completed in 10 minutes? Providing Structure by summarising, signposting and sequencing, Aiding Recall and Understanding by restating, ...all of these are also important techniques. This area will include use of resources to help those with disabilities, for example, or those patients whose first language is not English. Referrals, investigations and follow-up appointments should be appropriate, being mindful of limited resources.
PC13: The doctor specifies the conditions and interval for follow-up or review.

This criterion within the unit Make effective use of the consultation should be straightforward. It should be interpreted broadly, so that any reference to returning (“next week”, “when the tablets run out”, “if not better in a few days”, “see the nurse for a BP check in 1 month”, etc.) may be rewarded.
Appendix G – Word descriptors for QIP marking

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<thead>
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<th>Date *automatically inserted</th>
<th>Feedback</th>
<th>Capability</th>
<th>GPC</th>
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<td>Date *automatically inserted</td>
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<td>Meets expectations</td>
<td>Above expectations</td>
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<tr>
<td>Title is unclear or confusing, or has no significant justification based on links to personal or practice needs.</td>
<td>Clear title which is understandable, and has a link to personal or practice needs.</td>
<td>The title and reasons are clear and are based on an identified practice need or clear personal experience.</td>
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<tr>
<td>There is no reflection on the known guidance or evidence relating to this area. There is no consideration of the impact on patients.</td>
<td>There is reference to some appropriate guidance and/or to evidence.</td>
<td>The guidance and evidence that is identified is appropriate, clear and well chosen (not excessive).</td>
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<tr>
<td>There is consideration of the impact of the QIA on patients.</td>
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<td>The assessment of impact on patients includes reference to prevalence/incidence and severity etc.</td>
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<td></td>
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<td>Assessment of impact considers how teamwork has been made more effective.</td>
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**Project Title and why it was chosen**

*You should explain what trigger (case, data or events) led you to look at this area. You should comment on the likely impact of this on patients, and review the guidance or evidence that is relevant to the area (e.g. a literature review).*

**Project Aim**

*Consider:*

<table>
<thead>
<tr>
<th>The aim is vague with no specific goal or time</th>
<th>The goal set is specific with a clear time frame.</th>
<th>The aim is summarised in a SMART (Specific,</th>
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<td>Maintaining performance, learning and teaching,</td>
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<td>Patient safety and Quality improvement</td>
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</tbody>
</table>

Fitness to practise
Maintaining performance, learning and teaching
Professional values and behaviours
<table>
<thead>
<tr>
<th></th>
<th>Frame.</th>
<th>There is consideration of what is being accomplished or that a suggested change is an improvement.</th>
<th>Measurable, Achievable, Relevant and Time defined) format.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you trying to accomplish?</td>
<td>There is no clear consideration of what is being accomplished or that a suggested change is an improvement.</td>
<td>There is some suggestion that there is a connection with patient safety and/or patient care.</td>
<td>There is clear consideration of what is being accomplished and that a suggested change is an improvement.</td>
</tr>
<tr>
<td>How will you know that a change is an improvement?</td>
<td>It is not clear how the project will improve patient safety or patient care.</td>
<td>It is clear how the project will improve patient safety or patient care.</td>
<td>It is clear how the project will improve patient safety or patient care.</td>
</tr>
<tr>
<td>What change can you make that should result in improvement in patient safety or patient care?</td>
<td>when explaining your Project Aim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe what baseline data or information you gathered</td>
<td>Insufficient information is provided to demonstrate the 'problem' was fully understood prior to the improvement being designed and implemented.</td>
<td>There is enough evidence obtained to demonstrate the 'problem' was fully understood prior to implementing improvements.</td>
<td>The evidence which is obtained is well chosen and may be of different types using a range of QI tools. There is justification of the amount of evidence obtained (i.e. explanation of why there is not more or less evidence). There is clear presentation of the evidence.</td>
</tr>
<tr>
<td>Describe what subsequent data or information you gathered</td>
<td>The data shared is not capable of demonstrating the changes suggested e.g. because of the way it has been collected, or because the data is not appropriate.</td>
<td>The data provided is clear and the evaluation of the data is appropriate and considers other possible causes for the changes observed. Data collection is</td>
<td>The data is well presented; clearly evaluated and well chosen. There is evidence of multiple data collection at appropriate intervals in</td>
</tr>
</tbody>
</table>

**Quality improvement** requires attempting to measure some change, though the nature of the measurement will be different in different projects and some data could be available before the start of your personal involvement.

**Data gathering and interpretation**

**Making a diagnosis or decisions**

**Research and scholarship**

**Patient safety and Quality improvement**
**How did you plan and test out your changes?**

*Effective QI work involves testing out changes (small cycles of change) and then learning from this experience and building on it. How did you apply this principle to your QI project?*

- **There is no evidence of small cycles of change or use of model for improvement or PDSA (Plan, Do Study Act)**
- **There is a clear and appropriate use of a PDSA cycles in the planning and implementation of the project**
- **The project shows clear evidence of a PDSA approach.**
- **There is evidence of multiple and sequential tests of change.**

**How have you engaged the team, patients and other stakeholders throughout the project?**

*Describe any challenges of getting different team members engaged with your QIA. Describe how you maintained momentum e.g. planning for an early win:win.*

- **There is no team input or the description of this is unclear. There is inadequate reflection on steps taken to engage stakeholders. There is inadequate reflection on the challenges of engaging different team members with no reflection on**
- **There is a description of how different stakeholders were engaged which includes patient involvement. There is description of the challenges of engaging particular stakeholders which remains focused on this**
- **The description of how stakeholders (including patients) were engaged demonstrates insight into the need for adaptability and generating win : win positions. There is reflection on the particular difficulties of engaging some**

<table>
<thead>
<tr>
<th>Maintaining performance, learning and teaching</th>
<th>Leadership and team working, Professional values and behaviours, Capabilities in education and training</th>
<th>Patient safety and Quality improvement</th>
</tr>
</thead>
</table>

211
<table>
<thead>
<tr>
<th>Summarise the changes as a result of your work and how these will be maintained.</th>
</tr>
</thead>
</table>
| The summary provided is not clear or specific, or the conclusions offered are not consistent with the earlier work.
| The summary of changes is clear and appropriate.
| The summary of changes is clear and broken down to demonstrate how each part can be maintained. |

<table>
<thead>
<tr>
<th>If improvement was not achieved, explain why and what you learnt about this.</th>
</tr>
</thead>
</table>
| There is a reliance on people following new protocols and human behavioural change in order for the changes to be sustained.
| There is evidence of an understanding of the role in changing systems to embed improvement.
| There is evidence that systems have been changed so that it is harder to revert to old processes and easier to continue to follow the agreed new processes. This will ensure that change is embedded and sustainable ie not simply a protocol. |

<table>
<thead>
<tr>
<th>Describe how you relayed your results to the team and the feedback you received.</th>
</tr>
</thead>
</table>
| There is no clarity about the sustainability of the changes.
| Change has been embedded by the organisation. |

<table>
<thead>
<tr>
<th>What have you learnt and have you got any outstanding learning needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is little reflection on the personal learning</td>
</tr>
<tr>
<td>The reflection on QIP demonstrates</td>
</tr>
<tr>
<td>The reflection on this QIP goes beyond the meets</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working with colleagues and in teams, Organisation management and Leadership</th>
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<tbody>
<tr>
<td>Leadership and team working,</td>
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<table>
<thead>
<tr>
<th>Maintaining performance, learning and teaching,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional skills, Professional knowledge</td>
</tr>
</tbody>
</table>
Think about what you will maintain, improve and stop in QIA?

It is important to consider what changes you might need to make as you continue to engage with QIA, for example consider the size of project, the amount of evidence collected, how you worked with others, the effective use of IT, its value to long term care and its impact on sustainability (health outcomes for patients and populations from an environmental, social and financial perspective)

from the QIP which has been completed and how to use this in future QIP, leadership, or other situations.

appropriate personal learning about leading change and choosing effective tools to enable improvements to patient care / safety/ experience.

Consideration has been given to the value and sustainability of the QIP.

expectations descriptors and is clearly linked to plans for future QIP in a realistic and clear way.

The QIP highlighted the impact of sustainability on health outcomes from several different perspectives.

Completing this QIP is part of the minimum mandatory evidence: If not completed to an adequate standard this will lead to an unsatisfactory outcome.

‘Below expectations’ in some sections or overall does not mean that the project needs to be repeated although there may be agreement that this is the best way to get evidence for the competences which this part of training provides evidence for.
Appendix H - Audio-COT: Detailed Guide to the Performance Criteria (PC)

Consultation introduction

PC1 Introduces self and establishes identity of caller(s), ensuring confidentiality and consent
The doctor is heard clearly to state their name, professional role and where they are calling from (GP surgery/out of hours (OOH) setting). The doctor is also heard to establish the identity of the caller, and if not the patient, obtains full relationship and name of caller. The PC encourages the doctor to make every effort to speak directly to the patient, using a high level of tact and negotiation skills. When clinically appropriate, the doctor should consider speaking briefly to a child or a patient with communication difficulties.
The doctor overtly obtains consent to the telephone call being listened to by a Supervisor. If the doctor has initiated the call, s/he should check with the caller that it is convenient to speak.

PC 2 Establishes rapport
Rapport building is an integral part of the communication process. The doctor creates a comfortable 'state' where both parties converse freely and comfortably. An 'introductory verbal handshake' is offered. The doctor is observed listening well; recognising non-verbal cues, responding with soft 'ums', 'ahs' as they speak, using words the caller uses. The doctor is 'approachable' and makes the caller feel supported, safe, and provides a reassuring approach, which gives the caller confidence in the care being delivered. Displaying confidence in the clinical ability can be harder over the phone. This PC encourages the doctor to develop good rapport with patient to facilitate effective communication.

Information gathering

PC3 Identifies reason(s) for telephone call and excludes need for emergency response in a timely manner (when appropriate), demonstrating safe and effective prioritisation skills
The doctor is able succinctly to ascertain at the start of the consultation the reason for the call, allowing a timely and appropriate history to be taken. The doctor is able quickly to recognise and exclude/confirm the manifestations of serious disease, demonstrating an appropriate knowledge of acute life-threatening conditions, e.g. chest pain, bleeding, altered consciousness.
This PC expects the doctor to respond appropriately and demonstrate an awareness of the need for an emergency response, by requesting in a focused and systematic way any relevant information to exclude medical, surgical and psychiatric emergencies. The PC incorporates the doctor showing s/he is able to act on information in an appropriate and timely manner, which includes indications that an emergency response may be required. The doctor demonstrates a high level of prioritisation skills ensuring patient safety whilst maintaining efficiency. The doctor is able to prioritise the order of a telephone call, if appropriate, and the order in which problems are discussed on the telephone.

PC4 Encourages the patient's contribution using appropriate use of open and closed questions, demonstrating active listening and responds to auditory cues

The doctor uses an appropriate amount of open questions and implies 'active listening' by using reflection and facilitation. The doctor rarely interrupts the patient/caller and, if doing so, demonstrates clear advantages to their approach. The doctor effectively switches to closed questions during the telephone consultation if this is the most efficient method of obtaining the information, for example to determine whether or not a patient with headaches might have a serious illness such as raised intracranial pressure. The doctor does not pursue minor details or inappropriately explore rare diagnoses.

The doctor must choose the appropriate questioning technique to obtain sufficient information about symptoms and details of medical history, which in turn is part of defining the clinical problem(s). Appropriate questioning technique will allow a history in the degree of detail which is compatible with safety, but which takes account of the epidemiological realities of general practice.

The doctor is seen to encourage the patient's contribution at appropriate points in the consultation. This PC is particularly looking for evidence of a doctor's active listening skills, the ability to use open questions, to avoid unnecessary interruptions, and the use of non-verbal skills in exploring and clarifying the patient's symptoms. The doctor is seen to respond to signals (cues) that lead to a deeper understanding of the problem. This competence is to respond appropriately to important, significant (in terms of what emerges afterwards) cues. The use of the telephone loses the doctors ability to detect visual cues; therefore attention to auditory/non-verbal cues is imperative. This PC incorporates 'showing empathy'; if an empathetic response is observed, consideration should be given to whether it represents a response to a cue (i.e. the 'cue' may be explicit, but the emotional significance that is being responded to may be quite subtle).
The doctor quickly accesses Language Line or an alternative local translation service for non-English speakers. If appropriate, s/he may consider the use of a relative/friend to interpret for non-English speakers.

**PC5 Places complaint in appropriate psychosocial contexts**
The doctor uses appropriate psychological and social information to place the complaint(s) in context.
This PC expects doctors to consider relevant psychological, social (including occupational) aspects of the problem. These may be known beforehand, offered spontaneously by the patient, or elicited. The competence requires the use of the information in exploring the problem, e.g. “How does your backache affect your life as a builder?”
The doctor must utilise the psychosocial information gathered to help inform decisions and actions made throughout the telephone consultation. The doctor recognises the effect this may have on whether s/he decides to convert the telephone consultation to a home visit, bring the patient up to the surgery at an appropriate time interval, or manage purely on the telephone.

**PC 6 Explores the patient's health understanding/beliefs including identifying and addressing patients ideas, concerns and expectations**
The doctor demonstrates an effective exploration of the patient’s health understanding in the context of the problem discussed on the telephone.
This PC incorporates exploring the patient’s ideas, concerns and expectations, in the context of the patient’s current illness or problem e.g. callers concern regarding an elderly parent not coping.
This PC expects doctors to demonstrate the curiosity to find out what the patient really thinks – a cursory, “What do you think?” without any response to the answer will not do. But questions like “What did you think was going on?”, “What would be your worst fear with these symptoms?”, “Were you concerned this was serious?”, “What were you hoping I would do for this condition?” are much more likely to get a valuable response. This may include reflecting on PC5, such as "You said earlier xxx, what did you mean by that?" which may enable the patient to talk more easily about their concerns.

**Defines the clinical problem**
**PC 7 Takes an appropriately thorough and focused history to allow a safe assessment (includes/excludes likely relevant significant condition)**
The doctor obtains sufficient information to include or exclude likely relevant significant conditions and understand the problem.
This PC expects doctors to ask questions around relevant hypotheses. It is important to remember the context of general practice, and especially that trainees are not (usually) specialist-generalists in any field. The doctor makes use of the pre-existing medical notes on the system (if applicable) and takes enough history of presenting symptoms to be able to make a safe and accurate assessment of the patient, to enable a safe management decision. In the way the information is gathered, the doctor demonstrates an awareness of all the more serious causes of the presenting symptom(s).

In the OOH setting or with a temporary patient registered at the surgery, the doctor compensates for the lack of pre-existing notes available where information about the patient on the computer system may be sparse. The doctor takes enough history of presenting symptoms (and current medications, allergies and any relevant social history or circumstances, etc.) to be able to make a safe and accurate assessment of the patient's problem to enable a safe management decision.

The doctor appropriately manages the request of the patient/caller, e.g. prescribing appropriate amounts of medication, for example tramadol, on the telephone. The doctor uses a robust and effective structure to demonstrate well-developed triage skills for assessing clinical presentations from the information given to him/her. S/he demonstrates when to ask for more information if not enough is provided, or as a result of the response to a cue, some additional information is elicited leading to a deeper understanding of the problem.

The doctor must assess whether it is appropriate to undertake a physical or mental examination on the telephone. Although the doctor is unable to see the patient on the telephone, at times it can be helpful to ask the patient to perform examinations - e.g. “Does a rash go white when pressed?”, “Is the patient able to complete a full sentence in a breath/count to 10 in one breath?” An appropriate mental examination may be checking if a patient is suicidal – is the tone of voice, flow of conversation congruent to the history provided? An examination performed over the telephone could confirm or disprove hypotheses that could reasonably have been formed, OR is designed to address a patient's concern.

This PC covers medical safety; it addresses the focused enquiry that commonly occurs during the telephone consultation, not necessarily at a particular stage even during the explanation, or even as an afterthought.

**PC 8 Makes an appropriate working diagnosis**
There should be evidence observed that the doctor makes and records a clinically appropriate diagnosis or hypothesis.

**Management plan construction**
PC9 Creates an appropriate, effective and mutually acceptable treatment (including medication guidance) and management outcome
The doctor must give the patient the opportunity to be involved in significant management decisions. The PC recognises the doctor’s ability to establish the patient’s willingness to be involved (at least a third are unwilling), their ability to take decisions (some are not able), and the evidence-base on which any decisions are being made. The doctor does not necessarily need to take the patient right through to a decision. The PC incorporates the assessment of the doctor’s ability to negotiate, if appropriate, with the patient/caller, if they have initially been opposed to the management decisions but then agree with the outcome. The doctor should ensure the patient is fully consulted and understands the management decision, and as a result a mutually acceptable management plan is agreed.
There must be evidence of an adequate explanation of the patient’s problem, appropriate to the clinical context/caller. A short explanation may be enough but it must be relevant, understandable and appropriate. The PC encourages the doctor to incorporate some or all of the patient’s health beliefs, i.e. referring back to patient-held ideas during the explanation of the problem/diagnosis. Techniques such as summarising to clarify the problems will be used by the doctor to ensure understanding.
This PC includes an expectation that the management plan (including any medication guidance) relates directly, and is appropriate to, the working diagnosis and must represent good current medical practice. The management offered or agreed must be a safe plan even though it may not be what the doctor would do as first line.
Investigations and referral should be reasonable. The prescribed medication (if any) should be safe and reasonable, even if not the doctor’s preferred choice.

Closure of consultation
PC10 Seeks to confirm patient's understanding
The doctor specifically seeks to confirm the patient’s understanding of the diagnosis. S/he uses appropriate language to explain the problem or a diagnosis and seeks to confirm that the patient understands the diagnosis, e.g. “Does that make sense, is there anything you want to ask me?” or “so what are you going to do? /look out for?” etc.
This competence implies quite a discrete process: a digression after the explanation, to check how well it has been understood. A cursory, “Is that OK?”, is not enough. It must be an active seeking out of the patient’s understanding. Questions such as, “Tell me what you understand by that”, or “What does the term angina mean to you?”, and a dialogue between patient and doctor ensuring that the explanation is understood and accepted, are essential. This PC is more important in a telephone consultation than in a face-to-face consultation as visual cues of agreement are not available.
PC11 Provides appropriate safety-netting and follow-up instructions
The doctor provides clear and precise safety netting and follow-up instructions appropriate to the outcome of the telephone consultation. S/he provides clear instruction on contacting the surgery/OOH service again or other organisations if symptoms worsen, if the condition changes or the patient requires further information. The doctor also communicates clear time frames for the level of care agreed.
The safety-net instructions given should include a full description of relevant symptoms which indicate a significant worsening of the patient’s condition that may require earlier intervention, tailored to the needs of the patient/caller and safety/risk of the consultation (e.g. ‘If your headache is not better in 2 hours, ring back and we will re-assess the situation or sooner if you develop xxxx symptoms’).
The doctor checks that the patient/caller is happy with the outcome and able to comply with any advice given.

Effective use of the consultation
PC12: Manages and communicates risk and uncertainty appropriately
The doctor is able to tolerate uncertainty, including that experienced by the caller, where this is unavoidable. The doctor anticipates and uses strategies for managing uncertainty.
The doctor is able to communicate risk effectively to the caller and involves them in its management to an appropriate degree. The doctor uses strategies such as monitoring, outcomes assessment and feedback to minimise the adverse effects of risk.

PC13: Appropriate consultation time to clinical context (effective use of time taking into account the needs of other patients), with effective use of available resources
The doctor demonstrates an awareness of time-management by taking control of the call when appropriate and focusing the questions and responses accordingly, to ensure the outcome was reached in a timely and safe manner. This is particularly important in the OOH setting.
The PC encourages the doctor to use appropriate communication skills and awareness of time management: - for example, by taking control of the call and focusing the patient at all times when inclined to ‘ramble’, or by allowing the patient time to respond when appearing reluctant to discuss sensitive issues or demonstrating mental health issues e.g. suicidal ideation.
This PC also relates to the doctor using resources effectively. The doctor demonstrates an awareness of other resources to which it may be appropriate to refer, thus utilising the time more effectively. The doctor may signpost the patient/caller to a wide range
of resources, e.g. patient information leaflets online, a minor injuries unit, district nurse referral, routine GP review at a timely interval or voluntary care sector resources, e.g. the Samaritans.
N.B. in the UK there are large differences, due to local guidelines or resources, in the resources available and the availability of investigations in primary care, e.g. access to d-dimer blood test and ultrasound scans.

PC14: Accurate, relevant and concise record keeping to ensure safe continuing care of patient
The doctor provides a clear, concise, accurate and relevant contemporaneous record of the patient encounter that includes all salient points relating to the diagnosis and management of the situation. S/he allows others involved in the care of the patient to be fully informed of the encounter and avoids the use of repetition, unusual or unacceptable abbreviations or subjective language.
All relevant medical information is recorded including a working diagnosis and also relevant social information, information regarding the patient’s specific ideas and concerns and any advice about follow-up arrangements.
Appendix I – Blank Assessment Forms

The CEPS assessment form

Date: ..................................................  Clinical setting: ...(Drop down)........

Doctor's Name: .................................Doctor’s GMC number: .................................................................

Assessor's name.................................Assessor’s GMC /NMC number: .........................................................

Assessor's position:( Drop down box)............ Assessor’s email: ..............................

CEPS observed: (drop down box): Prostate/Prostate and Rectal/Rectal/Breast/Male Genital/Female Genital including bimanual and speculum/Other .......

Assessor declaration:
I confirm that I am a Doctor (GP, Consultant ST4 or above in experience or SAS equivalent) or a nurse who is appropriately experienced to carry out this assessment and I perform this clinical examination or procedure routinely as part of my work. Yes □

Title:...

Clinical Examination / Procedural Skill Observed: *

Observation and feedback on performance

To consider:

- Communication with the patient
- Awareness of Cultural and ethical factors
- Ability to perform clinical examination or procedural skill
- Consideration of patient and professionalism demonstrated
Agreed actions for further development:

Assessment of Performance
Based on this observation, please rate the trainees overall performance:

- Unable to perform the procedure appropriately
  - [ ]
- Able to perform the procedure but needs direct supervision and/or assistance
  - [ ]
- Able to perform the procedure with minimal supervision or assistance
  - [ ]
- Competent to perform the procedure unsupervised
  - [ ]

*Please note the presence of a chaperone is not assistance in this context.*
Interim ESR form - blank form
Currently under redesign
Case based Discussion when not in primary care

Date: ...........................................................................  Clinical setting:...

Doctor's Name: ..........................................................  Doctor's GMC number: ....................

Assessor's name: .......................................................  Assessor's GMC number: .................

Assessor's position: ...................................................  Assessor's email: ..............

Please note: The trainee needs to have selected and prepared 3-4 capability areas before the assessment.

Assessor declaration: I can confirm I have received appropriate training to complete this assessment form and that I am a consultant or a hospital doctor ST4 or above (or SAS equivalent): Yes □

Title:...

Brief description of case: (max 150 words)

Level of Complexity  Low □   Medium □   High □

Clinical experience Group(s) covered by event: Please select (max 2)

Clinical experience groups:

1. Infants, children and young people [under the age of 19yrs]
2. Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)
3. People with long-term conditions including cancer, multi-morbidity and disability
4. Older adults including frailty and/or people at end of life
5. Mental health (including addiction, alcohol and substance misuse)
6. Urgent and unscheduled care
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems)
9. Clinical problems not linked to a specific clinical experience group

**Grades**

The trainee should be graded in relation to those at the same stage of training. Please provide specific, constructive feedback both verbally and documented on this form that you feel will enhance the trainee’s performance for each capability area selected by the trainee. This will be used as evidence of trainee progression. (If the trainee selected incorrect capabilities or if additional capabilities were covered then please change and/or include these. No more than 4 capabilities should be covered in each CbD).

### 1. Capability area – Select relevant Capability

<table>
<thead>
<tr>
<th>Significantly below expectations</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Above Expectations</th>
</tr>
</thead>
</table>

Feedback on performance and justification for grade based on the capability:

Recommendations for further development based on the capability descriptors:

### 2. Capability area – Select relevant Capability

<table>
<thead>
<tr>
<th>Significantly below expectations</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Above Expectations</th>
</tr>
</thead>
</table>

Feedback on performance and justification for grade based on the capability:

Recommendations for further development based on the capability descriptors:

### 3. Capability area – Select relevant Capability

<table>
<thead>
<tr>
<th>Significantly below expectations</th>
<th>Below Expectations</th>
<th>Meets Expectations</th>
<th>Above Expectations</th>
</tr>
</thead>
</table>

Feedback on performance and justification for grade based on the capability:
4. Capability area – Select relevant Capability

| Significantly below expectations □ | Below Expectations □ | Meets Expectations □ | Above Expectations □ |

Feedback on performance and justification for grade based on the capability:

Recommendations for further development based on the capability descriptors:

Based on this observation, please rate the overall competence at which the trainee has shown that they are performing:

- Below the level expected prior to starting on a GP Training programme □
- Below the level expected of a GP trainee working in the current clinical post □
- At the level expected of a GP trainee working in the current clinical post □
- Above the level expected of a GP trainee working in the current clinical post □

Agreed Actions
Mini Clinical Examination Exercise (Mini-CEX) form when not in primary care

Date: .............................................................  Clinical setting:..........................

Doctor's Name: ..................................................  Doctor's GMC number..............

Assessor's name: ..................................................  Assessor's GMC number:..............

Assessor's position: ............................................  Assessor's email:.......................  

Assessor declaration: I can confirm I have received appropriate training to complete this assessment form and that I am a consultant or a hospital doctor ST4 or above (or SAS equivalent) Yes □

Title: ..................................................

Brief description of case: (max 150 words)

Level of Complexity  Low □  Medium □  High □

Clinical experience Group(s) covered by event: Please select (max 2)

Clinical experience groups:

1. Infants, children and young people [under the age of 19yrs]
2. Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast)
3. People with long-term conditions including cancer, multi-morbidity and disability
4. Older adults including frailty and/or people at end of life
5. Mental health (including addiction, alcohol and substance misuse)
6. Urgent and unscheduled care
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems)
9. Clinical problems not linked to a specific clinical experience group

Grading

The trainee should be graded in relation to those at the same stage of training. Please note the difference between: ‘Not applicable’ which means that the trainee did not cover the identified area as it was not within the context of the case and ‘Significantly below expectation and/or below expectation’ which means that either the trainee did not cover the identified area to a competent level or it was not demonstrated at all, and should have been.

Please provide specific, constructive feedback both verbally and documented on this form that you feel will enhance the trainee's performance. This will be used as evidence of the trainees' progression.

<table>
<thead>
<tr>
<th>Professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is respectful, courteous, appropriately confident, diligent and self-directed in their approach to patients and others. Adopts behaviours that maintain resilience. Makes appropriate ethical decisions.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Not Applicable □</th>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
<th>Meets Expectations □</th>
<th>Above Expectations □</th>
</tr>
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<tbody>
<tr>
<td>Comments (please include areas of strength and suggestions for development) *:</td>
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</table>

<table>
<thead>
<tr>
<th>Communication and consultation skills</th>
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</thead>
<tbody>
<tr>
<td>Provides patient friendly communication, establishing patient rapport, uses clear language. Explores patient’s health understanding and beliefs including identifying and addressing patient’s ideas, concerns and expectation. Understands situation in appropriate psychosocial context. The patient is appropriately involved throughout the consultation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not Applicable □</th>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical assessment and judgement:</th>
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</thead>
<tbody>
<tr>
<td>Takes a logical, appropriately thorough and focused history allowing a safe assessment. Performs an appropriate physical and/or mental state examination, selecting and interpreting appropriate investigations. Makes an appropriate working</td>
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</tbody>
</table>
diagnosis or decision. Please identify and comment on observed clinical skills.

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<tr>
<th></th>
<th>Not Applicable □</th>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
<th>Meets Expectations □</th>
<th>Above Expectations □</th>
</tr>
</thead>
</table>

Comments (please include areas of strength and suggestions for development) *:

**Clinical management**
Varies management options and prescriptions responsively and safely and in line with current guidelines. Makes appropriate use of referrals and prioritises care appropriately. Recognises limits and seeks appropriate advice.

<table>
<thead>
<tr>
<th></th>
<th>Not Applicable □</th>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
<th>Meets Expectations □</th>
<th>Above Expectations □</th>
</tr>
</thead>
</table>

Comments (please include areas of strength and suggestions for development) *:

**Organisation/Efficiency**
Works effectively and efficiently with others using the various teams’ expertise skillfully to enhance patient care. Prioritises well, and uses time and other resources appropriately.

<table>
<thead>
<tr>
<th></th>
<th>Not Applicable □</th>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
<th>Meets Expectations □</th>
<th>Above Expectations □</th>
</tr>
</thead>
</table>

Comments (please include areas of strength and suggestions for development) *:

Based on this observation, please rate the overall competence at which the trainee has shown that they are performing:

- Below the level expected prior to starting on a GP Training programme □
- Below the level expected of a GP trainee working in the current clinical post □
- At the level expected of a GP trainee working in the current clinical post □
- Above the level expected of a GP trainee working in the current clinical post □

**Agreed action for further development:**
Primary Care Consultation Observation Tool Form

Date: ..............................  
Clinical setting: ...(Drop down)........

Doctor's Name: ..............................  
Doctor's GMC number: ......................

Assessor's name: ..............................  
Assessor's GMC number: ......................

Assessor's position: ..............................  
Assessor's email: ..............................

Assessor declaration: I can confirm I have received appropriate training to complete this assessment form and that I am a GP Educational Supervisor or an approved Clinical Supervisor who has met the educator requirements of the GMC. Yes □

Title: ..............................

Brief description of case: (max 150 words)

Level of Complexity:  Low □  Medium □  High □

Time taken for the consultation, (in minutes)..............................

Clinical experience Groups (s) covered by event: Please select (max 2)

Clinical experience groups:

1. Infants, children and young people [under the age of 19yrs]
2. Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)
3. People with long-term conditions including cancer, multi-morbidity and disability
4. Older adults including frailty and/or people at end of life
5. Mental health (including addiction, alcohol and substance misuse)
6. Urgent and unscheduled care
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems)
9. Clinical problems not linked to a specific clinical experience group

**Grading**

Using the guide to the performance criteria for the COT please grade the trainee by ticking the appropriate competence level in the boxes below.

*The trainee should be graded in relation to the standard expected at certificate of completion of training (CCT).*

Please note the difference between: ‘Not applicable to this case’ which means that the trainee did not cover the identified area as it was not within the context of the case and ‘Needing further development below expectations/meets expectations’ which means that either the trainee did not cover the identified area to a competent level or it was not demonstrated at all, and should have been.

Please provide **specific, constructive feedback** verbally and documented on this form to the trainee that you feel will enhance their performance. This will be used as evidence of trainee progression.

<table>
<thead>
<tr>
<th>Context</th>
<th>Identified Area</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not applicable to this case</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needs Further Development Below Expectations</td>
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<td></td>
<td></td>
<td>Needs Further Development Meets Expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Competent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excellent</td>
</tr>
<tr>
<td>Information gathering</td>
<td>Encourages the patient’s contribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responds to cues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Places complaint in appropriate psychosocial contexts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explores patient’s health understanding/beliefs including identifying and addressing patients ideas and concerns and expectations</td>
<td></td>
</tr>
<tr>
<td>Defines the clinical problem</td>
<td>Takes an appropriately thorough and focused history to allow a safe assessment (includes/excludes likely relevant significant condition)</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Performance</strong></td>
<td><strong>Based on this observation, please rate the overall competence at which the trainee has shown that they are performing:</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Below the level expected prior to starting on a GP Training programme □ Below the level expected of a GP trainee working in the current clinical post □ At the level expected of a GP trainee working in the current clinical post □ Above the level expected of a GP trainee working in the current clinical post □</td>
<td></td>
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<tr>
<td></td>
<td>Observation and feedback on performance (please include any concerns regarding an unsafe consultation): □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreed actions for further development □</td>
<td></td>
</tr>
</tbody>
</table>

| Performs appropriate physical or mental state examination | □ |
| Makes an appropriate working diagnosis | □ |
| **Explain the problem to the patient** | Explains the problem in appropriate language □ |
| **Addresses the patients’ problem** | The management plan (including any prescription) is appropriate for the working diagnosis, □ The patient is given the opportunity to be involved in significant management decisions □ The doctor checks that there is shared understanding of the diagnosis, management plan, treatment, safety netting and follow up arrangements □ |
| **Makes effective use of the consultation** | Makes effective use of available resources □ The doctor specifies the conditions and interval for follow up or review □ |
# Quality Improvement Project (QIP): blank template

<table>
<thead>
<tr>
<th>Date (of GPSTR sharing)</th>
<th>Supervisor Feedback</th>
<th>GP Trainee entry</th>
<th>Below expectations, Meets expectations, Above Expectations</th>
<th>GP Supervisor comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>automatically inserted</em></td>
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</tbody>
</table>

**Project Title and why it was chosen**
You should explain what trigger (case, data or events) led you to look at this area. You should comment on the likely impact of this on patients, and review the guidance or evidence that is relevant to the area (e.g. a literature review).

**Project Aim**
Consider:
- What are you trying to accomplish?
- How will you know that a change is an improvement?
- What change can you make that should result in improvement in patient safety or patient care?
when explaining your Project Aim.
**Describe what baseline data or information you gathered**

You should explain how you understood the current position in order to decide that improvements were needed. Explain which QI tools or methods you used to fully understand the ‘problem’ you were trying to solve. Suitable methods would include QI tools for example; assessing baseline data, process-mapping, conducting a survey and using fishbone analysis. Quality improvement requires attempting to measure some change, though the nature of the measurement will be different in different projects and some data could be available before the start of your personal involvement.

**Describe what subsequent data or information you gathered**

*How did you measure and evaluate the impact of change? Please share enough data to demonstrate outcomes; you may not need to share all your data.*

**How did you plan and test out your changes?**

*Effective QI work involves testing out changes (small cycles of change) and then learning from this experience and building on it. How did you apply this principle to your QI project?*

**How have you engaged the team, patients and other stakeholders throughout the project?**

*Describe any challenges of getting different team members engaged with your QIA. Describe how you maintained momentum e.g. planning for an early win: win.*
Summarise the changes as a result of your work and how these will be maintained.

If improvement was not achieved, explain why and what you learnt about this.

Describe how you relayed your results to the team and the feedback you received.

What have you learnt and have you got any outstanding learning needs?

Think about what you will maintain, improve and stop in QIA?

It is important to consider what changes you might need to make as you continue to engage with QIP? (consider size of project, amount of evidence collected, and how you worked with others, effective use of IT etc.)

Based on this piece of work, please rate the overall competence at which the trainee has shown that they are performing:

- Below level expected prior to starting on a GP Training programme
- Below the level expected of a GP trainee working in the current clinical post
- At the level expected of a GP trainee working in the current clinical post
- Above the level expected of a GP trainee working in the current clinical post

Identified continued learning needs in relation to the QI process [to be completed after discussing the assessment with trainee]

Completion of this project is a mandatory part of GP Speciality Training; failure to complete all parts will affect training progression.
Clinical Supervisors Report when not in non-primary care placements

To be completed before the end of each non primary care placement

Please provide constructive feedback on the trainee's performance and suggestions for improvement based on your own observations as the Clinical Supervisor as well as observations from colleagues during the post.

Your assessment of this Trainee's performance in this role is comparing them to the expected level for a GP trainee at this stage in their training

The Clinical Supervisor is expected to have personally completed at least one of the mandatory Workplace Based Assessments before completion of the CSR.

Date: .................................................................
Doctor's Name: ........................................... Doctor's GMC number: ..............
Assessor's name: .............................................. Assessor's GMC number: ..............
Assessor's position: ........................................... Assessor's email: 

I confirm that this report is based on my own observations including at least one Mandatory assessment (CbD and/or Mini-CEX) carried out by myself, in addition to using the results of other workplace-based assessments and feedback from my colleagues. Yes ▢

1. **Professionalism** (includes being respectful, diligent and self-directed in their approach to patients and others and to their own learning needs, developing resilience, making appropriate ethical decisions)

   Capabilities: Maintaining Performance Learning and Teaching, Ethics, Fitness to practice

<table>
<thead>
<tr>
<th>Areas of strength</th>
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<table>
<thead>
<tr>
<th>Areas to develop in these capabilities</th>
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<thead>
<tr>
<th>Significantly Below Expectations □</th>
<th>Below Expectations □</th>
<th>Meeting Expectations □</th>
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</thead>
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2. **Communication and Consulting Skills** (includes communication with patients,
establishing patient rapport, managing challenging consultations, third-party consulting, the use of interpreters)

**Capability: Communication and consultation skills**

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<thead>
<tr>
<th>Significantly Below Expectations ☐</th>
<th>Below Expectations ☐</th>
<th>Meeting Expectations ☐</th>
<th>Above Expectations ☐</th>
</tr>
</thead>
</table>

3. **Working with colleagues and in teams** (includes working effectively with others, sharing information with colleagues, leadership, management and team-working skills)

**Capabilities: Working with colleagues and in teams, Organisation, Management and Leadership**

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</table>

4. **Clinical assessment** (includes patient history, Clinical Examination and Procedural Skills (CEPS), choosing investigations, and making an appropriate diagnosis or decision. Please also comment on clinical skills that have been observed)

**Capabilities: Data Gathering, CEPS, Making a diagnosis / decisions**

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#### 5. Management of Patients

(includes recognition and appropriate management of medical conditions encountered in the role, prescribing safely, and taking account of co-morbidity, poly-pharmacy. Managing uncertainty & risk)

Capabilities: Clinical management, Medical complexity

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</table>

### 6. Clinical record keeping

(includes showing an appropriate use of administration systems, effective and appropriate record-keeping and use of IT for the benefit of patient care)

Capabilities: Organisation, Management and Leadership

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<th>Areas of strength</th>
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<th>Areas to develop in this capability</th>
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</table>
7. **Context of care** (includes seeking to understand and support patients through an appreciation of the interplay between their disease and their lives and considering local pathways, formularies and resources)

*Capabilities: Holistic care, Community orientation*

### Areas of strength

### Areas to develop in these capabilities

<table>
<thead>
<tr>
<th>Significantly Below Expectations □</th>
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</table>

**In this post, compared to the expected level for a GP trainee at this stage of training, this trainee currently (please tick one of the following):**

<table>
<thead>
<tr>
<th>Level</th>
<th>Supervision definition</th>
<th>Tick one line</th>
</tr>
</thead>
</table>
| 1*    | **Cannot be left without direct supervision**  
Limited to observing care; and / or  
Seeing patients alone but not allowed to let patients leave the building or complete an episode of care before review by the supervisor.                                                                                       |              |
| 2*    | **Requires more supervision than expected in their clinical role**  
Requires direct supervision by named supervisor:  
The trainee may provide clinical care, but the supervisor, (in their absence delegated supervisor), is physically within the building and is immediately available if required to provide direct supervision on specific cases and non-immediate review of all cases. |              |
| 3     | **Requires expected levels of supervision in their clinical role**  
Requires indirect supervision by the named supervisor:                                                                                                                                                               |              |
The trainee may provide clinical care when the supervisor is at a distance and is available by telephone to provide advice or can attend jointly if required to provide direct supervision. The trainee does not need to have every case reviewed but a regular review of random or selected cases takes place at routine intervals.

*If levels 1 or 2. Please clarify if the issues or concerns relate to professional values or behaviours; or to communication skills, patient safety, clinical competence, organisational or timing issues; to personal issues; or other issues / concerns.

If you have entered any details in this box, please ensure you have contacted their local GP Associate Dean/Training Programme Director and if appropriate, their Educational Supervisor

Does the trainee need to have any particular supervision in their next post? Y/N

(If Y please give specific detail below)
Clinical Supervisors Report for Primary Care Placements in ST1 and ST2

To be completed before the end of each Primary care placement if any of the following apply:

- The Clinical Supervisor in practice is a different person from the Educational Supervisor
- The evidence within the ePortfolio would give a more complete picture of the trainee if a CSR were completed
- Either the trainee or supervisor feel it is appropriate

The trainee should be graded in relation to the standard expected at certificate of completion of training (CCT).

Please provide constructive feedback on the trainee’s performance and suggestions for improvement based on your own observations as the Clinical Supervisor as well as observations from colleagues during the post.

The Clinical Supervisor is expected to have personally completed at least one of the mandatory Workplace Based Assessments before completion of the CSR. It may be appropriate for several CSRs to be completed where there are concerns and there are two trained assessors in the practice or the trainee has an additional CS in another practice.

Date: .................................................................
Doctor’s Name: .....................................................  Doctor’s GMC number: .........................
Assessor’s name: ....................................................  Assessor’s GMC number: .........................
Assessor’s position: ...............................................  Assessor’s email: ........................................

I confirm that this report is based on my own observations including at least one Mandatory assessment (CbD and/or COT) carried out by myself, in addition to using the results of other workplace-based assessments and feedback from my colleagues.

Yes ☐

1. **Professionalism** (includes being respectful, diligent and self-directed in their approach to patients and others and to their own learning needs, developing resilience, making appropriate ethical decisions)

*Capabilities: Maintaining Performance Learning and Teaching, Ethics, Fitness to practice*

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<th>Areas of strength</th>
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</table>
2. Communication and Consulting Skills (includes communication with patients, establishing patient rapport, managing challenging consultations, third-party consulting, the use of interpreters)

**Capability: Communication and consultation skills**

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<tr>
<th>Areas to develop in these capabilities</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Needs Further Development Below Expectations □</td>
<td>Needs Further Development Meeting Expectations □</td>
</tr>
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</table>

3. Working with colleagues and in teams (includes working effectively with others, sharing information with colleagues, leadership, management and team-working skills)

**Capabilities: Working with colleagues and in teams, Organisation, Management and Leadership**

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<td>Needs Further Development Meeting Expectations □</td>
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Areas to develop in these capabilities

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<thead>
<tr>
<th>Needs Further Development Below Expectations □</th>
<th>Needs Further Development Meeting Expectations □</th>
<th>Competent □</th>
<th>Excellent □</th>
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4. **Clinical assessment** (includes patient history, Clinical Examination and Procedural Skills (CEPS), choosing investigations, and making an appropriate diagnosis or decision. Please also comment on clinical skills that have been observed)

*Capabilities: Data Gathering, CEPS, Making a diagnosis / decisions*

Areas of strength

Areas to develop in these capabilities

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5. **Management of Patients** (includes recognition and appropriate management of medical conditions encountered in the role, prescribing safely, and taking account of co-morbidity, poly-pharmacy. Managing uncertainty & risk)

*Capabilities: Clinical management, Medical complexity*

Areas of strength
6. **Clinical record keeping** (includes showing an appropriate use of administration systems, effective and appropriate record-keeping and use of IT for the benefit of patient care)
   *Capabilities: Organisation, Management and Leadership*

7. **Context of care** (includes seeking to understand and support patients through an appreciation of the interplay between their disease and their lives and considering local pathways, formularies and resources)
   *Capabilities: Holistic care, Community orientation*
Areas to develop in these capabilities

| Needs Further Development Below Expectations □ | Needs Further Development Meeting Expectations □ | Competent □ | Excellent □ |

In this post, compared to the expected level for a GP trainee at this stage of training, this trainee currently (please tick one of the following):

<table>
<thead>
<tr>
<th>Level</th>
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<tbody>
<tr>
<td>1*</td>
<td>Cannot be left without direct supervision Limited to observing care; and / or Seeing patients alone but not allowed to let patients leave the building or complete an episode of care before review by the supervisor.</td>
<td></td>
</tr>
<tr>
<td>2*</td>
<td>Requires more supervision than expected in their clinical role Requires direct supervision by named supervisor: The trainee may provide clinical care, but the supervisor, (in their absence delegated supervisor), is physically within the building and is immediately available if required to provide direct supervision on specific cases and non-immediate review of all cases.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Requires expected levels of supervision in their clinical role Requires indirect supervision by the named supervisor: The trainee may provide clinical care when the supervisor is at a distance (urgent /unscheduled care, home visits but not routine branch surgery work) and is available by telephone to provide advice or can attend jointly if required to provide direct supervision. The trainee does not need to have every case reviewed but a regular review of random or selected cases takes place at routine intervals.</td>
<td></td>
</tr>
</tbody>
</table>
Endorsement by Clinical Supervisor (Educational Supervisor if completing report)

Does the trainee need to have any particular supervision in their next post? Y or N/A

(If Y please give specific detail below)

Key

Please see word descriptors for explanations of needing Further Development, Competent and Excellent within each of the 13 capabilities

For the grading of the CSR:

Needs Further Development (NFD) Below Expectations - not meeting the level of any or only meeting one or two of the NFD capability word descriptors

Needs Further Development (NFD) Meets Expectations - meeting most of the NFD capability word descriptors

Competent - meeting some or all of the competent capability word descriptors

Excellent - meeting some or all of the excellent capability word descriptors

*If levels 1 or 2. Please clarify if the issues or concerns relate to professional values or behaviours; or to communication skills, patient safety, clinical competence, organisational or timing issues; to personal issues; or other issues / concerns.

If you have entered any details in this box, please ensure you have contacted their local GP Associate Dean/Training Programme Director and if appropriate, their Educational Supervisor.
Care Assessment Tool (CAT), including Case based Discussions
For use in primary care

Date: ................................................................. Clinical setting: ...(Drop down).....

Doctor’s Name: ........................................... Doctor’s GMC number: .................

Assessor’s name: .............................................. Assessor’s GMC number: .................

Assessor’s position: ........................................ Assessor’s email: 


**Please note: The trainee needs to have selected and prepared 3-4 capability areas before the assessment.**

Assessor declaration: I can confirm I have received appropriate training to complete this assessment form and that I am a GP Educational Supervisor or an approved Clinical Supervisor who has met the educator requirements of the GMC. Yes □

** On the ePortfolio link to CAT documents on WPBA website**

Type of CAT:
- Drop down list of types and select
  - Case based Discussion
  - Post prescribing assessment follow up review
  - Random case review
  - Referrals review
  - Other - please describe

Title: .................................

Brief description of case/ activity/assessment/ event: (max 150 words)


Complexity of the case: Low □  Medium □  High  □

Clinical experience Groups (s) covered by event: Please select (max 2)
Clinical experience groups:

1. Infants, children and young people [under the age of 19yrs]
2. Gender, reproductive and sexual health (including women’s, men’s, LGBTQ, gynaecology and breast)
3. People with long-term conditions including cancer, multi-morbidity and disability
4. Older adults including frailty and/or people at end of life
5. Mental health (including addiction, alcohol and substance misuse)
6. Urgent and unscheduled care
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems)
9. Clinical problems not linked to a specific clinical experience group

Grading
The trainee should be graded in relation to the standard expected at certificate of completion of training (CCT).

Please provide specific, constructive feedback both verbally and documented on this form that you feel will enhance the trainee’s performance for each capability area selected by the trainee. This will be used as evidence of trainee progression. (If the trainee selected incorrect capabilities or if additional capabilities were covered then please change and/or include these. No more than 4 capabilities should be covered in each CAT).

1. Capability area – Select relevant Capability

| Needs Further Development Below Expectations □ | Needs Further Development Meets Expectations □ | Competent □ | Excellent □ |

Feedback on performance and justification for grade based on the capability descriptors:

Recommendations for further development based on the capability descriptors:
### 2. Capability area – Select relevant Capability

<table>
<thead>
<tr>
<th>Needs Further Development Below Expectations □</th>
<th>Needs Further Development Meets Expectations □</th>
<th>Competent □</th>
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</table>

Feedback on performance and justification for grade based on the capability descriptors:

Recommendations for further development based on the capability descriptors:

### 3. Capability area – Select relevant Capability

<table>
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<tr>
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Feedback on performance and justification for grade based on the capability descriptors:

Recommendations for further development based on the capability descriptors:

### 4. Capability area – Select relevant Capability

<table>
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<tr>
<th>Needs Further Development Below Expectations □</th>
<th>Needs Further Development Meets Expectations □</th>
<th>Competent □</th>
<th>Excellent □</th>
</tr>
</thead>
</table>

Feedback on performance and justification for grade based on the capability descriptors:
Assessment of Performance
Based on this observation, please rate the overall competence at which the trainee has shown that they are performing:
Below the level expected prior to starting on a GP Training programme
☐
Below the level expected of a GP trainee working in the current clinical post
☐
At the level expected of a GP trainee working in the current clinical post
☐
Above the level expected of a GP trainee working in the current clinical post
☐

Agreed actions
Audio-COT

Date: .................................................................  Clinical setting: ...(Drop down).........

Doctor's Name: .....................................................  Doctor's GMC number: ....................

Assessor's name: ....................................................  Assessor's GMC number: .................

Assessor's position: ..............................................  Assessor's email:

..................................................

Type of call: Telephone triage / Telephone consultation / Out of hours

Assessor declaration: I can confirm I have received appropriate training to complete this assessment form and that I am a GP Educational Supervisor or an approved Clinical Supervisor who has met the educator requirements of the GMC. Yes □

** On the ePortfolio link to Audio-COT completion documents on WPBA website** (including the capability linkage document)

Title: .................................

Brief description of case: (max 150 words)

<table>
<thead>
<tr>
<th>Level of Complexity</th>
<th>Low □</th>
<th>Medium □</th>
<th>High □</th>
</tr>
</thead>
</table>

Clinical experience Groups (s) covered by event: Please select (max 2)

Clinical experience groups

1. Infants, children and young people [under the age of 19yrs]
2. Gender, reproductive and sexual health (including women's, men's, LGBTQ, gynaecology and breast)
3. People with long-term conditions including cancer, multi-morbidity and disability
4. Older adults including frailty and/or people at end of life
5. Mental health (including addiction, alcohol and substance misuse)
6. Urgent and unscheduled care
7. People with health disadvantage and vulnerabilities (including veterans, mental capacity difficulties, safeguarding and those with communication difficulties/disability)
8. Population Health and health promotion (including people with non-acute and/or non-chronic health problems)
9. Clinical problems not linked to a specific clinical experience group

Grading
Using the guide to the performance criteria for the Audio-COT please grade the trainee by ticking the appropriate competence level in the boxes below:

The trainee should be graded in relation to the standard expected at certificate of completion of training (CCT).

Please note the difference between: ‘Not applicable to this case’ which means that the trainee did not cover the identified area as it was not within the context of the case and Needing further development below expectations/meets expectations which means that either the trainee did not cover the identified area to a competent level or it was not demonstrated at all, and should have been.

Please provide specific, constructive feedback verbally and documented on this form to the trainee that you feel will enhance their performance. This will be used as evidence of trainee progression

<table>
<thead>
<tr>
<th>Context</th>
<th>Area</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable to this case</td>
<td>Needs Further Development Below Expectations</td>
</tr>
<tr>
<td>Consultation</td>
<td>Introduces self and establishes identity of caller(s), ensuring confidentiality and consent</td>
<td></td>
</tr>
<tr>
<td>introduction</td>
<td>Establishes rapport</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>Identifies reason(s) for telephone call and excludes need for emergency response in a timely manner (when appropriate), demonstrating safe and effective</td>
<td></td>
</tr>
<tr>
<td>gathering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prioritisation skills</td>
<td>Encourages the patient’s contribution using appropriate open and closed questions, demonstrating active listening and responding to auditory cues</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Places complaint in appropriate psycho-social contexts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explores patient's health understanding/beliefs including identifying and addressing patient's ideas, concerns and expectations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Defines the clinical problem</th>
<th>Takes an appropriately thorough and focused history to allow a safe assessment (includes/excludes likely relevant significant condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes an appropriate working diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management plan construction</th>
<th>Creates an appropriate, effective and mutually acceptable treatment (including medication guidance) and management outcome</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Closure of consultation</th>
<th>Seeks to confirm patient’s understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provides appropriate safety-netting and follow-up instructions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective use of the consultation</th>
<th>Manages and communicates risk and uncertainty appropriately</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appropriate consultation time to clinical context (effective use of time, taking into account the</td>
</tr>
</tbody>
</table>
needs of other patients), with effective use of available resources

| Accurate, relevant and concise record-keeping to ensure safe continuing care of patient |

Assessment of Performance
Based on this observation, please rate the overall competence at which the trainee has shown that they are performing:

- Below the level expected prior to starting on a GP Training programme
- Below the level expected of a GP trainee working in the current clinical post
- At the level expected of a GP trainee working in the current clinical post
- Above the level expected of a GP trainee working in the current clinical post

Observation and feedback on performance (please include any concerns regarding an unsafe consultation):

Agreed actions for further development:
Dear Patient, we would be grateful if you would complete this questionnaire about your visit to the doctor today. The doctor that you have seen is a fully qualified doctor who is learning to become a general practitioner. Feedback from this survey will enable them to identify areas that may need improvement. Your opinions are therefore very valuable.

Please answer all the questions below. There are no right or wrong answers and your doctor will not be able to identify your individual responses.

---

<table>
<thead>
<tr>
<th>Not relevant to this consultation</th>
<th>☺ 😐 ☑️</th>
<th>☺ 😐 ☑️</th>
<th>☺ 😐 ☑️</th>
<th>☺ 😐 ☑️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this doctor make you feel relaxed and welcome?</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you feel this doctor listened to you?</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
<td>Yes</td>
</tr>
<tr>
<td>Did the doctor explain things to you in a way you could understand?</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
<td>Yes</td>
</tr>
<tr>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>Not Applicable</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
</tr>
<tr>
<td>Do you have confidence in the decisions made about your condition or treatment?</td>
<td>Not Applicable</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
</tr>
<tr>
<td>Do you know what will happen next with your care?</td>
<td>Not Applicable</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
</tr>
<tr>
<td>Do you know what to do if your condition gets worse?</td>
<td>Not Applicable</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
</tr>
<tr>
<td>Did the doctor treat you with respect and dignity?</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you trust this doctor?</td>
<td>No, not at all</td>
<td>No, not really</td>
<td>Yes, but not fully</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Do you have any specific comments about this doctor from this consultation?
Leadership MSF

Doctor’s surname: ___________________________ Doctor’s forename: ___________________________
Doctor’s GMC number: ______________________ Training Number: _____________________________

Your role: Please circle:

self / doctor / other clinician / manager / admin staff/other

For each of the following statements please provide your assessment of this doctor’s leadership abilities:

1. Their organisational skills (including for example their time management, planning and adaptation to changing circumstances)

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Unable to grade</th>
</tr>
</thead>
</table>

2. Their willingness to take responsibility for their own decisions and continuing medical education

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Unable to grade</th>
</tr>
</thead>
</table>

3. Their ability to respond in a responsible and considered way when under pressure

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Unable to grade</th>
</tr>
</thead>
</table>

4. Their ability to work effectively within teams

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Outstanding</th>
<th>Unable to grade</th>
</tr>
</thead>
</table>

5. The extent to which they take an active part in maintaining and improving patient care

<table>
<thead>
<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Outstanding</th>
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</table>

Highlights in performance (areas to be commended):


Suggested areas for possible development in performance


Clinical Supervisors Report for Primary Care Placements in ST3

To be the end of each Primary care placement if any of the following apply:

- The Clinical Supervisor in practice is a different person from the Educational Supervisor
- The evidence within the portfolio would give a more complete picture of the trainee if a CSR were completed
- Either the trainee or supervisor feel it is appropriate

The trainee should be graded in relation to the standard expected at certificate of completion of training (CCT).

Please provide constructive feedback on the trainee's performance and suggestions for improvement based on your own observations as the Clinical Supervisor as well as observations from colleagues during the post.

The Clinical Supervisor is expected to have personally completed at least one of the mandatory Workplace Based Assessments before completion of the CSR. It may be appropriate for several CSRs to be completed where there are concerns and there are two trained CSs in the practice or the trainee has an additional CS in another practice.

Date: .................................................................
Doctor's Name: ....................................................
Doctor's GMC number: .................................
Assessor's name: ...................................................
Assessor's GMC number: ............................... Assessor's position: ........................................
Assessor's email: ..............................................

I confirm that this report is based on my own observations including at least one Mandatory assessment (CbD and/or COT) carried out by myself, in addition to using the results of other workplace-based assessments and feedback from my colleagues.

Yes [ □ ]

1. **Professionalism** (includes being respectful, diligent and self-directed in their approach to patients and others and to their own learning needs, developing resilience, making appropriate ethical decisions)

**Capabilities: Maintaining Performance Learning and Teaching, Ethics, Fitness to practice**

<table>
<thead>
<tr>
<th>Areas of strength</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Areas to develop in these capabilities

<table>
<thead>
<tr>
<th>Needs Further Development Below Expectations</th>
<th>Needs Further Development</th>
<th>Competent</th>
<th>Excellent</th>
</tr>
</thead>
</table>

2. **Communication and Consulting Skills** (includes communication with patients, establishing patient rapport, managing challenging consultations, third-party consulting, the use of interpreters)

*Capability: Communication and consultation skills*

Areas of strength

Areas to develop in this capability

<table>
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3. **Working with colleagues and in teams** (includes working effectively with others, sharing information with colleagues, leadership, management and team-working skills)

*Capabilities: Working with colleagues and in teams, Organisation, Management and Leadership*

Areas of strength

Areas to develop in these capabilities
4. **Clinical assessment** (includes patient history, Clinical Examination and Procedural Skills (CEPS), choosing investigations, and making an appropriate diagnosis or decision. Please also comment on clinical skills that have been observed)

*Capabilities: Data Gathering, CEPS, Making a diagnosis / decisions*

<table>
<thead>
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</table>

Areas of strength

Areas to develop in these capabilities

5. **Management of Patients** (includes recognition and appropriate management of medical conditions encountered in the role, prescribing safely, and taking account of co-morbidity, poly-pharmacy. Managing uncertainty & risk)

*Capabilities: Clinical management, Medical complexity*

<table>
<thead>
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<th>Excellent</th>
</tr>
</thead>
</table>

Areas of strength

Areas to develop in these capabilities
6. **Clinical record keeping** (includes showing an appropriate use of administration systems, effective and appropriate record-keeping and use of IT for the benefit of patient care)
   *Capabilities: Organisation, Management and Leadership*

<table>
<thead>
<tr>
<th>Needs Further Development Below Expectations □</th>
<th>Needs Further Development □</th>
<th>Competent □</th>
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<th>Competent □</th>
<th>Excellent □</th>
</tr>
</thead>
</table>

7. **Context of care** (includes seeking to understand and support patients through an appreciation of the interplay between their disease and their lives and considering local pathways, formularies and resources)
   *Capabilities: Holistic care, Community orientation*

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Areas to develop in these capabilities

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<th>Excellent</th>
</tr>
</thead>
</table>

In this post, compared to the expected level for a GP trainee at this stage of training, this trainee currently (please tick one of the following):

<table>
<thead>
<tr>
<th>Level</th>
<th>Supervision definition</th>
<th>Tick one line</th>
</tr>
</thead>
</table>
| 1*    | Cannot be left without direct supervision  
Limited to observing care; and / or  
Seeing patients alone but not allowed to let patients leave the building or complete an episode of care before review by the supervisor. |             |
| 2*    | Requires more supervision than expected in their clinical role  
Requires direct supervision by named supervisor:  
The trainee may provide clinical care, but the supervisor, (in their absence delegated supervisor), is physically within the building and is immediately available if required to provide direct supervision on specific cases and non-immediate review of all cases. |             |
| 3     | Requires expected levels of supervision in their clinical role  
Requires indirect supervision by the named supervisor:  
The trainee may provide clinical care when the supervisor is at a distance (urgent /unscheduled care, home visits but not routine branch surgery work) and is available by telephone to provide advice or can attend jointly if required to provide direct supervision.  
The trainee does not need to have every case reviewed but a regular review of random or selected cases takes place at routine intervals. |             |
| 4     | Requires no supervision in their clinical role  
It is expected trainees will only reach Level 4 shortly before completion of their training. |             |
*If levels 1 or 2. Please clarify if the issues or concerns relate to professional values or behaviours; or to communication skills, patient safety, clinical competence, organisational or timing issues; to personal issues; or other issues / concerns.

If you have entered any details in this box, please ensure you have contacted their local GP Associate Dean/Training Programme Director and if appropriate, their Educational Supervisor

If appropriate, does the trainee need to have any particular supervision in their next post? Y ☐  N/A ☐

(If Y please give specific detail below)

Key
Please see word descriptors for explanations of needing Further Development, Competent and Excellent within each of the 13 capabilities

For the grading of the CSR:

Needs Further Development (NFD) Below Expectations - not meeting the level of any or only meeting one or two of the NFD capability word descriptors

Needs Further Development (NFD) - meeting most of the NFD capability word descriptors

Competent - meeting the competent capability word descriptors

Excellent - meeting some or all of the excellent capability word descriptors
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AED</td>
<td>Automated External Defibrillator</td>
</tr>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
</tr>
<tr>
<td>AKT</td>
<td>Applied Knowledge Test</td>
</tr>
<tr>
<td>ARCP</td>
<td>Annual Review of Competence Progression</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>CAT</td>
<td>Care Assessment Tool</td>
</tr>
<tr>
<td>CbD</td>
<td>Case based Discussion</td>
</tr>
<tr>
<td>CCT</td>
<td>Certificate of Completion of Training</td>
</tr>
<tr>
<td>CEPS</td>
<td>Clinical Examination and Procedural Skills</td>
</tr>
<tr>
<td>COGPED</td>
<td>Committee of General Practice Education Directors</td>
</tr>
<tr>
<td>COT</td>
<td>Consultation Observation Tool</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardio- Pulmonary Resuscitation</td>
</tr>
<tr>
<td>CS</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>CSA</td>
<td>Clinical Skills Assessment</td>
</tr>
<tr>
<td>CSR</td>
<td>Clinical Supervisor's Report</td>
</tr>
<tr>
<td>EPA</td>
<td>Entrustable Professional Activity</td>
</tr>
<tr>
<td>ES</td>
<td>Educational Supervisor</td>
</tr>
<tr>
<td>ESR</td>
<td>Educational Supervisor's Review</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>Information, Management and Technology</td>
</tr>
<tr>
<td>IPU</td>
<td>Indicators of Potential Underperformance</td>
</tr>
<tr>
<td>LEA</td>
<td>Learning Event Analysis</td>
</tr>
<tr>
<td>LLE</td>
<td>Learning Log Entries</td>
</tr>
<tr>
<td>LTFTs</td>
<td>Less than full-time trainees</td>
</tr>
<tr>
<td>MiniCEX</td>
<td>Mini Clinical Evaluation Exercise</td>
</tr>
<tr>
<td>MSF</td>
<td>Multisource Feedback</td>
</tr>
<tr>
<td>NFD</td>
<td>Needs Further Development</td>
</tr>
</tbody>
</table>
OOH  Out of Hours
PDP  Personal Development Plan
PSQ  Patient Satisfaction Questionnaire
QIA  Quality Improvement Activity
QIP  Quality Improvement Programme
RCA  Recorded Consultation Assessment
SAS  Specialist and Associate Specialist
SEA  Significant Event Analysis
ST 1/2/3  Speciality Trainee in year 1/2/3
SMART  Specific / Measurable / Achievable / Realistic / Time-bound
UUC  Urgent and Unscheduled Care

Author - Dr Susan Bodgener WPBA Clinical lead for the RCGP
Enquiries – Postgraduatetraining@rcgp.org.uk