# A BRIEF GUIDE TO WORKPLACE BASED ASSESSMENT IN THE nMRCGP

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September 2007

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## 1. INTRODUCTION

The nMRCGP is an integrated training and assessment programme that comprises three complementary components:

- Applied Knowledge Test (AKT)
- Clinical Skills Assessment (CSA)
- Workplace based assessment (WPBA).

Each of these components is assessed independently and all three must be completed successfully in order for a GPStR to be eligible for a Certificate of Completion of Training and for full membership of the RCGP. Together the three components cover the curriculum for specialty training in general practice. The curriculum and the assessment programme have been approved by PMETB.

## 2. WORKPLACE BASED ASSESMENT

Workplace based assessment (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. It is a process through which evidence of competence in independent practice is gathered in a structured and systematic framework. Evidence is collected over all three years of training. The evidence is recorded in a web-based portfolio (the ePortfolio) and used to inform six monthly reviews (*see section 12*) and, at the end of training, to make a holistic, qualitative judgement about the readiness of the GPStR for independent practice.

WPBA is a developmental process. It will therefore provide feedback to the GPStR and drive learning. It will also indicate where a doctor is in difficulty. It is learner led: the GPStR decides which evidence to put forward for review and validation by the trainer. It is delivered locally by deaneries.

### What does WPBA Involve?

WPBA consists of a framework of twelve areas of professional competence (*these are described in section 3*) against which evidence is gathered using designated and validated tools. The use of each tool serves as an episode of evidence collection. The WPBA tools ensure the evidence is collected in the same way for each GPStR, and promote consistency among trainers and across deaneries.

The use of the tools does not involve pass/fail assessments; the judgement may be one of insufficient or inadequate evidence, particularly in the early stages of training, but this simply points to the need for further training. At regular points during training all the evidence available from the trainee is reviewed and a judgement is made about progress through each area of professional competence.

WPBA involves making qualitative not quantitative judgments. As the GPStR proceeds through training it would normally be expected that evidence of competence is demonstrated and the degree of readiness to practise is built up. The picture becomes clearer as more evidence is gathered.

The WPBA tools are:

- Case-based Discussion
- Consultation Observation Tool (in primary care only)
- Multi-Source Feedback
- Patient Satisfaction Questionnaire (in primary care only)
- Direct Observation of Procedural Skills (in hospital posts)
- Clinical Evaluation Exercise (Mini-CEX) (in hospital posts)
- Clinical Supervisors Report (in hospital posts).

**Why do we use WPBA**?

There are number of reasons for using WPBA:

- WPBA connects teaching, learning and assessment; it enables GPStRs to know what is expected of them and to demonstrate attainment over time.
- It offers authenticity: it allows the assessment to get as close as possible to the real situations in which doctors work.
- Some competences are not assessed effectively in any other way, e.g. probity or team working. Assessment of performance in the workplace provides us with the only route into many aspects of professionalism.
- It will provide feedback to the GPStR on areas of strength and developmental needs. There will be clarity and transparency about the outcomes of training at regular intervals throughout the training programme.
- WPBA is in keeping with the guidance from PMETB for all specialties and continues the approach which is used in the Foundation Programme.

**When is WPBA carried out?**

WPBA continues throughout the three years of GP specialty training. There are guidelines on how often each WPBA tool should be used to ensure there is a sufficiency of evidence at the point of each six monthly review. In some cases, if the evidence is inadequate or insufficient, the trainer and the GPStR will agree a plan to improve competence and may decide to apply the tools more frequently. All the evidence used in WPBA must be collected during the three year training period.

**FAQs**

**Q**: How does WPBA fit in with A Guide to Postgraduate Specialty Training in the UK (the Gold Guide)?
**A**. The WPBA arrangements in relation to educational supervision and the Annual Review of Trainee Competence Progression (ARCP) are set out in the Gold Guide to Specialty Training.

**Resources**

Deighan M. *The Learning and Teaching Guide*. London: Royal College of General Practitioners, 2007.
Swanwick, T and Chana, N. Workplace assessment for licensing in general practice. Discussion Paper. British Journal of General Practice. June 2005. pp 461-467

## 3. THE COMPETENCE FRAMEWORK

The competences which form the framework for WPBA are derived from the first Curriculum Statement, “Being a GP”. All trainers should have received a printed copy of this Statement through their deanery.

**What are the competences which form the framework for WPBA**?

The competence framework is set out below:

**1. Communication and consultation skills.** This competence is about communication with patients, and the use of recognised consultation techniques.

**2. Practising holistically:** 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:** 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 competence is about a conscious, structured approach to decision making.

**5. Clinical management:** the recognition and management of common medical conditions in primary care.

**6. Managing medical complexity and promoting health:** 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:** 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:** working effectively with other professionals to ensure patient care, including the sharing of information with colleagues.

**9. Community orientation:** the management of the health and social care of the practice population and local community.

**10. Maintaining performance, learning and teaching:** maintaining the performance and effective continuing professional development of oneself and others.

**11. Maintaining an ethical approach to practice:** practising ethically with integrity and a respect for diversity.

**12. Fitness to practise:** 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.

**How are the competences assessed?**

The competences are not content base but can be evidenced in a variety of different settings during training. There will be a process of triangulation whereby competences are assessed using different tools. Evidence of the competences should reflect the breadth of the curriculum but it is not expected that every area of the curriculum will be covered through WPBA. Some areas will be tested more appropriately through other components of the nMRCGP, the Applied Knowledge Test (AKT) or the Clinical Skills Assessment (CSA). The competences are assessed through a process of multiple sampling, providing multiple perspectives on the performance of the GPStR.

Evidence in each of the competence areas is gathered in different settings during the three years of training. Most GPStRs will not be able to show evidence of competence at the beginning of their training but will gradually build up evidence as training progresses. As the evidence in the e Portfolio begins to demonstrate where there are areas of strength and where there are developmental needs, then trainers will adapt the learning programme to facilitate collection of new evidence. The picture of competence should become more rounded and complete as the GPStR moves through the training programme.

Progress through each of the competence areas can be recorded as one of the following:

(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 is 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.

The WPBA tools where evidence for each competence is most likely to be found are shown below.

| Competence 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 and teaching | ✓ | | | | ✓ | ✓ |
| Maintaining an ethical approach | ✓ | | | ✓ | | ✓ |
| Fitness to practise | ✓ | | | ✓ | | ✓ |

The ePortfolio provides developmental descriptions (or word pictures) for each competence area and these will help to ensure trainers are making consistent judgements.

**FAQs**

**Q.** Why are there twelve competence areas when "Being a GP" lists only six?
**A**. The competences in the Curriculum Statement needed to be operationalised in a way which could be assessed. Some of the original competences needed to be sub-divided and made more specific to make it easier for trainers to identify appropriate evidence.

**Q**. Can you give me a definition of competence?
**A**. The PMETB defines being competent as having the requisite or adequate ability, having acquired the knowledge and skills necessary to perform those tasks which reflect the scope of professional practices. It may be different from performance which denotes what someone is actually doing in a real-life situation.

**Resources**

Being a GP. RCGP Curriculum Statement No.1 (Available to GP trainers through their deaneries and on the RCGP website)

Workplace Based Assessment. A paper from the PMETB Workplace Based Assessment Subcommittee. Jan 2005. http://www.pmetb.org.uk/media/

## 4. CASE-BASED DISCUSSION

**What is Case-Based Discussion**?

Case-based discussion (CbD) is a structured interview designed to explore professional judgement exercised in clinical cases which have been selected by the GPStR and presented for evaluation. Evidence collected through CbD will support the judgements made about the GPStRs at the six monthly and final reviews throughout the entire programme of GP specialty training. The CbD tool has been designed to be used in both hospital and GP settings.

CbDs may be carried out by GP trainers or educational supervisors or clinical supervisors, according to the arrangements made in each deanery

**How is a Case-Based Discussion Carried Out?**

The GPStR is responsible for selecting cases, requesting a CbD and ensuring the paperwork is properly completed. The GPStR and the trainer 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.

In ST1 and 2, the GPStR will select two cases and present copies of the clinical entries and relevant records to the clinical supervisor or educational supervisor one week before the discussion. The clinical or educational supervisor selects one of the cases for discussion. The discussion should be framed around the actual case and should not explore hypothetical events. Questions should be designed to elicit evidence of competence and should not shift into a test of knowledge.

In ST3, the GPStR will select four cases and present copies of the clinical entries and relevant records to the trainer or educational supervisor one week before the discussion. The trainer or educational supervisor selects one or two of the cases for discussion, depending on time available.

The trainer or educational supervisor records the evidence harvested for the CbD in the ePortfolio against the appropriate competence areas.

Trainers or educational supervisors should aim to cover as many competences as are relevant to each case and can be covered in the time frame. It is unreasonable to expect that all the competences will be covered in a single CbD but if too few are considered useful evidence will be overlooked and there would be inadequate sampling of all the competences. It is helpful to tell the GPStR at the beginning of the discussion which competence areas you expect to look at.

It is recommended that each discussion should take about thirty minutes, including the discussion itself, completing the rating form and giving feedback to the GPStR.

**How Many? How Often**?

A minimum of six CbDs should be carried out in each of ST1 and ST2 (three before each six month review) and twelve CbDs should be carried out in ST3 (six before the six month review and six before the final review).

These minimum requirements apply whether the GPStR is in a placement in primary or secondary care and whether they are in full time training or less than full time training. More CbDs can be done if this is agreed between the trainer and the GPStR. There may be occasions, for example, when the GPStR is short of evidence in a particular competence area and another one or two CbDs might help to fill this gap.

**FAQs**

**Q**. What sort of paperwork should the GPStR produce?
**A**. Just the actual written notes relating to the case under discussion. This might be paper-based or viewed on a computer screen.

**Q.** One or two CbDs at one sitting: does it matter?
**A**. No, it depends on how much time is available and what is agreed between the GPStR and whoever is doing the CbD.

**Q**. How much evidence relating to the CbD should be retained for quality assurance purposes?
**A**. Just the completed rating form, a note of areas for feedback and action points arising.

**Q**. How much should the trainer lead the GPStR in the questioning?
**A**. The trainer is eliciting evidence and may use any questioning style which they consider appropriate.

**Q**. Is it acceptable to use a case which has also been used for a debrief?
**A**. No, this would not be a CbD. The CbD and debrief should not be mixed but a debrief might occur after the CbD, for educational purposes.

**Resources**

Nav Chana, Patti Gardiner, Amar Rughani and Nicki Williams. *Talking the Talk: using case-based discussion in medical assessments.* London: Royal College of General Practitioners, 2007. This DVD and accompanying workbook on case-based discussion is on sale from the RCGP Bookshop.

Planning and Conducting the CbD Interview: available on the RCGP nMRCGP website http://www.rcgp.org.uk/docs/nMRCGP_How%20to%20plan%20and%20conduct%20the%20CBD%20interview.doc

CbD Structured Question Guidance: available on the RCGP nMRCGP website http://www.rcgp.org.uk/docs/nMRCGP_CBD%20Structured%20Question%20Guidance.doc

## 5. THE CONSULTATION OBSERVATION TOOL

The Consultation Observation Tool (COT**)** has been designed to be used by trainers as an evidence-collecting instrument to support the more holistic judgements made about GPStRs at the six monthly and final reviews when the GPStR is in primary care. The mini-CEX tool (*see section 8*) will be used for this purpose in a hospital setting.

### What is the Consultation Observation Tool?

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 GPStR and yield evidence which will be recorded in the ePortfolio. It is likely that more evidence will be generated from consultations with greater complexity.

The selected consultations are rated according to a set of criteria which have been developed from the experience with Summative Assessment and the MRCGP consultation skills module. These criteria are built into the ePortfolio.

### How is the Consultation Tool Applied?

The GPStR records a number of consultations on video and selects one for assessment and discussion, or the GPStR and the trainer agree on a prospective patient encounter which will be the subject of direct observation. In either case the patient must give consent in accordance with the guidelines for consenting patients.
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.

Time is set aside for both GPStR and trainer to view the consultation together during which time the trainer rates the evidence which they observe against the competence framework and COT criteria. The trainer then formulates a global judgement for the overall consultation and offers formal feedback on the consultation with recommendations for further work and development by the GPStR.

### How many? How often?

The requirement is for a minimum of six COTs or Mini-CEX in each of ST1 and ST2, (ensuring there are three before each six monthly review), and 12 COTs in ST3 (six before each six monthly review). The minimum requirement applies whether or not the GPStR is in full time training. If the GPStR spends some of their final year in hospital posts, then the point at which COTs take over from Mini-CEX may vary.

One consultation should be viewed at a time.

## FAQs

**Q.** Won't the GPStRs select the videoed consultations in which they think they did well?
**A.** Yes, probably, but this doesn't matter. If they are able to discriminate between good and poor consultations then they are showing professional development. However, GPsTRs should not be encouraged to spend a lot of time videoing different consultations. They need to understand that this is not a pass/fail exercise but just part of a wider picture of competence which they are building up.

**Q**. Are there any restrictions on the length of consultations to be videoed?
**A.** It is inadvisable for a consultation to be more than 15 minutes in duration, as the effective use of time is one of the performance criteria.

## Resources

COT: Detailed Guide to the Performance Criteria. Available on the RCGP nMRCGP website:
http://www.rcgp.org.uk/docs/nMRCGP_COT_Guide_to_Performance_Criteria.doc.

nMRCGP DVD: The COT. A Guide to the Consultation Observation Tool. Available from the RCGP bookshop and from the Wessex faculty office. £25, with discounts for RCGP members and associates. Discounts for bulk orders from the Wessex faculty office.

## 6. MULTI-SOURCE FEEDBACK

The Multi-Source Feedback (MSF**)** tool provides a sample of attitudes and opinions of colleagues on the clinical performance and professional behaviour of the GPStR. It helps to provide data for reflection on performance and gives useful feedback for self-evaluation.

### How to use the MSF

#### A. Collecting Feedback

The GPStR and trainer should agree a date for the MSF and a date for the GPStR and Educational Supervisor or GP Trainer or Clinical Supervisor 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.

The GPStR selects five clinicians with different job titles when in secondary care and five clinicians, mainly GPs, when in primary care. When the tool is used in primary care an additional five non clinicians are selected. All the respondents need to be people who have observed the GPStR in the workplace. The 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.
The Educational Supervisor or GP trainer (depending on the arrangements in each deanery) needs to be aware of which colleagues / staff members the GPStR invited to complete the MSF.

Respondents will connect to the internet and log onto the ePortfolio, giving name and GMC number of the GPStR. They will use a 7 point grade and enter feedback comments in two free text boxes. Clinicians will answer both questions. Non-clinicians answer just the first question.

The educational supervisor or trainer will verify with a sample of colleagues / staff members that they did indeed contribute to the MSF. It is important that when checking that colleagues or staff have contributed, that the educational supervisor or GP trainer is not made aware of any details of their entry to the MSF

#### B. Using Feedback

On the closing date the results will be sent to the Educational Supervisor. The results will be anonymous. Results will show the free text comments and the breakdown of scores. There will also be information on the mean, median and range of scores.
The Educational Supervisor will authorise the results to become available within the GPStR's ePortfolio and visible to the GP trainer. The GP Trainer or Educational Supervisor should try to assimilate the numerical scores and free text comments within the context of the GPStR's overall performance to date.

The feedback interview should be conducted in protected time with no interruptions. It will require excellent skills of giving feedback on the part of the interviewer. The interviewer should ensure that the GPStR understands the background to the use and purpose of the MSF tool. 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. Discussion should centre around the GPStR's expectations in relation to their scores.
The Professional Conversation log in the Education Section of the ePortfolio may be used to record the discussion and the action plan arising from it.

**How many? How often?**

Two cycles must be completed in ST1 (5 clinicians only) and two cycles in ST3 (5 clinicians and 5 non-clinicians).

**FAQs**

**Q**. Can the GPStR ask the same people to complete the MSF on both occasions or must they all be different? Is this feasible in small practices?
**A**. Yes, even GPStRs based in small practices should be able to identify sufficient clinical and non-clinical colleagues to complete the questionnaire.

**Q**. What happens if there is a poor response to the questionnaire?
**A**. Multi-source feedback is still possible if not all raters complete the questionnaire but efforts need to be made to get a good response.

**Q**. Should the GPStR see the raw feedback, including the free text, bearing in mind that it might be quite devastating?
**A.** The feedback will be sent first to the educational supervisor to enable them to prepare feedback based on the results. However, the unedited feedback will be sent to the GPStR.

**Resources**

The Multi-Source Feedback questionnaire is available as a word document on the RCGP nMRCGP website:
http://www.rcgp.org.uk/docs/nmrcgp_msf%20form%20from%20ePortfolio.doc

## 7. THE PATIENT SATISFACTION QUESTIONNAIRE

The Patient Satisfaction Questionnaire (PSQ) provides feedback to GPStRs by providing a measure of the patient's opinion of the doctor's relationship and empathy during a consultation. The evidence provided is useful in helping trainer and GPStR to address needs and facilitate educational development during the training period.

**How to Use the Patient Satisfaction Questionnaire**

**A. Obtaining Feedback**

The GPStR and trainer should agree a date for the PSQ and a date for the feedback interview. The questionnaires and letters of explanation should be handed to consecutive patients (irrespective of their likelihood of responding) by the receptionist. The receptionist and trainer should complete the declaration form and return to the Deanery.
Patients complete the questionnaire and hand them back to the receptionist. This should continue until 40 completed forms have been returned. This may take a number of days. The results should be entered into the GPStR's ePortfolio. Each deanery will decide who will do this.

**B. Using Feedback**

Once analysed, the results are sent to the Educational Supervisor. Results will be anonymous and will include mean, median and range for each question. The Educational Supervisor should l familiarises him/herself with the feedback prior to the feedback interview and assimilate the numerical scores within the context of the GPStR's overall performance. The Educational Supervisor can authorise the results to be transmitted to the GPStR's ePortfolio at any time. The GP trainer will then have access too.
The feedback interview should be conducted in protected time with no interruptions. It will require excellent skills of giving feedback on the part of the interviewer. 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. The interviewer should ensure that the trainee understands the background and purpose of the PSQ. Discussion should centre around the GPStR's expectations in relation to the mean, median and range for each question.
The Professional Conversation log in the Education Section of the ePortfolio may be used to record the interview and any action plan arising from it.

**How many? How often?**

The PSQ should be used once during months 31 to 34 (ST3, if in primary care). PSQ can take place in ST1 or ST2, if the GPStR is in primary care.
In other words the PSQ will be used only once if the GPStR is in general practice for 12 months but twice if they have more than 12 months in general practice.

**Resources**

A copy of the PSQ can be downloaded from the RCGP nMRCGP website:
**http://www.rcgp.org.uk/Docs/nMRCGP_all%20six%20assessment%20forms.doc**

## 8. 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 essential to providing high quality care.

**How to do a mini CEX**.

The Mini CEX may be overseen by the clinical supervisor, the trainer or the educational supervisor, depending on the arrangements in each deanery. The Mini CEX may be observed by staff grades, experienced specialty registrars or consultants.

Each Mini-CEX should represent a different clinical problem and GPStRs should sample from a wide range of problem groups by the end of the year. The interaction will be observed by a different observer on each occasion and the evidence will be rated and recorded in the ePortfolio. Immediate feedback will be provided by the observer rating the GPStR. A learning plan will be developed, based on the strengths and developmental needs observed.

**How many? How often?**

GPStRs will be expected to undertake six observed encounters (or COT in primary care) during ST1 and ST2 (three before each six month review).

## 9. DIRECT OBSERVATION OF PROCEDURAL SKILLS

Direct Observation of Procedural Skills (DOPS) is designed to provide feedback on procedural skills essential to the provision of good clinical care. The mandatory procedures have been selected as sufficiently important and/or technically demanding to warrant specific assessment.

### How to do DOPs

GPStRs will be asked to undertake observed encounters with a different observer for each encounter. They will normally be completed opportunistically during the first two years of training. Each DOPS should represent a different procedure. The GPStR chooses the timing, procedure and the observer. There may be a need to check that the skills have been retained and are used appropriately within the context of general practice.
The observers may be experienced SpRs, staff grades, appropriate nursing staff or consultants.

There are eight mandatory procedures to be covered:

Application of simple dressing
Breast examination
Cervical cytology
Female genital examination
Male genital examination
Prostate examination
Rectal examination
Testing for blood glucose

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

There are currently eleven optional procedures which should be recorded, if undertaken. The specific list will change from time to time. In addition, should the educational need arise, GPStRs may be requested to repeat DOPS assessment of Foundation procedural skills.

The eleven optional procedures are currently:

Aspiration of effusion
Cauterisation
Cryotherapy
Curettage/shave excision
Excision of skin lesions
Incision and drainage of abcess
Joint and peri-articular injections
Hormone replacement implants
Proctoscopy
Suturing of skin wound
Taking skin surface specimens for mycology

### How many? How often?

One DOPS should be carried out for each procedure, for at least the eight mandatory procedures. These need to be carried out until the mandatory skills log in the ePortfolio is complete. It is estimated that each DOPS will take between 10 and 20 minutes, including 5 - 15 minutes for assessment and 5 minutes for feedback.

## 10. THE CLINICAL SUPERVISORS REPORT

The Clinical Supervisors Report **(**CSR**)** forms part of the evidence which is gathered through WPBA**.** The ePortfolio has a section for the clinical supervisor to write a short structured report on the GPStR at the end of each hospital post. This covers:

- The knowledge base relevant to the post
- Practical skills relevant to the post
- The professional competences.

### What to do

The electronic form provides reminders of the definitions of the competences to make writing the report easier. It may also be helpful to refer to the relevant curriculum statement(s) on the RCGP website in reporting on the knowledge and skills relevant to the post.

The report should identify any significant developmental needs identified during a placement, and also point up any areas where the GPStR has shown particular strengths. The report should describe the progress of the GPStR in terms of the evidence of competence rather than pass or fail. This information will feed into the relevant six monthly reviews and at that point a decision will be taken as to whether additional training is needed.

### Resources

General practice specialty training: a brief guide for clinical supervisors. Available from deaneries and the RCGP website.

## 11. THE ePORTFOLIO

At the beginning of specialty training, when they register with the RCGP, each GPStR will be given access to the RCGP ePortfolio which will be used throughout the training period, in both hospital posts and primary care. It is accessed and updated through the internet. It is a record of learning with particular emphasis on clinical encounters. It can also capture details of achievement in the AKT and CSA and must be used in all stages of training to document evidence of WPBA.

### What is the ePortfolio?

Above all else the ePortfolio is where the GPStR records their learning in all its forms and settings. Its prime function is to be an educational tool that will record and facilitate the management of the journey of clinical and personal development through learning. It is the system used to record the evidence collected through the application of the WPBA tools. It might be described as the glue which holds the curriculum learning and assessment together.

All the facilities for recording applications of the WPBA tools are tagged to the competence areas so that an overall picture of competence is easily accessed. The trainer or educational supervisor will also have the opportunity to file items under a content heading

The ePortfolio should also be used to record and validate naturally occurring evidence against the competence framework. This is evidence which occurs in the course of practice and which illustrates the GPStR's competence. For example, the GPStR may do an evidence review on a specific topic and present it to a practice meeting. This might be taken as evidence of data gathering and interpretation, or communication skills. Evidence that a GPStR is late for surgeries on a regular basis might be discussed with the GPStR and recorded under teamwork. Naturally occurring evidence needs to be validated by the GP trainer.

The ePortfolio belongs to the GPStR but key parts of it are accessible to the trainer, educational supervisor and deanery administrators through a permissions system. All personal records will be hidden to all except the GPStR until they decide to share them. The ePortfolio includes places to record tutorials, formal educational sessions and a skills log. It has a diary and a mailbox. It will also contain links to learning resources that are being developed by the RCGP and has a personal area where individuals can save files, documents, certificates of learning and other digital materials.

Through the ePortfolio the GPStR can book places on the AKT and CSA and the results will come back into the portfolio. The Certification Unit of the RCGP will also be linked into the membership data and will receive the indication from the GPStR that they are ready for certification.

It is planned that the portfolio will eventually become the record for life-long learning.

**Why do we need an ePortfolio?**

By making use of the full capability of electronic systems, the ePortfolio can deliver all that is required to record, monitor and manage a GPStR's learning in one place.

A record of personal development and experience is becoming mandatory for all doctors. It provides evidence that training has taken place and allows the doctor to reflect on a range of learning opportunities.

By providing a structure for documenting the evidence harvested through WPBA tools, the ePortfolio helps to ensure that judgements about the GPStR's progress and achievement are based on a clear, systematically recorded picture of competence.

**FAQs**

**Q**: Where are significant events and audits recorded?
**A.** Demonstration of competence in competence area 10 (Maintaining performance, learning and teaching) explicitly requires the GPStR to provide evidence in these areas. Although the requirement to write a structured report (as in summative assessment) has been removed, the GPStR will still need to demonstrate competence in these areas by participating in significant event audits and clinical audit. The educational supervisor will assess competence in these areas by considering the evidence presented by the GPStR at the six monthly reviews.

## 12. REVIEWING THE EVIDENCE

WPBA is a process of collecting evidence to build up a qualitative picture of the GPStR's performance in training. The evidence collected in the ePortfolio will be reviewed at six monthly intervals by either the educational supervisor or the trainer (arrangements differ between deaneries) and there will be a final, holistic judgement (the final ARCP) at the end of training which will be based on a synthesis of all the evidence.

### How will the reviews be carried out?

For the six monthly reviews, the GPStR will first conduct a self-assessment. Progress will be assessed by the trainer or educational supervisor against each of the twelve competence areas. Each review will be informed by the evidence collected through the WPBA tools, augmented by any naturally occurring evidence. A learning plan will then be agreed. All this information will be recorded in a standardised format in the ePortfolio. It is anticipated that the review will take somewhere between 1 and 2 hours.

The reviews provide an opportunity to consider the breadth of coverage of the curriculum as well as the specified competence areas. It maybe useful to refer to the blue print, which demonstrates how different areas of the curriculum might be related to training experience but this should not be used as a rigid checklist

The reviews will not cover evidence of learning that is rich in knowledge, such as may arise from tutorials. However, this type of evidence will allow the GPStR and the trainer to monitor how the knowledge base of the curriculum is being covered in preparation for the AKT.

In the early stages of training it is unlikely that the GPStR will be able to provide evidence of readiness to practise. The structured evidence, considered against the competence framework will highlight the areas where the GPStR is doing well and those areas where more learning and support is needed. Thus each of the six monthly reviews will lead to a learning plan designed to enable the GPStR to collect more evidence of competence and to build up a richer picture of readiness for practice.

Toward the end of training a final review is conducted, this time without the self assessment of the GPStR. The trainer or educational supervisor will make a recommendation to the deanery regarding the overall competence of the GPStR. This recommendation will be subject to external moderation in the deanery by an expert panel including a lay person and a representative of the RCGP.

### What standards should be used?

The standard against which the GPStR is judged is always the level of competence expected of a doctor who is certified to practise independently as a general practitioner. This standard is used throughout the three years of training. This means that in the first two years of training the GPStR is being judged against the standard they should have reached at the end of training. Inevitably there will be less evidence from the application of the WPBA tools in the first two years of training, and more developmental needs will be identified. This is what the assessment system is designed to do, so that further training experiences can be directed toward the developmental needs of GPStRs.

The GPStR must show competence in all twelve competence areas by the end of year 3.

Trainers are expected to use their personal experience as a GP to judge whether the evidence for each competence area and the totality of evidence indicate that the GPStR is ready for independent practice.

**Why do we have six-monthly reviews?**

The six monthly reviews are used to provide feedback to the GPStR on overall progress, to identify areas where there needs to be more focused training and to identify doctors in difficulty. These reviews must be carried out even if they do not coincide exactly with the end of placements. This ensures there is sufficient evidence for useful feedback to be offered on every occasion. Doctors training flexibly are also required to undergo reviews at six monthly intervals and must collect the same amount of evidence for each review as full time trainees.

**FAQs**

**Q.** Should appraisals be incorporated into the review process?
**A**. The six monthly reviews are educational appraisals. The evidence collection and regular review process should satisfy any modification of the NHS appraisal process.

**Q**. What would an educational supervisor or trainer do if they have concerns about a GPStR?
**A**. The educational supervisor would follow the arrangements in their deanery for reporting concerns. Educational supervisors will need to be familiar with these arrangements, particularly in respect of serious concerns which arise outside the cycle of deanery panels. Serious issues of professional performance or ill health during hospital training will need to be handled by normal trust/PCT/deanery mechanisms.

**Q**. Should there be calibration of CbDs and COTs at scheme or at deanery level?
**A**. This is not necessary as these tools simply serve to gather information which is considered at the six monthly reviews. Although each CbD or COT is pushing the trainer to make judgements against the competences, the purpose of this is to elicit information which feeds into the overall picture of the GPStR and generates feedback to them. There is no pass or fail for CbDs and COTs or for any other separate WPBA tool.

**Q**. How much evidence of each competence does a GPStR need in order to complete the WPBA?
**A**. Assessment of competences is about making a qualitative judgement not a quantitative one. We would expect that at the end of ST3 the GPStR will have several sets of evidence in each competence area, collected from a range of settings and through different tools. However, the only requirement is that there is enough evidence to enable the trainer to feel confident that the GPStR is competent to practise. Each portfolio will look slightly different, but it should provide a rich picture of competence built up over three years. The “ticks” in the ePortfolio are simply a way of keeping a shared, transparent and systematic record of evidence.

**Q**. How do we record when a trainee is poor at his or her work, or incompetent?
**A**. The process of workplace based assessment is about recording when and at what level an individual demonstrates competence. If an individual is incompetent there are often reasons related to employment or personal reasons why that may be so, and they need to be addressed through the appropriate channels. Any probity issue should of course be recorded within the ePortfolio.

## 13. QUALITY ASSURANCE OF WORKPLACE BASED ASSESMENT

Deaneries are responsible for the management of the quality of WPBA locally. The RCGP has overall responsibility for ensuring quality through the design and development of the WPBA tools, providing national training and ensuring that deaneries are covering the curriculum and making consistent final decisions about the GPStRs.

### How is quality assured?

The clear specification of competence areas with the developmental word pictures will contribute to a uniformity of interpretation of the curriculum across deaneries.

Training GP trainers and educational supervisors is a key feature of quality management. The RCGP will provide at least one annual workshop for representatives selected by deaneries, and deaneries will provide local training where a shared understanding of the competence framework will be developed.

The main level of quality assurance and calibration is at the point of making the final, holistic summative judgement on the basis of a complete ePortfolio. EPortfolios will be reviewed by panels convened for this purpose by deaneries. An external assessor, recruited and trained by the RCGP, will be involved in this process to add further quality assurance.

### FAQs

**Q.** Is it acceptable to involve a second trainer in the review of evidence from a COT or CbD?
**A.** Yes. Trainers are encouraged to involve another local trainer in the assessment of some of the CbDs or COTs, in order to gain a shared understanding of the tools and to gain confidence in reviewing the evidence they yield. This is not mandatory but is one possible way of assuring quality.

## APPENDIX 1.

Summary of Evidence Collection

### Work Place Based Assessment Tools

In order for the trainer or educational supervisor to be in a position to monitor the progress of their GP trainee in the twelve work place based assessment professional competence areas, information relating to their performance needs to be collected throughout the training period using these tools:

**Case-based Discussions (CbD)**
Minimum number of assessments: 3 per six monthly review in ST1, 3 per six months in ST 2 and 6 per six months in ST3.

**Consultation Observation (COT)** in primary care or **Mini-CEX** in secondary care
Minimum number of assessments: 3 per six monthly review in ST1, 3 per six months in ST2 and 6 per six months in ST3.

**Direct Observation of Procedural Skills (DOPS)**
Candidates must be assessed in eight mandatory procedures and eleven optional procedures may also be attempted.

**Multi-Source Feedback (MSF)**
Two cycles must be completed in both ST1 (5 clinicians only) and ST3 (5 clinicians and 5 non-clinicians).

**Patient Satisfaction Questionnaire (PSQ)**
One cycle of 40 forms must be completed if the GPStR spends 12 months in primary care (in ST3). For GPStRs who spend more than 12 months in primary care a cycle should also be completed in ST1 or ST2 as appropriate.

There will also be **evidence recorded through direct observation** of the trainee by the trainer when in primary care and **Clinical Supervisors' Reports (CSR)** whilst in secondary care.