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Developing people for health and healthcare

Trainers Seminar (TS) Trainers Pack

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Trainers Seminar (TS) – Trainer Pack Contents

Trainers programme

Day 1

09:00	Arrival & Refreshments
09:30	Introduction & Welcome • Information on how the 2 days will run • Importance of completing review forms throughout the 2 days
10:00	Introduction to Small Group Work – COTs and teaching consultation skills
10:30	COTs and teaching consultation skills
11:30	Coffee Break
12:00	COTs and teaching consultation skills continued…
13:00	Lunch
14:00	COTs and teaching consultation skills continued…
15:00	Tea Break
15:30	COTs and teaching consultation skills continued…
16:30	Debrief
17:00	Finish

Day 2

09:00	Arrival & Refreshments
09:30	Introduction to Small Group Work – CBDs (please return to small groups that you were working in on day 1)
10:00	CBDs
11:00	Coffee Break
11:30	CBDs continued…
13:00	Lunch
14:00	Educational Supervisor Reports (ESRs)
15:45	Tea Break
16:00	Evaluation and form filling
16:45	Debrief
17:00	Finish

Getting your recordings ready

Dear Trainer,

We look forward to meeting you at the Trainers' Seminar shortly. For the seminar, you are required to bring a recording of the following material. **Please note, If you do not bring these recordings with you, you will be asked to leave the seminar.**

- A recording of a consultation performed by your trainee with a patient. Appropriate consent should be obtained from the patient and the consultation should be **no longer than 15 minutes in duration**.
- You should then record a tutorial where you assess that consultation for a COT and teach some consultation skills related to that recording.
- You should also record a tutorial of you performing a CBD with your trainee.

You are asked to bring your recording on a USB stick or (more preferably) a laptop. This is to hopefully reduce the number of potential IT issues on the day. Thank you.

If you plan to bring video file stored on a USB stick **only the following formats are acceptable** (often referred to as video containers or extensions).

- .avi
- .mov
- .mp4 (THE PREFERRED) – also known as MPEG-4

If you want to know what format your video file is, simply right click on its name, select properties and look under Type of File under the General tab. We'll be using a computer program called VLC media player to play your videos. Before you come to the course you can download this free software from the net and see if your video works. www.videolan.org/vlc/index.en_GB.html

More Information

If you're unfamiliar with these terms and would like to know more, these two links will explain things well.

- A video tutorial (less than 10 minutes long): www.youtube.com/watch?v=WpBjGUlBTHU
- A web page tutorial: www.dr-lex.be/info-stuff/mediaformats.html

If you would like to see some basic tutorials on video editing (and have some fun with your videos).

- If you're on a PC and using Windows Movie Maker: www.youtube.com/watch?v=7iSNpCri15w. Download Windows Movie Maker for free here: http://windows.microsoft.com/en-gb/windows-live/movie-maker
- If you're on a Mac and using iMovie: www.youtube.com/watch?v=uBMmGJwrv9c

A final note on confidentiality & security

Whichever media you choose to use to host your video file, please pay attention to its security (as it will be holding sensitive patient/trainee information). Make sure you retrieve your disk/stick at the end of each seminar day. You can buy an encrypted USB stick for extra protection (should you lose it, for example). Also remember to destroy video files once they are no longer required.

Note: selecting a file and hitting the Delete button or selecting the Delete option DOES NOT delete the file; it simply removes the name of the file – in the wrong hands, the file can be easily recovered. To securely erase the video file download the free program Eraser, but click on this link to read more: http://tinyurl.com/securewipe.

Finally, please don't wait until the last minute to do your videos. We hope you have some fun recording and editing them!

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TS Trainer Review Form

COT Assessment

Use this form as a space to record your developmental ideas and thoughts you have during the 2 training days. It will also help with the 1-1 meeting you will have with your facilitator on day 2 (the aim of which is to develop some sort of useful and tailored educational PDP). We suggest you make notes throughout the two seminar days (as 'hot issues' arise); try not to leave it all until the last day.

Trainer Name:		Practice:		Date:	
Tutor Name:					

1. Use the space below to record new things you have learnt from this session.

2. Can you list 2-3 things are you going to try as a result of this session?

CbD Assessment

3. Use the space below to record new things you have learnt from this session.

4. Can you list 2-3 things are you going to try as a result of this session?

Educational Supervision

1. What useful points are you taking away from the *Educational Supervision* session?

General Comments

Please feel free to use the space below for anything else you wish to make a note of

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Consultation Observation Tool

Doctor's Name: Doctor's GMC number: Date:

Assessor's name: Assessor's registration number:

Assessor's position:

Clinical setting: General Practice / OOH Name of organisation:

Outline of case

Using the detailed guide to the performance criteria for the COT please grade the trainee by ticking the appropriate competence level in the boxes below:

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 'NFD' (Needing further development)** 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.

Context	Identified Area	Scoring			
		Not applicable to this case	NFD	Competent	Excellent
Information gathering	Encourages the patient's contribution				
	Responds to cues				
	Places complaint in appropriate psychosocial contexts				
	Explores patient's health understanding/beliefs including identifying and addressing patients ideas and concerns and expectations				
Defines the clinical problem	Takes an appropriately thorough and focused history to allow a safe assessment (includes/excludes likely relevant significant condition)				
	Performs appropriate physical or mental state examination				
	Makes an appropriate working diagnosis				
Explains 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				
	Overall				

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 symptoms.

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 is the matter, 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 "**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 problem e.g. "how does your backache affect your life as a builder".*

PC4: The doctor explores the patient's health understanding.

This PC incorporates exploring the patients "ideas, concerns and expectations", in the context of the Unit - **"Discover the reasons for the patient's attendance"***. 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 (because the video may not be the best place for that to be assessed- however it may generate discussion in this area). 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.

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. It is essential for an adequate explanation.* 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 doctor specifically seeks to confirm the patient's understanding of the diagnosis

This competence implies a quite discrete process: a digression after the explanation, to check how well it has been understood. 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. 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.

PC10: 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. Please remember, however, that in* the UK there are large differences, due to local guidelines or resources, in the availability of investigations in primary care, such a PSA tests, access to ultrasound and echocardiography. 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!

PC11: 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.

PC12: Makes effective use of resources

This criterion relates to the doctor using resources effectively (e.g. effective use of time).

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.*

Principles of Agenda-Led Outcome Based Analysis

Organising The Feedback Process

Start With The Learner's Agenda

- Ask what problems the learner experienced and what help he would like from the rest of the group.

Look At The Outcomes Learner And Patient Are Trying To Achieve

- Thinking about where you are aiming and how you might get there encourages problem solving - effectiveness in communication is always dependent on what you and the patient are trying to achieve.

Encourage Self-Assessment And Self-Problem Solving First

- Allow the learner space to make suggestions before the group shares its ideas.

Involve The Whole Group In Problem Solving

- Encourage the group to work together to generate solutions not only to help the learner but also to help themselves in similar situations.

Giving Useful Feedback To Each Other

Use descriptive feedback to encourage a non-judgmental approach

- Descriptive feedback ensures that non-judgmental and specific comments are made and prevents vague generalisation.

Provide Balanced Feedback

- Encourage all group members to provide a balance in feedback of what worked well and what didn't work so well, thus supporting each other and maximising learning - we learn as much by analysing why something works as why it doesn't.

Make Offers And Suggestions; Generate Alternatives

- Make suggestions rather than prescriptive comments and reflect them back to the learner for consideration; think in terms of alternative approaches.

Be Well Intentioned, Valuing And Supportive

- It is the group's responsibility to be respectful and sensitive to each other.

Ensuring that analysis and feedback actually lead to deeper understanding and development of specific skills

Rehearse Suggestions

- Try out alternative phrasing and practice suggestions by role-play - when learning any skill, observation, feedback and rehearsal are required to effect change.

Value The Interview As A Gift Of Raw Material For The Group

- The interview provides the raw material around which the whole group can explore communication problems and issues: group members can learn as much as the learner being observed who should not be the constant centre of attention. All group members have a responsibility to make and rehearse suggestions.

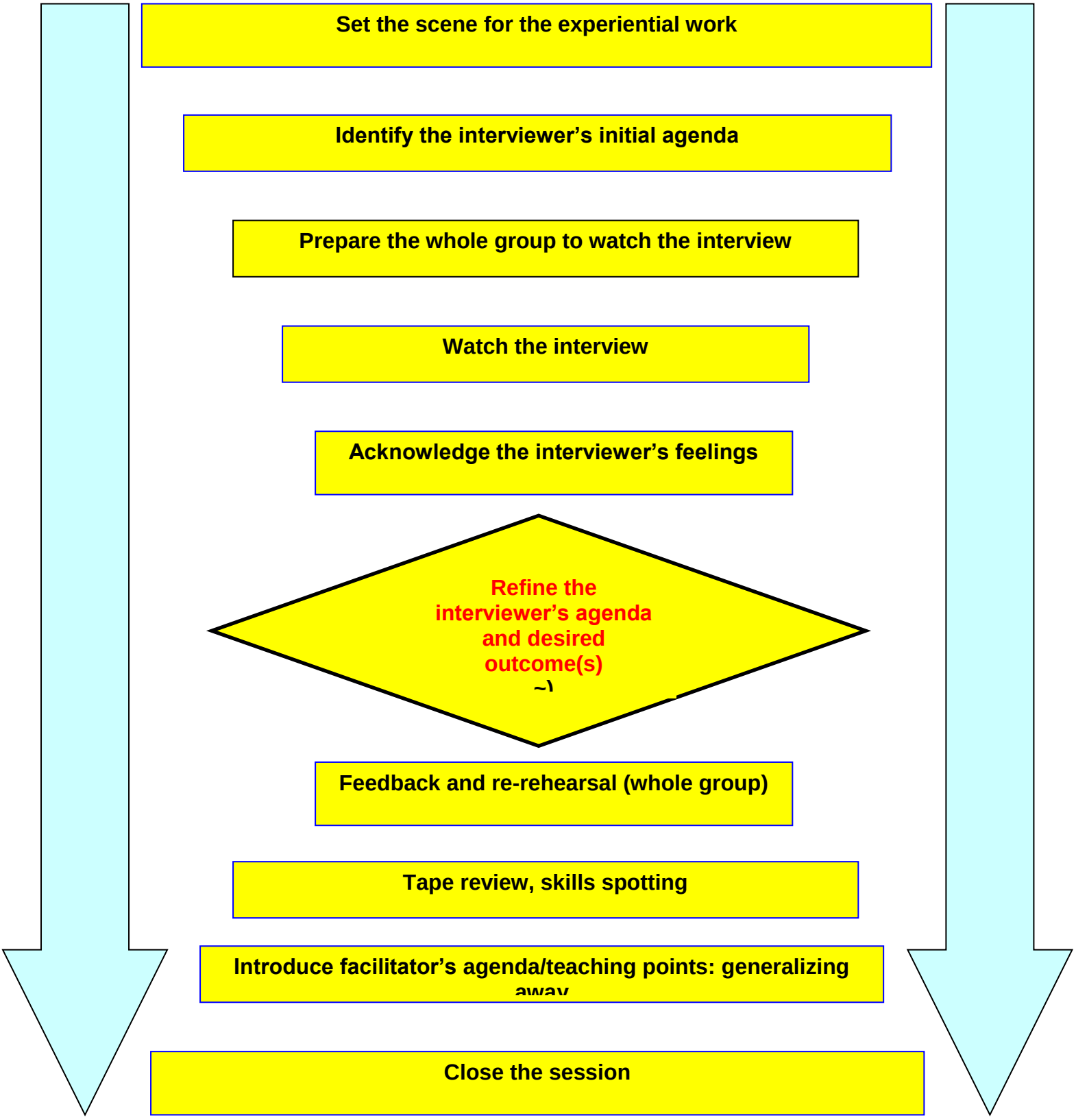
Opportunistically Introduce Theory, Research Evidence And Wider Discussion

- Offer to introduce concepts, principles, research evidence and wider discussion at opportune moments to illuminate learning for the group as a whole.

Structure And Summarise Learning So That A Constructive End Point Is Reached

- Structure and summarise learning throughout the session using the Calgary-Cambridge Guides to ensure that learners piece together the individual skills that arise into an overall conceptual framework.

ALOBA Flowchart – A Summary of the ALOBA Process (Group Based)



Planning and Conducting the CBD Interview

- One of two cases should be selected for the Discussions in years ST1 and ST2. Two out of four cases should be selected for Discussions in year ST3.

- There are descriptors of what constitutes *insufficient evidence, needs further development*, *competent* and *excellent* for each competency area in the Trainee ePortfolio and it is important that the assessor takes time to develop a clear understanding of what specific evidence will indicate each level of performance.

- The structured question guidance (see below – p.2) should be used to develop appropriate questions which will seek this evidence. It is helpful to record planned questions for easy reference throughout the interview.

- It is important to ensure that the Trainee has enough time to review the records and refresh their memory before the Discussion. The starting point for the interview should be the written records and an assessment of the quality of these records should be made and recorded.

- Using pre-prepared questions, explore the professional judgement demonstrated by the Trainee paying particular attention to situations in which uncertainty has arisen, or where a conflict of decision-making has arisen. 20 minutes should be allowed per case.

- It is important for the progress of the Trainee, that the interview is used to guide further development by offering structured feedback. The Discussions in years ST1 and ST2 should take no longer than 30 minutes, which allows about 10 minutes for feedback together with any recommendations for change.

- Throughout the Discussion, it is helpful to record evidence elicited on the notes sheet (see below – p.3). This information can then be used to inform the judgement on the level of performance of the Trainee against each competency area. At the end of **each case**, a judgement of the level of performance demonstrated by the registrar should be recorded on the marking grid along with recommendations for further development.

The RCGP gratefully acknowledges the help of the Oral Core

Group of the MRCGP examination in developing this CBD tool

CBD Structured Question Guidance

Defines the problem

- What are the issues raised in this case? What conflicts are you trying to resolve? Why did you find it difficult/challenging?

Integrates information

- What relevant information had you available? Why was this relevant?
- How did the data/information/evidence you had available help you to make your decision?
- How did you use the data/information/evidence available to you in this case? What other information could have been useful?

Prioritises options

- What were your options? Which did you choose? Why did you choose this one?
- What are the advantages/disadvantages of your decision? How do you balance them?

Considers implications

- What are the implications of your decision?
- For whom? (e.g. patient/relatives/doctor/practice/society) How might they feel about your choice?
- How does this influence your decision?

Justifies decision

- How do you justify your decision?
- What evidence/information have you to support your choice? Can you give me an example?
- Are you aware of any model or framework that helps you to justify your decision?
- How does it help you? Can you apply it to this case?
- Some people might argue, how would you convince them of your point of view? Why did you do this?

Practises ethically

- What ethical framework did you refer to in this case? How did you apply it? How did it help you decide what to do?
- How did you establish the patient's point of view?
- What are their rights? How did this influence your handling of the case?

Works in a team

- Which colleagues did you involve in this case? Why?
- How did you ensure you had effective communication with them?
- Who could you have involved? What might they have been able to offer? What is your role in this sort of situation?

Upholds duties of a doctor

- What are your responsibilities/duties? How do they apply to this case? How did you make sure you observed them? Why are they important?

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 competency area, concentrating instead on those most relevant to the case you choose. It should be unusual to cover more than four competency areas during a CbD. You should bear in mind the trainee's request to have evidence for certain competences to help them show evidence in all areas from a range of sources for each competency in this review period. The prompts below should generate information related to each competency 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 competency 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 ongoing 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 did 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, eg 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 ongoing 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 effect 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

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 safetynetting 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 assessed 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)

CBD Assessor Self-Rating Scale

Name:
Date:

This tool is to help trainers evaluate their performance in doing CBDs. On each line please choose the description you think is closest to what you see on the videotape of yourself, then put the corresponding score in the column on the right. You may find this form helpful as part of your Trainer peer appraisal (evaluating each other's video'd CBD).

The Setting of the CBD

	3	2	1	0	Score
A1	Comfortable, quiet, good light, good seating, ambience ideal.	Almost ideal but some deficiency.	Significant deficiency.	Uncomfortable, noisy, poor light, poor seating, ambience poor.	
A2	Not subject to interruption.	Minimal interruption.	Several interruptions.	Interruptions ruin the session.	

The Process of the CBD

	3	2	1	0	Score
B1	It is clear that the trainer has read and understood the case before the start of the session.	The trainer has read and understood most of the case before the session; there were only a couple of points that the trainee needed to correct them on.	The trainer has not read nor understood the case properly. There were a number of inaccuracies that the trainee had to rectify.	It is apparent that the trainer has not read the case at all. The GP trainee has not prepared either.	
B2	The trainer explicitly **summarises** which domains are going to be assessed at the beginning.	Trainer signposts some domains which are going to be assessed but not all.	The domains are mentioned but not in a CLEAR enough way.	No mention of any competencies which are going to be assessed at the beginning.	
	e.g. 'Today, were going to look at 4 competency domains. These are....'				
B3	Trainer **signposts each** competency domain before firing the questions related to that domain	Trainer signposts most competency domains before firing the questions .	Most questions are fired off without being told what competency domain they relate to.	There is no signposting to any competency domain before asking the questions.	
	e.g. 'Okay, let's move on. The next set of questions relate to the competency domain.....'				
B4	The trainer has clearly prepared the MAIN competency specific questions in advance	The trainer has clearly prepared the MAIN competency specific questions in advance.	Most of the questions were made up on the spot. Some had been prepared beforehand.	The trainer has not prepared any questions in advance. Most are thought off and fired on the spot.	
B5	Trainer asks questions which are clear and specific.	Questions are only occasionally unclear in meaning.	Questions are mostly unclear in meaning.	Questions are vague and muddled.	
B6	Questions are appropriate for the competency domain being tested.	Most questions asked are appropriate for the competency domain being tested. One or two are debateable.	For a lot of the questions it is debateable whether they are valid for the competency being assessed.	All or nearly all questions are not valid for the competency being assessed.	
B7	Trainer assesses each competency to some depth. The trainer asks challenging questions which really push the trainee.	Trainer assesses most competencies to some depth. There is some constructive challenge.	Mixed performance of depth vs breadth. Trainer challenges very little.	Exploration is superficial. There is no challenge.	
	Note that a trainer should have a main set of questions for each competency being assessed. The good CBD assessor will formulate and ask new questions in response to what the trainee says – to explore the competency area in a more deeply contextual way.				

Dr. Ramesh Mehay, Programme Director (Bradford VTS), 2010

B8	Trainer frequently asks the trainee to justify what they did (actions, behaviour, decisions).	There is some good evidence of seeking justification.	There is little evidence of seeking justification.	There is no seeking of justification for actions, behaviour or decisions.	
	A trainee might justify their behaviour based on a) written guidance/protocols b) the evidence c) on ethical grounds or d) after weighing up the pros and cons				
B9	Trainer does not ask any hypothetical 'What if' questions or scenarios.	Trainer asks the odd hypothetical question.	Trainer asks a number of hypothetical questions.	Nearly all questions are hypothetical. This was more of a random case analysis (RCA) that a CBD!	
B10	Trainer reads trainee's verbal and non verbal cues – and explores further.	Trainer reads and explores some cues but misses others.	Most cues are missed.	Does not pick up on any cues.	
	'You seem a bit hesitant about that....' or 'You say that you thoroughly explored xxxx but in the clinical notes, you've not made any reference to it. Why is there the discrepancy?'				
B11	The trainer encourages and gives time to allow the trainee to express him or herself.	The trainee, on the whole, is encouraged and given time to express him or herself.	The trainee is often not given enough time to express him or herself.	The trainer interrupts too quickly and is not particularly encouraging. The questions and environment are threatening as evidenced by the behaviour of the trainee.	
B12	Good rapport, mutual respect and sensitivity evident	Rapport mostly good, trainer sensitive	Little evidence of rapport, trainer insensitive at times	Relationship appears cold or hostile, lack of mutual respect, trainer insensitive	

The Feedback at the End

	3	2	1	0	Score
C1	GP trainee is encouraged to self evaluate their performance in specific terms – what was good, what needs work.	GP trainee is reasonably encouraged to self evaluate.	GP trainee is briefly and superficially encouraged to self evaluate.	Trainer does not ask the GP trainee to self evaluate.	
C2	The trainer gives **specific and constructive** feedback on what went well.	There was some explicit statement of what was done well.	There was some statement of what was done well but this was rather vague and unclear.	There was not feedback given on what was done well.	
C3	The trainer gives **specific and constructive** feedback what needs working on.	There was some feedback on what needs working on. A few smaller areas missed.	There was some feedback on what needs working on but this was unclear and vague.	There was no feedback on what needs working on.	
C4	Trainer is sensitive in giving feedback.	Trainer is mostly sensitive.	Mixed performance of sensitivity and insensitivity.	Feedback given in a destructive manner.	
C5	The trainer discusses learning plans to tackle those future learning needs.	There was some discussion of learning plans.	There was some discussion of learning plans but this was vague or superficial.	There was no discussion on future learning plans.	
C6	Trainer checks with GP trainee to see if they understand and are agreeable with the recommendations made.	Recommendations mostly checked and okayed with GP trainee.	Understanding/agreement of GP trainee is superficial.	No explicit step is made to check that the GP trainee's understanding or whether they are agreeable with the recommendations.	
	Sometimes a trainee might not agree with what you say (even though you may be right). The good trainer will always seek to clarify the reasons behind the disagreement in order to get both parties amicably on the same track.				
C7	Useful summarising done by either trainer or GP trainee.	Summarising attempted, mostly useful.	Some attempt at summarising, but was not useful.	No evidence of summarising.	

Do you want to improve and become even better?

1. Then read the document called *'Hot tips for Doing CBDs – for trainers'* on www.bradfordvts.co.uk (click MRCGP, then CBD and you'll find it in the downloads section there)

CBD – What the Competencies Mean

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*	**1. Communication and Consulting Skills** *This competency is about communication with patients, and the use of recognised consultation techniques*		
	Needs Further Development	**Competent**	**Excellent**
Does not establish rapport with the patient Makes inappropriate assumptions about the patients agenda Misses / ignores significant cues Does not give space and time to the patient when this is needed	Develops a working relationship with the patient, but one in which the problem rather than the person is the focus	Explores the patient's agenda, health beliefs and preferences. Elicits psychological and social information to place the patient's problem in context	Incorporates the patient's perspective and context when negotiating the management plan
The approach is inappropriately doctor- centred	Produces management plans that are appropriate to the patient's problem	Works in partnership with the patient, negotiating a mutually acceptable plan that respects the patient's agenda and preference for involvement	Whenever possible, adopts plans that respect the patient's autonomy
Uses stock phrases / inappropriate medical jargon rather than tailoring the language to the patients' needs and context	Provides explanations that are relevant and understandable to the patient, using appropriate language	Explores the patient's understanding of what has taken place	Uses a variety of communication techniques and materials to adapt explanations to the needs of the patient
Has a blinkered approach and is unable to adapt the consultation despite cues or new information	Achieves the tasks of the consultation but uses a rigid approach	Flexibly and efficiently achieves consultation tasks, responding to the consultation preferences of the patient	Appropriately uses advanced consultation skills such as confrontation or catharsis to achieve better patient outcomes

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*	**2. Practising Holistically** *This competency is about the ability of the doctor to operate in physical, psychological, socio-economic and cultural dimensions, taking into account feelings as well as thoughts*		
	Needs Further Development	**Competent**	**Excellent**
Treats the disease, not the patient	Enquires into both physical and psychological aspects of the patient's problem	Demonstrates understanding of the patient in relation to their socio-economic and cultural background	Uses this understanding to inform discussion and to generate practical suggestions for patient management
	Recognises the impact of the problem on the patient	Additionally, recognises the impact of the problem on the patient's family/carers	Recognises and shows understanding of the limits of the doctor's ability to intervene in the holistic care of the patient
	Uses him/herself as the sole means of supporting the patient	Utilises appropriate support agencies (including primary health care team members) targeted to the needs of the patient	Organises appropriate support for the patient's family and carers

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Has an approach which is disorganised, chaotic, inflexible or inefficient Does not use significant data as a prompt to gather further information Does not look for red flags appropriately Fails to identify normality
Examination technique is poor Fails to identify significant physical or psychological signs

3. Data Gathering and Interpretation

This competency is about the gathering and use of data for clinical judgement, the choice of examination and investigations and their interpretation

Needs Further Development	Competent	Excellent
Obtains information from the patient that is relevant to their problem	Systematically gathers information, using questions appropriately targeted to the problem Makes appropriate use of existing information about the problem and the patient's context	Proficiently identifies the nature and scope of enquiry needed to investigate the problem
Employs examinations and investigations that are broadly in line with the patient's problem.	Chooses examinations and targets investigations appropriately	
Identifies abnormal findings and results	Identifies the implications of findings and results	Uses an incremental approach, basing further enquiries, examinations and tests on what is already known and what is later discovered

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Is indecisive, illogical or incorrect in decision- making Fails to consider the serious possibilities. Is dogmatic/closed to other ideas Too frequently has late or missed diagnoses

4. Making a diagnosis/making decisions

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

Needs Further Development	Competent	Excellent
Taking relevant data into account, clarifies the problem and the nature of the decision required	Addresses problems that present early and in an undifferentiated way by integrating information to aid pattern recognition Uses time as a diagnostic tool Uses an understanding of probability based on prevalence, incidence and natural history of illness to aid decision-making	Uses methods such as models and scripts to identify patterns quickly and reliably. Uses an analytical approach to novel situations where probability cannot be readily applied
Generates and tests an appropriate hypothesis Makes decisions by applying rules or plans	Revises hypotheses in the light of additional information Thinks flexibly around problems, generating functional solutions	No longer relies on rules alone but is able to use and justify discretionary judgement in situations of uncertainty

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Asks for help inappropriately: either too much or too little
Does not think ahead, safety net appropriately or follow-through adequately

5. Clinical Management

This competency is about the recognition and management of common medical conditions in primary care

Needs Further Development	Competent	Excellent
Recognises the presentation of common physical, psychological and social problems	Utilises the natural history of common problems in developing management plans	Monitors patient's progress to identify quickly unexpected deviations from anticipated path
Responds to the problem by routinely suggesting intervention	Considers simple therapy/expectant measures where appropriate	Uses drug & non-drug methods in the treatment of the patient, appropriately using traditional & complementary medical approaches
Uses appropriate but limited management options with little flexibility for the preferences of others	Varies management options responsively according to the circumstances, priorities and preferences of those involved	Generates and offers justifiable approaches where specific guidelines are not available
Makes appropriate prescribing decisions, routinely using important sources of information	Routinely checks on drug interactions and side effects and shows awareness of national and local prescribing guidance	Prescribes cost-effectively but is able to justify transgressions of this principle
Performs up to, but does not exceed, the limits of their own competence	Refers appropriately & co-ordinates care with other professionals in primary care and other specialists	Identifies and encourages the development of new resources where these are needed
Ensures that continuity of care can be provided for the patient's problem e.g. through adequate record keeping	Provides continuity of care for the patient rather than just the problem, reviewing care at suitable intervals	Contributes to an organisational infrastructure & professional culture that allows continuity of care to be facilitated and valued
Responds rapidly and skilfully to emergencies	Appropriately follows-up patients who have experienced a medical emergency, and their family	Ensures that emergency care is co- ordinated within the practice team and integrated with the emergency services

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Inappropriately burdens the patient with uncertainty Finds it difficult to suggest a way forward in unfamiliar circumstances
Often gives up in complex or uncertain situations. Is easily discouraged or frustrated, for example by slow progress or lack of patient engagement

6. Managing Medical Complexity

This competency is about aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty and risk, and the approach to health rather than just illness

Needs Further Development	Competent	Excellent
Manages health problems separately, without necessarily considering the implications of co-morbidity.	Simultaneously manages the patient's health problems, both acute and chronic	Accepts responsibility for coordinating the management of the patient's acute and chronic problems over time
Draws conclusions when appropriate Appropriately prioritises management approaches, based on an assessment of patient risk	Is able to tolerate uncertainty, including that experienced by the patient, where this is unavoidable Communicates risk effectively to patients & involves them in its management to the appropriate degree	Anticipates and uses strategies for managing uncertainty Uses strategies such as monitoring, outcomes assessment and feedback to minimise the adverse effects of risk
Maintains a positive attitude to the patient's health	Consistently encourages improvement and rehabilitation and, where appropriate, recovery. Encourages the patient to participate in appropriate health promotion and disease prevention strategies.	Coordinates a team based approach to health promotion, prevention, cure, care and palliation and rehabilitation

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Consults with the computer rather than the patient
Records show poor entries e.g. too short, too long, unfocused, failing to code properly or respond to prompts

7. 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.

Needs Further Development	Competent	Excellent
Demonstrates a rudimentary 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
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.
Personal organisational and time-management 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	Manages own work effectively whilst maintaining awareness of other people's workload. Offers help sensitively but recognises own limitations
Responds positively to change in the organisation	Helps to support change in the organisation. This may include making constructive suggestions	Actively facilitates change in the organisation. This will include the evaluation of the effectiveness of any changes implemented
Manages own workload responsibly	Responds positively when services are under pressure in a responsible and considered way.	Willing to take a lead role in helping the organisation to respond to exceptional demand.

Indicators of Potential Underperformance ***Not** a level below NFD* *See Guidance*
Has an inflexible approach to working with colleagues
Works in isolation Gives little support to team members Doesn't appreciate the value of the team Inappropriately leaves their work for others to pick up Feedback (formal or informal) from colleagues raises concerns

8. Working with Colleagues and in Teams

This competency is working effectively with other professionals to ensure patient care, including the sharing of information with colleagues

Needs Further Development	Competent	Excellent
Meets contractual obligations to be available for patient care	Provides appropriate availability to colleagues	Anticipates situations that might interfere with availability & ensures that patient care is not compromised
Appropriately utilises the roles and abilities of other team members When requested to do so, appropriately provides information to others involved in the care of the patient	Works co-operatively with the other members of the team, seeking their views, acknowledging their contribution and using their skills appropriately Communicates proactively with team members so that patient care is not compromised In relation to the circumstances, chooses an appropriate mode of communication to share information with colleagues and uses it effectively	Encourages the contribution of colleagues and contributes to the development of the team

Indicators of Potential Underperformance ***Not** a level below NFD* *See Guidance*
Fails to take responsibility for using resources in line with local and national guidance

9. Community Orientation

This competency is about the management of the health and social care of the practice population and local community

Needs Further Development	Competent	Excellent
Identifies important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features	Applies an understanding of these features to improve the management of the practice's patient population	Uses an understanding of these features to contribute to the development of local healthcare delivery e.g. service design
Identifies important elements of local health care provision in hospital and in the community and how these can be appropriately accessed by doctors and patients	Uses this understanding to inform referral practices and to encourage patients to access available resources	Uses an understanding of the resources and the financial and regulatory frameworks within which primary care operates, to improve local healthcare
Identifies how the limitations of local healthcare resources might impact upon patient care	Optimises the use of limited resources, e.g. through cost-effective prescribing	Balances the needs of individual patients with the health needs of the local community, within the available resources

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*	10. Maintaining Performance, Learning and Teaching *This competency is about maintaining performance & effective continuing professional development of oneself and others*		
	Needs Further Development	**Competent**	**Excellent**
	Accesses the available evidence, including the medical literature, clinical performance standards and guidelines for patient care	Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision-making	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.
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 Reacts with resistance to feedback that is perceived as critical Fails to make adequate educational progress	Routinely engages in study to keep abreast of evolving clinical practice and contemporary medical issues	Shows a commitment to professional development through reflection on performance and the identification of and attention to learning needs Evaluates the process of learning so as to make future learning cycles more effective	Systematically evaluates performance against external standards, using this information to inform peer discussion. Demonstrates how elements of personal development are related to the needs of the organisation. Uses the mechanism of professional development to aid career planning.
	Changes behaviour appropriately in response to the clinical governance activities of the practice, in particular to the agreed outcomes of audit and significant event analysis Recognises situations, e.g. via risk assessment, where patient safety could be compromised	Participates in audit where appropriate and uses audit activity to evaluate and suggest improvements in personal and practice performance Engages in significant event reviews and learns from them as a team-based exercise	By involving the team and the locality, encourages and facilitates wider participation and application of clinical governance activities
	Contributes to the education of students and colleagues	Identifies learning objectives and uses teaching methods appropriate to these Assists in making assessments of learners	Evaluates outcomes of teaching, seeking feedback on performance. Uses formative assessment and constructs educational plans. Ensures students and junior colleagues are appropriately supervised.

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Does not consider ethical principles, such as good vs harm, and use this to make balanced decisions
Fails to show willingness to reflect on own attitudes

11. Maintaining an Ethical Approach to Practise

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

Needs Further Development	Competent	Excellent
Observes the professional codes of practice, showing awareness of their own values, attitudes and ethics and how these might influence professional behaviour	Identifies and discusses ethical conflicts in clinical practice	Anticipates and avoids situations where personal and professional interests might be brought into conflict
Treats patients, colleagues and others equitably and with respect for their beliefs, preferences, dignity and rights	Recognises and takes action to address prejudice, oppression and unfair discrimination within the self, other individuals and within systems	Actively promotes equality of opportunity for patients to access health care and for individuals to achieve their potential
Recognises that people are different and does not discriminate against them because of those differences	Values diversity by harnessing differences between people for the benefit of practice and patients alike	

Indicators of Potential Underperformance ***Not*** *a level below NFD* *See Guidance*
Fails to respect the requirements of the organisation e.g. meeting deadlines, producing documentation, observing contractual oblig. Has repeated unexplained or unplanned absences from professional commitments
Prioritises own interests above those of patient Fails to cope adequately with pressure e.g. dealing with stress or managing time
Is the subject of multiple complaints

12. Fitness to Practise

This competency is about the doctor's awareness of when his/her own performance, conduct or health, or that of others might put patients at risk and the action taken to protect patients

Needs Further Development	Competent	Excellent
Understands and maintains awareness of the GMC duties of a doctor	Observes the accepted codes of practice in order to minimise the risk of disciplinary action or litigation	Encourages scrutiny and justifies professional behaviour to colleagues
Attends to professional demands whilst showing awareness of the importance of addressing personal needs	Achieves a balance between professional and personal demands that protects professional obligations & preserves health	Anticipates situations that might damage the work/life balance and seeks to minimise the adverse effects
Attends to physical or mental illness or habit that might interfere seriously with the competent delivery of patient care	Proactive in taking steps to maintain personal health	Promotes an organisational culture in which the health of its members is valued and supported
Notifies when his/her own or a colleague's performance, conduct or health might be putting patients at risk	Promptly, discreetly and impartially ascertains the facts of the case, takes advice from colleagues and, if appropriate, engages in a referral procedure	Provides positive support to colleagues who have made mistakes or whose performance gives cause for concern
Responds to complaints appropriately	Where personal performance is an issue, seeks advice & engages in remedial action	Uses mechanisms to learn from performance issues and to prevent them from occurring in the organisation

CBD Question Maker for Trainers (Ram's)

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.

Practising Holistically - *physical, psychological, socio-economic and cultural dimensions; patient's feelings and thoughts*

- What was the patient's agenda (I.C.E.)? How did you elicit this? Why present now? What feelings did you explore?
- Did you identify any ongoing problems which might have affected this particular complaint?
- How did you establish the patient's point of view? What consultation skills did you use to do this?
- What effect did the symptoms have on the patient's work, family and other parts of their life? (illness vs. Disease)
- How did the symptoms affect him/her psychosocially? What phrases did you use to elicit these?
- Were there any cultural dimensions to this consultation? How did you pick these up?
- Did you explore the impact it had on other family members? What did you find? How did you support them?

GRADE

Needs further development	*Competent*	*Excellent*
● *Enquires into both physical and psychological aspects of the patient's problem.* ● *Recognises the impact of the problem on the patient.* ● *Uses him/herself as the sole means of supporting the patient.*	● *Demonstrates understanding of the patient in relation to their socio-economic and cultural background* ● *Additionally, recognises the impact of the problem on the patient's family/carers.* ● *Utilises appropriate support agencies (including primary health care team members) targeted to the needs of the patient.*	● *Uses this understanding to inform discussion and to generate practical suggestions for patient management.* ● *Recognises and shows understanding of the limits of the doctor's ability to intervene in the holistic care of the patient.* ● *Organises appropriate support for the patient's family and carers.*

Data gathering and interpretation - *gathering and using data for clinical judgement, the choice of examination and investigations and their interpretation.*

- Specifics about the case: duration, symptoms, specific features like biological features for depression etc. What phrase did you use?
- Excluding the serious stuff. For example: What alarm features did you enquire about?; How did you carry out a suicidal risk assessment?; How did you exclude a brain tumour? etc.
- What consultation skills did you use to obtain the history in this case? Examples of phrases used.
- What pre-existing information did you use to help formulate your diagnosis/decision? (consultations, summary, letters, investigations)
- Had you gathered any further information about this case from others?
- What bits of information (from Hx/Ex/Ix) did you find helpful in this case? Why? How did you elicit those?
- What examination/investigations did you make? Why did you do those (justify)? Were there any abnormalities?
- I see from the notes that there is no reference to examining her "chest" (say). Why is it not there?
- What prior knowledge of the patient did you have which affected the outcome of your consultation(s)?

GRADE

Needs further development	*Competent*	*Excellent*
● *Obtains information from the patient that is relevant to their problem.* ● *Employs examinations and investigations that are broadly in line with the patient's problem.* ● *Identifies abnormal findings and results*	●*Systematically gathers information, using questions appropriately targeted to the problem.* ● *Makes appropriate use of existing information about the problem and the patient's context.* ● *Chooses examinations and targets investigations appropriately.* ● *Identifies the implications of findings and results.*	● *Proficiently identifies the nature and scope of enquiry needed to investigate the problem.* ● *Uses an incremental approach, basing further enquiries, examinations and tests on what is already known and what is later discovered.*

DIAGNOSIS

- What were you particularly worried about in this case?
- What differential diagnoses did you consider? What features made each one more or less likely?
- How did you come to your final working diagnosis? Remind me which bits of the history and examination were instrumental in this?
- Did you use any tools, guidelines or frameworks to help you with the diagnosis?

TREATMENT DECISIONS

- What were your 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 the patient feel about your choice of treatment? Did this influence your final decision?
- Did you consider the implications of your decision for the relatives/doctor/practice/society? In what way?
- Did you use any tools, guidelines or frameworks to help you with treatment decisions?

Making diagnoses & decisions - *conscious, structured approach to decision-making*

GRADE

Needs further development	*Competent*	*Excellent*
● *Taking relevant data into account, clarifies the problem and the nature of the decision required.* ● *Generates and tests an appropriate hypothesis.* ● *Makes decisions by applying rules or plans.*	● *Addresses problems that present early and in an undifferentiated way by integrating information to aid pattern recognition.* ● *Uses time as a diagnostic tool.* ● *Uses an understanding of probability based on prevalence, incidence and natural history of illness to aid decision-making.* ● *Revises hypotheses in the light of additional information.* ● *Thinks flexibly around problems, generating functional solutions.*	● *Uses methods such as models and scripts to identify patterns quickly and reliably.* ● *Uses an analytical approach to novel situations where probability cannot be readily applied.* ● *No longer relies on rules alone but is able to use and justify discretionary judgement in situations of uncertainty.*

Developed by Dr. Ramesh Mehay, Programme Director Bradford VTS (Dec 2006, updated April 2010). Look at www.bradfordvts.co.uk for more resources.

Clinical Management - *recognition and management of common medical conditions*

- What were your main priorities here (physical, psychological, social)? How did that affect your final management plan?
- What management options did you consider at the time? What were they? 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 xxx? How did you come to choosing that? What does the evidence say about it? Do you know how much that costs? Why not xxx which is cheaper and effective? What else is the patient on: did you check for interactions?
- Why did you do those investigations? What were you looking for?
- Did you make a referral to or involve anyone else? Did you speak to anyone first? What did you actually put in the referral letter?
- Did you use any guidelines to help you?
- Describe how you monitored the patient's progress. How did you ensure continuity of care? Did you put into place any follow up/review? Why do you want to see her again?

GRADE

Needs further development	*Competent*	*Excellent*
● *Recognises the presentation of common physical, psychological and social problems.*	● *Utilises the natural history of common problems in developing management plans.*	● *Monitors the patient's progress to identify quickly unexpected deviations from the anticipated path*
● *Responds to the problem by routinely suggesting intervention*	● *Considers simple therapy/expectant measures where appropriate*	● *Uses drug and non-drug methods in the treatment of the patient, appropriately using traditional and complementary medical approaches*
● *Uses appropriate but limited management options with little flexibility for the preferences of others*	● *Varies management options responsively according to the circumstances, priorities and preferences of those involved*	● *Generates and offers justifiable approaches where specific guidelines are not available*
● *Makes appropriate prescribing decisions, routinely using important sources of information*	● *Routinely checks on drug interactions and side effects and shows awareness of national and local prescribing guidance*	● *Prescribes cost-effectively but is able to justify transgressions of this principle*
● *Performs up to, but does not exceed, the limits of their own competence*	● *Refers appropriately and co-ordinates care with other professionals in primary care and with other specialists*	● *Identifies and encourages the development of new resources where these are needed*
● *Ensures that continuity of care can be provided for the patient's problem e.g. through adequate record keeping*	● *Provides continuity of care for the patient rather than just the problem, reviewing care at suitable intervals. Appropriately follows-up patients who have experienced a medical emergency, and their family*	● *Contributes to an organisational infrastructure and professional culture that allows continuity of care to be facilitated and valued*
● *Responds rapidly and skilfully to emergencies*		● *Ensures that emergency care is co-ordinated within the practice team and integrated with the emergency services*

Managing medical complexity - *beyond managing straight-forward problems, eg managing co-morbidity, uncertainty & risk, approach to health rather than just illness*

- How did you generally FEEL about this case? (concentrate on feelings). What made this case particularly difficult? 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 co-ordinate in this consultation – from the acute to the chronic co-morbidities. Did you find it difficult? What strategies did you use to co-ordinate it all?
- Do you think the patient kind of pushed you into investigation/referral/treatment (e.g. with abx)? How do you feel about this? What did you learn from this case?
- What did you do to alter his help seeking behaviour?
- Was there a difference of agendas? How did you tackle this? (e.g. demanding patient, difficult angry patient, overbearing heart sinks etc). Tell me exactly how you managed to merge agendas.
- Were there any ongoing problems that added to the complexity of this case?
- 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?
- How did you make use of time? (either using time as a tool for diagnosis or time management)
- Did you use any health promotion strategies? How did you encourage the patient to stop smoking/lose weight/go back to work/other rehabilitation and recovery?

GRADE

Needs further development	*Competent*	*Excellent*
● *Manages health problems separately, without necessarily considering the implications of co-morbidity.*	●*Simultaneously manages the patient's health problems, both acute and chronic*	● *Accepts responsibility for coordinating the management of the patient's acute and chronic problems over time*
● *Draws conclusions when it is appropriate to do so*	● *Is able to tolerate uncertainty, including that experienced by the patient, where this is unavoidable*	● *Anticipates and uses strategies for managing uncertainty.*
● *Appropriately prioritises management approaches, based on an assessment of patient risk*	● *Communicates risk effectively to patients and involves them in its management to the appropriate degree.*	● *Uses strategies such as monitoring, outcomes assessment and feedback to minimise the adverse effects of risk*
● *Maintains a positive attitude to the patient's health*	●*Consistently encourages improvement and rehabilitation and, where appropriate, recovery.*	● *Coordinates a team-based approach to health promotion, prevention, cure, care and palliation and rehabilitation*
	● *Encourages the patient to participate in appropriate health promotion and disease prevention strategies*	

Developed by Dr. Ramesh Mehay, Programme Director Bradford VTS (Dec 2006, updated April 2010). Look at www.bradfordvts.co.uk for more resources.

Primary care admin and IMT - *primary care admin systems, effective recordkeeping and online info to aid patient care*

- Look at the trainee's computer record entry: satisfactory? Ask trainee: *"Do you think what you have documented is coherent and comprehensible?"* Have any important negatives been left out? Have they captured the patient's narrative? Is it concise yet thorough?
- Did they use Read codes: the right ones? Why those Read codes? Why are Read codes important? Did they add anything to the patient's summary section? (e.g. new diagnosis of COPD/Angina etc)
- Have they written up a future management plan for colleagues (in case they're not there at review)? Why not?
- Consultation entry added in a timely manner? (esp. Important for home visits)
- How did you use the computer in the consultation? (previous consults, results, opening letter, online resources etc.)
- Were there any inaccuracies in the records that you corrected?
- What consultation skills did you use to stop it from interrupting the flow of the consultation or obstructing rapport?
- How did the use of the computer improve or help you with the care of the patient?
- Did you use any part of the computer system to communicate with others? (e.g. email, electronic referrals and so on)
- Did you use any online information or resources to help you? What? Why? How?

GRADE

Needs further development	*Competent*	*Excellent*
● *Demonstrates a rudimentary understanding of the organisation of primary care and the use of primary care computer systems* ● *Uses the computer record and online information during the consultation* ● *Routinely records and codes each clinical contact in a timely manner and follows the record-keeping conventions of the practice*	● *Uses the primary care organisational and IMT systems routinely and appropriately in-patient care* ● *Uses the computer during the consultation whilst maintaining rapport with the patient* ● *Produces records that are coherent and comprehensible, appropriately and securely sharing these with others who have legitimate access to them*	● *Uses and modifies organisational and IMT systems to facilitate:* *- Clinical care to individuals and communities* *- Clinical governance* *- Practice administration* ● *Incorporates the computer records and online information in the consultation to improve communication with the patient* ● *Seeks to improve the quality and usefulness of the medical record e.g. through audit*

- Did you involve anyone else in this case? Who? Why? How did they help?
- Did you involve any other organisations/agencies in this case? For what purpose?
- Did anyone else provide you with information you found useful with your case?
- What information did you provide with your referral? How was this passed on?
- How did you ensure you had effective communication with others involved in this particular case?
- If many people/organisations are involved in the case, ask: *"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 coordinate the overall care to promote more effective team working?"*
- What steps did you take to ensure continuity of care (in case you're not there for the next)?

Working with colleagues and in teams - *working effectively; sharing information with colleagues*

GRADE

Needs further development	*Competent*	*Excellent*
● *Meets contractual obligations to be available for patient care* ● *Appropriately utilises the roles and abilities of other team members.* ● *When requested to do so, appropriately provides information to others involved in the care of the patient*	● *Provides appropriate availability to colleagues* ● *Works co-operatively with the other members of the team, seeking their views, acknowledging their contribution and using their skills appropriately.* ● *Communicates proactively with team members so that patient care is not compromised.* ● *In relation to the circumstances, chooses an appropriate mode of communication to share information with colleagues and uses it effectively*	● *Anticipates situations that might interfere with availability and ensures that patient care is not compromised* ● *Encourages the contribution of colleagues and contributes to the development of the team*

- Had you any thoughts at the time about the cost of investigation/treatment/referral? Tell me what you considered.
- Did you think about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more about the conflicts. How did you balance the needs of this patient against the needs of the whole practice 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. weight loss/exercise classes)
- 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 practice population? Did you do anything to make this happen?

Community orientation - *management of health and social care of local community*

GRADE

Needs further development	*Competent*	*Excellent*
● *Identifies important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features* ● *Identifies important elements of local health care provision in hospital and in the community and how these can be appropriately accessed by doctors and patients* ● *Identifies how the limitations of local healthcare resources might impact upon patient care*	● *Applies an understanding of these features to improve the management of the practice's patient population* ● *Uses this understanding to inform referral practices and to encourage patients to access available resources* ● *Optimises the use of limited resources, e.g. through cost-effective prescribing*	● *Uses an understanding of these features to contribute to the development of local healthcare delivery e.g. service design.* ● *Uses an understanding of the resources and the financial and regulatory frameworks within which primary care operates, to improve local healthcare* ● *Balances the needs of individual patients with the health needs of the local community, within the available resources*

Developed by Dr. Ramesh Mehay, Programme Director Bradford VTS (Dec 2006, updated April 2010). Look at www.bradfordvts.co.uk for more resources.

Maintaining an ethical approach to practice - *ethical practise, integrity, respect for diversity*

- Had you any ethical considerations when dealing with this case? What were they? So how did you resolve this? (e.g. sick notes – individual vs. society; rights based versus utilitarian approach)
- Did any of your own values affect/nearly affect this case? What particular professional codes of practise did you have to make sure you adhered to in this case? (e.g. with gay patients, ethnic minorities, asylum seekers, those on benefits and so on)
- Do you think you might have directly/indirectly discriminated and therefore judged this patient because of their xxxx? If not – how did you anticipate it – making sure the patient didn't feel discriminated against?? (e.g. with gay patients, ethnic minorities, asylum seekers and so on)
- 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 reassure the patient about confidentiality? (esp. in cases where the patient is a teenager)

GRADE

Needs further development	*Competent*	*Excellent*
● *Observes the professional codes of practice, showing awareness of their own values, attitudes and ethics and how these might influence professional behaviour* ● *Treats patients, colleagues and others equitably and with respect for their beliefs, preferences, dignity and rights* ● *Recognises that people are different and does not discriminate against them because of those differences*	● *Identifies and discusses ethical conflicts in clinical practice* ● *Recognises and takes action to address prejudice, oppression and unfair discrimination within the self, other individuals and within systems*	● *Anticipates and avoids situations where personal and professional interests might be brought into conflict* ● *Actively promotes equality of opportunity for patients to access health care and for individuals to achieve their potential* ● *Values diversity by harnessing differences between people for the benefit of practice and patients alike*

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. No doubt it must have caused some internal feelings. How did you manage or neutralise those to ensure they did not impact on the next patient consultation?
- How were things at home at the time of the consultation? Any difficulties? (If yes): what strategies did you use to ensure that they did not impact on the consultation?
- Safety Netting: did you advise on when to come back? What did you actually say? (protecting patients)
- Chaperones: did you use a chaperone? So what was the purpose of getting the chaperone? Was it for your benefit or theirs? (protecting patients, protecting doctors)
- After the consultation, did you have any thoughts on your performance (including knowledge)? Did you have any thoughts on how your performance could have been bettered? What were these? Have you made any plans to tackle them? (PUNs and DENs)
- Were there any significant events 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 the MPPS/MDU for advice? (If relevant to the case) Why did you call them? What did you ask? What did they say?

GRADE

Needs further development	*Competent*	*Excellent*
● *Understands and maintains awareness of the GMC duties of a doctor* ● *Attends to professional demands whilst showing awareness of the importance of addressing personal needs* ● *Attends to physical or mental illness or habit that might interfere seriously with the competent delivery of patient care* ● *Notifies when his/her own or a colleague's performance, conduct or health might be putting patients at risk* ● *Where personal performance is an issue, seeks advice and engages in remedial action*	● *Observes the accepted codes of practice in order to minimise the risk of disciplinary action or litigation* ● *Achieves a balance between professional and personal demands that protects professional obligations and preserves health* ● *Proactive in taking steps to maintain personal health* ●*Promptly, discreetly and impartially ascertains the facts of the case, takes advice from colleagues and, if appropriate, engages in a referral procedure.* ● *Uses mechanisms to learn from performance issues and to prevent them from occurring in the organisation*	● *Encourages scrutiny and justifies professional behaviour to colleagues.* ● *Anticipates situations that might damage the work/life balance and seeks to minimise the adverse effects* ● *Promotes an organisational culture in which the health of its members is valued and supported* ● *Provides positive support to colleagues who have made mistakes or whose performance gives cause for concern*

OTHER NOTES FOR TRAINERS:

- *When asking the GP trainee to present the case, start by asking them: 1. What issues they felt the case raised, 2. What issues they felt needed resolving and 3. What bits they found challenging/difficult? This will help you focus your questions.*
- *It is very important that questions are based on the "here and now" e.g. 'What were her concerns then?'; 'What did she think was going on?'; 'How did you elicit that?'.*
- *Stay away from "What if....." questions. It is permissible to ask: "What is your next step?" but not to take them down a line of hypothetical exploration.*
- *The grade 'needs further development' (NFD) IS NOT A FAIL. It simply means the trainee has more to learn. Don't be scared of awarding an NFD grade: in fact, if it applies, you have a responsibility to give it. An NFD grade is expected for many ST1s and ST2s. Think – can ST1s and ST2s really be competent or excellent in everything, before finishing their training? (I don't think so!)*
- *GMC duties of a doctor: 1. Make the care of your patient your first concern, 2. Protect and promote the health of patients and the public, 3. Provide a good standard of practice and care, 4. Treat patients as individuals and respect their dignity, 5. Work in partnership with patients, 6. Be honest and open and act with integrity*

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CBD Question Maker for Trainers (Pennine's)

Practising Holistically

- Describe the medical dimensions of this consultation.
- Describe the psychological dimensions of this consultation.
- Describe the socio-economic dimensions of this consultation.
- Describe the cultural dimensions of this consultation.
- What feelings did you need to explore?
- What consultation skills did you use?
- How would you define your limits?
- How did you provide "holistic" support to family/carers?
- How did the problem(s) impact on family and others?
- What other agencies have you used to provide support?

Data Gathering and Interpretation

- What information did you gather from history/examination/investigations?
- What was your working diagnosis?
- What abnormalities did you identify on examination/investigation?
- What pre-existing information did you refer to (consultations/summary/letters/investigations)?
- Justify the examination that you chose to perform.
- Justify your choice of investigations.
- Describe where and how your history/examination/investigations are recorded in a systematic manner.
- How did initial investigations and examination lead to further investigations?
- What questions/investigations did you use to confirm or refute your original working diagnosis?

Making Diagnosis/Decisions

- What differential diagnosis did you consider?
- What features would make each diagnosis more/less likely?
- How did you make use of time?
- What information did you gather and how did this affect the likely diagnosis?
- Are there other diagnoses that remain unexplored?

Clinical Management

- Describe how you monitored the patient's progress.
- What management have you provided?
- How do you decide on these management options?
- Describe any guidelines that you used.
- Justify your prescribing.
- Justify your referral.
- What information did you provide with your referral?
- How did you ensure continuity of care?
- What follow up have you arranged?
- Describe any un-met patient's needs.

Managing Medical Complexity

- Describe the aspects of this patient's management that you co-ordinated?
- What were the areas of uncertainty? What strategies did you use to manage uncertainty?
- How did you explain "risk" to patients? How did you involve the patient in risk management?
- How did you encourage rehabilitation/recovery?
- Describe any health promotion strategies that you used.

Primary Care Administration, Information Management and Technology

- Describe how the information from this consultation was recorded on the computer.
- What read codes have been used, why are they important?
- What has been added to the patient's summary?
- What is already in this patient's problem summary?
- How are investigations/communications recorded?
- How did use of the computer system improve/facilitate patient care?
- How did you manage the use of the computer in this consultation?
- How did you ensure your record was useful to others?
- What steps did you take to keep the records secure?
- Is this patient's record relevant to QOF for this practice?
- Did you use other online resources

Working with Colleagues and in Teams

- What other team members were involved?
- What information did you provide to other team members? How was this information passed on?
- What information did you receive from other team members?
- From whom did you seek advice?
- What skills do you not have that were provided by others?
- What steps did you take to ensure continuity of care?
- How did you plan for the times when you were not available?
- What did you do to promote effective team working?

Community Orientation

- Are there any factors in the local community which m
- ight impact on this patient's care (epidemiological/social/economic/cultural)?
- What elements of health/social care provision did you need to access?
- What limitation in provision did you identify?
- How did you deal with these constraints and limitations?
- What changes and provision would help our practice population?
- How did you balance the needs of this patient against the needs of the whole practice population?
- Describe any conflicts in the above.
- Describe how you considered the use of limited resources (time/prescribing costs/secondary care)?

Maintaining an Ethical Approach to Practise

- What ethical dilemmas does this case raise? How do you respond to the ethical problems raised?
- What professional code of practise did you need to apply?
- Where can such codes be found for reference?
- How did you avoid discrimination?
- What conflicts of personal and professional interest might have arisen?
- How would you deal with this?

Fitness to Practise

- What headings of the GMC 'Duties of a Doctor' are relevant here?
- What personal needs do you need to balance against professional demands?
- What issues relating to a colleagues performance did you take into account?
- How can you show that you are maintaining personal health?
- What advice do you seek?
- What referrals did you make?
- What elements of your own performance have you reflected on?
- What scrutiny have you made of your professional behaviour and how is this supported by organisational culture?
- What hazards to work/life balance did you identify?

Quality and the Educational Supervisor's Report

This session looks at the quality of the Educational Supervisor's reports written by the trainers in your group. Use one of their previous reports as reference material to lead a general discussion about writing the report.

In order to gain the MRCGP qualification, Workplace Based Assessment (WPBA) needs to be completed satisfactorily, along with the Clinical Skills Assessment (CSA) and the Applied Knowledge Test (AKT).

The educational supervisor's report (ESR) is a key piece of evidence to demonstrate that the trainee is progressing satisfactorily and is working towards attaining the RCGP competences. It is important that reports are of a high standard and reliably inform the decision about whether the candidate can be recommended for certificate of completion of training (CCT).

An Educational Supervisor's Report (ESR) is required at least every 6 months throughout speciality training. This is mandated by the GMC.
Topics to potentially discuss are as follows:

What are the purposes of the ESR?

1. To authenticate the collated evidence within the ePortfolio.
2. To summarise progress towards the attainment of competences through the programme.
3. To map out where the trainee is on his or her trajectory of professional development, aiming towards achieving a certificate of completion of training (CCT).
4. To provide a summary of strengths and weaknesses and to highlight areas of positive and negative performance.
5. To document evidence of specific learning needs, including any areas where evidence is lacking.
6. To provide recommendations for direction of travel – professionally and within the particular speciality, relating to the stage of the trainee's career.
7. To provide feedback for the trainee – don't forget the formative element of ESRs, especially earlier on in training.

Why is it important the ESR is of a high standard?

1. Workplace based assessment (WPBA) constitutes one-third of the MRCGP and carries equal weight to the clinical skills assessment (CSA) and applied knowledge test (AKT).
2. The ESR, if done correctly, summarises formal evidence of a trainee's performance in WPBA. It is an outcome judgement that the competency standards are being developed, or in the case of the final review, that the competences have been achieved.
3. The ESR is a key piece of evidence for the Annual Review of Competence Progression (ARCP) panel; a panel can take place only if there has been an ESR within the past 2 months. As the panel uses the ESR to help guide their decision about the trainee's progression, there are obvious implications for patient safety if it isn't up to standard.
4. The last two ESRs from the training programme are carried over into the trainee's RCGP Revalidation ePortfolio.
5. The ESR provides agreed learning objectives for the trainee over his/her forthcoming placements or in the next stage of his/her career after completion of his/her programme.

Common criticisms of ESRs

1. Copying the trainee's self-ratings or log entries and pasting them directly into the competency rating statements without adequate explanation.
2. Writing competence ratings which are entirely subjective with no linked evidence to justify the rating.
3. Agreeing with the trainee's self-rating statements without providing further evidence if the self-ratings are of a poor standard and lack adequate evidence.
4. Failing to suggest (SMART) future development actions – statement such as "continue as before" or similar are not acceptable.
5. Failing to identify missing mandatory assessments (MiniCEXs, COTs, CBDs, MSF, PSQ etc), an adequate PDP, quality and quantity of learning log entries and, in the final review, the presence of valid evidence of CPR/AED update training. WPBA undertaken by appropriate grade doctors or appropriately trained clinicians for CEPS
6. Failing to provide adequate recommendations for a trainee's future development if the trainee is not progressing satisfactorily.

What constitutes an acceptable ESR?

Acceptable

1. Judgements are generally referenced to a range of the available, relevant evidence, and include interpretation of this evidence.
2. Judgements appear to be justifiable.
3. Suggestions for trainee development are routinely made and appear to be appropriate.

Needs further development

1. The educational supervisor (ES) has not based his/her judgement on appropriate evidence supplied by trainee and/or the ES.
2. When making their judgement, the ES has failed to show appropriate interpretation of the evidence.
3. The ES has failed to provide appropriate action plans for future trainee development, including in the final review of GP Training.

How do you do the ESR – what process do you follow?

1. Look at the outcome of the last ARCP and the previous ESR.
2. Look at the educators' notes – are any themes emerging?
3. Identify learning log entries (focusing on clinical encounters, significant event analyses and audit) which give significant evidence of competency progress.
4. Review the former and current personal development plan (PDP).
5. Review the WBPA (miniCEXs, COTs, CBDs, MSF, PSQ, CSR, checking that the trainee has achieved the required number and the nature of comments, positive or negative, highlights and weaknesses, specific areas of strength or concern.
6. Look at the curriculum coverage and check this is increasing equitably across all areas and is appropriate for the current stage of training.
7. Are CEPS (Clinical Examination and Procedural Skills) being achieved as expected?
8. Which competency areas lack evidence?
9. Review the trainee's self-rating of the 13 competency areas and rate them.
10. Follow with a face-to-face interview with the trainee to discuss their perception of their progress. Areas which are particularly strong or weak in the ePortfolio should be explored. Areas for development should be agreed upon, so that useful objectives can be provided in the competency ratings and subsequently transferred across to the trainee's PDP. Once

completed the report is signed off by the trainer and trainee. If the trainee does not sign it off it can't be used by the ARCP panel.

What criteria do you use when assigning a competency to a log entry?

1. A linkage is an indication that, in the view of the ES, the log entry provides evidence that the trainee is progressing towards attaining the specified competency.
2. The trainer links competences, but ONLY if the log entry is clearly about that competency AND the trainee has made a clear reflection and analysis in terms of that competency. It is unusual to link more than 3 competency areas to a single log entry.
3. The trainee, meanwhile, links his/her entry to curriculum coverage – s/he should choose one or two areas of the curriculum which s/he feels most closely relate to the entry. The trainer should verify that the linkage is justified and has the ability to undo the link if s/he feels appropriate, although it should be noted that curriculum linkage is only about what the entry relates to, rather than reflecting the depth of knowledge gained or proficiency demonstrated.

How do you decide whether an entry is reflective or not? Are there any criteria that you use?

There are various ways of assessing reflection. Essentially, you are asking yourself whether the trainee has explored the meaning of the case and how it will affect his/her future practice.
The RCGP WPBA Standards Group states that a log entry should ideally show:

1. Evidence of critical thinking and analysis, describing the trainee's own thought processes.
2. Some self-awareness, demonstrating openness and honesty about performance and some consideration of feelings generated.
3. Some evidence of learning, appropriately describing what needs to be learned, why and how.
4. Appropriate linkage to the curriculum.
5. Demonstration of behaviour that allows linkage to one or more competency areas.

ICSE is a useful acronym to consider:

- Information provided
- Critical Analysis
- Self awareness
- Evidence of learnin

Not acceptable	Acceptable	Excellent
Information provided is entirely descriptive, with no evidence of reflection	Limited use of other sources of information to put the event into context	Uses a range of sources to clarify thought and feelings. Demonstrates well developed analysis and critical thinking e.g. using evidence base to justify or change behaviour
Critical analysis. No evidence of analysis (i.e. an attempt to make sense of thoughts, perceptions and emotions)	Some evidence of critical thinking and analysis, describing own thought processes	Shows insight, seeing performance in relation to what might be expected of doctors
Self-awareness. None	Some self-awareness, demonstrating openness and honesty about performance and some consideration of feelings generated	Consideration of the thoughts and feelings of others, as well as him/herself
Evidence of learning. No evidence (i.e. clarification of what needs to be learned and why)	Some evidence of learning, appropriately describing what needs to be learned, why and how	Good evidence of learning, with critical assessment, prioritisation, and planning of learning