

DERBY VOCATIONAL TRAINING SCHEME FOR GENERAL PRACTICE

**AN *almost* COMPLETE
GUIDE TO THE
nMRCGP**

Including:

**THE CERTIFICATE OF
COMPLETION OF TRAINING
IN GENERAL PRACTICE (CCT)**

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**ROYAL COLLEGE OF
GENERAL PRACTITIONERS MEMBERSHIP
EXAMINATION BY ASSESSMENT
(nMRCGP)**

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ASSOCIATED ASSESSMENT TOOLS

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SECTION 1

1.1 INTRODUCTION

This booklet has been compiled as a guide to obtaining a Certificate of Completion of Training in General Practice (CCT) and the single Training Assessment System for UK trained doctors.

All the information contained in this guide has been extracted from the RCGP website.

You will find further information and regular updates on the following websites

Royal College of General Practitioners (RCGP)

www.rcgp.org.uk

Postgraduate Medical Education Training Board (PMETB)

www.pmetb.org.uk

PLEASE ACCESS THESE WEBSITES REGULARLY!

1.2 GP CORE CURRICULUM STATEMENTS

- 1 Being a General Practitioner**
- 2 The General Practice Consultation**
- 3 Personal and Professional Responsibilities**
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
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- 11 Sexual Health**
- 12 Care of People with Cancer & Palliative Care**
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 - 15.8 Respiratory Problems
 - 15.9 Rheumatology and Conditions of the Musculoskeletal System (including Trauma)
 - 15.10 Skin Problems

SECTION 2

2.1 ASSOCIATE MEMBERSHIP OF THE RCGP

Associate membership is specifically targeted at:

- Doctors in GP training
- Doctors who have chosen not to pursue membership but wish to be linked in some way to the College

While associates are not classed as members of the College and may not vote at general meetings, there are many benefits involved in being associated with the College, particularly for doctors in training.

Associates in Training

As part of the reform of postgraduate medical education for general practice, the College now plays an active role in the Certification process. Doctors applying for a Certificate of Completion of Training from the Postgraduate Medical Education Training Board (PMETB) must register with the College who sign off the individual components of their training. Trainees are encouraged to sign up with the College at **the start of their training**, or as soon as possible thereafter. The cost to register with the College is a one-off fee of £350, which typically includes up to three years free membership of the College as an Associate in Training, during which time you will hopefully complete your training and progress to full membership of the College by passing the College exam. Further details about registering with the College are available from the Certification Unit or telephone 020 7930 7228.

Aside from the new links with Certification, the College recognises the importance of encouraging and supporting doctors in training, and is continuing to look for ways of doing this. In addition to the wide range of information available from a variety of sources, including online access to the British Journal of General Practice, the College runs a number of events across the country designed to help young doctors prepare for, and meet the requirements of, the College exam.

In addition to doctors in training, the College has a number of Associates who are either in general practice, or another medical specialty, who are not eligible for membership but wish to remain associated with the College. To qualify for Associateship, you must be a fully registered medical practitioner.

As an Associate you are eligible for many of the benefits of membership, including access to information and invitation to events.

If you are interested in joining please use the online application forms.

Applying for Certification

The RCGP's Certification Unit evaluates general practice training and makes recommendations for Certificates of Completion of Training (CCT) to the Postgraduate Medical Education and Training Board (PMETB).

In addition to evaluating CCT training programmes the Unit can give informal advice and information about general practice training to those already in a general practice programme as well as to doctors who are considering undertaking training for general practice and who want advice about the further training they require.

Anyone who is undertaking a training programme for general practice leading to a CCT should register with the Certification Unit.

Trainees who will be applying for a Certificate confirming Eligibility for GP Registration (CEGPR) under the equivalence provisions of Article 11 of the PMETB Order do not need to register with the Unit, but are welcome to contact us for information or advice as described above.

Please check our What's New section for the most up to date information and advice about specialty training in general practice. Alternatively, you may find the answer to your question in our Frequently Asked Questions section.

We can be contacted by telephone, email or post, but unfortunately we do not have the facilities to see enquirers in person. Our telephone enquiry line is open from Monday to Friday between 9.00pm and 5.00pm.

Associates in Training should telephone the Certification Unit

Telephone: 020 317 08230 (choose option 1 to reach the certification team)

Fax: 020 317 08232

Email: certification@rcgp.org.uk

2.2 THE CCT APPLICATION PROCESS: A STEP BY STEP GUIDE

This section is intended to explain the registration and application process to doctors who will be applying for a certificate, or for an assessment of their training under Article 10 of the General and Specialist Medical Practice (Education and Qualifications) Order. The Order can be accessed on the Postgraduate Medical Education and Training Board's (PMETB) website at <http://www.pmetb.org.uk/> and further guidance can be found elsewhere on this site. Those who feel that their training does not conform to the criteria for a CCT, as laid down in Article 10, will need to contact PMETB for more information about making an application for a Statement of Eligibility Registration under Article 11 of the Order.

Step 1. Doctors in training should register with the RCGP at the beginning of their training programme.

The Royal College of General Practitioners took on this role on 30 September 2005. Therefore, those who began their training before that date will not have been able to register at the beginning of their programme. Anyone who is already in training for general practice should register well in advance of the completion of their training programme.

Step 2. To register with the RCGP you will need to submit a completed application form (available on the RCGP website: www.rcgp.org.uk), a copy of your current, annual General Medical Council registration certificate and a fee of £350.

The fee should be paid by a cheque made payable to the Royal College of General Practitioners. This is a one off payment which will cover all submissions to the Certification Unit. This fee will also entitle you to associate membership of the RCGP. If you have already completed some of your training programme it is advisable to also submit completed VTR (or VTR / RITA) forms to document the posts you have undertaken so far.

Step 3. Once you have registered you should submit VTR forms to the RCGP's Certification Unit to document each training post as you complete it.

This will enable the Certification Unit to monitor your training programme to ensure that it meets the requirements of the Order. This will also speed up your application for a certificate at the end of your training programme as you will then only have to submit your final VTR form to the Certification Unit. You will not receive a formal evaluation after each submission, but receipt of your forms will be acknowledged and a member of the Certification team will contact you directly if there are any questions or problems with your documentation or training programme.

Step 4. When you are in the final six weeks of your training programme you should submit your final VTR form to the Certification Unit with a copy of your current GMC registration certificate. At this time you will also need to make an application to PMETB. You will need to obtain a PMETB application form from the Certification Unit. If you have already registered with the Unit it will be sent to you automatically. This form should be completed and sent directly to PMETB with the required fee and supporting documentation. For information about current fees please contact PMETB's website : <http://www.pmetb.org.uk/>.

When the Certification Unit receives your final VTR form it will check whether your application is complete, and whether your training complies with Article 10 of the Regulations. It will then recommend to PMETB whether or not you are eligible for a CCT. PMETB will marry this recommendation up with your application to them and, if appropriate, will then issue a certificate to you. If PMETB decide that you are not eligible for a certificate they will communicate this to you in writing with reasons and a recommendation of the further training that you will need to undertake.

Step 5. If you are constructing your own programme and have undertaken approved UK training posts that were not part of a Vocational Training Scheme and you require an assessment of this experience prior to joining a shortened training programme then you will need to register with the Certification Unit and submit your VTR forms as described in step 2 above.

The fee of £350 is the same and covers advice and evaluations leading to the issue of a certificate.

SECTION 3

3.1 CERTIFICATE OF COMPLETION OF TRAINING (CCT) AND NEW MEMBERSHIP ASSESSMENT

From August 2007 there will be a single training and assessment system for UK trained doctors wishing to obtain a CCT (Certificate of Completion of Training) in General Practice. Satisfactory completion of the scheme will be an essential requirement for entry to the General Medical Council's GP Register and for membership of the Royal College of General Practitioners.

The nMRCGP is an integrated assessment programme that includes three components:

- Applied Knowledge Test (AKT)
- Clinical Skills Assessment (CSA)
- Workplace-Based Assessment (WPBA)

Each of these is independent and will test different skills but together they will cover the curriculum for specialty training for general practice.

Evidence for the workplace-based assessment will be collected in the e-portfolio of each GP trainee.

3.2 ASSESSMENT TOOLS TABLE & ACRONYMS

(Each column represents 4 months)

ASSESSMENT TOOLS	1st Year			2nd Year			3rd Year (General Practice)		
	ST1	ST1	ST1	ST2	ST2	ST2	ST3	ST3	ST3
Mini CEX *	x 2	x 2	x 2	x 2	x 2	x 2			
COT **	x 2	x 2	x 2	x 2	x 2	x 2	← x 12 →		
CBD	x 2	x 2	x 2	x 2	x 2	x 2	← x 12 →		
MSF	← 5 clinicians x 2 → 5 or 6 months then 2 months later						← 5 clinicians, 5 non-clinicians x 2 → 29 or 30 months then 31 or 32 months		
PSQ							← x 1 →		
DOPS	UNTIL MANDATORY SECTION OF LOG COMPLETE								
CSR	SUMMARY OF PROGRESS. DUTY TO ALERT COURSE ORGANISERS IF PROGRESS IS NOT SATISFACTORY.								
AKT	ANY TIME BUT RECOMMEND IN FINAL YEAR AT DESIGNATED COMPUTER EQUIPPED TEST CENTRES								
CSA	TO BE HELD 3 TIMES A YEAR AT RCGP CENTRE IN CROYDON (February, May & October)								
WPBA	COMPETENCY- BASED TRAINING RECORDED OVER THE THREE YEARS								
e-PORTFOLIO	TO BE USED TO RECORD ALL OF THE ABOVE								

Abbreviation	What it stands for ...
AKT	Applied Knowledge Test
CBD	Case Based Discussions
COT **	Consultation Observation Tool (Primary Care only)
CSA	Clinical Skills Assessment
CSR	Clinical Supervisors Report
DOPS	Direct Observation of Procedural Skills
E-portfolio	Electronic Portfolio
Mini CEX *	Mini Clinical Evaluation Exercise (Secondary Care only)
MSF	Multi-source Feedback (<i>Web based</i>)
PSQ	Patient Satisfaction Questionnaire (Primary Care only)
WPBA	Work-place Based Assessments

3.3 APPLIED KNOWLEDGE TEST (AKT)

The Applied Knowledge Test is a summative assessment of the knowledge base that underpins independent general practice within the United Kingdom. Candidates who pass this assessment will have demonstrated their competence in applying knowledge at a level which is sufficiently high for independent practice.

The test will take the form of a three-hour 200 item multiple-choice test. Currently the MCQ for Summative Assessment and the MRCGP Multiple Choice Paper are both paper and pencil examinations. The AKT, by contrast, will be delivered using computer terminals at 147 Pearson Vue professional testing centres around the UK. However, question formats will be the same as for the current MCP.

Approximately 80% of question items will be on clinical medicine, 10% on critical appraisal and evidence based clinical practice and 10% on health informatics and administrative issues. All questions will address important issues relating to UK general practice and will focus mainly on higher order problem solving rather than just the simple recall of basic facts.

On three days each year candidates will be able to sit the AKT at one of the Pearson Vue centres. Candidates registered for the nMRCGP will call Pearson Vue to book a test and choose a centre. The earlier a candidate books, the greater the chances of their preferred centre being available: candidates booking late may need to travel a bit further. Pearson Vue will confirm each booking by e-mail. The First AKT will be held on 31st October 2007.

Appropriate arrangements will be made for candidates with special needs, as far as these can be accommodated. The AKT will comply with all relevant UK legislation in this respect, but candidates should notify the RCGP of any special requirements at the earliest possible opportunity.

Candidates will present themselves at the test centre with two pieces of identification (details to be provided). They will then sit the test at a computer workstation, using a mouse and keyboard to select their answers. A tutorial will be available, but it is hoped that all candidates will familiarise themselves with the test format in advance by working through examples of test items available as a Word document download.

The RCGP will communicate results to candidates soon after each test. Unsuccessful candidates will be able to resit the AKT by applying to the RCGP and booking a new test with Pearson Vue. Feedback will be sent to candidates on their performance in each of the three key subject areas tested with appropriate comparative data for meaningful interpretations to be made.

Detailed feedback will be provided for deaneries and other interested parties about the overall performance of the candidature as a whole, after each examination.

Whilst candidates will be eligible to attempt the AKT at any point during their time in GP specialty training, it is anticipated that the most appropriate point, and that providing the highest chance of success, will be whilst working as a GP trainee in ST3.

APPLIED KNOWLEDGE TEST (AKT) SAMPLE QUESTIONS

Questions are derived from accredited and referenced sources, including review articles and original papers in journals readily available to all general practitioners: primarily from *Clinical Evidence*, *British Medical Journal*, *NICE Guidelines*, *British Journal of General Practice*, *Drugs and Therapeutics Bulletin* or *Cochrane Reviews*.

Occasionally a question may use original material from published papers, and the item may take longer to complete. This variation in question time will have been taken into account in constructing the total paper.

The current edition of the British National Formulary is the reference source for therapeutics questions, including the general information on prescribing. Some questions may refer to the unlicensed but widely accepted use of specific drugs.

Some of these questions relate to current best practice. They should be answered in relation to published evidence and not according to an individual's local arrangements.

Calculators are NOT necessary for statistical questions, and so will NOT be allowed.

Pictorial data such as charts, risk charts and photographs may be included in the questions.

The paper contains a number of different format questions including some or all of the following:

Extending Matching Questions (EMQ) in which a scenario has to be matched to an answer from a list of options. You may feel that there are several possible answers but you must choose only the most likely from the option list.

THEME: Reduced Vision

Option list:

- | | |
|--|--|
| A Basilar migraine | F Occlusion of the central retinal vein |
| B Cerebral tumour | G Optic Neuritis |
| C Cranial arteritis | H Retinal detachment |
| D Macular degeneration | I Tobacco optic neuropathy |
| E Occlusion of the central retinal artery | |

Instruction:

For each patient with reduced vision, select the **single most likely** diagnosis. Each option may be used once, more than once, or not at all.

Items:

- 1 A 75-year-old man, who is a heavy smoker, with blood pressure of 170/105, complains of floaters in the right eye for many months and flashing lights in bright sunshine. He has now noticed a 'curtain' across the vision of his right eye.
- 2 70-year-old woman complains of shadows, which sometimes obscure her vision for a few minutes. She has felt unwell recently with loss of weight and face pain when chewing food.
- 3 A 45-year-old woman, who is a heavy smoker, with blood pressure of 170/110, complains of impaired vision in the left eye. She has difficulty discriminating colours and has noticed that her eye aches when looking to the side.

THEME: Contraceptive advice

- A 7 days of extra contraceptive precautions required
- B 14 days of extra contraceptive precautions required
- C Emergency contraception required
- D No extra precautions required
- E Omit pill free week

For each patient described below, select the **single most appropriate** statement of advice from the list above. Each option may be used once, more than once or not at all

- 4 A 24-year-old woman is taking the combined contraceptive pill. She is on day 19 of the packet and rings to say that she forgot her pill yesterday morning and had intercourse last night. She has taken her pill this morning. Her last period was normal and she has taken all the other pills accurately.
- 5 A 36-year-old woman is taking the progesterone only pill. She is on day 14 of the packet and rings to say that she forgot her pill yesterday and had intercourse last night. She has taken her pill this morning. Her last period was normal and she has taken all the other pills accurately.
- 6 A 28-year-old woman had her first baby 8 weeks ago. She is not breast feeding and wishes to restart contraception straight away. She has not started menstruating yet and receives her first dose of Depo-Provera that day.
- 7 A 26-year-old woman is taking the combined contraceptive pill. She forgot to start her new packet of pills 3 days ago and had intercourse last night. Her last period was normal and she had taken her previous pack of pills accurately.

- 8 A 24-year-old woman is taking the combined contraceptive pill. She is on day 19 of the packet and requires erythromycin for a skin infection as she is allergic to penicillin.

Picture Format

THEME: Eye problems



- 9 A 42-year-old woman who has previously had treatment for cervical CIN 2, has had a lump affecting her left upper lid for three months. It is asymptomatic. What is the single most likely diagnosis in this patient?
Select one answer only
- A entropion
 - B meibomian cyst
 - C metastatic deposit
 - D stye
 - E xanthelasma

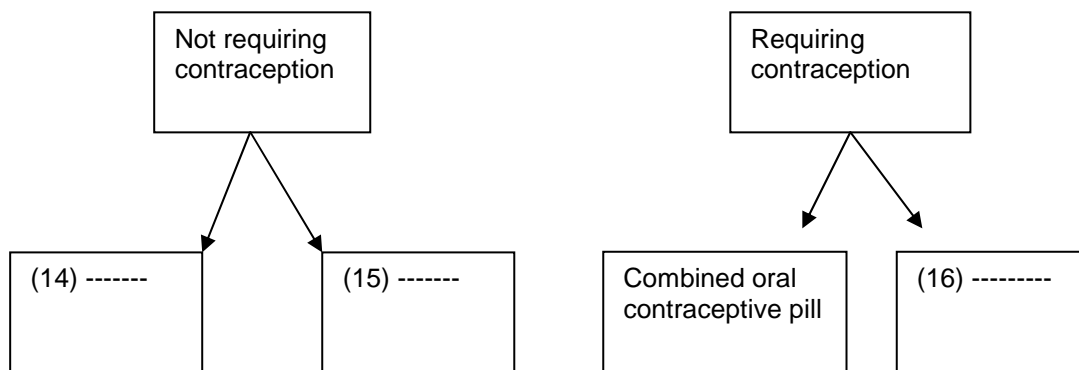
Single Best Answer (SBA) questions in which a statement or stem is followed by a variable number of items, only **one** of which is correct.

- 10 According to current evidence, in the management of croup in a 2-year-old child, which is the single most effective treatment to shorten the course of the condition? **Select one option only.**
- A Place the child in a steam filled bathroom
 - B Administer inhaled budesonide
 - C Prescribe amoxicillin 125 mg t.d.s. for five days
 - D Administer inhaled salbutamol
 - E Prescribe paediatric cough suppressant containing codeine
 - F Administer inhaled tribavirin

- 11 Which **ONE** of the following plasma glucose levels (on two occasions) is diagnostic of diabetes mellitus? **Select one option only.**
- A Fasting plasma glucose >5 mmol/L
 - B Fasting plasma glucose >6 mmol/L
 - C Fasting plasma glucose >7 mmol/L
 - D Random plasma glucose >10 mmol/L
 - E Random plasma glucose >9 mmol/L
- 12 According to current evidence, which **ONE** of the following drugs produces the **MOST** significant reduction in menstrual flow for women with menorrhagia? **Select one option only.**
- A diclofenac
 - B ethamsylate
 - C flurbiprofen
 - D mefenamic acid
 - E norethisterone
 - F tranexamic acid
- 13 An 18-year-old patient presents with a two day exacerbation of asthma following a worsening of hay fever. After a salbutamol nebuliser her peak flow rate increases from 250 to 450L/minute and she feels much better. Which is the **SINGLE MOST** appropriate next management step? **Select one option only.**
- A Nebulised salbutamol as required
 - B No further treatment
 - C Oral amoxicillin
 - D Oral chlorphenamine
 - E Oral prednisolone

Table/Algorithm Completion is the format often found in guidelines to advise on management decisions. You are asked to select the correct answer to complete the table or diagram.

THEME: Medical management of menorrhagia



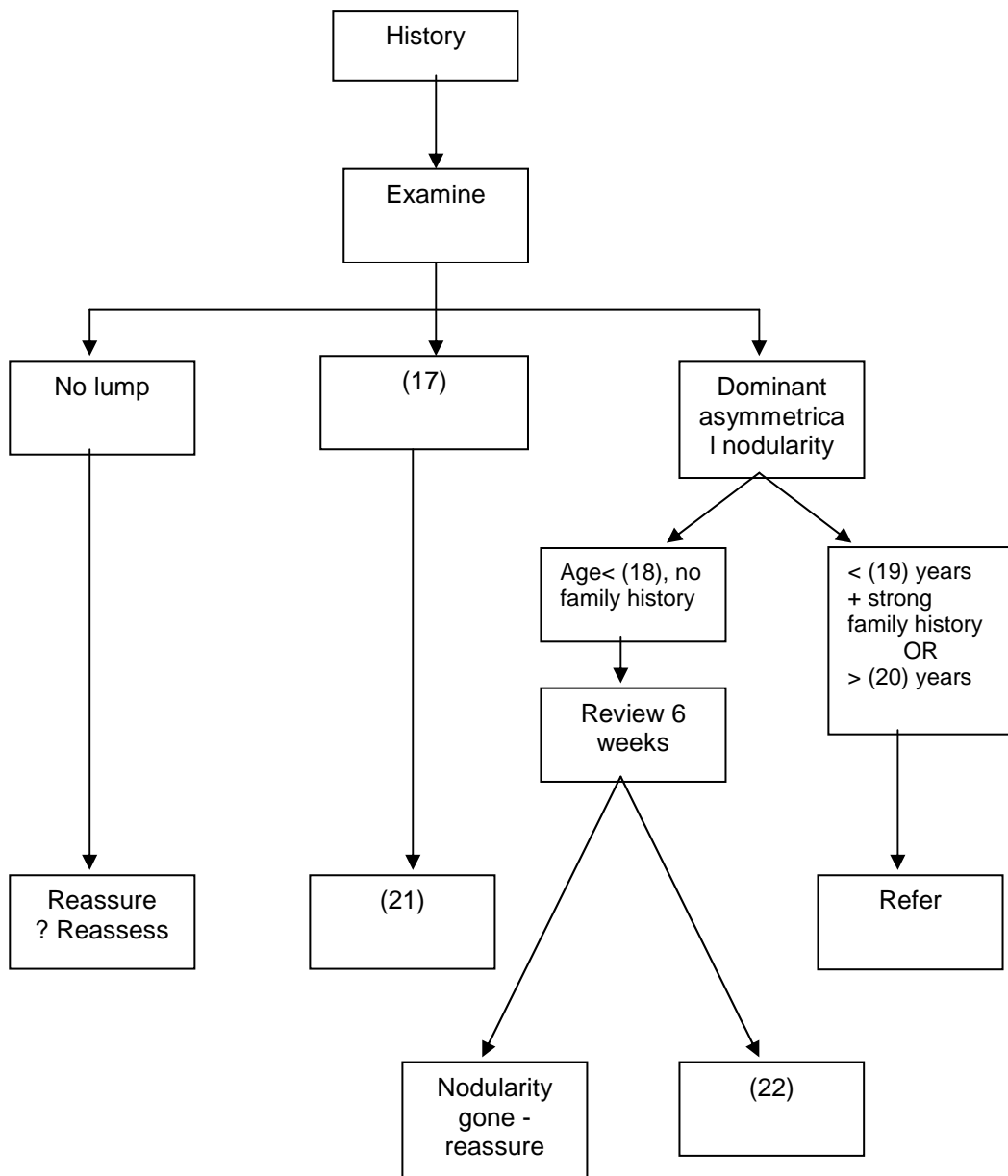
For each of the numbered gaps above, select ONE option from the list below to complete the algorithm, based on current evidence. **Select ONE option only.**

- A Copper intra-uterine device
- B Cyclical medroxyprogesterone acetate
- C Cyclical norethisterone
- D Inert intra-uterine device
- E Levonorgestrel releasing intra-uterine system
- F Mefenamic acid
- G Nonoxinol '9'
- H Tibolone
- I Tranexamic acid

THEME: NHS breast screening referral guidelines

For each numbered question, select the CORRECT option to complete the algorithm from the list below. Each answer may be used once, more than once or not at all.

- A age 25
- B age 35
- C age 45
- D age 55
- E Discrete lump
- F Dominant asymmetrical nodularity
- G Symmetrical nodularity
- H Refer
- I Review
- J Reassure



These 22 questions should have taken you about 20 minutes

3.4 CLINICAL SKILLS ASSESSMENT (CSA)

The Clinical Skills Assessment (CSA) is 'an assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice'.

This component of the nMRCGP will be available from October 2007. The assessment will be available during a 3 or 4 week period in sessions in February, May and October each year. It will take place in one location, initially in Croydon, and in later years in a purpose-built centre in London.

Each candidate will be given a consulting room and will have appointments with 13 patients, each lasting around 10 minutes. The performance will be graded as Clear Pass, Marginal Pass, Marginal Fail or Clear Fail.

The CSA will test mainly from the following areas of the curriculum:

Primary Care Management - recognition and management of common medical conditions in primary care.

Problem Solving Skills - gathering and using data for clinical judgement, choice of examination, investigations and their interpretation. Demonstration of a structured and flexible approach to decision making.

Comprehensive Approach - demonstration of proficiency in the management of co-morbidity and risk.

Person-centred Care - communication with patient and the use of recognised consultation techniques to promote a shared approach to managing problems.

Attitudinal Aspects - practising ethically with respect for equality and diversity, with accepted professional codes of conduct.

The CSA will also test:

Clinical Practical Skills - demonstrating proficiency in performing physical examinations and using diagnostic/therapeutic instruments.

INTRODUCTION TO THE CASES IN THE CLINICAL SKILLS ASSESSMENT

Cases are written by experienced General Practitioner case writers, who are members of the MRCGP Panel or Deanery representatives across the UK. All have undergone training in case writing.

Cases are chosen to fit into a blueprint derived from the MRCGP curriculum, and each case can be related to a specific section of one or more of the Curriculum Statements (which can all be found on the RCGP website). Cases are often

informed by real life situations the case writers have experienced themselves and are therefore representative of current British general practice.

Each case consists of several sections: instructions to the role player playing the part of the patient, instructions to the assessor and the case notes. Candidates will only see the case notes, of course! These are constructed to look as similar to medical case notes as possible, although they are not electronically presented. Relevant details are presented, including relevant past medical history, current medication and social habits etc. The last consultation may also be there, or a relevant letter from secondary care, test results, ECGs etc. The case notes are kept to the essential minimum so that candidates do not have to wade through unnecessary details to learn about their 'patients'.

The final and most important part of the case is the marking schedule. This has been carefully tailored to the assessment purpose of the case and some examples are given below. The following broad areas, or "domains" are assessed in each of the cases:

- Information gathering
- Clinical management
- Interpersonal skills

In the marking schedule, guidance is provided to assessors as to what to look for in terms of appropriate or inappropriate behaviour in the given situation. Assessors use this guidance and their observations to mark each domain separately and then, based on this, produce an 'overall' grade for the case. There are four possible grades, which are:

- Clear pass
- Marginal pass
- Marginal fail
- Clear fail

The candidate needs to pass a certain number of cases to pass the assessment overall. The decision on what this number will be, will depend on the outcome of the currently running national standard setting exercise. Candidates will be sent feedback on their performance in the CSA after the assessment.

How the cases will be used in the CSA

The CSA will take place on three purpose-designed floors of a modern tower block situated directly opposite East Croydon station in south London. Candidates will have to register on arrival, bringing proof of identity with them. Two sessions will run each day, each comprising three identical circuits (one on each floor).

Each circuit will consist of thirteen 10-minute stations. Candidates will be allocated a 'consulting room', with very basic medical kit provided. They will be expected to bring their own equipment with them – the equipment generally found in a 'Doctors' bag'. Details of these contents will be sent out with confirmation of candidates' applications to take the assessment.

Candidates remain in their room throughout the assessment, only leaving for a short coffee break at a designated time. At the start of the assessment a buzzer will sound, and the first 'patient' will knock on the candidate's door. These patients are all role players who have been given a specific role to play, based on the case instructions and marking schedule. Role players will have been standardised across the three floors so that all role players for a given case are playing their role in the same way.

At the end of 10 minutes, another buzzer will sound, and the role player will leave the room. After a short break of 2 minutes, the next case begins with the sounding of the next buzzer. This process is repeated until all 13 cases have been seen.

The cases are marked by MRCGP assessors, who are all trained assessors of postgraduate general practice. Each assessor marks the same case all day, so that marking is calibrated and reliable. Assessors follow the role player into the room and mark the case as it unfolds, sitting out of the candidate's line of view. They do not interact with the candidate unless required to do so. Examples when this might occur are if the candidate wishes to examine the patient in a way that is unnecessary for the case marking, or requests a piece of information that the role player cannot provide or indicates that they would normally use a particular piece of clinical equipment. Most of the time, they will remain observant, but silent.

Case selection for each session is decided according to a pre-determined formula. This will include a selection of acute, chronic and undifferentiated presentations, psychological/social cases and cases based on health promotion issues. Within these parameters, cases will be selected to display a range of ages, one or two cases will be based on some aspect of diversity and there will be a selection of male and female patients. Clinically, cases will span those clinical areas in the MRCGP curriculum that can be tested in the CSA environment. A few cases might require a clinical examination skill to be demonstrated.

Preparing for the CSA

The CSA cases are all written by GPs active in British National Health Service and reflect real-life presentations. Therefore, candidates should have no great difficulty in taking the CSA, so long as they have had experience in NHS general practice. For this reason candidates are recommended to have firstly completed at least 6 months of British NHS GP practice.

Although up to date knowledge of general practice and of general medicine is necessary to pass this assessment, it is not primarily a test of knowledge. It is a

test of the ability to integrate clinical and communication skills, to produce a consultation that is meaningful to both patient and doctor and which moves the patient forward towards a justifiable management of their presenting problem.

Showing an ability to engage patients in the consultation, using recognised interpersonal skills (such as enquiring about the patient's health beliefs and incorporating these into the explanation given to the patient), is an important part of the work of general practice and is assessed within the 'interpersonal skills' domain of the marking schedules. Valuing patients' contributions and respecting their autonomy and decision-making is also assessed in some cases.

Efficient and targeted data-gathering, together with correct diagnoses and management plans that are congruent with current accepted British general practice is also assessed. Some cases will require a physical clinical examination and candidates will be expected to be knowledgeable in the appropriate use of medical instruments and in examination techniques. Fluency of these procedures will be rewarded.

The overall mark given to the case will depend on the candidate's ability to combine the two areas of clinical consulting with interpersonal skills.

The following tips may help candidates prepare for the CSA:

- Obtain the Curriculum Statements from the RCGP website and read through them thoroughly. Each curriculum statement has a section on common and important conditions and cases are quite likely to be based on one of these.
- Video your own consultations and watch them with a colleague, bearing in mind the points made above about the integration of clinical approach and interpersonal skills. You might want to watch your consultations several times, marking them for either of the two skills, and then for the combination of both. This should give you some idea of the gaps in your performance and where you could be working to improve.
- Consider the types of clinical examination you could be asked to perform during the CSA, and practise focussed examinations. There are some examinations that you are unlikely to be asked to demonstrate (for example, intimate examinations on a role player, or examinations that might cause discomfort if repeated over and over during an assessment day), but you could be asked to assess a leg, an arm, a chest, an abdomen etc. Make sure you are conversant with any medical equipment you might need and can handle it with confidence.
- Think about the sort of letters you receive from secondary care and the types of test results you see (ECGs, spirometry, blood test results, urinalysis results, skin scrapings, swabs etc). Make sure you can interpret them correctly and explain them to a patient.

SELECTION OF SAMPLES CSA CASES*

1. Diabetes and depression

Summary of the case presentation:

The patient is a woman with well controlled Type 1 diabetes mellitus. She is presenting with the symptoms of depression. The candidate's task is to find out why she has presented and obtain the relevant details that enable the following decisions to be made:

- What is the main problem here? Is it the diabetes or something else?
- If it is something else, could it be low mood in which case is the patient clinically depressed or just fed up?

Having made these decisions, the candidate has to formulate a diagnosis and consider the clinical priorities, involving the patient in developing a shared management plan. All of this has to be done in a patient-centred way, obtaining her ideas, concerns and expectations and incorporating these into the explanation given to her.

Appendix 1 shows a 'typical' set of case notes, as you might expect to see in the CSA.

Why is this type of case being chosen?

This case illustrates the co-morbidity often seen in general practice presentations. The candidate is given the opportunity to demonstrate his/her skill in identifying the constituents at play, prioritising them and dealing with the problem presented in the consultation. In this case, the woman's diabetes is well controlled and she has no diabetic complications. The candidate simply has to establish this and then move on to diagnosing her presenting 'problem'. On the face of it, having two conditions in a consultation may seem complicated and challenging, but the task required is much more focused and should be manageable in the 10 minutes allowed for the case.

2 'Tired all the time'

Summary of the case presentation

This woman has just returned to work after the birth of her second child. She has seen the practice nurse recently for a contraception check up, and told her she was feeling tired all the time. A series of blood tests, including full blood count, thyroid function tests, urea and electrolytes, creatinine, liver function tests and fasting blood sugar have all come back as normal. She is hoping for a diagnosis and treatment, probably in the form of some sort of medication.

The task here is to take account of the normal blood results and, with a focussed history, ensure that all likely physical causes of tiredness have been excluded. At the same time the candidate must obtain the patient's view of her tiredness and ascertain her expectations. A social history should be taken.

Having decided that the patient's tiredness does not appear to have a physical cause, and that she is not clinically depressed either, the candidate needs to explain this assessment sensitively, suggesting that there are important social factors from

the history that could be causing the tiredness (back to work after maternity leave, a busy job and two small children at home). The candidate, having helped the patient recognise this likely cause, should then discuss with her ways in which these factors could be manipulated to help her manage more easily (opportunities for time for herself, using parents to help out with child care, possible job share or job change etc).

Why is this type of case being chosen?

This case is a good example of an undifferentiated presentation. The candidate needs to work through a diagnostic sieve to get to the decision that the cause of tiredness in this instance is likely to be due to social factors. In order to explain this properly to the patient, the candidate needs to adopt a patient centred approach that both gathers all the necessary personal information as well as uses this information in the explanation back to the patient. He/ she will need to explore the various ways in which the patient could adapt her lifestyle to help her cope and reduce her tiredness levels.

3 Constipation in a child

Summary of the case presentation

This is typical of the type of paediatric case that might appear. Due to constraints with using child role players, some cases are written in such a way that a parent comes to talk about their child in that child's absence.

In this case, the child is aged 2 and is troubled with constipation. Her diet is low in fibre and is similar to her mother's. Mum has her own stresses, being a single unemployed parent with low-income. She brought the child last week to the GP (another partner), who did not prescribe anything and advised a high-fibre diet and plenty of fluids. Mum is not happy for this situation to carry on and wants something for the child to relieve the problem.

The candidate would be expected to take a focussed history from the mother about the nature and duration of the constipation. The case notes from the previous consultation show that the mother appeared to want a prescription (which she did not get). The candidate would need to confirm and explore the mother's expectations in this respect. If the candidate mentioned a growth chart to the mother, he/she would receive the chart from the assessor. This shows normal growth and development to date. To be successful, candidates would be required to show their ability to negotiate and develop a shared plan with the patient, for example negotiating with the mother to work on the child's diet while perhaps agreeing to the prescription of a laxative. Appropriate use of other members of the team, such as the Health Visitor in the first instance or perhaps a paediatric dietician could also be mentioned, demonstrating an understanding of team working. Because this case is designed to test the ability to share understanding, giving the mother a leaflet on prevention of constipation in children would not gain any marks unless its contents were also discussed and explained.

Why is this type of case being chosen?

This type of case has been chosen to illustrate how problems affecting quite young children can be introduced into the CSA, so that ability to deal with a range of age groups can be demonstrated.

4 Palpitations

Summary of the case presentation

The patient is a businessman who has noticed intermittent but apparently severe palpitations while at a conference in Dublin recently. He noticed that they came on when he was eating, so much so that he was forced to sit down on a couple of occasions. He was previously an infrequent attender at the practice. This is his second consultation – at the first one, another partner saw him and arranged some preliminary tests. He has no pain or palpitations at the time he sees either doctor.

This case is an example of an acute presentation of a man with intermittent palpitations. It is designed to test the candidate's approach to taking a focussed cardiovascular history, performing a suitable cardiovascular examination and from this constructing a rational investigation and management plan with the patient.

In order to give the candidate time to do a cardiovascular examination if he/she thinks it necessary, much of the history has already been provided. Another task for the candidate is to confirm the history, interpret the results and explain them to the patient.

Why is this type of case being chosen?

In this case, the assessor will expect the candidate to examine the patient and some of the marks awarded will be for the nature of this examination, the technique and fluency with which it is carried out. The role player will not have any cardiac physical signs, but you could be asked to look at an ECG taken 'earlier', for example. A full cardiovascular examination is NOT expected here, as this is a case that should (and can) be performed in 10 minutes, but it should be focussed so that any significant cardiac pathology is unlikely to be missed. This would include examination of the pulse, blood pressure, JVP and auscultation of the chest.

5 Sick note request

Summary of the case presentation

This is a case testing the candidate's attitudes to patients and his/her value judgements in an 'ethical' issue. The patient is a middle-aged lorry driver, an ex-drug user, Hepatitis C +ve, with intermittent low back pain. He has just lost his job because his driving licence has been taken away for repeated speeding offences. He is requesting a sick note, hoping the candidate will give him one on the grounds of stress. He is annoyed to be in this position as he feels the 'system' has been unjust towards him.

The candidate has to find out the reason for his attendance and take a good social and psychological history from this patient. He/she needs to decide if a sick note is warranted in this situation and if the patient has a condition that precludes him from working, in compliance with the Department of Work and Pensions guidelines. Integrated with this, the candidate needs to demonstrate continued interest and empathy with the patient and respect for his autonomy, while negotiating the issues surrounding the request for a sick note. If this is done successfully it is unlikely the patient will cause a major fuss, although he is likely to remain dissatisfied.

Why is this type of case being chosen?

This case tests psychological/social aspects of a presentation, assessing the candidate's approach to challenging patients and ability to discuss and negotiate his/her decisions with a patient who disagrees with them. The candidate's attitude and interpersonal skills are key to performance in this case.

Appendix 1: Sample case notes

You are a locum General Practitioner who has recently finished the local vocational training scheme.

Name	Clare Morgan
Date of birth (Age)	45
Address	47 Boxter Close, Stoke Newington
Social and Family History	Married, two children
Past medical history	Type 1 diabetes since age 17, currently on Mixtard 30, bd injections. Regular annual reviews, compliant with medication and follow ups. Well controlled for many years with no significant complications.
Current medication	Mixtard30 insulin Aspirin 75 mg daily Simvastatin 20mg daily
Blood tests	Diabetes blood tests done 2 weeks previously at Annual Review Clinic by practice nurse:
HbA1c	7.3%
Fasting Cholesterol	4.0 mmol ⁻¹
Triglycerides	1.0 mmol ⁻¹
BP	128/78
All diabetes blood screening checks normal	
	<ul style="list-style-type: none">• feet examination normal• eyes recent check at optician - normal

Sample cases prepared by Kamila Hawthorne, Mark Coombe, Chris Elfes and Mei Ling Denney on behalf of the CSA Operations Group. May 2007.

3.5 WORK-PLACE BASED ASSESSMENTS (WPBA)

Definition

For the purposes of the nMRCGP assessment programme WPBA is defined as *the evaluation of a doctor's progress over time in their performance in those areas of professional practice best tested in the workplace.*

Why WPBA?

The WPBA proposal is based on contemporary educational design in keeping with guidance from the PMETB and best assessment practice in medical education rather than traditional psychometric considerations.

The plans for the proposed changes in WPBA will bring general practice into line with other specialties and the Foundation Programme.

Teaching, learning and assessment will be closely linked in the WPBA by:

- Having the opportunity for gathering evidence of actual performance in the workplace
- Allowing assessment of aspects of professional behaviour that have proved difficult to assess in traditional assessments e.g. examinations.

In addition WPBA aims to:

- Provide feedback on areas of strength and development needs
- Identify trainees in difficulty
- Drive learning in important areas of competency
- Determine fitness to progress onto the next stage of the trainee's career

The nMRCGP proposed WPBA model

There has been a considerable amount of work undertaken in deaneries throughout the UK to pilot a range of assessment tools for potential use in the work place. The joint Royal College of General Practitioners/ National Summative Assessment Board working group reviewed the various assessment tools in December 2006 and has made a number of recommendations.

The structured trainer's report and the current VTR form sign-off of posts or placements will be replaced by the competency based enhanced training record (ETR) which effectively will be an **electronic portfolio** of evidence. The twelve competency areas which will be assessed have been derived from the RCGP curriculum and are listed in Appendix 2.

The ETR will be a web-based and structured longitudinal assessment of a trainee's progress over the entire three year training programme, mediated by regular staged and evidenced reviews into which the external tools will feed.

The external work-based assessments will be:

- web-based multi-source feedback (MSF)
- patient satisfaction questionnaire (PSQ)

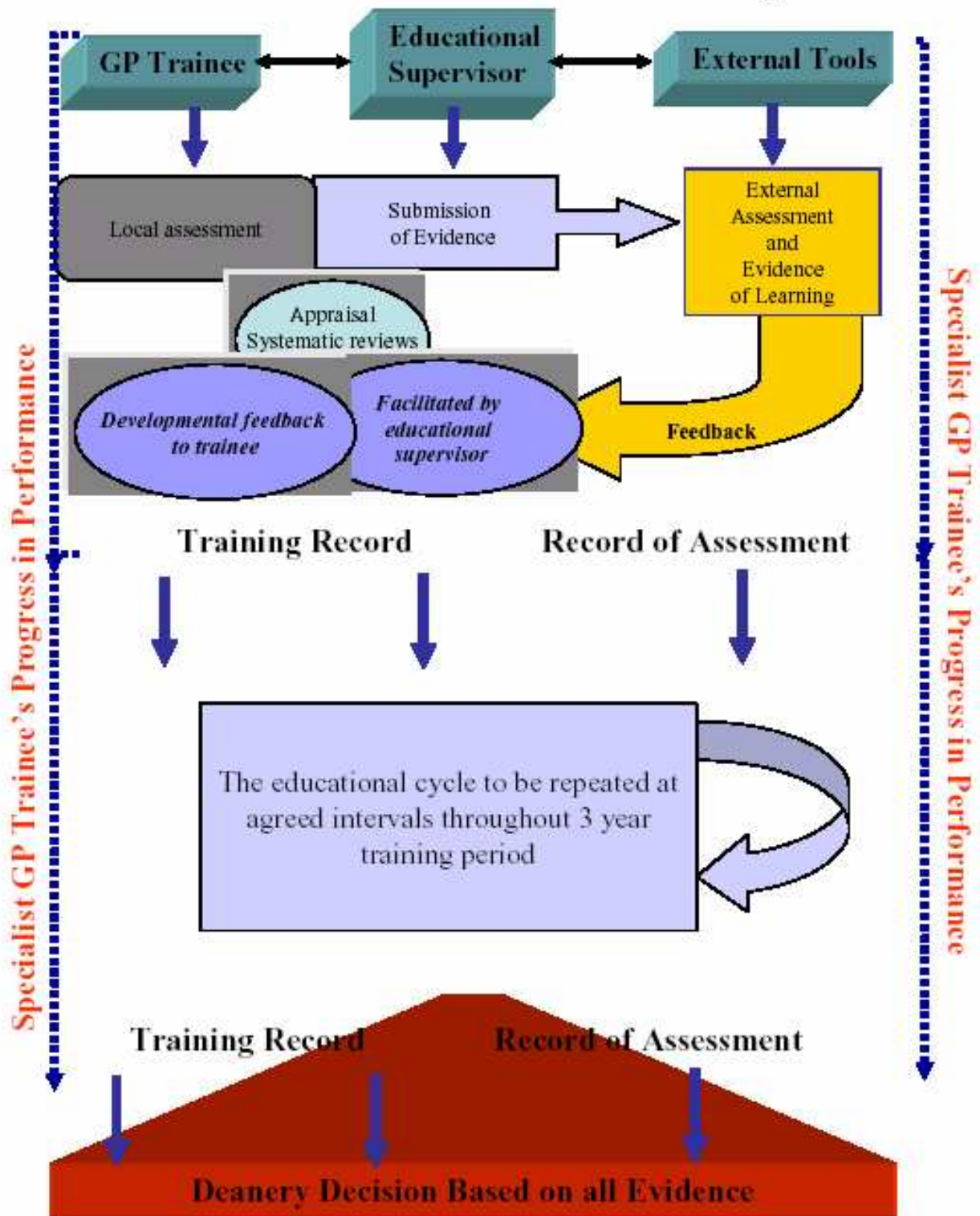
Each review will be informed by core information provided by specifically designed tools selected for use in the workplace including:

- case based discussion (CBD)
- a consultation observation tool (COT) largely based on the MRCGP video performance criteria
- other tools as appropriate, for example in hospital settings, such as mini clinical evaluation exercise (CEX) or direct observation of practical/procedural skills (DOPS)

For the purposes of the WPBA in the nMRCGP, significant event analysis and audit are treated as clinical governance processes rather than additional assessment tools. Trainees will be required to demonstrate active engagement in these processes, which have been explicitly written into the revised competency framework.

The flowchart on the following page shows how the assessments integrate with the training process.

The Educational Model of WPBA for nMRCGP Figure 1



Summary of the competency areas for WPBA

(Appendix 2)

1. Communication and consultation skills

This competency is about communication with patients, and the use of recognised consultation techniques

2. Practising holistically

This competency is about the ability of the doctor to operate in physical, psychological, socioeconomic and cultural dimensions, taking into account feelings as well as thoughts

3. Data gathering and interpretation

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

4. Making a diagnosis / making decisions

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

5. Clinical management

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

6. Managing medical complexity and promoting health

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

7. Primary care administration and IMT

This competency is about the appropriate use of primary care administration systems, effective recordkeeping and information technology for the benefit of patient care

8. Working with colleagues and in teams

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

9. Community orientation

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

10. Maintaining performance, learning and teaching

This competency is about maintaining the performance and effective continuing professional development of oneself and others

11. Maintaining an ethical approach to practice

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

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

The relationship between these competency areas and the curriculum is shown in the Blueprint and will be described in the e-Portfolio.

Where to find the Evidence

Competency Area	MSF	PSQ	COT	CBD	CEX	CSR
Communication and consultation skills	✓	✓	✓		✓	✓
Practising holistically		✓	✓	✓		✓
Data gathering and interpretation	✓		✓	✓	✓	✓
Making a diagnosis/decisions	✓		✓	✓	✓	✓
Clinical management	✓		✓	✓	✓	✓
Managing medical complexity				✓	✓	✓
Primary care admin and IMT				✓		
Working with colleagues and in teams	✓			✓		✓
Community orientation				✓		✓
Maintaining performance, learning & teaching	✓				✓	✓
Maintaining an ethical approach	✓			✓		✓
Fitness to practise	✓			✓		✓

3.6 THE e-PORTFOLIO

The evidence for WPBA will be recorded in a web-based e-portfolio. The e-portfolio is much more than an electronic record of specialist training, updated and accessible through the internet, it records details of achievement in the Applied Knowledge Test and Clinical Skills Assessment, and documents all stages of training, records evidence of WPBA, reviews with educational supervisors and the subsequent development as a General Practitioner.

A record of personal development and experience is becoming mandatory for all doctors. It provides evidence that training has taken place and allows the GP trainee to reflect on a range of learning opportunities. The WPBA is defined as the evaluation of a doctor's progress in their performance over time, in those areas of professional practice best tested in the workplace.

Workplace-based assessment brings together teaching, learning and assessment. Trainees will know what is expected of them and will have the opportunity to demonstrate attainment over time in a variety of contexts. The assessment recorded in the e-Portfolio will be drawn from performance and evaluation taking place in the real situations in which doctors work. It also allows competency in areas such as team-working to be appraised in a manner which cannot be done by the AKT and the CSA.

Many tools will be completed on-line without the contributor having to enter the e-Portfolio. Writing to many parts of the e-Portfolio will be limited to the trainer or educational supervisor. The personal section of the e-Portfolio will be hidden to all except the GP trainee.

The AKT and CSA must be passed before the e-Portfolio can be signed off as a complete record of GP training and a recommendation of certification (CCT), inclusion in the General Medical Council's GP Register and applying for membership of the Royal College of General Practitioners.

SECTION 4

4.1

Training Record

Every six months, the GP trainee will meet with their trainer or educational supervisor to complete an interim review of progress. Evidence collected is reviewed, a self-assessment conducted and the trainee's progress assessed by the trainer in each of the twelve competency areas. Towards the end of training, a final review is conducted, this time without the trainee's self-assessment. Successful completion requires achievement in each of the twelve competency areas. The trainer makes a recommendation to the deanery regarding the competence of the trainee. A failure to reach the standard will trigger a review by an expert deanery panel, which will make decisions and recommendations as to whether the workplace-based assessment has been completed satisfactorily.

Curriculum coverage

Episodes of learning that are rich in knowledge, such as those that may arise from tutorials, will not be assessed, but will allow trainees and educators to monitor how the knowledge base of the curriculum is being covered in preparation for the Applied Knowledge Test.

Skills

A technical skills log records assessment by DOPS building on those examination and procedural skills acquired in Foundation.

Professional Competencies

Progression across the twelve competency areas is recorded at regular, evidenced, staging reviews. These areas have been identified as those areas of professional practice that are best tested in the workplace. The areas, although derived from the RCGP curriculum, do not represent general practice in its entirety and should not be treated as a comprehensive curriculum for professional training.

Each area has been defined in terms of developmental word pictures that reflect increasing expertise:

(I) Insufficient evidence

From the available evidence, the doctor's performance cannot be placed on a higher point of this developmental scale.

(N) Needs further development

Rigid adherence to taught rules or plans. Superficial grasp of unconnected facts. Unable to apply knowledge. Little situational perception or discretionary judgement.

(C) Competent

Accesses and applies coherent and appropriate chunks of knowledge. Able to see actions in terms of longer-term goals. Demonstrates conscious and deliberate planning with increased level of efficiency. Copes with crowdedness and able to prioritise.

(E) Excellent

Intuitive and holistic grasp of situations. No longer relies on rules or maxims. Identifies underlying principles and patterns to define and solve problems. Relates recalled information to the goals of the present situation and is aware of the conditions for application of that knowledge.

SECTION 5

5.1 EVIDENCE GATHERING – HOW THE TOOLS WORK

Each tool, be it COT, CBD or mini-CEX, is a device for gathering evidence.

This evidence is collected by the trainee in their portfolio, and at the 6 month reviews conducted by the educational supervisor, is used to inform decision made about the trainee's progress.

It is important then to note that there is no *pass/fail* standard to any of these workplace-based assessments. The tools simply serve to harvest information and provide the supervisor with material for feedback, identification of learning needs and possible recommendations for change for the trainee.

Across the 12 competency areas in workplace-based assessment, progression towards expertise is described in terms of **insufficient evidence, needs further development, competent** and **excellent**. The competent level reflects the standard for independent practice. By the end of the training period, a level of **competent** is expected across all of the areas and it is entirely likely that some trainees in ST1 and ST2 will have developmental needs within some areas and conversely, may achieve excellence in others.

A minimum amount of evidence to be collected prior to each review has been advised, but it is perfectly acceptable, and indeed expected, for more assessments to be performed, or evidence recorded, in order to build up a richer picture of the trainee.

5.2 REQUIRED EVIDENCE

Prior to each review meeting with your named Educational Supervisor, you are required to collect a number of pieces of evidence to support judgments that will be made about your progress.

Specialty Training Year 1 (ST1)
Minimums prior to 6 months (6m) review
3 x COT or mini-CEX
3 x CBD
1 x MSF, 5 clinicians only
DOPS, if in secondary care
Clinical supervisors' reports, if in secondary care
Minimums prior to 12 months (12m) review
3 x COT or mini-CEX
3 x CBD
1 x MSF, 5 clinicians only
1 x PSQ, if in primary care
DOPS, if in secondary care
Clinical supervisors' reports, if in secondary care
Specialty Training Year 2 (ST2)
Minimums prior to 18 months (18m) review
3 x COT or mini-CEX
3 x CBD
1 x PSQ, if not completed in ST1
DOPS, if in secondary care
Clinical supervisors' reports, if in secondary care
Minimums prior to 24 months (24m) review
3 x COT or mini-CEX
3 x CBD
1 x PSQ, if not completed in ST1
Specialty Training Year 3 (Primary Care)
See RCGP website, Derby VTS website and VTS CD for information only
Notes
<ol style="list-style-type: none"> 1. Throughout the training, mini-CEX and COT assessments will be used interchangeably. The former being adopted in the secondary care setting, the latter in primary care. 2. DOPS assessment will only need to be carried out until the mandatory practical skills have been assessed as satisfactory. 3. Patient satisfaction will only be assessed in the primary care setting. 4. Multi-source feedback will involve clinical raters only when in secondary care and both clinical and non-clinical raters when in primary care.

5.3 MINI CLINICAL EVALUATION EXERCISE (mini-CEX)

Mini-CEX is a 15 minute snapshot of doctor/patient interaction, within a secondary care setting. It is designed to assess the clinical skills, attitudes and behaviours of trainees essential to providing high quality care.

Trainees will be asked to undertake six observed encounters during 12 months, with a different observer for each encounter. Each of these encounters should represent a different clinical problem and trainees should sample from a wide range of problem groups within the year.

Immediate feedback will be provided after each encounter, by the observer rating the trainee. Trainers and trainees will need to identify and agree strengths, areas for development and an action plan for each encounter.

Assessors

These may be staff grades, experienced specialty registrars (ST3 or above) or consultants.

Number of assessments required per year

A minimum of 3 in 6 months, whilst in secondary care.

Estimated time required

20 minutes (15 minutes for assessment and 5 minutes for feedback).

5.4 CONSULTATION OBSERVATION TOOL (COT)

This tool has been designed to be used by trainers as an evidence-collecting instrument to support the more holistic judgements made about GP trainees at the interim and final reviews during GP settings. The mini-CEX tool will be used for this purpose in a hospital setting.

The starting point for this assessment is either a video recorded consultation or a consultation directly observed by the trainer. In either case the observation should generate discussion and feedback for the GP trainee.

What to do

The GP trainee records a number of consultations on video and selects one for assessment and discussion, or the trainee and the trainer agree one prospective patient encounter which will be the subject of direct observation. In either case the trainee must ensure that the patient has given consent as per the Guidelines for consenting patients.

- Time is set aside for both GP trainee and trainer to view the consultation together during which time the trainer grades on the form each of the items as **I** (*insufficient evidence*) **N** (*needs further development*) **C** (*competent*) or **E** (*excellent*). A detailed guide to these performance criteria can be found in *COT: Detailed Guide to Performance Criteria*.
- The trainer then formulates a global judgement for the overall consultation and offers formal feedback on the assessment conducted with recommendations for further work and development by the trainee.

How many consultations should be viewed?

One consultation should be viewed for in-training assessment purposes at each “sitting.” Prior to an interim review at 6 months, six such assessments should be made, thus allowing the exploration of a minimum total of 12 cases over a training year spent in general practice.

Assessors

While the trainer may well conduct the majority of these assessments, it is recommended that in order to improve reliability of this tool at least one other assessor (another trainer or course organiser or programme director) is involved in rating a few of the cases.

Consultation selection

Consultations should be selected across a range of patient contexts and over the entire period of training spent in general practice and should include at least one case from each of the following categories:

- Children (a child aged 10 or under)
- Older adults (an adult aged more than 75 years old)
- Mental health

It is likely that more evidence will be generated from consultations with greater complexity.

5.5 CASE BASED DISCUSSION (CBD)

Case-based discussion (CBD) is a structured interview designed to explore professional judgement exercised in clinical cases which have been selected by the GP trainee and presented for evaluation. Evidence collected through CBD interviews (called 'Discussions' below) will support the judgements made about trainees at the interim and final reviews throughout the entire programme of GP training. The CBD tool has been designed to be used in both hospital and GP settings.

Professional judgement may be considered as the ability to make holistic, balanced and justifiable decisions in situations of complexity and uncertainty. It may include the ability to make rational decisions in the absence of complete information or evidence, and to take action or even do nothing in such situations. It requires a selection of attributes: recognising uncertainty/complexity, application or use of medical knowledge, application or use of ethical and legal frameworks, ability to prioritise options, consider implications and justify decisions.

How to start

- The GP trainee is responsible for selecting cases, organising the Discussion and ensuring the paperwork is properly completed.
- The trainee should ensure that a balance of cases are represented including those involving children, mental health, cancer/palliative care and older adults, across varying contexts i.e. surgery, home visits and out-of-hours contacts.

How many cases should be discussed?

Years ST1 and ST2

- For each Discussion the trainee will select two cases and present copies of the clinical entries and relevant records to the assessor one week before the discussion.
- The assessor selects one of the cases for discussion.

Prior to each interim review, discussions of a minimum of 3 cases should have taken place, discussing 3 out of 6 cases. There will be 2 reviews each year, and therefore a minimum of 6 cases each year.

Year ST3

- For each Discussion the trainee will select four cases and present copies of the clinical entries and relevant records to the assessor one week before the discussion.
- The assessor selects one or two of the cases for each session, depending on time available.

Prior to the 30 month review, discussions of a minimum of 6 cases should have taken place. If one case is discussed at each session, then there would have been 6 cases from a possible 24 during the six months. If two cases are discussed at each session, then there would have been 12 cases from a possible 24.

Prior to the final review, discussions of a minimum of 6 more cases should have taken place, discussing 6 more cases from a possible 24.

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 e-portfolio 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 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 GP 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. 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?

CBD Notes Sheet

	Proposed questions	Evidence obtained
Practising holistically		
Data gathering and interpretation		
Making diagnoses /decisions		
Clinical management		
Managing medical complexity		
Primary Care Administration and IMT		
Working with colleagues and in teams		
Community orientation		
Maintaining an ethical approach to practice		
Fitness to practise		

CBD Form

Doctor's Surname	Forename	GMC Number
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Clinical setting: Name of organization:	Hospital	General Practice
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<i>Please tick, referring to the competency area descriptors in the e-portfolio</i>	Insufficient evidence or not assessed	Needs further development	Competent	Excellent
Practising holistically				
Data gathering and interpretation				
Making diagnoses/decisions				
Clinical management				
Managing medical complexity				
Primary care administration/IMT				
Working with colleagues and in teams				
Community orientation				
Maintaining an ethical approach				
Fitness to practise				

Overall assessment: Please tick			Feedback and recommendations for further development:
Needs further	Competent	Excellent	
Agreed action:			
Assessor's signature:			Date
Assessors name			Time taken for discussion
			Time taken for feedback

5.6 MULTI-SOURCE FEEDBACK (MSF)

This tool provides a sample of attitudes and opinions of colleagues on the clinical performance and professional behaviour of the GP Registrar (GPStR) and helps to provide data for reflection on performance and gives useful feedback for self-evaluation.

MSF will take place as follows:

During months 5 or 6 (Specialty Training Year 1) and then 2 months later;
5 clinicians completing both questions.

During months 28 or 29 or 30 (Specialty Training Year 3) and then 2 months later; 5 clinicians completing both questions and 5 non-clinicians completing question 1.

Process: Obtaining Feedback (using the MSF tool)

1. GPStR and trainer should agree a date for the MSF and a date for the GPStR and trainer to discuss the feedback generated by the MSF. It is important that protected time is set aside for the interview, which will be held after the closing date for responses.
2. GPStR selects 5 clinicians, mainly GPs when in primary care and 5 clinicians with different job titles when in secondary care.
3. GPStR gives all respondents the instruction letter which explains the process and gives details of how to input, and the closing date by which their feedback should be given.
4. Respondents connect to internet and log onto www.eportfolio.rcgp.org/forms when it goes live in August, giving name and GMC number of the registrar. They will use a 7 point grade and enter feedback comments in two free text boxes. Clinicians, who will be asked for their GMC or NMC number, will answer both questions. Non-clinicians answer just question 1.

Process: Using Feedback (how the MSF feedback will be generated and used)

5. The results will be anonymous to the GPStR and trainer.
6. On the closing date the results will be sent to the trainer by email. They can also be accessed by the Deanery and RCGP if necessary.
7. Results will show the free text comments and the breakdown of scores, with a comparison of scores for other GPStR taking the equivalent MSF (i.e. in ST1). There will also be information on the mean, median and range of scores.

8. The trainer should familiarise him or herself with the feedback prior to the interview and pay particular attention to the free text comments.
9. The trainer should try and assimilate the numerical scores and free text comments within the context of the trainee's overall performance to date. The trainer then allows the data to be forwarded to the ePortfolio of the GPStR.
10. The trainer should ensure that the GPStR understands the background to the use and purpose of the MSF tool.
11. The interview should be conducted in protected time with no interruptions. Different individuals may require different lengths of time for reflection. It may be necessary to schedule the feedback for more than one occasion in order to make best use of data.
12. The trainer's skill in feedback will be vital to this process.
13. The data will include the mean, median and range of scores. Discussion should centre around the GPStR's expectations in relation to these scores.
14. In order to evaluate the success (or otherwise) of the feedback process, it is suggested the Trainer and Trainee Diary is used, or another diary system is used.
15. If the trainer has any areas of serious concern regarding either the content of the assessment or anticipated difficulties in giving feedback he/she should contact their local course organiser/associate adviser for further discussion prior to interview.
16. The second MSF should take place two months after the first. This will be soon after the interview for the first.

A version of the MSF form follows.

RCGP MSF Form

Part 1						
This part should be completed by all respondents						
Please select the most appropriate description which defines your Job Title:*	<input type="text" value="Select"/>					
Please provide your assessment of this doctor's overall professional behaviour*						
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Very Poor	Poor	Fair	Good	Very Good	Excellent	Outstanding
Notes: You may wish to consider the following:						
The doctor...						
<ul style="list-style-type: none">• is caring of patients• is respectful to patients• show no prejudice in the care of patients• communicates effectively with patients• respects other colleagues' roles in the health care team• works constructively in the health care team• communicates effectively with colleagues• speaks good English and at an appropriate level for patients• does not shirk his/her responsibilities• demonstrates commitment to their work as a member of the team• takes responsibility for own learning						
Comments (Where possible please justify comments with examples)						
Highlights in performance (areas to be commended)*						
<div style="border: 1px solid black; height: 60px; width: 100%;"></div>						
Possible suggested areas for development in performance*						
<div style="border: 1px solid black; height: 60px; width: 100%;"></div>						

Part 2

To be completed by Clinical staff only

Please provide your assessment of this doctor's overall clinical performance

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Very Poor	Poor	Fair	Good	Very Good	Excellent	Outstanding

Notes: You may wish to consider the following:

The doctor's ability to...

- *conduct a thorough history and physical*
- *identify patients' problems*
- *take a diagnostic patient-centred approach*
- *select appropriate diagnostic tests*
- *involve members of the primary health care team appropriately*
- *learn from clinical practice*
- *perform clinical and technical skills skillfully*
- *manage time appropriately*

Comments (Where possible please justify comments with examples)

Highlights in performance (areas to be commended)*

Possible suggested areas for development in performance*

Acknowledgements: This two question Multi-Source Feedback (MSF) was developed by Drs Douglas Murphy, David Bruce and Kevin Eva on behalf of NHS Education Scotland (2005-2006). The measure is available for use free of charge for staff of the NHS and for research purposes, but cannot be used for commercial purposes. Anyone wishing to use the measure should contact and register with either Douglas Murphy douglas.murphy@nes.scot.nhs.uk or David Bruce david.bruce@nes.scot.nhs.uk .

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5.7 DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS)

DOPS is designed to provide feedback on procedural skills essential to the provision of good clinical care. The mandatory procedures chosen have been selected as sufficiently important and/or technically demanding to warrant specific assessment. Trainees will be asked to undertake observed encounters during the three years with a different observer for each encounter. Each DOPS should represent a different procedure. The registrar chooses the timing, procedure and observer.

There are **6 mandatory procedures** to be covered:

1. Breast examination
2. Female genital examination
3. Prostate examination
4. Male genital examination
5. Rectal examination
6. Cervical cytology

Some of these procedures may be combined e.g. prostate and rectal examinations

There are **9 optional procedures** which should be recorded, if undertaken:

1. Cryotherapy
2. Cauterisation
3. Aspiration of effusion
4. Joint and peri-articular injections
5. Hormone replacement implants of all types/any types
6. Curettage/shave excision
7. Incision & drainage of abscess
8. Excision of skin lesions
9. Proctoscopy

In addition, should the educational need arise, registrars may be requested to repeat DOPS assessment of Foundation procedural skills.

Assessors

Experienced SpRs, staff grades, appropriate nursing staff or consultants in a secondary care setting, or the GP trainer, appropriate nurses or other GPs in a primary care setting.

Number of assessments

One for each procedure, for at least the 7 mandatory procedures

Estimated time required

10 - 20 minutes (5 - 15 minutes for assessment, 5 minutes for feedback)

5.8 CLINICAL SUPERVISOR'S REPORT

Clinical Supervisor's Report (General Practice Specialty Training)

The appearance of this form will be slightly different on the internet. It will conform to the RCGP style.

The purpose of this report is to inform the regular reviews that are conducted of a GP specialty registrar's progress through structured training. The report should reflect your experience of the trainee's performance during their clinical placement and should be discussed with the trainee before submitting.

The report relates to three main areas:

- Knowledge (relevant to the placement)
- Practical skills
- Professional competencies

The Trainee	Full name	GMC Number
	Date of Birth	National training number
	Address	

The Post or Placement	Hospital/Institution	Specialty	
	Address		
	Months	Fromday.....month.....year	Today.....month.....year
	<ul style="list-style-type: none"> • The training was full-time <i>Please delete as appropriate</i> • The training was part-time and the ratio of part-time to full-time was..... 		

1. Knowledge-base relevant to the placement

Insufficient Evidence	Needs Further Development	Competent	Excellent
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Feedback on areas for further development

2. Practical Skills relevant to the placement

Insufficient Evidence	Needs Further Development	Competent	Excellent
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Feedback on areas for further development

3. Professional Competencies

	Insufficient Evidence	Needs further development	Competent	Excellent
1. Communication and consultation skills ⁱ				
2. Practising holistically ⁱⁱ				
3. Data gathering and interpretation ⁱⁱⁱ				
4. Making diagnosis/ making decisions ^{iv}				
5. Clinical Management ^v				
6. Managing medical complexity ^{vi}				
7. Primary care administration and IMT ^{vii}				
8. Working with colleagues and in teams ^{viii}				
9. Community orientation ^{ix}				
10. Maintaining performance, learning and teaching ^x				
11. Maintaining an ethical approach to practise ^{xi}				
12. Fitness to practise ^{xii}				

Feedback on areas for further development

Endorsement	Endorsement by Clinical Supervisor
	<p>I confirm that the above is based on my own observations and the results of workplace-based assessments and has been discussed with the trainee concerned</p> <p>Name _____ Signed _____ Date _____</p>

Notes:

ⁱ This competency is about communication with patients and the use of recognised consultation techniques. Behaviours you may wish to consider: listening well, exploring patients ideas, providing good explanations, checking the patient' s understanding, tailoring communication to the patient' s needs.

ⁱⁱ This competency is about the ability of the doctor to consider physical, psychological, socioeconomic and cultural aspects, taking into account feelings as well as thoughts. Behaviours you may wish to consider: exploring the way in which the problem affects the patient's life, exploring the impact of the problem on the patient' s family/carers

ⁱⁱⁱ This competency is about the gathering and use of data for clinical judgement, the choice of examination and investigations and their interpretation. Behaviours you may wish to consider: systematically gathering information, using questions that are appropriately focused, making use of existing information, choosing physical examinations and targeting investigations appropriately, making appropriate inferences from the findings and results.

^{iv} This competency is about a deliberate, structured approach to decision-making. Behaviours you may wish to consider: clarifying the decision that is required, integrating information to aid pattern recognition, using probability to decide what is likely, revising hypotheses in the light of further information, thinking flexibly around the problem

^v This competency is about the recognition and management of medical conditions. Behaviours you may wish to consider: recognising common presentations, utilising the natural history in management decisions, using simple measures when appropriate, varying management options when required, prescribing appropriately, referring appropriately and coordinating care with other colleagues, responding quickly and skilfully in emergencies.

^{vi} This competency is about aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty, risk and thinking about health rather than just illness. Behaviours you may wish to consider: simultaneously managing the patients health problems both acute and chronic, tolerating uncertainty where this is unavoidable, explaining risks associated with management to the patients, encouraging patients to have a positive approach to their health.

^{vii} This competency is about the appropriate use of primary care administration systems, effective record-keeping and information technology for the benefit of patient care. Behaviours you may wish to consider: using administrative and computer systems appropriately, keeping good clinical records (timely, coded, sufficiently comprehensive)

^{viii} This competency is working effectively with other professionals to ensure patient care, including the sharing of information with colleagues. Behaviours you may wish to consider: being available to colleagues, working cooperatively, sharing information with others involved in the patient's care, using appropriate methods of communication according to the circumstances.

^{ix} This competency is about the management of the health and social care of patients in the local community. Behaviours you may wish to consider: identifying important characteristics of the local community that might impact upon patient care, particularly the epidemiological, social, economic and ethnic features, using this understanding to improve patient management, identifying resources in the community, encouraging patients to access available resources, using health care resources effectively e.g. through cost-effective prescribing.

^x This competency is about maintaining the performance and effective continuing professional development of oneself and others. Behaviours you may wish to consider: appropriately using evidence-based medicine, keeping up-to-date, identifying and addressing learning needs, participating in audit and significant event reviews, Contributing to the ongoing learning of students and colleagues

^{xi} This competency is about practising ethically with integrity and a respect for diversity. Behaviours you may wish to consider: Identifying and discussing ethical issues in clinical practice. Treating patients, colleagues and others fairly and with respect for their beliefs, preferences, dignity and rights. Valuing differences between people and avoiding prejudice.

^{xii} 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. Behaviours you may wish to consider: observing the accepted codes of professional practice, allowing scrutiny and justifying professional behaviour to colleagues, achieving a healthy balance between professional and personal demands, seeking advice and engaging in remedial action where personal performance is an issue

5.9 ENHANCED TRAINER'S REPORT (ETR)

This document can be found by going to:

www.gpcurriculum.co.uk/Downloads/ETR.pdf